Tier Four Funding of NHS Inpatient Detoxification Units

NHS addictions provider alliance

Contents

Executive summary

This document, prepared by the NHS Inpatient Network (IPN), a subgroup of the NHS Addictions Provider Alliance (NHS APA), outlines the current NHS inpatient detox provision in England, challenges faced by services, the risks these challenges pose, and makes recommendations as to how alternative commissioning arrangements can secure the future of these services and improve the quality of care.

Currently, there are two ways in which inpatient detoxification can take place: through medically monitored detox or through medically managed detox. The significant difference between the two types of detoxification is the level of acuity that each type of provision can safely manage. Medically managed detox services are able to deal with complex physical, mental health and behavioural issues and provide 24-hour nursing care whereas medically monitored detox services are only able to support patients with less complex needs and are unable to provide 24-hour nursing care.

While there are other, non-NHS medically-managed inpatient detox services, it is only the NHS inpatient units that are Consultant Psychiatrist-led and hospital-based, enabling the NHS units to manage the most complex patients that other services (both medically monitored and medically managed) feel unable to support.

NHS inpatient units are fundamentally different to all other detox and rehabilitation services in England. As shown below, they are unique in seven key ways:

1. **The level and extent with which NHS IPUs are able to assess complexity/acuity**
2. **The ability to effectively manage cognitive impairment**
3. **The ability to manage complex mental and physical comorbidities**
4. **The presence of a range of professionals including social workers, psychologists, pharmacists to enhance packages of care**
5. **NHS Hospital-based (NHS Mental health Trust)**
6. **Lead by a Consultant Addictions Psychiatrist (CAP)**
7. **Provision of training and guidance**

As of 1st January 2019, there are five NHS inpatient units operating in England: Acer, Edward Myers, Chapman Barker, Bridge House and Merseycare.

At present, four of the units are members of NHS APA and represented in this business case document. These four units treated a total of 1742 patients in 2017/18, with an average successful completion rate of 81.49%. They currently receive approximately £7.1million of funding in total. This funding is provided through a mixture of Local Authority contracts, Local Authority spot purchasing, acute Trusts and a small number of private patients.

However, all four IPUs have stated that their funding feels either 'precarious' or 'very precarious', backed up by recent reductions in funding and the unexpected closure of other NHS IPUs over the last five years due to funding cuts. Levels of funding are decreasing and the current short-term, reduced-budget contracts being offered by Local Authority commissioners have created a precarious financial situation for each NHS IPU.

Alongside this, NHS inpatient units are seeing higher levels of complexity and acuity in the patients that are being referred. Patients are needing increasing levels of testing, engagement with in-house and allied health professionals, treatment and observation to support their detox and comorbid physical or psychiatric health conditions. This, combined with flat or falling funding, is not sustainable.

The challenges outlined above have serious repercussions for every NHS IPU but also create significant risks for all other drug and alcohol services. Without NHS IPUs to manage and treat the most complex and acute patients that other services feel unable to manage, there will be an increase in the number of substance use and alcohol-related deaths and morbidity (such as liver disease). There is also a high risk of increased admission rates, re-admissions, length of stay and costs to acute trusts, mental health trusts, primary care, adult social care, the criminal justice system and other agencies.

As a collective of NHS IPUs, we believe that the acute nature of the clinical services we provide to patients who have diverse and complex mental and physical health needs has many similarities to other Tier 4 services that are directly commissioned by NHS England. For example, Specialised Perinatal Mental Health Inpatient Services (Mother and Baby Units). The similarities between the mental and physical health needs of these patients as well as the models of clinical interventions delivered in comparison to that of the NHS IPUs is striking. The vignettes in section three of the business case and in the Appendix clearly articulate that patients who present to the NHS IPUs have at least the same (if not a greater) level of acuity as the NHS England Commissioned Tier 4 Specialised Perinatal Mental Health Inpatient Units.

As such, we recommend that the commissioning arrangements for NHS Inpatient Detox units are changed to allow NHS England to directly commission/fund all existing NHS Inpatient Detox Units under a single specification in line with similar Tier 4 specialist services. The APA and Inpatient Network believe there would be substantial improvements to patient care planning and interventions if NHS IPUs were directly commissioned/funded in this way. It would also stop these specialist and essential services from being eroded away under the current localised commissioning arrangements.

At this time, the four units which are part of NHS APA (Acer, Edward Myers, Chapman Barker and Bridge House) are asking to be moved to Tier 4 commissioning arrangements with NHS England to the value of £7.1million.

However, it should be acknowledged that the one other NHS Unit, Merseycare, should be considered in any decision making.

The NHS APA and Inpatient Network firmly believe that the recommendation above is essential to ensuring that patients suffering from acute mental and physical health problems as a result of alcohol and substance use:

- **Are prevented from dying prematurely**
- **Experience enhanced quality of life**
- **Are helped to recover from episodes of ill health**
- **Have a positive experience of care**
- **Are treated and cared for in a safe environment which protects them from avoidable harm.**

NHS APA and the Inpatient Network wish to meet with NHS England and Public Health England to discuss future commissioning/funding arrangements for the NHS Inpatient Detox Units.

As the Dame Carol Black Review [2019] highlights 3 key points in relation to complex patients, current commissioning arrangements and loss of skills, which is particularly true for NHS expertise in the form of consultant addiction psychiatrists, clinical psychologists and nurses:

- **The demand for opiates and crack/ cocaine, and deaths from misuse of these substances, is closely associated with poverty and deprivation. There is an ageing population of heroin users with severe health needs, some of whom are using crack cocaine too, but there is also a new population of younger crack cocaine users that do not use heroin**
- **Treatment in the community is the responsibility of Local Authorities. Spending on treatment has reduced significantly because Local Government budgets have been squeezed and central Government funding and oversight has fallen away. There is significant local variation, with some Local Authorities having reduced treatment expenditure by 40%**
- **Local Authorities commission treatment from NHS Trusts and third sector providers. A prolonged shortage of funding has resulted in a loss of skills, expertise and capacity from this sector. Treatment providers often have to prioritise the severe needs of the long-term heroin using population, meaning that services for other drug users have had less investment.**

At a time when a national pandemic has emerged 3 of the 4 NHS inpatient units which form this submission have continued to respond positively to planned and unplanned admissions. Along with the one NHS unit most other non-NHS units have closed. Again, this shows the resilience of the NHS inpatient units and that they have been essential in ensuring that capacity in acute physical hospitals is maximised.

Introduction

This business case has been prepared by members of the Inpatient Network (IPN) which is part of the NHS Addictions Provider Alliance (APA). The APA is a coalition of 15 NHS-provided community and inpatient alcohol and substance misuse providers from across England.

The APA's main objectives are to ensure that our members are:

- **Contributing our expertise and resources to the government and sector's drug and alcohol policy development**
- **Contributing to the development of academic research with the aim of positively contributing to developments in the sector**
- **Ensuring that the voice of service users and carers who use our services are represented**
- **Working collaboratively with other organisations and stakeholders across and connected to the drug and alcohol treatment sector.**

The purpose of this document is to provide NHS England and Public Health England with an overview of the issues facing specialist inpatient drug and alcohol services, their impact on patient care and the potential risks of continuing with the current model of commissioning this provision.

The following provides a brief description of the current landscape under which providers of inpatient alcohol and substance misuse providers operate:

Current provision

As of 1st January 2019, there are currently five NHS inpatient alcohol and substance misuse units operating in England. These are as follows:

1. **ACER**
   Blackberry Hill Hospital, Bristol
2. **Edward Myers**
   Harplands Hospital, Stoke-On-Trent
3. **Chapman Barker**
   Prestwich Hospital, Manchester
4. **Bridge House**
   Maidstone
5. **Merseycare**
   Liverpool

Total Funding For Inpatient Network Units

Unit	Total Income	Income sources
Un ACER - Blackberry Hill Hospital, Bristol it	Approx. £1.1m	£550k from direct award from Bristol Public Health. £550k required from spot purchases from other local authorities.
Edward Myers - Harplands Hospital, Stoke-On-Trent	Approx. £1.6m	Secured income (Local Community Teams, Hospital Transfers) around 40% of income; Rest of income would be unsecured from Frameworks and/or Spot purchasing by other community teams and private admissions.
Chapman Barker - Prestwich Hospital, Manchester	Approx. £3.4m	£2.59m required from Local Authority spot purchases, £0.81m funded from RADAR [8 of the 36 beds].
Bridge House - Maidstone	Approx. £1m	All from spot funding, 99% from the Local Authority, 1% from one acute trust.
Total	**Approx. £7.1m**	

Where NHS IPUs sit in the alcohol and substance misuse pathway

Detoxification can be undertaken safely and effectively in a number of settings from community to inpatient services. NICE CG52 states community detox should be the default approach, except for those who:

- **have not benefited from previous formal community-based detoxification**
- **need medical and/or nursing care because of significant comorbid physical or mental health problems**
- **require complex polydrug detoxification, such as concurrent detoxification from alcohol or benzodiazepines**
- **are experiencing significant social problems that will limit the benefit of community-based detoxification.**

There is clear guidance from NICE (CG52, CG100 & CG115) with recommended criteria for community and inpatient detoxification. However, drug and alcohol service providers are working considerably beyond this guidance for community detoxes due to the ever growing demand and lack of availability of inpatient detoxification provision.

For many, community assisted withdrawal is not clinically appropriate and as NICE CG52 states:

Residential detoxification should normally only be considered for people who have significant comorbid physical or mental health problems, or who require concurrent detoxification from opioids or benzodiazepines or sequential detoxification from opioids opioids and alcohol.

Whilst:

Residential detoxification may also be considered for people who have less severe levels of opioid dependence, for example those earlier in their drug-using career, or for people who would benefit significantly from a residential rehabilitation programme during and after detoxification.

In addition, and more specifically:

Inpatient, rather than residential, detoxification should normally only be considered for people who need a high level of medical and/or nursing support because of significant and severe comorbid physical or mental health problems, or who need concurrent detoxification from alcohol or other drugs that requires a high level of medical and nursing expertise.

Inpatient treatment for patients with drug and/or alcohol dependency is often inappropriately viewed as simply ‘detox’. However, patients actually need a great deal more than that: a comprehensive package of care designed to meet their needs.

Currently, there are two mechanisms by which inpatient detoxification can take place*:

Medically Managed Inpatient Detoxification (Predominantly NHS Inpatient Detox services)

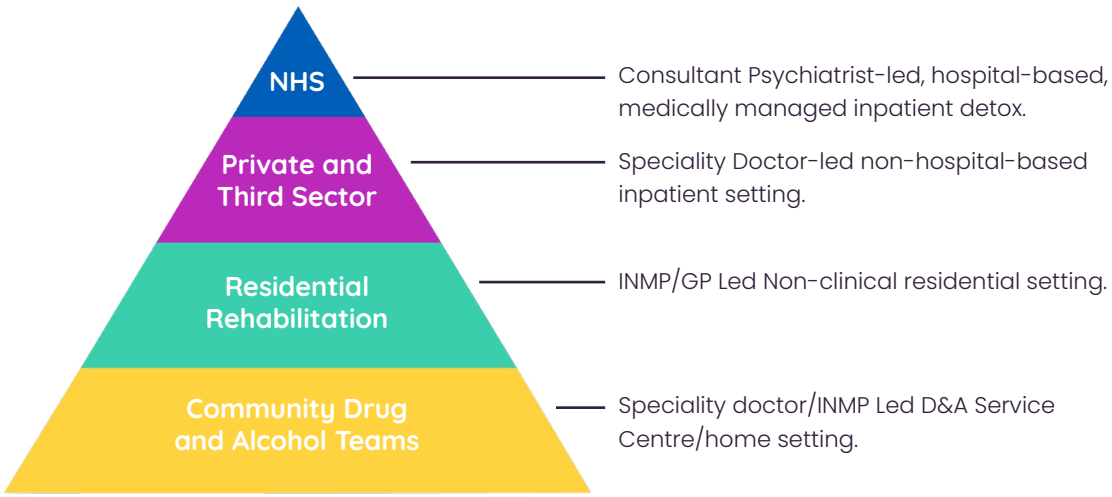
- **Able to deal with complex physical and mental health issues**
- **May have facility to support pregnant service users**
- **Able to deal with challenging behavioural issues**
- **Provide 24 hour nursing care**
- **Minimum Mon–Fri 9.00–17.00 medic availability & out-of-hours cover**
- **Clear liaison with GPs**
- **Ability to dispense medications on-site**
- **Clear pathways with, or supported by, acute hospitals.**

Medically Monitored Inpatient Detoxification (Third Sector services)

- **Able to deal with challenging behavioural issues**
- **Support for people with less complex physical and mental health issues**
- **Ability to dispense medications on-site**
- **Minimum Mon–Fri 9.00–17.00 and out of hours on-call support**
- **Clear liaison with GPs.**

However, when scrutinised more closely, it is clear that there is a gradation of clinical ability to respond to those requiring medically managed inpatient detoxification and stabilisation.

As is evidenced on page 08, some medically managed units are better able to respond to the higher levels of acuity and complexity than others. This means that they are not all the same, as shown below. It is only NHS IPUs that provide consultant psychiatrist led, hospital-based and medically managed services.



* taken from the October 2018 Change Grow Live Inpatient Provision Framework Tender Submission Guidance.

Number of service users supported over the last 3 years

Year	Total number of Service Users supported	Total Number of beds [for the 4 NHS units]	Average % Successful Completions
2017/2018	1742	69	81.49%
2016/2017	1705	68	82.96%
2015/2016	1410	67	84.92%

Over the last three years, NHS IPUs have seen both a strong increase in the number of patients admitted to their services and a significant increase in the level of acuity and complexity of the patients admitted. Unsurprisingly, this has impacted on the percentage of successful completions. However, the average number of successful completions is still very high given the level of complexity and acuity presented.

Current Commissioning Arrangements

Unit	Commissioning Arrangements	Contract End Date
ACER - Blackberry Hill Hospital, Bristol	Commissioned via Bristol City Council (Public health) for 5 direct award beds.	31.01.21
Edward Myers - Harplands Hospital, Stoke On Trent	Commissioned via Staffordshire and Stoke-on-Trent Councils (Public health).	Staffordshire: 01.04.20 Stoke-On-Trent: 01.01.23
Chapman Barker - Prestwich Hospital, Manchester	36 beds. 8 block contract with GM CCG's for RADAR, remaining 28 are spot purchased via various frameworks and individual arrangements with local authorities.	CCG contract has just been extended but it is currently unclear how long for.
Bridge House - Maidstone	All income is spot funding: 99% from the Local Authorities, 1% from one acute trust.	N/A

Challenges

NHS inpatient units are currently faced with an incredibly challenging landscape. Levels of funding are decreasing and the current short-term, reduced-budget contracts being offered by Local Authority commissioners have created a precarious financial situation for each NHS IPU.

There are only five NHS IPUs left in England, resulting in limited coverage nationally. Some patients must travel across the country for access to the service they need and others are unable to access the services of NHS inpatient detox units at all, despite their being a clear need.

Alongside this, NHS inpatient units are seeing higher levels of complexity and acuity in patients that are being referred. Patients are needing increasing levels of testing, engagement with in-house and allied health professionals, treatment and observation to support their detox and comorbid physical or psychiatric health conditions. This, combined with flat or falling funding, is not sustainable.

Risks

The challenges outlined above have serious repercussions for every NHS IPU but also create significant risks for all other drug and alcohol services.

Without change, the current challenges will result in the closure of NHS IPUs. However, it will not negatively affect Local Authorities if they do not commission NHS medically managed IPUs. Instead, the most complex patients will not receive the treatment they need, will reach crisis and turn to A&E services, impacting on Clinical Commissioning Groups' budgets.

Without NHS IPUs to manage and treat the most complex and acute patients that other services feel unable to manage, there will be an increase in the number of substance use and alcohol-related deaths and morbidity (such as liver disease).

There is also a high risk of increased admission rates, re-admissions, length of stay and costs to acute trusts, mental health trusts, primary care, adult social care, the criminal justice system and other agencies.

For instance, in Kent, 25% of re-admissions to inpatient psychiatric facilities are judged to be mainly or solely due to untreated substance use problems. Nationally, there are more than 20,000 admissions to acute hospitals each year due to alcohol-related liver disease.

Without change, there will be poorer outcomes for community substance use treatment providers due to them attempting to manage patients in the community who are unable to access inpatient services, or who's access to inpatient services is severely delayed due to lack of beds. Attempting to support these patients will lead to increased costs as well as significant waiting lists for beds in non-NHS inpatient units.

There is risk of neglect or iatrogenic harm due to patients being seen in non-NHS IPU services by non-specialists. For example, the prescribing of opioids or benzodiazepines to patients who do not need them, risking iatrogenic addiction, overdose and substance-related death. Across England, only NHS IPUs are addiction psychiatrist led, hospital based and medically managed.

In addition to the risks to patients, the current uncertainty around the future of NHS IPUs is leading to a loss of highly qualified, experienced staff and difficulties in recruiting. The closure of units is also reducing the number of training posts available and the expertise to train the substance use treatment experts of the future.

Lack of investment is also resulting in the deterioration of the physical infrastructure of existing units meaning they will, in time, become unfit for purpose.

Why NHS inpatient units are unique

NHS inpatient units are fundamentally different to all other detox and rehabilitation services in England. As shown below, they are unique in seven key ways.

1. The level and extent with which NHS IPUs are able to assess complexity/acuity

NHS inpatient detox units are able to assess the complexity and acuity of patients to a much greater extent than other detox and rehabilitation services.

Pre-admission, referrals are managed by a team of highly skilled professionals such as nursing managers, consultant additions psychiatrists and allied professionals who, due to each unit's place as part of a NHS mental health trust, have ready access to each patient's electronic patient notes. These notes can be used to assess risk, the severity of any mental health conditions, results from blood tests and any other special investigations that may have been carried out prior to referral.

The professional team can then use this information to create a holistic and multidimensional care package for the patient, focusing on all their medical and psychiatric needs, not just their current addiction problem.

At intake and during admission, standardised assessment tools are used to properly assess the acuity and complexity of both substance use and physical health. Commonly used tests include: alcometer, SADQ/CIWA/COWS, drug toxicology, ECG, blood sugar monitoring, temperature, blood and urine testing, peak flow testing for respiratory diseases, blood pressure testing, use of risk management tools for physical health risk. Through being part of larger NHS Trusts, NHS IPUs have 24 hour medical staff cover and access to hospital facilities and equipment.

Staff also assess mental health and have expertise in psychopharmacology, especially in relation to managing severely or multiply-dependent individuals to ensure safe medical detox and stabilisation regimes. Staff monitor for potential interactions between the treatment of mental health and physical health conditions. For example, respiratory depression in a patient with COPD who has been prescribed multiple psychotropic medications.

Ongoing screening and assessment takes place during every patient's stay in an NHS IPU. This clarifies clinical uncertainty, identifies unmet need and allows clinicians to adjust discharge plans based on these needs. For example, assessing the presence/severity of: cognitive impairment; post traumatic stress disorder and other mental health comorbidity; liver disease, COPD, diabetes, infections or other physical health conditions.

Discharge planning begins plying to admission and continues throughout a patient's stay. This involves multi-agency review and communication with a range of services such as GP, general medical and psychiatric services, IAPT, probation, housing rehabilitation units, safeguarding agencies and others, as needed.

NHS IPUs provide detailed discharge summaries which include recommendations for onward monitoring and treatment in all relevant areas. For instance: addictions, mental health, physical health, social environment and support, safeguarding and any other areas of risk.

The extensive and ongoing assessment of complexity and acuity which takes place within NHS inpatient services ensures each patient receives the best quality care for all of their health needs.

vignette

Katie was 28 and had been known to addiction services all her adult life. She was referred for detoxification from methadone, heroin and crack cocaine. She had a history of dependency on alcohol when not using heroin.

Although she was described as intelligent and came from a middle-class background, her referral came with a number of red flags. She had had significant periods of homelessness although at the time she was staying with her parents, although relationships with them were poor.

She had various psychiatric labels including autistic spectrum disorder, eating disorder, bipolar disorder, PTSD and emotionally unstable personality disorder. Her concordance with opioid-substitution treatment was poor, partly because her family were vociferously opposed to such treatment and Katie was herself ambivalent about the benefits and risks of such treatment. Most of concern was the report that a year previously she had been admitted to a non-NHS detox and residential rehab facility with a poor outcome. She had decompensated emotionally at the end of that detoxification period, was aggressive to staff, self-discharged early, had a relapse and was hospitalised following an accidental heroin overdose.

Given these red flags the inpatient unit liaised extensively with her GP to obtain all relevant records in relation to her previous psychiatric care. This revealed she was known to CAMHs from age 7 with a diagnosis of autistic spectrum disorder exacerbated by dysfunctional parenting, maternal depression and father's bouts of excess drinking. At age 9 she had come to the attention of social services and the police due to recurrent running away from the family home, substance abuse and sexual exploitation. From age 16 onwards she was known to a variety of services, usually on a crisis basis for her substance use, rough sleeping, overdoses both accidental and deliberate, offending and being offended to, often a victim of domestic violence with a sexual component.

At intake she was assessed at length, both with and without her parents who brought her for admission, with a view to assess the relationships with the various parties and their differing attitudes to various treatment options, facts about the treatment provided in her previous detox, understanding the poor outcome/her mental health decompensation and how such an outcome might be ameliorated. Various facets of her presentation were extracted early in her admission including autistic features such as her dislikes for certain foods, not wanting to be watched eating or partake of group meals, communication problems and obsessionality leading to potential misunderstandings with staff. A detailed trauma assessment was completed noting she had marked PTSD and the poor outcome of her previous detox was, in large, due to her inability to manage severe PTSD symptoms (nightmares and flashbacks) and their behavioural sequelae such as demands for increasing amounts for sedative-hypnotic medication and conflict with staff e.g. not feeling able to sleep in her allocated room due to flashbacks of sexual assault/wishing to sleep in a lounge where she would feel safe and be observed by staff.

Her treatment and management therefore composed many facets. The lead consultant held detailed discussions with her about the various pharmacological effects of methadone (e.g. impact on traumatic symptomatology as well as on opioid addiction), treatment options, agreeing boundaries to the use/prescribing of sedative-hypnotics and treatment strategies aimed at her PTSD and symptoms of autism; a care plan that was informed by her responses to issues (e.g. not sleeping in her room, not eating with peers) and staff adjusting their communication style to fit hers. As a result she successfully completed detoxification and with a reduction in PTSD symptomatology. At her three months follow-up, her GP advised that whilst she was by no means drug free, she had not returned to regular class A drug use, was stable in mental health, engaged with planned services and had not required the intervention of emergency services.

– Patient at Bridge House Unit

2. The ability to effectively manage cognitive impairment

Up to 40% of patients with chronic alcohol dependence have some degree of cognitive impairment. NHS inpatient detox units see a high prevalence of patients presenting with cognitive impairment. This is predominantly due to other, non-NHS units feeling unable to accept these referrals because of the challenges in managing the risk factors associated with cognitive impairment while going through the detox process, such as a history of seizures or the severe level of alcohol dependence.

Cognitive impairment has many potential causes, both physical and psychological, meaning that several steps need to be taken to understand the causes and before making clinical decisions about the most suitable approach to managing the condition.

NHS IPUs use screening tools (such as ACE III or MOCAM) to detect particular problems associated with alcohol-related brain damage while also collating and reviewing information from multiple other sources to fully understand other potential causes. This process is in-depth, analysing sources such as: history from the GP and family/supporting agencies; patient's presentation on the ward; feedback from ward staff, results from blood tests and specialist investigations used to determine the severity of the deficits; as well as assessments of the patient's capacity for decision making, potential vulnerability, and any statutory concerns.

Once causes of the cognitive impairment have been ascertained, remedial action or treatment is undertaken, such as treating reversible causes, prescribing reviews/describing of drugs contributing to the impairment, treating or referring for treatment of psychiatric conditions. These actions are reviewed and the NHS IPU liaises with the referrer and other relevant agencies to ensure that appropriate management and interventions continue once the patient is discharged from the IPU.

vignette

Due to the neurotoxic effect of alcohol on the brain with long-term/excessive use, it is not surprising that long-term drinkers often present with cognitive deficits. The most common deficits seen in practice are as regards the learning and retention of new information (with remote memory often being intact). Such deficits impact greatly on the individual's day-day functioning.

J, a 56 year old man was a double graduate from Cambridge who worked as a teacher for a number of years before retiring in 2001. In relation to his drinking, the client recalled that he first drank alcohol at the age of eighteen to nineteen, and how when he started playing less sports at university, his drinking increased and became a daily feature from that point on. In the past the client sustained a number of alcohol related seizures. After one such seizure the client fell in his bathroom and was unconscious for a period of time. Prior to his admission to the Chapman Barker Unit the client was drinking about eight cans of 9% lager on a daily basis. He was referred to the neuropsychologist on the unit for psychometric testing.

Testing with J was slightly curtailed as he insisted on giving a complete history of his drinking and related psychological problems. Nonetheless, testing showed areas of clear deficits. These include acquired deficits as regards aspects of visuo-spatial functioning and with his performance on a Blocks (constructional) task being notably poor. Memory testing also showed marked problems with the learning and retention of new information – poor scores on the recognition stages of these tasks indicated poor registration of new information. In the clinical report, it was concluded that J would need significant support from community staff to develop the effective use of memory aids to supplement his day-day memory functioning. Furthermore, his garrulous style gave indications of some executive/'frontal lobe' impairment, with the likely need for additional support to structure and organise his days effectively.

J returned home after three weeks of inpatient treatment – he was reviewed and given feedback by the neuropsychologist, regarding the extent of cognitive issues likely to be due to his alcohol use, and the importance of ongoing abstinence in alcohol related brain damage (ARBD). In terms of his prognosis, he was also advised of techniques that would help to support his difficulties. With an accurate diagnosis, this allowed a referral to adult social care for additional support.

- Patient at Chapman Barker Unit

3. The ability to manage complex mental and physical comorbidities

A recent acuity audit across the NHS inpatient services has highlighted the complexity and multi-morbidity of patients, both physically and psychologically.

A typical admission will have a family history of addiction as well as experience of childhood trauma, bereavement, domestic violence, injuries and other deprivations. A patient may be severely dependent on substances with a host of issues directly associated with this such as toxic effects of substance use, poor nutrition, vomiting, metabolic disorders and seizures. There are high levels of common comorbidities such as hypertension, diabetes, chronic lung conditions and infections.

Increasingly, patients live in a state of chronic poor health, with very complex pharmacological combinations leading to poor concordance, drug to drug interactions and the unintended effects of drugs being prescribed at toxic levels due to, for instance, undiagnosed liver disease. A patient's quality of life is often poor, commonly exacerbated by a symptom like insomnia due to a combination of other physical and psychiatric problems, for instance, pain, pruritus, cough, and Post Traumatic Stress Disorder.

NHS inpatient detox services are able to respond to such complexity through structured, comprehensive and ongoing assessments of patients conducted using rating scales and special investigations. Once symptoms of withdrawal and comorbid health conditions have been assessed or diagnosed, an individualised, recovery-orientated care plan is developed.

Half of all patients admitted to NHS inpatient detox units have complex trauma, with many meeting the diagnostic criteria for post traumatic stress disorder and experiencing symptoms such as flashbacks or nightmares. Due to this, a trauma-focused approach to care is undertaken.

High staffing levels combined with the expert oversight of the Consultant Psychiatrist and skills of the Multidisciplinary Team at NHS inpatient detox units allows for a circumscribed yet flexible approach. As NHS detox units are hospital-based, it is possible to quickly and easily get advice and make referrals to and from other medical specialists in the main hospital if needed.

vignette

LF was referred to Acer for a 4 week admission to detox from alcohol (40 units daily), methadone, opiates and cocaine. She had complex physical and mental health needs, which would have made community detox extremely challenging, if not impossible.

Physical Health

LF has a diagnosis of Congenital Anogenital Syndrome, for which she had been under the long-term care of endocrinologists in Poole. As a result of this condition she was prescribed daily oral steroids (Prednisolone and Fludrocortisone) and was required to intermittently self-catheterise due to indeterminate genitalia and urethral stricture. Due to her use of long-term steroids, there was a significant risk of Addisonian Crisis being precipitated by detox, especially if complicated by vomiting.

Following discussion with her Endocrinology consultant, a plan was made to manage this risk by increasing her steroid prescription during the initial stages of detox, with gradual reduction when she was more stable. Emergency intramuscular hydrocortisone was made available should she vomit, which was required on a number of occasions.

Ms LF had prominent symptoms of vomiting and retching throughout her admission, and a number of "funny turns", without clear aetiology. She was reviewed on a number of occasions by ward doctors, and discussed at length with her consultant endocrinologist in Poole and medical team locally at Southmead Hospital. Attempts were made to manage these symptoms using a combination of intramuscular antiemetics and hydrocortisone when required. It was felt that there was a significant psychosomatic element to these symptoms, which made management particularly challenging. LF required transfer to local general hospital for investigation and management of this during her detox.

Ms LF also has Brittle Asthma, which had necessitated ITU admissions in the past. She required close monitoring of respiratory symptoms, and was provided with nebulisers when necessary. She also required support around management of self-catheterisation.

Mental Health

LF has a history of significant childhood trauma and had experienced domestic violence in her adult life. She has been under the care of her local CMHT long-term and has complex difficulties around attachment, low mood, anxiety and managing distress. She had a history of self-harm and overdose. Her difficulties could be conceptualised as 'Emotionally Unstable Personality Disorder'.

Prior to admission LF had experienced a series of losses, including very recently having her children permanently taken into care, the sudden death of her mother a few months prior to admission and the death of her husband 1.5 years previously. She recognised these events as destabilising and very distressing, and described feeling suicidal and hopeless as a result.

On the day of admission, LF became rapidly unwell with reduced GCS, reduced respiratory rate and hypotension. She required emergency care from the ward medical and nursing team whilst an ambulance was awaited, she was peri-arrest prior to their arrival. It later transpired that LF had taken a significant overdose of methadone, cocaine and pregabalin prior to admission, although she had denied this to staff until later. Staff were involved in the management of the emergency situation and in ongoing risk assessment and management in relation to suicidal ideation, distress and anxiety throughout her admission.

LF displayed disordered attachment behaviours, and required a significant amount of emotional support and boundaried care from staff, in order to support her through her detox. As part of this, we liaised with her CMHT consultant psychiatrist to develop a more complete understanding of her needs and to arrange adequate follow-up care.

In addition to her illicit substance use and alcohol, LF had considerable psychiatric polypharmacy and it was felt that during her admission it would be important (and safer) to rationalise her prescribed medication. Therefore, in liaison with her consultant psychiatrist and GP, she was supported to reduce and discontinue trazodone, gabapentin, propranolol, amitriptyline and diazepam.

- Patient at Acer Unit

4. The presence of a range of professionals including social workers, psychologists and pharmacists to enhance packages of care.

NHS inpatient detox services have access to advice and support from both non-addictions psychiatric/psychological specialties and physical health professionals to manage the complex range and severity of conditions commonly presented. For example, specialists in eating disorders, perinatal psychiatry, forensic psychiatry, crisis teams and other approved mental health professional services as well as wound care specialists, dieticians, physiotherapists, pharmacists and other physical health specialists are available as needed.

This enhances the quality and suitability of the care package and also allows for treatment of comorbid physical and psychological/ psychiatric conditions that will potentially impact on the long term success of rehabilitation and the patient's quality of life.

vignette

HB presented to a local charity (One-25) at 32 weeks pregnant. She was street homeless, sex-working and using £100- £200 heroin IV and £100-£200 crack IV daily. She had not received any antenatal care and was not in contact with drug and alcohol services. She was extremely vulnerable and lacked any social support network in Bristol.

HB was referred for an urgent admission to Acer unit for opiate stabilisation and crack detox, which was facilitated within a few days of referral. During her admission, the team liaised with specialist midwives and supported HB to attend antenatal appointments and scans. Staff provided regular updates to her antenatal team regarding her progress and any concerns around the unborn child.

HB also had access to medical reviews 24/7 from on-call junior doctors, who provided review and management of issues such as chest infection, swollen legs, candida, reflux and urinary symptoms and who (if necessary) could have referred her for further care under hospital teams.

The medical team liaised with pharmacists to review all prescribing options and to consider risk vs benefit analysis of prescribed medications, to ensure optimal safety for Miss HB and her child.

The ward team liaised closely with her community support workers from BDP (Bristol Drug Project), One-25 charity and social workers, and hosted a multi-agency meeting to develop a robust and safe discharge plan, including support around accessing housing and benefits. This also took into account safeguarding proceedings following the birth of her child. The ward staff were very involved in supporting HB to complete necessary paperwork and benefit applications as part of this process and supported her in maintaining contact and developing relationships with her community team.

The medical team also discussed HB's admission and current situation with her GP and provided written information to hand-over care to GP at the end of her admission.

HB had a successful admission and stabilised on Methadone. Scans and obstetric reviews during her admission were satisfactory; her obstetric consultant was reportedly satisfied with the baby's growth and HB's progress. She was discharged with ongoing support and temporary housing in place. There was a plan in place to consider further Acer admission following birth for HB to detox from Methadone and then for a 6 month mother and baby placement at a specialist rehabilitation unit.

- Patient at Acer Unit

5. NHS Hospital-based (NHS Mental health Trust)

The NHS Mental Health Trusts where NHS inpatient detox units are based are each linked to local NHS acute physical health hospitals through a reciprocated on call system. This provides a link and level of response that stand-alone non-NHS units cannot replicate. This close working relationship with acute physical health hospitals also allows for the provision of phlebotomy, ECG and other special investigations, with access to immediate results through web-based laboratory websites.

Due to their locations, NHS IPUs have access to on-site junior medical staff and the advice of consultant-level physicians out of hours to assess changes in a patient's presentation and prevent/respond to psychiatric and medical emergencies.

NHS IPUs are able to take direct transfers from other hospitals. NHS detox units will commonly have contracts or clinical pathways/funding streams with acute hospital services to admit certain patients from their wards or casualty departments. In other circumstances they are able to accept out-of-area patients directly from other hospitals where the patient is already known to the local community addictions service.

NHS IPUs also have on site pharmacy and pharmacists: as experts in medicines management and developed specialisms for drugs & alcohol, all NHS inpatient units have access to an on site pharmacist with regular visits to support the clinical work of the ward. Furthermore, on site pharmacy services provide ease of access to medications and the hospital site enables medication availability out-of-hours.

Hence, the expertise, medicines management and accessibility of the associated resources are greatly enhanced through the NHS over non-NHS provision. This allows for the management of greater acuity and provides a highly responsive system to support medication regimens.

vignette

KS, 26 year old female referred to Chapman Barker unit for methadone stabilisation and detox and benzodiazepine detoxification. She had been diagnosed with acute myeloid leukaemia. She had completed 4 rounds of chemotherapy, successfully going into remission, but had experienced a recurrence. Her haematologist had advised that the prognosis was poor but that due to ongoing heroin and illicit benzodiazepine use they were unable to offer anything but supportive treatment. However, her sister had been identified as a suitable bone marrow donor should she be able to successfully stop illicit use and detoxify.

She had been using heroin since the age of 14 and had completed detoxifications and rehabilitation in the past, but had been unable to maintain abstinence. She was prescribed methadone by her community team. She had a history of low mood, self-harm and previous suicide attempts. She disclosed that she had been raped at the age of 14.

On admission to the unit her blood tests revealed a Blast Cell Crisis (99% of her blood cells were immature) and the physicians at the unit liaised with her treating haematologist. Barrier nursing was commenced on the unit to prevent infection and ambulance transport was arranged to her treating hospital in a neighbouring county to commence low dose chemotherapy. There was daily liaison with the acute ward, in order to help stabilise K onto an adequate dose of methadone and benzodiazepine. She was stabilised on methadone 55mg and lorazepam 0.5mg qds and transferred back to the unit after 1 week. There had been an improvement in her blood results with a reduction in blast cells but her white cell count and platelets remained extremely low.

Twice weekly transfer to day hospital was arranged in order for her to have platelet and packed red cell transfusions.

In order for her to look at bone marrow transplant the haematology team required her to be detoxified from methadone and lorazepam, the methadone detoxification was successfully completed and she completed lorazepam detoxification in the community. During her admission we were able to identify a day based rehabilitation unit that were able to facilitate her need to attend hospital for chemotherapy.

There were additional times when she required urgent review out of hours, due to development (on separate occasions) of nosebleeds, hypotension and cold-like symptoms. As a hospital site we were able to utilise on call doctors to review and manage these episodes.

During her 6 week admission to the unit, K required input on a daily basis from our physicians, with regular blood tests, at times hourly monitoring of vital signs, ability to quickly and effectively discuss and transfer to the acute NHS hospital. K had dietician input, additional nursing input due to the requirement to barrier nurse. She had twice weekly, consultant psychiatrist led ward reviews. She was seen by the therapy team and physiotherapy. Her complex prescribing regimes were supported by the trust specialist substance misuse pharmacist. The unit social worker was able to help support the family in their role as carers and help to identify suitable ongoing rehabilitation.

On successful completion of her detox, the haematology team agreed to move her from supportive care back to active treatment.

- Patient at Chapman Barker Unit

6. Lead by a Consultant Addictions Psychiatrist (CAP)

Unlike other rehabilitation and detox services, NHS inpatient detox units are lead by a Consultant Addictions Psychiatrist (CAP). The CAP is an experienced doctor who has undergone approved training in addictions psychiatry as well as other psychiatric disciplines. Consultant Addictions Psychiatrists develop practice, leads the inpatient service and links with other services/the NHS Trust in which the service is located.

As outlined in the GMC Good Practice Domains, CAPs provide clinical leadership in terms of screening patients/referrals, diagnoses, prognosis, personalised treatment and support, risk assessment, stratification and management, including inter-professional liaison and onward re-referral to other services. CAPs are also normally approved under S12 of the Mental Health Act (1983) for the assessment of compulsory treatment of mental disorders. This enables NHS IPUs to manage much greater complexity and acuity.

CAPs are also involved in research and teaching and may be a medical academic or an active participant in research teams. They are able to interpret the latest research and national/international clinical guidelines and consider how the findings can be translated into providing improved clinical care. CAPs involved in research can implement new practices and help devise a new evidence base to advance the field. All Consultants have extensive teaching experience and CAPs use this experience to train and update staff on new developments.

vignette

AH was a 27 year old female, referred for alcohol detoxification from 120 miles away due to the lack of a suitable detoxification unit in her area to help support the complexity of mental health needs. On admission to the unit the history, examination, investigations and treatment plan were initiated by a Core Trainee (CT) in psychiatry, under the supervision of a senior trainee (ST) in psychiatry based at the unit.

AH had first used alcohol at the age of 9 years, but described it becoming problematic from the age of 11 years, with the GP noting an episode of possible delirium tremens at the age of 18. She had a long history of mental health issues starting in childhood and had been known to child and adolescent mental health services. She was diagnosed with emotionally unstable personality disorder, bulimia and post-traumatic stress disorder following childhood sexual abuse from the age of 7 years. She had been admitted under the Mental Health Act to hospital for a period of 2 years at the age of 21 and had an extensive history of self-harm (including burns requiring skin grafts) and suicide attempts.

During the first week of her alcohol detoxification, she was seen by both core and senior trainees and was reviewed in the consultant psychiatrist led ward round. Her alcohol detoxification was progressing, but she continued to experience thoughts of self-harm. Her medication was reviewed and, along with input from the unit psychologist, the therapy team saw her on a daily basis, utilising a trauma-informed care approach. During the second week of her admission, there had been 2 episodes of self-harm on the unit along with suicidal thoughts, she was seen and assessed by the senior trainee in psychiatry under supervision of the consultant psychiatrist and parameters were discussed regarding risk, ongoing management, and consideration regarding use of the Mental Health Act.

The CT in the team was due to present at the trust MRCPsych training programme and, with the patient's permission, presented her case to trainees in psychiatry across the trust. This provided teaching on comorbid mental health and substance misuse issues, including assessment and management. Attending the meetings are other consultant psychiatrists, allowing for discussion and second opinion regarding treatment interventions which were then included within the management plan.

AH successfully completed her detoxification, with no further self harm or suicidal ideation, and was discharged to longer term rehabilitation with a consultant to consultant referral to the local mental health services, who agreed to see and assess her once in rehab.

- Patient in Chapman Barker Unit

7. Provision of training and guidance

Each NHS IPU has a wide range of professionals at different stages of training attached to it including students in medicine, nursing, pharmacy, social work and other disciplines. Junior doctors at all levels and types of training will rotate through an IPU. Students cannot get this medical training in alcohol and substance use detox and rehabilitation anywhere else, meaning that IPUs are the only places in England to be training staff to enter this area of the medical field.

NHS detox services provide advice and training to non-addictions services in relation to the management of addictions issues (such as training GPs and the unit's host Mental Health Trust on the implementation of the latest 'Orange Book' guidance on trauma-focused care in substance use services). Staff from local and distant community agencies will visit the units to learn about their activities and the challenges in managing severely dependent individuals.

The NHS inpatient detox units provide advice to non-addictions services in relation to the management of additions issues. For example, if a patient is admitted to a ward or a Place of Safety out of hours.

The IPUs also support the development of volunteers and experts by experience, some of whom will go on to join the professionals.

vignette

The value of medical and nursing training being undertaken on our units has been illustrated in some of the other cases presented. With specific focus on nurse training students have 12 week placements on the Edward Myers Unit, 1st 2nd and 3rd year students. The unit is utilised as a training area by Keele University however, more recently this has opened up to students from Staffordshire University. In addition there is the opportunity to offer placements with agreement from the Ward Manager from other areas as elective placements. Edward Myers Unit has also proven to be a popular bespoke placement for students who attend for 2 or 3 days from there allocated placement and is utilised by community teams who have students who need to meet learning needs around medication administration.

Nursing students provided the feedback below:

> **"I have enjoyed my placement at the Edward Myers so far, due to learning about both physical and mental health and the link that the two have in addictions. Being able to have the opportunity to have 8 weeks here has allowed for me to gain new skills of taking bloods as well as IV medications. Also, learning about the detox process and drugs used including pabrinex, diazepam and lorazepam. As well as the paperwork side of things including risk assessment."**

> **"Edward Myers offers a lot of learning opportunities. Students have the opportunity to develop skills such as taking bloods, carrying out physical observations, carrying out an assessment for alcohol withdrawal (CIWA), administering medication, carrying out admissions and risk assessments. Other placements I have been to haven't used a CIWA, so this has been a good opportunity for me to develop my skills. It is good to see the effects on physical health and how addiction affects this. It has been a good opportunity to see a person's journey from when they are admitted on to the ward and through their detox and to see how they progress whilst on the ward. There is opportunity to spend 1-1 time with the patients and understand their situations and help them through their detox. Students also have the opportunity of working within a multidisciplinary team. The ward staff are very welcoming and helpful in assisting students to develop their skills and helping us to achieve our learning objectives."**

> **"This placement really helped me to feel empowered and helped to build my confidence massively. I feel had this placement been my final placement then I would have felt very happy to move on and work there. The skills they helped me to build and the confidence and trust that they had in me was very different to any other placement and made me feel prepared and encouraged to qualify next year. I had very little confidence in myself beforehand and didn't feel prepared to qualify in the following year."**

- Provided by Edward Myers Unit

The challenging landscape that Inpatient Detox Units are facing and the unique, medically managed way in which they provide their services is clearly articulated in the Introduction section and Context section of this document.

As a collective of NHS Inpatient Units, we believe that the acute nature of the clinical services we provide to patients who have diverse and complex mental and physical health needs has many similarities with other Tier 4 services that are directly commissioned by NHS England. For example, The NHS England Specification for Specialised Perinatal Mental Health Inpatient Services (Mother and Baby Units) states that patients often present with severe health needs:

> **"which include antenatal and postnatal depression, anxiety disorders including obsessive compulsive disorder and panic disorder, eating disorders, post-traumatic stress disorder, relapse of known severe mental illnesses including schizophrenia, schizoaffective disorder and bipolar affective disorder and postpartum psychosis".**

The specification states that the primary aim of Mother and Baby Units should be to:

> **"Provide appropriate facilities, treatments and interventions to meet the special needs of mothers and their infants including both physical and psychological care"**

The similarities between the mental and physical health needs of these patients as well as the models of clinical interventions delivered in comparison with that of NHS Inpatient Detox Units is striking. The vignettes in section 3 clearly articulate that service users who present to Inpatient Detox Units have at least the same (if not a greater) level of acute physical and mental health needs as the NHS England Commissioned Tier 4 Specialised Perinatal Mental Health Inpatient Units.

We also believe that there are other key similarities in other NHS England Tier 4 specifications such as:

- Veterans' post traumatic stress disorder programme
- Severe obsessive compulsive disorder and body dysmorphic disorder services
- Secure mental health services

The APA and Inpatient Network believe that there would be substantial improvements to patient care planning and interventions if NHS Inpatient Detox Units were to be directly commissioned/funded by NHS England. In particular, it would allow for more integrated pathways of support between other specialised services. It would also ensure that these specialist and essential services are not eroded away under the current localised commissioning arrangements. There is clearly a risk of this happening over the coming months and years, as articulated in section 2.

As such, the primary recommendation from this Outline Business Case is that:

> **The commissioning arrangements for NHS Inpatient Detox Units is changed to allow NHS England to directly commission/ fund all existing NHS Inpatient Detox Units under a single specification in line with similar Tier 4 specialist services identified above.**

This will safeguard the existence of these acute services in the short term and allow a stable foundation from which to ensure that there is sufficient access to this provision across England for the patients.

However, we believe that the current number of, and funding for, Inpatient Detox Units is not sufficient to meet the current, nor the likely future demand for this type of provision. Indeed, we believe there will need to be additional investment in the near future to ensure that there is sufficient coverage of Inpatient Detox provision throughout England and that they are sufficiently resourced and equipped to deliver the highest standards of care. As such, our secondary recommendation is that:

> **NHS England, in partnership with Public Health England and the NHS Addictions Provider Alliance, undertake further reviews of the demand for this provision as well as scoping what a sufficient national model of NHS Inpatient Detox provision could look like, so that it can inform future investment and commissioning decisions in this sector.**

The NHS APA and collective of NHS Inpatient Detox Units firmly believe that the recommendations above are essential in ensuring that patients suffering from acute mental and physical health problems as a result of alcohol and substance misuse:

- Are prevented from dying prematurely
- Experience enhanced quality of life.
- Are helped to recover from episodes of ill health
- Have a positive experience of care
- Are treated and cared for in safe environment which protects them from avoidable harm.

Next steps

The NHS APA and the Inpatient Network have prepared and submitted an application for specialist commissioning via NHSE.