Phase One Report: Good Practice Guide for pathways into, through and out of Residential Rehabilitation in Scotland

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Scottish Government
Riaghaltas na h-Alba
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Contents

1. Policy context

Improving access to residential rehabilitation as a treatment option is a key part of the National Mission to save and improve lives. The Government is clear that residential rehabilitation should be part of the full range of drug prevention and treatment services available to people in all local authority areas. This is in line with the recommendations of the Residential Rehabilitation Working Group (December 2020)[1]. Of the total £250 million investment, £100 million is to be spent on residential rehabilitation over the next five years.

There are three strands to our national approach to achieving these improvements in treatment options and recovery pathways:

1. Investing in a significant increase in the capacity of residential rehabilitation services;
2. Improving pathways into and from rehabilitation services, in particular for those with multiple complex needs;
3. Developing a standardised approach to commissioning residential rehabilitation services.

The Pathways programme specifically addresses the following recommendations from the Residential Rehabilitation Working Group:

[1] Residential Rehabilitation Working Group (2020) *Recommendations on drug and alcohol residential treatment services* (Scottish Government)

- **Access**: There should be access to residential treatment on an equitable basis across Scotland.
- **Pathways**: Referral pathways should be clear, consistent and easy to navigate
- **Standardisation**: A standardised approach to support good practice should be developed

More information on the Pathways programme can be found in the SG Bridging Narrative, which was published alongside this guidance.

2. Phase One: Developing understanding of emerging good practice

In order to better understand the pathways to and from residential rehabilitation (RR) in Scotland and the interventions delivered during RR, the Scottish Government, supported by the Residential Rehabilitation Development Working Group (RRDWG), committed to undertake a programme of research. A survey was designed and sent out to Alcohol and Drug Partnerships (ADPs) to better understand their current funding pathways and how they support individuals seeking residential rehabilitation to enter into a suitable rehab programme. Residential Rehabilitation Providers were surveyed separately. These added to earlier work in 2020 with ADPs, providers, and those with lived experience. From these reference groups, calls emerged for simpler funding, more choice and opportunity, earlier interventions, more joined-up services and a better understanding of non-linear journeys.

Reports detailing the analysis from the ADP and providers surveys have been published alongside this guidance. The results of the surveys have helped to inform the development of guidance on good practice pathways. A third component of this suite of work – consultation with individuals with lived/living experience of undergoing placements in residential rehabilitation – will be undertaken during phase two, as part of the aim to provide opportunities for people with lived experience, communities and partners to engage in the planning and design of pathways. .

A stakeholder engagement event was organised for ADPs and providers in June 2021. Participants worked to develop journeys to, through and from rehab for various user personas. The identification of key considerations and barriers aimed to establish a shared understanding between providers and ADPs of the challenges faced by service users at different stages in the process. This helped to foster discussion and encourage learning on complex and specific needs. These reflections aided in the development of guidance on good practice pathways and in breaking down barriers to people getting the help they need, in terms of being referred to both residential rehab and to other health and social care services.

As the RRDWG and Scottish Government research has already identified, there are many barriers for individuals who seek residential treatment for drug and alcohol problems in Scotland. In some areas there has been effectively no access and in others, access has been limited. Although the research has identified many challenges, it has also highlighted examples of good practice which can be transferred across Scotland. Through the pathways programme, and through

ongoing work to standardise the approach to commissioning, it is our aim that the good practice we have identified will become embedded as standard practice.

3. RRDWG guidance to support development pathways

3.1. The importance of developing clear pathways:

For those individuals opting for residential treatment in time-limited programmes of intensive recovery support it is important that pathways to, and entry criteria for, accessing such programmes should be as clear as possible to staff and drug service users.[2] The types of services available and how to access them should be published clearly on ADP and other relevant websites. Training for keyworkers and members of local service user forums should be considered. Pathways should be documented in strategy and operational documents and there should clarity around referral criteria, assessment procedures and options.

3.2. Referrals:

Residential rehabilitation should be seen as a critical element in integrated care pathways[3] sitting within a balanced local treatment system (ROSC), even when referral is being made to out-of-area residential services. Out-of-area referrals may be needed for certain client groups who would benefit from removal from their local context, to move away from danger or other blocks to recovery[4]. Local access is preferable where suitable services exist, but regional approaches should be encouraged in order to maximise the use of existing services, particularly for clients with specific needs.

Some professionals may express concerns around safety or have the perception that there is a lack of evidence for residential rehabilitation. Such concerns should be explored and addressed. It may be necessary to seek further opinion and advocacy where there is disagreement. Research is ongoing to increase the evidence base for residential treatment in Scotland; a Monitoring, Evaluation and Research Advisory Group (MERAG) has recently been convened to develop an understanding of the client groups that benefit from rehab.

Offering service users choice is key to empowering them to be involved in their care plan and residential rehabilitation should be discussed regularly as a treatment option. Residential interventions can be considered at treatment entry, during reviews and at treatment exit. In order to ensure residential treatment remains an option, keyworkers and clients should discuss this during reviews of the care plan, ideally every three months.[5]

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[2] Dept. Health & Social Care (2017) *Drug misuse and dependence: UK guidelines on clinical management*

[3] National Treatment Agency. (2006). *Models of residential rehabilitation for drug and alcohol misusers*

[4] Welsh Assembly Government. (2004). *Service Framework for Residential Rehabilitation*. (p.4)

[5] Dept. Health & Social Care. (2017). *Drug misuse and dependence: UK guidelines on clinical management*

3.3. Examples of people who may be best suited to residential rehabilitation:

Existing guidance and research suggest that residential rehabilitation should be available to:

- Those with the most complex needs;
- Those who have not previously benefited from previous community-based psychosocial treatment;
- Those seeking abstinence and who have significant comorbid physical, mental health or social (e.g., housing) problems[6];
- Those with low drug problem severity, but high-risk factors paired with low recovery capital[7].

There are some people who desire to go directly into residential treatment, and some may benefit from doing so. Such decisions will need to rely on best judgement.[5]

3.4. Assessment:

Assessment is based on need and is carried out by providers or by referring agencies - these include a wide range of statutory and third-sector organisations.[8] Detailed information on assessment can be found in the 2017 publication, *Drug misuse and dependence: UK guidelines on clinical management.*[9] Each potential service user referred to a residential rehabilitation service must have a robust assessment and risk management plan carried out, which will establish individual needs.

Assessment procedures should be designed to be thorough and ensure that both the needs of the individual and safety and integrity of the service are taken into consideration. The most common reasons that individuals are assessed as unsuitable for rehab are mental health issues; particularly complex or severe and enduring needs.[8] Where there is no provision for specialist residential services, it is important that efforts are made to support these individuals in accessing other services, which may aid in a future assessment of suitability for residential treatment. Decisions should be made on clear eligibility criteria with a risk management plan in place.

The Assessment and risk management plans should include:

- Information on substance use history including any previous treatment interventions
- Current substance use status and results from recent toxicology
- Medical background including physical and mental health issues
- Social background including parenting/responsibilities, relationship, peer/social networks and family history
- Offending behaviour history including link to substance use
- Exploration and identification of strengths
- Education and employment
- Continuity needs for ongoing treatment / aftercare

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[6] National Institute for Health and Care Excellence (NICE). (2007). *Drug misuse in over 16s: psychosocial interventions. (*p.27)

[7] White, W.L., & Cloud, W. (2008). *Recovery Capital: A Primer for Addictions Professionals*

[8] Scottish Government. (2021). Results from the Residential Rehabilitation Providers Survey.

[9] Dept. Health & Social Care. (2017). *Drug misuse and dependence: UK guidelines on clinical management.* (Chapter 2)

- Motivation and readiness to engage in a residential rehabilitation programme
- Informed Consent to engage and share information with relevant partners e.g. GP, Care Manager, Commissioner
- Detoxification needs

3.5. Pre-rehab:

Aside from the assessment, there should be clear arrangements to prepare people for treatment where a clear overview is given of the elements of residential rehabilitation. There should be an introduction to the treatment setting through a visit and the service user should have a comprehensive understanding of what will be expected of them once in treatment. It may be helpful to offer an opportunity to speak to current or former residents. This could take the form of structured group work preparation, which can be delivered during assessment while individuals await admission. Activities should aim to encourage the individual to develop commitment and motivation towards the programme, including through goal and expectation setting.[10]

Stabilisation of drug use in community treatment settings or prior detoxification may be required prior to entry to residential rehabilitation. Particular care is to ensure that treatments are available for the management of withdrawal if required, for example, alcohol and opiates. Care is required on discharge from these settings, because of overdose risks.[10] Higher risk detoxification (e.g. for alcohol, benzodiazepines and gamma-hydroxybutyrate) needs careful assessment and may best be conducted in an inpatient detoxification unit. Commissioners and clinicians may want to develop risk-managed detoxification pathways for those using illicit benzodiazepines. In the instance that a rehab service is not able to provide detoxification, ADPs should work to facilitate relationships with outpatient and inpatient detoxification services to enable smoother transitions for service users. Where possible this should involve a direct transfer from detoxification to rehab, in order to minimise the risk of relapse while awaiting admission to a residential facility. An assessment of detoxification provision will help to identify any local gaps, such as those reported in the providers survey[12].

3.6. Rehab Phase:

Guidance on care planning can be found in *Drug misuse and dependence: UK guidelines on clinical management* (2.2.4.2).[11] Each care plan should include a review to plan aftercare as a resident comes towards the end of treatment. For out of area rehabilitation episodes, on discharge a referral into a support service in the area the client is moving to should be made, with an appointment given as quickly as possible and at least within the same week as discharge takes place. Signposting into local recovery activities/meetings can then be made immediately. Written communication should take place with the referrer and the resident's GP within a few days of discharge. All services should have unplanned discharge policies.

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[10] Dept. Health & Social Care. (2017). *Drug misuse and dependence: UK guidelines on clinical management*

Harm reduction planning is also integral to safe pathways and should be discussed as part of recovery planning from the start of a residential stay. Overdose prevention education should thus be a key part of residential treatment programmes and consideration should be given to teaching resuscitation skills. At present, three (15.8%) residential services in Scotland offer naloxone kits to all individuals attending their facility.[11] Given the potential for reversing opioid overdoses to save lives, training in the use of naloxone should be more widespread, particularly in first responders likely to be available to administer naloxone. There should be a supply of naloxone kits offered to opiate users after detoxification in hospital or residential care.[11]
Service users should be offered blood-borne virus screening either in-house or by referral. Residents with positive tests should be referred for consideration of treatment.

3.7. Post-rehab/ Aftercare:

Residential detoxification and rehabilitation programmes should not be seen as stand-alone interventions, but rather as components of an integrated package of care. Adequate preparation and after-care provided in community settings are key to the success of residential treatments.[12]
Pre-scheduled recovery check-ups should be arranged to monitor recovery, adjust recovery supports and to support rapid access back into treatment at early signs of relapse risk if appropriate. This may be facilitated by the provider or through local recovery services. Service users should be facilitated as a matter of course to link with mutual aid organisations such as Narcotics Anonymous, Cocaine Anonymous, Alcoholics Anonymous and SMART Recovery groups.[12]

Studies of continuing care following residential treatment suggest that the following may improve outcomes:

- At least monthly contact for the first year of recovery, with adjustments as necessary (up or down according to the client's level of functioning);
- Extended contact for years, rather than months;
- Availability of medications where necessary;
- Availability of treatment options of varying types and intensities, should the need arise.[13]

Continuing care may be provided in a variety of different ways, including through specific aftercare plans, telephone-based follow up and recovery management check-ups. Recovery housing – including those based on the Oxford house model and similar models – can offer support advantages to those willing to live together in the community post-treatment.

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[11] Scottish Government. (2021). Results from the Residential Rehabilitation Providers Survey.
[12] Effective Interventions Unit. (2004). *Residential detoxification and rehabilitation services for drug users: A review*. Scottish Executive. (p.2)
[13] European Monitoring Centre for Drugs and Drug Addiction. (2014). *Residential treatment for drug use in Europe, EMCDDA Papers.* Publications Office of the European Union, (p.14)

4. Emerging principles of good practice for pathways

The following points have emerged as broad principles of good practice for pathways. We have particularly sought to highlight guidance which supports multiple routes to residential rehabilitation, from different settings and via multiple referrers. We envision the checklist below as a practical self-assessment tool for ADPs – working through each list should enable ADPs to reflect on the opportunities for pathway improvement within their own region and identify the support needed to facilitate this.

General Points	Status
Detail who is responsible for the care of the individual at every step of the journey (from preparation for RR, referral to aftercare and connection with home services).	☐
Include consideration of especially vulnerable groups.	☐
Include specific pathways for people from multiple different settings and referrers (e.g. prison pathway, from homelessness, from community treatment, from NHS detox, returning to rehab after relapse etc.).	☐
Seek to join detox pathways to rehab pathways and address barriers to complex detoxes, ensuring appropriate experienced clinical oversight.	☐
Tailor pathways to statutory, third-sector and private providers, where appropriate.	☐

Referrals	Status
Include different referral routes (e.g. health services (GPs, drug and alcohol community services, NHS detox, stabilisation units, mental health settings, A&E); criminal justice pathways (including prison and other criminal justice settings); homelessness settings; self-referral, etc.).	☐
Dedicated key workers are be supported and empowered to include residential rehab in the “menu” of treatment options from the initial contact with services. There are protocols around discussion and expectation setting about what residential rehabilitation will involve, and what will be expected of the individual throughout.	☐
Include a pathway for those not deemed clinically appropriate to either work towards this or a pathway to established alternative treatment options.	☐
The design of pathways considers how to address commonly cited barriers to accessing residential rehab, such as ‘readiness’, motivation and concerns about distance to services or loss of connection with supportive relationships. This includes work to overcome barriers encountered by those accessing Opioid Substitution Therapy (OST) who wish to access residential rehabilitation.	☐

Assessment	Status

Include information on waiting times, detailing when an assessment and decision should have taken place. These should also set out which individuals are to be involved in the assessment process (for each different type of referral pathway) and any required training/competencies for these individuals.	☐
Registration of all individuals assessed for rehab with ADP.	☐
Pathways for those not currently clinically assessed as appropriate for rehab to other treatment options or support; a standardised appeals process for individuals who do not agree with this decision. Candour in presenting reasoning to clients.	☐
Assessment involves awareness around protected characteristics and consideration of those with multiple complex needs (trauma and any other medical, social and mental health problems that may impede treatment); complications, risk assessment and the needs of dependent children.	☐
All requesting an assessment for RR to be offered an assessment for RR.	☐
Multi-agency assessment, joint where possible with provider and involving other professionals as appropriate.	☐
Relationship building between providers, ADP and community services – work to improve links and streamline processes to reduce repetition.	☐

Pre-Rehab	Status
Preparatory programme for residential rehabilitation is incorporated into the pathway for those accessing rehab from all pathways (e.g. prison to rehab, homelessness, general referrals).	☐
Protocols around choice of residential rehabilitation provider which empower the individual. This involves discussion of the different modalities which are available, and what is suitable for the individual.	☐
Protocols around visits or open days (where possible) to the residential rehabilitation provider in order to establish relationships (introducing people to the programme community, using peers with lived experience, etc.) and give insight into the facility's model and philosophy.	☐
Preparation delivered by/on behalf of the provider follows the model of treatment they are entering. Where possible, a regional approach (close to home/rehab site) could allow rehabs to provide prep for structured support using peers and staff. Clear lines of responsibility between ADP and provider on who is responsible for delivering this.	☐
Work to identify and move towards addressing other needs (including health (mental health, trauma) and practical (financial etc.). Where these needs are not being met, this does not prejudice the client's opportunity to access residential rehabilitation.	☐
Protocols around preparatory work with family (if appropriate). Families and loved ones are supported in understanding the benefits, challenges and risks	☐

of residential rehab and support is in place for families who may struggle with a loved one going to a residential facility.	
Timely access to detox and seamless integration between detox and rehab, with same-day access to rehab where detox is completed in a separate service.	☐
Identify a specific contact person who remains in touch with the individual in the lead up to rehab, during rehab and post rehab.	☐

Rehab Phase	Status
The process of co-producing a plan for exiting/post-rehab with the individual at an early stage in the rehab process is built into the pathway (e.g. planning for employment/ volunteering/training/ education and housing post-rehab/ aftercare started during placement to enable smooth transition).	☐
Standardised protocols for the contact mentioned above around how contact with the individual (or facility on behalf of the individual) is maintained though the placement.	☐
Allowing for engagement with external volunteering/employment opportunities, where appropriate, for those at the later stages of their placement. There should be clear agreement from the outset around whose responsibility this is – particularly where clients travel long distances for RR.	☐
Support provided to families and loved ones whilst individual is in placement (e.g., family therapy, if appropriate).	☐
Continuity of care throughout the rehab process – referring agency attends reviews; ongoing access to advocacy during placement; links to recovery communities in home area.	☐
Guidance provided on how an individual can potentially move to a different rehab should this one not be right for them.	☐

Post-Rehab	Status
Pathways back into residential rehabilitation for those who relapse following a placement.	☐
Standardised protocols around harm-reduction (e.g. the provision of Naloxone to those appropriate; overdose prevention training etc.).	☐
Need-responsive aftercare pathways for an individual, including the identification of services which are available to the individual, how long these will be available for and who is now responsible for the continued care of the individual.	☐
Assertive referral to mutual aid and Lived Experience Recovery Organisations (LEROs).	☐
Process for monitoring of individual outcomes and how this is reported back to the ADP.	☐
Protocols for ADP liaising with provider at end of placement to agree an appropriate aftercare plan.	☐
Aftercare plan with a dedicated member of staff allocated to the client.	☐

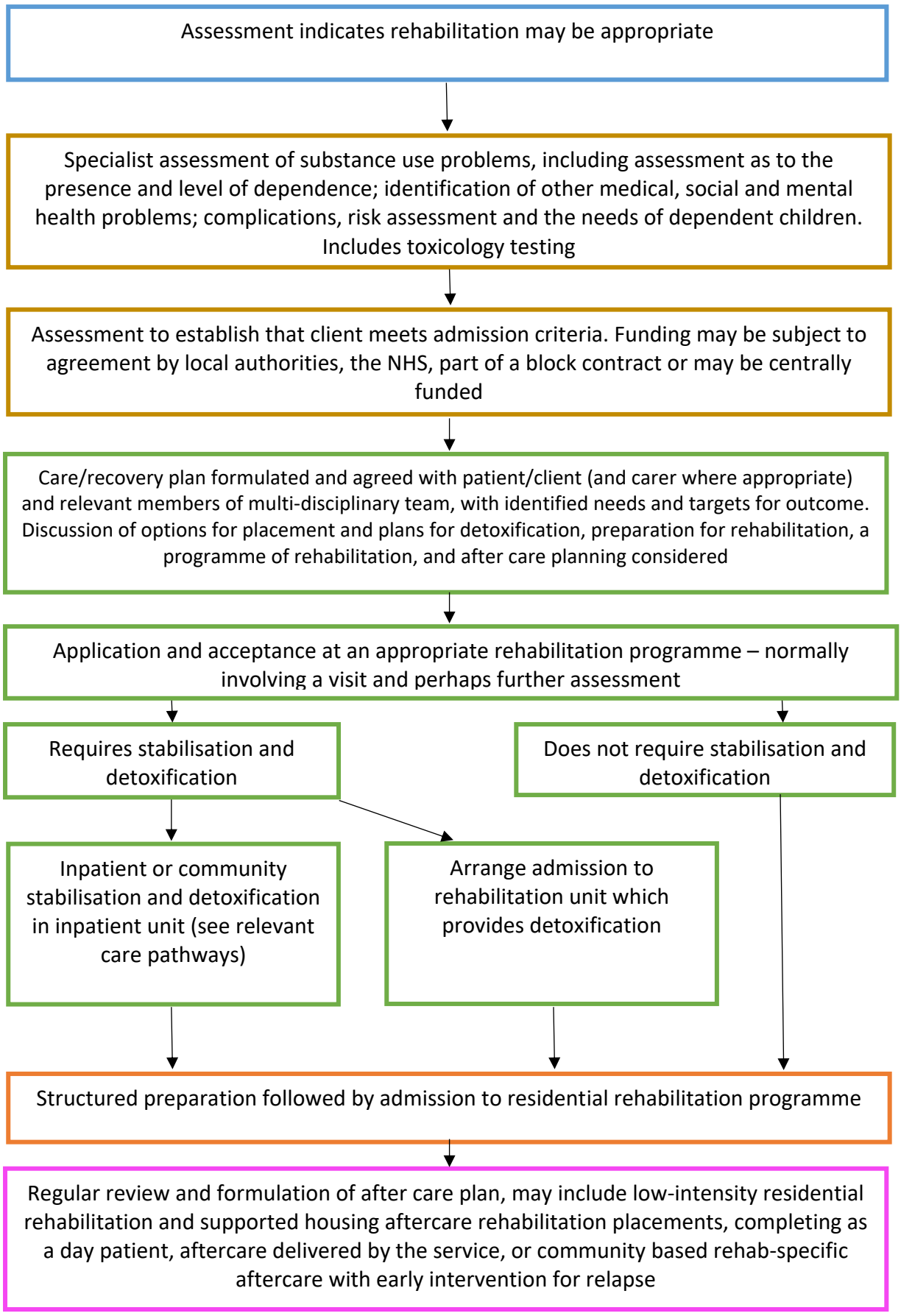
Funding	Status
A standardised protocol for accessing statutory funding, the criteria for this, and for how long this funding is for (including standardised funding paperwork and a standardised appeals process).	☐
Should a candidate be assessed as unsuitable for statutory funding, there is clear sign-posting to third sector organisations or other treatment options.	☐
The process of identifying funding does not impact on the individual - as far as they are concerned the RR episode is free at the point of delivery (no funding panel 'dragons' den').	☐
Financial assessments are conducted fully prior to a residential stay when service users are required to make a contribution, in order to avoid distress to service users and financial loss to other organisations.	
Funding covers all care elements rather than adding 'client contributions' which can often have an impact on someone's stay.	☐
Block contracting or funding to service are preferable to spot purchasing in funding individual placements, in order to facilitate capacity planning among providers.	☐

5. Universal pathway

Based on the emerging best practice that this report identifies and drawing from the Welsh Assembly Government's care pathway[14], a template for a universal pathway has been created. Each colour corresponds to a heading in section 4, which sets out emerging principles of good practice for pathways – this seeks to enable ADPs to contextualise these wider principles within the stages of an example pathway. This template is intended to act as an aid for ADPs in the development of their own pathways, although it is not exhaustive and should be used in conjunction with the more detailed guidance set out earlier in this report.

[14] Welsh Assembly Government. (2004). *Service Framework for Residential Rehabilitation*. (p.7)

Universal Pathway Template



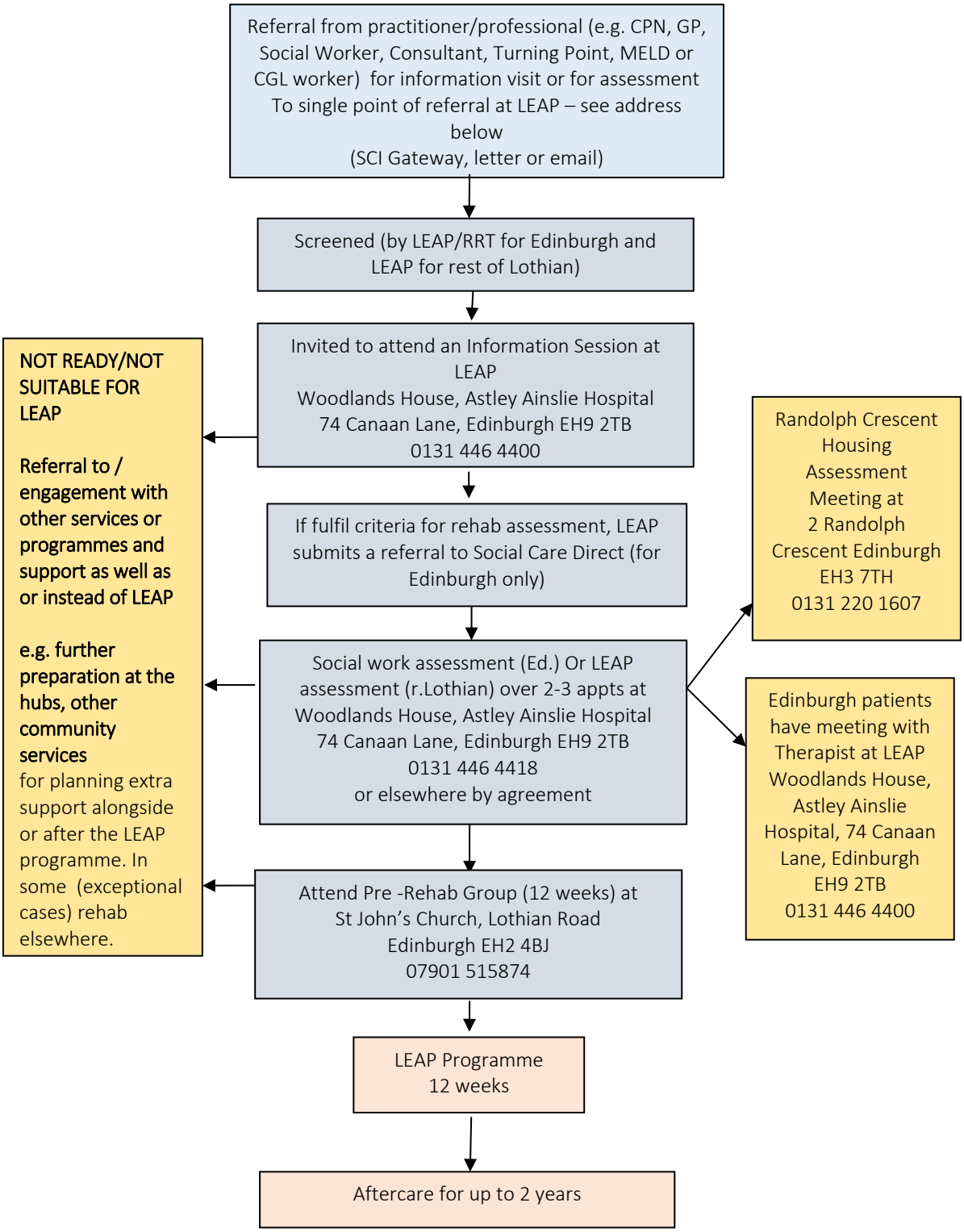
6. Examples of good practice pathways

As part of the recent Alcohol and Drug Partnership's (ADP) Pathways Survey[15], all 31 ADPs have been requested to submit written documentation relating to the pathways into, through and out of residential rehabilitation for those seeking abstinence from alcohol and drugs in their local area. ADPs were given the opportunity to provide documentation from the time of survey to the 2nd of September 2021.

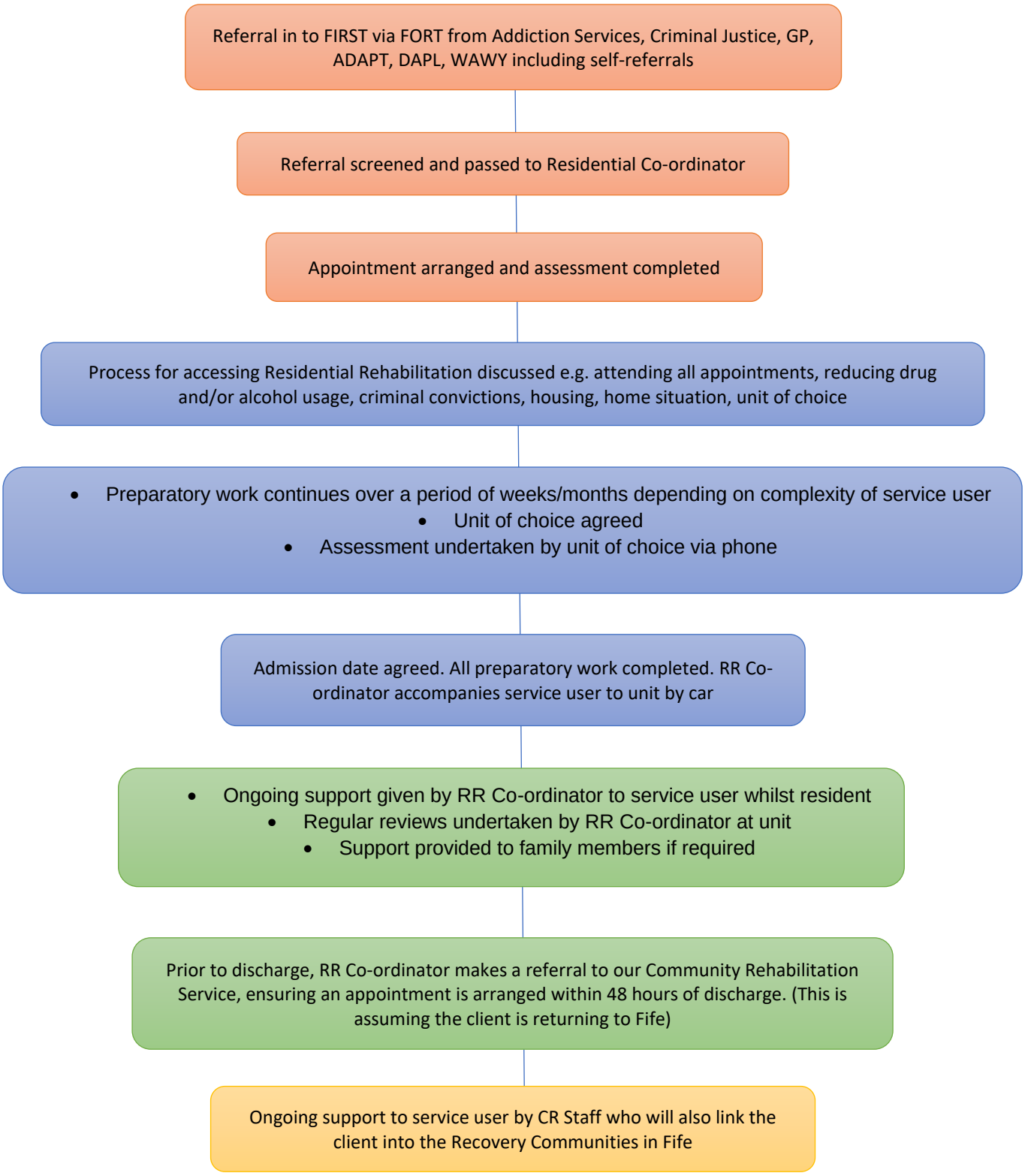
From these written pathway documents, the RRDWG has highlighted examples which are identified as containing elements of emerging good practice. Presented below are the pathways from NHS Lothian (including City of Edinburgh, MELDAP and West Lothian), Fife and Argyll & Bute.

[15] Scottish Government. (2021). Results from the Alcohol & Drug Partnerships Survey

7.1. Edinburgh/MELDAP/West Lothian ADPs (NHS Lothian)



7.2. Fife ADP (NHS Fife)



7.3. Argyll & Bute ADP (NHS Highland)