



Residential rehab is recognised as one of our most effective treatment resources, yet the sector is being hampered by mixed messages – government promises of more bed spaces at the same time as lack of commitment to current provision. Time for clarity and action, says Nick Barton.

Among NTORS' more memorable conclusions could be found the following statement: 'The clients in the residential programmes presented with some of the most severe problems and complex needs, and these clients made some of the greatest treatment gains.'

Given that NTORS – the National Treatment Outcome Study, started in 1995 – informed much of the treatment strategy, you would be forgiven for thinking that this ringing endorsement would have resulted in a period of stability and security for the residential sector. Not a bit of it. Eight years into the current drug strategy, and only now are we hearing officials talking up the value of residential treatment. Frequently, and for many years both before and since NTORS, it has been described with justification, as a 'national resource'. The trouble is, as a result of neglect, this key treatment resource – especially where the voluntary sector is concerned – is under serious threat.

The essence of the government's belated epiphany lies in the realisation that not every person currently dependent on substances wants to spend the foreseeable future living a life mediated by medication. There is also a growing recognition that a policy of harm reduction, if indiscriminately applied, can lead to harm production. Perhaps, we have had to admit that there has been just a little too much methadone in our treatment madness and that we have

herded rather too many pliable clients down a pharmaceutical cul-de-sac.

So, the official talk is now of 'exits'. Strangely, references are made to 'exits from treatment' rather than from dependence, which is what the treatment, including the residential option should presumably be aiming for and what so many clients clearly aspire to. Of course if you restrict your view of what constitutes treatment to methadone prescribing, then seeing residential treatment as an exit from treatment begins to make sense. Actually, what we should be talking of is entrances to appropriate residential treatment at the appropriate time and to pathways of care within that sector that help sustain recovery and achieve reintegration. In this play of human suffering, only once we have got the entrances right can we sort out the exits. Wasn't this what Models of Care and Integrated Care Pathways were supposed to be about?

With the new found enthusiasm for Tier 4, talk has been emanating from the NTA and the Department of Health of building capacity in the residential

treatment sector. While, in one sense, this is a good sign in that it means someone in authority is at least thinking seriously about this important national resource, it raises qualms. Those many providers currently struggling to cope with the financial impact of beds remaining empty over a long period, or, in some cases, contemplating or even managing closures must wonder at the sense of any initiative to add more bed spaces at this time. Surely if we start increasing the stock before we have fully got to grips with the reasons for the serious under use of the residential option, we risk further undermining the current provision.

So what is causing the under use of Tier 4? One of the most significant problems is commissioning – or, more accurately, the lack of it. There has been purchasing but little in the way of genuine, well-informed commissioning. This has partly been the result of there being little or no incentive within the treatment system to arrange for residential treatment to be made available to a local population. (And we

must remember that although there may be a local need, in the case of residential treatment there doesn't have to be local provision. In fact it may be better for such provision to be provided at a distance to help extricate a person from the harmful environment of their using. Some research to test this proposition is needed.)

There is little strategic planning where Tier 4 is concerned with which poor local needs assessment goes hand in hand. Good examples – and thankfully there are some – are not emulated. In fact, in many areas no attempt appears to be made to track down examples of good practice, with a stubborn parochialism and attachment to historic practice holding sway. Commissioner/purchaser/referrer attitudes to Tier 4 are often riddled with blind prejudices that are underpinned by personal ideologies, assumptions and beliefs rather than professional knowledge of the range of provision and considered reference to the evidence base.

'Budget Anxiety Disorder' is also a prevalent condition. Residential

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treatment may in the short term seem expensive, but we need to consider the costs of someone not receiving the appropriate treatment at the right time. The attitude to providers is often paternalistic and in some instances, downright hostile. There seems to be no induction of new staff when commissioners leave. The model for effective management of the relationship between the various local funding partners and stakeholders, if one exists at all, is inconsistently applied and the relationship itself often seems dysfunctional.

In many instances, where residential treatment is concerned, Models of Care appears to be viewed as a template for operating what amounts to a crude and haphazard hierarchical obstacle course to test a client's motivation or to get away with the least amount of expenditure in the short term. Models of Care should in fact be used as a rational guide to commissioning and referring, to help ensure that clients enter the right treatment at the right time according to a thorough assessment of their presenting need. As a result, clients who should be steered to residential treatment are often inappropriately diverted to day programmes of one kind or another, with the residential option seen only as a last resort or even perverse reward in case of failure, which under such demoralising circumstances is more than likely. Difficulties in getting referred to community based residential units may partly account for the increasingly common reports of people committing crimes expressly to gain access to prison treatment programmes.

Then there is the continuing tension between health and social care funding that inhibits access. Take for instance the case of the person who wanted to go to a residential centre away from his home area where he could receive a detox fully integrated with psycho-social treatment. The local authority would not pay the full cost from the community care budget because detox is health-care and they said he should use the local NHS in-patient unit for detox and then go to another residential programme funded by the local authority. The

trouble is he could not get into the ward because there were so few beds. Anyway he didn't want to, because he knew from previous experience that it was a demoralising over-medicalised environment that would not respond to him as a whole person and was too close to the pull of his home turf. Of course it's impossible not to wonder what happened to the so-called pooled treatment budget in such an instance. We might also ask why we continue to commission high-cost psychiatrist-led services to provide anything other than a safety net for the severest conditions, when there are residential (non-hospital) facilities that arguably offer far better value.

Where contracts that have been organised and funded with residential providers in the voluntary sector, there have been instances of them not having been used – not only a scandalous waste of money, but of lives. In other areas, available funding has simply not been drawn on and therefore it has been clawed back. The excessive amount of the treatment budget that has gone into pharmaceutical harm minimisation has sometimes been at the expense of the comprehensively harm reducing benefit of residential treatment. Residential treatment waits at the end of the queue, which means that those who need its services, who are usually the most harmed and harm-producing individuals are not receiving the help they desperately need. Everyone pays a price for this folly.

While I question the need to build capacity in these circumstances, I acknowledge that in the end if we get the system functioning as it should, there may well be a need for more facilities. The NTA's 2005 needs assessment for residential rehabilitation and in-patient treatment conducted by Dr David Best, Professor Ed Day and their teams respectively, certainly made a convincing case. But before we rush off to the planners and builders, we must get to grips with the question as to why so many of those people who need this intervention are not currently gaining access to it. Once we have

understood and removed the blockages in the current system and it is running properly, we can begin to invest in reorganising and extending its provision.

Creating a new, or expanding an existing facility is always an exciting proposition and it might well be a venture that attracts capital investment

something about at Clouds where our training programmes in partnership with the University of Bath are now responsible for producing a very significant proportion of new counsellors to the field and for helping to develop existing professionals. However, as productive as we are in

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from government. But of course that is only a small part of the story. Where is the revenue going to come from to sustain the project? Few existing services can generate enough income to pay their way, let alone acquire sufficient resources to make a concerted effort to improve quality and effectiveness. Residential treatment has a high proportion of fixed costs, many of them prescribed by the exigencies of registration. The few variables are related to the numbers of patients or clients in beds at any given time, such as food and laundry. Despite the government's target date of April 2006, it remains almost impossible to achieve 'full cost recovery' in negotiations with statutory authorities unless you are prepared either to receive no referrals or to compromise on quality.

There is also the question of who is going to run and staff new facilities. As any employer in the sector knows, it is devilishly difficult to recruit practitioners of the quality needed to ensure a safe and effective service. That is something we are trying to do

this respect, we could not turn out enough graduates to staff a greatly expanded sector in the short term without increased resources.

There is a serious underestimation of what is needed to provide a safe, efficient and effective residential treatment service. This is one of the reasons that in terms of quality, the field has historically settled for less than should be provided and can be provided. No-one has been well served by this state of affairs: clients, their families, referrers, funders, or taxpayers. What has been achieved has often been so in spite of what's provided, not because of it.

Although it is very late in the day, we do have an opportunity once and for all to establish a sustainable and effective residential treatment resource. We need to get a move on before even more damage is done.

*Nick Barton is chief executive of the charity Clouds, whose services include Clouds House, a residential treatment centre in Wiltshire.*

# mixed messages