Pathways into, through and out of Residential Rehabilitation in Scotland:

Summary of Findings and Considerations from the ADP and Providers Residential Rehabilitation Pathways Surveys

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1. Overview and Background

The level of harms from alcohol and drugs in Scotland are high in comparison to the rest of the UK and Europe, and cause avoidable damage to people's lives, families and communities. Tackling the high level of drugs deaths in Scotland is a priority for the Scottish Government. On 20th January 2021, the First Minister made a statement to parliament which set out a National Mission to reduce drug deaths through improvements to treatment, recovery and other support services. One of the five priorities set out by the First Minister was increasing capacity and improving access to residential rehabilitation.

This report is published alongside, and summarises, three reports of surveys undertaken with Alcohol and Drug Partnerships (ADPs) and residential rehabilitation providers which explore, in detail, pathways into, through and out of residential rehab across Scotland. These reports will serve as a baseline to better inform ongoing funding strategies and to help identify specific barriers and facilitators to accessing residential rehab where it is deemed clinically appropriate for individuals to receive this form of treatment. These reports have also informed the work of the Residential Rehabilitation Development Working Group (RRDWG) including the guidance on good practice pathways.

This suite of reports follows previous research undertaken to support the work of the Residential Rehab Working Group. In December 2020, the Scottish Government published a mapping report to better understand the current residential rehab landscape in Scotland, which was followed by a report on capacity. These reports served primarily as scene setting exercises and highlighted the need to better understand how people enter, experience and leave residential rehab, including how this varies for individuals across Scotland. The mapping and capacity reports informed a set of recommendations by the working group to the Scottish Government which included that "The Scottish Government should facilitate research into residential treatment pathways, models, outcomes, value for money and service user experience to understand who will benefit most from it." This suite of reports aims to address this recommendation.

This summary report first outlines the methodological approach taken in these surveys of ADPs and residential rehabilitation providers, before drawing together findings in relation to six key themes from the resultant reports. It then notes a number of considerations for improving pathways into, through and out of residential rehabilitation across Scotland, and details the actions which the Scottish Government is currently undertaking in each of these areas.

2. Pathways Programme Aims

Referral pathways to residential rehabilitation and aftercare pathways following rehabilitation should be clear, consistent and easy to navigate. Through the pathways programme, from which this suite of reports are an output, we are thus seeking to achieve the following aims:

- Increased access to residential rehabilitation through publicly funded routes.
- People feel more supported and have more choice in their treatment journey to residential rehabilitation.
- Specific pathways are in place to support vulnerable groups or those with Multiple and Complex Needs.
- A 'no wrong door approach' means that connected services e.g. housing, criminal justice, community outreach are all aware of the pathways to support people.
- PANEL principles (Participation, Accountability, Non-Discrimination, Empowerment and Legality) are applied in the development of pathways in all ADP areas, via increased capability and system improvements.
- ADPs and the wider Health and Social Care Partnerships (HSCPs) network feel supported to make sense of complex systems and pathways.
- Increased capability within ADPs and wider HSCPs on quality improvement and pathway development.

The initial phase has focussed on developing an understanding of emerging good practice. We have endeavoured to summarise findings from the review of current pathways and challenges in order to provide examples of good practice of pathways into, through and out of residential rehabilitation. This will help inform local decision-making around use of new Scottish Government financial resource.

3. Methodology

Residential rehabilitation was defined, as in the mapping report, as facilities offering programmes which aim to support individuals to attain an alcohol or drug-free lifestyle and be re-integrated into society, and which provide intensive psychosocial support and a structured programme of daily activities which residents are required to attend over a fixed period of time.

3.1 Survey of Alcohol and Drug Partnerships (ADPs)

A survey was sent by email to all 31 ADPs in Scotland to better understand their current funding pathways and how they support individuals seeking residential rehabilitation to enter into a suitable rehab programme. The survey was designed to provide an overview of how ADPs and their partner organisations[1] responded to the needs of individuals in their area. Questions primarily related to the 2019/20 financial

[1] The term 'partner organisations' is used throughout this report, and relates to the statutory, third-sector and private organisations which are represented on the ADP. While this varies between ADPs, these typically include the local NHS Board, Local Authority and a number of other statutory bodies.

year in order to capture a snapshot of these pathways before the impact of COVID-19 and of additional Scottish Government funding to improve access to and provision of residential rehabilitation. Questions were developed in consultation with the RRDWG and policy officials, and were user tested by a selected group of ADP lead officers.

The survey comprised of 63 questions, including questions on accessibility, resourcing and demand, the pre-rehab phase, the residential phase, and the post-rehab phase of care pathways. While these questions were mainly multiple choice, the survey also included a number of open text questions in order to gather more detail on responses and gain a deeper understanding of specific aspects of these pathways. ADP lead officers were asked to email back their response within a two week timeframe. Due to this relatively short timeframe, ADPs who had not completed the survey were contacted by a member of the analytical team to ensure they had opportunity to be included in this research.

Data was collected between the 30th of April and 21st of June 2021.

3.2 Survey of Residential Rehabilitation Providers

A survey was sent by email to all 20 residential rehabilitation providers in Scotland to better understand their current provision, and how individuals come to access their facilities. Residential rehabilitation was defined, as in the mapping report, as facilities offering programmes which aim to support individuals to attain an alcohol or drug-free lifestyle and be re-integrated into society, and which provide intensive psychosocial support and a structured programme of daily activities which residents are required to attend over a fixed period of time. Questions related both to the 2019/20 financial year (in order to capture a snapshot of these pathways before the impact of COVID-19 and of additional Scottish Government funding to improve access to and provision of residential rehabilitation) as well as the most recent financial year 2020/21. Questions were developed in consultation with the RRDWG and policy officials.

The survey was extensive, comprising of 100 questions, including questions on access, resourcing and demand, the pre-rehab phase, the residential phase, and the post-rehab phase of care pathways. While these questions were mainly multiple choice, the survey also included a number of open text questions in order to gather more detail on responses and gain a deeper understanding of specific aspects of these pathways. Contacts at each provider were asked to email back their response within a three week timeframe. Due to this relatively short timeframe, those who had not completed the survey were contacted by a member of the analytical team to ensure they had opportunity to be included in this research.

Questions exploring the Prison to Rehab pathway formed part of this wider survey exploring the pathways into, through and out of residential rehabilitation across Scotland. Results from these questions were consolidated into a standalone report. There were a total of 8 questions on referrals from prison, including four specifically on the Prison to Rehab pathway. These questions on the Prison to Rehab Pathway were all open ended, qualitative questions in order to ensure that as much detail as

possible was gathered on this pathway. These questions were developed in consultation with the RRDWG and policy officials.

Data was collected between the 15th July and 28th August 2021.

4. Analysis of Key Findings

Six key themes draw together the reports of the surveys undertaken with ADPs and residential rehabilitation providers. These themes relate to a number of key aspects of pathways into, through and out of residential rehabilitation across Scotland. These key themes are;

- accessibility of residential rehabilitation
- resourcing and demand;
- pre-rehab phase of pathways;
- residential phase of pathways
- post-rehab phase of pathways;
- and general comments made by ADPs and providers.

Key findings across these six themes are presented below. As had been expected, there was some variation between these two reports in certain areas. These are attributable to the methodological approach, which relied on subjective responses by key contacts across both ADPs and providers, as well as to differences in monitoring and reporting mechanisms across ADPs and rehab providers. It is also possible that these reflect the different perspectives of ADPs and providers.

4.1 Accessibility of Rehab

These surveys highlighted a number of issues creating barriers to access to residential rehabilitation for particular groups.

- **Benzodiazepines –** Both providers and ADPs suggested that there were substantial barriers to accessing rehab for individuals who were engaging in problem use of benzodiazepines. Providers suggested a range of reasons for this, including a lack of clinical staff and challenges accessing NHS inpatient drug detox.
- **Mental Health Comorbidities** – Similar barriers for individuals with severe and enduring mental health comorbidities were highlighted. Providers suggested that the lack of appropriate clinical staff, and potential challenges in terms of the safety and efficacy of rehab for the individual and other residents, limited access to those with such needs.
- **Funding –** Accessing funding often provides a barrier to accessing rehab. With providers reporting that self-funding remained the most common funding pathway in 2019/20 and 2020/21 (32% and 35% of placements, respectively), there remains a need for improving access to statutory funding for placements, particularly across the nine ADPs reporting underdeveloped pathways.

- **Demographic Groups** – Inequalities were highlighted in terms of access for particular demographic groups, including women and younger people, suggesting the need to develop both access and provision for these groups.

4.2 Resourcing and demand

- **Funding of Placements** – ADP and other statutory funding contributes a relatively small proportion of placements. Providers report that around one in seven placements are ADP funded, with more than twice as many placements self-funded.
- **Programme Costs –** Placement costs ranged from £6,504 to £27,500 (£350 to £5,540 per week) making the average cost of a placement in a core programme in rehab in Scotland £18,112. Average costs for an ADP-funded placement were significantly lower due to the tendency to use NHS and third sector providers.
- **Lack of Consistent Approach to Monitoring of Statutory Funded Placements** – A number of ADPs reported that they were unable to provide data on the number of placements which they or partner statutory organisations had funded.
- **Disparity in funding arrangements –** Both ADPs and providers reported an array of different funding arrangements. Six ADPs, and five providers, reported holding block-contracts or framework agreements with each other, while others described spot-purchasing placements.

4.3 Pre-rehab phase of the pathway

- **Detoxification** – The surveys of ADPs and providers both highlighted a number of issues in relation to detoxification. Both surveys highlighted a need for greater monitoring of detoxification placements; most ADPs did not have access to reliable information on how many people were accessing rehab, and the number of individuals on waiting lists. While over half (56%) of ADPs reported that detox was available within rehab facilities in their ADP area, only nine rehabs reported that individuals had accessed detox at facilities in their area in 2019/20 and 2020/21. Further, in the survey of providers, data was missing on detox for a large proportion of reported placements, suggesting a need for greater link-up and communication between detox, rehab providers and ADPs, and the need to ensure that individuals are detoxing in safe and monitored ways (particularly for alcohol and benzodiazepines). Both reports suggested that waiting times for detoxification varied substantially, and were particularly extensive within some localities, having a knock-on effect on access to rehab placements.
- **Preparatory Work –** Both surveys highlighted wide variation in terms of preparatory work, both in terms of the availability of preparatory work, and who is responsible for providing this important stage of the pathway. Particular issues were identified in relation to the Prison to Rehab pathway, with some providers highlighting that individuals were not adequately prepared while in prison.
- **Waiting Times –** While both ADPs and providers highlighted that waiting times formed a significant issue (up to 9 months at one provider), and that this was partially attributable to capacity constraints, providers also noted that, on

an average day in the month prior to survey, they were running at around two-thirds (66%) of full capacity. These findings suggest a need to increase overall capacity but also the potential improve communication across ADPs to use unused capacity where appropriate.

4.4 Residential phase of the pathway

- **Range of provision** – Both surveys highlighted wide variation in terms of the programmes, models and core programme lengths (5 to 156 weeks) across Scotland's residential rehabilitation facilities.
- **Workforce –** The providers highlighted wide variation in staff vocations across facilities, which included a range of medical staff, management staff, and support staff. Some facilities do not employ in-house medical and/or nursing staff, with some citing financial constraints for this, while others emphasised following a social rather than medical model and so having a greater need for other members of staff. The need for more trained psychologists and medical/clinical staff was highlighted by some. The scope and content of training received by staff also varied widely between facilities. The providers survey did highlight a relatively high proportion of the workforce having lived experience of recovery (an estimated 186 of roughly 534 workers in residential rehab, or 35%).

4.5 Post-rehab phase of the pathway

- **Aftercare –** Both reports highlighted the lack of standardisation of aftercare, and the need to improve provision. While 90% of providers reported offering a range of therapeutic aftercare programmes, and while 90% of ADPs noted that they or partner organisations provided aftercare for individuals within their area, both surveys highlighted wide variation in terms of who was responsible for individuals. Providers highlighted that cases whereby the individual had returned to the ADP area following an external rehab placement were particularly challenging in terms of ensuring joined-up care.

4.6 General Comments

- **Communication –** The responses from both providers and ADPs highlighted that there is a need to improve communication between these two parties, but also between other statutory funders, referrers and other stakeholders.
- **Lived Experience** – Both surveys highlighted a need to engage individuals with lived experience more effectively at all stages of the residential rehabilitation journey, and in all aspects of the system.

5. Considerations and Progress to Date

This programme of research has been agile and dynamic and researchers have worked closely with the policy team and the RRDWG, reporting findings as early as possible to support evidence-based policy. As a result, the Scottish Government work streams to respond to the issues and considerations highlighted in this suite of reports are underway. This section presents the key considerations raised by the findings of the reports and the progress so far towards addressing them.

In order to fully understand the challenges for pathways into, through and after residential rehab, it is important to incorporate the voice of lived experience. While lived experience is represented within the RRDWG and the reference group which informed the previous mapping work and recommendations, it is also our intention to undertake a short programme of structured qualitative research with people with lived experience of residential rehab based on the findings of these reports.

Key considerations are as follows[2];

1. **A need to develop standards regarding the pathways around access, assessment, referrals, funding, and aftercare** – There is substantial variation in the pathways into, through and out of residential rehabilitation across ADPs, and an appetite for greater guidance around pathways. The implementation of standards across each ADP, alongside guidance, would allow for the development of these pathways and the minimisation of geographic inequalities in access to rehab and aftercare.

   We have worked with the RRDWG to identify emerging best practice among existing pathways, in order to establish standardised recommendations. This guidance has been published alongside this summary and is intended to aid ADPs in pathway development. The wider pathways programme will involve the implementation of this guidance in an applied setting – seeking to design, embed and sustain good pathways so that 'best' practice becomes standard. Our research has identified a need to support ADPs in this crucial step and we intend to work closely with them and other stakeholders in the health and social care system.

2. **A need to minimise structural barriers which reduce equity of access** – While it is necessary that certain entry criteria and person-centred clinical judgement are in place to ensure the safety and efficacy of rehab for the individual and others attending these facilities, current referral and entry criteria sometimes include unnecessarily prohibitive barriers. Financial barriers are also apparent, as well as wide variation in funding mechanisms for individual placements. The Prison to Rehab pathway is nationally funded, while other funding pathways are coordinated locally, which creates regional disparity in the accessibility of statutory pathways. There is a need to ensure clearer pathways and greater access to statutory funding for rehab placements across all areas, with specific work needed across the nine ADPs identified as having underdeveloped pathways.

[2] These considerations are not in any particular order.

We have acted to address the specific barriers identified by our research, through direct interventions such as the Dual Housing Support Fund, which offers a short-term solution for the challenges for those facing the impossible choice of keeping their tenancy and going to rehab. We have created a checklist and template universal pathway as part of our guidance on good practice – this is intended to encourage ADPs to evaluate their own pathways and identify any gaps and we are committed to working with the sector to facilitate this. Regional and national approaches to commissioning are also being considered and it is hoped that this could help to lessen the disparity between individuals' experiences in different parts of the country. By increasing the funding allocation to ADPs to be spent on residential rehab and exploring options for national commissioning, we are aiming to increase publically funded placements by at least 300% over 5 years so that by 2025/26 at least 1000 people are publically funded for their rehab placement.

3. **A need to improve access for specific groups** – There is scope to improve access to rehab for a range of groups, including women, people with children, younger people, people coming from prison, and people with multiple and complex needs. There is a specific need to address barriers to people with mental health comorbidities, albeit with person-focused clinical decisions to determine whether rehab is the most suitable treatment option. Pathways should ensure equity of access. This may require long-term support for existing providers to adapt their services, or the development of services tailored towards the specific needs of these groups.

   We have emphasised the consideration of vulnerable groups in our Good Practice Guidance on Pathways and we intend to work, within the pathways programme, to identify and minimise any further gaps in existing provision. We have established the Residential Rehabilitation Rapid Capacity Programme (RRRCP) as part of the Recovery Fund to increase capacity of services with a particular focus on improving provision for women and those with childcare responsibilities. We have also acted to address specific barriers for example through the Dual Housing Support Fund, the prison to rehab pathway and developing guidance for testing and vaccination for those accessing residential rehabilitation services. By working to improve specific referral pathways, we aim to widen access to residential rehabilitation for people with particular needs by providing equity of access and emphasising the no-wrong-door approach.

4. **A need to establish a centralised list of approved rehabs** – Only a few ADPs maintain a list of preferred rehab providers, and there is more general need to improve communication between ADPs and providers. A centralised list of approved residential rehabilitation providers, made available both online and in physical form, could assist in raising awareness among ADPs of the specific offerings of rehab providers. This centralised list would help to inform choice regarding individual placements.

To inform our creation of this centralised system, we have established a Service Directory subgroup. This group will advise us on the creation of a digitally-inclusive service directory which will seek to provide thorough and up-to-date information on services in order to empower clients, loved ones and referrers in decisions around residential rehabilitation. We are also considering the option of having a national framework agreement for residential rehabilitation providers, which would further integrate the referral process and help to ensure the quality of services.

5. **A need to set up a monitoring and reporting system** – Monitoring and reporting of placements is implemented differently across localities. A national system for monitoring and reporting (particularly statutory funded placements) would aid the improvement of pathways. This should include both detox and rehab. It should also include outcomes, given the hesitancy of some ADPs to fund rehab due a perceived lack of evidence. However, there is a need to avoid incentivising providers to restrict admission to those with less severe challenges, potentially excluding those with complex needs.

   We have developed a mechanism for aggregate data collection on ADP funded placements between April and September this year. Public Health Scotland will publish a report with this data once finalised. We are working at pace to establish a more detailed data reporting arrangements so that we can track how the investment in residential rehab is translating into increased placements. This will start with the essential information and be iterated to include outcomes information in future. A Monitoring, Evaluation & Research Advisory Group has been established by Public Health Scotland to inform this work. The implementation of a more robust, standardised system will aid in developing our understanding of pathways into, through and out of rehab so that we are able to identify strategic targets for improvement.

6. **A need to develop specific preparatory programmes** – There is significant variation in preparatory work for residential rehab, both in terms of programmes offered and the agencies responsible for this preparatory work. There is also an opportunity to learn from and share best practice. Specific consideration should be given to individuals who are to access residential rehabilitation through the Prison to Rehab pathway, given the challenge for prisons to engage in the necessary preparatory work.

   Emerging best practice recommendations emphasise this need for robust preparation for those accessing rehab from all pathways. High-quality preparation is crucial to the experience an individual has while in residential treatment and thus to their outcomes afterwards. Earlier this year, we announced a £13.5 million uplift to Alcohol & Drug Partnerships and a further £14.4 million for front-line services, part of which has been allocated specifically towards residential rehabilitation. We have instructed ADPs to use this not only to increase placements but also to help support people into rehab via structured preparation. Of our £5 million Improvement Fund, £3 million has been allocated for residential rehabilitation and this aims to improve existing provision, such as through preparation programmes, outreach, workforce and support for Lived Experience Recovery Organisations (LEROs).

7. **A need to establish structured links to detox** – Poor access to detox forms a barrier to accessing rehab, particularly for those seeking recovery from benzodiazepine use or those who otherwise require complex detox. Less than half of rehab facilities offer in-house detox, and there are long waiting times for external detox facilities. Many of those accessing rehab detox without medical assistance, or through unknown pathways. There is a need to increase detox provision, and for greater alignment with rehabs. Specific pathways for people taking high doses of benzodiazepines or engaging in complex poly-drug use may be beneficial.

   Our Good Practice Guidance on Pathways reaffirms the need for providers to strengthen their connections with detox facilities – we will aim to support with improving the integration of these services through the pathways programme. To help lessen barriers to detox, this year's £5 million ADP uplift allocation for residential rehabilitation can also be used on detox facilities which are linked to a rehab service. Over the next five years, we are also releasing £5 million per year via the Service Improvement Fund and £5 million per year via the Recovery Fund, which aim to improve services, increase capacity and support access at all stages of the rehabilitation pathway.

8. **A need to ensure robust exit planning and continuity of care** – While most providers offer aftercare, and while aftercare is available in most ADP areas, there is a lack of clarity around who is responsible for aftercare, particularly for non-local placements. This could heighten risk, particularly for those making unplanned exits. It is also vital to improve clarity around options to return to rehab. Evidence-based guidance regarding if and how re-admittance should be arranged would support decision making.

   Guidance around best practice will help to establish a standardised approach to exit planning, given that this is a particularly vulnerable point in the user pathway. This will help to ensure that adequate aftercare is provided and that rapid re-entry into community or residential treatment is available if needed. We have also made £5 million per year available through the Improvement Fund, which can be used to strengthen projects which provide continuity of care following a residential placement.

9. **The potential to extend the Prison To Rehab pathway –** The Prison to Rehab pathway had been developed in order to improve links between prison and rehab in the context of COVID-19. This pathway has led to a substantial number of people accessing rehab following prison. A number of providers have also developed relationships with the Scottish Prison Service. These findings suggest that this pathway should be extended, alongside improvements to the preparatory work undertaken within prisons.

   We are therefore committed to building on the success of the Prison to Rehab pathway, which supports people to continue their recovery journey at a time when community support and connection with others in recovery can be challenging. We plan to improve the programme and will work closely with

prisons and justice stakeholders to strengthen this pathway and increase preparatory work in custody.

10. **A need for an increase in the supply of Naloxone to rehab facilities –** There is substantial variation in the provision of Naloxone, with similar disparity in terms of training individuals to administer Naloxone. Work should be undertaken to provide clear access to a supply of Naloxone, with guidelines for the distribution of Naloxone and training to staff and individuals resident at all facilities. Naloxone kits should be provided to individuals withdrawing from opioids at the detox stage, with access monitored throughout their placement.

    Harm reduction must remain a cornerstone of our approach, particularly given the increased dangers of overdose immediately following residential treatment. We have worked to maximise the range of services which can distribute naloxone and recently commissioned a campaign to encourage public awareness of its life-saving potential in the event of an overdose. Our research highlights an opportunity to do more within residential facilities and we will work to ensure Naloxone provision and training is seen as a fundamental aspect of a good practice pathway.

11. **A need for greater communication channels between statutory agencies and providers –** There are challenges in relation to communication between ADPs and providers, and between ADPs and SG. Establishing clear lines of communication, including channels for discussion of pathways on a regular basis, would be beneficial in improving pathways.

    We will therefore seek to facilitate greater integration between services. Our guidance on pathways should help clarify the roles and intersection of various services and we will continue to explore how we can improve communication channels through the pathways programme. Engagement events will be key in establishing regular discussion and we are considering how regional improvement hubs could aid in knowledge sharing between services, in order to create a more joined-up experience for service users.

6. Conclusions

The findings presented in this report and in the accompanying full reports of the ADP and rehab providers surveys, have been crucial in improving our understanding of the pathways into, through and out of residential rehabilitation in Scotland. Importantly, they identify a number of areas for improvement. As detailed throughout, the Scottish Government are undertaking a range of actions targeted at all aspects of these pathways. These reports have been central to informing the work of the Residential Rehabilitation Development Working Group (RRDWG); particularly in the development of guidance on good practice pathways.

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Any enquiries regarding this publication should be sent to us at

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