2026

CollectiveVoice

The National Alliance of Drug and Alcohol Treatment and Recovery Charities

# Improving access and outcomes in residential treatment:

## A PRACTICAL GUIDE FOR COMMISSIONERS AND LOCAL PROVIDERS

# Contents

## How to improve the accessibility and outcomes of residential treatment as part of a local substance use treatment and recovery system: A guide for commissioners and community treatment providers.

## SUMMARY

Residential rehabilitation should be an integral – and accessible – part of the menu of options available to people seeking treatment for their substance use. It is evidence-based and cost-effective, and treatment providers have shown themselves to be flexible and innovative in responding to emerging challenges such as an increasing proportion of people presenting with co-occurring conditions, and the physical health harm of chronic ketamine use.

In Dame Carol Black's independent review of drugs, published in 2021, she concluded that changes were required to ensure the accessibility and sustainability of residential treatment, asking the Department of Health and Social Care (DHSC) to conduct a review of the approach to this specific treatment option.

At the time of writing, the situation remains critical. Too few people are currently able to access residential treatment, and the present approach to funding, commissioning and referring people to residential rehab has put the long-term sustainability of treatment centres at risk.

However, we are optimistic that we can work together with Government and the full range of delivery partners to develop a more sustainable approach and ensure that people can continue to benefit from residential treatment.

This doesn't just mean asking for system or policy change; we can and must do better within the current system.

This paper therefore outlines the evidence for making use of residential treatment options, before identifying key steps that local commissioners and community treatment providers can take to improve the accessibility and outcomes of residential treatment in their own area.

## SUMMARY CONTINUED

**Our observations and suggestions are as follows:**

1. Aim to fund rehab places without asking for client contributions
2. Avoid panel processes that create barriers or delays
3. Referral and preparation processes for rehab should not require clients to prove motivation
4. Ensure people are able to access rehab multiple times if required
5. Ensure clients and staff are aware of rehab as a genuine option throughout a treatment journey and staff are able to respond in a timely way
6. Ensure communication and payment around cancellations reflects the time and cost this poses to the residential provider
7. Ensure there are clear, accessible pathways into detox and from detox to rehab
8. Ensure length of stay is in line with evidence and good practice guidance
9. Involve residential providers in local systems, including workforce development initiatives
10. Ensure there are specific pathways tailored to key referral routes, including people leaving prison, those who are rough sleeping or homeless, and people in hospital

Commissioners and community treatment providers can play a key role by ensuring that residential treatment is prioritised and sufficiently resourced, with clear pathways to ensure accessibility.

Collective Voice and its members continue to work closely with the English Substance Use Commissioners Group and would welcome the opportunity to collaborate with individual local commissioners directly to support them in this work. We hope this guide will be a key step in working together across the field to do better for the people we serve, helping more people secure recovery.

# 1

## INTRODUCTION

The Collective Voice Tier 4 Forum have sought feedback and information from across a range of providers to inform this paper on residential treatment. We hope to share this with commissioners and other relevant organisations and individuals with the aim of working together to make the system better for those requiring our services.

Residential rehabilitation is a treatment option that is recommended by the National Institute for Health and Care Excellence (NICE) and regulated by the Care Quality Commission (CQC) and referenced in the clinical guidelines for drug misuse and dependence as well as alcohol treatment.[1] Residential rehabilitation services have been operating for over 50 years in the UK, and providers have many decades of experience. Evidence shows that residential treatment can be a positive option for a range of people, at a range of stages in their treatment journey, and should not just be considered as a 'last resort' option.

However, we have serious concerns that residential services will become unsustainable under current funding and procurement arrangements, which would mean that people would not be able to access a key treatment option that might help them change their lives. And if we don't act now, access will only get worse.

In 2021 Dame Carol Black wrote a report that outlined the challenges in the substance use treatment and recovery field – saying that services were 'on their knees' – and set out a series of recommendations to put the sector back on its feet.[2] The previous Government's drugs strategy, published in 2021, accepted almost all of these recommendations, and injected new investment into the field. However, little of this funding has reached residential services.

1 Clinical guidelines for alcohol treatment - 14. Residential treatment and intensive structured day programmes - Guidance - GOV.UK

https://assets.publishing.service.gov.uk/media/5a821e3340f0b62305b92945/clinical_guidelines_2017.pdf

2 https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

# 1

The current responsible Minister, Ashley Dalton, has recently restated the commitment of the Government: "The Department set an ambition that 2% of the drug and alcohol treatment population should be accessing residential treatment. We remain committed to this ambition and continue to work with the sector to achieve this."[3] We are still a long way from reaching this level.

There can be a perception that residential treatment, rather than being a crucial part of the treatment system, is something of a luxury. There is no reliable income stream for providers, and a lack of dedicated investment in capital and workforce, as funders face pressures to focus on the short term – or even individual placements – rather than building for the future.

Residential rehab units are not spread according to need across the country, and there is a lack of specialist provision that caters for some of the most vulnerable in our society, such as adolescents, families and women escaping intimate partner abuse, all as a result of underfunding and a lack of coordination and planning in this area over many years.

This isn't a question of quality; inspections and outcomes show that the residential provision we do have is performing well despite these challenges. But the options are limited, with some areas of the country and particular groups of people lacking appropriate or accessible provision.

There are also other barriers to people accessing rehab through local treatment systems. Relevant staff are not always well-informed about what residential treatment entails, or how to access it. Local systems sometimes ask clients to demonstrate motivation in ways that end up limiting access to treatment. Some areas require clients to attend or write to panels to assess their suitability to access rehab.

[3] Minister Ashley Dalton, 18 November 2025, https://questions-statements.parliament.uk/written-questions/detail/2025-11-10/88618/

# 1

Given the variation in how residential services are commissioned and utilised across different local authorities, we have developed this guide to help commissioners and practitioners make the most effective use of this essential treatment option, drawing directly from residential and community providers and feedback from people who have been through treatment themselves. We begin by outlining the evidence for residential treatment options, before identifying how access to and outcomes from these services can be improved within the current system.

Many of the barriers we describe in this guide originate in the systems that we have created or maintained as a field – meaning they are within our collective power to change. Commissioners can play a key role in this by ensuring that residential treatment is prioritised and sufficiently resourced, with clear pathways to ensure accessibility – and service providers have a responsibility to help deliver this vision in practice. We hope this guide supports continued collaboration across the sector, improves outcomes for the people we serve, and helps more individuals access recovery.

# 2

## RESIDENTIAL TREATMENT WORKS

Residential support is an established and effective treatment option for a wide range of individuals. Its value is recognised within NICE guidance, referenced in the new 'Orange Book' of clinical guidelines on 'drug misuse and dependence', as well as the Alcohol Clinical Guidelines, and supported by multiple studies.

Residential settings may be particularly effective for people with multiple needs. In community settings, it can sometimes be challenging to access several interventions in a timely manner or to sequence them effectively.

Residential treatment should therefore not be viewed in opposition to community-based care. Evidence and national guidance make clear that both are essential components of a comprehensive treatment system – one that can meet the full spectrum of needs among people seeking help for substance use.

**TESTIMONY FROM BAC O'CONNOR CLIENTS:**

*I was very scared about going into rehab but it was the best thing I have ever done. Now I have my family back and proud of me. I have now got my own place with my eldest daughter moving in with me. I now see all of my kids for four years I didn't see them at all.*

*The programme has been amazing couldn't say a bad word about therapy, the staff are all really good at supporting and their day to day duties, the structure in the house has been amazing the routine has really give me confidence in looking after myself in the future, I feel I can transfer the structure to college and day to day life. My self-worth is really high and the work I've done on myself is priceless.*

# 3

## RESIDENTIAL TREATMENT IS FLEXIBLE AND RESPONSIVE, MEETING EMERGING CHALLENGES

The substances available and patterns of use and harm are continually evolving – arguably faster than ever before, and with greater risks, as we have seen the growth of online drugs markets and new synthetic substances. This means that treatment must be responsive to the new harm and needs of potential clients.

Given their model of intensive, wraparound support, residential services are well-placed to respond to these emerging challenges and have led the way in responding to issues such as the rising use of ketamine.

Ketamine use has increased considerably in recent years, especially amongst young people, with 6.5% of those aged 18-24 in 2025 reporting they had ever used it compared to just 3.4% in 2017.[4] This can bring with it increasingly complex physical and mental health issues, with associated support needs, as Collective Voice and Choices have discussed elsewhere.[5] Residential services have experience of supporting individuals with their ketamine use and adapting their services to this growing issue, as shown by the case study below, which details just one example of the tailored support residential services can offer as well as supporting individuals for other non-opiate substance use, as shown by the case study below, which details just one example of the tailored support residential services can offer.

4 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/drugmisuseinenglandandwalesappendixtable]

5 **"Choices Rehabs Respond to Surge in Ketamine-Related Admissions with Innovative Care Adaptations", November 2025, available from** https://choicesrehabs.com/media/

https://www.collectivevoice.org.uk/blog/ketamine-current-challenges-successes-and-next-steps-for-treatment/

# 3

**PHOENIX FUTURES CASE STUDY**

*Nicole is a mum to 1 year old daughter. She was taking ketamine daily anally. She had physical health needs including an anal prolapse and incontinence. She was wearing pads continuously which her GP refused to prescribe as it was not a 'medical' cause and a specialist had agreed. She was struggling to pay for these. She was told surgery on her bladder would not be considered until she was abstinent. Following an inpatient detox she arrived at the Phoenix National Family Service with her daughter.*

**SERVICE ADAPTATIONS AND SUPPORT**

- Funded the pads and continuously advocated for prescribing of these
- Highlighted discrepancy in prescribing approaches across local authorities which meant disruption to continuation of medication
- Supported daily phone calls and advocated for the surgery she required and was able to get her the operation during her residential stay
- Planned activities from shop runs to days out meticulously ensuring access to toilets discreetly, so she did not feel excluded or that she was causing disruption
- Increased flexibility around urine testing and switched to oral tests accordingly
- Safely adapted medication times to respond to pain needs
- Worked specifically on behaviours that were to avoid/ minimise the need for the toilet but directly impacted on health and nutrition

# 4

## RESIDENTIAL TREATMENT IS COST EFFECTIVE

Every £1 spent on drug and alcohol treatment saves £4 in costs to society.[6] Research from the Department of Work and Pensions suggested that people who had a residential element to their treatment had higher rates of positive outcomes than those who only received support in community-based services. This difference was particularly marked for people who started treatment facing the greatest challenges, who had rates of positive outcomes around three times that of similar people on community pathways.[7]

We recognise that funders may sometimes feel cautious about committing to a full residential rehabilitation placement; however, investing in effective rehab delivers far greater value – both clinically and financially – than continuing with interventions that are failing to achieve meaningful change. For example, Hard Edges calculated that severe and multiple disadvantage - including substance use issues - creates costs for public services, averaging a total of £250,000 per person for the time they are living with these issues.[8] By contrast, one set of estimates suggests that a year in residential treatment offers a net saving of around £44,000.[9]

6 https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

7 Department for Work & Pensions (2015) "Understanding the costs and savings to public services of different treatment pathways for clients dependent on opiates", available from https://assets.publishing.service.gov.uk/media/5a7dee3de5274a2e87dae71c/treatment-pathways-ad-hoc-report-17.pdf (accessed 29/01/2026)

8 https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

9 https://www.anatreatmentcentres.com/wp-content/uploads/2021/10/DDN-October2021-RJCosts-article3.pdf

# 5

## HOW TO IMPROVE ACCESS AND OUTCOMES IN THE CURRENT SYSTEM

We know that the current approach to funding and commissioning residential treatment is not working. In Dame Carol Black's independent review, she identified that change was required to ensure the accessibility and sustainability of residential treatment, and included a specific recommendation stating that there should be a review of high-cost low-volume services such as residential treatment, and "DHSC should introduce a regional or sub-regional approach to commissioning these services to ensure national coverage."

While DHSC has published self-assessment guidance for local areas to review their approach to residential treatment,[10] and this holds great potential to improve local access to residential treatment, we believe that Dame Carol's recommendation still applies: there should be regional or sub-regional commissioning of residential treatment, and the Government should take a lead in providing the structure and impetus for this to be developed.

However, we cannot only wait for national policy change; we can do better within the current system. This section of the paper outlines key steps that local commissioners and service providers can take to improve the accessibility and outcomes of residential treatment in their own area. The remainder of this paper therefore focuses on practical steps that individual local areas can take right now, and we encourage local authorities and providers of community and residential services to work together to implement these recommendations.

10 https://www.gov.uk/government/publications/residential-drug-and-alcohol-treatment-self-assessment-toolkit/residential-drug-and-alcohol-treatment-self-assessment-guidance

# 5

Our recommendations are designed to be complementary to the self-assessment and guidance provided by DHSC. For example, that guide includes statements such as "Community treatment staff [should] discuss the option of residential treatment with people entering treatment and also regularly discuss it throughout a person's treatment journey," which echoes one of our recommendations here. However, we perhaps go into more detail on how exactly funders and providers should approach key issues such as referrals, length of stay and client contributions.

There are also further steps that commissioners can take in collaboration with providers and each other. They could themselves move towards more regional and sub-regional procurement arrangements, and work to develop a more consistent approach, perhaps even agreeing a national specification for residential treatment. Certainly, we would encourage coordinating and harmonising referral and assessment protocols to ensure fairness and efficiency across the country. Collective Voice and its members continue to work closely with the English Substance Use Commissioners Group (ESUCG) and would welcome the opportunity to collaborate with commissioners directly to support them in this work.

## 5.1 AIM TO FUND REHAB PLACES WITHOUT ASKING FOR CLIENT CONTRIBUTIONS

Sometimes clients are asked to contribute financially to the costs of their stay in rehab. Clients do not generally contribute to other forms of substance use treatment, so this feels inequitable and unhelpful to set apart residential settings as somehow exceptional.

Asking for client contributions can discourage people from accessing residential rehab, and if they have to use their benefits they risk losing their accommodation, which could then disrupt the stability in their wider life, which is not conducive to building recovery.

There is also significant administration involved in collecting and monitoring these contributions, which may outweigh the value of the money received. This makes the requirement seem more like a moral expectation – that clients should prove their commitment to treatment by paying – though it is unclear why this applies only to residential rehab and not to other interventions.

This approach also seems at odds with the evidence on contingency management, which takes the opposite approach, rewarding someone for engaging in treatment rather than imposing a financial penalty on them.[11]

Where client contributions are requested, issues with communication and consistency can pose further challenges. An unclear explanation of the amount of or reason for contributions can cause clients to disengage during or prior to treatment. Inconsistencies between local authority contribution policies can also cause friction between rehab residents whose places may be funded differently.

We know that in some cases requiring client contributions may be part of an agreement a commissioner makes with a local authority social care department: accessing social care funding means participating in a system that is structured around people contributing to their own care at the point of use, unlike general healthcare in England. However, the price of this agreement is not only the cash the client pays, but the damage done to the wider system in terms of access and equity. We therefore recommend that local authorities do not ask for client contributions for stays in residential rehab.

### 5.2 AVOID PANEL PROCESSES THAT CREATE BARRIERS OR DELAYS

Some areas ask clients and staff to submit applications for residential rehab to a panel. This approach is not taken for other forms of substance use treatment, such as prescribing medication or referring someone to a specific group or form of talking therapy. Instead, such decisions are generally left to the professional judgement either of an individual keyworker or a multi-disciplinary team meeting (MDT).

Panel processes are often viewed as barriers by both clients and professionals, potentially discouraging referrals to residential rehabilitation. For clients, panels can feel intimidating, requiring them to justify their readiness for treatment, which may deter them from pursuing rehab. These processes can also introduce avoidable delays and uncertainty, conflicting with best practice that prioritises timely engagement and capitalises on reachable and teachable moments.

11 https://www.nice.org.uk/guidance/CG51/chapter/appendix-contingency-management-key-elements-in-the-delivery-of-a-programme

5

Not all panels produce the same level of barriers – some areas have refined referral processes to commissioners' panels to ensure that there is a better chance of referrals being approved. However, in general, panels are not a supportive or effective method to assess whether a person is suitable for rehab. Other mechanisms, including working closely with a person's keyworker, may be more appropriate.

This is in line with the latest guidance from the Department of Health and Social Care, which states in the recently published alcohol treatment clinical guidelines that there should be 'no unnecessary delays' in someone's route to rehab.

> Staffordshire does not have a residential rehabilitation panel. Workers refer directly to BAC O'Connor and then a weekly MDT with all partners in the STaRS service is held to discuss people on the residential rehab list to manage risk, changing priorities, and ensure bloods and GP info is gathered. The two LEROs in the system, alongside the community keyworkers, continue to support people on the list whilst all relevant information is gathered for assessment and admission.

### 5.3 REFERRAL AND PREPARATION PROCESSES FOR REHAB SHOULD NOT REQUIRE CLIENTS TO PROVE MOTIVATION

Many clients describe being at 'rock bottom' before coming to residential services. Despite this, high levels of motivation are often expected through an arduous and unfamiliar process to secure funding. Some areas ask that individuals prove their motivation – for example by attending a series of group workshops – to demonstrate that their residential placement will be a worthwhile investment.

Motivation is much misunderstood when it comes to rehab. What rehab providers are looking for when someone comes to treatment is that they've taken the time to reflect on why they want to access rehab and they've thought about how this specific service and approach will meet their needs and aims.

This is different from expecting people to 'prove' they really want or deserve rehab, which is how referral processes and preparation work can sometimes feel. A ‘prove you’re worth it’ approach is something we do not apply anywhere else in behaviour change work. There is no evidence that ‘prove you’re worth it’ approaches work, but there are a number of evidence-based tools to identify and encourage motivation, such as motivational interviewing.

Residential rehab programmes are specifically designed to engage and support people who may be unfamiliar with the setting, or alternatively who have experienced treatment – and relapse – before. So, while information should be provided on what rehab looks like and people should understand and be prepared for their stay, there should be no blanket requirement to attend specific preparation work or demonstrate motivation prior to entering residential treatment. Again, the alcohol clinical guidelines are a useful source of information and advice on how to think about motivation and preparation. They state: “There should be no standard requirements that everyone attends a set number of groups or appointments before accessing intensive structured treatment, because these requirements can create barriers to accessing treatment.”

### 5.4 ENSURE PEOPLE ARE ABLE TO ACCESS REHAB MULTIPLE TIMES IF REQUIRED

Some local authorities have been less inclined to fund rehab for people who have had a residential placement before but didn't complete it. If people have already tried rehab once, they can sometimes be made to ‘prove’ themselves even more to be considered ‘worthy’ of another chance.

This approach would not be tolerated in other areas of health and social care. As Dame Carol Black’s landmark review emphasised in 2021, substance use issues can be characterised as a chronic, relapsing condition. It is therefore understandable that repeated episodes of treatment are often required before someone sustains recovery. The average number of recovery attempts for people with a drug or alcohol problem is between two (median average) and five (mean average).[12] It is illogical and unfair to penalise people for displaying the symptoms of the condition they are actively seeking support to address.

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6602820/

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## 5.5 ENSURE CLIENTS AND STAFF ARE AWARE OF REHAB AS A GENUINE OPTION THROUGHOUT A TREATMENT JOURNEY AND STAFF ARE ABLE TO RESPOND IN A TIMELY WAY

Many people who have been through treatment state they were either not told residential rehabilitation was an option or found the process difficult, with the discussion seeming to focus primarily on the accessibility of funding, rather than the best treatment option for their needs at the time.

Residential treatment should be considered regularly throughout someone's treatment journey. It should be outlined from the beginning as an available option and then borne in mind by both client and practitioner as progress and options are reviewed. Keyworkers are generally very aware of their clients' needs and wishes and should be empowered to assess whether rehab is a suitable option for their client and to advocate for them. Keyworkers therefore need a good understanding of local processes for rehab referrals and should feel they can play a central role in this process.

When there are discussions about residential treatment, it is essential that this is timely and approached with a sense of urgency. Systems should be able to provide the right intervention at the right time, to make the most of teachable / reachable moments. Unfortunately, staff workloads can delay people's entry to rehab if the necessary documentation, such as GP summaries and blood tests, isn't organised and shared on time. Bureaucratic delays can cause clients to miss critical moments of readiness for treatment. If decisions take a long time, and someone stops engaging with the process, service or local authority, they may not be considered for rehab or their funding may be withheld.

In Stoke, BAC O'Connor are part of the Community Drug and Alcohol Service (CDAS), and all CDAS staff spend a day at the residential rehab to ensure they are aware of the service and how to refer people in. This allows them to talk with knowledge and insight to their clients in 1:1 sessions.

Staffordshire StaRs (MPFT) have BAC O Connor detox and rehab facility in the partnership contract so all workers offer both detox and rehab, in a welcome group and also when people telephone the service asking for support.

### 5.6 ENSURE COMMUNICATION AND PAYMENT AROUND CANCELLATIONS REFLECTS THE TIME AND COST THIS POSES TO THE RESIDENTIAL PROVIDER

Cancellations, particularly those made last-minute, can be an additional pressure on residential services. A vacancy cannot usually be filled at short notice, because the provider will still need to carry out the standard process of checks and assessments to ensure that the individual being referred receives the right care, with a clear plan – and the person accessing support may not be free to attend at short notice, given other commitments in their life.

So, in reality, it tends to take about three weeks to fill an unexpectedly 'vacant' bed, meaning a cancelled placement leaves a significant funding gap. This is in addition to the time the provider will have spent on assessment and preparation with the person who had been planning to come to rehab.

It is important to ensure that work beforehand helps prepare clients for rehab as far as possible to avoid this possibility, but where cancellations do occur, there needs to be a mechanism to reflect this reality of the time and work required to fill the vacancy. Spot purchasing by bed night makes for an insecure financial model that doesn't recognise this.

# 5

While some services already charge for cancellations or partial stays, because empty beds cannot be filled at short notice, others avoid doing so for fear of losing commissioner referrals. However, not addressing the cost of cancellations is a short-term approach that puts the sustainability of this provision at risk. Any cancellation fee should fairly reflect the time required to refill the space.

Block bookings, as often used through consortia commissioning arrangements, are another way to ensure stability for residential rehab providers to lessen the impact of cancellations. We advise commissioners to explore the possibility of using this model, as several areas do – including Staffordshire, described in the case study below.

The Staffordshire commissioner block books beds with BAC O'Connor which provides financial stability, reduces the financial risk with regards to cancellations and – importantly – allows more people to access residential rehab because the block booking price for places can be lower than the spot purchased rate, give the stability this commissioning approach provides, allowing the residential provider to plan ahead with financial security.

### 5.7 ENSURE THERE ARE CLEAR, ACCESSIBLE PATHWAYS INTO DETOX AND FROM DETOX TO REHAB

Lack of access to suitable detox can prove a barrier to accessing residential rehab. Some rehab providers can offer detox on site, but even in these cases there may be needs that are better met by an alternative detox provider, even if that particular rehab provider is the best option for that client.

A delay in being able to access detox or not having a smooth pathway straight from detox into rehab can put someone's treatment journey at risk, with all the associated issues for missing a reachable moment described above.

Clear pathways and strong communication between detox providers and rehab are therefore essential, and should be actively coordinated and reviewed by local community commissioners.

The Birmingham CGL Service consists of five hubs which historically referred clients for detox to either a central CGL detox unit (Park House) or to a local hospital setting. Referrals were made by individual recovery coordinators to the units, which in turn would communicate directly back to the recovery coordinators with requests for information, tests, admissions dates, and information relating to discharge.

With the advent of the West Midlands Framework for detox and rehab, a decision was made to centralise referrals to provide a consistent, planned and equitable service to all service users referred for inpatient detox (this was later spread to referrals for community detoxification placements).

A dedicated Detox and Rehabilitation Team were recruited with responsibility for processing of referrals, associated communications, admission/discharge planning activities, and preparatory interventions including one to one discussions, group work and referrals to other teams to build recovery capital. This has led to a greater choice for individuals seeking this form of treatment, with clients being an active participant in their journey and onward recovery.

Having a greater choice and a centralised team to manage the client detox journey, waiting times are now much more easily managed as clients, detox units and key workers are getting the right information at the right time, reducing delays and repeat investigations.

### 5.8 ENSURE LENGTH OF STAY IS IN LINE WITH EVIDENCE AND GOOD PRACTICE GUIDANCE

The length of people's stays in residential treatment has reduced over the last seven years, which owes more to funding constraints than client need. As we have described above, if anything the complexity of clients has only increased in this period. DHSC cites research on long-term residential treatment published by the American Psychological Association to note that if people stay in residential treatment for a minimum of 90 days, they will have better outcomes when they complete the programme.[13]

The clinical guidelines for alcohol treatment echo this point and explain that whilst there is no single figure for optimal treatment length for everyone, some studies suggest that longer treatment length is associated with better treatment outcomes and length of stay needed is person-dependent.[14] However, most local authority-funded placements in England are for twelve weeks, when the research and guidelines seem to suggest this length of time would be better understood as a *minimum* for most people, rather than a standard.

Local processes should try to ensure there is some clarity and stability for the client at the outset - that is, people should know how long they are likely to stay for. Given that a stay of up to six months is frequently useful, and uncertainty and review processes can be unsettling for clients and disruptive to their recovery, we recommend that local areas should enable most clients to stay for up to six months where needed as a default and avoid unnecessary additional 'panel' type processes for approving extensions.

13 https://psycnet.apa.org/doi/10.1037/0893-164X.11.4.279

14 Clinical guidelines for alcohol treatment - 14. Residential treatment and intensive structured day programmes - Guidance - GOV.UK see specific reference: https://www.jsatjournal.com/article/S0740-5472(17)30291-X/fulltext

### 5.9 INVOLVE RESIDENTIAL PROVIDERS IN LOCAL SYSTEMS, INCLUDING WORKFORCE DEVELOPMENT INITIATIVES

Historically, a large proportion of those working in the sector had either worked in residential settings or been through residential treatment as clients themselves, but given the lack of recruitment in the past decade and the reduction in the use of residential, some of this institutional knowledge and memory has been lost.

Ideally, staff induction and training would mirror other professions where people gain experience across varied settings. Just as future GPs spend time in emergency departments, staff in the substance use treatment system should rotate through residential units, detox services, needle exchanges, community provision, recovery support, and criminal justice settings.

This cross-system exposure strengthens knowledge, improves accessibility, and enhances the effectiveness of all interventions. We therefore recommend that local commissioners and community treatment providers involve residential providers in staff induction, training, and wider system development work. At the very least, induction for new staff should include visits to residential rehab. Collective Voice and Choices are very happy to help facilitate open days and placements where this is of interest to commissioners and community-based staff.

> STaRS staff are all aware of the services available to people across the whole system. Partner inductions have been developed recently and all staff starting with any of the four partners involved in STaRS have time in each service as part of their induction. Community staff talk to people about residential treatment as an option for them throughout their recovery journey.

### 5.10 ENSURE THERE ARE SPECIFIC PATHWAYS TAILORED TO KEY REFERRAL ROUTES, INCLUDING PEOPLE LEAVING PRISON, THOSE WHO ARE ROUGH SLEEPING OR HOMELESS, AND PEOPLE IN HOSPITAL

NICE guidance states that there should be particular consideration of residential rehab for those 'who have significant comorbid physical, mental health or social (for example, housing) problems', which would include criminal justice involvement. Indeed, specific reference is made to the importance of a pathway from prison: 'For people who have made an informed decision to remain abstinent after release from prison, residential treatment should be considered as part of an overall care plan'.[15] There is also a need for dedicated pathways for women (especially mothers) and better inclusion of LGBTQ+ individuals. However, tailored pathways are not always clear or well-used in the current system.

There are examples of coordinated work nationally and regionally on these issues with leadership from DHSC. For example, the ARROW project is piloting direct access to residential treatment for women on release from prison, and a new tiered pathway for people rough sleeping in London includes the development of a fast-track pathway to residential treatment.[16] These existing projects provide a blueprint for local commissioners to establish pathways for specific referral routes and priority areas for their local system.

15 https://www.nice.org.uk/guidance/cg51/chapter/Recommendations#residential-prison-and-inpatient-care

16 https://www.york.ac.uk/business-society/research/spsw/the-arrow-project/

# 6

## CONCLUSION

This guide is designed to offer clear, realistic and practical support to commissioners, team leaders and all those involved in designing and delivering treatment and recovery services.

We hope you have found it helpful, but we appreciate that it is not in itself a universal plan for how to commission residential services or design effective and accessible pathways. Just as every person accessing support should be treated as an individual, so each area will need to implement solutions that work best for its unique needs and circumstances.

Nor is this guide set in stone or designed to be the last word on the subject. We are always keen to discuss challenges and opportunities across the field – and beyond – to better understand how we can improve support for people facing issues around alcohol or other drugs. We welcome feedback and would be happy to hear your thoughts both on this publication and on other ways we might work to improve treatment in the future.

Finally, we will continue to work for wider policy and system change to ensure that commissioners and providers are able to operate in a more sustainable, cohesive way, and we look forward to dialogue with Government on how we might improve access to residential treatment specifically. Where we face system-wide issues, we must work together across organisational and professional boundaries to ensure people are able to access the support they need.

If we could sum up the recommendations of this paper in one phrase, it would be to ensure that residential provision is an accessible option at the heart of local treatment systems. Systems should understand and appreciate local rehabs as assets. In practice, this means, for example, that staff in commissioning teams and community providers should visit residential services - and vice versa. When we spend time with staff and listen to people who have accessed rehab, not only will challenges become clear, but also the solutions and indeed further opportunities to improve our support offer. Collectively, we need to view residential treatment less in terms of a negotiated business transaction for a placement, and more as an option and opportunity within a wider commitment to provide high-quality care and support. This commitment to care is how we will save and improve more lives.

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# CollectiveVoice

The National Alliance of Drug and Alcohol Treatment and Recovery Charities

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Collective Voice is the alliance of charities that provide drug and alcohol treatment and recovery services across England. We believe that anyone with a drug or alcohol problem should be able to access effective, evidence-based and person-centred support. We know that treatment and wider support have a transformative power for people with alcohol or other drug issues, their families, and communities. Charities play a key role in providing this support. Collective Voice seeks to ensure that the knowledge and expertise of our field contributes to the development of policy and practice.

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