

## Tier 4 drug treatment in England: Summary of inpatient provision and needs assessment



## In brief

### Background and aims

According to *Models of care* (NTA, 2002), Tier 4 services are “aimed at individuals with a high level of presenting need” and consist of “abstinence-oriented programmes, detoxification services, or services which stabilise clients” (*Models of care*, page 19). The forthcoming update to *Models of care* (in press) emphasises the importance of specialist inpatient interventions which are necessary to support clients with complex drug, alcohol and health needs, those in crisis and those requiring medication stabilisation.

This briefing focuses on Tier 4a provision, which covers a diverse array of inpatient detoxification and residential rehabilitation services, and does not cover Tier 4b provision (highly specialised non-substance misuse services, such as liver units).

The programme sought to assess regional and national levels of Tier 4 provision for primary drug users and to estimate future levels of need for both inpatient detoxification (IPD) and residential rehabilitation (RR). It is part of a wider work programme which aims to increase effectiveness and improve capacity for Tier 4 services.

There were two main pieces of work, one reviewing the type and structure of provision of IPD and the second assessing needs for all Tier 4a provision. While the review of IPD services was based on a survey method, multiple methods were used for the overall needs assessment, including:

- analysis of existing data sources, including NTA treatment plans existing local needs assessment and the National Drug Treatment Monitoring System (NDTMS)
- survey data covering 149 joint commissioning managers and 105 residential services
- qualitative and quantitative research involving users and carers
- epidemiological needs mapping using existing theoretical models.

### Findings

The IPD review identified considerable variability in detox provision across three main settings – specialist units, residential rehabilitation services that offered an initial detoxification procedure and generic medical and psychiatric wards that provided detoxification from drug misuse. There were problems identified with the level of medical cover, the adequacy of staffing levels and the effectiveness of care planning and integration into throughcare and aftercare.

The overall findings of each study were that, despite some individual examples of excellent service planning and delivery, the system as a whole was characterised by:

- insufficient supply of Tier 4 provision (especially for IPD) which fails to meet overall demand and varies sharply in regional availability
- differing beliefs among commissions regarding the role and purpose of Tier 4 interventions and use of the evidence-based commissioning of Tier 4 services
- inconsistencies regarding treatment planning and co-ordination, especially in relation to integrated care pathways between IPD and aftercare programmes
- inconsistent levels of client preparation, assessment and onward referral arrangements, and poor use of the available time for harm reduction and health interventions
- perceptions by users and carers of Tier 4 services being difficult to access, of insufficient duration and poorly mapped against the needs of sub-populations with particular problem profiles.

### Main implications

- The current level of provision is insufficient to meet demand. This underprovision will intensify if the Public Sector Agreement target to increase numbers in treatment is met without expanding Tier 4 capacity. The treatment effectiveness agenda increases the need for services required to achieve and sustain abstinence in those completing the treatment journey.
- The number of residential rehabilitation places needed, as a minimum, is likely to be in the region of 24,585 covering 16,390 inpatient detoxification services and 8,195 residential rehabilitation places (representing increases of 30 per cent and 34 per cent respectively).
- Improvements are needed in the commissioning, management and flexibility of existing services to ensure that inpatient detoxification facilities are only used as part of a coherent treatment plan with adequate assurances of effective post-release support.

The NTA will seek to address some of these issues through the treatment effectiveness agenda, the focus on effective, needs-based commissioning and the focus on care plan and co-ordination across the treatment journey.

## Introduction

This briefing combines two pieces of work commissioned as part of the NTA Tier 4 programme – a national assessment of needs for Tier 4 services and a review of current provision of inpatient detoxification for drug users across England. The overlap between the projects meant that the research teams worked closely to ensure consistency with the same broad themes dominating the two pieces of work. The results from each are presented separately before the conclusions from the two are synthesised.

## Aims

This study sought to map regional and national levels of Tier 4 residential rehabilitation provision for primary drug users (matching the IPD review reported later) and to develop and apply an appropriate epidemiological planning model, designed to estimate levels of need for the period 2005–08, for both IPD and RR services. The work arose from concerns about Tier 4 capacity, accessibility and rising waiting times, in relation to other modalities. The NTA's Public Sector Agreement target – requiring the doubling the numbers in treatment between 1998 and 2008 – added urgency to the need to obtain more accurate, national information on service uptake and future need. The treatment effectiveness agenda provides a clear mandate for improved provision of services oriented towards establishing safe and effective drug abstinence and assisting in the maintenance of that state.

The study is predicated on UK and international evidence that abstinence oriented detoxification is likely to be more successful in residential settings<sup>1</sup> and that enhanced outcomes are achieved when residential rehabilitation and inpatient detoxification are offered as an integrated package.<sup>2</sup>

Data collection strategies employed are outlined below.

- A survey of residential rehabilitation managers to audit how services are planned, funded and delivered.
- Survey of drug service commissioners, designed to provide information about how services across drug action team (DAT) areas are commissioned, how eligibility is determined, performance is managed and evaluated, and how places are utilised. This element also sought to obtain and analyse the results of locally conducted needs assessments and the most recent local treatment plans to assess the existing evidence base for unmet need in each drug action team (DAT).
- Qualitative and quantitative research involving users and carers.<sup>3</sup> This element, conducted via focus groups and surveys, was designed to capture the views and experiences of people involved in attempting to access Tier 4 services and who had experienced this form of treatment provision.
- An epidemiological planning approach, designed to show quantifiable estimations of the numbers of people requiring Tier 4 services at a local and national level, to calculate needs including but not restricted to expressed demand.
- Finally, generating comparative data with a parallel study of inpatient detoxification services in England by the University of Birmingham, by including additional questions on the residential rehabilitation questionnaire.

1 Gossop, M. (2004) Detoxification treatment: Limitations and opportunities.

2 Ghodse, H, *et al* (1997) Changing pattern of drug use in individuals with severe drug dependence following inpatient treatment. *Int J Psych Clin Pract*, 1: 287-294.

3 Two focus groups involving users and carers, commissioners, DATs and service providers and users and carers (37 and 38 participants respectively); and a survey of 136 service users and 36 carers, drawn from focus group participants, a treatment service located in Stockton on Tees in the North East Region. This sample was supplemented by postal return from the Oxford Users network in the South East region.

## Findings: Survey of residential rehabilitation providers

Sixty-one per cent of the 105 identified RR services responded to the survey. The services reported an average of 58 drug admissions annually, which if extrapolated up to a national level equates to 6,090 residential rehabilitation episodes during 2003/04 for drugs. However, failure to differentiate between drug and alcohol beds and limited data recording means that this is an estimate, markedly larger than the NDTMS reported 4,601 residential admissions estimated from NDTMS. The bed occupancy rate was reported as 74 per cent (albeit, ranges for both admissions and bed occupancy rates were wide, between 1 and 211 and 40–98 per cent respectively, and the average utilisation quoted in the BedVacs<sup>4</sup> report is significantly higher). Service managers also reported an average waiting time of two weeks for admission to RR. Exactly half the agencies did not have “drug specific” beds and only a few reserved beds for clients referred through the Drug Intervention Programme. Community care teams, self-referral and Tier 2 and 3 services constituted the main referral sources, but there was marked variability in commissioning and provision.

### Survey of commissioners

#### Residential rehabilitation

Forty-five per cent of the 149 joint commissioning managers in England returned the survey. The mean waiting time reported by the residential managers was just over two weeks (which is broadly consistent with the reported National Drug Treatment Monitoring System figures) and each DAT referred an average of 51 clients for RR, of which 30 were admitted. Of the numbers admitted, 19 completed treatment (constituting an overall completion rate of 34 per cent). Most referrals (59 per cent) arrived via community treatment rather than inpatient services. Commissioners perceived the need for an additional 33 places on average per DAT, which would amount to an overall 95 per cent increase in provision of RR to fulfil this need.

#### Inpatient detoxification

For inpatient detoxification, the mean waiting time was slightly longer – four weeks – in the DATs covered by the participating commissioners. Referral rates were broadly similar: each DAT referred an average of 51 clients, of which 32 were actually admitted to IPD services, of whom 22 completed treatment (a completion rate of 34 per cent). Most referrals came via Tier 3 services, although criminal justice interventions were another major route. Commissioners reported a perceived need for 76 additional places on average for IPD per DAT, which amounts to an overall 161 per cent increase in provision, based on their estimates of current provision.

The unsatisfactory levels of admission and completion reported by commissioners may reflect inadequate pre-assessment arrangements (only 69 per cent of clients referred to RR received an assessment, compared with 92 per cent of those referred for IPD), combined with insufficient time in treatment (the latter was a recurrent theme raised in the qualitative research). It may also reflect delays in obtaining community care funding (a major source of residential rehabilitation funding) which results in unnecessary time lags in assessment and availability, and inadequate time in treatment.

### Insufficient provision of Tier 4 services with marked regional variations

All sources used in this study (commissioners’ estimates, survey information, theoretical systems models and feedback from users and carers) pointed to insufficient Tier 4 provision compounded by wide regional variation, although problems with each of the sources for estimation means that there are marked discrepancies between the extent of underprovision.

Findings also revealed little connection between numbers of problematic drug users<sup>4</sup> and the availability of drug treatment. Factors such as historical commissioning patterns, differing beliefs on the role of Tier 4 treatment, and the effectiveness of Tiers 2 and 3 (i.e. in terms of capacity to retain clients in the community) are among the main factors influencing the availability of Tier 4 treatment. This was reflected in marked regional variability in the level of provision and in the underlying resource expenditure on this form of provision.

### Client preparation, assessment, throughcare and aftercare

Qualitative findings from the user focus groups, together with survey findings, highlighted weaknesses in all aspects of client preparation, assessment, throughcare and aftercare, as well as a perceived inflexibility in matching provision to individual client needs.

### Users and carers need more information and improved access

Users perceived that both forms of residential treatment were important to their long-term treatment goals, with 46 per cent and 58 per cent respectively reporting that IPD and RR would help them achieve their goals. However, both forms of treatment were not perceived as being easy to obtain: 64 per cent reported difficulties in accessing IPD and 52 per cent RR. Focus group findings highlighted the perception that Tier 4 treatment is seen as difficult to obtain, too short and inflexible.

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4 An online list of bed vacancies operated on behalf of the NTA.

Carers identified the main advantages of Tier 4 services, as a whole, as respite and space (for themselves and the users), safety and as a means of helping users become drug free. Less satisfactory aspects included a lack of help, advice and family liaison, and the logistical difficulties of maintaining contact with sometimes distantly located services. In particular, they requested more help and involvement for themselves and for users throughout the treatment process and greater opportunity for more information and feedback. This implies that services need to improve engagement and communication with carers.

### Treatment for specific groups

Groups most likely to be under-represented in Tier 4 treatment include women with children (particularly under six months old) and, to a lesser extent, young people, non-English speakers and people with co-morbid mental health problems. There was no clear evidence that minority ethnic groups or users of particular substances were being systematically underserved, or that the increased volume of clients referred through the criminal justice system adversely affected access to treatment for others, although the reports on this latter group were inconsistent.

### Poor local needs assessment practice and understanding of the evidence base

Only 34 per cent of the commissioners who replied had carried out local needs assessments (despite this activity being an integral part of the DAT treatment planning process) and only 33 residential services (52%) had taken part in any research, evaluation or audit projects within the last five years. This low level of systematic data collection may have hindered effective local needs measurement and monitoring, and prevents evidence-based improvements in service provision.

## Findings: Study of inpatient detoxification

Seventy one per cent of the 129 inpatient detoxification units responded to the survey, conducted by the University of Birmingham. The authors estimated that a total of 10,771 IPD admissions took place in 2003/4 (with the average length of stay ranging from four to 77 days). The study found that:

- 6,829 admissions took place in specialist units (specialist services solely treat substance misuse in either standalone facilities or wards within psychiatric or general medical facilities)
- 2,077 in general psychiatry wards (theoretically available for drug users but often occupied by medical or general psychiatric patients)

- 1,805 in residential rehabilitation settings (where medically assisted detoxification is generally a prelude to longer residential treatment).

The study also shed light on the way IPD services are delivered and how they fit into the overall drug treatment system. The work highlighted variations in scope, physical location, staffing and clinical practice and an overall absence of minimum standards and consistency of provision, even among the specialist providers of IPD services.

### Clinical arrangements and care planning

The majority of services offered mainly abstinence focused (detoxification) treatment, with very few offering stabilisation or standard harm-reduction activities such as blood-borne virus screening and vaccination, or overdose prevention. Despite the need for poly-drug focused services, over 40 per cent of responding services did not cater for cocaine or amphetamine users.

Overall, IPD services were poorly integrated into the wider treatment system, as approximately one-third did not require patients to have an aftercare plan in place at the start of treatment. In addition, the services themselves offered varying levels of psychosocial treatment, with specialist services providing, on average, nearly six times as many hours of programmed therapy as the services based on general psychiatric wards.

### Staff and facilities

Specialist services and beds located on general psychiatric wards received the greatest input from doctors, nurses and occupational therapists, whereas rehabilitation units were staffed with greater numbers of drug workers, counsellors and complementary therapists. Not all services had basic facilities for treating a drug-using population with physical health problems, with wheelchair access unavailable in one-third of services and no dedicated clinical room in a quarter of services.

### Research and information management

There were major limitations in standard data collection on admissions and outcomes and very few examples of clinical audit and other research taking place in the units involved in the study.

## Perceptions of the service

Sixty-three per cent of specialist IPD clinicians felt that the number of beds in their service was “inadequate” or “totally inadequate” and more than half felt that the range of services offered were either “inadequate” or “totally inadequate”. There were general concerns expressed about the lack of suitable facilities, appropriate treatment options and clinical skills, usually (but not exclusively) associated with provision on general psychiatric wards. Along with RR managers, there were concerns about both the number of places and the effectiveness of treatment that could be offered, compounded by practical issues around space, staff competence and training and the appropriateness of the referrals they received.

## Future provision

If we assume a service utilisation ratio of 15 per cent, for all those with some contact with treatment services in 2007/08 who will require residential treatment, and the target of 163,900 is met by that year, and we assume that two-thirds of this requirement is for IPD and one-third for RR, then:

- there will have to be provision for 16,390 episodes of IPD – on the basis of total existing provision this will involve an increase from 10,711 – the estimated number of episodes of IPD from the IPD survey work done by Day et al (2005). If, however, we were to exclude individuals treated in general medical or psychiatric wards, then the current estimate of provision would be 8,634, requiring an additional 7,756 places to be available by 2007/08 to meet the 10 per cent treatment target. This would involve an increase of 90 per cent of the IPD provision available currently in either RR or specialist inpatient units, and would represent the more evidence-based assessment of increase in adequate IPD provision
- residential rehabilitation places should be increased from 6,090 to 8,195, which represents a 35 per cent increase.

The overall model is a combination of the levels of need estimated in the IPD and RR providers’ surveys – and the service utilisation ratio of 15 per cent set against the NTA’s drug treatment expansion targets (163,900 problem drug users in structured treatment by 2008). However these figures are likely to be an underestimation as they are based on a static model of the drug using population, and do not include those currently accessed through Tier 4b services and those not accessed through the current survey methods. It also does not account for the possibility of exceeding the target and improving the quality of treatment continuity across treatment modalities.

The greater emphasis on treatment effectiveness may well result in a larger proportion of drug users reaching the end of their PDU career requiring IPD and RR to help them achieve long-term non-problem status.

## Practice implication of this study

This study has provided data from a range of sources indicating insufficient Tier 4 treatment provision both in terms of quantity and quality, although the extent of this unmet need is not evenly spread across the country. Overall limitations in provision were exacerbated by problems with the integration of Tier 4 services (especially between inpatient detoxification, residential rehabilitation and aftercare), and the inconsistency in commissioning patterns across DATs and regions. In addition to the overall lack of beds for Tier 4 provision, there are also particular groups whose needs are not being served in the current system.

The IPD review highlighted weaknesses with the inpatient detoxification provision and an absence of a coherent sense of a “national detoxification service”. The high numbers of clients receiving IPD in psychiatric wards (where higher rates of drop-out and client dissatisfaction were reported) and/or leaving detoxification without adequate follow-on care is not conducive to effective care co-ordination or achievement of three month retention targets, and has been demonstrated to result in poorer treatment outcomes.<sup>5</sup> The shortfall in IPD beds should not be redressed by using beds in general psychiatry wards, other than as a treatment of the last resort.

Services must be commissioned in a manner consistent with an evidence base that monitors outcomes in relation to a general set of principles guiding treatment trajectories. The NTA’s treatment effectiveness programme will support this end by including research into outcomes for Tier 4 services (including assessment of modality and duration of stay in RR) and also the development of epidemiological needs assessment planning models.

There is evidence that Tier 4 services can be effective, but only when they are applied flexibly and within a coherent planning process with adequate preparation prior to admission and aftercare following discharge. IPD, in particular, is not an adequate intervention if provided in isolation but can be extremely effective when provided as part of a care planning process.

<sup>5</sup> Strang, J., Marks, I., Dawes, S., *et al* (1997) Type of hospital setting and treatment outcome with heroin addicts. *British Journal of Psychiatry*, 171: 335-339.

## Recommendations

### Inpatient detoxification

- Develop minimum clinical standards including a requirement for basic clinical examination facilities, consensus on duration and referral criteria and policies on care planning and follow-up care. These must then be applied consistently across the country.
- Address basic staffing problems to allow adequate minimum standards of care and to ensure appropriate medical coverage across all IPD providers.
- Produce medical guidelines for inpatient detoxification (similar to the Department of Health clinical guidelines for community services) to improve consistency of provision.
- Encourage services to provide a full range of inpatient services for a wide range of drug and alcohol misuse and provide better links to follow-on aftercare services.
- Form a national network of specialist inpatient services which collects clinical and non clinical data.
- Joint training and consultation between residential rehabilitation services, treatment planners and Tier 4 services, to ensure fair and consistent client placement and effective throughcare and case management.
- Better training for commissioners on how to work with the community care system, accompanied by the development of shared assessment instruments for use across services.
- Improved services for young people and women, particularly those with dependent children, possibly through shared care arrangements, and more flexible use of specialist services to meet local needs.
- Ongoing monitoring for marginalised groups, including local analysis of prevalence mapped against options for local provision and funding mechanisms.
- The development of a common evaluation and monitoring system to enable local assessment of the effectiveness of commissioning of treatment, its underlying principles and its impact on overall prevalence and incidence of drug use.

### Promote evidence-based commissioning

- Encourage commissioners to focus on specialist providers or, where appropriate, rehabilitation units with adequate medical care, rather than beds on psychiatric wards. It is essential that there is improved consistency in the provision.

### Improve information

- More comprehensive information, including a directory of services (covering statutory and non statutory services) and regular bed mapping (similar to the Bedvacs system used for residential services). The researchers found identifying services carrying out IPD to be extremely problematic and this issue needs to be addressed.
- Carry out further research which assesses effects of different treatment technologies (i.e. detoxification for abstinence and detoxification for stabilisation; effectiveness of different rehabilitation models), and other detoxification settings such as general hospitals and prisons.

### Residential rehabilitation

- Effective funding and co-ordination of commissioning to enable better care planning and co-ordination, especially from inpatient detoxification to residential rehabilitation.
- Adequate aftercare provision and supported housing if required. It is essential that the commissioning of Tier 4 services is co-ordinated to ensure consistency with the treatment journey and DAT level need, and that provision is mapped against the progress of clients and tailored to meet their needs. This may involve some level of regional co-ordination.

## Study limitations

The absence of a validated epidemiological model for calculating drug treatment needs has hindered the ability of this study to effectively map future needs for Tier 4 services. Additional problems are outlined below.

- Difficulties in establishing the numbers receiving Tier 4 provision, owing to incomplete data sets (for example the NDTMS does not comprehensively cover all Tier 4 services).
- A corresponding lack of information for those in other parts of the drug treatment system, not included in the NDTMS (such as Tier 2, a potential gateway to Tier 4 services). This study has by necessity used the conservative assumption that all need for Tier 4 services is generated from within structured treatment.
- A heterogeneity of different types of treatment settings and treatment periods, as well as difficulties in disaggregating beds used for alcohol and drugs.
- A lack of reliable local data on need and outdated national prevalence data prevented adequate measurement of the current likely size of the PDU population or local patterns of treatment need.
- The lack of consensus about the key features of optimal inpatient detoxification / residential rehabilitation treatment.

## Reader information

<b>Document purpose</b>	To provide managers and commissioners of drug treatment services with summary findings from a review inpatient detoxification provision, and a needs assessment of both residential rehabilitation and inpatient services in England.	<b>Cross reference</b>	A national survey of inpatient drug treatment services in England, NTA, 2005 National needs assessment for Tier 4 drug treatment services in England, NTA, 2005
<b>Title</b>	Tier 4 drug treatment services in England: summary of inpatient provision and needs assessment	<b>Action required</b>	Providers and commissioners to use evidence to inform treatment planning and commissioning.
<b>Authors</b>	Dr David Best, Alison O'Grady, Ioanna Charalampous and Dawn Gordon, National Treatment Agency	<b>Timing</b>	Ongoing
<b>Publication date</b>	June 2005	<b>Contact details</b>	National Treatment Agency for Substance Misuse  Until 16 July 2005: 5th floor, Hannibal House, Elephant and Castle, London SE1 6TE. Tel 020 7972 2214. Fax 020 7972 2248.  <b>From 18 July 2005:</b> 8th floor, Hercules House, Hercules Road, London SE1 7DU. Tel 020 7261 8801. Fax 020 7261 8883.  Email nta.enquiries@nta-nhs.org.uk www.nta.nhs.uk
<b>Target audience</b>	Providers and commissioners of drug treatment services in England, and service user and carer groups.	<b>Gateway/ROCR approval</b>	The NTA is a self-regulating agency in relation to Department of Health Gateway
<b>Circulation list</b>	Managers and commissioners of treatment services Co-ordinators and chairs of local partnership (e.g. drug action teams and crime and disorder reduction partnerships) Service user and carer groups Regional government department leads on drugs Central government department leads on drugs Royal colleges	<b>© National Treatment Agency, London, 2005</b>	The text in this document may be reproduced free of charge in any format or media without requiring specific permission. This is subject to the material not being used in a derogatory manner or in a misleading context. The source of the material must be acknowledged as the National Treatment Agency. The title of the document must be included when being reproduced as part of another publication or service.
<b>Description</b>	A summary of key findings, implications and recommendations from: <ul style="list-style-type: none"> <li>● a review of the type and structure of inpatient detoxification provision</li> <li>● an assessment of needs for all tier 4 provision (including residential rehabilitation and inpatient detoxification services).</li> </ul>		

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