



*National Treatment Agency  
for Substance Misuse*

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**Models of residential rehabilitation for drug and  
alcohol misusers**

October 2006

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# 1 Executive summary

## 1.1 Key points

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Residential rehabilitation is:

- A highly effective form of treatment for drug and alcohol misusers who wish to achieve a drug-free lifestyle
- Appropriate for a range of drug and alcohol misusers at different stages of their treatment journey
- An essential – but often missing or inadequate – element in treatment systems
- Most effective when aftercare is planned before the end of treatment.

## 1.2 Background

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Residential rehabilitation is a critical element in integrated care pathways. When used appropriately it can be an effective treatment suitable for a range of drug and alcohol misusers at different stages in their treatment journeys and is especially important in providing a pathway out of dependency or through which clients might ultimately exit treatment. However, residential rehabilitation has not experienced the same growth as community-based treatment options, and there is a need to increase both the number of beds and the use of residential treatment (Best *et al.*, 2005).

## 1.3 Types of residential rehabilitation

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A range of residential rehabilitation services needs to be available to drug and alcohol misusing clients seeking treatment. The programmes they offer can be differentiated according to factors such as principal aims and client group, and length of stay. Programmes are principally either rehabilitative or supportive, long stay or short stay, but one service may provide programmes that bridge these differences.

**Rehabilitative** programmes provide accommodation and a structured, care-planned programme of therapeutic and other activities. They are suitable for clients with medium or high dependence on drugs and/or alcohol and medium to high care needs. Rehabilitative programmes subdivide into:

- **Long stay** programmes – these run for approximately six months or more and are better suited to clients whose drug and alcohol use is long-term and entrenched, and who are likely to be socially excluded, unemployed, in severe housing need, lacking in life skills, and persistent, prolific offenders
- **Short stay** programmes usually last less than 12 weeks. They further sub-divide into:
  - **Intensive** programmes that provide intensive medical and therapeutic interventions for clients likely to be in housing need, with complex medical needs and likely to need to require long stay residential treatment or structured community treatment
  - **Lower intensity** programmes for clients with shorter drug and alcohol misuse histories and who are more likely to be able to return to employment and housing with community or family support.

**Supportive** programmes provide accommodation, often following treatment in a rehabilitative programme, with specialist drug/alcohol and non-drug/alcohol related support. They are suitable for clients with low dependence on drugs and alcohol or who are now abstinent and have low care needs.

## **1.4 Residential rehabilitation in treatment systems**

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Local drug and alcohol partnerships should ensure the commissioning of residential rehabilitation treatment is firmly embedded within local treatment systems and attention given to entry and exit routes. Residential rehabilitation will not be effective unless:

- Clients are comprehensively assessed
- Client choice is respected
- Care is planned and reviewed
- Drug and alcohol use is stabilised or clients have been detoxified
- Aftercare is integral
- Housing needs are met
- Education, training and employment support are addressed
- Social and life skills have been developed
- Departure is planned.

## **1.5 Standards and competences**

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Residential rehabilitation services are required or expected to comply with a wide range of standards according to the services they provide and their registration status. Their staff will need appropriate competences in line with Drug and Alcohol National Occupational Standards (DANOS).

Registered care homes will need to meet national minimum standards and will be inspected by the Commission for Social Care Inspection (CSCI).

Independent healthcare providers will need to meet national minimum standards and will be inspected by the Healthcare Commission.

Services funded through Supporting People will be regularly reviewed by local Supporting People teams to ensure they meet standards laid down by central government.

Specialist services working with specific groups of drug and alcohol misusers may need to meet additional standards appropriate to their work, e.g. family services working under local child protection standards.

Residential rehabilitation services will be subject to the Healthcare Commission / NTA improvement review process in 2007/8.

All services should be aware of local procedures for the protection of vulnerable adults (POVA).

All services must also comply with health and safety legislation, environmental health and fire regulations. Many will have or be working towards independent drug and alcohol service standards or accreditation. They may also hold or be working towards non-drug/alcohol specific standards and accreditation.

## **1.6 Other differentiating factors**

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Residential rehabilitation services are based on a number of different “philosophies” describing aspects of their ethos, theoretical underpinning, belief systems and method of working. These philosophies are not simple categorisations and are not mutually exclusive.

Some residential rehabilitation services target specific groups of drug and alcohol misusers and provide interventions and services appropriate to the needs of these groups, which include drug-using pregnant women, drug and alcohol misusers with severe and enduring mental illness, and families and drug/alcohol users in crisis.

### **1.7 Assisted withdrawal in residential rehabilitation**

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Assisted withdrawal provided in residential rehabilitation is an important service both as an option for some clients returning to treatment in the community and for those then going into a full residential rehabilitation programme. Dependent upon the nature of the service being provided and the clients accepted for treatment, assisted withdrawal will need to meet additional sets of standards and staff competences, including clinical governance.

Most assisted withdrawal in residential rehabilitation is likely to qualify as “medically monitored”, i.e. “most appropriate for individuals with lower levels of dependence and without a range of associated medical and psychiatric problems” (SCAN, 2006), and providing one or both of two levels of care:

- With 24-hour nursing cover – providing more specialised skills and higher, medical staffing levels required to cope with more complex cases with greater needs. Without 24-hour nursing cover – straightforward withdrawal from opiates.

Where an assisted withdrawal programme in residential rehabilitation is sufficiently specialist that it qualifies as a “medically managed” inpatient service, it should meet the standards and criteria detailed in guidance from the Specialist Clinical Addictions Network (SCAN, 2006).

### **1.8 Funding and monitoring**

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There are a range of funding and monitoring issues critical to the provision of residential rehabilitation. These include:

- Charges – and who is required to meet them – may vary widely according to the type of residential rehabilitation and the services provided
- A mixed economy of funding sources is necessary to secure the provision of residential rehabilitation. Over-reliance on community care funding alone seems to produce financial difficulties. Local drug and alcohol partnerships should use a mixture of pooled treatment budget, community care and Supporting People funding as appropriate.
- A mix of block and spot contracts improves provider security and commissioning flexibility
- Residential rehabilitation services must comply with NDTMS reporting requirements and should accurately report their vacancies on the NTA’s residential bed vacancies system (BEDVACS) in order to allow accurate tracking of the state and performance of the sector
- Relationships between residential rehabilitation services and local drug and alcohol partnerships need to be improved, especially in the service’s “host” partnership area. Services need to develop positive relationships with joint commissioning managers as well as with community care or Supporting People managers.

## **2 Introduction**

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This document seeks to clarify the nature of residential rehabilitation services and the range of services that should be available to residents of a local drug and alcohol partnership area, and will

inform the commissioning of residential rehabilitation at local, regional and supra-regional levels. It supplements and should be read alongside other guidance, including:

- Models of Care for Treatment of Adult Drug Misusers: Update 2006 (NTA, 2006a)
- Models of Care for Alcohol Misuse (DH, 2006)
- Care Planning Practice Guide (NTA 2006b).

It also complements guidance on commissioning Tier 4 services.

It is intended primarily for local drug and alcohol treatment commissioners, regional commissioning groups and providers of residential rehabilitation. It will also be useful to community services providing assessment and referral to residential rehabilitation services.

The document covers adult drug and alcohol treatment services for those aged 18 and over, although some residential services may take 16 and 17 year olds. The models described apply to services for drug misusers only, alcohol misusers only and drug and alcohol misusers.

It does not cover prison-based Tier 4 residential rehabilitation.

The model upon which this document is based was drawn up in consultation with members of EATA and others, some of whom provided initial advice while others contributed to a small working group. A draft of the document was consulted on in June and July 2006, and comments received from a range of interests, including major providers of residential rehabilitation, independent residential rehabilitation services, commissioners and statutory bodies including the Commission for Social Care Inspection (CSCI) and the Department of Health's Care Services Improvement Partnership (CSIP).

## 3 Background

### 3.1 What is residential rehabilitation?

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Models of Care: Update 2006 (NTA, 2006a) defines four tiers of interventions for drug and alcohol misusers. Drug and alcohol residential rehabilitation programmes are Tier 4 interventions that provide accommodation in a drug-free environment<sup>1</sup> and a range of structured interventions to address drug and alcohol misuse, including – but not limited to – abstinence-orientated interventions. Services have some common and defining characteristics but they also vary widely in, for example:

- Length of stay
- Registration status
- Philosophy and programme of care
- Which client groups they target
- Whether or not they provide services for men and women

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<sup>1</sup> An environment in which illicit drugs (and usually alcohol) are explicitly not permitted. There may be drug testing to ensure residents are not misusing drugs, property and personal searches to ensure drugs and drink are not brought on to the premises, and – in addition to explicit rules enforced by staff – there will also be peer pressure and censure to maintain the environment.

Many services, however, will allow residents to take appropriate and necessary prescribed medication: most commonly, in services that work with dual diagnosis, anti-depressant and anti-psychotic medication. Services offering assisted withdrawal/detoxification will usually prescribe medication to alleviate the effects of withdrawal. Some services may prescribe medication that blocks the effect of illicit drugs, reduces cravings or sensitizes the body to alcohol. A very small number of services may allow prescribed substitute drugs.

- Whether or not they provide services for drugs and/or alcohol misuse (and other dependencies or mental health problems)
- Whether or not assisted withdrawal (detoxification) or later stages of supported accommodation are provided.

The NTA's model differentiates and defines residential rehabilitation into a number of programme types defined by the clients for whom they are most suitable and identifying characteristics of the programmes. Individual residential rehabilitation services may provide one or more of these programmes on one or more sites.

**Residential rehabilitation** divides into:

- **Rehabilitative** programmes that provide accommodation and a structured, care planned programme of therapeutic and other activities. They are suitable for clients with medium or high dependence on drugs and alcohol, and medium-to-high care needs

Rehabilitative programmes sub-divide into:

- **Long stay** programmes that run for approximately six months or more and are generally better suited to clients whose drug and alcohol use is long-term and entrenched, and who are likely to be socially-excluded, unemployed, in severe housing need, lacking in life skills, and persistent, prolific offenders
- **Short stay** programmes that usually last less than 12 weeks. They further sub-divide into:
  - **Intensive** programmes that provide intensive medical and therapeutic interventions for clients likely to be in housing need, with complex medical needs and likely to need to go on to long stay residential treatment or structured community treatment
    - **Lower intensity** programmes for clients with shorter drug and alcohol histories and who are more likely to be able to return to employment/housing with community/family support

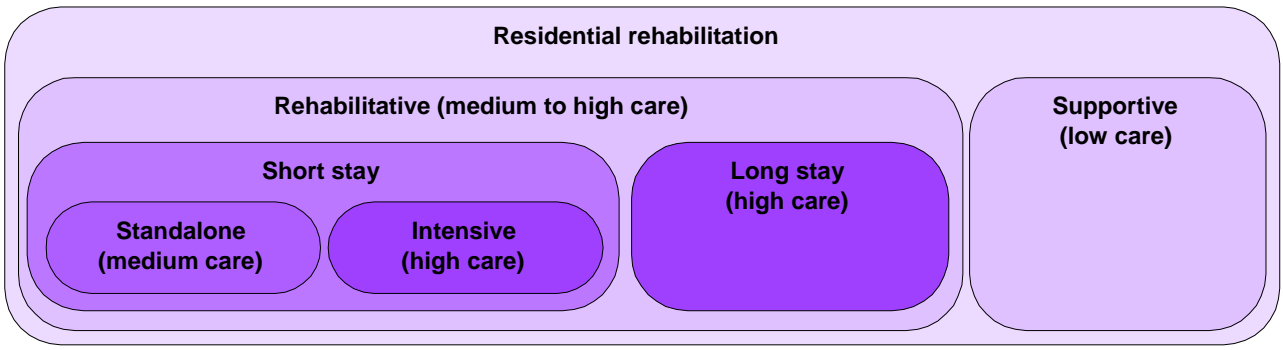
Both types of short stay programme are commonly provided in the same service to different client types, who may benefit from the mix.

- **Supportive** programmes provide accommodation, often following treatment in a rehabilitative programme, with specialist drug/alcohol and non-drug/alcohol related support. They are suitable for clients with low dependence on drugs and alcohol or who are now abstinent and have low care needs.

In all the models it is possible that the treatment programme may be provided at a site separate from the accommodation. However, in order to qualify as residential rehabilitation, the programme must be integral to the service provided, and usually attendance will be a requirement. This model of separate sites is most common in services operating supportive programmes, possible but uncommon with long stay programmes and unlikely to occur with short stay programmes.

Clients do not necessarily remain in a single model for the duration of their treatment but may move between them as appropriate within an integrated care pathway, especially from intensive short stay to long stay, and from long stay to supportive. This may or may not mean moving between different services or between different premises operated by the same service.

The relationship between these models is summarised in the diagram below and expanded upon on the following page.



## Residential rehabilitation

### Service characteristics:

- Tier 4 services that provide accommodation in an illicit-drug-free environment and a range of structured interventions to address drug and alcohol misuse, including - but not limited to - abstinence-orientated interventions.

### Client characteristics:

- meet (or have previously met) International Classification for Diseases (ICD) 10 / Diagnostic and Statistical Manual (DSM) IV dependence criteria\*

### Rehabilitative (medium to high care)

#### Programme characteristics:

- structured programme of treatment and/or rehabilitation activities, to assist clients to develop and practise the skills to manage substance use and related problems.
- client resides in-house (although programme may be at another site, as long as integral)
- 24 hour staff cover on site

#### Client characteristics:

- medium or high dependence on drugs
- complex problems related to drug misuse and perhaps found it difficult to achieve abstinence in the community
- require respite and an intensive programme of support and care which cannot realistically be delivered in a community or outpatient setting
- need to receive treatment away from their usual drug-oriented community or family environment
- want a treatment that is residential and are willing to accept restrictions on their liberty for the duration of the programme

### Short stay

#### Programme characteristics:

- less than 12 weeks

#### Standalone (medium care)

##### Programme characteristics:

- 6-12 weeks
- lower intensity interventions

##### Client characteristics:

- medium dependence
- less entrenched drug history
- return to employment/housing & community/family support

#### Intensive (high care)

##### Programme characteristics:

- intensive medical and therapeutic interventions

##### Client characteristics:

- as for long stay, plus
- complex medical needs
- likely to need to go on to long stay residential treatment

### Long stay (high care)

#### Programme characteristics:

- usually 6-12 months
- longer programmes often in stages

#### Client characteristics (more likely with longer programmes):

- high dependence
- socially-excluded, unemployed
- in severe housing need
- persistent, prolific offenders

### Supportive (low care)

#### Programme characteristics:

- 3 months+, flexible housing and related recovery/support services such as lifestyle counselling, coaching for activities of daily living, community reintegration, vocational counselling and mutual aid

- provided prior to, during, or following treatment, often accessed off site

- lower staff:client ratio than rehabilitative treatment

- 24 hour staff cover, but may be on call

#### Client characteristics:

- low dependence on drugs or abstinence
- in housing need
- require a stable, supportive environment
- completed rehabilitative treatment or able to benefit from community-based treatment

\* The International Classification of Diseases (ICD) is a standard diagnostic classification for all general epidemiological and many health management purposes. Detailed ICD 10 guidance relevant to drug and alcohol dependence is at <http://www3.who.int/icd/currentversion/gf10.htm>. Simplified, it defines a dependence syndrome as including “a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.”

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a US diagnostic (as well as statistical) tool used by clinicians. DSM IV defines substance dependence as applying to someone whose substance use history includes (1) substance abuse; (2) continuation of use despite related problems; (3) increase in tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

## **3.2 Evidence base**

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Residential rehabilitation for drug misusers has demonstrated improved outcomes in a series of research studies (Bennett and Rigby, 1990; Gossop *et al.*, 1999; De Leon and Janchill, 1982). Clients rated it most highly of all interventions (NTA, 2006c). Evidence is limited but suggests that clients with more severe problems will experience better outcomes from treatment stays of 90 days or longer (Simpson, 1997).

In the US Drug Abuse Treatment Outcome Study (DATOS), drug use outcomes after one year were good for clients who were treated in long-term residential and short-term inpatient treatment modalities in the United States. Regular cocaine use (the most common presenting problem) was reduced to about one third of intake levels among clients from both the long-term and short-term programmes, as was regular use of heroin (Hubbard *et al.*, 1997). Rates of abstinence from illicit drugs have also been found to improve after residential treatment. In the UK, NTORS examined outcomes after discharge from 16 residential rehabilitation programmes. About half of the clients (51%) had been abstinent from heroin and other opiates throughout the three months prior to follow-up: rates of drug injection were also halved, and rates of needle sharing were reduced to less than a third of intake levels (Gossop *et al.*, 1999).

Evaluations have been conducted with therapeutic communities with programme durations varying from short term with aftercare, to long term programmes of over one year duration. Improved outcomes were more likely to be found among patients who spent longer periods of time in treatment, and episodes of at least three months were more likely to be associated with positive outcomes (Simpson, 1997). The reductions in illicit drug use that have been found after residential treatment have also been shown to be relatively robust and to persist across lengthy follow-up periods (Simpson *et al.*, 1979; De Leon, 1989).

One issue that affects many research evaluations of residential rehabilitation programmes is that treatment drop-out is common. In common with outcomes from other treatment modalities, those clients who completed residential programmes achieved better outcomes on drug use, crime, employment and other social functioning measures (DeLeon, Janchill and Wexler, 1982; Hubbard *et al.*, 1989). Retention is therefore critical for the effectiveness of residential rehabilitation programmes and is addressed in section 4.2.7.

## **3.3 Residential rehabilitation in the context of an integrated care pathway approach**

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Residential rehabilitation is a critical element in integrated care pathways. It is an effective treatment suitable for a range of drug and alcohol misusers at different stages in their treatment journeys and is especially important in providing a pathway out of dependency or through which clients might ultimately exit treatment. Making effective use of residential rehabilitation requires that:

1. Clients are comprehensively assessed

All clients considered for residential rehabilitation must have received a comprehensive drug and alcohol misuse assessment. If community care funding is sought they must also receive a Community Care assessment.

2. Client choice is respected

Client choice must be respected and reflected in the identification of a suitable residential service (within reasonable limits consistent with other health and social care). This is enshrined in health and social care legislation but may also improve outcomes if clients feel they have been involved in planning their treatment and placed where they want to go.

3. Care is planned and reviewed

The outcome of the comprehensive assessment will be a care plan specifying the need for residential rehabilitation and proposed arrangements for reintegration into the community (although these may change during treatment).

4. Drug and alcohol use is stabilised or clients have been detoxified

Residential rehabilitation programmes generally require residents to be drug and alcohol-free, although some can provide assisted withdrawal as a precursor to the programme and many will work with continued prescribed medication.

5. Aftercare is integral

Aftercare is addressed and planned for as an integral part of the care plan, ideally prior to admission and certainly prior to planned departure. This includes drug/alcohol and non-drug/alcohol related aftercare needs.

6. Housing needs are met

Housing needs are taken into account and plans to address housing need are developed in advance of planned departure.

7. Education, training and employment support are addressed

Treatment that attends to medical and psychological needs is not enough. Relapse will be less likely if drug and alcohol misusers leaving residential rehabilitation are able to continue to meaningfully structure their days and engage in activities that provide a source of self-esteem, legal income, etc.

8. Social and life skills have been developed

Drug and alcohol misusers with social and life skills deficits that may have contributed to their drug and alcohol misuse need interventions to develop these skills.

9. Departure is planned

Plans are in place to cover unplanned as well as planned departure from a programme of residential rehabilitation.

### **3.4 Residential rehabilitation as part of locally commissioned systems of drug and alcohol treatment**

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Residential rehabilitation is often spot purchased (i.e. a single placement made for a single client) rather than commissioned as part of local treatment systems. This may lead to financial instability for providers unable to predict when their beds will be filled and a lack of integration with treatment

systems, including a risk that aftercare for clients leaving residential rehabilitation may not be properly planned. However, an over-reliance on block contracting with a small number of providers may limit client choice and provider flexibility. There is a need to develop balanced models according to local need.

Residential rehabilitation has not experienced the same growth as community-based treatment options, and there is a need to increase both the number of beds and the use of residential treatment (Best *et al.*, 2005). This need is being met, in part, by a capital funding programme in 2006/07 and 2007/08 and a cross-government work programme. The success of the programme will require commissioners, care management teams and providers to work together at a local and regional level.

Residential rehabilitation is often a national resource and different models of local, regional and supra-regional commissioning may be needed. There is more guidance in the Initial Guide for the Commissioning of Inpatient and Residential Rehabilitation Drug and Alcohol Treatment Interventions as Part of Treatment Systems (Home Office, NTA, DH, 2006). Further guidance on commissioning residential rehabilitation has been issued alongside this document.

- More flexible funding models which pool community care monies with pooled treatment budget and other health and social care funding may also be necessary. Commissioning guidance emphasises this, and the importance of commissioners using a mixed economy to purchase or commission Tier 4 treatment. In particular, sole reliance on community care funding for residential rehabilitation is unlikely to be sufficient and other funding arrangements should also be used to supplement and lever community care.
- Commissioning guidance also emphasises a mix of block and spot purchasing of residential rehabilitation places, and a move towards contracting with preferred providers able to demonstrate the quality and effectiveness of their services.

### **3.5 Matching clients to appropriate services**

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The choice of an appropriate residential service is affected by a number of factors:

#### **3.5.1 Client-programme matching**

Matching clients' needs to appropriate residential services is not an exact science. However, there are some guiding factors, which are described separately for each of the programme types in this guidance. In very broad terms, long-stay rehabilitative programmes will be better suited to clients with longer histories of complex drug and alcohol misuse, and related health, social and criminal problems, who perhaps have greater care needs or skills deficits.

Clients' needs may be determined by a range of factors, not necessarily directly related to their drug and alcohol misuse, and these must also be taken into account. For example, clients experiencing domestic violence should be matched with a service that has policies and procedures to prioritise the safety of women and children living with or escaping abusive relationships.

#### **3.5.2 Location**

Location is a complex issue. Residential rehabilitation services are located all over the country, in rural, urban and suburban areas. However, there are clusters of services in some seaside areas and many of the larger, long-established services are in rural areas.

Drug and alcohol misusing clients may feel they need to get away from the area in which they have been using and, in some cases, having spent time in a service in a "nice" area that they then associate with good things (becoming drug-free, making friends, etc), may plan to resettle in that area. For many people, especially those without strong family or community ties, this may be a perfectly reasonable idea, although it can lead to pressures on health and social services, housing and, perhaps, employment in popular areas of resettlement.

However, many clients may ultimately want or need to return to their families, communities, housing and employment after residential rehabilitation. It may be that it is easier to maintain the links they will need for successful resettlement if they remain in the area or at least relatively near. It may also be easier for “local” residential rehabilitation services to build links with the range of services needed in an integrated treatment system and for resettlement, and to access a range of local funding options.

For many residential services the challenge is to successfully integrate with the local treatment system while also remaining a national resource.

### **3.5.3 Need to balance resident group**

Although some types of residential services may be generally better suited to clients with a particular range of characteristics, it is also important for most services to maintain a mixed and balanced client group. This is in the service's interests as it prevents a concentration of particular problems and issues that may be demanding of limited staff expertise or may require especially high levels of supervision. It is also in clients' interests since it ensures that the resident group has a range of experience, skills and attributes that they can contribute in mutual support, and better reflects the range of personalities and problems they will have to live with in the community.

### **3.5.4 Client choice**

Referrers have an obligation to consider client choice in selecting an appropriate service. Clients may know of and value a particular residential service through the experience of other drug and alcohol misusers or even from a previous stay.

Although client choice may sometimes appear to be based on apparently arbitrary principles, referrers should factor into their considerations the beneficial impact of client choice being met. Put simply, if a client feels good about where they are going for treatment they may stay longer and do better.

### **3.5.5 Commissioner/purchaser choice**

In an ideal world, the choice of an appropriate residential service might only be determined by the first three factors. However, in the real world, commissioners and care managers will know some services and their staff better than others, may have experienced positive (or negative) outcomes with particular services, and may be used to and more comfortable with the referral processes for some services. This is inevitable and not, in itself, a bad thing. A commissioner or care manager who has close links with a service is likely to better understand its programme and which clients can benefit.

However, commissioners and care managers will need to ensure that a range of effective, high-quality residential rehabilitation options is available to their clients and that this is not unduly limited by personal knowledge, relationships or preferences. The National Drug Treatment Monitoring System (NDTMS) is a valuable source of comparable data on key issues such as service waiting times, retention rates and completion rates.

### **3.5.6 Length of stay and cost**

Although client needs should be the principal determining factor in opting for residential treatment and determining an appropriate service, commissioners and care managers will inevitably be influenced by length of stay and cost. It is important that they carefully assess what is on offer, the quality and effectiveness of the programme and its suitability for the client.

Selecting a lower cost or shorter programme may provide short-term cost savings but, if treatment fails and the client returns to drug and alcohol misuse (with its associated crime and health costs) or needs further treatment, the long-term costs may be far higher. This is why proper assessment and preparation are vital to ensure that clients access appropriate levels of service.

It also needs to be recognised that clients' needs will change during treatment, and especially during intensive residential treatment. Regular reviews by the service and referring keyworker will highlight these changes and the need to consider either extending the length of stay in the programme or transferring to a programme better suited to meet the changed needs.

### **3.6 Charges for residential rehabilitation**

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The per capita charges made by residential rehabilitation services will vary according to a number of factors, including:

- The length of the programme: short programmes may make a higher weekly charge
- The level of medical and social care provided and the service's resulting registration. On average, a scale of charges from highest to lowest will contain:
  - Independent hospitals
  - Care homes with nursing
  - Care homes
  - Unregistered services
- Whether the service receives funding from sources such as Supporting People, which will tend to keep charges down
- Whether the service receives charitable support for its activities, which will tend to keep charges down.

Other factors include:

- The standard of "hotel" services – private services with single rooms, extensive grounds and expensive furnishings charge much more than charitable organisations with shared rooms, in smaller properties with average facilities
- Location – London and the Home Counties tend to be more expensive for property, facilities and staff and this is often reflected in charges.

It is important that purchasers and commissioners recognise and reflect in the charges they are willing to pay:

- The compact with the voluntary sector, which agrees the need for full cost recovery
- The costs of providing resettlement, post-treatment support or aftercare

### **3.7 Stages**

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This document avoids differentiating residential rehabilitation programmes according to the traditional "stages" of treatment. This is because:

- There has been little agreement on the definitions of first (or primary), second (or secondary) and third stage and they have come to mean different things to different people
- Stages are traditionally associated with 12-Step treatments and may seem to exclude other programme types.

However, we are aware that many people still use the "stages" and will want to map the programmes in this model to them. As an approximate guide:

- First stage usually corresponds to short stay rehabilitative programmes or the initial stages (up to 12 weeks) of long stay rehabilitative programmes

- Second stage usually corresponds to the later stages (over 12 weeks) of long stay rehabilitative programmes
- Third stage usually corresponds to supportive programmes or to supported housing that is not included in the definition of residential rehabilitation.

### **3.8 Beyond residential services**

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Residential rehabilitation services have often used their experience and expertise to diversify and may additionally provide a range of community treatment and resettlement options. These were described by SCODA ten years ago (SCODA, 1997) and are still relevant. They are often accessible to non-resident referrals as well as to residents in and leaving the programme. They include:

- Supported housing
- Education, skills and vocational training
- Structured day programmes
- Floating support, domiciliary or home care.

## **4 Rehabilitative programmes**

### **4.1 Programme types and length of stay**

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Research has found improved outcomes to be more likely among clients who spend longer periods of time in treatment. Episodes of at least three months are more likely to be associated with positive outcomes (Simpson, 1997). However, this minimum time in treatment applies across treatment types (Gossop *et al.*, 1999) so it may be that a shorter programme of residential rehabilitation followed by time in community treatment is as effective as a longer residential rehabilitation programme.

On its own, though, this minimum time before treatment begins to show real benefits is misleading. Longer periods in treatment, up to one year or more, show continuing improvement in outcomes (Simpson *et al.*, 1997). Programme completion (Simpson and Savage, 1980; Hubbard *et al.*, 1989) and clients' active participation and engagement (Simpson *et al.*, 1995; McLellan *et al.*, 1993) are also critical factors.

#### **4.1.1 Long stay**

Long stay residential rehabilitation programmes are usually between six and 12 months in duration. In longer programmes this duration may be divided into different stages, perhaps across different buildings. Assisted withdrawal may or may not be provided as a precursor to entry into the main programme.

Long stay programmes are commonly in services that have accommodation and treatment on the same site, often in a single large building. A small number of long stay programmes are provided by services that provide accommodation and treatment on separate sites. They will differ from supportive programmes by usually having 24-hour staff cover on site in the accommodation building.

Australian literature (NSW Health Department, 2000) suggests that longer-term treatment services should be targeted to:

- People with severe alcohol and drug use problems, where these problems pose a significant risk to the health and welfare of the person themselves and others

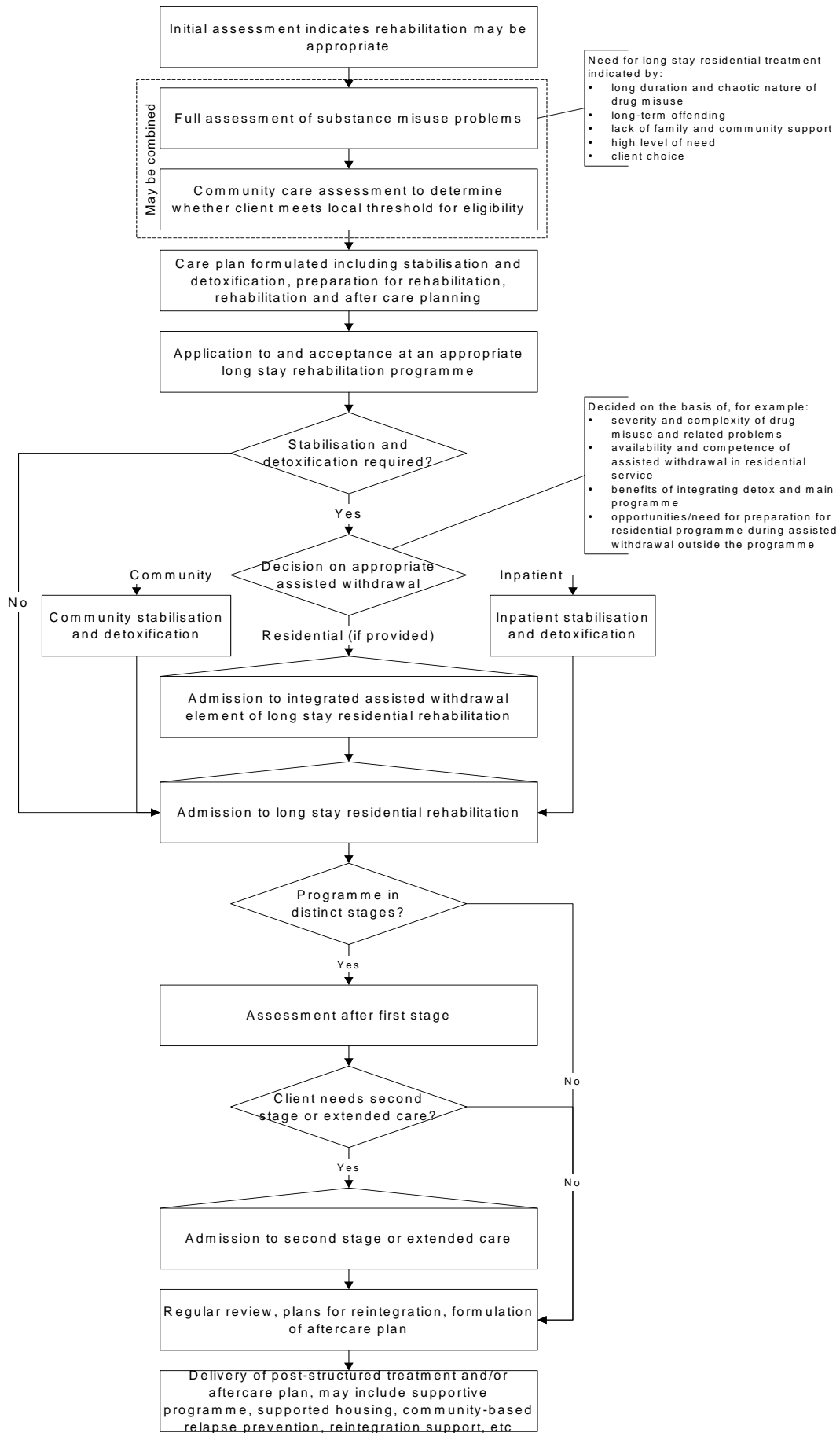
- People for whom non-residential or short term treatment options have failed to address their treatment needs in the past
- People whose home setting or social circumstances are not supportive of non-residential treatment options, to the extent that such treatment options are unlikely to succeed
- People with significant co-morbid disorders, requiring longer stabilisation.

Longer long-stay programmes are generally better suited to clients who are chaotic and socially excluded and who may be characterised by poor educational and social skills attainment, unemployment, severe housing need, and persistent and prolific offending.

However, there may be some clients who will benefit from a long stay programme at an earlier stage in their drug and alcohol misusing careers.

Long stay programmes vary markedly in their philosophy (see section six).

An example of a care pathway into and through a long stay programme is shown in the flowchart overleaf.



**An example of an integrated care pathway for a client going into long stay treatment**

## **4.1.2 Short stay**

Two different programme types are included in this heading. Both have a duration of less than 12 weeks. Both short stay programme types may be provided by a single service.

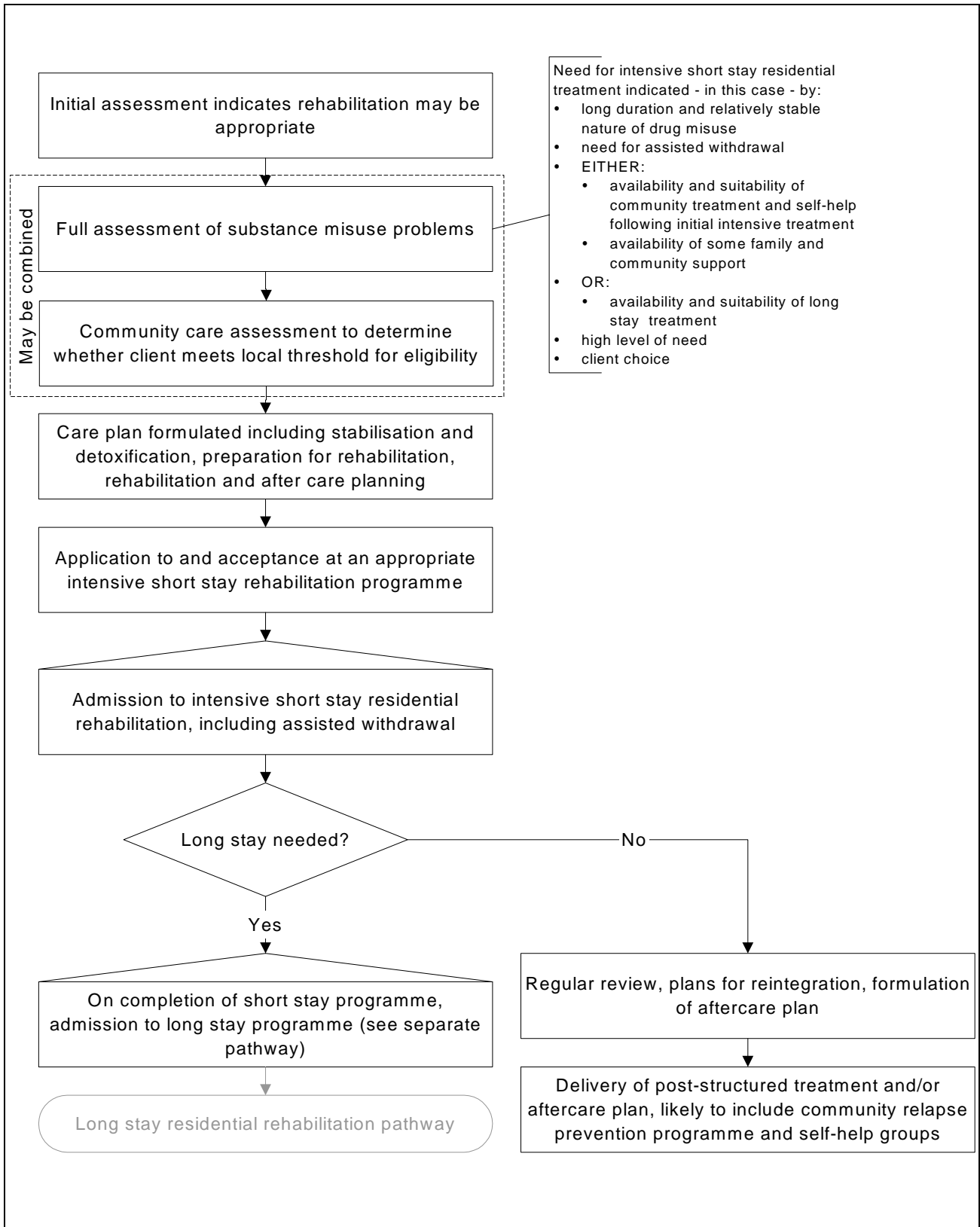
### **4.1.2.1 Intensive short stay**

Typically these programmes are up to 12 weeks in duration, and usually include assisted withdrawal. They cater for the needs of clients who require intensive short-term support with an emphasis on medical and cognitive behavioural interventions, often as a precursor to entry into a long stay programme – perhaps one that does not provide assisted withdrawal.

These services are likely to take similar clients to the long stay programmes they feed.

They are more likely to be registered as care homes with nursing.

An example of a care pathway into and through an intensive short stay programme is shown in the flow chart overleaf.



**An example of an integrated care pathway for a client going into an intensive short stay programme**

#### **4.1.2.2 Lower intensity short stay**

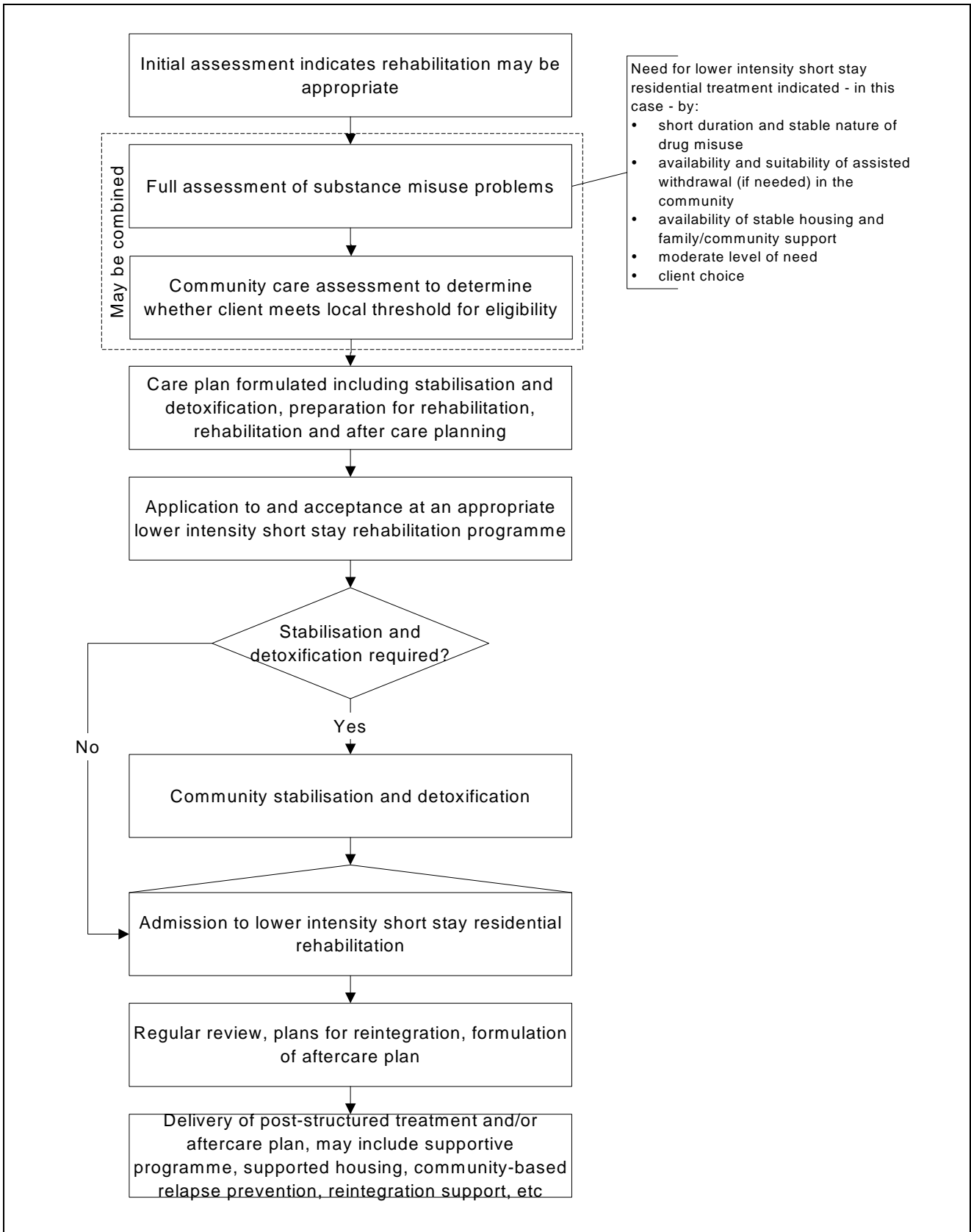
Typically these programmes are around six weeks in duration, but may be up to 12 weeks, and may include assisted withdrawal. They cater for the needs of clients who require short-term support with an emphasis on cognitive behavioural therapy and relapse prevention interventions.

The available literature suggests that this type of service should be targeted to people who have:

- Less entrenched histories of substance dependence
- Previous histories of outpatient treatment failure
- No previous history of treatment failure in residential settings
- No significant cognitive impairment
- Less severe co-morbidity (mild depression or anxiety, stable psychotic conditions)
- Better psycho-social supports including employment opportunities.

There is some evidence that the short stay residential treatment programs have a higher success rate, in terms of completion of treatment and post treatment outcomes, for clients with primary alcohol dependence than for clients with primary opioid dependence. In terms of the treatment approach, a review of the literature suggests that such programmes are not effective as a post detoxification intervention unless they incorporate a progression to structured options such as supervised half-way house accommodation or daily/weekly participation in a non-residential treatment program (NSW Health Department, 2000).

An example of a care pathway into and through a lower intensity short stay programme is shown in the flow chart overleaf.



**An example of an integrated care pathway for a client going into a lower intensity short stay programme**

## 4.2 Common elements

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Individual rehabilitative programmes vary widely in terms of, for example:

- Length of stay
- Philosophy and programme of care
- Whether or not assisted withdrawal (detoxification) is provided
- Whether or not later stages of supported accommodation are provided.

However, there are elements that are common to all and these are described in the following pages.

### 4.2.1 Definition

Rehabilitative programmes have the following defining characteristics:

- They provide accommodation for drug and alcohol misusers in a drug-free environment (see footnote 1)
- They provide a structured, care planned programme of therapeutic and other activities
- The programme, at least initially, usually places more emphasis on dealing with immediate issues surrounding drug and alcohol misuse rather than on skills to enhance success at independent living (although this emphasis will shift during the programme, especially a long-stay programme)
- Clients are required to be drug and alcohol-free before entry onto the main programme (although, in some cases, assisted withdrawal can be provided as a precursor)
- Staff are on site 24-hours a day, although this may not be the case in the later stages of a long-stay programme.

### 4.2.2 Eligibility

Residential treatment may be appropriate at any stage in a drug and alcohol misuser's treatment journey. It should not be reserved for those who have failed in other treatment options or have especially entrenched drug and alcohol use or very complex needs. Drug and alcohol misusers most suitable for rehabilitative programmes are likely to be those who:

- Have medium to high dependence on drugs and alcohol
- Want to be drug free (see footnote 1), at least for the duration of the programme
- Have found it difficult to achieve abstinence in the community
- Have complex problems related to their drug and alcohol misuse
- Require respite and an intense programme of support and care which cannot realistically be delivered in a community or outpatient setting
- Need to receive treatment away from their usual drug and alcohol-oriented community or family environment
- Want a treatment that is residential and are willing to accept restrictions on their liberty for the duration of the programme.

Clients going into residential rehabilitation as part of a court-ordered Drug Rehabilitation Requirement will usually fall within the high seriousness of offence sentencing band or, if they have a low seriousness of offence, will have a high treatment need and wish (and may already be in the process of applying) to access residential treatment (NPS, 2005).

Rehabilitative programmes may not be suitable for those who:

- Have needs that require supervision in a controlled medical environment
- Want to continue to use some drugs or drink during treatment
- Cannot or will not comply with restrictions on liberty
- And, depending on the type of unit, the programme and its ability to provide specialist care and treatment, may also not be suitable for those:
  - In education, training or employment that would be best maintained during treatment
  - With dependants for whom alternative arrangements for care cannot be made or would be inappropriate
  - With severe co-existing substance misuse and mental health problems.

#### **4.2.3 Assessment and preparation**

All clients considered for rehabilitative programmes must have received a comprehensive drug and alcohol misuse assessment, and will have a care plan that indicates a need for residential treatment.

If community care funding is sought they must also receive a Community Care assessment. In some cases – especially where Community Care assessment has been contracted out to a community drug and alcohol service – this may be carried out by the same person and possibly at the same time as the comprehensive assessment. If not, common assessment forms can reduce the need to repeatedly ask the same questions.

In addition, most residential services will perform their own assessment before a client is accepted for the programme. Where practical, this will usually take place at the service and will include an assessment of:

- Support and care needs
- Risks to themselves, staff and the current resident group
- Medical needs
- Psychological and social needs
- Understanding of the programme and their choice of treatment
- Compatibility with the programme and current resident group.

The service's assessment will take account of and perhaps further assist in the development of the care plan and Community Care assessment.

Where it is not possible for the client to attend the service for assessment, staff may travel to carry out the assessment or accept the assessment of another professional, perhaps one who has been trained by the service to conduct their assessments. Alternatively, the service may conduct an assessment by telephone.

There is more detailed guidance on assessment in Models of Care: Update 2006 (NTA, 2006a) and the Care Planning Practice Guide (NTA, 2006b).

Applicants should be offered the opportunity to visit the service, especially if the programme is a longer one, since it may be their home for some months. Some services provide the facility for or expect applicants to stay overnight. Visiting will not always be feasible because of travel distance, level of intoxication, personal circumstances, imprisonment, etc.

If a client has been accepted for residential rehabilitation in an area away from the local or referring area, the referring agency should either directly advise social services in the area in which the

residential rehabilitation service is located or ensure there is a suitable mechanism in place by which the residential rehabilitation service informs their local social services department. This will be important in case of unplanned departure from the programme.

Some services are able to provide a “holding” programme to support residents waiting to join the programme. Elements of a holding programme might include:

- Telephone support
- Counselling
- Support groups.

Occasionally, holding accommodation may be available; somewhere a drug and alcohol misuser hoping to go into a rehabilitative programme can stay while assessment is carried out and funding secured.

In some cases, making regular contact – such as telephoning in every week or more – may be a condition of applicants remaining eligible for admission.

Escorting clients from home, prison or a community drug and alcohol service can help ensure that they do not drop out before reaching the residential service.

#### **4.2.4 Entry and induction**

On entry, the residential service will usually carry out a further assessment. This will be designed to clarify and expand upon pre-admission assessments and determine specific needs for support and development, especially in the early stages of the programme. In most cases it should be conducted by the keyworker allocated to develop and review the client’s care plan.

Most services will conduct a search of the new resident and their belongings to ensure that no drugs, alcohol or weapons are brought into the house. Prescribed medicines – if permitted – will usually be taken and securely stored for the resident.

All new residents should be provided with copies of relevant policies and procedures.

Rehabilitative programmes offer a number of different mechanisms to inform new residents about the programme and provide them with a gradual and supportive introduction to it. Induction procedures can improve retention and outcomes, and include:

- Beginners’ groups
- Individual support by staff or through mentoring by established residents
- Background and supporting documents.

Services may also provide induction for partners or family members so they know what is going to happen, how they can help and what support is available for them.

#### **4.2.5 Care planned treatment**

All rehabilitative services should provide a programme approach with individual care planning. There should be one-to-one sessions with a keyworker at least once a week and a daily programme of activities including some or all of the following:

- Group work on a range of drug and alcohol related issues from harm reduction to understanding patterns and triggers to drug and alcohol use, relapse prevention work, motivational enhancement, building support networks and other psychosocial interventions
- Sport and other physical activities
- Life skills e.g. budgeting, cooking, managing tenancies

- Art, crafts, music and other recreational activities
- Vocational or educational activities e.g. literacy, NVQs
- Family work.

There will also be access to medical and dental care, and perhaps complementary therapies.

The care plan should be reviewed regularly throughout treatment, by the allocated keyworker and with the client. Because clients and their needs can change rapidly and dramatically in residential rehabilitation, it may be appropriate to review the care plan more frequently than in the community, perhaps monthly. The client's local care manager or DIP case manager, who retains responsibility for care co-ordination or throughcare, and any other agencies involved in care delivery should be involved in the review and informed of the outcome, although it may not be feasible for the care/case manager to attend every review.

Detailed guidance and resources on care planning are in the NTA's Care Planning Practice Guide (NTA, 2006b).

#### **4.2.6 Throughcare**

Throughcare is a crucial aspect of the Drug Interventions Programme and refers to arrangements for continuous support of a drug misuser from the point of arrest to sentence and beyond, including those making the transition from prison to the community. A client referred into residential rehabilitation via a local criminal justice integrated team will have a case manager oversee their entire course of treatment.

#### **4.2.7 Retention and completion**

Stopping clients dropping out of treatment before completion and retaining them in treatment for at least three months are crucial in improving the effectiveness of residential rehabilitation programmes.

The latest figure for retention of clients in residential rehabilitation for 12 weeks and more is over 62 per cent (1 April 2005 to 18 March 2006), compared to over 76 per cent across all drug treatment services. Although residential services have already achieved the 2008 target of 62 per cent they should continue to aim to improve retention. This is especially important in residential services, in which the evidence suggests that even longer stays produce continued improvements in outcomes.

Research for the NTA indicates that retention and completion rates in residential rehabilitation are higher in programmes with:

- Fewer beds and mostly single room occupancy
- Eight hours a week or less on housekeeping duties
- Higher weekly fees
- Between one and two hours per week of individual counselling
- Higher ratios of staff to clients (Meier, 2005).

Engagement and retention in drug and alcohol treatment services generally are improved by:

- Encouraging reminders
- Motivational interventions
- Quicker entry into treatment
- Client induction

- Clients being escorted to and between services (NTA, 2005a).

Treatment completion should be planned and managed as part of the care plan. The keyworker and the client, together with the care manager responsible for throughcare, should consider interventions in the community to support changes achieved or to continue to address a range of needs e.g. stable housing, education and employment. This is covered in more detail in section 4.2.9 on reintegration into a local community. The process of treatment completion should also involve the drawing up of an “aftercare plan” or “post structured treatment plan” to ensure that all support for the client that is already in place continues if necessary, and that any support not in place can be mobilised in time for the client leaving treatment.

#### **4.2.8 Discharge**

Discharge from residential rehabilitation should be planned and implemented in a structured way, even in the case of a disciplinary discharge. Discharge as part of planned completion of a programme should involve the aspects of reintegration described in the next section.

A resident discharged from a rehabilitative programme ahead of planned completion must be provided with support to minimise the chances or impact of relapse. Whether discharge is planned or unplanned residential rehabilitation services should, as appropriate:

- Immediately advise the referring agency and care manager, including – if the client is under a Drug Rehabilitation Requirement or other order – the criminal justice integrated team or probation officer
- Advise social services of the area to which the ex-resident is expected to locate
- Provide advice on the risk of overdose due to decreased tolerance
- Provide condoms and clean injecting equipment
- Provide contact details for community services and self-help groups
- Escort clients to their next care planned intervention or to aftercare
- Provide travel expenses
- Assist with appropriate temporary accommodation.

#### **4.2.9 Reintegration into a local community**

Reintegrating drug and alcohol misusers into the community is a staged process that should start well before planned departure and continue after a resident has left a residential rehabilitation programme. It is the responsibility of commissioners and services making placements in residential rehabilitation to ensure that reintegration is in place. However, depending on where the resident settles, the resources of the residential rehabilitation service and the services they are contracted to provide, the elements of reintegration may be provided by the residential rehabilitation service or shared with community services. These are vital interventions in ensuring that a drug and alcohol misuser completing residential rehabilitation is protected from relapse and must be properly planned and funded to protect the investment and gains made in their residential treatment.

Some residential rehabilitation services employ specialist resettlement workers who can offer support, advocacy and advice to residents approaching the end of the programme and to ex-residents. Purchasers should consider who is best placed to provide resettlement support and how it is funded. Resettlement support provided by a residential rehabilitation service is enhanced by the staff’s understanding of the programme and relationships built up with residents.

#### **Preparation for leaving**

The transition to living outside the intensive support of a rehabilitative programme should be managed carefully. All residential services should assess life skills and most programmes, especially longer ones, should include life skills education and activities. Towards the end of the

programme residents should be involved in a planned series of activities designed to foster their independence, confidence, community support networks, access to education, training or employment, continued treatment and permanent housing. These might include:

- Encouragement to undertake voluntary work, either in the community or with other clients, to prepare them for the working environment
- Employment in the final stages of the programme
- Early planning and preparation for challenges
- Participation in Narcotics Anonymous or Alcoholics Anonymous groups or non 12-Step equivalents
- Application or nomination for move-on accommodation, e.g. supported housing provided by social landlords.

Drug and alcohol misusers leaving rehabilitative programmes may still need drug and alcohol-related support. This may be a part of their care planned treatment that continues after their stay in a residential rehabilitation service or provided as aftercare.

Whether there is continued care or aftercare following residential rehabilitation, there should be planned follow-up and evaluation of outcomes.

### **Continued care or treatment**

Treatment may continue as part of the care plan after a resident leaves residential rehabilitation. Such treatment might include:

- Attendance at a structured day programme
- Continuing support from staff such as counselling and advice
- Continued but reduced attendance at therapeutic groups.

### **Aftercare**

Aftercare is defined as interventions provided after the end of a care plan. However, it should be planned ahead of departure and reflected in the care plan. It should address both drug and alcohol and non-drug and alcohol related needs.

Models of Care: Update 2006 (NTA, 2006a) lists the range of support that might be provided as aftercare:

**Drug-related support** could include open-access relapse prevention, mutual support groups (e.g. AA/NA or equivalent user-led groups), and advice and harm reduction support. In addition, a range of open-access and low-threshold interventions should be available to provide specific interventions to people who have completed treatment, but who may want or need to have occasional non-care planned support.

**Non-drug-related support** can cover a range of issues such as access to housing, supported accommodation, relationship support, education and training, support to gain employment, and parenting and childcare responsibilities. In addition, women's services, peer mentor programmes and other social and activity groups can form elements of non-drug related support.

Aftercare following residential treatment and perhaps provided by the residential service might include the following specific elements.

#### ***Drug and alcohol-related aftercare:***

- Continuing support from staff such as counselling and advice

- Continued but reduced attendance at therapeutic groups
- Telephone support and follow-up (ex-residents may be able to phone to speak with staff or the service may make regular contact with the ex-resident to check their progress and offer support)
- Informal drop-in access to a day programme
- Peer support programmes, perhaps including ex-residents returning to the service to support each other or residents still on the programme
- Participation in Narcotics Anonymous or Alcoholics Anonymous groups or non-12 step mutual aid groups.

***Non-drug and alcohol related aftercare:***

- Appropriate housing, perhaps including halfway houses
- Use of telephones, and use of the internet for job searching
- Making links with colleges or providing funding for courses
- Social events such as reunions, barbecues and football matches.

(Fox *et al.*, 2005)

A post-structured treatment or aftercare plan should also include options for rapid access back into treatment if the client requires it. In most cases, this is unlikely to include a rapid return to the residential rehabilitation programme but may include assisted withdrawal and other interventions operated by the residential rehabilitation provider or others to quickly respond to relapse.

**4.2.10 Registration and inspection**

Most rehabilitative programmes are considered to meet the current criteria for – and are required to register as – care homes with or without nursing, and are inspected by the Commission for Social Care Inspection (CSCI). The requirement to register with or without nursing is usually determined by the level of assisted withdrawal provided (see section eight).

Some rehabilitative programmes – especially those providing independent hospital services for a range of client groups – meet the criteria for and are registered as providers of independent healthcare, and are inspected by the Healthcare Commission. Most are classed as independent mental health establishments. They are required to apply for registration with the Healthcare Commission, and must be registered before they can provide a service.

Some services – those not providing personal care or independent healthcare – may not be registered. If funded under the Supporting People programme they will be regularly reviewed by local Supporting People teams to ensure they meet standards laid down by central government.

**4.2.11 Standards and guidelines that need to be followed**

The principal standards to be adopted will be determined by the registration of the service.

Registered care homes must meet National Minimum Standards for Care Homes for Adults (18–65). Some concessions have been made to elements of the standards to accommodate the special needs of drug and alcohol treatment services, e.g. restrictions on visitors. Clients must be informed of these variations, which should be specified in the initial contract. Exemptions from the standard can be allowed only if they can be justified by the therapeutic needs of the programme. CSCI inspectors have been issued with guidance on applying the standards to drug and alcohol registered care homes (CSCI, 2006).

Those taking clients under the age of 18 will also need to meet Supplementary Standards for Care Homes Accommodating Young People Aged 16 and 17 and may have to meet additional criteria

and follow additional guidance to ensure that their premises and programme are appropriate and safe for young people. A young person's specialist drug worker should be involved in the assessment of a 16-year-old considered for adult residential treatment.

Independent health care providers are required to meet National Minimum Standards for Independent Health Care.

National minimum standards cover a wide range of service, premises and personnel issues, including, for example:

- Care planning
- Complaints and protection procedures
- Bedroom sizes and sharing
- Healthcare and medication
- Management and staff competence (see next section)
- Confidentiality, privacy and liberty.

Services offering psychosocial interventions will be required to follow forthcoming National Institute for Health and Clinical Excellence (NICE) guidelines (expected July 2007, see section ten). Services offering assisted withdrawal will also be required to follow forthcoming NICE guidelines on detoxification (see section eight).

There may also be additional standards and guidelines to be followed according to the client group serviced, for example, services taking drug and alcohol misusers and their children.

Services funded under the Supporting People programme need to meet standards laid down by central government. These standards are meant to ensure that residents are:

- Assessed for the service they need and given a support plan
- Safe and secure in their accommodation
- Protected from abuse or harm
- Able to use the services it is assessed they need.

Local Supporting People teams review services regularly to check standards are being met.

Some services may also have or be working towards independent drug and alcohol service standards, such as Quality in Alcohol and Drug Services (QuADS), or accreditation such as that offered by the European Association for the Treatment of Addiction (EATA). They may also hold or be working towards non-drug and alcohol specific standards and accreditation such as the Investors in People standard, Health Quality Service accreditation or ISO 9000. Internet links for all these systems are contained in section ten.

Residential rehabilitation services must also comply with health and safety legislation, environmental health and fire regulations.

Residential rehabilitation services will also be subject to the Healthcare Commission / NTA improvement review process in 2007/8. Criteria will be developed during 2006/7 (in partnership with CSCI) and all services will be benchmarked against the criteria in autumn 2007. Services and areas found to be below the national standard will be expected to improve.

#### **4.2.12 Staff competence and coverage**

The range of staff competences should be appropriate to the programme provided and may also be determined by the registration status of the service and the requirements of the relevant national minimum standards.

Staff in registered care homes must be qualified, competent and experienced in accordance with National Minimum Standards for Care Homes for Adults (18–65) and requirements set down by the Commission for Social Care Inspection (CSCI) and Skills for Care. Managers must have an appropriate qualification in Care (NVQ Level 4 or qualified nurse) and have, or be working towards, a recognised qualification in management (NVQ Level 4 or equivalent). Staff will usually hold or be working towards either a Level 2 or 3 NVQ in Health and Social Care or a nursing qualification.

Staff in independent healthcare must be qualified, competent and experienced in accordance with National Minimum Standards for Independent Health Care and requirements set down by the Healthcare Commission. Medical practitioners must be registered with the General Medical Council (GMC) and hold appropriate qualifications. Healthcare professionals must be appropriately qualified and trained for the roles they undertake.

Drug and Alcohol National Occupational Standards (DANOS) (Skills for Health, 2003) offer a description of good practice and competence in the planning and delivery of services to substance misusers in all settings. They specify the competences expected of those working in drug and alcohol services and should be used in preparing assessment criteria for appointing and supervising staff.

Doctors providing medical care for the residents of a rehabilitative programmes will need to demonstrate the competences and training defined in Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (RCPsych and RCGP, 2005), also summarised in NTA, 2005b. Required competences and training will be defined by the client group and the nature of the medical care being provided. For example, a GP providing general medical care to the residents of a rehabilitative programme may only be required to have had basic medical training and some vocational training, but a doctor supervising assisted withdrawal in the detoxification element of a residential rehabilitation programme will need more specialist training and qualifications.

Some staff may also have or be working towards independent professional accreditation or certification such as the Federation of Drug and Alcohol Professionals' Drug & Alcohol Professional Certification scheme.

Staff will usually provide 24 hour cover on site. Unless assisted withdrawal is provided medical staff may not be on site in the evening and at weekends but will usually be on call.

#### **4.2.13 Premises, facilities and equipment**

Rehabilitative programmes registered as care homes or independent healthcare providers are required to meet specified National Minimum Standards on premises, facilities and equipment. Some variations from the care standards may be allowed but generally only if they can be justified on grounds of clinical need or avoidance of risk, and if they are made clear to potential service users and are a stated part of the ethos and treatment programme of the service.

Where move-on accommodation is provided by a social landlord and has been funded by the housing corporation, the design of the scheme will be required to meet the housing corporation's development standards and any local planning authority requirements. In addition, housing-related support services funded under the Supporting People programme will be required to meet appropriate service standards. This could include physical standards such as, for example:

- Adaptations for disability
- Security measures

- Installation of emergency alarms.

#### **4.2.14 Performance management and data compliance**

Although residential rehabilitation is often a national resource, it is an important part of local treatment systems and should be performance managed by local drug and alcohol partnerships as part of contractual arrangements.

Residential rehabilitation services are required to keep records consistent with the NDMTS minimum dataset and to complete monthly NDTMS returns on all clients in residence. These requirements should be written into spot and block purchase contracts. Returns provide important data for local, regional and national treatment planning and should be completed carefully and fully, including differentiating the local drug and alcohol area in which the service is located and the area that has placed a resident.

The accurate calculation of waiting times for residential rehabilitation requires that NDTMS returns include the correct dates for date referred to modality, referral date, date of first appointment and modality start date. Please refer to NTA guidance.

## 5 Supportive programmes

### 5.1 Definition

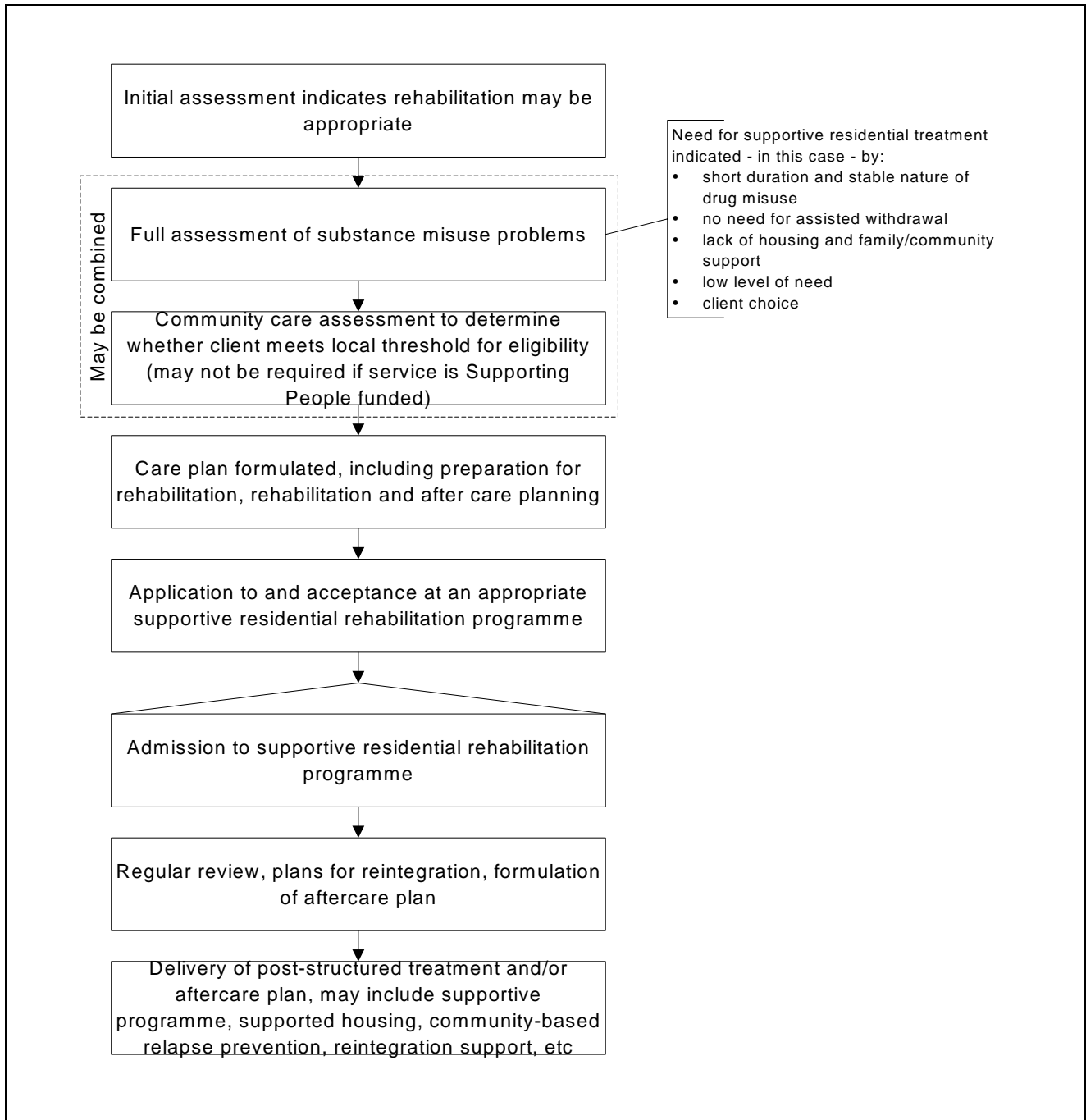
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Supportive programmes have the following defining characteristics:

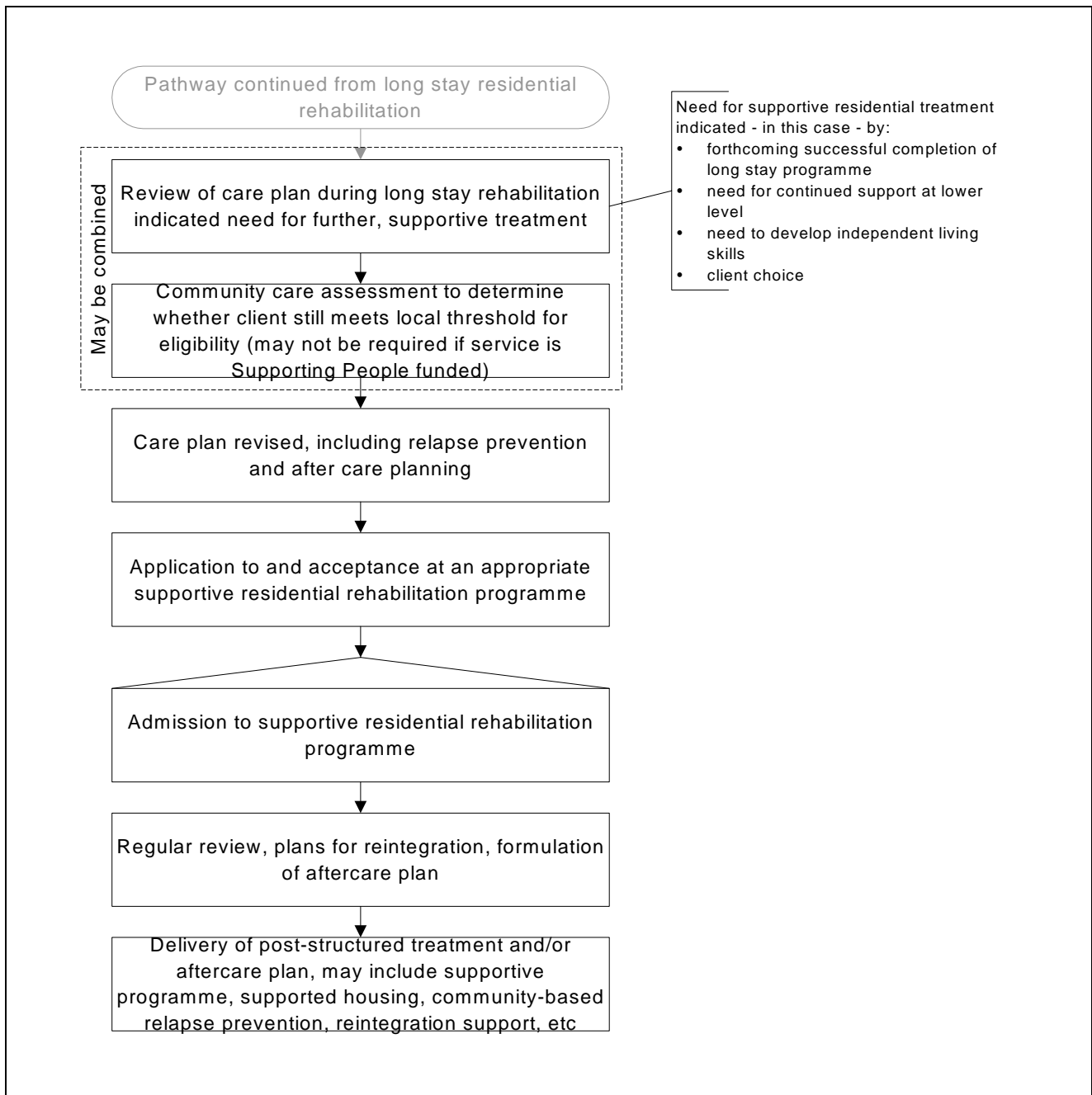
- They provide accommodation for drug and alcohol misusers in a drug-free environment
- They include specialist drug and alcohol and non-drug and alcohol related support
- They may follow care in a rehabilitative programme, or provide a secure base from which clients go to attend therapeutic drug/alcohol and non-drug/alcohol related interventions nearby
- The programme places more emphasis on skills to enhance success at independent living than on dealing with immediate issues surrounding drug and alcohol misuse
- Clients are required to be drug and alcohol-free before entry (although, in rare cases, assisted withdrawal can be provided as a precursor). Some prescribed medication may be allowed, especially where needed to control a psychiatric problem.

Supportive programmes may be in self-contained services or an integral part of a longer residential rehabilitation service but usually in a different building.

Two examples of care pathways into and through supportive programmes are shown in the next two flowcharts.



**An example of an integrated care pathway for a client going straight into supportive treatment**



**An example of an integrated care pathway for a client going into supportive treatment following long stay residential rehabilitation**

Many of the characteristics and criteria applying to supportive programmes will be the same as for rehabilitative programmes. Rather than repeat these here, the following sections generally only describe clear differences between the two.

**5.2 Eligibility**

Drug and alcohol misusers most suitable for supportive programmes are those who:

- Have completed a rehabilitative programme or do not need the level of intensive intervention provided by a rehabilitative programme

- Have been detoxified or abstinent (unless their drug and alcohol misuse is stable and non-complex, and detoxification can be achieved with GP support)
- Want to continue to be drug and alcohol-free, at least for the duration of the programme
- Are in housing need
- Require respite which cannot realistically be delivered in a community or outpatient setting
- Need to receive treatment away from their usual drug or alcohol-oriented community or family environment
- Want a treatment that is residential and are willing to accept restrictions on their liberty for the duration of the programme.

Drug and alcohol misusers who may not be suitable for supportive programmes include those who:

- Have dependants for whom alternative arrangements for care cannot be made or would be inappropriate
- Have severe co-existing substance misuse and mental health problems.

### **5.3 Length of stay**

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Supportive programmes are usually three months or more in duration. Their length of stay is often quite flexible to meet the needs of clients who may either become independent quite quickly or continue to need support for longer than initially anticipated.

### **5.4 Assessment and preparation**

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Clients moving from a rehabilitative to a supportive programme will usually not require an additional comprehensive drug and alcohol assessment and, especially if moving between services operated by the same provider, may not require the service's assessment.

Clients moving straight into a supportive programme from the community will need to:

- Have been given a comprehensive assessment to determine their needs and how these might best be met, and an assessment by the residential service to ensure that the service is able to meet their needs
- Have a care plan if they have been assessed as needing care and treatment
- Have a support plan that identifies their housing-related support needs if the programme is in supported accommodation funded by local Supporting People arrangements
- Have been detoxified or abstinent (unless their drug and alcohol misuse is straightforward and detoxification can be achieved with GP support)
- Have been assessed as not needing to address primary drug and alcohol-related treatment needs or had these needs met by a community treatment service.

### **5.5 Structured interventions**

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Drug and alcohol treatment provided in a supportive programme will usually be provided as part of a care plan but ongoing support and other interventions may be provided as aftercare following the completion of a care plan.

Key working should continue throughout any care planned treatment.

The programme of interventions is likely to be far less intensive than in a rehabilitative programme and will allow more time for self-directed activities. There will be more emphasis on skills to

enhance success at independent living. There will usually still be therapeutic and peer support groups, although much less frequently than in rehabilitative programmes.

Assisted withdrawal is not usually provided for in supportive programmes. However, some services use local GPs to prescribe and provide medical support.

## **5.6 Reintegration into a local community**

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In addition to the preparation for reintegration that goes on within the programme and which is similar to that in rehabilitative programmes, residents in supportive programmes are likely to spend time outside the programme engaged in voluntary work, education, training or employment. Supportive programmes will often have strong links with local education, training and employment bodies and may be able to provide residents with easier access to programmes and opportunities than they could achieve on their own.

Support and independence are likely to be staged so that, as the resident gains confidence and independence, and spends more time making their own arrangements and away from the service, the level of support and expectation of involvement in the programme will be reduced.

## **5.7 Registration and inspection**

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Supportive programmes are unlikely to meet the criteria for registration as either an independent healthcare provider or a care home with nursing. Depending on the level of care provided and on historical arrangements, they may be registered as care homes and inspected by the Commission for Social Care Inspection (CSCI). Where only housing-related support is provided and the service receives Supporting People funding, local Supporting People requirements will apply.

## **5.8 Standards and guidelines that need to be followed**

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In line with the requirements to register, independent healthcare standards are unlikely to apply to supportive programmes. Care standards will apply to registered care homes and – because of the greater emphasis on independence and less central role of any therapeutic programme – it may be less likely that variations from the standards will be permitted.

It is more likely than for rehabilitative programmes that supportive programmes will not be registered as care homes. Services funded under the Supporting People programme will be required to meet standards laid down by central government and will be regularly reviewed by local Supporting People teams.

## **5.9 Staff competence and coverage**

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Staff competence required will be in line with any registration.

Staffing will usually include 24-hour cover. Outside office hours staff may not be on site but on call.

## **5.10 Premises, facilities and equipment**

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If registered as a care home, care standards for premises, facilities and equipment will have to be met, and it is less likely that concessions to the standards will be permitted. For example, all residents may need to be accommodated in single rooms.

Services that have received housing corporation capital subsidy will be required to meet their development standards and any local planning requirements.

Services funded under the Supporting People programme will be required to meet appropriate physical standards.

## **6 Different philosophies and allied programme differences**

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Residential rehabilitation services are based on a number of different philosophies. These describe aspects of their ethos, theoretical underpinning, belief systems and method of working, and influence the programme they run. These philosophies are not simple categorisations and are not mutually exclusive. Increasingly, services combine different treatment strategies to meet individual client needs.

In matching clients to suitable services, it will be important to match a client's understanding of their drug and alcohol misuse, approach to treatment, personality, history and other factors to a suitable philosophy. This is difficult to describe fully but a few examples include:

- A client who is uninterested in long-term abstinence may be unsuitable for a strict 12-Step model
- Treatment that emphasises confrontation, subordination, powerlessness, and isolation may be unsuitable for women with histories of domestic violence (Swan *et al.*, 2001)
- Psychopaths and purposefully violent offenders may learn additional techniques of control and manipulation in therapeutic treatment.

### **6.1 12 Step**

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This is an increasingly broad term stemming from the 12 steps of the Alcoholics Anonymous model, which views addiction as a disease. Residents will usually work their way through the steps as part of a planned programme of care. Services or the sub-services within them – different programme stages or even different buildings – may operate through ranges of these steps, for example first stage covering Steps 1–5 and second stage covering steps 6–12. The model is increasingly being modified and adapted to allow greater flexibility and individual care planning, and services may refer to their programmes as modified 12-Step or modified Minnesota model. Residents will often spend time in “step” groups, in addition to other individual and group therapeutic activities.

The residential element of 12-Step programmes is often quite short (less than three months) but ex-residents will be expected to continue to attend AA/NA group meetings in the community.

Just under half of the services in the NTA's online directory of residential rehabilitation describe themselves as 12-Step.

### **6.2 Therapeutic community**

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In a therapeutic community staff and clients participate together as members of a social and learning community. The service may have a hierarchical structure which residents work through and in which each stage has a different pattern of activity, together with growing freedom and responsibilities. Time will be spent in therapeutic groupwork, one-to-one keywork, developing practical skills and interests, education and training.

Like 12-Step programmes, therapeutic community models have been adapted over the years and made shorter and more flexible. The intensive nature of their approach to individual psychology still means that they tend to be among the longer programmes (six to 12 months).

Over half of the services in the NTA's online directory describe themselves as therapeutic communities.

### **6.3 Cognitive-behavioural and social learning**

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These are programmes that include psychological treatments such as cognitive behavioural therapy (CBT), in which actions are believed to influence future behaviour.

Seventy per cent of the services in the NTA's online directory describe themselves as providing cognitive behavioural or social learning therapies.

### **6.4 Personal and skills development**

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The programme in a service operating a personal or skills development model may focus less on psychological therapeutic interventions and more on the practical skills and knowledge needed to get by in the wider community. They may be closely linked with local education or employment training providers and residents will spend much of their time in structured programmes of educational classes, training activities and group work. There may also be opportunities for work experience.

### **6.5 Faith-based**

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Faith-based services have religious staff and may or may not require that residents share their faith or participate in faith-related activities. These activities will include time studying religious texts and the lessons to be learned from them, in discussion and in prayer.

Less than ten per cent of the services in the NTA's online directory describe themselves as faith-based.

## **7 Residential rehabilitation for targeted groups**

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Some residential rehabilitation services target specific groups of drug and alcohol misusers and provide interventions and services appropriate to these groups. These are uncommon and, as specialist services with narrowly-defined client groups, are more likely to be provided as national resources. Some are faced with special difficulties in funding their services. They are the area of residential rehabilitation most in need of expansion and development.

### **7.1 Drug and alcohol-using women**

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Some women, including those with a history of sexual abuse or domestic violence, may benefit from a women-only service. The programme in these services may place more emphasis on tackling these issues and on gender-specific issues.

### **7.2 Drug and alcohol-using pregnant women**

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Services for drug and alcohol-using pregnant women will have access to specialist pregnancy and antenatal care. They will be closely involved with local antenatal services.

Because of the risks involved in detoxifying pregnant women, most residential rehabilitation services taking pregnant women will only do so after assisted withdrawal has been arranged elsewhere.

### **7.3 Drug and alcohol users with severe and enduring mental illness**

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Most residential rehabilitation services are able to work with drug and alcohol-misusing clients with co-existing mental illness. However, many will exclude those with severe and enduring mental health problems because of both the risk they might present to other residents and an inability to participate fully in the programme. Services will conduct a needs and risk assessment to assess these factors.

Services that are able to work with severe and enduring mental illness will usually have the following facilities as a minimum:

- Willingness and ability to take and work with residents taking prescribed anti-depressant and anti-psychotic medication
- Liaison and referral arrangements with local mental health services
- Specialist staff, including qualified registered mental nurses and at least one consultant psychiatrist and psychologist on call 24-hours a day.

### **7.4 Families**

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Residential rehabilitation services for families provide accommodation for drug and alcohol users and their children. They will provide creche or other childcare facilities while residents are in counselling or groupwork, and family therapeutic and education interventions, such as parenting education. There may also be specialist therapeutic interventions for the children.

These services must be linked with local child protection mechanisms and will need to adhere to additional standards and guidelines to those for adult-only services. Their staff will also need to demonstrate different or additional competences including, for example, childcare workers being NNEB qualified. There will also be additional requirements to ensure that the building and facilities are child safe.

### **7.5 Drug and alcohol misusers in crisis**

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Crisis intervention units take drug and alcohol misusers whose drug and alcohol misuse is highly chaotic or which has severely damaged their health, or who are in other life-threatening situations. They will usually provide assisted withdrawal or stabilisation as appropriate, a period of respite and intensive support, and an opportunity to consider options for the future.

Their programmes are short-term and residents will usually go on to longer term support either in the community or in longer term residential rehabilitation. They will usually have higher levels of specialised medical staff.

### **7.6 Young people**

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This guidance is intended for adult residential rehabilitation services. Services for young people should refer to other guidance on providing drug services to young people (see NTA, 2005c). A very small number of adult residential drug and alcohol services will also take residents under 18. The principle is that “services should be provided on the basis of need not on the criterion of age”. Therefore, if a person aged under 18 has needs that can best be met by an adult service, then this would be the most appropriate placement, as long as this is not detrimental to the service being offered to other clients (NTA, 2005c).

Adult services that do take young people will have to meet additional criteria and follow additional guidance to ensure that their premises and programme are appropriate and safe for young people (see NTA, 2005c). A young person’s specialist drug worker should be involved in the assessment of a 16-year-old considered for adult residential treatment.

## 7.7 Drug and alcohol-misusing offenders

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Some services are for people on probation or ex-offenders. These are likely to have strong links with the local probation service, perhaps with input from probation staff. Counselling and group work may focus more on offending behaviour.

# 8 Assisted withdrawal (detoxification) in residential rehabilitation

## 8.1 Definition

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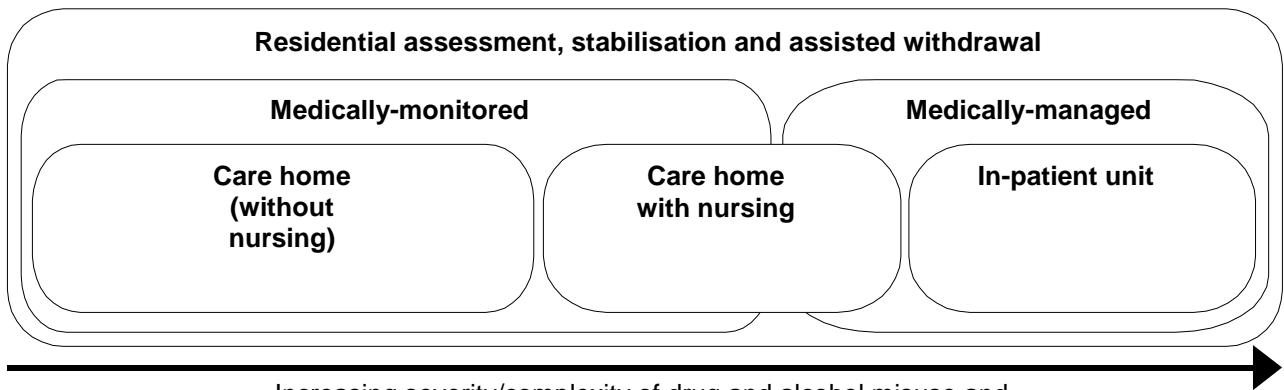
Assisted withdrawal (or detoxification) in residential rehabilitation is usually provided as a precursor to entry into the main residential rehabilitation programme or to structured support in the community.

Assisted withdrawal in residential rehabilitation involves coming off misused drugs and alcohol with the assistance of medication and perhaps nursing and other support. Some aspects of longer-term treatment or the main rehabilitation programme will usually also be introduced, including psychosocial interventions such as counselling and groupwork.

Services differ in the level of assisted withdrawal service they provide, and the nature of drug and alcohol misuse and complexity of medical need they are able to deal with. In reality, a continuum of care and treatment exists but this can be divided into:

- **Medically-monitored treatment** is “provided in non-acute medical settings ... and is most appropriate for individuals with lower levels of dependence and without a range of associated medical and psychiatric problems” (SCAN, 2006), and is the subject of this section eight. Medically-monitored treatment is further sub-divided into two levels of care:
  - With 24 hour nursing cover – providing more specialised skills and higher, medical staffing levels required to cope with more complex cases with greater needs.
  - Without 24 hour nursing cover – straightforward withdrawal from opiates.
  - Further criteria for these two levels of treatment are provided in the following sections.
- **Medically-managed treatment** involves the provision of assessment, withdrawal and stabilisation (and perhaps only this service) to poly-drug and alcohol misusing clients with associated medical and psychiatric problems, whose severe and complex needs require supervision in a controlled medical environment. These programmes are not the subject of this section eight. Guidance from the Specialist Clinical Addictions Network (SCAN, 2006) describes their aims and objectives, elements of treatment, inclusion and exclusion criteria, best clinical practice, appropriate staffing, competences and management, etc.

These differences are depicted in the following diagram.



Increasing severity/complexity of drug and alcohol misuse and related problems that the service is able to deal with.

Services able to deal with “higher end” clients will, of course, also be able to work with clients at the lower end of severity/complexity.

## 8.2 Eligibility

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In addition to the general eligibility requirements for rehabilitative programmes (see section 3.2.2), medically-monitored assisted withdrawal in residential rehabilitation is generally suitable for:

- Those whose drug and alcohol use is relatively straightforward or stabilised, although services registered as care homes with nursing, and with appropriately trained and qualified staff cover, may well be suitable for more complex and demanding cases. See also sections 8.8 and 8.10
- Those going straight into the main residential programme after assisted withdrawal/detoxification or for whom community drug and alcohol treatment has been arranged
- Those who are liable to drop out of treatment between assisted withdrawal/detoxification and residential rehabilitation if they are not provided consecutively and on the same site
- Those for whom a care package covering the entire programme of care (assisted withdrawal/detoxification, residential or community rehabilitation programme, aftercare) has been agreed.
- Medically-monitored treatment without 24-hour nursing cover will generally be unsuitable for clients with:
  - High consumption levels that cannot be accommodated within protocols
  - Chaotic polydrug misuse, especially high-dose benzodiazepines and high-dose alcohol
  - Significant physical or psychiatric illness likely to be exacerbated by the withdrawal process to the extent that hospitalisation may be required.

Medically monitored assisted withdrawal in residential rehabilitation is not suitable for those with substance-related problems that are sufficiently severe and/or complex that they require medical, psychiatric and psychological care 24 hours a day (SCAN, 2006).

## 8.3 Length

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A survey of inpatient services suggested that assisted withdrawal in residential rehabilitation lasts for between six and 28 days, and averages 16.2 days (Day *et al.*, 2005).

Residential rehabilitation services reporting length of detox in the NTA's online residential directory suggest that the length of assisted withdrawal averages (range):

- Opiates 2.4 weeks (1 day – 6 weeks)
- Alcohol 1.8 weeks (2 days – 6 weeks)
- Stimulants 2.1 weeks (3 days – 6 weeks)
- Benzodiazepines 3.4 weeks (7 days – 8 weeks)

However, some services appear to report only the length of the actual detoxification and others the (longer) length of the detox phase of the programme.

## 8.4 Assessment and preparation

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As for residential rehabilitation, drug and alcohol misusers must have a comprehensive assessment to determine their need for assisted withdrawal in residential rehabilitation. Health funding may pay for the assisted withdrawal part of the programme but, if community care funding is required for the main residential programme, a community care assessment will be needed.

## **8.5 Entry and induction**

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In addition to the general requirements for rehabilitative programmes (see section 4.2.4), entry into an assisted withdrawal programme will require a full assessment of medical and health needs.

## **8.6 Care planned assisted withdrawal treatment**

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There are three key elements to the treatment provided as part of care planned assisted withdrawal:

### 1. Medical treatment to assist withdrawal

Treatment for the physical and psychological symptoms of withdrawal.

### 2. Harm reduction and health interventions

These will include:

- Medical treatment for the consequences of drug and alcohol misuse, e.g. abscesses
- Addressing nutritional deficiencies
- Access to tests for HIV and hepatitis B and C with informed consent
- Access to vaccination for hepatitis A and B.

### 3. Other interventions

Dependent upon the physical and mental state of the client, assisted withdrawal programmes will offer a range of psychosocial interventions, including:

- Physical activity and relaxation/sleep aid work
- Harm reduction and relapse prevention work
- One-to-one psychosocial interventions
- Group work
- Family work.

They may also address other physical health and fitness needs.

## **8.7 Completing an assisted withdrawal treatment**

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Clients completing a programme of assisted withdrawal will usually already have been accepted onto a full residential rehabilitation programme or structured community treatment and will move straight from one to the other.

## **8.8 Registration**

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Most residential rehabilitation services providing medically monitored assisted withdrawal on site – without nursing cover and providing straightforward assisted withdrawal in simple cases – will be registered as care homes (without nursing).

Services providing medically monitored assisted withdrawal to more complex cases and with nursing cover will be registered as care homes with nursing or, rarely, independent healthcare providers.

Some services – providing simple detoxification through a GP – may be unregistered.

## **8.9 Standards and clinical guidelines that need to be followed**

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Programmes for assisted withdrawal in residential rehabilitation will be subject to many of the same standards and guidelines as the main programme, including national minimum standards according to their registration (see section 4.2.11).

However, their specialist medical input and the risks arising in withdrawing drug and alcohol misusers will mean that additional standards apply.

Clinical governance or equivalent systems should be in place to improve the standard of clinical practice, and will include:

- Education
- Clinical audit
- Clinical effectiveness
- Risk management
- Research and development
- Openness.

Programmes must follow Drug Misuse and Dependence: Guidelines on Clinical Management (DH, 1999) and its forthcoming update (expected early 2007), and forthcoming NICE guidelines on detoxification (expected July 2007, see section ten).

Some services may also have or be working towards independent health accreditation schemes such as Health Quality Service accreditation (see section ten).

## **8.10 Staff competence and coverage**

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The competences required of a doctor working in the assisted withdrawal unit of a residential rehabilitation service will be greater than those for a doctor providing medical care for the residents of a residential rehabilitation service without assisted withdrawal facilities. They are detailed in Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (RCPsych & RCGP, 2005). The precise requirements will depend on the complexity of needs of clients being accepted and the responsibilities of the doctor. Medically managed assisted withdrawal in residential rehabilitation should be headed by a doctor who is either a substance misuse specialist or consultant, with the consequent training and experience that these demand. Other medical staff with lesser competences may provide medical input but should be supervised by a substance misuse specialist or consultant in addiction psychiatry.

In services providing only medically monitored assisted withdrawal from opiates to relatively stable clients, the competences required of the doctor will be less. For example, GPs with appropriate substance misuse training may be able to competently manage the service, although they should have access to and perhaps receive clinical supervision from a substance misuse specialist or consultant in addiction psychiatry.

Staff will be expected to meet the competence standards required by their role and the national minimum standards applying to the service. Usually, managers will have an appropriate qualification in Care (NVQ Level 4 or qualified nurse) and have, or be working towards a recognised qualification in management (NVQ Level 4 or equivalent). Other staff will require either a Level 2 or 3 NVQ in Health and Social Care or a nursing qualification.

### **8.11 Premises, facilities and equipment**

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The service in which assisted withdrawal is provided will be required to meet specified national minimum standards on the premises, facilities and equipment. Some variations from these may be allowed but generally only if they can be justified on grounds of clinical need or avoidance of risk and if they are made clear to potential service users and are a stated part of the ethos and treatment programme of the service.

A residential rehabilitation service providing medically-managed assisted withdrawal is likely to be registered as either a care home with nursing or an independent healthcare provider and there may be higher and additional standards for facilities and equipment than for care homes without nursing.

## **9 Other residential models not covered here**

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This document is specifically about the range of residential rehabilitation services that should be available to drug and alcohol-misusing clients in every local drug and alcohol partnership area. There are other residential interventions that fall outside of the definition of residential rehabilitation but which are vital elements of treatment systems and without which residential rehabilitation may be less effective.

### **9.1 Inpatient treatment**

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Inpatient treatment of drug and alcohol misusers is the other Tier 4 intervention. Inpatient treatment is “assessment, stabilisation and/or withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours” (SCAN, 2006). It is appropriate for those with complex drug and alcohol misuse problems who need medically managed treatment. Detailed information on inpatient treatment is contained in a recent report from the Specialist Clinical Addiction Network (SCAN, 2006).

### **9.2 Supported accommodation**

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This is for people who do not have a stable home environment. It helps them achieve lasting change and assists in their re-introduction to the community. Support generally includes, as a minimum, a housing support worker and perhaps a floating drug and alcohol support worker. Staff cover is not 24 hours on site but may include 24 hours on call.

Typical housing-related support services include:

- Help with budgeting and managing tenancy
- Help filling in claim forms or arranging for professionals to call
- Help with accessing education or work
- Help or training to help to move on to less supported accommodation
- Help maintaining the safety and security of the home
- An emergency alarm.

There is a wide variety of supported accommodation commissioned by local authorities and provided by social landlords and not-for-profit organisations. In some instances specialist drug and alcohol interventions are provided to residents in supported accommodation as part of local drug and alcohol partnership arrangements and/or aftercare plans. The primary aim of these services will be an ongoing structured programme of interventions as a condition of moving to supported housing.

Other forms of supported accommodation cater for a range of client groups with a diverse range of housing and housing-related support needs, not just drug and alcohol misusers. Examples of the diverse range of supported accommodation for drug and alcohol misusers will be set out in a forthcoming report from the Housing Learning and Improvement Network in the Care Services Improvement Partnership at the Department of Health (see <http://www.changeagentteam.org.uk/housing>).

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## 10 References and links

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## 10.2 Links

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### 10.2.1 NTA publications and care plan toolkit

- <http://www.nta.nhs.uk>

### 10.2.2 Service standards and accreditation

- European Association for the Treatment of Addiction (EATA) accreditation <http://www.eata.org.uk>
- Health Quality Service accreditation <http://www.hqs.org.uk>
- Investors in People Standard <http://www.investorsinpeople.co.uk>
- ISO 9000 <http://www.iso.org>
- Quality in Alcohol and Drug Services (QuADS) <http://www.drugscope.org.uk>

### 10.2.3 Staff competence, occupational standards and accreditation

- Drug and Alcohol National Occupational Standards (DANOS) <http://www.skillsforhealth.org.uk/>
- Federation of Drug and Alcohol Professionals <http://www.fdap.org.uk>

### 10.2.4 Clinical guidelines

- Drug misuse and dependence: guidelines on clinical management <http://www.dh.gov.uk/assetRoot/04/07/81/98/04078198.pdf>
- National Institute for Health and Clinical Excellence (NICE) <http://www.nice.org.uk>

### 10.2.5 Housing with care and support

- Housing Learning and Improvement Network <http://www.changeagentteam.org.uk/housing>