Guidance for Commissioners
on the procurement of Tier 4 Interventions

1. Background and Introduction

The England Substance Use Commissioner Group was established in 2021 and is a peer network run by commissioners for commissioners. A number of sub-groups/work-streams were established based on the Group's agreed priorities, of which Tier 4 provision was one. As a result, the Tier 4 Sub-Group have produced this guide to aid commissioners in either beginning to commission tier 4 services or who are re-commissioning services.

This guidance is not intended to be a full step-by-step guide but more as a list of factors to consider to meet the procurement needs/priorities of your own local authority/consortia. The following guidance is best suited to the procurement of planned admissions, local authorities might want to consider developing a separate process to manage emergency admissions. Local commissioners may wish to produce local operational guidance for their community providers regarding tier 4 provision which will meet their local requirements.

Tier 4 provision for this guidance, is inpatient detoxification, stabilisation and assessment in medically managed and/or monitored facility and residential rehabilitation which may offer a combination of inpatient detoxification, primary, secondary and tertiary care / support.

There are two distinct roles for commissioners in relation to Tier 4 provision, as there are for community and wider provision:

a) As Strategic Systems leads and stewards responsible for the whole of the treatment system, including pathways through and the 'joins' between services, as systems produce outcomes, not services; and
b) As the lead for procurement, purchasing and contracting services

This guidance pertains predominantly to the latter. Remember as a systems lead there is a recognised need for commissioners to stimulate the market towards meeting local needs and not to continue with the practise that may have been delivered for years.

Within your treatment system you will find that potentially more people may require access to inpatient facilities than residential rehabilitation especially if you have good community provision available for aftercare. Remember it is not necessary for all residents to have both inpatient detoxification and residential rehabilitation, and that some residential rehabilitation units undertake medically managed / monitored detoxification themselves lessening the requirement to undertake a separate episode in an inpatient facility – this will depend on assessed need.

2. General

Procurement Arrangements – Options

There are a number of different arrangements which can be used to procure Tier 4 provision. It is up to local authorities to determine what arrangements they may wish to undertake based on local need / demand, local authority procurement regulations and budgets.

2.1 Spot Purchase

Is the purchase of goods or services on an ad-hoc or unplanned basis. Spot purchasing often occurs when there is an immediate requirement and a "purchase" has to be made on short notice.

Advantages	Disadvantages
Flexibility of using providers off a framework which could meet the clients needs	Need to produce a contract and specification for each placement
	Workers will spend lots of time ringing around to source placements and vacancies
	May go over your local authority financial regulations threshold
	Need to check financial viability of the rehab, CQC reports, NDTMS reporting and insurance to ensure that the placement meets local authority standards

2.2 Framework Contract (sometimes called Call-Off Contract)

An agreement between one or more Contracting Authorities and one or more providers which establishes the "framework" for future requirements (Call-Off Contracts) for services.

For example, a local authority can have a framework agreement with 18 different Tier 4 providers; the agreement is not a guarantee for providers that their services will be used but allows for commissioners to call-off/use any provider depending on the suitability of their programme for the individual. Other factors that may affect whether a provider is used is capacity of the provider and location. Commissioners are permitted to use a provider not included in the framework in exceptional circumstances e.g. to procure specialist family Tier 4 provision for a pregnant woman or for a family unit.

Advantages	Disadvantages
Using one procurement process, commissioners are able to secure a	Framework agreements last for a maximum of 4 years, during this time

range of providers to use (no individual contracts)	new providers are not permitted to join it.
Checks on financial viability, insurance and CQC inspections will have already been undertaken	Frameworks can be unappealing to providers as they are not a guarantee of activity
Frameworks can have set prices for the life time of the framework, or break for prices to be renegotiated or a framework whereby each placement is negotiated based on service users needs	If price is set for life time of the contract, providers could inflate their framework price to cover them for rises over the life of the framework

2.3 Dynamic Purchasing System

Similar to a Framework Agreement but it is wholly electronic and, unlike a Framework Agreement, new providers can join the DPS at any time during its validity.

Advantages	**Disadvantages**
New providers can join at frequency agreed with local authority procurement departments	Providers have reported the process can be time consuming and resource intensive
Checks on financial viability, insurance and CQC inspections will have already been undertaken	If providers increase costs, the capped price mechanism can limit the number of providers available to use.

2.4 Block Contract

Some commissioning authorities may wish to tender for block purchasing of beds in particular facilities i.e. inpatient detox unit. Prices will be fixed per night or in some cases for the whole facility, and it will be up to the commissioning agency to ensure that all the bed spaces are utilised.

Advantages	**Disadvantages**
Only one contract to manage for provision	Provision and/or provider may not meet clients needs, without commissioner and referrer engagement
Can increase engagement between Providers and commissioners to co-design and develop provision to better meet local needs	Can create volatility in the market if one local authority block contracts as this may disadvantage neighbouring local authorities residents
Provides guaranteed income for providers, which can improve focus upon quality	
Can deliver economies of scale,	

2.5 Consortia procurement arrangements

Options for procurement should also consider whether to commission as a stand alone local authority or on a more regional/sub-regional basis.

Advantages	Disadvantages
Larger budgets (by pooling budgets), this can be more attractive to providers	Time required to administer and manage Consortia arrangements
Can provide even more economies of scale for commissioning authorities.	Providers may potentially have to manage different local pathways and processes to T4
Less onerous for commissioners and providers (one procurement exercise rather than several)	
Sharing expertise and commissioning resource	

In a consortia arrangement it is normal practice for there to be a Lead Commissioning Authority, so planning for procurement / commissioning resource, or how other authorities may input into the process should be considered. A simple "inter-authority" agreement is a good way of defining roles and responsibilities within the consortia. Whichever approach you choose to suit your own local authority/consortia there a number of factors you will need to consider (due diligence):

Have you got processes in place to ensure:

- Providers are CQC registered
- Providers work to NICE guidance
- Providers are meeting quality standards
- Providers have the correct level of insurance
- Premises and buildings are safe, and compliant with equality legislation
- Providers are managing funding correctly
- Providers are using NDTMS
- Staffing levels and mix are appropriate
- Service users can independently report back to the placing authority on their experience
- Provider policies and procedures are up-to-date and reviewed regularly.
- Providers are learning and changing/improving in response to feedback and unplanned discharges

2.6 Community providers procure tier 4 provision

Commissioners may wish to devolve the responsibility of procuring tier 4 provision to their commissioned community provider. In some cases the commissioner may retain one element and devolve the other element to their community provider. Even if the budget and responsibility has been devolved to the community provider,

commissioners still have a duty of care to ensure that the standards that apply if a commissioner is procuring a placement is in place with the community provider ie: contracts in place, purchasing arrangement agreed which is transparent, quality assurance processes in place; assessments, criteria and decision making for placements is transparent and that the community provider can evidence processes if audited.

Commissioners may want to consider including the monitoring of tier 4 budgets in their contract monitoring processes with community services.

Advantages	**Disadvantages**
Contracts will be in place with community provider and not commissioner	Tier 4 budget may be moved to other community interventions and not spent on tier 4
Can streamline decision making processes if just between community provider and tier 4 provider	Close monitoring of budget, spend and placements will be required by commissioner
	You need to think about how to get the funding back from the community provider if not spent on tier 4 provision.
	How will residents appeal if they were not successful in their application.

Tier 4 Applications/Assessment

Where possible there should be consistent and universal documentation to support the application process (especially in consortia arrangements or if the arrangement sits with the community provider). You might want to develop a "standard" application form, and decisions will need to be made about the type of information that is required in addition to that provided by the person making the application:

- Medical (current and historic if appropriate) including medication
- Mental Health
- Social Care including housing situation
- Offending history (where appropriate)
- What the service users has been undertaking for preparation to prepare themselves for tier 4 provision
- What is going to be in place for aftercare
- Transportation requirements eg how will the service user get to the tier 4 provision is additional funding required for an escort if going on public transport
- Any specific requirements e.g. if someone has mobility issues, requires female only provision or transgender provision
- Family/Carer views and support required (where appropriate)
- Provision required i.e. inpatient detox, stabilisation, assessment and/or rehab; and
- Whether the service user is asked to contribute in the form of a letter or supporting statement.

You may also want to think about who will complete the application/assessment for residential treatment, this could be key workers working in community substance misuse services or social workers with a substance misuse specialism (care managers). This may be governed on where the budget sits e.g., local authority (public health or adult social care) or community service providers.

Decision Making Process

There will need to be some consideration of how decisions about Tier 4 applications are going to be implemented, and who will be involved in that decision making process.

This can be guided by who has responsibility for managing the Tier 4 budget, some local authorities manage the budget via Public Health or Adult Social Care, while others have transferred the budget to community substance misuse service providers. However, the decision-making process should ideally be needs-led and not funding led.

You may want to consider developing a Tier 4 panel, which meets regularly to review applications, this can include commissioners, representation from Adult Social Care, community substance misuse services, the referring agency (if not substance misuse services) e.g. probation, other relevant professionals including clinicians and the service user themselves. Alternatively, you may want to consider community service providers managing the applications, but there should be an agreed, documented process including agreement on how finance records will be maintained.

Another consideration is how you want to manage requests for extensions once someone is already placed in Tier 4 provision. This could include a request from the provider of a report outlining what has been achieved so far and why an extension is required.

Appeal Process

Some local authorities have implemented an appeal process for those applications that are declined. In these instances having a documented decision making process is vital. You will need to consider the documentation needed for an appeal process and how decisions about who has overall responsibility to review appeals will be made.

Where consortia arrangements exist this should be included in the inter-authority agreement.

If you decide to develop an appeal process, the details of how appeals are managed should be made available to all applicants.

Criteria for Tier 4 Provision

Commissioning authorities, regardless of whether they are commissioners or commissioned community providers, should have a criteria for applications to any tier 4 provision. This will support the appeal process, should you wish to develop one, and also supports key workers in having discussions with service users about

tier 4 options and managing expectations. How broad or narrow you make your criteria is a local decision to make but some things you may want to think about are:

- History of treatment – residential and/or community provision
- History of detoxes – community and/or inpatient/ residential provision including hospital and private detoxes
- Current engagement with community substance misuse services (although you may want to be flexible on this for certain individuals e.g. rough sleepers who may have had sporadic engagement with services)
- Does the service user have any personal care needs (this may reduce the opportunity for different aspects of tier 4 provision)
- Does your area accept people to go to rehab who are abstinent ie people who have been in prison for a long time?
- Does your area allow people who have outstanding court cases to go to rehab? (this may be costly if they have to have volunteers to escort them from the rehab to court daily with overnight costs and/or disruptive for other residents if someone is in court all week)
- Whether full or partial detoxes will be considered e.g. someone may require an alcohol detox but still wishes to remain on opiate substitute medication.
- Expectation that individuals will engage in preparation sessions either one-to-one or in groups.

Planning and preparation for Admission to Tier 4 provision

Thought should be given to how the admission and planning process will be implemented. A few factors to consider are:

- If there is a waiting list, engagement with current community substance services should continue, consideration should be given if engagement should increase whilst they are waiting.
- Contingency plans if a placement breaks down - You might want to consider asking providers to agree to a loop system, whereby if a placement breaks down, the individual can be transferred to another appropriate provider almost immediately to ensure a seamless treatment episode and/or who should the service user contact when they return back to the local authority area. You also need to consider who and how are the commissioning agency going to fund travel /purchase a ticket home or to another residential provider if appropriate and also what community provision will be available in the local area if the individuals returns early whether they are abstinent or need prescribing.
- Aftercare planning - what support from community provider(s) will be available to the service user on successful completion of tier 4 provision? Who will be responsible for contacting the individual on their return? Who will support with establishing new social networks etc?. Remember the tier 4 provider and service user should have a copy of the aftercare plan before admission
- Does the individual have appropriate accommodation to return to? If not what action needs to be taken prior to admission? Do you need someone to go in before the individual returns to clean up the accommodation ie friend, relative

or peer? Or will you arrange for this to be done before admission with the individual?

- Do family members/carers need support whilst the individual is in residential treatment and on their return?
- How frequently will reviews take place whilst the individual is in tier 4 treatment and who is responsible for conducting the reviews?. Regular contact should be maintained and plans kept under review.
- Who will arrange the transport to and from the tier 4 provider(s)?
- Does the individual need to be escorted to the tier 4 provider? Peer support can be an effective resource to support people on their journey to their placement?
- How will pets be cared for whilst the person is in tier 4 treatment? And who will fund any kennels/catteries etc?
- How will contact with family members/carers and/or children be managed?
- Does additional provision need to be organised for children whilst the parent is in tier 4 provision?
- Will visits be permitted?

To give individuals the best chance of tier 4 treatment being successful there needs to be an element of preparation especially if this is their first experience. Individuals should be made aware of:

- In residential rehabilitation the requirement to undertake therapeutic duties as part of their treatment e.g. cooking, cleaning communal areas.
- That they may have to share a bedroom and/or bathroom and that they will need to keep these clean and tidy.
- The requirement to attend group therapy daily as well as one to one key working sessions.
- Boundaries and regulations that they will be expected to adhere to, and the possible consequences if they don't.
- May be required to attend mutual aid meetings in the evenings and at weekends.
- They will have limited access to their mobile phone.
- They may be limited access to receive visitors.
- In inpatient facilities they will not be able to leave the facility until their detoxification has been completed and they are discharged.
- In residential rehabilitation they will only be able to leave the treatment centre after they have been there after a certain period of time for leisure activities and usually not on their own.

Individuals may have a number of concerns about what will happen while they are away, so consideration should be given to:

- How are bills going to be paid?
- Do they have enough credit on their phone for the duration of their admission?
- Does the individual have enough permitted medication to last for the entire length of the placement?
- How will the individual receive benefits?

- Does the individual have enough medication to last the admission, if they are prescribed medication for other ailments?
- Do they need to open a bank account?
- What are the smoking policies of the provider? Will they need to consider nicotine replacement?
- What toiletries do they need to take?
- Will dietary requirements be met?

Funding, Payment and Client Contribution

Tier 4 providers calculate their charges in varying ways. Some offer an all-inclusive weekly price, some offer a nightly rate. Others may make a separate charge for activities and services considered to fall outside the scope of their regular charge. However providers calculate charges you will need to agree terms with them including:

- Will payment be made in arrears at the end of each month or in advance? You may wish to check your local authority financial regulations about payments before placing this within the contract / service specification.
- If in advance you will need to agree a recharge mechanism if a placement ends earlier than expected? How will payment be calculated for an unplanned exit, up until day of discharge or day after?
- If client dies does payment cover the period until personal effects removed, end of week or 24 hours after death?

You will also need to decide whether financial assessments of those applying for residential rehabilitation provision will be completed to calculate how much contribution they could make towards the cost of the placement. Most local authorities have teams who can undertake financial assessments, and this part of the process should be explained to service users wishing to apply for residential rehabilitation. However, in recent years some local authorities have moved away from calculating and collecting client contribution and fund the entire cost of the placement. If you decide to apply client contribution you will also need to agree how that is collected by whom and how is the provider going to be contacted for the amount to be collected? When this has been decided, make sure that the commissioning agency has placed this into the Contract with the provider.

Client contributions should not be requested for individuals going into inpatient detoxification / stabilisation / assessment provision whether they are standalone or part of a residential rehabilitation provider.

3. Inpatient Facilities

Inpatient facilities can offer a variety of interventions around medical provision. Not all inpatient facilities will offer the full range of medical interventions. Medical interventions can consist of

- Medically supervised assessment (including psychiatrist overview of prescribing)
- Medically supervised stabilisation of prescribed medication;

- Medically supervised detoxification (detox) from a variety of substance

Some facilities may also offer:

- Psychosocial interventions, including motivational and treatment engagement tools
- Physical and mental-health screening; and
- Advice and information for carers and family members.

The length of stay at any inpatient facility will be determined by the tier 4 provider after the assessment. This usually ranges from 7-21 days, although in some cases, where there are also complex health issues or poly drug use this can be as long as 45 days.

There are different types of facility available. Some tier 4 units are linked to and/or in the grounds of acute hospital trusts, some are provided by third sector organisations, some are linked to rehab provision, and some are stand alone.

Most inpatient providers will offer a range of detox types including primary alcohol, primary drug, poly drug, drug & alcohol combined, and stabilisation. Some detox providers can offer specific drug detoxes such as GHB/GBL detoxes. Each provider should provide copies of their detox regimes as part of any quality assurance checks you wish to carry out.

Currently, there are two ways in which inpatient detox can take place:

Medically managed (CQC registered) – there is 24-hour, medically directed evaluation, care and treatment of substance misuse disorders on site. Staffing model may include psychiatrist input into complex medication regimes in addition to specialist substance misuse RGN / RMNs. Doctors will have the ability to diagnose, assess, plan and deliver support, care and medical treatments to individuals with the most severe and complex diagnoses and needs. This includes the assessment and management of their risks, and the effective and safe provision for any complex prescribing needs, and polypharmacy. Alongside this, staff have a role in the providing safe and effective choice of highly specialised psychosocial interventions or suitable interventions for those with severe and complex needs. Medically managed treatment should be offered to those with severe substance misuse disorders/ complex needs.

Medically monitored (CQC registered) – enough medical supervision is provided by a visiting GP/other doctor, who is appropriately trained (e.g. RCGP parts 1+2) with sufficient knowledge of and competence in the management of addiction problems. The facility may have a non-medical prescriber (NMP), 24 hour nursing or suitably competent HCAs in addition to qualified recovery workers, and volunteers with lived experience. Medically monitored treatment is likely to be the model in residential rehabilitation settings, but some may offer medically managed treatment.

Services should not accept referrals of people whose needs they are not competent to meet.

Towards the end of the placement, regardless of the intervention delivered, there will need to be a process for joint discharge planning between the detox provider and the community substance misuse service. You might want to consider who takes responsibility for leading this process and also to ensure that the discharge plan is co-produced with the service user.

There is a need for commissioners, as system stewards, to facilitate increased understanding and awareness of these differences with community providers staff and assure themselves of correct utilisation of interventions with their residents.

The main reasons that placements fail is due to lack of preparation with the individual. Individuals need to be aware of what they will be going through, what potentially detoxification drugs may be used and what their aftercare plan should be. Individuals should be also made aware that the success of individuals just having a detox is low and that psychosocial support before and after admission is advised. If you have access to a virtual tour of a facility, it is good to show the individual and their family members this before admission to allay fears.

In the case of individuals accessing an inpatient facility for stabilisation and / or assessment, the community prescribing provider and Inpatient facility should liaise before admission to agree a clinical plan, potential length of stay and communication regarding any changes that may need to be made during the individuals stay.

4. Residential Rehabilitation

Residential rehabilitation (rehab) describes a drug and/or alcohol treatment programme that is provided in a residential setting with psychosocial interventions. Rehabs are usually abstinence-based and provide an intense programme of support and care aimed at people who have difficulty becoming drug free in the community.

They are provided as either traditional rehabilitation models or newer, more locally-based models.

Traditional models of rehab often involve the person having a complete break from their current circumstances and staying at a centre that is away from their home and drug/alcohol-using environment.

Newer models of residential treatment are emerging across the country, which include supported housing provision linked to structured treatment and other local services. This is sometimes called quasi residential rehabilitation or community rehabilitation programmes.

Some rehabs provide residential treatment in ‘stages’. Although this is not universally the case, ‘stages’ of rehab can broadly be described as:

- Primary: First stage usually corresponds the initial stages (up to 12 weeks) of long-stay rehabilitative programmes, focusing on intensive therapeutic interventions and the immediate responses to becoming drug and/or alcohol free. In some cases these can have medically managed or medical monitored detoxification as part of the first stage package.

- Secondary: Second stage usually corresponds to the later stages (more than 12 weeks) of long-stay rehabilitative programmes, focusing on the development of life skills, reintegration through education, training or employment-focused needs; the skills required to sustain a drug and/or alcohol-free lifestyle while still receiving intensive support from the programme. Not all individuals entering into rehab will require second stage interventions. In a lot of cases this can be delivered back in their home authority by community provision.

- Tertiary: Third stage is offered by some organisations and usually corresponds to independent living and supported housing with some support and mentoring maintained with the main rehab. Again not all individuals will require this additional support after rehab and this can be delivered by community providers.

Rehab placements for Stage 1 usually last 6 – 12 weeks. Funding for the next stage(s) may need to be agreed. You may want to consider how funding for subsequent stages will be agreed, who will be involved in the decision making process, what information you need to agree subsequent stages.

Rehab 'Philosophies' and Approaches
There are 6 main philosophies or approaches provided by traditional model rehabs. These philosophies will influence how the programme is run, although increasingly services combine different elements of the philosophies to meet individual client needs.

In identifying the suitable service, it is important to match a client's understanding of their drug and/or alcohol misuse to the rehab's approach to treatment and particular philosophy:

<u>12 Step</u>

- This is an increasingly broad term stemming from the 12 steps of the Minnesota Model and is associated with the approaches of Narcotics/Alcoholics Anonymous (NA/AA). Addiction is viewed as a disease and residents usually work their way through the 12 steps as part of a planned programme of recovery. The model is increasingly being modified and adapted to allow greater flexibility and individual care planning, and services may refer to their programmes as modified 12-Step or modified Minnesota model.

Therapeutic Community

- In a therapeutic community, staff and clients participate together as members of a social and learning community. The service may have a hierarchical structure which residents work through and in which each stage has a different pattern of activity, together with growing freedom and responsibilities. Time will be spent in therapeutic group work, one-to-one keywork sessions, developing practical skills and interests, education and training. Like 12-Step programmes, therapeutic community models have been adapted over the years and made shorter and more flexible. The intensive nature of their approach to individual psychology still means that they tend to be among the longer programmes (6 – 12 months)

Christian Philosophy/Faith-Based

- Faith-based services have religious staff and may or may not require residents to share their faith or participate in faith-related activities. These activities will include; time studying religious texts and the lessons to be learned from them, in discussion and in prayer.

Eclectic/Integrated

- These are programmes which do not adhere to a particular philosophy and use a range of different methods and interventions focused on meeting the needs of individual residents.

Cognitive-Behavioural Therapy (CBT) And Social Learning

- These are programmes that include psychological treatments such as CBT, in which actions are believed to influence future behaviour.

Personal And Skills Development

- The programme in a service operating a personal or skills development model may focus less on psychological therapeutic interventions and more on the practical skills and knowledge needed to get by in the wider community. They may be closely linked with local education or employment training providers and residents will spend much of their time in structured programmes of educational classes, training activities and group work.

Some rehab providers offer detoxification programmes, the advantage of this model is less travelling for the individual and a seamless transition from detox to rehab.

When making commissioning decisions about the types of rehabs you want to procure, or you wish your community provider to procure, it's worth considering other types of "specialist" provision to ensure you have a broad range of options, for example, female only, male only, complex needs, co-existing mental health and substance misuse needs.

Most rehab providers will offer similar types of interventions despite their philosophies, approach, or specialism. Largely this will include psychosocial groups and one-to-ones, key working, access to mutual aid (especially in the evenings and at weekends), living skills, support around education, training or employment needs and preparation for moving back into the community. Residents will also be required to undertake therapeutic duties e.g. cooking, cleaning communal areas.

Towards the end of the placement there will need to be a process for joint discharge planning between the rehab provider and the community substance misuse service. You might want to consider who takes responsibility for leading this process and also to ensure that the discharge plan is co-produced with the service user.

5. Service Specification

Regardless of whether the Commissioner or the commissioned community provider is procuring tier 4 provision, a contract and service specification should be in place with each provision used if utilising public funding. Factors to think about when producing a service specification / contract are:

Commissioners Obligations
Providers Obligations
The role of the Providers Representative
Provider's Staff – training, qualifications, supervision
Assessment Process
Individual Service Take Up/Entry to treatment
Temporary Absence from the Treatment Centre
Discharge process from the facility – successful and unsuccessful
Transportation – to and from the facility
Monitoring Performance and Quality
Safeguarding Children and Vulnerable Adults
Quality Assurance and standards
Complaints
Emergency Closure of Provider's premises
Death of a Service User and reporting requirements related to this
Payment Arrangements
Service Users Personal Allowance
Resolution of Disputes
Contract Termination
Standard contract terms and conditions
Service Standards

6. Contract Monitoring

Like all contracts you or the commissioning agency will need to develop ways in which to monitor the contract/performance of each residential provider commissioned. Simple outcomes like successful completions, unplanned exits etc can be determined from NDTMS. However, you may want to consider focussing on the quality of provision rather than numbers? Some useful guidance was developed in 2011 "Residential Rehabilitation Quality Standards Framework" which is included as an appendix to this guide that might be a good starting point.

Other factors to consider:

- How frequent will performance/quality monitoring information be requested from providers?
- If in a consortium, how will this be shared with all commissioning authorities?

- Can case studies be requested for residents from your local authority?
- Can an annual audit of placements be conducted at the end of the financial year by the commissioning authority?
- Are NICE guidelines being adhered to?
- Are policies and procedures including detox regimes up-to-date and have appropriate review cycles?

7. References

Further information on standards within residential rehabilitation and inpatient facilities are available within:

Drug misuse and dependence; UK guidelines on clinical management 2017

Brief_guide_SMS_Detoxificatoin_and_withdrawal_from_drugs_and_alcohol.pdf (cqc.org.uk)

Monitoring questions for residential and community substance misuse services - Care Quality Commission (cqc.org.uk)

Exchange Supplies Rehab Handbook

NTA residential-drug-treatment-services-good-practice-in-the-field

NTA national-needs-assessment-for-tier-4-drugs-services-in-england