



The poor relation

Do tier 4 services always lose out?

Peter Walker looks at how to arrest the decline in rehab and promote recovery



Tier four residential services have been in decline since the inception of the first national drug strategy in 1998. There are two main reasons for this. The first is the decision not to assign responsibility for the funding of tier 4 services nationally, to the NTA or similar body, or locally, to drug action teams, while the second is the decision to pursue primarily a harm reduction approach to drug misuse and so marginalise the abstinence-based approaches of most rehabs.

The combined impact is a national reduction in take up of tier 4 services and the closure of many rehabs. While the number of people engaged in treatment has increased dramatically, the number of drug-free outcomes has been negligible.

Only recently has the NTA given serious attention to the protection and promotion of residential services, with a number of reports and initiatives. These have been seen as an attempt to reverse the decline in the use of tier 4 and bolster opportunities for clients to achieve drug-free exits from treatment, in line with the new national drug strategy which states 'The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency.'

In Bristol, as in most other parts of the country, local tier 4 services until recently sat outside of the local drug strategy team (DST – equivalent to a DAT) commissioning framework, with most providers seeking referrals on a spot purchase basis from local, regional and national sources. Again, like most other areas, Bristol purchased tier 4 treatment from a wide range of rehabs, some local and some much further afield.

In 2007 the DST began to take a more strategic interest in tier 4, with the development of a 'preferred providers' list of rehabs. The aim was to make greater use of local provision, much of which was part-funded by Bristol City Council through the Supporting People budget, and to achieve better value for money.

In 2008 the DST and the Supporting People team recommissioned all Supporting People-funded drug and alcohol accommodation, including most local tier 4 provision, and commissioned a number of new accommodation and non accommodation based housing support services. For the first time – and

possibly uniquely in the UK – the DST had in place a specialist accommodation service directly linked to treatment services. In all, 52 tier 4 beds were commissioned from three local providers and the DST agreed a number of block purchase agreements to cover the cost of treatment in some, but not all, of the bedspaces. However, despite this recommissioning exercise, all three providers have seen a continued overall decline in the use of their tier 4 provision with no apparent link to performance, as outcomes remain good.

Access to tier 4 is different to other treatment services in that a specific assessment process has to be conducted and, in most cases, individual funding has to be secured or approved. This process is perceived by both clients and drug workers as an impediment to referrals and access.

An audit in Bristol found that the average time taken to complete a community care assessment for drug misusers was 16 days, with the shortest time one day and the longest 46 days. The common assessment form used to assess the needs of drug users for all other services – aimed at enabling the swift transfer of information and avoidance of multiple assessments – is not considered appropriate for tier 4 clients, adding to delays. It's also known that clients have often been required to 'prove' their motivation, while missed appointments and lapses are considered to mean they are not 'ready' for rehab. These conditions are not applied to clients accessing community-based treatment services.

In July this year a seminar was convened for all those with an interest in tier 4

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services in Bristol, to address the low level of referrals. Delegates endorsed the high quality and importance of local tier 4 services and identified a range of possible causes for low referral rates. These included the lack of strategic importance given to tier 4 compared to harm reduction services, lack of local accountability and responsibility for tier 4, and lack of awareness of the availability of tier 4 services among professional and clients.

Also identified were low levels of client expectation regarding rehab availability, lack of ambition on the part of harm reduction drugs workers in supporting clients to achieve abstinence, and a perception among drug workers of insurmountable obstacles to accessing tier 4. There was also a feeling that clients could get their needs met through community rather than residential-based services – an inability to differentiate between the needs of clients and to match services appropriately.

In Bristol there are an estimated 6,000 problematic drug misusers – 4,000 of whom are engaged in treatment, with approximately 1,500 prescribed methadone. However in 2007-08 just 100 (63 drugs and 37 alcohol) placements were made in tier 4. In 2008/09 this figure had fallen to 83 (40 drugs and 43 alcohol) – less than 1.8 per cent of those in treatment.

Given that most drug users engage with treatment because they want to get off drugs, this low figure suggests the treatment system is not necessarily helping clients achieve their aspirations. The need for treatment services to be more ambitious to enable clients to become drug free is a view now expressed by the NTA.

To date, the national drug strategy has been weighted in favour of harm reduction, with a particular emphasis on methadone. The system has also been heavily target-driven – getting people into, and retaining them in, treatment. There have been no incentives to move people out of treatment and no drug-free targets. As a consequence, referrals from tier 2/3 service providers to tier 4 inpatient and rehabilitation services have been low.

The national drug policy has clearly shifted to state that the goal of all treatment is abstinence, and any change in policy should there be a change of government is, if anything, likely to emphasize even further the importance of drug-free outcomes as the objective of treatment. Recently shadow home secretary Chris Grayling said 'We need an abstinence-based approach to treatment... There is increasing evidence that the current approach of stabilisation is not working.'

A wide range of actions can be taken to improve the current situation and increase tier 4 take up. In Bristol the DST has established a tier 4 group to address the changes needed to improve referral rates. But there are specific actions that could be agreed at a strategic level which would make a difference, including reviewing local treatment systems in line with NTA priorities to focus on recovery, removing obstacles to achieve equality of access – replacing the requirement for a community care assessment – and widely publicising the availability of tier 4 provision to counter client perceptions that it is too difficult or too expensive to access.

Others include establishing a training programme for tier 2 and 3 drug workers to equip them with the skills to be 'more ambitious' for their clients in achieving a drug-free life, monitoring tier 2 and 3 services to ensure there are consistent levels of referrals to tier 4, setting local targets for getting people off drugs and financially securing existing tier 4 provision to guarantee future availability.

Most people recognise the quality and importance of residential services to the treatment system. However, low referral rates threaten the very survival of that key part of the system, just at the time when government and NTA policy is seeking the kind of results that residential services have consistently delivered. The challenge for commissioners is to safeguard tier 4 provision as the basis of a recovery-orientated treated system and ensure that more people have the opportunity to lead a drug-free life by increasing referrals. This will involve a cultural shift among many commissioners and providers, as treatment moves away from focusing on getting more people into treatment and keeping them there, to helping them exit treatment drug free.

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