Rehabs
a crisis in waiting

Lack of investment and referrals could turn Britain into a country where only the wealthy can enter rehab, warns Bill Puddicombe

IF you ask pretty much anyone in the street what the most likely form of treatment for someone with a long-term problem with drugs would be, they are likely to say "rehab". They envisage a place where people can stay to recover, re-evaluate and start over.

There are two good reasons why this is the case. The first is that it's the most established treatment for substance misuse, with the best evidence base. The second is because of the stream of stories in the media about celebrities who have got into difficulties with drugs and ended up there.

For the last 30 years residential rehabilitation has been at the core of Britain's response to drug-related harm. There is a real risk, however, that soon its availability will be limited to those who can afford to pay for it themselves.

I started as the Chief Executive of Phoenix House in 1998, before the current stream of investment started to flow into drug treatment services. At a meeting with a number of other care providers with the then Drug Czar we were told that the next year or so would be tough but that, if we hung on in there, there would be new funding for drug treatment services. Sure enough there has been, with enormous development in the availability of a range of services.

Home Office figures indicate that £573 million will be spent directly by government on treatment services in England alone in 2005–6. Given that estimates of those needing the services are generally around 250,000, this is a fairly generous settlement. But it is worrying to see that this investment has had little effect on the availability of residential rehab and that the number of people being referred and receiving this kind of treatment actually appears to be decreasing.

Staff at Phoenix House, the largest provider of residential rehab to people in social exclusion in Britain, have had ample opportunity to observe this trend, anxiously, on a day-to-day basis. The root of the problem, no one will be surprised to learn, is money. Not necessarily that there is not enough – but that it is in the wrong place.

Little of the £573 million quoted above, nor any of the £165 million that forms the criminal justice-based DIP (Drugs Intervention Programme), goes to pay for residential rehab. Despite the Home Office, the Department of Health and the NTA stating categorically that residential rehab is a necessary part of the range of drug treatment available, the funding for it is still separate from most other treatment funding. Instead it comes from local authorities' Community Care budgets, the same pot that pays for residential homes for people who are elderly, amongst other things. While the funding for all other kinds of drug treatment has increased enormously since 1998, that for residential rehab remains a tiny proportion of local authority budgets.

> **'Services are having to close unless providers are prepared to underwrite them with their own reserves'**

There is a clear will on some parts of government to sort this out. This month new government guidance to encourage and clarify the commissioning of Tier 4 services will be issued. Even so, services are having to close unless providers are prepared to underwrite them with their own reserves.

Part of the problem is that no one local authority

Bill Puddicombe is Chief Executive of Phoenix House

or PCT area is likely to need a rehab of their own. It is not a service that is required in high volumes and is not suitable for many potential clients – such as those who manage to maintain employment. All of the revenue funding for drug treatment is allotted to local areas through Drug Action Teams via PCTs. There is no mechanism for funding services that are needed by more than one area or a region or sub-region. This doesn't make sense. Illicit drug misusers are a mobile population and often chose to move areas when they wish to undergo treatment to avoid existing contacts and vulnerabilities.

So where has all that investment gone, if not into the best known, best researched, tried and tested mode of treatment? There has been an enormous growth in services that are less intensive and that deal with more immediate problems such as substitute prescribing to avert risks from overdose and injection. There has also been an increase in day services. These services are needed as part of the spectrum of interventions – no one would argue with that. If we are to have a system of drug treatment that deals with a range of people's needs then we must have a range of treatments that are there to meet that.

The problem is that residential rehab, which concentrates on offering an opportunity for whole-scale change in a person's life, is taking second, third or fourth place behind other interventions that may not create the same opportunities.

A key aim of the drug strategy is to increase the numbers of drug users in treatment. Clearly this figure is quicker reached by providing low intensity services for shorter periods. Whether this actually serves the needs of the population is another matter.

It is not pleasant to imagine that the UK will become a country where the wealthy and well-known will be able to access residential treatment and those in social exclusion will not. The fact remains that for a proportion of the substance misusing population, what ever economic group they belong to, residential rehab is the best option for turning their lives around. ■

Rehab meltdown

AN increasing number of residential rehab beds are lying unused, according to a survey by drug treatment body EATA (European Association for the Treatment of Addiction).

The survey, across 659 beds in 23 residential rehabs, found what EATA describe as "a dangerous downward trend" in occupancy levels of beds. Despite target occupancy levels of 86 per cent, rehabs are reporting that only 74 per cent of beds are now being taken up – a fall from 82 per cent in 2003.

"We found that occupancy levels are way below target levels for business planning and budgeting purposes," said EATA chief executive Ian Robinson. "Services are having to survive by digging into depleted reserves. If the current trend continues it is inevitable that some services will be forced to close. There is a risk that residential rehab will only be available or those who can afford to pay for it or those who have expensive health insurance. Yet it is those with no fixed abode, no family networks and all of the disadvantages of social exclusion who may be the most in need."

Robinson said that although residential rehab has been proven to be an effective form of treatment, many DATs ignored rehabs or failed to refer clients to them. "There remains an unacceptable bias against abstinence services."

Treatment's poor relation

In 1990 the NHS and Community Care Bill failed to ring -fence local authority money for drug and alcohol residential rehabs – despite intense lobbying by SCODA, Alcohol Concern, Phoenix House and Turning Point.

With no tradition of looking after drug users, campaigners warned that local authorities would divert community care cash to 'higher priority' groups if it was not ring-fenced.

In 1992 the then Minister for Health Brian Mawhinney scrapped plans for a three-year grant to safeguard funding for cash-strapped residential rehabs. Alcohol Concern's Eric Appleby predicted "wholesale closures" of rehabs unless the grant was reinstated. Although this did not transpire, Robinson says rehabs have been struggling for funding ever since.