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▶ The role of residential rehab in an integrated treatment system.

National Treatment Agency for Substance Misuse.
[UK] National Treatment Agency for Substance Misuse, 2012.

An audit for England's National Treatment Agency for Substance Misuse finds residential services so entwined with non-residential in the treatment careers of residents that it is not possible disaggregate their contribution; since a few months of such care costs as much as five years of non-residential care, showing value for money is critical.

Summary This is one of a series of reports from the National Treatment Agency for Substance Misuse – a special health authority which aims to improve treatment for drug problems in England – presenting a picture of this treatment based on data from the National Drug Treatment Monitoring System.

Background

Residential rehabilitation services are run by voluntary and private sector organisations, offering structured programmes which may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills. Across the wide range of types of residential rehabilitation, differing in philosophy, intensity, inclusion criteria, programme content and duration, often the only common factors are that residents stay overnight to receive treatment, and are expected to be drug and alcohol free before they start the programme.

Although locations are shifting to more local services, commitment to abstinence remains fundamental for most rehabilitation providers, placing the onus on prospective residents to be motivated to be drug-free beforehand. Sometimes detoxification is offered by the residential services themselves as the first stage of treatment; otherwise people who need detoxification are referred to NHS services first.

In 2010–11 commissioners in England planned to spend about £42 million on residential rehabilitation. Average cost per week is around £600 and stays average 13 weeks, meaning every episode costs on average about £8000. Together with preparatory

detoxification and other services the figure rises to about £10,000. In contrast, the average annual unit cost of non-residential treatment for a heroin addict is about £2000. Extra cost means that residential rehabilitation accounts for 2% of treatment activity in terms of user numbers but 10% of central treatment funding.

When the National Institute for Health and Clinical Excellence (NICE) reviewed the evidence for drug treatment services in 2007, it said community services should be the frontline treatment option for most drug dependent people, but also recommended residential rehabilitation for those seeking abstinence who had significant co-morbid physical, mental health or social problems – the most complex cases.

2010–2011 audit and main findings

To clarify the role and performance of residential rehabilitation services, early in 2012 an audit was conducted of records submitted by these services to the National Drug Treatment Monitoring System. Its timing made it possible to track up to the end of March 2012 the progress of people in rehabilitation in England in the financial year from April 2010 to the end of March 2011, enabling the National Treatment Agency for Substance Misuse for the first time to provide a detailed breakdown of longer-term outcomes to which residential rehabilitation contributed.

The audit found that 4166 individuals in drug treatment in financial year 2010–2011 had been in residential rehabilitation as part of their latest treatment or (virtually) unbroken series of treatments. For three quarters (76%) this had followed non-residential treatment.

Of the 4166, 3972 were no longer in residential rehabilitation at the end of March 2012. Of these, 1880 or 45% of all residents were no longer in treatment of any kind after having been judged by their last treatment service to have overcome their dependence and no longer be in need of structured drug treatment. Most (1110) had left the treatment system direct from the residential rehabilitation service, but 770 had left after follow-on non-residential treatment.

These 1880 apparently successful treatment exits were counterbalanced by 960 former residents who dropped out of the treatment system while still considered to be in need of further help, of whom nearly half (428) did so directly from the residential rehabilitation service.

Another 1130 residents were still in the treatment system at the end of March 2012, the great majority (83%) in services other than residential rehabilitation.

Broadly speaking, the data tells us that for every ten drug users who were in treatment that year and accessed residential rehabilitation on their treatment journey:
- three successfully overcame their dependence directly from residential rehabilitation;
- one dropped out of treatment altogether;
- the remaining six received further structured support from the treatment system, of whom two went on to overcome their dependence and complete their treatment journey with a non-residential provider, two were still in the treatment system, and at least one dropped out at a later stage.

Just over a third of residents left their rehabilitation service in an unplanned way, neither having completed their programme nor been deliberately transferred to another service.

However, 1013 of these 1441 former residents continued to access treatment elsewhere in the community. Usually residents left because they dropped out of or declined treatment; generally (more than 60%) this happens within the first month, often within the first fortnight.

These findings should be seen in the light of the nature of the caseload. Compared to other services, residential rehabilitation services tend to see proportionately more presentations from people who use heroin *and* crack − 60% of the total − and their clients are also more likely to be injecting, involved in polydrug use, or offenders. These are the most complex cases least likely to achieve a successful outcome, marked by a history of unplanned treatment episodes. However, they also have some plusses in their favour. Usually they are abstinent from drugs and alcohol, committed to becoming substance free leaving treatment, and have been assessed as capable of achieving abstinence and prepared to do so. Though residential rehabilitation tends to see people with more difficulties, these services do not usually admit highly problematic users until some preparation has already happened in the community. Often local authorities will not agree to fund people they believe are not ready for rehabilitation.

Variation between services and residents

Based on successful completions (either directly or via follow-on treatment), after attending the 'best' rehabilitation services, three quarters of residents overcame addiction, but after the 'worst', less than 10%. Of the 73 residential rehabilitation services submitting returns for more than 10 people in the year, about a dozen can claim 60% or more of their residents went on to overcome their dependence, with or without the help of other services. However, about half the residents at over half of the services do not overcome their addiction. A minority of services have success rates of 20% or less. There is no clear relationship between the outcomes achieved by providers and the complexity of their caseloads or costs of their services.

Most residential rehabilitation facilities also treat people severely dependent on alcohol. Although many fewer people are treated for alcohol dependence in England (about 110,000) than for drug problems (about 200,000), the proportion in residential rehabilitation (3%) is similar. Compared to the drug users, outcomes were consistently better for the 3881 residents who in 2010−11 spent some time in residential rehabilitation during their alcohol treatment journey. For example, compared to 28% of drug users, 38% left the treatment system directly from residential rehabilitation having been assessed as no longer dependent or in need of further structured treatment. The drop-out rate too was lower − 24% of problem drinkers versus 36% of drug users.

The authors' conclusions

The findings show that residential rehabilitation is a vital and potent component of the drug and alcohol treatment system and should continue to be so − not as an alternative to community treatment, but as one potential element of a successful recovery journey. Residential rehabilitation is integrated in the network of services that form local treatment systems. Most residents enter residential rehabilitation from other treatment services, and rehabilitation is not always an 'exit door' from the treatment system; people completing their residential treatment often require continued structured support from other parts of the system before they are ready to complete their treatment for drug or alcohol dependence. Non-residential and residential services play a significant

and mutually-reinforcing role in fostering recovery, raising a question over how to assess residential rehabilitation's distinctive contribution to the drug treatment system as a whole.

The high level of early drop-out suggests that many drug users put forward for residential rehabilitation may not be ready to undertake such intensive programmes, and highlights the importance of effective preparation and robust engagement on the part of services referring people to rehabilitation and the receiving providers. Better outcomes among drinkers are possibly due to the greater personal resources they bring to the challenge of overcoming addiction, such as motivation and determination and social and family support.

Residential rehabilitation services see relatively complex cases with multiple difficulties. It seems likely that they will need to focus even more on this complex user group. With budgets under pressure, commissioners may increasingly choose to treat people in non-residential services, often as effective as more expensive residential options. But although the capacity and capability of non-residential drug treatment has improved, there remains a core of complex drug users for whom these services are not enough; it is likely be with these people that residential rehabilitation can add value in helping them towards recovery.

Providers able consistently to demonstrate they add value will find their services continue to be commissioned. Those that can't will be at risk in an unforgiving financial environment. It is apparent from this audit that some providers need to improve their performance if they are to maintain their position in the drug treatment market.

FINDINGS As a review of therapeutic communities found, it is hard for residential services to prove superiority to non-residential alternatives partly due to significant shortcomings in the studies, but perhaps mainly due to an inherent limitation of randomised trials of residential versus non-residential care. Such studies must select patients who can safely and practically be sent to either option and who are willing to leave the choice to chance, yet any advantages of residential care are likely to be most apparent among homeless clients, those whose vulnerability makes non-residential care unsafe, or those with strong preferences. Given this winnowing of the caseload, not surprisingly outcomes are often equivalent.

A review by Drug and Alcohol Findings of studies comparing residential and non-residential care concluded that residential settings help extricate residents from particularly damaging environments, but also that the added benefits can fade after discharge back into the resident's previous environment. Those who have particularly benefited have been people at risk of suicide and clients with relatively severe psychiatric problems, in some cases combined with severe employment or family problems, supporting the general contention that more severely dependent and problematic clients differentially benefit from residential care. Where studies have found no added benefit for more severe cases this may have been because the service's caseload was limited in severity, or because the study set severity limits so that all the subjects could safely be sent to either residential or non-residential care.

Other attributes found in some studies to favour residential care include low cognitive functioning, homelessness, low social support, and poor employment prospects. What

matters in any particular situation will depend on the range of problems in the caseload and the alternative treatments on offer. For example, if very severe cases are admitted beyond the capacity of any of the options, or if the caseload is unproblematic enough to do well whatever the treatment, then none will seem preferable. Similarly, where these are available, intensive non-residential options (but not routine outpatient care) may almost match residential settings even for severe cases.

One point of contention is whether residential services should be reserved only for people shown to have been failed by non-residential (and cheaper) alternatives, or whether those keen to do so should be able to pursue their recovery through residential rehabilitation from the start. The featured report interprets recommendations from the National Institute for Clinical Excellence (NICE) as indicating that "community services should be the frontline treatment option for most drug-dependent people". In fact the experts at NICE were more definitive, saying prospective residents should "have not benefited from previous community-based psychosocial treatment". The implication is that even the highly vulnerable and multiply disadvantaged cases referred to residential services must first have tried and done poorly in non-residential options, risking life-threatening relapse and a possibly extended addiction career which could have been terminated sooner. The opposing argument is that predicting for whom non-residential care will prove inadequate is such an imprecise science that 'suck it and see' is the only realistic strategy; trying residential services first risks unnecessary expenditure which drains treatment resources.

The featured report adopts the rule of thumb that successfully completing treatment is indicative of successful treatment. For the National Treatment Agency for Substance Misuse, 'successfully completing' (1 2) means that, as reported by the treatment service from which the patient last exits, they are no longer seen as requiring structured drug treatment, and have left treatment (not just that service, but the system as a whole) no longer dependent on any illicit drug, and not using opiates or crack cocaine. They may be using other illicit drugs in a non-dependent manner and may be drinking and smoking to any degree.

The argument that successful completion is evidence of successful treatment rests partly on an analysis of patients leaving treatment for drug problems in 2005/06. Over the next four years, 57% who left having successfully completed avoided being officially recorded as problematic users of illegal drugs, neither being picked up by criminal justice system nets intended to identify problem drug users, nor returning to treatment on their own initiatives. This record of 57% seemingly staying recovered from their dependence compared with a figure of 43% among patients who left *without* having successfully completed treatment. The difference of 14% is appreciable, but not as large as would be expected if successful completion correlated strongly with successful treatment in terms of lasting recovery. Nevertheless it is enough to justify conclusions based on the assumption that successful completion is a better outcome than patients leaving treatment before the service considers them free of dependence and/or use of heroin or crack cocaine.

The early drop-out problem highlighted by the report may also be a feature of non-residential services offering structured rehabilitation programmes. Methadone and other opiate substitute maintenance services do not have a set programme to be completed and typically act like an on-off switch, quickly exerting an impact on crime and opiate use and often seeing a reversal when people leave. For methadone the key figure is retention time, which for about two thirds in England in 2010/11 was at least a year. The comparison between the costs of residential rehabilitation and of methadone services is made purely from the point of view of the drug service commissioner. It does not take in to account the relieving of costs elsewhere in the public sector due to the provision of accommodation and associated costs which are part of the residential package, nor any extra savings due to the virtual elimination of substance use and crime while residents remain at the centre. Nor are longer term savings taken in to account, though it is unclear whether these are greater for residential services.

For example, when the DORIS study in Scotland reassessed patients 33 months after entering treatment for drug problems, whether they had initially entered residential rehabilitation or other types of services was unrelated to their employment record.

Without making any specific reservations about the featured report, it should also be borne in mind that analysts with an interest in the success of a programme they are evaluating tend to produce more positive analyses than independent analysts – in research terms, the 'allegiance effect'. It is part of the remit of the National Treatment Agency for Substance Misuse to have an interest in the success of addiction treatment in England, to improve this, and to show this has been done by producing reports such as the featured report.

For more on residential rehabilitation see this introduction and one-click search for relevant Findings analyses.

Thanks for their comments on this entry to Rowdy Yates of the University of Stirling in Scotland. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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