Comment

Mixed messages create a united response: save our rehabs

In our last issue's cover story, Nick Barton of Clouds put out an SOS for residential rehabs, saying we need to act now or risk losing this essential resource. Here we publish responses to that article from rehabs all over the country, which illustrate only too well the scale of the crisis.

'Our local purchasers are using us less, based upon previous over-spend.'

I read Nick Barton's article with great interest and concern as I fully agree with the major points.

We have noticed that more of our purchasers are starting to negotiate block contracts with us. This is surely good housekeeping all round, rather than relying on spot purchases – which are based on what have become hollow promises of budgetary increases. The main problem at this time for us seems to stem from the fact that most of the purchasers we work with have no idea what their budget is for the forthcoming year. Our local purchasers are using us less, which they say is solely based upon previous financial over-spend.

I find all this strange as it was only a few months ago in London that the NTA were patting themselves on the back telling us all what a good job they had done and how more clients than ever were accessing treatment. This depends on what treatment is considered to be in the first place. To prescribe an addictive substance in order to maintain someone on it instead of them using heroin is hardly (in my opinion) treatment. It is merely a prescribing service for opiate users.

Steve Spiegel, founder, The Providence Projects

'It is time to understand that most of our clients will cost the NHS and social services in the long term.'

In Torbay we have a lack of funding for such residential care, so I don't take any placements from this area due to this – which upsets the GPs and the Local Health Trust. But what are we supposed to do? After all, even though we are in the care sector, we are specialists in our own field. This type of care is special and needs to be accepted as that. Most London boroughs do this, but the odd ones don't.

It is time to understand that most of our clients will cost the NHS and social services in the long term through A&E admissions and social services' time being taken up. So we are the go-betweens who are trying to provide services that will take most of the pressure off their funds.

We only get the local alcohol counselling services involved if the client walks through their doors. So it's down to our services to take up a case when it's close to far too late to help. This also needs to be looked at.

My speciality is Korsacoff's Syndrome and locally this is also treated with lack of funding support. So we have to go outside to get placements – which is a great shame because alcohol has no boundaries. Many people come from outside areas – but there are just as many locally not being funded for treatment, and living in hostels untreated.

Steven Todd, Manager, Vanehill Specialist Care Homes, Torquay.

'We are experiencing a drop... The merry-go-round continues.'

Nick Barton has his finger firmly on the pulse. As a registered provider, we are experiencing a drop in funded placements. The non-registered supported accommodation field has spawned an abundance of bed-spaces which, locally at least, run at capacity. Thus service users stay in their home area, with inherent difficulties, attending day care if it's available. The merry-go-round continues.

Dominic Castle, Weymouth Aftercare Centre

'The biggest threat facing our service is now a seasonal lottery.'

Nick Barton has crystallised the main threats facing the residential treatment sector in a coherent and frank article. Our experiences echo those outlined and I would say that the biggest threat facing our service users at the moment is not only one of a postcode lottery for funding but now a seasonal lottery.

Funding often runs out by the end of the calendar year, never mind the following April. This leads to a situation of over demand in the first half of the year where the collective services are unable to meet demand, and half empty services in the latter half.

Firstly then, we need to be vigilant about the timing of surveys of demand and capacity that inform spending plans and secondly, seriously consider regional block purchasing which will ultimately serve the needs of our clients far more effectively than the current dysfunctional system.

Jon Harman, director, Ravenscourt Trust, Bognor Regis

'It poses a real threat to the survival of this unique project.'

Trevi House was established in 1993 to allow women the opportunity to undergo treatment and rehabilitation from drug and alcohol dependency in conjunction with their children.

In the last 12 years we have accommodated 600 women and over 700 children and have established a reputation for excellence in the field. We offer an environment in which women and their children can achieve rehabilitation and a rebuilding of their relationship.

During the next financial year, Trevi House will be completely dependant on operational funding to survive. Due to recent changes in funding structures the organisation has lost £72,000 in funding for the 06/07 financial year, comprising £36,000 from the Health Authority and £36,000 from Supporting People. As Trevi takes families nationally (as well as locally) we are now judged unentitled to local DAT funding.

This next financial year is dependant on 100 per cent occupancy. To date, in this financial year, we have not reached full occupancy, due to a drop in referrals both locally and nationally. This has occurred because of restrictions on budgets. This deficit poses a real threat to the survival of this unique project.

This is the first time in Trevi House's existence that we are solely reliant on full capacity – and in this day and age is this a reality?

Angie Brooks, director, Trevi House, Plymouth

'I have been involved in having to close two residential treatment centres... I believe many more will follow.'

At Yeldall Manor, a 35 bed residential treatment centre in Berkshire, we face many of the issues that Nick Barton highlighted in his article, but I would like to focus on just two.

Firstly, we have been running for some time with empty beds, whilst hearing regularly from commissioners of their frustration in not being able to place clients due to long waiting lists. Having talked to other providers of residential treatment centres, it seems we are not alone in hearing this. All commissioners and providers want is to see clients placed into appropriate services. Surely we should be capable of putting the client and the empty bed together to provide the services that many of them tell us they need and want.

Secondly, no-one can doubt that the government has put a lot of money into drug treatment – but how much of it actually gets to those clients that need it, compared to the increased bureaucracy around the country? The vision of full cost recovery is a good one, but how important is it to those commissioners operating on very tight budgets? When you talk to commissioners about the need to increase fees to achieve full cost recovery, they appear to go deaf.

Finally, in the last two years I have been involved in having to close two residential treatment centres due to lack of funding, including one of only a handful in the UK working with women and their children.

Sadly, unless we resolve the empty bed syndrome and are able to achieve full cost recovery, I believe many more will follow.

Ken Wiltshire, director, Yeldall Manor, Berkshire

'Residential care is approximately half the cost of day care, but delivers four times the provision.'

As a relatively new provider, our perspective accords with the difficulties

articulated by Nick Barton. Our experience of commissioners indicates reluctance on their part to commission residential services, often on the basis of 'cost benefit analysis'. Referrals invariably relate to clients with highly complex needs and/or those who have repeatedly failed to engage in other treatment environments.

A simplistic 'cost benefit analysis' often adopted by commissioners fails to recognise the following issues:

Residential services are required by law to be registered with the Commission for Social Care Inspection (CSCI) and are open to independent regulation and inspection. The registration process involves the comprehensive and independent vetting of organisations providing residential services.

The provision of National Minimum Standards (Care Standards Act 2000) gives a transparent quality-auditing tool, by which the quality of service delivery can be gauged; this is in addition to any other occupational standards (*eg* DANOS) or simply returning data to the NTA.

By adopting a more comprehensive analysis of comparable weekly fees, it is clear that residential services often provide truly cost efficient provision.

Assuming the mean average of a range of residential and day care weekly fees could give the following equations for residential and day care: A weekly fee of £700 for residential care, divided by 168 hours of care gives an hourly cost of £4.12. For day care, a weekly fee of £350 divided by 40 hours of care gives as hourly cost of £8.75.

Residential care is approximately half the cost of day care, but delivers four times the provision. Even when applying a simplistic cost benefit analysis that is not formulated on a 'like for like' basis, residential options still provide better value for money.

There is a very real possibility that under utilising the residential sector now, which is already resulting in residential closures, will signal a severe contraction of residential services in the future.

Ciara Aylett, treatment director, Wellington Lodge, Middlesex

'The unit is in jeopardy… this latest crisis is the straw that will break the camel's back.'

Middlegate is a unique residential substance misuse rehabilitation unit that has been caring for young people for 11 years with an 82 per cent success rate. It has treated well over 400 young people throughout the UK and Ireland suffering from the effects of substance misuse as result of abuse, peer pressure, family breakdown, boredom *etc*. We have the capacity for nine beds.

Over the last two years, because the government appears not to have followed its own policies on Every Child Matters, we have been forced to lay off ten excellent trained adolescent drugs/programme workers and mothball a four-bedded unit. Now, because of the current crisis in funding, largely as a result of financial lack of clarity in the NHS, it has only two young people on the remaining unit. The future of this unit and the care for young people in various tiers, including residential, is being put in jeopardy and will only be secured with the early release of funds.

The Middlegate team has responded to this crisis by reducing hours and being flexible, whilst remaining dedicated to the care and treatment of all young people placed in their care. Within eight weeks however, if referrals are not made and funding is released, Middlegate will be forced to close its doors for the last time.

We offer a unique method of treatment which is designed to build up a young person's confidence and self esteem in order that beneficial and positive choices are made in the future. We have a non-judgmental, holistic approach to working with young people and has a multidisciplinary team to support this.

Our workers are drug and children specialists and this is where the caring and true application of Every Child Matters occurs, using a mix of techniques designed to raise the young person's self esteem and developing skills, either on a one-to-one basis (behaviour rationalisation) or in group work or through activities.

Middlegate is registered as a children's home and is subject to at least two unannounced inspections by CSCI every year. The latest inspection saw our management being awarded six four stars in its report. This is equivalent to the best local authority or hospital rating and is quite an achievement. It requires hard work and dedication by all staff and management and has developed over the years since its inception.

This latest crisis is the straw that will break the proverbial camel's back. Unless funding is secured within eight weeks, then the expertise and skill that has been built up over the years in treating young people will be lost forever. Let us not forget the young people of today are the adults of tomorrow.

Chris Robertson, Middlegate Lodge, Lincolnshire

'We are now in receipt of fewer referrals… Staff are caught up in a demoralising cycle of anxiety.'

Cranstoun seconds the absurdity of a lack of strategic thinking in relation to residential provision, despite it being the most demonstrably effective intervention for specific client groups. Our experience so far this year has been dogged by low occupancy in certain services. Following very good occupancy for two years running, we are now in receipt of fewer referrals and of those referrals received, delays caused by detox waiting times. As a consequence, the notion of investing in a capital expenditure programme when existing bed spaces are under-utilised, appears nonsensical as a commissioning strategy going forward.

On the issue of cost of providing high care services, it could be argued this is perhaps more keenly felt by London-based and other 'city' providers. The costs of retaining staff in London and associated costs of living in the capital means that these services may well be relatively more expensive to operate. Furthermore, in a sector that has been subject to systematic reduction in, and disinvestment of, funding streams over many years, we are now required to seek full cost recovery from social services departments, and it is therefore understandable that they in turn are experiencing expenditure pressures.

In would appear that a DAT's interest in tier 4 services generally revolves around supporting 'their' numbers in treatment. More often than not it appears to be more by default than design that residential provision is included at all in planning, with little or no long-term strategic planning applied to the development of the residential treatment sector.

On the quality front, experience suggests that some commissioning/purchasing authorities have little understanding of what constitutes the basis for good quality residential provision, or the subtle differences between high care and supported housing services. There appears to be little in the way of comprehensive guidance on the quality agenda, *ie* with little movement beyond basic assessment of standards as dictated by QuADS.

'Best value' is often cited as a rationale for purchasing or commissioning with little in the form of criteria being made available as the basis used for assessing such. The same applies to notions of 'value for money' in terms of a lack of available criteria for assessment.

The issue of client choice seems to be diminishing as a principle, with placements appearing to be highly subjective. Furthermore, it is difficult to receive qualitative feedback from purchasers and/or commissioners as regards funding decisions.

When services are delivered from such an insecure and unstable funding base it can be difficult as a provider to remain focused on quality issues. Staff are understandably caught up in a demoralising cycle of anxiety about the future of their jobs and temporary staff are used more as a consequence of operating in a very 'temporary' environment.

Whilst there is some activity at the NTA around tier 4, is there really enough going on which suggests a strategic way forward *ie*, change in the right direction?

In 1991 John Marsden (*All change after the DSS*) undertook a comprehensive exercise to determine the actual and true cost of a residential placement. This exercise should perhaps be repeated now to determine the cost of high care rehabs and detox beds, as a starting point.

Mandy Reed, area manager, Cranstoun Drug Services, London

'Action needs to be taken before the system erodes.'

In response to Nick Barton's article, I have to say that in my experience of working in both Tier 4 services and private addictions, access to both beds and residential rehabilitation has become more problematic. Historically we have had good provision in our borough, but beds have been cut and access to rehab is increasingly limited.

We all know that those who have access to residential care fare better but, shockingly, many drug workers in maintenance clinics have never seen a client get clean. Effective residential care only works when the Models of Care and Integrated care pathways, which everyone agrees are desperately needed, are clearly defined.

I agree with Nick that action needs to be taken before the system erodes. We have to find a way of working together to provide quality and viable care that has been proven to be effective. More importantly, the friction between healthcare and social care needs to be addressed – we still see this as a major contributing factor to preventing timely access to care. There needs to be flexibility and we need to listen to the needs of clients and those around them.

Paulene Caesar, Ward Manager, Capio Nightingale Addictions Unit, London

'We have experienced a drop in referrals again… it's very worrying.'

We are experiencing exactly the situation Nick Barton mentions. Towards the end of last year, our numbers dropped to eight from 20 (our capacity is 22). We then filled up, but in the last three weeks have experienced a drop in referrals again and at present have 16 in the community, clients due to complete soon, and fewer coming in than we would expect at this time of year.

It is very worrying considering that the work we do is of a high standard, we have a very good reputation and have excellent Inspection reports from CSCI.

Anita Howard, Thurston House, London