Improving services for substance misuse
Diversity, and inpatient and residential rehabilitation services

Joint service review
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The National Treatment Agency

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

The NTA works in partnership with national, regional and local agencies to:

• Ensure the efficient use of public funding to support effective, appropriate and accessible drug treatment services.
• Promote evidence-based and coordinated practice, by identifying and disseminating best practice.
• Improve performance by developing standards and guidance for drug treatment, promoting user and carer involvement, and expanding and developing the drug treatment workforce.
• Monitor and develop the effectiveness of drug treatment.

The NTA has achieved the Department of Health’s targets to:

• Double the number of people in treatment between 1998 and 2008
• Increase the percentage of those successfully completing or appropriately continuing treatment year on year.

It is now in the front-line of a cross-Government drive to reduce the harm caused by drugs and its task is to improve the quality of treatment in order to maximise the benefit to individuals, families and communities.

The NTA will be judged against its ability to deliver better treatment and better treatment outcomes for the diverse range of people who need it.

The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission’s role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

• Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
• Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
• Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission’s work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

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The NTA will be judged against its ability to deliver better treatment and better treatment outcomes for the diverse range of people who need it.
Introduction

In 2005, the National Treatment Agency for Substance Misuse (NTA), in partnership with the Healthcare Commission, embarked on a joint three-year programme of annual reviews of substance misuse services. This was a key element of the NTA’s initiative to enhance the quality, consistency and effectiveness of drug treatment in England.

The service reviews are designed to assess the provision and commissioning of drug treatment against key indicators. They provide a benchmark of the quality of drug treatment and information on areas of weakness, against which improvement can be planned. The service reviews were:

- **2005/06**: Community prescribing services, and care planning and coordination.
- **2006/07**: Commissioning drug treatment and harm reduction services.
- **2007/08**: Diversity, and inpatient and residential rehabilitation services.

The third review was also delivered with the cooperation of the Commission for Social Care Inspection (CSCI). CSCI inspect and regulate many inpatient and residential services and have fully endorsed and supported this review.

This report outlines the results of the final review on diversity, and inpatient and residential rehabilitation services.

Drug treatment is provided by a network of services, commissioned by 149 local partnerships of statutory agencies. The partnerships bring together representatives of local organisations involved in the delivery of the Government’s drug strategy, including primary care trusts, local authorities, the police and the probation service. For this review, the key outcome and quality measures were developed around two separate themes:

**Diversity**: meeting the needs of people from a diverse range of communities or groups. Substance misuse affects a broad range of communities and people with diverse needs. It is therefore vital to ensure that drug treatment is able to meet these needs appropriately and effectively. Commissioning and providing drug treatment must be compliant with statutory requirements concerning disability, race, gender, sexuality, religion and age. How well commissioners and providers of services understand the diverse needs of their local communities, and then commission and deliver services that meet these needs, is central to this theme.

**Commissioning and providing inpatient detoxification/stabilisation and residential rehabilitation (Tier 4) services**: inpatient and residential drug treatment services (known as Tier 4 services) can provide effective responses to the needs of those with the most severe drug problems. They can enable drug misusers to move towards long-term abstinence when appropriate. Inpatient drug treatment usually involves short episodes of hospital-based (or equivalent) medical treatment. This normally includes 24-hour medical cover and assisted withdrawal from illegal and substitute drugs. Inpatient drug treatment can also assess and stabilise chaotic service users. Residential rehabilitation services deliver programmes designed to support service users to live drug-free lives, focusing on the coping strategies and life skills required to achieve this.

Historically, residential rehabilitation placements were funded by local areas from local authority budgets, and specialist local authority teams case-managed these placements.
The extent to which these arrangements have been integrated with broader commissioning and delivery of drug treatment services is central to this theme of the review. Inpatient and residential services play a key role in NTA’s vision for a national treatment system that is ambitious for its service users in terms of achieving abstinence.

Within these two themes, the review established 11 criteria. These criteria were assessed using 40 questions with related indicators. Each question was scored on a scale of 1 to 4, using “weak” (1), “fair” (2), “good” (3) or “excellent” (4). These question scores were then used to calculate criteria level scores and overall scores for each local drug partnership, using the same scale.

**Results**

The overall results for local drug partnerships show that the vast majority are performing well: 72% had an overall score of good and a further 15% had an overall score of excellent. None had an overall score of weak and 13% had an overall score of fair. Therefore, all 149 local drug partnerships were assessed to be performing at an acceptable level or better. However, the review identified that the majority of partnerships underperformed in some key areas, which showed that there was room for improvement on specific issues.

The scores of local drug partnerships that relate specifically to inpatient and residential rehabilitation services (Tier 4 services) are aggregations of the scores achieved by the Tier 4 services that they commissioned during the review period. But because Tier 4 services are commissioned from a complex national network of services, frequently on a case-by-case basis, these service providers were also given their own individual scores.

There was a similar pattern of results for Tier 4 service providers: over half (56%) of inpatient treatment services were scored as good and a further 21% were scored excellent. For residential rehabilitation services, 56% were scored as good and a further 11% were scored as excellent.

**Diversity**

The needs assessments undertaken by local drug partnerships had a good focus on diversity issues. However, in many partnerships this did not carry through adequately into strategic planning. Systematically developing an assessment of local need and strategically planning drug treatment against that assessment are key commissioning mechanisms. They are also central to addressing the needs of diverse groups and communities. Nearly all local drug partnerships (99%) had carried out a needs assessment that identified the needs of diverse populations within the locality. This shows widespread good practice in relation to diversity.

However, 72% of local drug partnerships scored fair and a further 4% scored weak on the question that asked if they had a treatment plan with an effective focus on diversity. This shows that there has been national progress in understanding the differing needs of communities, but this has not had enough impact on the resultant strategic plans. There has been some good progress in this area, but local drug partnerships need to do more to address diversity and equality issues when planning treatment.
The vast majority of the public body members of local drug partnerships and NHS service providers fulfilled their statutory duties to develop equality schemes for race, gender and disability. However, they should give a more specific focus to substance misuse services when carrying out their statutory duties in relation to diversity.

The review highlighted substantial evidence of compliance with statutory duties relating to diversity:

- There was 100% compliance with developing equality schemes across primary care trusts, local authorities and the police. Also, 100% of probation services had race equality schemes and 99% had gender and disability schemes.
- 60% of partnerships monitored the ethnicity of 98% to 99% of their service users and a further 26% monitored the ethnicity of 100% of their service users.
- Nearly all NHS service providers (99%) had developed race, gender and disability schemes.
- Nearly all services (95%) reviewed data on service uptake by diverse communities annually, and 92% of services used this data to plan services.

However, there was specific underperformance in relation to how local drug partnerships and service providers address diversity issues. This related particularly to the degree of specific focus given to substance misuse services as part of organisations’ broader delivery of diversity duties.

- Only just over half (54%) of the local drug partnerships had undertaken a race equality impact assessment specifically of substance misuse services. Similarly, only 18% of NHS service providers had undertaken impact assessments of their substance misuse services specifically for either race, gender and disability. This is particularly significant as substance misuse affects different communities or groups in different ways.
- Many of the contracts between local drug partnerships and community-based drug treatment services do not include sufficient requirements to comply with equality and diversity legislation. Nearly two-thirds (64%) of partnerships scored weak on this question and a further 10% scored fair. Over a half to two-thirds of the requirements which were specified were not included in contracts that were signed and dated.
- The majority of service providers did not consult broadly enough with diverse communities when reviewing and planning their services – particularly with groups not currently using services (only 31% of services consulted with communities who were not currently accessing services).
- NHS services address disability issues less consistently than gender and race issues when reviewing their services. Seventy-eight per cent used data on gender and race to plan improvements, compared with only 53% in relation to disability.

Improving services for substance misuse
Commissioning inpatient and residential rehabilitation (Tier 4) services

There was evidence of good practice in commissioning both inpatient and residential rehabilitation services.

- The majority (70%) of local drug partnerships commission all their inpatient detoxification services from specialist substance misuse units. Evidence shows that providing specialist substance misuse services, as opposed to detoxification on general psychiatric wards, offers a more comprehensive service and achieves better outcomes.

- There was good awareness of the eligibility criteria for inpatient and residential services within local drug treatment systems: 89% of local drug partnerships said all their community-based services were fully aware of the local criteria.

- Local drug partnerships were more likely to commission placements from the better performing inpatient and residential services. This demonstrates that commissioners focused on the quality of services when making commissioning decisions.

However, in a significant number of local drug partnerships the commissioning of residential rehabilitation services was **not adequately integrated with other drug treatment commissioning mechanisms**. Historically, the commissioning of residential rehabilitation placements was distinct from other commissioning processes. They were often purchased by local authority community care teams on an individual case-by-case basis, in isolation from the local drug partnership, from a national network of independent services. This has made the commissioning of residential rehabilitation services complex and potentially problematic. Integration with other drug treatment and commissioning mechanisms is emphasised in current guidance from the NTA to ensure that residential drug treatment is an effective and integrated part of local drug treatment services. The review showed that the majority of local drug partnerships had revised their procedures to come into line with this guidance. However, there were some key shortfalls in a significant minority:

- 49% of local drug partnerships did not integrate the management of the residential rehabilitation budget with the main local drug treatment budget.

- In 30% of local drug partnerships, decisions about the level of residential rehabilitation budget were made solely by the local authority.

- In 23% of local drug partnerships, decisions on spending the residential rehabilitation budget were made solely by the community care team.

Furthermore, the review showed that less than half (44%) of local drug partnerships had increased their funding for residential rehabilitation services above the rate of inflation in the last five years. In the context of significant increases in drug treatment budgets in recent years, this finding is a matter of concern.

There was a lack of integration of inpatient and residential services with community-based services. To enable both inpatient and residential services to operate as an effective and integrated component of drug treatment systems, local areas need good pathways between community, inpatient and residential services. Service users usually use residential rehabilitation services outside the area in which they live. Appropriately timed entry and supported exit from inpatient and residential services are essential to more successful outcomes for service users. There is also a significant risk of overdose following...
detoxification if service users return to drug use, due to their decreased tolerance levels. It is therefore essential that inpatient and residential services are integrated effectively with community-based services. Some key issues in relation to integration were:

- Around two-thirds (68%) of local drug partnerships did not monitor occurrences of overdose post-discharge from inpatient detoxification services.
- 42% of local drug partnerships did not monitor how many service users accessed community-based services after discharge from residential rehabilitation services.
- 37% of local drug partnerships did not specify throughcare and aftercare arrangements in all their spot-purchase* agreements with residential rehabilitation services.
- A third (33%) of local drug partnerships did not specify throughcare and aftercare arrangements in all their block contracts for inpatient detoxification. Furthermore, only 38% of local partnerships specified throughcare and aftercare arrangements when spot-purchasing in inpatient services.
- Just over a third (34%) of local drug partnerships did not contract with their community-based services to undertake risk assessments with service users following unplanned discharge from inpatient and residential services.

Providing inpatient and residential rehabilitation services

There was widespread evidence of good practice in providing both inpatient and residential rehabilitation services:

- 86% of inpatient detoxification services had prescribing regimes that were in line with NICE clinical guidelines.
- The majority (71%) of inpatient and residential rehabilitation services had induction, training and appraisal programmes with which to support and develop staff.
- The majority (88%) of inpatient and residential rehabilitation services had policies on the development of exit plans for service users to ensure effective re-integration back into the community and the provision of appropriate aftercare.
- All inpatient services and nearly all residential rehabilitation services (97%) had procedures for notifying community-based care coordinators of unplanned discharge.

Inpatient and residential services need to further develop their evidence-based programme manuals. Manuals on the content of treatment programmes should be accessible to all staff and should ensure that programmes are consistent, quality-assured and evidence-based. Forty-three per cent of inpatient services and 50% of residential rehabilitation services were scored weak. There were marked shortfalls in relation to some elements of treatment, particularly blood-borne virus services and protocols, and employment-related interventions.

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* Spot-purchasing is contracting or purchasing arrangements that relate to a single placement made for a single service user (NTA, October 2006).
The policies on unplanned discharge of some inpatient and residential services were deficient in some key areas. If a service user leaves an inpatient or residential rehabilitation service at short notice, in an unplanned way, their health can be put at risk and it can potentially affect other local services. These risks can be reduced if there are appropriate procedures in place. Twenty-three per cent of residential rehabilitation services did not have a policy specifying that an assessment of risk of overdose be carried out in the event of an unplanned discharge. In addition, 17% of inpatient detoxification services did not have procedures to inform local community-based services of the likelihood of an unplanned discharged service user using their services.

There was significant under-reporting to the National Drug Treatment Monitoring System (NDTMS) by inpatient and residential rehabilitation services on their activity. Twenty-eight per cent of inpatient services and 41% of residential rehabilitation services were either not reporting any data or were reporting incomplete data to the national database (NDTMS). It is a national priority to improve this situation as the local and national strategic planning of inpatient and residential services is dependant on accurate information.

Priorities for action

The review provides a helpful picture of the national strengths and weaknesses in relation to the two themes of the review, as well as valuable data to initiate local action. Although progress has been made, there are still a number of areas for improvement.

The following are priorities for local drug partnerships in relation to diversity:

- Treatment planning should focus appropriately on the needs of diverse communities and ensure these are appropriately met.
- Members of local drug partnerships and NHS service providers should ensure that substance misuse is directly addressed in their race equality schemes and in the delivery of their statutory duties in relation to diversity.
- Commissioners should ensure that all contracts include requirements for compliance with all relevant equality and diversity legislation.
- Local drug partnerships should focus on ensuring that services are accessible and relevant to crack cocaine misusers, to increase the proportion accessing services.
- Service providers and local drug partnerships should consult more broadly with the communities they service, including with diverse groups and communities (particularly those not currently accessing drug treatment), and involve them in planning services.
In relation to commissioning inpatient and residential rehabilitation services, local drug partnerships should:

- Review the management of residential rehabilitation budgets and the degree of partnership involvement.
- Ensure that contracts with inpatient and residential services include all the elements outlined in national guidance, with a particular focus on throughcare and aftercare and reporting requirements of the national database (NDTMS).
- Review the data they collect in relation to inpatient and residential services, focusing on monitoring integrated care pathways between community-based services and inpatient and residential services. They should also improve their monitoring of incidents of overdose following inpatient and residential interventions.
- Focus on commissioning integrated pathways into and out of inpatient and residential services, ensuring that community-based services are clearly contracted to support this model.

Inpatient and residential service providers should:

- Develop their evidence-based manuals, ensuring they are comprehensive, accessible to all staff and cover essential elements of service provision. They should focus particularly on improving the testing and treatment of blood-borne viruses and also the employment-led elements of programmes.
- Ensure that policies and protocols relating to exit plans and unplanned discharge are robust and contain all the elements outlined in national guidance.
- Register and submit valid data to the national database (NDTMS).

Promoting improvements

All local drug partnerships have used the results of this review to develop action plans for 2009. NTA’s regional teams and strategic health authorities will monitor their performance against these plans. Furthermore, NTA have supported approximately 10% of the weakest performing partnerships in developing their action plans.

In addition, six inpatient or residential service providers were also supported in developing action plans, and NTA also delivered national workshops on improving aspects of delivery. All inpatient and residential services were encouraged to develop action plans and share these with the commissioners of their services.

This review was the last of the three joint service reviews of substance misuse by the Healthcare Commission and NTA. Together, all three reviews will provide a key vehicle for improving the provision of drug treatment services to support the Government’s drug strategy. The NTA will publish a report on the combined impact of all three reviews on the provision of drug treatment services later in 2009.

The scores achieved by each local drug partnership and inpatient and residential service are published on the websites of the Healthcare Commission: www.healthcarecommission.org.uk, and the NTA: www.nta.nhs.uk.
The year 2008 marked a watershed for drug treatment in England. As the Government’s previous 10-year drug strategy (1998-2008) ended, figures show that more than 202,000 people were recorded as receiving treatment for substance misuse during 2007/08, up by 138% from the 1998/99 baseline of 85,000.

Drug treatment remains a priority and the Government’s new drug strategy, launched in February 2008, puts drug treatment at its core. New challenges include a greater focus on treatment outcomes and a wider social purpose to re-integrate drug misusers into society. Evidence shows clearly that most drug misusers benefit from treatment, and the community also benefits because treatment stabilises lives, results in fewer crimes and reduces health risks to individuals, families and communities. The suite of clinical guidelines from the Department of Health and the National Institute for Health and Clinical Excellence (NICE), published in 2007, endorsed the fact that evidence-based drug treatment can be highly effective.

Models of care, published by the National Treatment Agency (NTA) in 2002 and revised in 2006, provided national guidance on the framework of drug treatment services that should be provided in each local area. This guidance placed an emphasis on improving the journeys of service users through treatment. It included improving people’s access to treatment and their initial retention, improving treatment with care-planning and evidence-based treatment, helping drug misusers to re-integrate into local communities, and having better planned exits for those who are able to achieve abstinence from drugs.

Local areas have been tasked with developing local systems of treatment to help drug misusers reduce the harm caused by their drug misuse and to overcome dependence. There has been much progress, but there are still significant areas for improvement and a need for increased consistency in providing services.

It was in this context that the NTA and the Healthcare Commission agreed to work in partnership on a series of three reviews into key aspects of services for substance misuse.

Service reviews look at whether healthcare organisations are improving the care and treatment they provide to patients. They focus on particular aspects of healthcare that are of national importance and where there are opportunities for organisations to make substantial local improvements to the quality of services. Their aim is to encourage each organisation taking part, or in the review of substance misuse services each local drug partnership, to improve the quality of services it provides to service users.

The two organisations worked jointly to set up the process for the reviews and the work is governed by a memorandum of understanding. The NTA is the specialist sponsor and the Healthcare Commission the inspector and regulator.
The topics for these reviews were:

- **2005/06**: Community prescribing services, and care planning and coordination.
- **2006/07**: Commissioning drug treatment and harm reduction services.
- **2007/08**: Diversity, and inpatient and residential rehabilitation services (as defined in *Models of care 2006*).

This third review was also delivered in cooperation with the Commission for Social Care Inspection (CSCI). CSCI inspect and regulate many inpatient and residential services and have fully endorsed and supported this review. This review focuses on two themes: diversity, and inpatient and residential drug treatment services. The context of these themes is outlined as follows.

All three reviews have been ground-breaking in terms of measuring and improving the quality of drug treatment in England.

**Diversity**

This theme assesses how effectively local drug treatment services meet the needs of people from a diverse range of communities and groups.

Issues relating to substance misuse affect a broad spectrum of communities and people with diverse needs. It is therefore vital to ensure that drug treatment is able to meet these needs appropriately and effectively.

The NTA, as the delivery assurance body for drug treatment services, is committed to assessing, monitoring and planning to improve services wherever particular communities or people with diverse needs are not receiving appropriate services. This review itself builds on and complements the audits of NHS equality publications and the review of equality in NHS trusts, undertaken by the Healthcare Commission from 2006 to 2008.

Commissioning and providing drug treatment must be compliant with statutory requirements concerning: gender; sexuality; religion; age (Equality Act 2006); race (Race Relations (Amendment) Act 2000) and disability (Disability Discrimination Act 2005). Organisations have positive duties under this legislation in relation to gender, race and disability. The review focuses on these three positive duties, as compliance with them can be systematically assessed, but organisations have broader duties, beyond these, regarding sexuality, religion and age.

How well commissioners and providers of services understand the diverse needs of local communities and then commission and deliver services that meet these needs is central to this theme.
Inpatient and residential rehabilitation (Tier 4) services

This theme assesses the commissioning and provision of both inpatient and residential drug treatment services, more commonly known as ‘Tier 4’ services. The NTA’s Models of care: Update 2006 defines Tier 4 treatment services as: inpatient assessment, stabilisation and assisted withdrawal services, residential rehabilitation services and aftercare. This review addressed specifically inpatient assessment/detoxification/stabilisation and residential rehabilitation interventions. Appendix A gives the full definitions contained in Models of care: Update 2006.

Inpatient drug treatment services can provide effective responses to the needs of those with the most severe drug problems and complex needs. It can enable drug misusers to move towards long-term abstinence when appropriate. Inpatient services can also assess and stabilise chaotic service users.

Residential drug treatment services form an integral part of locally-commissioned drug treatment systems. However, they have not uniformly benefited from the improvement in capacity and quality experienced by community-based treatments since the launch of the previous national Drug Strategy in 1998. In fact, the lack of effective commissioning processes and structures for inpatient and residential services in some areas has “resulted in impeded growth and a failure to guarantee income streams” (NTA, 2008*).

Historically, residential rehabilitation placements were funded by local areas from local authority budgets and specialist local authority teams case-managed these placements. The extent to which these arrangements have been integrated with broader commissioning and delivery of drug treatment services is central to this theme of the review.

Improving the provision of Tier 4 services is an essential element of the NTA’s initiative to enhance the quality, consistency and effectiveness of drug treatment. These services have a key role in the NTA’s vision for a national treatment system that is ambitious for its service users, in terms of them achieving abstinence whenever possible and providing harm reduction services whenever necessary. To help achieve this, the NTA has already published guidance on commissioning residential services – specifically the Models of residential rehabilitation for drug and alcohol misusers (2006)*, Commissioning Tier 4 drug treatment (2006)* and Improving the quality and provision of Tier 4 interventions as part of client treatment journeys (2008).*

Tier 4 drug treatment services are provided by NHS, charitable and independent bodies, including registered care homes, registered nursing homes, independent hospitals, NHS units and unregistered establishments. They are, therefore, subject to a range of registration and inspection frameworks, making it difficult to assess the overall quality of the sector.
Service reviews are based on a standardised approach that is information-based and targeted. The method is designed to encourage significant improvement without imposing a large burden on healthcare organisations.

There are two stages to this service review. Firstly, we assess the performance of all organisations that took part in the review. In the second stage, the NTA works with the minority (about 10% to 15%) of organisations that received the weakest assessments and who may require help to develop action plans to improve their performance.

Drug treatment is provided within partnerships or treatment communities, as opposed to individual services, so the review focused on treatment across these partnerships. These were defined in terms of local drug partnerships or action teams (referred to throughout as local drug partnerships).

The assessment checks the performance of local drug partnerships against key measures of outcome and quality that provide an indication of their overall effectiveness and their inpatient and residential services. These measures were based on national policy, guidance and standards of good practice, and developed through engagement with service users, carers, providers (including clinicians and other experts) and commissioners of services.

The assessment framework consisted of 40 questions. Each question was scored on a scale of 1 to 4 and scores for questions were aggregated, using a standard set of rules, into criteria scores and then again into overall scores, using the same scale of 1 to 4. The scale used was: “weak” (1), “fair” (2), “good” (3) or “excellent” (4).

Both inpatient and residential rehabilitation services have been given their own individual scores, because many are commissioned by local drug partnerships from a national marketplace. These scores are based only on the elements of the review that related to providing inpatient and residential services. The scores of specific inpatient and residential service providers were also used to calculate the scores of the local drug partnerships which commissioned their services. They were attributed to local partnerships proportionately to the amount of provision the local drug partnership commissioned from a particular service provider. The impact of the score of an inpatient or residential provider on the score of a local drug partnership was directly related to the number of admissions that it purchased from the provider.

Most of the information used in the review was taken from questionnaires completed by community-based drug services for the ‘diversity’ theme, and by inpatient and residential services for the ‘inpatient and residential services’ theme. Local drug partnerships completed questionnaires for both themes. There were 1,478 questionnaires completed for the review, which represented a response rate of 99%. Other information for the review came from the National Drug Treatment Monitoring System (NDTMS, the national drug treatment database), the NTA regional teams and the NTA’s Third National Service User Survey.

A vital component of this review was the spot-checking process. The review team looked at the questionnaires of five local drug partnerships and six inpatient and residential service providers to ensure that the answers given could be supported by evidence, such as policies and procedures referred to in their answers. The organisations were selected based on analysis.
of the questionnaires. All organisations submitting questionnaires were informed about this process before completing questionnaires. They were asked to collate an evidence portfolio that supported their responses to the questionnaire, which would be reviewed during the spot-checks. Where organisations could not provide evidence for their answers, the answers and scores were changed accordingly. The process was a mechanism to ensure that organisations’ responses to questions were accurate.

In the second and final stage of the review, all local drug partnerships used the results to develop action plans for 2009 to address the shortfalls in commissioning and service provision identified by the review. The NTA’s regional teams and the strategic health authorities will monitor their performance against these plans. All inpatient and residential rehabilitation services were encouraged to develop action plans and share these with the commissioners of their services. Furthermore, approximately 10% of the weakest performing local drug partnerships were supported in developing action plans by the NTA. Six inpatient or residential service providers were also supported in developing plans, and NTA organised national workshops on improving aspects of service delivery.

Further detail on the methodology and the development of the review can be found in Appendix B.

The criteria

The assessment framework consisted of 11 criteria (or key headings) with 40 questions distributed across the criteria. The 11 criteria were placed into the two themes of ‘diversity’ and ‘inpatient and residential rehabilitation services’. The criteria are set out in box 1 on the next page.
Theme 1: Diversity
The following criteria were developed to assess the performance of local drug treatment partnerships in relation to the accommodation of diverse needs in community-based services.

1. Local commissioning partnerships ensure that the requirements of the Race Relations (Amendment) Act 2000, the Equality Act 2006 and the Disability Discrimination Act 2005 are complied with in the local treatment system.

2. Local commissioning partnerships carry out needs assessments and treatment planning which includes the identification of, and response to, the needs of diverse populations.

3. Local commissioning partnerships commission services to meet the needs of diverse populations.


5. Service providers ensure the delivery of services and/or interventions that meet the needs of local diverse populations.

6. Service providers plan and provide services in a way that considers and respects the views of service users and other service providers.

Theme 2: Commissioning inpatient and residential rehabilitation (Tier 4) services
The following criteria were developed to assess the commissioning/purchasing and provision of Tier 4 drug treatment services (including both inpatient detoxification/stabilisation and residential rehabilitation interventions).

7. Local commissioning partnerships have effective commissioning and/or purchasing processes for Tier 4 inpatient interventions.

8. Local commissioning partnerships have effective commissioning and/or purchasing processes for Tier 4 residential rehabilitation interventions.

9. Service users have prompt and flexible access to Tier 4 interventions.

10. Service providers deliver Tier 4 interventions in line with up-to-date evidence that relates to the type of intervention or programme being delivered.

11. Service providers provide Tier 4 interventions in a safe environment staffed by competent practitioners.

Scores for criteria 9, 10 and 11 were used in the assessments of Tier 4 services, for both inpatient and residential rehabilitation services.
Key overall results

Overall scores

The following analysis of results covers all 149 local drug partnerships that were assessed, as well as the 90 inpatient service providers and 104 residential rehabilitation service providers. The scores provide a numeric summary of the performance in each local drug partnership and inpatient or residential rehabilitation service. Appendix B describes how we calculated the overall scores.

Figure 1 shows the distribution of total scores for all 149 local drug partnerships out of a highest achievable score of 43. The overall scores for local drug partnerships represent the combination of scores for the two themes. The chart shows the thresholds for overall scores of 1 to 4, “fair” (2), “good” (3) or “excellent” (4).

The scores show that while the vast majority of partnerships are performing within acceptable levels, there is some room for improvement.

No local drug partnerships were scored at level 1 (“weak”), in this review. The majority (72%) were scored as good overall, but only 15% were scored as excellent. Thirteen per cent were scored as fair, indicating areas for improvement within these local drug partnerships. Within these overall results, some local drug partnerships had significant areas for improvement against one theme or aspect of the review. These issues are explored later in the report and call for immediate action to be taken by local drug partnerships.
Figure 2 above shows the number and percentage of overall rating scores achieved by inpatient services, out of a highest achievable score of 12.

Inpatient services were given individual scores based on their performance against the three criteria of the review that focused specifically on providing inpatient services (criteria 9, 10 and 11).

Six inpatient services were scored as weak because, although they were commissioned by local drug partnerships to provide services during the review period, and as such were nominated to provide data, they failed to submit any data to the review. A fifth of inpatient services were scored as excellent and just over half (55%) were scored as good. Just under a fifth (17%) were scored as fair.

These results demonstrate widespread good practice in this area of service.
Figure 3 shows the number and percentage of overall rating scores achieved by residential rehabilitation services, out of a highest achievable score of 12. Residential rehabilitation services were given individual scores based on their performance against the three criteria of the review that focused specifically on providing these services (criterion 9, 10 and 11).

Three residential rehabilitation services were assessed as weak because they failed to submit any data to the review. Just over a tenth (11%) of residential rehabilitation services were scored as excellent and 56% were scored as good. Just under a third (31%) were scored as fair, indicating that a significant proportion need to respond to shortfalls identified by the review.
Regional variations in results

Regional differences in scores were clearly evident and are shown in figures 4, 5 and 6. There are also clear variations within the nine regions themselves, as shown in figures 7, 8 and 9.

The variations cover a mean score range of 2.6 to 3.3 (figure 4). London, the North West and the South West are the top-performing regions overall.

**Figure 4: Mean category score (1 to 4) for each region**

<table>
<thead>
<tr>
<th>Region</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>3.3</td>
</tr>
<tr>
<td>North West</td>
<td>3.1</td>
</tr>
<tr>
<td>South West</td>
<td>3.1</td>
</tr>
<tr>
<td>South East</td>
<td>3.0</td>
</tr>
<tr>
<td>West Midlands</td>
<td>2.9</td>
</tr>
<tr>
<td>North East</td>
<td>2.9</td>
</tr>
<tr>
<td>East Midlands</td>
<td>2.9</td>
</tr>
<tr>
<td>Yorkshire &amp; Humberside</td>
<td>2.7</td>
</tr>
<tr>
<td>Eastern</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Figure 5 below represents the average scores for local drug partnerships by region for the diversity theme of the review.

The scores fall into three clear groups:
- London and the East Midlands scored significantly better than any other regions.
- Five regions achieved average scores.
- Yorkshire & Humberside and the Eastern region achieved the lowest scores for the diversity theme.

Figure 6 over the page shows the average scores for regions for the inpatient and residential rehabilitation services theme of the review.

The London region performed best against both themes in the review. The East Midlands region was one of the highest performers on the diversity theme, but one of the lowest performers on the inpatient and residential rehabilitation services theme.

London and the North West are in the top three regions for both themes of the review and the overall score.
The three maps on the following pages are divided into the nine NTA regions of England that follow the boundaries of Government Offices and show the rating scores awarded to local drug partnerships.

The first map (figure 7) shows the overall score for both themes combined; the second map (figure 8) shows the score for the diversity theme; and the third map (figure 9) shows the score for the inpatient and residential rehabilitation (Tier 4) services theme of the review.
Key overall results continued

Figure 7: Distribution of regional scores – local drug partnerships’ overall scores

Key for partnerships’ scores
- **Excellent**
- **Good**
- **Fair**

Note: The regions shown are the nine NTA regions, which are the same as the Government Offices.
### Improving services for substance misuse

#### North East
- 1 County Durham
- 2 Darlington
- 3 Gateshead
- 4 Hartlepool
- 5 Middlesbrough
- 6 Newcastle upon Tyne
- 7 North Tyneside
- 8 Northumberland
- 9 Redcar and Cleveland
- 10 South Tyneside
- 11 Stockton-on-Tees
- 12 Sunderland

#### Yorkshire & Humberside
- 1 Barnsley
- 2 Bradford
- 3 Calderdale
- 4 Doncaster
- 5 East Riding of Yorkshire
- 6 Kingston upon Hull
- 7 Kirklees
- 8 Leeds
- 9 North East Lincolnshire
- 10 North Lincolnshire
- 11 North Yorkshire
- 12 Rotherham
- 13 Sheffield
- 14 Wakefield
- 15 York

#### North West
- 1 Blackburn with Darwen
- 2 Blackpool
- 3 Bolton
- 4 Bury
- 5 Cheshire
- 6 Cumbria
- 7 Halton
- 8 Knowsley
- 9 Lancashire
- 10 Liverpool
- 11 Manchester
- 12 Oldham
- 13 Rochdale
- 14 Salford
- 15 Sefton
- 16 St Helens
- 17 Stockport
- 18 Tameside
- 19 Trafford
- 20 Warrington
- 21 Wigan
- 22 Wirral

#### East Midlands
- 1 Derby
- 2 Derbyshire
- 3 Leicester
- 4 Leicestershire
- 5 Lincolnshire
- 6 Northamptonshire
- 7 Nottingham
- 8 Nottinghamshire
- 9 Rutland

#### West Midlands
- 1 Birmingham
- 2 Coventry
- 3 Dudley
- 4 Herefordshire
- 5 Sandwell
- 6 Shropshire
- 7 Solihull
- 8 Staffordshire
- 9 Stoke-on-Trent
- 10 Telford and Wrekin
- 11 Walsall
- 12 Warwickshire
- 13 Wolverhampton
- 14 Worcestershire

#### London
- 1 Barking and Dagenham
- 2 Barnet
- 3 Bexley
- 4 Brent
- 5 Bromley
- 6 Camden
- 7 City of London
- 8 Croydon
- 9 Ealing
- 10 Enfield
- 11 Greenwich
- 12 Hackney
- 13 Hammersmith and Fulham
- 14 Haringey
- 15 Harrow
- 16 Havering
- 17 Hillingdon
- 18 Hounslow
- 19 Islington
- 20 Kensington and Chelsea
- 21 Kingston upon Thames
- 22 Lambeth
- 23 Lewisham
- 24 Merton
- 25 Newham
- 26 Redbridge
- 27 Richmond upon Thames
- 28 Southwark
- 29 Sutton
- 30 Tower Hamlets
- 31 Waltham Forest
- 32 Wandsworth
- 33 Westminster

#### South East
- 1 Bracknell Forest
- 2 Brighton and Hove
- 3 Buckinghamshire
- 4 East Sussex
- 5 Hampshire
- 6 Kent
- 7 Isle of Wight
- 8 Medway towns
- 9 Milton Keynes
- 10 Oxfordshire
- 11 Portsmouth
- 12 Reading
- 13 Slough
- 14 Southampton
- 15 Surrey
- 16 West Berkshire
- 17 West Sussex
- 18 Windsor and Maidenhead
- 19 Wokingham

#### South West
- 1 Bath and North East Somerset
- 2 Bournemouth
- 3 Bristol
- 4 Cornwall & Isles of Scilly
- 5 Devon
- 6 Dorset
- 7 Gloucestershire
- 8 North Somerset
- 9 Plymouth
- 10 Poole
- 11 Somerset
- 12 South Gloucestershire
- 13 Swindon
- 14 Torbay
- 15 Wiltshire

---

**Key for partnerships’ scores**

- Excellent
- Good
- Fair
Figure 8: Local drug partnerships’ scores for diversity

Key for partnerships’ scores
- Excellent
- Good
- Fair

Note: The regions shown are the nine NTA regions, which are the same as the Government Offices.
Improving services for substance misuse
Figure 9: Local drug partnerships’ scores for inpatient and residential rehabilitation services

Key for partnerships’ scores
- **Green**: Excellent
- **Blue**: Good
- **Red**: Fair

Note: The regions shown are the nine NTA regions, which are the same as the Government Offices.
The criteria for this theme of the review are set out in box 1 on page 15. Figure 10 shows how these criteria fit into the assessment framework.

Criterion 5 was the highest scoring criterion in this theme. This related to whether service providers ensure that the delivery of services meets the needs of local diverse populations.

Figure 10: The assessment framework for the diversity theme

<table>
<thead>
<tr>
<th>Outcome level</th>
<th>Criteria level</th>
<th>Question level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Needs assessments and treatment planning include identification of, and response to, the needs of diverse populations.</td>
<td>Monitoring of ethnicity is effective.</td>
</tr>
<tr>
<td></td>
<td>Services are commissioned to meet the needs of diverse populations.</td>
<td>Needs assessments identify the needs of diverse populations.</td>
</tr>
<tr>
<td></td>
<td>Service providers comply with the requirements of the Race Relations (Amendment) Act 2000, Equality Act 2006 and Disability Discrimination Act 2005.</td>
<td>Treatment plan has an effective focus on diversity.</td>
</tr>
<tr>
<td></td>
<td>Service providers ensure the delivery of services and/or interventions that meet the needs of diverse populations.</td>
<td>An appropriate range of services for diverse populations is commissioned.</td>
</tr>
<tr>
<td></td>
<td>Services are planned and provided in a way that respects the views of service users and other service providers.</td>
<td>Staff in the joint commissioning team are trained in commissioning services for diverse populations.</td>
</tr>
<tr>
<td></td>
<td>Services are planned and provided in a way that respects the views of service users and other service providers.</td>
<td>NHS providers have developed and implemented race, gender and disability equality schemes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Voluntary sector providers are implementing good practice with respect to equality legislation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service providers use monitoring data to plan appropriate provision.</td>
</tr>
<tr>
<td>Improvements in:</td>
<td></td>
<td>Service users feel respected by service providers.</td>
</tr>
<tr>
<td>• Drug and alcohol use</td>
<td></td>
<td>Staff are managed and supported to deliver services to diverse populations.</td>
</tr>
<tr>
<td>• Physical health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Psychological health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Criminal involvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Eighty per cent of partnerships were scored as “good” and only 20% scored as “fair”, with no local drug partnerships scored as “weak”. It was not possible to be scored as “excellent” for this criterion. The second strongest criterion (criterion 1) related to whether local commissioning partnerships ensure that they comply with the requirements of the Race Relations (Amendment) Act 2000, the Equality Act 2006 and the Disability Discrimination Act 2005 in the local treatment system. For this criterion, 59% were scored as good and 16% as excellent.

The weakest criterion in the diversity theme at a national level related to whether local commissioning partnerships commissioned services to meet the needs of diverse populations (criterion 3), where only 40% were scored as good and nearly half (49%) were scored as fair. Only 3% of local drug partnerships scored excellent for this criterion. The second weakest criterion related to whether service providers plan and monitor services in a way that considers and respects the views of service users and other service providers (criterion 6). For this criterion, 39% were scored as fair and only 2% scored as excellent.

The following section takes each criterion in the diversity theme in turn, and looks at the responses of the local drug partnerships.

**Figure 11: Distribution of scores for local drug partnerships in the diversity theme**
Local drug partnerships’ compliance with diversity legislation

Criterion 1: Local commissioning partnerships ensure that the requirements of the Race Relations (Amendment) Act 2000, the Equality Act 2006 and the Disability Discrimination Act 2005 are complied with in the local treatment system.

This criterion was chosen because each public body in a local drug partnership has statutory duties in relation to diversity. The public bodies that are members of local drug partnerships are: primary care trusts, the probation service, the police and local authorities. Their compliance with these duties is a key mechanism to ensure that the services they provide meet the diverse needs of the populations they serve. At the time of the review, all public bodies were expected to have developed a race equality scheme and to have developed or made progress on the development of gender equality and disability equality schemes for their own services.

Analysis of results for criterion 1

Question 1: Have the public body members of the local drug partnership fulfilled their statutory duties to develop equality schemes for race, gender and disability?

This was the strongest-performing question, with 55% of partnerships scored as good and a further 43% scored as excellent. Compliance with developing schemes was 100% across primary care trusts, local authorities and the police. All probation services (100%) had race schemes and 99% had gender and disability schemes. Up to 40% of these schemes specifically mentioned substance misuse services, which was the requirement to achieve a score of excellent.

Question 2: Have the public body members of the local drug partnership implemented the positive duties required as part of the development of equality schemes for race, gender, and disability?

This question showed the weakest performance in criterion 1. Almost half (46%) of partnerships were scored weak and a further 13% scored fair. The question focused on whether member organisations of local drug partnerships had undertaken a race equality impact assessment (REIA) specifically relating to substance misuse services on behalf of the partnership. Just over half (54%) of the local drug partnerships had undertaken a REIA specifically of substance misuse services. It also asked if black and minority ethnic (BME) communities were consulted as part of the REIA and if the results of the REIA had been published. Only 36% had consulted BME communities as part of a REIA and less than a quarter had published the REIA.

Table 1: Results of criterion 1 by question

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>1%</td>
<td>46%</td>
<td>2%</td>
</tr>
<tr>
<td>Fair</td>
<td>1%</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>Good</td>
<td>55%</td>
<td>21%</td>
<td>60%</td>
</tr>
<tr>
<td>Excellent</td>
<td>43%</td>
<td>19%</td>
<td>26%</td>
</tr>
</tbody>
</table>
Question 3: How effective is the local drug partnership’s monitoring of ethnicity?  
This was assessed using the National Drug Treatment Monitoring System (NDTMS), the national database for drug treatment, and assessed the completeness of the data for ethnic monitoring. Sixty per cent of partnerships were scored good on this question, indicating data completeness of 98% to 99%, and a further 26% scored excellent, indicating that all records had valid ethnic monitoring.

Needs assessments and treatment planning for diverse populations

Criterion 2: Local commissioning partnerships carry out needs assessments and treatment planning which includes the identification of, and response to, the needs of diverse populations.

The processes by which commissioners assess and understand local need and plan accordingly are central and vital elements of effective commissioning. If local drug treatment systems are to effectively meet the requirements of drug misusers from diverse communities, consideration of their needs must be central to the processes for local needs assessment and treatment planning. These are key instruments in the NTA’s drive to improve the quality and effectiveness of drug treatment.

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Fair</td>
<td>29%</td>
<td>72%</td>
</tr>
<tr>
<td>Good</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td>Excellent</td>
<td>43%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Analysis of results for criterion 2

Question 1: Has the local drug partnership carried out a needs assessment which includes consideration of the needs of diverse populations within the locality?
The strongest performance for this criterion was on question 1, with 27% of partnerships scoring good and a further 43% scoring excellent. Nearly all local drug partnerships (99%) had carried out a needs assessment that identified the needs of diverse populations within the locality. In addition, nearly all local drug partnerships (96%) analysed available data on diverse populations in the local community to identify currently unmet needs. The weakest elements of the question related to involving service users from diverse groups when considering local needs (73%) and cross-referencing with appropriate local community groups or forums (81%).

Question 2: Does the local drug partnership have a treatment plan with an effective focus on diversity?
Question 2 in criterion 2 scored much weaker, with 72% of local drug partnerships scoring fair and a further 4% scoring weak. The maximum score on this question was ‘good’, which was achieved by the remaining 24%. The question asked if local drug partnerships had considered the need for four key types of drug treatment specifically for diverse groups. It then went on to ask if this need was appropriately responded to.

Of the four key types of treatment, the least consideration had been given to Tier 4 (inpatient and residential) interventions. Only 32% of partnerships had fully identified the needs of diverse communities in relation to Tier 4 services, and only 26% reported them as being addressed. The second least considered type of treatment in relation to diverse needs was harm reduction services, with only 43% of partnerships fully identifying the needs of diverse communities and only 33% addressing them. These are clearly key shortfalls in relation to planning services for diverse communities.

This criterion demonstrates that, although there has been national progress in understanding the differing needs of communities, this has not yet had enough impact on the resultant strategic plans and these plans may not yet have gone far enough in addressing diverse needs on a national basis.
Commissioning services to meet the needs of diverse populations

Criterion 3: Local commissioning partnerships

Commissioning services to meet the needs of diverse populations.

Commissioning partnerships play a key role in ensuring that appropriate services are provided to meet the diverse needs of the communities they serve. Commissioners should strategically plan what their local treatment system contains to ensure that it meets the diverse needs of the community and that service providers are contracted to meet the needs of diverse communities.

Analysis of results for criterion 3

This was the weakest scoring criterion in the diversity theme.

Question 1: Does the local drug partnership ensure that information is made available to diverse populations?

Performance was mixed on question 1, with a quarter (24%) scored as weak and half (49%) scored as good (the maximum score available for this question). Over half (57%) of the partnerships provided information that was presented visually for service users with literacy needs, and over two-thirds (68%) provided leaflets in a range of languages spoken locally.

Question 2: Do current service level agreements and contracts include expectations that service providers comply with statutory requirements?

Question 2 showed the weakest performance in this criterion. Nearly two-thirds (64%) of partnerships were scored as weak and a further 10% were scored as fair. The maximum score available in the question was in the “good” category, attained by only 26% of partnerships. Over a half to two-thirds of the requirements that were specified in the question were not included in contracts that were signed and dated. Eighty-two per cent of partnerships specified compliance with the Race Relations Act (1976) as amended by the Race Relations (Amendment) Act 2000 in all their contracts, but only 54% specified compliance with the Sex Discrimination (Gender Reassignment) Regulations 1999 in all their contracts. For the other eight pieces of legislation specified by the review, compliance ranged from 57% to 79%.

Question 3: Are joint commissioning managers and members of the joint commissioning team trained in commissioning services for diverse populations?

This question showed the strongest performance for this criterion, with 19% of partnerships scoring good and a further 54% scoring excellent. Although 91% of joint commissioning managers had undertaken training in diversity and equality issues, only 62% had undertaken training specifically on commissioning services for diverse populations.

Table 3: Results of criterion 3 by question

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>24%</td>
<td>64%</td>
<td>26%</td>
<td>2%</td>
</tr>
<tr>
<td>Fair</td>
<td>27%</td>
<td>10%</td>
<td>1%</td>
<td>79%</td>
</tr>
<tr>
<td>Good</td>
<td>49%</td>
<td>26%</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>Excellent</td>
<td>N/A</td>
<td>N/A</td>
<td>54%</td>
<td>1%</td>
</tr>
</tbody>
</table>
**Question 4: Does the local partnership commission services that meet the needs of stimulant users?**
Seventy-nine per cent scored fair on this question, indicating a national shortfall in provision for this particular group.

Overall, 95% of local drug partnerships said that they commissioned services that meet the needs of stimulant misusers. We combined this information with information on the percentage of crack cocaine misusers who access these services in an area, using drug treatment uptake data and drug prevalence data. The analysis showed that in 50% of local drug partnerships, less than 30% of crack misusers accessed drug treatment services and in a further 30% of partnerships, between 30% and 40% of crack misusers accessed services. In a fifth (20%) of local drug partnerships, 40% or more of the estimated number of crack cocaine misusers accessed drug treatment. This compares to 84% of partnerships with 40% or more of the estimated number of heroin misusers accessing drug treatment, showing that crack cocaine misusers are less likely to access drug treatment services than heroin misusers.

---

**Service providers’ compliance with diversity legislation**

**Criterion 4: Service providers comply with the requirements of the Race Relations (Amendment) Act 2000, the Equality Act 2006 and the Disability Discrimination Act 2005.**

NHS drug treatment providers have statutory duties in relation to diversity. They are expected to have developed a race equality scheme and to have developed, or made progress on the development of, gender equality and disability equality schemes. These statutory duties are potentially key mechanisms to ensure that services meet the diverse needs in local areas.

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**Table 4: Results of criterion 4 by question**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Fair</td>
<td>46%</td>
<td>45%</td>
</tr>
<tr>
<td>Good</td>
<td>18%</td>
<td>48%</td>
</tr>
<tr>
<td>Excellent</td>
<td>34%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Analysis of results for criterion 4**

**Question 1: Do service providers fulfil the requirements of the Race Relations (Amendment) Act 2000, the Equality Act 2006, and the Disability Discrimination Act 2005 in relation to equality schemes?**
Question 1 was the worst performing question for this criterion, with 52% scoring excellent or good and 48% scoring fair or poor. Nearly all (99%) NHS service providers had developed race, gender and disability schemes.
However, the other element of the question asked if the organisation had developed race, gender and disability impact assessments specifically of substance misuse services. Only 18% of NHS service providers had undertaken service-specific impact assessment for either race, gender or disability. This potentially increases the risk in the majority of services that equality schemes do not directly have an impact on delivering substance misuse services.

**Question 2: Have race, gender and disability equality issues been addressed in the regular reviews of the drug treatment service?**

In relation to race and gender, the vast majority of statutory services (90%) collected data on service uptake by ethnicity and gender. Eighty-five per cent analysed the data by ethnicity and 87% analysed the data by gender. In addition, 78% of statutory services used the analysis of data from ethnicity monitoring to plan improvement and 82% used the analysis of data on gender to plan improvements. However, a smaller number of services were compliant with these requirements in relation to disability: only 70% collected data on disability, only 56% analysed this data and only 53% used it to plan improvement. This question clearly demonstrates that statutory services address disability issues less consistently than gender and race issues, through their reviews of service provision.

**Services meeting the needs of diverse populations**

**Criterion 5: Service providers ensure the delivery of provision and/or interventions that meet the needs of local diverse populations.**

Drug treatment services need to be tailored to meet the needs of different groups of service users. The nature of a service user’s needs has a significant impact on how they experience a service. Therefore, providing services in the same way for everybody may marginalise or exclude some service users because of their specific needs or requirements.

<table>
<thead>
<tr>
<th>Table 5: Results of criterion 5 by question</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Weak</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
</tbody>
</table>

**Analysis of results for criterion 5**

This was the best performing criterion in the diversity theme, with very few weak scores.

**Question 1: Does the service provider use data on uptake of services by diverse populations to plan provision?**

Question 1 had the best scores, with 92% of local drug partnerships scoring excellent, 95% of services reviewing data annually and 93% using it to plan provision.
Question 2: Does the service provider carry out a Disability Discrimination Act (1995) access audit?

Question 2 was the weakest performing question in criterion 5, with 65% of local drug partnerships scoring fair and 4% scoring weak. Eighty-one per cent of services had carried out a Disability Discrimination Act (1995) access audit and used it to make adjustments to practices, policies, and procedures. However, only 40% of services made the audit available to the public.

Question 3: Does the service provider have access to trained interpreters?

Eighty-four per cent of local drug partnerships scored good, and 91% of services had access to a range of interpretation services that reflect the diversity of languages spoken by the service user group. In addition, 88% of services had access to trained interpreters who can offer communication using sign language.

Planning services

Criterion 6: Service providers plan and provide services in a way that considers and respects the views of service users and other service providers.

Consulting with people from diverse communities and then delivering services in a manner that shows them respect is key to addressing diversity issues and a core requirement throughout equality and diversity legislation. It is difficult to meet diverse needs without the input of direct experience. It is also vital that staff are appropriately supported and trained in equality and diversity issues to ensure that all members of the local community have a positive experience of services.

<table>
<thead>
<tr>
<th>Table 6: Results of criterion 6 by question</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Weak</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
</tbody>
</table>
Analysis of results for criterion 6
This was the second weakest performing criterion in the diversity theme.

Question 1: Does the service provider consider the views of diverse populations when reviewing and planning the service?
Eighteen per cent of partnerships were scored as weak on this question and a further 41% were scored as fair. Fifty-nine per cent of services consulted with diverse populations who are currently in contact with services, as part of their review of services, but only 31% undertook the same consultation with those not currently accessing services. In relation to planning, only half included representatives from diverse groups, who are not current service users, in their planning groups. Finally, only 54% included service users and representatives who are not current service users from diverse groups in management committees, boards and other governance structures.

Question 2: What is the service user’s experience of being respected by service providers?
Question 2 was the weakest in criterion 6. For this question, we used service users’ answers from the NTA’s Third National Service User Survey, on whether they felt they were treated with respect by the staff delivering services. Twenty-six per cent of partnerships were scored as weak on this question and a further 51% were scored fair.

Question 3: Does the service manage and support staff to deliver services to diverse populations?
The strongest performance for this criterion was for question 3, with almost half (48%) of local drug partnerships being scored as good and almost half (48%) being scored as excellent. This demonstrated that diversity issues are integrated into the induction, training and management mechanisms in the vast majority of services.
Results for the inpatient and residential rehabilitation (Tier 4) services theme

The criteria for this theme of the review are set out in figure 1 on page 15. They were developed to assess the commissioning/purchasing and provision of Tier 4 drug treatment services (including both inpatient detoxification/stabilisation and residential rehabilitation interventions). Figure 12 shows how these criteria fit into the assessment framework.

The strongest performing criterion for this theme of the review related to whether services provide inpatient and residential interventions in safe environments that are staffed by competent practitioners (criterion 11). Fifty-nine per cent of local drug partnerships were scored as “good” and 34% scored “excellent” for this criterion. The second strongest performing criterion for this theme (criterion 10) assessed if programmes were delivered in line with an evidence-based manual. Fifty-five per cent of local drug partnerships were scored as good and 34% scored excellent. Both of these criteria related
to the quality of services as did criterion 9, the next strongest criterion for this theme.

The weakest performing criterion was on the commissioning of residential rehabilitation services (criterion 8). Over half (59%) of local drug partnerships scored “fair” and 3% scored “weak” for this criterion. The second weakest criterion related to the commissioning of inpatient services (criterion 7) with 42% scoring fair and 4% scoring weak. Both of these weaker performing criteria related to the commissioning mechanisms and practices used by local drug partnerships for commissioning inpatient and residential rehabilitation services.

The following section takes each criterion in turn and looks at the responses of the local drug partnerships and inpatient and residential service providers. The first two criteria in the theme (criteria 7 and 8) relate specifically to commissioning mechanisms and practices. The next three (criteria 9, 10 and 11) relate to the quality of services provided. We calculated the scores for local drug partnerships for these three criteria using the scores of the services they commissioned. The performance of the local drug partnerships and of the service providers are analysed in turn.
Commissioning systems for inpatient services

Criterion 7: Local commissioning partnerships have effective commissioning and/or purchasing processes for inpatient interventions.

Inpatient services play a vital role in drug treatment systems and can be effective in supporting service users to achieve abstinence or stabilise their drug use. Their role is vital in working with people with the most severe and complex problems and those whose needs cannot be appropriately met in a community setting. It is vital that inpatient services are integrated with community-based services to be an effective component of drug treatment systems, in terms of the pathways that service users take in and out of the services. Commissioners have a central role in ensuring this integration. The commissioning of inpatient services has been complex historically because:

- In many areas, several local drug partnerships commission services from one inpatient service.
- There is a shortage of services in some areas.
- The type of treatment is expensive, but is used in a comparatively few number of cases.

### Analysis of results for criterion 7

This was the second weakest criterion in this theme of the review.

**Question 1:** Are all members of the local commissioning partnership, service providers and service users made aware of the local eligibility criteria to receive funding for inpatient services?

This question showed the strongest performance for this criterion, with over half (52%) of local drug partnerships scoring “excellent” and 9% scoring “good”. However, a significant proportion scored “fair” (30%) and 9% scored “weak”, indicating that there is significant room for improvement in 39% of partnerships. Only 60% of local drug partnerships used documents as a way to make service providers and service users aware of the eligibility criteria for inpatient detoxification services.

**Question 2:** How are inpatient detoxification/stabilisation and maintenance services commissioned or purchased?

This was the weakest performing question in criterion 7, with 34% of partnerships scoring weak, and 23% scoring fair. This question looked at both block contracted and spot purchased* services, and asked whether the contracts included specified elements such as criteria for access, costs, and throughcare and aftercare arrangements** for service users. For block contracted services, the number of agreements that included each element ranged from 56% to 70%. However, for spot purchase contracts, the range of agreements including the required elements ranged from 32% to 47%.

<table>
<thead>
<tr>
<th>Table 7: Results of criterion 7 by question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>----</td>
</tr>
<tr>
<td>Weak</td>
</tr>
<tr>
<td>Fair</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
</tbody>
</table>

* Definition of spot-purchasing: Contracting or purchasing arrangements that relate to a single placement made for a single service user (NTA, October 2006).

** Throughcare’ describes arrangements for ensuring the continuity of care provided to a drug misuser from the first point of contact with drug treatment, through subsequent interventions, to discharge. ‘Aftercare’ is a package of support that is planned with the drug misuser to support them when they leave structured treatment. Its aim is to sustain treatment gains and further develop community re-integration.
A particularly significant shortfall was that only two-thirds (67%) of local drug partnerships specified throughcare and aftercare arrangements in all of their block contracts for inpatient detoxification. In addition, only 38% of local drug partnerships specified throughcare and aftercare arrangements in all of their spot-purchase contracts for inpatient detoxification. This is a significant problem, which has been identified previously (Strang et al 2005, p7)

Question 3: What proportion of each type of inpatient detoxification/stabilisation and maintenance service is provided in the locality?
Seventy-two per cent of local drug partnerships were scored as good – the maximum score available for this question. Seventy per cent of local drug partnerships commission all of their inpatient services from specialist substance misuse units. The evidence (Strang et al, 2005, p7)

Question 4: What data sources does the partnership use to monitor inpatient detoxification/stabilisation and maintenance services and their outcomes?
This question highlighted other significant shortfalls in criterion 7, as only around a third (32%) of local drug partnerships monitored occurrences of overdose after discharge from inpatient services.

Question 5: How integrated are community care pathways with inpatient detoxification/stabilisation and maintenance interventions?
Two-thirds (66%) of local drug partnerships contracted their community-based services to undertake risk assessments with service users following unplanned discharge from inpatient services. There is a significant risk of death from overdose following detoxification if service users return to drug use, due to their decreased tolerance to drugs. In this context, there is a significant commissioning shortfall in around a third (34%) of local drug partnerships.
Commissioning systems for residential rehabilitation services

Criterion 8: Local commissioning partnerships have effective commissioning and/or purchasing processes for residential rehabilitation interventions.

Residential rehabilitation services can enable drug misusers to move towards long-term abstinence when appropriate and, as such, they form an essential element of a drug treatment system. They provide longer term therapeutic interventions and can be effective at integrating drug misusers into the community. They are appropriate for drug misusers with the most severe and complex problems and those whose needs cannot be appropriately met in a community setting. If residential rehabilitation services are to be an effective element of a local drug treatment system, they must be effectively commissioned. Residential rehabilitation placements are normally purchased on an individual case-by-case basis by specialist local authority teams (community care teams), from a national network of independent services. Service users usually use residential rehabilitation services outside the area in which they live.

All of these factors combine to make the commissioning of residential rehabilitation services complex and potentially problematic. Integration with other drug treatment and commissioning mechanisms is emphasised in current guidance. The lack of effective commissioning processes and structures for residential rehabilitation services in some areas has resulted in “impeded growth and a failure to guarantee income streams” (NTA, 2008, p7).

### Table 8: Results of criterion 8 by question

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>7%</td>
<td>50%</td>
<td>21%</td>
<td>10%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Fair</td>
<td>38%</td>
<td>16%</td>
<td>25%</td>
<td>50%</td>
<td>41%</td>
<td>9%</td>
</tr>
<tr>
<td>Good</td>
<td>19%</td>
<td>34%</td>
<td>17%</td>
<td>40%</td>
<td>32%</td>
<td>61%</td>
</tr>
<tr>
<td>Excellent</td>
<td>36%</td>
<td>N/A</td>
<td>37%</td>
<td>N/A</td>
<td>17%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Analysis of results for criterion 8**

**Question 1:** Are all members of the local commissioning partnership, service providers and service users made aware of the local Fair Access to Care (FACS)* eligibility criteria to receive funding for residential rehabilitation services?

This question showed the strongest performance for criterion 8, with 19% of local drug partnerships scoring good and a further 36% scoring excellent. Eighty-nine per cent of local drug partnerships said all their community-based services were fully aware of the local criteria.

**Question 2:** How are residential rehabilitation services commissioned or purchased?

This was the weakest element in criterion 8. Half (50%) of local drug partnerships were scored as weak on this question and a further 16% scored fair. This question was similar to question 2 in criterion 7, but looked at contracts for residential rehabilitation as opposed to inpatient services. The results were the reverse of those for inpatient services, with spot-purchase agreements much more likely to have the required elements. This finding may reflect the greater use of spot purchasing for residential rehabilitation services.

*The Fair Access to Care Services (FACS) guidance provides a framework for councils with social service responsibilities to determine the eligibility criteria for adult social care. Fair Access to Care Services – guidance on eligibility criteria for adult social care [Department of Health, 2003].
Around half (49%) of local drug partnerships did not specify in all of their spot-purchase contracts that residential rehabilitation services should report activity to the National Drug Treatment Monitoring System national database, which is a national requirement. Another particularly significant shortfall was that only two-thirds (66%) of local drug partnerships specified throughcare and aftercare arrangements in all of their spot-purchase agreements with residential rehabilitation services.

**Question 3: How many community care assessments for possible suitability to receive residential rehabilitation services were carried out in the past year?**
This question asked how many service users were assessed as being appropriate for residential rehabilitation and compared it to the number that then went on to receive funded places. Seventeen per cent of partnerships were scored as good on this question and a further 37% scored excellent.

**Question 4: How is the budget for access to residential rehabilitation services managed?**
This asked if the budget for residential rehabilitation services was managed in line with national guidance. Half (50%) of local drug partnerships were scored as fair and 10% as weak for this question. The key reason for this was that around half (49%) of local drug partnerships did not manage their residential rehabilitation and pooled treatment budget in an integrated way. In 30% of partnerships, decisions about the budget were made solely by the local authority, and in 23% of partnerships decisions about how the budget was spent were made solely by the community care team.

Fifteen per cent of local drug partnerships reported no increase in the local residential rehabilitation budget in the last five years and 41% reported increases in line with or below inflation. This finding is concerning in the context of significant increases in pooled treatment budgets since 2001 and guidance on the use of pooled treatment budgets for residential rehabilitation (NTA, 2006).

**Question 5: What data sources does the partnership use to monitor residential rehabilitation provision and its outcomes?**
Only 31% of local drug partnerships monitored occurrences of overdose post-discharge from residential rehabilitation services, and only 58% monitored how many service users accessed community-based services after discharge from residential rehabilitation services. Both of these shortfalls are priorities to be addressed by local drug partnerships.

**Question 6: How integrated are community care pathways with residential rehabilitation services?**
As with inpatient detoxification commissioning, only 66% of local drug partnerships contracted their community-based services to undertake risk assessments with service users following unplanned discharge from residential rehabilitation services.
The remaining criteria (9, 10 and 11) all pertain to the quality of Tier 4 (inpatient and residential rehabilitation) services. The scores of local drug partnerships are aggregations of the scores achieved by the inpatient and residential services they commissioned during the review period. Inpatient and residential services have also been given their own individual scores based on their performance for these three criteria. The analysis of each question relates to the scores achieved by local drug partnerships and is immediately followed by an analysis of the scores achieved by the inpatient and residential services, which was used to calculate the scores of local drug partnerships.

Service users’ access to inpatient and residential interventions

Criterion 9: Service users have prompt and flexible access to Tier 4 interventions.

Local areas need to have good pathways between community services, inpatient services and residential rehabilitation services, so that inpatient and residential rehabilitation services can operate as an effective and integrated component of drug treatment systems. Appropriately timed entry and supported exit from inpatient and residential services are related to more successful outcomes for service users. The integration between community-based, inpatient and residential rehabilitation services is vital, particularly because inpatient and residential services are provided from a complex national network of services. Service users often use services outside their local area and commissioners also often commission services from a broad range of providers. Therefore, achieving adequate integration can be challenging.

| Table 9: Results of criterion 9 by question for local drug partnerships |
|--------------------------|---|---|---|---|---|
|                       | Q1 | Q2 | Q3 | Q4 | Q5 |
| Weak                   | 6% | 56%| 1% | 0% | 3% |
| Fair                   | 17%| 38%| 5% | 4% | 7% |
| Good                   | 77%| 6% | 95%| 96%| 40%|
| Excellent              | N/A| N/A| N/A| N/A| 50%|

Results for the inpatient and residential rehabilitation (Tier 4) services theme continued
Analysis of results for criterion 9

Overall, residential rehabilitation services scored higher than inpatient services on access by service users.

Question 1: Does the service have an information pack that can be made available to service users?
This was the third strongest question in the criterion, with 77% of local drug partnerships scoring “good”, 17% scoring “fair” and 6% scoring “weak”. Twenty-eight per cent of inpatient detoxification providers were scored as weak, compared to 63% of residential rehabilitation services. A score of weak meant that less than 83% of service users entered the service within three weeks of referral or that the service was not submitting valid data to the National Drug Treatment Monitoring System (NDTMS), the data from which was used to calculate waiting times. A quarter (26%) of inpatient services and 37% of residential rehabilitation services were either not reporting any data to the NDTMS database or did not submit sufficient data against which to calculate waiting times. It is a national priority to improve this situation as the local and national strategic planning of inpatient and residential services is dependant on accurate information. Inpatient and residential services continue to significantly lag behind community-based services in this regard.

Question 2: How do the service’s waiting times compare with national targets?
This was the weakest scoring question in criterion 9, with 56% of local drug partnerships scoring weak, based on the performance of the inpatient and residential service they commissioned. Two-thirds (67%) of inpatient services were scored as weak, compared to 63% of residential rehabilitation services. A score of weak meant that less than 83% of service users entered the service within three weeks of referral or that the service was not submitting valid data to the National Drug Treatment Monitoring System (NDTMS), the data from which was used to calculate waiting times. A quarter (26%) of inpatient services and 37% of residential rehabilitation services were either not reporting any data to the NDTMS database or did not submit sufficient data against which to calculate waiting times. It is a national priority to improve this situation as the local and national strategic planning of inpatient and residential services is dependant on accurate information. Inpatient and residential services continue to significantly lag behind community-based services in this regard.

Question 3: Does the service have eligibility criteria?
Ninety-five per cent of local drug partnerships were scored as good, based on the scores of the services they commissioned (a score of good was the highest score available for this question). Residential rehabilitation services achieved higher scores for this question compared to inpatient services – 16% of inpatient services were scored weak compared to 5% of residential rehabilitation services. Generally, compliance with the specified eligibility criteria was very high, ranging from 84% to 95%. However, 12% of inpatient services did not have either eligibility or exclusion criteria relating to pregnant women.

### Table 10: Results of criterion 9 by question for inpatient detoxification services

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>28%</td>
<td>67%</td>
<td>16%</td>
<td>8%</td>
<td>18%</td>
</tr>
<tr>
<td>Fair</td>
<td>2%</td>
<td>12%</td>
<td>9%</td>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>Good</td>
<td>70%</td>
<td>21%</td>
<td>76%</td>
<td>90%</td>
<td>24%</td>
</tr>
<tr>
<td>Excellent</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>48%</td>
</tr>
</tbody>
</table>

### Table 11: Results of criterion 9 by question for residential rehabilitation services

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>9%</td>
<td>63%</td>
<td>5%</td>
<td>8%</td>
<td>33%</td>
</tr>
<tr>
<td>Fair</td>
<td>4%</td>
<td>13%</td>
<td>13%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Good</td>
<td>88%</td>
<td>24%</td>
<td>82%</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>Excellent</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50%</td>
</tr>
</tbody>
</table>
Question 4: Does the service prepare exit strategy plans prior to, or on, admission?
This question had the strongest performance in criterion 9, and related to the development and delivery of exit plans to ensure the effective re-integration of service users back into the community and the provision of appropriate aftercare. Virtually all (96%) local drug partnerships were scored as good for this question. Ninety-seven per cent of residential rehabilitation services reported having procedures for notifying community-based care coordinators of unplanned discharge, compared with 100% of inpatient providers. Ninety-one per cent of residential rehabilitation services had procedures for ensuring drug-related support after discharge, compared to 98% for inpatient providers.

Question 5: Does the service have a policy for unplanned discharge?
Question 5 was the second weakest scoring question for service user access, with half (50%) of local drug partnerships scoring excellent and 40% scoring good. However, given the importance of this question in relation to the safety of service users and its importance to the communities where inpatient and residential services are located, there are some significant shortfalls which need to be addressed as a matter of priority. These are outlined in table 12.

Table 12: Elements not included in the unplanned discharge policies of Tier 4 services

<table>
<thead>
<tr>
<th>Criteria for unplanned discharge?</th>
<th>% of inpatient services whose policy did not include this element</th>
<th>% of residential rehabilitation services whose policy did not include this element</th>
</tr>
</thead>
<tbody>
<tr>
<td>A policy for arranging transport for the service user’s journey, post-discharge, to a place of safety?</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>A procedure for informing the funding partnership or community care manager or named contact?</td>
<td>33%</td>
<td>18%</td>
</tr>
<tr>
<td>An assessment of the risk of unplanned discharge, which includes:</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Provision of harm reduction advice and equipment</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>Assessment of the risk of overdose</td>
<td>10%</td>
<td>23%</td>
</tr>
<tr>
<td>Procedures to inform services local to the Tier 4 service if the service user poses a risk to others</td>
<td>7%</td>
<td>20%</td>
</tr>
<tr>
<td>Procedures to inform services local to the Tier 4 service if the service user is likely to stay and use services in the area.</td>
<td>17%</td>
<td>27%</td>
</tr>
</tbody>
</table>
Programmes delivered in line with evidence-based manuals

**Criterion 10: Service providers deliver Tier 4 interventions in line with up-to-date evidence that relates to the type of intervention or programme being delivered.**

The use of an evidence-based manual is good practice and has been shown to enable consistent and comprehensive practice. Inpatient and residential services deliver complex and multi-faceted treatment programmes. Having programmes consolidated into a single manual, which is accessible to all staff, is an important indicator of the quality assurance of the contents of the programme. It may also allow programmes to evolve and develop more effectively in the light of new evidence, guidance and feedback from service users.

**Table 13: Results of criterion 10 by question for local drug partnerships**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>9%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>Fair</td>
<td>24%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Good</td>
<td>37%</td>
<td>58%</td>
<td>19%</td>
</tr>
<tr>
<td>Excellent</td>
<td>30%</td>
<td>35%</td>
<td>70%</td>
</tr>
</tbody>
</table>

**Table 14: Results of criterion 10 by question for in-patient detoxification services**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>43%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Fair</td>
<td>0%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Good</td>
<td>11%</td>
<td>36%</td>
<td>12%</td>
</tr>
<tr>
<td>Excellent</td>
<td>46%</td>
<td>38%</td>
<td>69%</td>
</tr>
</tbody>
</table>

**Table 15: Results of criterion 10 by question for residential rehabilitation services**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>50%</td>
<td>9%</td>
</tr>
<tr>
<td>Fair</td>
<td>5%</td>
<td>24%</td>
</tr>
<tr>
<td>Good</td>
<td>0%</td>
<td>32%</td>
</tr>
<tr>
<td>Excellent</td>
<td>45%</td>
<td>36%</td>
</tr>
</tbody>
</table>

**Analysis of results for criterion 10**

**Question 1: Does the service offer a programme delivered in line with an evidence-based manual?**

Question 1 showed the weakest performance for criterion 10, with around a quarter (24%) of local drug partnerships being scored as fair and 9% scored as weak. Forty-three per cent of inpatient services and half (50%) of residential rehabilitation services were scored as weak for this question. The question specified which aspect of inpatient and residential treatment should be included in the service’s evidence-based programme manual. Table 16 outlines the key shortfalls in response to this question. The marked shortfalls in relation to blood-borne viruses are a key priority. Over a third (34%) of all cases of hepatitis B and over 90% of hepatitis C diagnoses are associated with injecting drug use in England (Health Protection Agency, 2007). When a service user becomes drug-free in inpatient or residential services, it may be the first time that they have been stable enough or ready to take tests for blood-borne viruses.

Other priorities to be addressed are the shortfalls in relation to skills training and programme content focusing on entry or re-entry to employment in residential rehabilitation services. This is particularly relevant given the focus in the Government’s drug strategy on re-integrating drug misusers into employment (HM Government, 2008).
Question 2: What methods does the service use to review and adapt its programme in the light of evidence and monitoring information?
Fifty-eight per cent of local drug partnerships were scored as good and 35% excellent for this question. Nine per cent of residential rehabilitation services and 18% of inpatient services scored weak for this question. Variations related to the use of clinical audit, where 76% of residential rehabilitation services used this mechanism to review and adapt their programme, compared to 88% of inpatient services. The analysis of untoward incidents was not undertaken by 4% of residential rehabilitation services and the analysis of complaints was not undertaken by 2% of residential rehabilitation services. All inpatient services used both of these elements when reviewing and adapting their programmes.

Question 3: Are prescribing regimes in line with NICE clinical guidelines?
The strongest performance for this criterion was for question 3, which asked inpatient services if their prescribing regimes were in line with the 2007 clinical guidelines from the National Institute for Health and Clinical Excellence (NICE). Seventy per cent of partnerships scored excellent for this question and 19% were scored as good. However, 14% of inpatient services were scored as weak for this question. This was because: 5% of inpatient services reported using dihydrocodeine routinely in opioid detoxification; 5% reported using Clonidine routinely in opioid detoxification; and 2% reported routinely using rapid detoxification. Routinely using any of these regimes is not in line with the NICE clinical guidelines. The vast majority (86%) routinely used methadone or buprenorphine as their primary medications in detoxification, in line with the NICE clinical guidance.

*Models of care, 2006, defined evidence-based psychosocial interventions, delivered as part of a client’s care plan, which assist the client to make changes in their drug and alcohol using behaviour. These interventions are normally time limited and should be delivered by competent practitioners.*

---

Table 16: Elements not included in the evidenced-based programme manuals of Tier 4 services

<table>
<thead>
<tr>
<th>Programme element</th>
<th>% of inpatient services that did not have a manual including this element</th>
<th>% of residential rehabilitation services that did not have a manual including this element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual health advice</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Advice on blood-borne viruses</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>Testing for blood-borne viruses</td>
<td>26%</td>
<td>40%</td>
</tr>
<tr>
<td>Hepatitis B immunisation/protocols</td>
<td>32%</td>
<td>43%</td>
</tr>
<tr>
<td>Structured psychosocial interventions*</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Vocational skills training</td>
<td>N/A</td>
<td>45%</td>
</tr>
<tr>
<td>Entry/re-entry to employment</td>
<td>N/A</td>
<td>45%</td>
</tr>
<tr>
<td>Housing support</td>
<td>N/A</td>
<td>12%</td>
</tr>
</tbody>
</table>

* Models of care, 2006, defined evidence-based psychosocial interventions, delivered as part of a client’s care plan, which assist the client to make changes in their drug and alcohol using behaviour. These interventions are normally time limited and should be delivered by competent practitioners.
Safe environments staffed by competent practitioners

Criterion 11: Service providers provide Tier 4 interventions in a safe environment staffed by competent practitioners.

Competent staff and robust risk management are key to the delivery of effective inpatient and residential services and ensuring that interventions are provided in a safe environment. Exposing service users to risks such as volatile or chaotic environments is counterproductive to working effectively with drug misusers. Accurately assessing and responding to the risks service users are exposed to because of their drug misuse or lifestyle is vital in drug treatment. It is also important to effectively assess and manage the risks faced by individual service users, staff and other service users during inpatient or residential treatment. In both the Department of Health’s *Standards for Better Health* and the registration criteria of the Commission for Social Care and Inspection, inpatient and residential service providers have to meet requirements in relation to the training and management of staff.

### Table 17: Results of criterion 11 by question for local drug partnerships

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Fair</td>
<td>13%</td>
<td>3%</td>
<td>38%</td>
</tr>
<tr>
<td>Good</td>
<td>40%</td>
<td>97%</td>
<td>49%</td>
</tr>
<tr>
<td>Excellent</td>
<td>44%</td>
<td>N/A</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Table 18: Results of criterion 11 by question for in-patient detoxification services

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>24%</td>
<td>7%</td>
<td>34%</td>
</tr>
<tr>
<td>Fair</td>
<td>2%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Good</td>
<td>1%</td>
<td>91%</td>
<td>32%</td>
</tr>
<tr>
<td>Excellent</td>
<td>72%</td>
<td>N/A</td>
<td>27%</td>
</tr>
</tbody>
</table>

### Table 19: Results of criterion 11 by question for residential rehabilitation services

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>38%</td>
<td>3%</td>
<td>43%</td>
</tr>
<tr>
<td>Fair</td>
<td>2%</td>
<td>6%</td>
<td>21%</td>
</tr>
<tr>
<td>Good</td>
<td>5%</td>
<td>91%</td>
<td>25%</td>
</tr>
<tr>
<td>Excellent</td>
<td>56%</td>
<td>N/A</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Analysis of results for criterion 11**

**Question 1:** Does the service manage and support staff (including managers) to deliver Tier 4 interventions in line with national guidance?

Local drug partnerships scored well for question 1, with 40% scoring good and 44% scoring excellent. Seventy-two per cent of inpatient services scored excellent compared to just over half (56%) of residential rehabilitation services. Key differences related to the provision of training, and resources identified to support training, in which inpatient services scored higher. Generally, there was a high degree of compliance with the specified elements, particularly in relation to induction programmes and appraisals.
The lowest scoring elements related to supervision for staff: 14% of inpatient services and 11% residential rehabilitation services stated that not all their staff received management supervision* once a month. In addition, 13% of inpatient services and 12% of residential rehabilitation services stated that not all of their clinical and counselling staff received clinical supervision** and/or counselling supervision once a month. This is a clear priority for this minority of services because supervision is a key tool to ensure the competence staff, and to quality assure and develop the services they deliver.

Question 2: Do service users have risk assessments carried out on admission and as part of care planning?
This question showed the strongest performance for criterion 11, and asked if services carried out risk assessments on service users’ drug use, lifestyle and their personal safety and the safety of others. The question asked specifically if risk assessments were carried out before admission, on admission and as part of care planning. Ninety-seven per cent of local drug partnerships achieved a score of good (the highest score awarded for this question) with none scoring weak.

All residential rehabilitation services (100%) undertook a risk assessment of service users before admission, whereas 1% of inpatient providers did not. Ninety-six per cent of residential rehabilitation services carry out risk assessments of service users at both admission and as part of care planning, compared to 99% of inpatient services.

Question 3: What are the programme rates for successful completion (including planned discharge) of the programme for the last six months?
This was the weakest question in the criterion, with 3% of local drug partnerships receiving a score of weak and 38% scoring fair. However, 34% of inpatient services and 43% of residential rehabilitation services were scored weak for this question. The inpatient and residential services themselves scored lower for this question than local drug partnerships. This is because of the way their scores were aggregated to local drug partnerships (proportionately to admission rates). This process resulted in better scores for partnerships, indicating that services that had weak scores for this question were only used in lower volumes by local drug partnerships. Table 20 shows the successful completion rates of inpatient and residential services.

* Managerial supervision involves issues related to an employee’s job description or their workplace and includes prioritising workloads, monitoring work and work performance, sharing information relevant to work, clarifying task boundaries and identifying training and development needs. (NTA, Developing drug service policies: 6 Supervision and appraisal, 2004).

** Clinical, practice or specialist supervision is a professional relationship between the practitioner engaged in professional practice and a clinical, specialist or practice supervisor. It is a “formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations”. (NTA, Developing drug service policies: 6 Supervision and appraisal, 2004).
The number of services that are not submitting valid data to NDTMS is a major concern. It is a national priority to improve this situation, as the local and national strategic planning of inpatient and residential services relies on accurate information. Compliance with the NDTMS reporting requirement was higher among inpatient services. Successful completion rates for those services that did submit valid data were higher for inpatient services than for residential rehabilitation services. A factor contributing to this difference could be that inpatient programmes usually last for around two to four weeks, compared with residential rehabilitation programmes which are normally three to six months long. Fifty-nine per cent of inpatient services scored good or excellent compared to 36% of residential rehabilitation services. Twenty-three per cent of residential rehabilitation services had a successful completion rate below 40%. It is a clear priority for these services to address this fundamental issue.

<table>
<thead>
<tr>
<th>Services not submitting valid data to NDTMS on successful completion rates</th>
<th>Inpatient services</th>
<th>Residential rehabilitation services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services with a successful completion rate of less than 20%</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Services with a successful completion rate of 20% to 39%</td>
<td>7%</td>
<td>21%</td>
</tr>
<tr>
<td>Services with a successful completion rate of 40% to 69%</td>
<td>32%</td>
<td>25%</td>
</tr>
<tr>
<td>Services with a successful completion rate of 70% and above</td>
<td>27%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Table 20: Results for question 3 on successful completion rates
Diversity

The service review provides a helpful picture of both the strengths and weaknesses of local efforts to address diversity issues.

There was evidence of significant progress in addressing some diversity issues:

In general, the needs assessment undertaken by local drug partnerships had a good focus on diversity issues. Nearly all (99%) local drug partnerships had carried out a needs assessment that identified the needs of diverse populations within the locality, with 27% of partnerships scoring “good” and a further 43% scoring “excellent” for this question.

The public body members of the local drug partnerships have fulfilled their statutory duties to develop equality schemes for race, gender and disability. Fifty-five per cent of partnerships were scored as good on this question and a further 43% scored excellent. Compliance with developing schemes was 100% across primary care trusts, local authorities and the police. In addition, 100% of probation services had race equality schemes and 99% had gender and disability schemes.

Local drug partnerships have made good progress in their ethnic monitoring. Sixty per cent of partnerships had monitored the ethnicity of 98% to 99% of the service users in their services, and a further 26% had monitored the ethnicity of 100% of service users.

Commissioners and service providers had good access to training on diversity issues. Ninety-one per cent of joint commissioning managers had undertaken training in diversity and equality issues and 62% had undertaken training on commissioning services for diverse populations. The review also demonstrated that diversity issues are integrated into the induction, training and management mechanisms in the vast majority of community-based services.

Nearly all services reviewed data on service uptake by diverse communities annually and used it to plan the provision of services. Ninety-two per cent of local drug partnerships scored ‘excellent’ for this question.

However, there are some key areas for improvement in relation to diversity as follows:

Many local drug partnerships’ strategic plans for drug treatment did not have an adequate focus on diversity issues. Seventy-two per cent of local drug partnerships were scored “fair” and a further 4% scored “weak” on this question. Nationally, the types of treatment given the least consideration, in relation to meeting the needs of diverse groups, were inpatient and residential rehabilitation services, and harm reduction services. This demonstrates that there has been national progress in understanding the differing needs of communities, but this has not had enough impact on the resultant strategic plans. There has been some good progress in this area, but local drug partnerships need to do more to address diversity and equality issues through treatment planning.
Local drug partnerships and service providers should give a more specific focus to substance misuse services when undertaking their duties required by diversity legislation. Only just over half (54%) of local drug partnerships had undertaken a specific race equality impact assessment of substance misuse services. Similarly, only 18% of NHS service providers had undertaken equality impact assessments for either race, gender or disability on their substance misuse services specifically. This is particularly significant as substance misuse issues affect different communities or groups in different ways.

Many of the contracts local drug partnerships have with community-based drug treatment services do not include sufficient requirements to comply with equality and diversity legislation. Over two-thirds (64%) of partnerships were scored as weak on this question and a further 10% were scored as fair. Over a half to two-thirds of the requirements that were specified were not included in contracts that were signed and dated. Eighty-two per cent of partnerships specified compliance with the Race Relations Act (1976) as amended by the Race Relations (Amendment) Act 2000 in all their contracts, but only 54% specified the Sex Discrimination (Gender Reassignment) Regulations 1999 in all their contracts. For the other eight pieces of legislation the review specified, compliance ranged from 57% to 79%.

Crack cocaine misusers, a section of the drug-using population with specific needs, are under-represented in drug treatment services, compared to the prevalence of crack misuse. The review showed that in half of local drug partnerships, less than 30% of crack misusers accessed drug treatment. In a fifth (20%) of local drug partnerships, 40% or more of the estimated number of crack cocaine misusers accessed drug treatment. This compares to 84% of partnerships with 40% or more of the estimated number of heroin misusers accessing drug treatment.

Substance misuse services should consult more broadly with the whole community, with an increased focus on groups not currently using services. Services should also involve these groups more in planning services. Only 31% of services carried out consultation when reviewing and planning their services with those not currently accessing services.

NHS services address disability issues less consistently than gender and race issues when reviewing their service provision. Seventy-eight per cent of services used data on gender and race to plan improvements, compared to only 53% who used data on disability.
Commissioning inpatient and residential rehabilitation services

The results of this review provide essential benchmarking and a platform for improvement around commissioning inpatient and residential services. The results for the commissioning criteria were not as positive as the results for the service provision criteria in the inpatient and residential services theme of the review.

The review highlighted some progress in relation to the commissioning of inpatient and residential services:

Seventy per cent of local drug partnerships commission all their inpatient detoxification services from specialist substance misuse units. The evidence (Strang et al, 2005, p7) shows that providing specialist substance misuse services, as opposed to detoxification on general psychiatric wards, offers a more comprehensive service and has better outcomes.

There was good awareness of the eligibility criteria for inpatient and residential services within local drug treatment systems. Eighty-nine per cent of local drug partnerships said that all their community-based services were fully aware of the local criteria.

Local drug partnerships were more likely to commission placements from the better-performing inpatient and residential services. The review demonstrated that nationally, local drug partnerships commission placements in a greater volume from services that performed well in the review, demonstrating that commissioners focused on the quality of services when making commissioning decisions.

However, there were significant areas for improvement in relation to the commissioning of residential and inpatient services:

In many local drug partnerships, the budget for residential rehabilitation services was not managed in line with national guidance. The review showed that many partnerships’ budgets for residential rehabilitation services were not managed in line with national guidance (NTA, 2006). In particular:

• 49% of local drug partnerships did not integrate the management of the residential rehabilitation budget and the pooled treatment budget.
• In 30% of local drug partnerships, decisions about the level of residential rehabilitation budget were made solely by the local authority.
• In 23% of local drug partnerships, decisions about how the residential rehabilitation budget was spent were made solely by the community care team.

Furthermore, the review showed that less than half (44%) of local drug partnerships had increased their funding for providing residential rehabilitation services above the rate of inflation in the last five years. In the context of significant increases in pooled treatment budgets since 2001 and guidance on the use of pooled treatment budgets for residential rehabilitation (NTA, 2006), this finding is a matter of concern.

There were significant shortfalls in how local drug partnerships contracted with inpatient and residential services. These shortfalls related to both inpatient services and residential rehabilitation services. In particular, a significant minority (33%) of local drug partnerships did not specify throughcare and aftercare arrangements in all of their block contracts for inpatient services.
detoxification. Furthermore, only 38% of local partnerships specified throughcare and aftercare arrangements when spot-purchasing* in inpatient services. Sixty-six per cent of local drug partnerships specified throughcare and aftercare arrangements in all of their spot-purchase agreements with residential rehabilitation services. Finally, 49% of local drug partnerships did not specify in all of their spot-purchase contracts that residential rehabilitation services should report activity to the National Drug Treatment Monitoring System (NDTMS).

There were shortfalls in the integration between community-based services and inpatient and residential services. Only 66% of local drug partnerships contracted their community-based services to carry out risk assessments with service users following unplanned discharge from inpatient detoxification services and residential rehabilitation services. There is a significant risk of overdose following detoxification if service users return to drug use, due to their decreased tolerance levels. In this context, there is a significant commissioning shortfall in 34% of local drug partnerships.

There were significant gaps in monitoring inpatient and residential services by local drug partnerships. For example, only 32% of local drug partnerships monitored occurrences of overdose post-discharge from inpatient detoxification services. Only 58% of local drug partnerships monitored how many service users accessed community-based services after discharge from residential rehabilitation services.

**Provision of inpatient and residential rehabilitation services**

The service review provides a helpful picture of both the strengths and weaknesses of the national provision of inpatient and residential rehabilitation services as follows:

Eighty-six per cent of inpatient detoxification services had prescribing regimes that were in line with NICE clinical guidelines. However, 14% of inpatient services were using regimes that were not in line with the guidelines.

The majority of inpatient and residential rehabilitation services (71%) had induction, training and appraisal programmes with which to support and develop staff. However, 14% of inpatient services and 11% residential rehabilitation services stated that not all their staff receive management supervision once a month.

The majority of inpatient and residential rehabilitation services had policies on the development of exit plans for service users, to ensure effective re-integration back into the community, and on the provision of appropriate aftercare. However, inpatient services had slightly better procedures in relation to these plans. Ninety-seven per cent of residential rehabilitation services had procedures for notifying community-based care coordinators of unplanned discharge, compared with 100% of inpatient providers.

The review highlighted some significant areas for improvement in relation to providing inpatient and residential services:

* Contracting or purchasing arrangements that relate to a single placement made for a single service user (NTA, October 2006).
Inpatient and residential rehabilitation services need to further develop their evidence-based programme manuals. Manuals on the content of treatment programmes should be accessible to all staff and they should ensure that programmes are consistent, quality-assured and evidence-based. Forty-three per cent of inpatient services and 50% of residential rehabilitation services were scored as weak for the question that asked if services offer a programme delivered in line with an evidence-based manual. There were noticeable shortfalls of some elements of treatment not being included in services’ programme manuals, particularly blood-borne virus services and protocols, and employment-related interventions.

There was significant under-reporting to the National Drug Treatment Monitoring System (NDTMS) by inpatient and residential rehabilitation services on their activity. Twenty-eight per cent of inpatient services and 41% of residential rehabilitation services were either not reporting any data or were reporting incomplete data to the national database. It is a national priority to improve this situation as the local and national strategic planning of inpatient and residential provision is dependant on accurate information.

There were some significant shortfalls in the unplanned discharge policies of some inpatient and residential services. Twenty-three per cent of residential rehabilitation services did not have a policy specifying that an assessment of risk of overdose be carried out in the event of an unplanned discharge. In addition, 17% of inpatient detoxification services did not have procedures to inform local community-based services of the likelihood of an unplanned discharged service user using their services.

Next steps

The review provides local drug partnerships and inpatient and residential service providers with a clear agenda against which to plan improvement. All partnerships have already used the results to develop action plans and the NTA’s regional teams and strategic health authorities will monitor their performance against these plans. NTA supported approximately 10% of the weakest-performing areas in developing action plans.

Six inpatient and residential services were supported in developing plans, and national workshops on improving aspects of delivery were organised for service providers. All inpatient and residential services were encouraged to develop action plans and share these with the commissioners of their services.

Overall, improvement in performance will be monitored by the NTA’s regional teams and regional stakeholders, on an ongoing basis, through quarterly performance assurance arrangements with all local drug partnerships.

In order to make improvements in relation to diversity:

- Treatment planning should give appropriate focus to the needs of diverse communities and ensure these are appropriately met.
- Local drug partnership members and NHS service providers should ensure that substance misuse services are directly addressed in their race equality schemes and in the delivery of their statutory duties in relation to diversity.
- Commissioners should ensure that all contracts include requirements for compliance with all relevant equality and diversity legislation.
• Local drug partnerships should focus on ensuring that services are accessible and relevant to crack cocaine misusers, to increase the proportion of them who access services.

• Service providers and local drug partnerships should consult more broadly with the communities they serve, including with diverse groups and communities (particularly those not currently accessing drug treatment), and involve them in service planning.

In relation to commissioning inpatient and residential services, local drug partnerships should focus on:

• Reviewing the management of residential rehabilitation budgets and the degree of local drug partnership involvement.

• Ensuring that contracts with Tier 4 services include all the elements outlined in national guidance, with a particular focus on throughcare and aftercare and national database (NDTMS) reporting requirements.

• Reviewing the data collected by commissioners in relation to inpatient and residential services, focusing on the monitoring of integrated care pathways between community-based services and inpatient and residential services. Incidents of overdose following inpatient and residential interventions also require close monitoring.

• Commissioning integrated pathways into and out of inpatient and residential services, ensuring that community-based services are clearly contracted to support this model.

Inpatient and residential rehabilitation services should address the following issues:

• Developing evidence-based manuals which are comprehensive, accessible to all staff and cover essential elements of inpatient and residential service provision. In particular, they should focus on improving the testing and treatment of blood-borne viruses and the employment-led elements of programmes.

• Ensuring that policies and protocols relating to exit plans and unplanned discharge are robust and include all the elements outlined in national guidance.

• Registering and submitting valid data to the national database (NDTMS) by all inpatient and residential services.

The findings of this review, combined with the findings of the reviews carried out in 2005/06 and 2006/07, represent a significant assessment of performance and a platform on which to plan significant improvement.

The NTA will also publish good practice briefings on each theme of the review, outlining the key aspects of the commissioning and service delivery of high-scoring drug partnerships and services.

This review was the last of three joint reviews of services for substance misuse, carried out by the Healthcare Commission and NTA.
Appendix A: Definition of inpatient and residential rehabilitation (Tier 4) services

Inpatient services, as defined in the NTA’s Models of care for treatment of adult drug misusers: Update 2006

“Inpatient drug treatment interventions usually involve short episodes of hospital-based (or equivalent) drug and alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for treatment such as:

• Medically supervised assessment.
• Stabilisation on substitute medication.
• Detoxification/assisted withdrawal from illegal and substitute drugs and alcohol in the case of poly dependence.
• Specialist inpatient treatments for stimulant users.
• Emergency medical care for drug users in drug-related crisis.

The multidisciplinary team can include psychologists, nurses, pharmacists, occupational therapists, social workers, and other activity and support staff.

Inpatient drug treatment should be provided within a care plan with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

The three main settings for inpatient treatment are:

• General hospital psychiatric units.
• Specialist drug misuse inpatient units in hospitals.
• Residential rehabilitation units (as a precursor to the rehabilitation programme).”
Residential rehabilitation services, as defined by *Models of care, 2006*

“Drug residential rehabilitation consists of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence orientated drug interventions within the context of residential accommodation.

Residential rehabilitation programmes should include care planning with regular keyworking with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

There is a range of residential rehabilitation services, which includes:

- Drug and alcohol residential rehabilitation services whose programmes to suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-Step programmes and faith-based (usually Christian) programmes.
- Residential drug and alcohol crisis intervention services (in larger urban areas).
- Inpatient detoxification directly attached to residential rehabilitation programmes.
- Residential treatment programmes for specific client groups (for example, drug-using pregnant women, drug misusers with liver problems, drug misusers with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug services (Tier 3 or 4, depending on local arrangements) and other specialist inpatient units.
- Some drug-specific therapeutic communities and 12-Step programmes in prisons.
- “Second stage” rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive keywork and a range of drug and non-drug-related support.
- Other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby site(s).”
Appendix B: The methodology and development process of the review

Assessment frameworks
The framework through which performance is measured is called an assessment framework. These frameworks are developed by working with those using and providing services, and other experts, to ascertain the key features that are important in delivering quality services to the people using those services. An assessment framework does not measure everything that must be in place to deliver a quality service, but focuses on key features that have a significant impact on the outcomes for service users. Assessment frameworks must relate back to the Department of Health’s Standards for Better Health.14

By working with those in the substance misuse field (especially service users, commissioners and service providers), we generated key criteria and questions that captured the important distinguishing features that can assess the performance of services and treatment systems. This covers both the service user’s perspective and outcomes of services. It was necessary to determine what information was needed to answer these questions and, when it did not exist in national datasets, it was collected from each local drug partnership or Tier 4 service. We made assessments of quality based on information collected from a variety of sources. This framework was used to make an initial assessment of the performance of each local drug partnership and inpatient and residential service. We collected data to inform the assessment framework and scores for each criterion were constructed by applying pre-determined rules.

Background work
The NTA mapped the existing key standards used in the substance misuse field against Department of Health standards. The mapping included a range of key standards, including Models of care, national occupational standards, commissioning guidelines, a sector-specific set of standards developed by the Substance Misuse Advisory Service (SMAS) on commissioning, and Organisational Standards for providers (QuADS) from Drugscope and Alcohol Concern. This mapping provided a platform to support the development of criteria and questions.

Engagement with the sector
The NTA established an expert group to support the development of the 2007/08 substance misuse review. The network included membership from all relevant professional and membership bodies, other regulatory bodies, NHS providers, voluntary sector providers, service users and carers, and commissioners. Members of the network were selected by an application process according to geographical spread, role, membership of the local networks (for dissemination and feedback), and relevant previous experience.
Drafting the assessment framework

Once an initial draft of the assessment framework was prepared, it went through a process of peer review. This involved dissemination of the document to several groups of people and holding a series of meetings to consult on the document in detail. These groups included:

- The expert group.
- NTA staff.
- Relevant Healthcare Commission staff.
- Drug treatment providers and commissioners.

Piloting the assessment framework

The initial drafts of the assessment framework, questionnaires and scoring construction were created from developmental work undertaken with the expert groups and development sites (a number of partnerships). The first expert group consultation took place in February 2007 followed by the second consultation in November 2007. The draft assessment framework was then piloted. Piloting consisted of the 20 sites completing bespoke questionnaires in November 2007.

From November 2007 to March 2008, the findings from the pilot were reviewed and used to inform a redrafting of the assessment framework and questionnaires. Some of the changes included clearer wording and adjustments to the questions or scoring, in particular relating to data for the diversity theme.

Final draft documents were further refined by the NTA, the Healthcare Commission, and the Department of Health.

The final assessment framework and allied documents were signed off by the Healthcare Commission and the NTA, the Review of Central Returns (ROCR) team, and the Department of Health.

Data collection and analysis

Bespoke data was collected from March through to May 2008. We also used other data from the National Drug Treatment Monitoring System (NDTMS), the NTA’s 2007 annual service user survey and the NTA’s regional teams.

Data input, analysis and quality assurance took place until August 2007. Anonymised data was published in September 2008. Each local partnership and Tier 4 provider had two weeks to submit queries and ratification requests if they had questions about their results. All requests for ratifications were answered within four weeks and all partnerships and Tier 4 providers were notified of their updated scores by the end of October. Final attributed scores were published in January 2009.
Assessment framework overview and scoring

The assessment framework consisted of 11 criteria (or key headings) across the two themes; 40 questions were clustered around these criteria. Each question was scored on a 1 to 4 scale and question scores were aggregated via a standard set of rules into criteria scores and then again into overall scores using the same 1 to 4 scale.

In the review of substance misuse services, an overall score of "weak" (1), "fair" (2), "good" (3) or "excellent" (4) was applied to each local drug partnership. Ranges of scores were set for each scoring band. A maximum score of 43 was possible for most partnerships. The overall performance ranges were:

- Excellent: 35 to 43
- Good: 28 to 34
- Fair: 17 to 27
- Weak: 11 to 16

A small number of partnerships were scored against a 10-criteria framework because one of the questions in criterion 4 was not applicable to them. These partnerships were scored on the following scale:

- Excellent: 31 to 39
- Good: 25 to 30
- Fair: 15 to 24
- Weak: 10 to 14

A primary care trust, as a commissioning body, has significant influence over the performance of the local drug partnership and was, therefore, awarded the same score as the local drug partnership or partnerships. The sum of scores for criteria was used to establish the overall score for each local drug partnership and the relative position or ranking of each partnership.
References


If you would like this information in other formats or languages, please telephone 0845 601 3012.