

## COMMISSIONING RECOVERY: PIECE TOGETHER A COHERENT PICTURE

*“We cannot overcommunicate with commissioners” – getting addicts into rehab nowadays means many organisations, people and processes all contributing to the jigsaw that makes up a complete person in recovery. Huseyin Djemil guides.*

I was working with an abstinence-based residential rehabilitation centre for addicts recently: it had called me in because referrals to the rehab were low, as were resident numbers, and it needed help. The staff felt they were doing what they had always done, that they had remained consistent – and so something else must be the cause of their current difficulty.

If you read my last blog (<http://thegoodconsultant.blogspot.com/2011/10/commissioner-prime-provider-or-new-gang.html>), you will know that I am an advocate of resi rehab and of recovery. I am in recovery today due in no small measure to my experiences in rehab over 25 years ago.

Working with rehabs to turn them round is not unlike a rehab working with a patient to help them get their life back on track. It is tough. It is made worse because the rehab, like the patient, must arrive at their own conclusions, find and muster their own motivation and eventually take responsibility for themselves. As the facilitator of this process, you often ‘see’ things before the client does but must work with them so that they gain an understanding of the problem and the possible solutions for themselves.

Asking for help is a good first step, even if the motivation is often triggered not by a genuine desire to change, but because of impending doom such as low resident numbers, poor financial state, difficulties retaining residents and/or staff, and similar scenarios.

This particular rehab, like others I worked with, was frustrated at low resident numbers. In reality, staff were doing what they had always done, but in a world where things have been getting progressively worse for resi rehabs. And, because the promise of the new “recovery” strategy had not yet actualised, doing what they had always done is no longer good enough.

After an initial chat with the director and one of the trustees, I agreed an initial scoping exercise, to lead to a firm and comprehensive plan of action. Scoping would cover all aspects of the client journey from pre-referral to exit and aftercare.

● This meant looking at how the rehab communicated its presence to the outside world: where was it listed, its website and literature, how it generated referrals, how it initiated and sustained relationships with commissioners both locally and further afield, what ‘outside’ meetings its staff attended, did it have open days for commissioners / referrers etc.

● I looked at what happens when referrals are received, how quickly enquiries were followed up, what data systems were in place for referrals, clients on the waiting list, commissioners, etc (data systems need to be about retrieval not storage). I also assessed how up-to-date the referrals and admissions staffs were with the *Community Care Act*, and Department of Health and National Treatment Agency guidance etc.

● I walked a typical client through the process of induction and went through the normal contracting process in some detail to see how effective the rehab systems were for new residents and for commissioners alike.

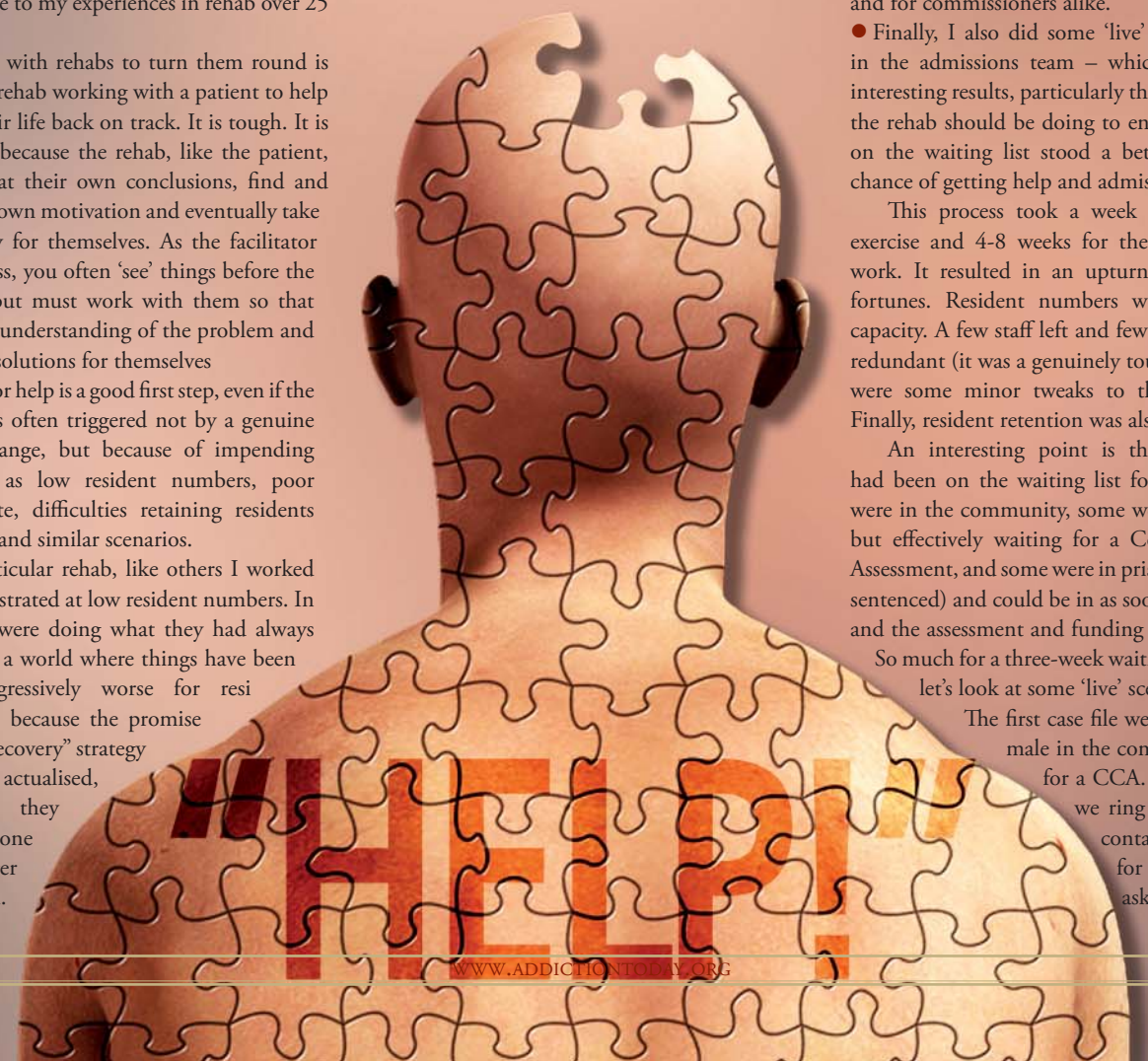
● Finally, I also did some ‘live’ work with staff in the admissions team – which yielded some interesting results, particularly that there was a lot the rehab should be doing to ensure that people on the waiting list stood a better-than-average chance of getting help and admission.

This process took a week for the scoping exercise and 4-8 weeks for the more intensive work. It resulted in an upturn in that rehab’s fortunes. Resident numbers were up to near capacity. A few staff left and few had to be made redundant (it was a genuinely tough time). There were some minor tweaks to the programmes. Finally, resident retention was also up.

An interesting point is that some clients had been on the waiting list for months, some were in the community, some were ‘rehab ready’ but effectively waiting for a Community Care Assessment, and some were in prison (remand and sentenced) and could be in as soon as her majesty and the assessment and funding process allowed.

So much for a three-week waiting list target. So let’s look at some ‘live’ scenarios.

The first case file we looked at was a male in the community waiting for a CCA. I suggested that we ring the social work contact responsible for the CCA to ask if it had been



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completed yet. So that's what we did and we got through to the social work team admin who informed us that the social worker was not in the office. We asked where he was: "out" came the response. The rehab staff member thanked her, hung up and wrote a note in the file. She was about to move onto the next file when I asked "Is that it?". "What else can I do?" the staff member said. "He's not there."

#### KNOW THE RULES.

Sometimes, staff get themselves into a rut, particularly when they are not clear about what they can and should expect from staff in statutory agencies and when they are not clear about the rules, the law, and the rights and responsibilities of the client, social workers and Drug/Alcohol Action Team staff, etc and their role in the complex process of a patient accessing rehab

In the case of this particular staff member, I explained the relevant points of the *Community Care Act* ([www.legislation.gov.uk/ukpga/1990/19/contents](http://www.legislation.gov.uk/ukpga/1990/19/contents)), which make it clear that clients have the right to an assessment ([www.legislation.gov.uk/ukpga/1990/19/section/47](http://www.legislation.gov.uk/ukpga/1990/19/section/47)) followed by a care plan – and the provision of care if eligible.

The client should also play an active part in the assessment process, which should be done *with* not *to* him or her.

Armed with the right information and the persistence which comes from having support on hand, we rang back. After escalating the matter to the social worker's manager and being clear that we would further escalate the matter – given the unacceptable delays – we managed to get a revised date for a CCA, which the rehab would follow up of course.

Knowing the rules gives confidence to the enquirer, persistence and a willingness to escalate issues up the line-management chain and to complain, using official channels and in creative ways – for example, get clients to ask their MP for help if need be, get to know and quote the law and the guidance – are the keys to getting results when

it comes to holding statutory agencies to account when they do not do what they are supposed to do. They should not refuse to undertake timely assessments for all sorts of spurious reasons such as the budget is used up: your client still has a right to an assessment; even if they must wait for care, there is much they can address while they wait. They should not refuse to assess while the client is in prison: they can assess over the phone, or via an official or facilitated visit, they can use prison staff [the Carat team] to assess the client. They should not say your clients need is not in the right category – see FACS below. They still must assess and provide a clear care plan that is appropriate to the presenting need.

In assessing the client, social services or the joint DAAT /Social Services tier 4 assessor must use *Fair Access to Care Services* criteria ([www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_113154](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113154)) to determine eligibility/level of need.

This is usually split across four levels. From top down they are: critical, substantial, moderate and low. Many councils /DAATS treat only critical and substantial need so, increasingly, clients in need of resi rehab are forced to try but fail at all other community treatment options first, usually because DAATS have invested most of their considerable resources in community services, the bulk of it being tier-3 prescribing services.

#### THE DRUG/ALCOHOL ACTION TEAM.

I have worked not only with rehabs in crisis, but also with DAATS wanting to review their tier-4 processes to improve detox and rehab care pathways, ensure better client/treatment outcomes, and improve budgets for tier 4-services or make the existing budget go further.

One of my recent clients was a DAAT which needed help because clients were getting stuck in a treatment roundabout. Everyone in need of tier-4, resi rehab services had to wait an age to get a referral: they were forced to try and fail at everything else on offer in the community first.

They also needed a community care assessment which, due to lack of CCA staff, was taking 6-8 weeks alone. Beyond that was the job of building the 'client case for rehab' to take to a funding panel, getting a decision, then looking at matching the client to an appropriate rehab, which was taking another 8-12 weeks. After rehab, if the client came back, they received a generic aftercare service.

This particular DAAT was spending only about £200,000 on rehab, from a total declared budget for treatment of almost £4million.

With help, the DAAT improved the assessment and decision-making process, which was reduced to less than four weeks from referral, through assessment and to funding decision.

Clients no longer had to waste time exhausting community services first. The DAAT also streamlined the budget management process ensuring it was never wildly under- or over-spent. It even managed to target under-spend elsewhere in the treatment system to resi rehab. It regularly aims for 10% of new treatment journeys getting into rehab. Rehab outcomes were also improved by ensuring a more varied list of service providers, better client matching and preparation for rehab and better contracting, including price, with the rehabs being used.

Aftercare, instead of being generic, became part of the treatment-matching process. It was considered as part of the care plan before rehab, not as an afterthought if the client made it back.

Working with a DAAT – and a whole treatment system, rather than one provider – was very interesting because it was clear that most of the professionals could not navigate the system either. New care pathways were required and these were publicised throughout the treatment system.

User groups were told about them, as they also found it hard to advocate for people who wanted rehab and abstinence. They had not been geared up for it, did not know the rules, and were very 'script' oriented.

#### RECOMMENDATIONS.

**Useful guidance** – there is a lot from the NTA, which is not widely publicised and thus not widely used. Some is a bit out of date, but it could improve commissioning of resi rehab and help rehabs to press the case for their clients, and improve their own practice. Guides include:

- *Commissioning for recovery* ([www.nta.nhs.uk/uploads/commissioning\\_for\\_recovery\\_january\\_2010.pdf](http://www.nta.nhs.uk/uploads/commissioning_for_recovery_january_2010.pdf))
- *Residential treatment services: good practice in the field* ([www.nta.nhs.uk/uploads/nta\\_tier\\_4\\_full\\_0609.pdf](http://www.nta.nhs.uk/uploads/nta_tier_4_full_0609.pdf))
- *Improving the quality and provision of tier4 drug treatment interventions (2008)* ([www.nta.nhs.uk/uploads/nta\\_improving\\_the\\_quality\\_and\\_provision\\_of\\_tier\\_4\\_drug\\_treatment\\_interventions\\_2008.pdf](http://www.nta.nhs.uk/uploads/nta_improving_the_quality_and_provision_of_tier_4_drug_treatment_interventions_2008.pdf))
- *NTA models of residential rehab for drug and alcohol misusers* ([www.nta.nhs.uk/uploads/nta\\_models\\_of\\_residential\\_rehab\\_drug\\_and\\_alc.pdf](http://www.nta.nhs.uk/uploads/nta_models_of_residential_rehab_drug_and_alc.pdf)),
- *NTA staff development toolkit drug alcohol residential services* ([www.nta.nhs.uk/uploads/nta\\_staff\\_dev\\_toolkit\\_drug\\_alcohol\\_residential\\_services\\_2003\\_sdresi.pdf](http://www.nta.nhs.uk/uploads/nta_staff_dev_toolkit_drug_alcohol_residential_services_2003_sdresi.pdf))
- *NTA voluntary sector compact - guidance* ([www.nta.nhs.uk/uploads/nta\\_vs\\_compact\\_guidance.pdf](http://www.nta.nhs.uk/uploads/nta_vs_compact_guidance.pdf)).

**Local substance misuse partnerships should review** current care pathways, assessment and decision-making processes relating to resi rehab and/or tier4 in general, with the aim of at least 10% of all new treatment journeys getting access to resi rehab – and perhaps apportioning 10-15% of DAAT resources. Following on from this...

- Any client on methadone for four or more years should get the chance to apply for detox/rehab as a priority.
- Any one starting out on a drug-using career, where treatment gains can be quickly consolidated should be assessed for detox/rehab and, where appropriate, offered the opportunity to go to resi rehab.
- Any stimulant user in a tier-2/3 service should be given the chance to apply for a rehab assessment/ placement.

● There should be workforce development training relating to tier-4 assessment and care planning.

● There should be a transparent and realistic target for all patients wanting access to resi rehab – a 'starter for 10' might be no more than 6 weeks from a person asking for rehab as a treatment option to stepping through the door of a rehab if assessed as eligible.

● Serious consideration should be given to streamlining the funding of resi rehab. The *Community Care Act* came into force in the early 1990s, there were no DAATS, no £millions spent on treatment and thus no treatment infrastructure. It made sense at that time to devolve the power to assess and treat people in need to local authority social work departments. But with a treatment infrastructure in place now, this should be reviewed and simplified.

I have achieved this on a local – county and unitary – level. It should not be beyond the current coalition to instigate this nationally

The requirement to re-balance the treatment system in this country is real but it is not happening with the urgency required. Too much of the treatment budget is still spent on prescribing services. Local substance-misuse partnerships are fiddling round the edges as they try to build recovery, mutual aid groups and the like – sometimes only by changing names of existing practices.

I do hope that the message of the need for resi rehab and a rebalancing of the treatment system gets through.

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