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

Results from the Alcohol and Drug Partnership (ADP) Survey

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Riaghaltas na h-Alba
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Executive summary

Overview

- In 2019/20, 24 ADPs (77%) reported having pathways into residential rehabilitation via the ADP or partner organisations for individuals in their area. Seven (23%) ADPs reported either funding no referrals to residential rehabilitation and making no significant investment in rehab services.

Access, Referrals and Resourcing

- In 2019/20, an estimated minimum of 300 residential rehab placements for the treatment of drugs and/or alcohol were funded by ADPs (either directly or through partner organisations).
- A minority of ADPs (23%) reported either funding no referrals to residential rehab and making no significant investment in rehab services in 2019/20.
- NHS services were by far the most common services referring individuals to residential rehab, with 79% and 76% of ADPs stating that NHS alcohol and NHS drug services, respectively, referred individuals in 2019/20.
- An average of 89% of individuals who received an assessment for residential rehabilitation were referred to rehab.
- The majority of ADPs (86%) do not maintain a list of preferred residential rehabilitation providers for placing individuals in rehab.
- Just under a third of ADPs (31%) reported that they or their partner organisations hold block-contracts/framework agreements with rehabs. The majority (58%) reported that they or partner organisations spot-purchase individual placements.
- The average reported length for which funding is provided by the ADP or partner organisations for individual residential placements was 13 weeks. Placements ranged from 4 to 26 weeks.
- Around one in six (16%) ADPs reported that they provided funding to rehab facilities for running costs in 2019/20.
- The average waiting time for access to residential rehabilitation ranged from 4 to 44 weeks, averaging 15 weeks.
- 72% and 55% of ADPs reported a current waiting list for inpatient hospital detox for alcohol and drugs, respectively, with waiting times ranging from 3 to 17 weeks, averaging around 8 weeks.

Aftercare and Outcomes

- The majority of ADPs (72%) reported that the ADP or partner organisations took measures to ensure that individuals have access to appropriate housing tenure upon completion of residential rehabilitation.
- The majority of ADPs (69%) reported that they or their partner organisations took measures to ensure that individuals have access to employment, work-placements or voluntary opportunities upon completion of rehab placements.
- The vast majority of ADPs (90%) reported that planning for aftercare was actively undertaken by the ADP or partner organisations during placements.
- The majority of ADPs (72%) reported that either all individuals, or specific groups of people, are provided with naloxone kits during their placement.
- Around a fifth of ADPs (21%), reported that they monitor longer-term outcomes of residential rehabilitation placements for individuals in their area.

1. 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 drug related 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 was increasing capacity and improving access to residential rehabilitation.

Previously, to support the work of a working group on residential rehab, chaired by David McCartney, 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 further explore and better understand how people enter, experience and leave residential rehab, and 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 and Alcohol and Drug Partnerships should work together to scope and compare current referral pathways, including referral criteria and inclusions/exclusions.'

This report is published as part of a suite of reports exploring pathways into, through and out of residential rehab in Scotland, which aims to address this recommendation by the working group. This report provides an overview of how Alcohol and Drug Partnerships (ADPs) - responsible for developing local strategies to deliver national outcomes and commissioning services – work to support individuals to receive residential treatment for problem drug and alcohol use in 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. These reports have also informed the work of the Residential Rehabilitation Development Working Group (RRDWG) including the guidance on good practice pathways.

2. Methodology

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.

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.

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 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. The full survey is available in Appendix A. 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.

[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.

3. Main findings

3.1 Demographics and Response Rates

Replies were received from all 31 ADPs in Scotland[2]. It is important to note that ADP areas vary considerably by size, population and demographic. A breakdown of these ADP areas by their deprivation profiles is provided in Appendix B, and an urban/rural breakdown is provided in Appendix C.

Previous mapping and capacity reports found 20 residential rehabilitation facilities across Scotland, with 42% of ADPs having at least one residential rehabilitation facility in their local ADP area. The majority of ADPs with no local provision reported sending individuals to rehab facilities outwith the local ADP area, whether in the wider NHS health-board area or further afield. A breakdown of residential rehabilitation facilities by ADP area and NHS health board is provided in Appendix D.

3.2 Accessibility of rehab

Public and sector awareness Residential Rehabilitation

ADPs reported utilising a range of means of communication to both inform the public on how to access residential rehab, and to promote residential rehab to referral services. Most ADPs (90%) reported that verbal recommendation from referrers was used to inform the public about residential rehab. This was followed by the use of online resources (40%), leaflets (35%), and open days (21%). Most ADPs suggested that no specific work had been undertaken to promote and facilitate referrals from relevant services to rehab in their area. However, a number reported undertaking training with staff working in relevant services and making use of existing communication structures to discuss residential rehabilitation with relevant services. One ADP had developed 'access to rehab' guidelines with an accompanying launch event.

Identification, Assessment and Referral of Candidates for Residential Rehabilitation

ADPs reported that referrals to residential rehabilitation had been made from a wide range of statutory and third-sector agencies in 2019/20. NHS alcohol services referred individuals to residential rehabilitation across 79% of ADPs, while NHS drug services referred individuals across just over three quarters (76%) of ADPs. Referrals from Criminal Justice social work and GPs took place in just over a third of ADP areas (35%), referrals form criminal justice took place in 31% of ADPs, from homelessness shelters in 28% of ADPs, and from hospitals in 21% of ADPs. Referrals from mental health and peer led initiatives took place in 21% of ADPs, referrals from women's support services in 17% of ADPs, from prison

[2] A total of 29 replies were received, with two of the survey responses containing data relating to two neighbouring ADP areas. Survey data received was not fully complete by all ADPs as some data were either not available or not known to the ADP at the time of survey. The percentages provided in this report should be use for indicative purposes and may not be representative if base sizes are low.

services in 14% of ADPs, and children and young person's services in only 10% of ADPs.

Just over two-thirds (69%) of ADPs reported being aware of the use of specific criteria used by individual referring agencies in their area. A number of these ADPs highlighted that these referring agencies used written referral protocols with varying degrees of flexibility, while others reported on criteria which were not standardised in local policy. The most common entry criteria reported by ADPs included:

- an expression of interest and clear motivation towards achieving abstinence through residential rehabilitation;
- attempts to achieve and maintain abstinence in the community have previously been unsuccessful (either having tried a number of, or having 'exhausted', community-based services);
- engagement in at least one preparatory and/or detoxification programme(s);
- the individual is willing and cognitively able to participate in a group setting;
- the individual is at substantial or critical risk of alcohol and/or drug harms;
- abstinence from alcohol and drugs prior to their placement; and
- the individual agrees to a financial assessment and is willing to contribute funds obtained through benefits.

Most of these ADPs also noted age restrictions for services, with residential care typically restricted to adults above the age of either 16 or 18, with no upper age limit.

In 2019/20 ADPs reported that on average 89% of individuals who received an assessment for residential rehabilitation went on to be admitted to rehab. It should be noted that not all ADPs held this data, as a substantial number of ADPs do not gather data on the number of individuals who are assessed for rehab.

A range of individuals were involved in the assessment process, with substantial variation between ADPs. Alongside the individual seeking to access rehab and their families/carers, other key individuals were involved in the assessment process. These included dedicated/key social workers or care mangers, representatives from the residential rehabilitation provider, ADP representatives (if ADP funded), third-sector rehabilitation coordinators, GPs, doctors, medical officers, psychologists, psychiatrists, occupational therapists, community addiction psychiatrists, community psychiatric nurses and those from other social work departments where relevant.

Just over a fifth (21%) of ADPs reported that they had specific pathways for individuals with specific needs and/or vulnerabilities. These included a pathway for women, a pathway for specific offending history and a pathway for those leaving prison. While the majority of ADPs reported having no specific pathways in place for individuals with specific needs and/or vulnerabilities, a number noted that they took an individualised, person-centred approach in directing these individuals to rehab or other suitable support. A number also noted that such individuals were often able to be accommodated within general residential provision, and that assessments of risk to the individual (and others in the facility) were undertaken where necessary.

ADPs reported a wide range of reasons for which individuals were deemed not suitable for residential rehabilitation in 2019/20. The foremost reason reported was a perceived lack of motivation for change on behalf of the individual, primarily evidenced by a failure to engage in the assessment or preparatory process. Some ADPs suggested that the lack of availability of provision for individuals with more complex needs (such as those with complex mental or physical health conditions, unstable drug use, poly drug use and/or those with high levels of benzodiazepines or prescribed medication) was a principal reason that these individuals were deemed unsuitable for rehab. A lack of available funding was also cited as a key barrier to referral by a number of ADPs, while the individual losing interest during waiting periods was cited by another. A number of ADPs suggested that the individual not having exhausted local resources was a key reason that their assessment for residential rehabilitation was unsuccessful. The individual being deemed not to be ready for residential rehabilitation at the time of assessment was another common reason for not being referred to rehab. This decision was described as being made either by the individual themselves or by the assessors.

Most ADPs suggested that individuals continued to receive ongoing community support when residential rehabilitation was deemed unsuitable. This included continued engagement with community addiction workers and community mental health teams. A number reported that individuals were diverted to alternate options such as inpatient detox, crisis services, residential stabilisation services and other forms of community support.

For those whom residential rehab is considered unsuitable on the basis of specific mental health needs (including acute psychosis or high risk of suicide), ADPs reported a variety of pathways into different forms of treatment. A number of ADPs suggested that inpatient detox in a hospital setting was typically deemed most appropriate. Others suggested that individuals with specific mental health needs are typically cared for by a range of agencies, including community mental health teams, addiction services (including addiction psychiatry) and, if necessary, crisis teams or acute psychiatric inpatient care settings. A number suggested that third-sector organisations played a central role in providing care to these individuals, while others suggested that these individuals were in the care of statutory services. Two ADPs reported a mental health and alcohol and drug recovery service interface policy which was in place to ensure a joined up approach for individuals with dual diagnoses. A number of ADPs noted that they were not aware of facilities being available for individuals with specific mental health needs or that specific pathways were in place for this.

A minority of ADPs (N=7; 23%) reported either funding no referrals to residential rehab and making no significant investment in residential rehab services in 2019/20. In addition to these, a further two ADPs reported having no specific pathway in place for individuals to enter residential rehab, despite funding a small number of placements in that year. This indicates that 9 ADP areas have underdeveloped pathways to residential rehab.

Selection of Residential Rehabilitation Facility

The majority of ADPs (86%) reported not maintaining a list of approved or preferred residential rehab facilities to assist placing individuals in residential rehabilitation. The ADPs who did report that they maintained a list suggested that these preferred providers were selected on the basis of the accreditations of the facility, the suitability of their programme, the availability of data on outcomes, the location of the facility and the cost of a placement of individuals in the facility. The ADPs who did not maintain a list of residential rehabs cited a number of reasons for this; primarily, sending too few individuals to maintain a preferred provider list, and taking a person-centred approach which looked at the most suitable facility for the individual.

The majority of ADPs suggested that the individual has a degree of input into the decision as to what facility they attend. This decision was typically made through discussion with a care manager, residential rehabilitation coordinator or similar to establish clinical need and the suitability of a rehab facility in terms of programme type and location. Where ADPs had a preferred provider, individuals were often given the opportunity to identify and suggest an alternative facility. A number of ADPs had 'second choice' provider options available to individuals, with programme types/locations different to the preferred provider. One ADP noted that individuals were given the names and details of a range of providers to select from. All ADPs offering individual input highlighted that this choice was often limited by a number of factors including location, availability of places and cost.

3.3 Resourcing and demand

Individual Placements

In 2019/20, an estimated minimum total of 300 residential rehab placements for the treatment of drugs and/or alcohol were funded by ADPs (either directly or through partner organisations), with 162 being for drugs and alcohol dependencies, and 138 for alcohol dependency alone[3]. The majority (61%) of these were for placements within the ADP area, 26% were within the health board area, 7% were to specialist facilities for complex needs, and 5% to placements outwith the local ADP or health board area. A number of ADPs mentioned that funding for residential rehabilitation placements was controlled by Health and Social Care Partnerships (HSCPs), NHS Board or Local Authority budgets and, as such, were not able to report on how many placements were funded through this route in their ADP area. The estimates presented are therefore likely to be an under-representation of the number of the total statutory funded residential rehab placements.

The majority of ADPs (59%) reported that agencies, other than the Scottish government funded residential rehab placements in their area. Agencies that funded placements included social work (in 38% of ADP areas), NHS boards (in 31%

[3] A significant number of ADPs we not able to provide an accurate estimate for funded placements in their area and so estimates should only be used to infer a minimum number of placements.

of ADP areas), rehab facilities (in 14% of ADP areas) , and other charitable organisations (in 4% of ADP areas).

Only 14% of ADPs reported having a system in place which records all individuals from the ADP area who gain access to a residential rehab placement. A number reported that it is particularly challenging to monitor placements which have not come through the ADP or partner organisations (e.g. those which have been funded privately, through insurance or through charitable funding). This was particularly the case when these placements were in private or third-sector facilities.

Funding of Residential Rehabilitation Facilities

Just under a third of ADPs (31%) reported that they or their partner organisations maintain active block-contracts or framework agreements with individual residential rehab providers. Partner organisations who maintained block-contracts included the local NHS Board. Of those that did not have block-contract arrangements in place, one suggested that this was due to a lack of availability at providers due to other ADPs maintaining block contracts with them. Two ADPs suggested that they were unsure whether any such arrangements were in place between partner organisations and rehab facilities.

The majority of ADPs (58%) reported that they or their partner organisations spot purchased individual placements at residential rehab facilities as and when needed. These ADPs reported that the partner organisations through which funding for spot purchasing was sourced included the NHS Health Board and Local Authority.

The average reported length for which funding was provided by the ADP or partner organisations for residential placements was around 13 weeks. A number of these ADPs highlighted that there was a degree of flexibility based on individual need. Some ADPs who did not provide this information stated that length of stay was based on the individual needs and the number of weeks funded varied per person. Further, a number of ADPs who had suggested that they provided funding for extended periods of time described relatively small numbers of individuals receiving funding through the ADP or partner organisations.

Three quarters of ADPs (75%) reported that there was no maximum time limit for which funding is provided by the ADP or partner organisations for individual placements. The length of time for which an individual would receive ADP funding was reported to be based on the needs of the individual (reported by 72% of ADPs), the program length (55%), funding and budget limitations (24%), and the need to consider the impact on a residents housing benefits status (21%).

The majority of ADPs (84%) did not report having provided funding to individual residential rehabilitation facilities in 2019/20, other than supporting individual placements. Five ADPs reported providing such funding. Three of these ADPs – all in the same Health Board area – provided contributions towards running costs (averaging an annual contribution of around £30,000 each) for one facility which primarily operates as a detox but which offers those undergoing detox the

opportunity to subsequently engage in residential rehabilitation. One ADP provided £80,000 to a small residential rehabilitation facility in 2019/20 under the service level agreement to deliver agreed outcomes which are monitored on an annual basis.

3.4 Pre-rehab phase of the pathway

Waiting Times

The average waiting time for access to residential rehabilitation in 2019/20 ranged from 4 – 44 weeks, averaging 15 weeks. It should be noted that not all ADPs were able to provide this information. The main reason for individuals being on a waiting list was waiting for a bed to become available due to demand outstripping capacity. Four ADPs reported that individuals were waiting due to not having yet obtained financial support, while another four suggested that individuals were currently on their waiting list due to the time required to stabilise or reduce the dosage of their drug or medication. Two suggested that individuals had typically been on the waiting list as they had been waiting for their assessment meeting.

In general, ADPs reported that the responsibility for care of the individual while on the waiting list lay with the services with which they were previously involved, and/or from which they were referred. ADPs reported involvement from drug and alcohol recovery services, NHS addiction services (community teams), third sector organisations, nurses and support workers. One ADP suggested that the rehab facility was responsible for the care of the individual while on the waiting list, while a greater number suggested that the rehab facility offered support but was not the primary agency responsible for the individual's care. One ADP highlighted that individuals who have self-referred to rehab are able to draw on community support.

Preparation for Residential Rehab

The majority of ADPs (72%) reported that community alcohol and drug services (either third-sector or statutory) would be responsible for the programme of preparatory work for individuals accessing residential rehabilitation. Just under half (48%) reported that either social work services or the rehab provider themselves would be involved the preparatory care of an individual.

Less than half of ADPs (41%) reported that they were aware of specific preparatory programs within their ADP area for individuals who have been accepted onto a residential rehab programme. This preparatory work typically involved both practical and psychosocial preparation. Practical preparation, in general, involved reducing any barriers or any personal issues which may jeopardise the success of the placement, including; the stabilisation of alcohol and/or drug use; liaising with the family; liaising with housing services; and resolving any criminal justice matters. Psychosocial preparation involved the development of recovery capital, harm reduction (including relapse prevention), motivational enhancement and setting goals and expectations for rehabilitation for both the individual and family. Three ADPs reported access to a structured 12 week 'prep for rehab' programme offered by one facility, while the support across others appeared less structured and often undertaken by a range of relevant agencies in partnership. A

number of ADPs also suggested that individuals who had been accepted onto a rehab programme were directed towards a range of community-based services, including mutual aid, lived experience recovery organisations, SMART recovery organisations, and third-sector counselling services.

Detoxification

In 2019/20 all ADPs reported having some form of detox available in their ADP area. The majority of ADPs (93%) reported having a specific community alcohol detox programme, 89% reported having inpatient hospital alcohol detox, 79% reported having a specific community detox programme for drugs, 72% reported having inpatient hospital detox for drugs, and 59% that detox was available with a rehab facility in their ADP area. In relation to accessing detox as preparation for residential rehabilitation, the majority of ADPs suggested that detox was accessed through local Drug and Alcohol Recovery Services, while some suggested that residential rehab facilities make referrals. This detox component was funded in a range of ways; primarily through NHS Board funding, Health and Social Care budget, and through the ADP budget for drug and alcohol services.

Waiting lists for detox varied across the ADPs, with the majority reporting a current waiting list for inpatient hospital alcohol detox and inpatient hospital detox for drugs (72% and 55%, respectively). This waiting period was reported to be due to the number of beds available in the unit, staffing availability (for community detoxification) and, in a number of ADPs, was flexible based on the severity of individual need. Among those who reported waiting times, these ranged from 3 to 17 weeks, averaging around 8 weeks. A number reported that these waiting times were longer than usual due to COVID-19 restrictions.

Most ADPs did not report having access to reliable information on how many people were waiting to access an inpatient detox programme. Similarly, only 45% of ADPs were able to provide reliable information on the number of individuals who accessed detox as a specific preparatory step before entering rehab in 2019/20. Based on the information that was provided, on average an estimated 45% of residential rehab residents accessed a structured form of detox prior to entering the residential rehab program. This makes up an estimated 11% of all people in structured detox programs.[4] All ADPs who reported that individuals had accessed inpatient detox as a specific preparation for a rehab placement stated that there was no waiting period between detox and rehab.

3.5 Residential phase of the pathway

Individual and Family Support During a Residential Programme

There was substantial variation in how community alcohol and drug services continue to engage with individuals during their residential stay. While ADPs typically suggested that the level of contact was based on individual need or

[4] Note that as less than half of ADP were able to provide this data, the estimates provided should only be used on an indicative basis and may not be representative of Scotland as a whole.

individualised to their care plan, most described a relatively standardised approach to engaging with individuals. Most commonly, ADPs reported that the ADP or community-based services maintained regular contact with individuals in rehab. A number did so by telephone and/or text and, less commonly, through face-to-face contact (particularly for non-local placements, and increasingly so during COVID-19). Some ADPs described more formalised contact, such as those stating that the primary contact was scheduled reviews undertaken at appropriate milestones (e.g. half-way through the placement and pre-discharge). Where reported, contact was typically initiated by the key worker/agency, while three ADPs noted that individuals are able to contact their key worker as much as is necessary.

A small number of ADPs noted specific challenges in maintaining contact with individuals in residential care (prior to COVID-19). Some noted difficulties in undertaking face-to-face visits with those in placements outwith the ADP area given resource constraints, while one suggested that the ADP was often unaware of individuals' placements if the person was not previously known to alcohol and drug recovery services. One mentioned that providers' expectations on how often contact should be made can present a challenge.

The majority of ADPs (72%) reported that centrally funded family support was available in their ADP area. A number of ADPs also reported that they funded specific activities such as family therapy and peer support.

Exit Planning Prior to Leaving a Residential Programme

The majority of ADPs (72%) reported that the ADP or partner organisations take steps to ensure individuals have access to appropriate housing tenure upon completion of their stay in rehab. Those responsible for this varied between ADP areas. Primarily, ADPs liaised with housing services to make suitable arrangements, but a wide range of agencies were noted as also being responsible, namely; community addictions team, social work, social care, NHS addictions services, BAS support workers, third-sector organisations, referring organisations and the rehab providers themselves.

Just under half of ADPs (45%) reported that there are pathways to supported accommodation for individuals leaving a residential rehab program[5]. The majority of those with such pathways in place described using a 'Housing First'[6] approach. Others reported that they put individuals in contact with housing associations, supported accommodation flats and hostels. A number of these noted that the individual's care manager was involved in coordinating this.

The majority of ADPs (69%) reported that specific measures are taken by the ADP or partner organisations to ensure that individuals have access to some form of employment, work-placements or voluntary opportunities upon completion of their rehab placement. The majority of these ADPs described established links with third-sector partners who undertake this work by helping

[5] A number ADPs who did not report having a pathways in place noted that these were in development, and that they currently assess individuals on a case-by-case basis for referral to universal services.
[6] Housing First - Homeless Network Scotland: we are all in

people to access training, adult learning, volunteering and/or employment. Where detailed, volunteering opportunities were typically undertaken with third-sector organisations in the alcohol and drugs recovery field, and included roles such as community outreach and peer support work, with a small number of these potentially leading to future employment. A smaller number described volunteering roles in recovery settings, or alongside other people in recovery.

The vast majority of ADPs (90%) reported that planning for aftercare is actively undertaken by the ADP or partner organisations as part of an individual's residential placement. There was wide variation in the reported agencies involved in this planning process and in the delivery of aftercare. Some ADPs suggested that the rehab provider and individual residents were involved in the planning process, while others noted a range of statutory and third-sector agencies being central to this process. A number of ADPs highlighted multi-agency involvement, with the formation of services shaped by the individual's needs. In addition, ADPs noted variation in when this process begins, namely from the pre-admission assessment phase to a few weeks before the end of a placement.

3.6 Post-rehab phase of the pathway

Care of Individuals

ADPs reported wide variation in the services who are responsible for providing aftercare to an individual following their stay in residential rehab. These typically centred on community-based services, often working collaboratively depending on individual need. For example, one mentioned that NHS, social work, housing, third sector and the rehab providers themselves all contribute to the support to individuals following residential rehabilitation placements. A number of ADPs suggested that the individual's care manager was responsible for organising aftercare, while others suggested that the responsibility for care rested solely on the referring agencies. Three ADPs mentioned that the rehab provider themselves was primarily responsible for the provision of aftercare to individuals completing placements.

There was substantial variation in relation to how soon ADPs reported that they or their partner organisations engage proactively in contacting individuals making planned exits from rehab. Five stated that contact is made immediately, while another four suggested that contact is made within the first week, with one of these noting that this is undertaken sooner if the individual requires medication. A number of ADPs suggested that the length of time and nature of contact is based on individual needs, with discharge planning undertaken during the individual's placement and dates for follow-up agreed then.

Around a quarter (26%) of ADPs reported that they or their partner organisations made contact with individuals following an unplanned exit from rehab immediately. Two reported they do so within the first week, while another two suggested that the time taken to reach out is based on individual needs. One ADP mentioned that they would utilise a range of means to contact individuals who have made unplanned exits in order to establish what mode of alternative treatment would

best suit their needs. One ADP suggested that individuals who had made an unplanned exit from a placement would likely need to self-refer to services.

ADPs highlighted a range of challenges in relation to engaging with individuals who have been discharged from residential rehabilitation placements. Foremost were challenges in relation to maintaining contact with and supporting individuals who have relapsed. One highlighted that active outreach and encouragement to re-engage with services is crucial during this period, given the risk of overdose, self-harm or suicide. Linked to this, a number of ADPs spoke of specific challenges in relation to providing support to individuals who are back in a home or neighbourhood environment where others continue to use alcohol and/or drugs. A number of ADPs highlighted specific challenges for those who had made unplanned exits for reasons such as disengagement with services in general or not wanting any further support from the ADP. Some ADPs also noted that they were not always informed of discharges from out of area facilities.

A range of reasons as to why individuals make unplanned exits from residential care were highlighted by ADPs. The most frequently reported reason was around the timing of a placement when taking into account other circumstances. Some highlighted that a lack of preparation is often a causal factor, with others reporting that programme available was not fully suited to the needs of the individual. Other reasons included not adapting to being away from home and family, relapsing during their stay, financial worries and/ or fear of homelessness. A number of ADPs reported individuals leaving placements early due to feeling that they have gained all they need from the placement. Two highlighted that providers, on occasion, make these decisions, including where the individual has developed disruptive relationships with others at the facility.

<u>Aftercare Services</u>

The majority of ADPs reported that the ADP or partner organisations funded specific aftercare services within their ADP area. These included lived experience recovery organisations (reported by 69% of ADPs), peer support and individual therapy (66%), group therapy and SMART recovery organisation programs (55%), peer mentor schemes (38%), mutual aid (31%), and volunteer support schemes (24%).

The majority of ADPs suggested that some form of active linkage to mutual aid and lived experience recovery organisations was undertaken for individuals completing residential rehabilitation placements. The majority of these ADPs suggested that mutual aid or lived experience recovery organisations operated in their local area (either funded in part or full by the ADP or by third-sector agencies) which individuals are signposted to during or following their placement. Signposting was undertaken by a range of agencies, including the rehab provider, NHS substance use service, the ADP and drug and alcohol recovery services. Some ADPs suggested that peer supporters (individuals with lived experience) were involved in linking individuals to recovery groups and activities. Some ADPs reported that aftercare begins during the residents' placement in order to smooth the transition and allow relationships with aftercare groups to be formed. A number of ADPs suggested that they had no specific guidelines or activities in relation to active

linkage, while another suggested that they were unsure whether such linkage was undertaken in their area. While not specifically asked about monitoring linkage, two ADPs highlighted that they monitor linkage to these organisations, while two others reported that they do not.

The majority of ADPs reported that services do not place time limits on aftercare for individuals leaving residential rehabilitation placements, however there was a range in the length of programmes available. The majority described a person-centred approach based on individual need which lasts as long as the individual requires. One provider used by three ADPs offers aftercare for up to two years, while one ADP reported that their local policy states that aftercare is available for up to six months, although is flexible depending on individual need. One ADP highlighted that they proactively follow-up individuals who do not engage in aftercare services.

ADPs noted a wide range of measures taken to link individuals making unplanned exits from residential rehabilitation placements to aftercare services. Most described a proactive response from alcohol and drug services, including visiting the individual's home, contacting pharmacies, phone calls to their family, sending letters to their home address, and getting in contact with relevant services to attempt to re-engage the individual. Care navigators were used to undertake this work by five ADPs, while outreach was undertaken as part of a social work intervention by one ADP. One provider used by three ADPs establishes contact and creates a recovery plan at short notice with clear linkages back to lived experience recovery organisations, mutual aid and clear advice on pathways back into treatment. A number of ADPs suggested that this assertive diversion was made to specific, intensive support, while a similar number suggested that there is no difference in aftercare between planned and unplanned exits.

Harm Reduction and Relapse Pathways

ADPs reported that a wide range of harm reduction measures were undertaken with individuals during residential rehabilitation placements. These were primarily provided by the rehab facility, and centred on information provision and signposting to training sessions. Themes included the risks associated with ongoing alcohol and/or drug use and/or smoking; the transmission of blood borne viruses; how to manage triggers; men's/women's health issues; the administration of Naloxone; and overdose prevention and resuscitation skills. A number of ADPs highlighted that the ADP had discussions with a key worker during their placement in order to arrange return to the community and to discuss harm reduction following their placement. One provider used by three ADPs, which offers detox, offers to re-titrate the patient back to a therapeutic dose if the individual chooses to leave during opioid detox, asking the community prescriber to follow up with these individuals.

The majority of ADPs (72%) reported that either all people, or specific groups of people, are provided with naloxone kits upon leaving residential care. Of the 27% of ADPs who did not routinely supply or were not aware of supplying naloxone to individuals leaving rehab, a number mentioned that this was due to the residential providers supplying this directly or that residential providers would support an individual to acquire a kit via established NHS routes.

Twelve (38%) ADPs reported that there were specific pathways back to residential rehab for individuals who have relapsed having completed a placement previously. Only three of these ADPs suggested that, depending on the circumstances, an early readmission may take place, although uncommon. The majority of ADPs suggested that individuals relapsing to alcohol and/or drug use following a placement would be considered through the universal assessment and referral process.

The majority of ADPs (83%) reported that individuals who had previously made an unplanned exit from residential rehab would be reconsidered for a new placement in the future should this be clinically appropriate. Some of these ADPs noted previous instances where this had been the case. One of these ADPs noted that their policy states that these individuals may be excluded from doing so within a year following an unplanned discharge, while another three suggested that it would be reasonable to await a change in circumstances (either internal or external to the person) before considering the same intervention again. Another ADP noted that assessment and preparatory work would consider the reasons for the previous unplanned exit and seek to address these in order to support the completion of any further placements.

Outcomes

Around a fifth of ADPs (21%), reported that they monitor longer-term outcomes of residential rehabilitation placements for individuals in their ADP area. This mostly included partner organisations and rehab facilities themselves sharing aggregate data or data on individuals with the ADP, however this was not a standardised process. ADPs who did not monitor outcomes mentioned that this was due to a number of reasons including; residential rehabilitation was not dealt with by the ADP but other organisations; they relied on individual case records not specific to residential rehab; not having an agreed system in place to monitor placements; and not having a rehab pathway in place. Some of these ADPs noted that this would be developed going forward.

3.7 Standardisation, COVID-19 Impact and Barriers and Facilitators

Standardisation

Around half of ADPs (52%) reported that they have a standardised process in place for aspects around residential rehabilitation such as funding, referral, assessment, access and aftercare. A number of these ADPs had written protocols. A small number of other ADPs suggested that the funding component was standardised, while the process of assessment, referral and care was not, while others reported the opposite. The majority of ADPs who are yet to adopt or do not have such pathways in place mention that these were currently in development.

COVID-19 Impact

The majority of ADPs suggested that COVID-19 had impacted on residential rehabilitation pathways in some way. A delay in admissions throughout the pandemic was described by nine ADPs, with one ADP highlighting that this was due to a lack of face-to-face consultations and a withdrawal of clinics in line with public health guidance. Five ADPs described the temporary halting of residential rehabilitation admissions in March 2020, three lasting until April and one lasting until mid-late 2020. Two ADPs highlighted that all day attendance for rehabilitation has been stopped altogether. A number of ADPs also described a range of isolation protocols undertaken by facilities, with providers having described these in detail in a recent COVID-19 testing, vaccination and isolation report[7]; one ADP suggested that isolation protocols had impacted on some individuals who were reluctant to isolate upon entering residential rehabilitation. Two ADPs suggested that aftercare is now undertaken primarily remotely, while another suggested that key aspects of preparatory work for rehab in their area had ceased due to the pandemic. Three ADPs suggested that there had been a reduction in numbers attending, one citing fear and anxiety among those on the waiting list as central to this. Another highlighted a 60% loss of capacity. Three ADPs using one provider suggested that waiting times had extended from 12-16 weeks to over a year, with harms having occurred to those on the waiting list. Five ADPs suggested that COVID-19 had made no impact to their pathways, while two were not sure.

Barriers and facilitators

ADPs reported a wide range of factors which challenge the prioritisation of commissioning or resourcing of residential rehabilitation from a strategic planning perspective.

Barriers included:

- budgetary considerations were the most frequently cited barrier, with the ‘high-cost, low volume’ nature of rehab in comparison with other services, coupled with ADP budget limitations, leading to the prioritisation of other services;
- a perceived lack of evidence for efficacy of residential rehabilitation in comparison with other services and the need to fund services which offer ‘best value’;
- procurement of rehab provided a barrier, given that ad-hoc placements was time consuming and complex and vast variability in cost between providers.
- supporting parents with children considering higher costs associated with a whole family approach and the lack of residential provision tailored towards this population group; and
- increasing poly-drug use and lack of services tailored for this including safe detox options.

[7] Coronavirus (COVID-19) residential rehabilitation - testing, vaccination and infection control: status report - gov.scot (www.gov.scot)

Specific facilitators were identified by a comparably small number of ADPs. Three ADPs had access to a statutory facility, with the **reputation of the facility** and the **establishment of a funding framework** being referenced as helping to facilitate the prioritisation of residential rehabilitation at the ADP level. One of these facilities, however, suggested that a fund for out of area placements would be beneficial in order to widen the scope of those that can benefit from residential rehabilitation.

Improving Residential Rehabilitation

ADPs highlighted a range of measures which they felt would improve access to, and the success of, residential rehabilitation for individuals who experience problem alcohol and drug use. A wide range of answers relating to all aspects of the pathways into, through and out of rehab were provided by 28 ADPs. These summarised below and presented under the following themes: 'access, referral and resourcing'; 'rehab provision'; and 'pre- and post-rehab'.

Referrals, Access and Resourcing

A number of ADPs suggested that there is a need to further establish the **evidence base on outcomes from residential rehabilitation** whereby the referral process, and confidence in funding and referring at the ADP level, could be improved. This may be achieved by facilities sharing information on outcomes along with outcomes of other forms of treatment in the community. The latter helping to justify the allocation of funding towards rehab.

ADPs highlighted a need to **target of residential rehabilitation** to individuals who would benefit most from this type of intervention. This includes a need for the provision of training and other resources to ensure a greater understanding from referrers of the complexities of rehab in terms of access, what is involved, risks around leaving, funding and perceptions of 'rehab readiness'.

A **standardised and clinically recognised criteria** for when rehab is likely to be most effective (or what is deemed 'rehab ready') was identified as being a measure which would lead to a more robust assessment of suitability for rehab. This may also include the requirement for specific preparatory work to ensure the everyone entering rehab is 'rehab ready'. It was suggested that this would allow this service to be available for more people who require it, and increase the likelihood of success.

A number of ADPs reported a need to further establish existing and new referral routes through **increased promotional work, and establishing a national procurement framework** to ensure consistency, fairness and equity for all seeking treatment, irrespective of postcode. This would increase transparency in relation to governance of services, and of pricing structures from providers.

Many ADPs identified a need for **additional funding and strategic approach** for residential rehabilitation placements along with a long-term funding plan which allows commissioners to increase capacity, undertake needs assessment, and adhere to procurement procedures. Procurement of residential rehabilitation may benefit from a more strategic approach as opposed to ADP's ad-hoc procurement arrangements.

A need to **develop the residential rehab workforce** was specifically identified by a number of ADPs. Some specified that this should be undertaken in order to improve the visibility and awareness of pathways, and should include training opportunities for staff who feed into all stages of the pathway including referring agencies, funding bodies, rehab staff and those working in the community in preparatory and aftercare services.

A common suggestion was regarding improvements in **access to detox prior to residential rehabilitation**, and in particular the need to overcome specific challenges in accessing NHS inpatient drug detox (particularly of benzodiazepines). Given the requirement for abstinence (or to be below a certain dosage of medication) upon entry to the majority of residential rehabilitation facilities, these ADPs suggested that it would be beneficial to build on the capacity of existing residential providers to be able to provide residential detoxification where possible, or alternatively arrangements with local NHS inpatient detox units dedicated to rehab patients for the provision of drug detox.

Improving Rehab Provision

A number of ADPs highlighted the need to establish specific pathways into residential treatment for individuals with **complex drug use** (e.g. illicit benzodiazepines, higher opiate replacement doses, poly drug use). It was suggested that this may include additional provision of **crisis/ stabilisation provision facilities** for individuals and will help reduce stigma and the marginalisation of this particularly vulnerable and hard to reach group.

ADPs reported the need to **increase the range and types of residential care** programmes available at a national level allowing individuals and referring agencies to explore a number of residential rehab programmes options and embark on one most suited to individual needs. This would include a widening the range of treatment modalities available at local levels including psychosocial support, as well as specific support for individuals affected by past traumas, confidence building and social/life skills (including budgeting, social skills, cooking). Additionally, where no local rehab facilities exist, the creation of new facilities would reduce the dislocation involved in placements far from home.

A number of responses highlighted the need for rehabs to cater for **specific vulnerable groups**; such as women with children or families, and those with multiple and complex physical and/or mental health care needs. In addition, there may be a need to **develop non-residential rehabilitation programmes** to enable those who are unable to commit to a residential program to be able to access rehab (e.g. individuals with family or other caring responsibilities, or those in education or employment).

Before and after rehab

The need to further develop and standardise **continuity of care of sufficient intensity** before, through and after periods of rehabilitation was highlighted by ADPs as a key area for improvement. Some noted that this was in order to avoid a ‘cliff-

edge' scenario sometimes experienced after leaving residential care when retuning to community care. This period is widely recognised as being a particularly vulnerable time for individuals in terms of relapse and overdose, as a result of decreased tolerance. Some suggested that a more gradual transference from residential to community may help with resettlement, particularly when dedicated 'recovery houses' were also made available.

Some ADPs identified a need to increase **support for individuals to enter employment, training or volunteering opportunities** which may be aided by establishing a dedicated resource for preparatory and aftercare work. In addition, involvement from a multidisciplinary team consisting of mental health workers, social work and housing services along with community groups such as walking and running groups, fitness classes, art classes would improve social inclusion following a placement.

The need to employing **peer supporters** and those with lived experience to assistant an individual to bridge the gap between community support and residential support on discharge was also mentioned by a number of ADPs.

4. Appendices

Appendix A – Full Survey Distributed to ADPs

1. Access

Awareness and Orientation towards Residential Rehabilitation

1.1 Are there specific activities to promote and facilitate referrals to residential rehabilitation (e.g. events/ training/ other communications) among those working in relevant services? Please provide details (max 300 words).

1.2 In your ADP area, how is information on accessing residential rehabilitation made available to members of the public who may benefit from this form of support?

Individual verbal recommendation from treatment services	☐	
Leaflets	☐	
Posters	☐	
Open days	☐	
Website/Social Media	☐	Please provide details
Media in accessible formats (e.g. different languages)	☐	Please provide details
Other	☐	Please provide details
No specific activities	☐	Please provide details

Identification, Assessment and Referral of Candidates for Residential Rehabilitation

1.3 Which agencies referred individuals from the ADP area for assessment for residential rehabilitation in 2019/20?

Alcohol services (council)	☐	GPs	☐
Alcohol services (NHS)	☐	Women's support services	☐
Alcohol services (3rd sector)	☐	Children and Young people support services	☐
Drug services (council)	☐		
Drug services (NHS)	☐	Mental health services	☐
Drug services (3rd sector)	☐	Criminal Justice Social Work	☐
Community Justice services	☐	Prison Services	☐
Hospital	☐	Mobile/outreach services	☐
Homelessness services	☐	Other	☐
Peer-led initiatives	☐		

If other, please provide details. If the number of referrals from each agency is known, please state (max 200 words).

1.4 Do the above agencies have criteria which must be met for individuals to be referred for assessment for residential rehabilitation?

Yes ☐

No ☐

If known, please provide details. If there is a written policy/protocol/guidance document, can you please attach alongside this survey (max 200 words).

1.5 Are individuals from the ADP area able to self-refer for assessment for access to residential rehabilitation?

Yes ☐

No ☐

Please provide details (max 200 words).

1.6 How many individuals from the ADP area were assessed for residential rehabilitation in 2019/20, and how many individuals were referred to residential rehabilitation facilities following this assessment?

Assessed for residential rehabilitation - Please select a number

Referred to residential rehabilitation - Please select a number

1.7 Who is involved in the assessment of individuals for residential rehabilitation? Please provide details, including the occupational titles of the individuals involved (max 200 words).

1.8 In the assessment process, what were the main reasons that individuals were deemed not to be suitable for residential rehabilitation in 2019/20? What happens to these individuals? Is there an opportunity to appeal/ review these decisions? Please provide details (max 300 words).

1.9 Does the ADP currently have specific pathways into residential rehabilitation for individuals with specific needs/ vulnerabilities?

Women ☐

Specific Mental Health Comorbidities ☐

Pregnant women/women with children ☐

Specific Offending Histories (e.g. arson or violent crime) ☐

Homeless individuals ☐

Children/Young People ☐

Other ☐

No specific pathways ☐

Please provide details (max 300 words).

1.10 What treatment/recovery services are available for individuals for whom residential rehab is considered unsuitable on the basis of specific mental health needs (e.g. those experiencing acute psychosis or those at high risk of suicide)? Are there specific protocols in place to ensure continued and joined up support is provided? Please provide details (max 300 words).

Selection of Residential Rehabilitation Facility

1.11 Does the ADP maintain a list of approved/preferred residential rehabilitation providers?

Yes ☐
No ☐

If so, please list these providers (max 100 words).

1.12 If such a list exists, on what criteria are these approved providers selected?

Outcomes data ☐
Cost ☐
Specific Accreditation (eg. Care Inspectorate Rating) ☐
Location ☐
Suitability of programme ☐
Other ☐

If other or specific accreditation please provide details (max 300 words).

1.13 What input does the individual have in selecting the residential rehabilitation facility they are referred to? Please provide details (200 words).

2. Resourcing and Demand

Individual Placements

2.1 In 2019/20, how many individual residential rehabilitation placements were funded (either directly or through partner organisations) using Scottish Government alcohol/drug funding allocated to your ADP?

Alcohol only

Placements within ADP area	Please select a number
Placements in rest of NHS Health Board area	Please select a number
Placements outwith the ADP/health board area	Please select a number
Specialist facilities for people with complex needs (e.g. specific mental health needs)	Please select a number
Other (please provide details)	Please select a number

Click or tap here to enter text.

Drugs (including those with problematic use of both alcohol and drugs)

Placements within ADP area	Please select a number
Placements in rest of NHS Health Board area	Please select a number
Placements outwith the ADP/health board area	Please select a number
Specialist facilities for complex needs (e.g. specific mental health needs	Please select a number
Other (please provide details)	Please select a number

Please provide details, including whether this funding was allocated to partner organisations on behalf of the ADP. If referrals were made to specialist facilities for complex needs, please provide details (max 200 words).

2.2 In your ADP area in 2019/20, which other agencies funded individual residential rehabilitation placements (through funding streams other than Scottish Government alcohol/drug funding allocated to your ADP)?

NHS Board	☐
Social Work Services/Local Authority	☐
Health and Social Care Partnership	☐
Internally charity-funded (by rehab facility)	☐
External charity	☐
Other	☐
Not applicable	☐

Please provide details (including who funds specific pathways) (max 200 words).

2.3 Do you have a system which records all individuals from the ADP area who access residential rehabilitation placements (including those funded privately or by third-sector or statutory funding)?

Yes	☐
No	☐

Please provide details (max 200 words).

2.4 Within your ADP area, do the ADP or partner organisations hold a block-contract or framework agreement for residential rehabilitation placements? (If a contract or agreement is held with a statutory service, please state yes and provide details).

	Through Scottish Government alcohol/drug funding allocated to your ADP	Through other agencies (using funding streams/arrangements other than Scottish Government alcohol/drug funding allocated to your ADP)
Yes	☐	☐
No	☐	☐

If yes, please give details of the facilities used, the nature of the contract or agreement, and the number of placements/ beds under this agreement. If through other agencies, please provide details (max 200 words).

2.5 Aside from any block-contracted beds, are individual residential rehabilitation placements also 'spot-purchased' by the ADP or partner organisations?

	Through Scottish Government alcohol/drug funding allocated to your ADP	Through other agencies (using funding streams/arrangements other than Scottish Government alcohol/drug funding allocated to your ADP)
Yes	☐	☐
No	☐	☐

If yes, please give details of the facilities used, the number of placements spot-purchased and if there is a contract or agreement in place relating to these. If through other agencies, please provide details (max 200 words).

2.6 Generally, in your ADP area what is the length of time for which the ADP or partner organisations provide funding for individual placements in residential rehabilitation provided (excluding unplanned exits)?
Choose an item.
Please provide details (optional) (max 100 words).

2.7 Within your ADP area is there a maximum time limit for which funding is provided by the ADP or partner organisations for individual placements (excluding unplanned exits)?

Yes ☐
No ☐

If yes, please provide details (max 200 words).

2.8 On what criteria is the decision made regarding the length of time for which residential rehabilitation placements are funded by the ADP?

Individual Need ☐
Budget / funding limitations ☐
Rehab provider specific programme length ☐
Potential for loss of housing benefit ☐
Other ☐

Please provide details (max 200 words).

Funding of Residential Rehabilitation Facilities

2.9 Other than supporting individual placements, did the ADP provide funding to individual rehab facilities in 2019/20? If so, which facilities was this funding provided to, how much was provided and what was this funding provided for (e.g. for additional staffing, renovation etc.)? Please provide details (300 words).

3. Pre-Rehab

Waiting Period

3.1 What were the main reasons for individuals being on a waiting list to access residential rehabilitation? Please provide details, particularly for individuals waiting for a substantial period of time (Max 300 words).

3.2 What was the average number of individuals from your ADP area on a waiting list for access to residential rehabilitation in 2019/20? (If possible, please sum the daily number of individuals on the waiting list in 2019/20 and divide by the number of days for which data is available).

3.3 What was the average waiting time for individuals from the ADP area to access residential rehabilitation in 2019/20? (If possible, please sum the daily waiting times for 2019/20 and divide by number of days for which data is available).

3.4 In March 2021, what was the average daily number of individuals on the waiting list for access to residential rehabilitation in your ADP area?

3.5 During this waiting period, who is responsible for the care of the individual? Please provide details (max 200 words).

Preparation for Residential Rehab (Prior to Detoxification)

3.6 Who is involved in the preparation of individuals for placement in residential rehabilitation?

Self-directed preparatory work only ☐
Community alcohol/drug services ☐
Residential rehabilitation provider ☐
Social work services ☐
Other ☐
If other, please provide details (max 100 words).

3.7 Aside from detoxification, what does this preparatory period of work involve? Please provide details (300 words).

3.8 Are there specific preparatory programmes available for individuals in the ADP area who have been accepted for residential rehabilitation placements?

Yes ☐
No ☐
Please provide details (max 100 words).

Detoxification

3.9 What detoxification options are available in your ADP area in 2019/20?

Specific community alcohol detox programme ☐
Specific community drug detox programme ☐

Inpatient hospital alcohol detox	☐
Inpatient hospital drug detox	☐
Detox within residential rehab facility	☐
Other	☐
No specific detox options available	☐

If other, please provide details. Please provide the names of each facility (max 200 words).

3.10 How is detoxification as preparation for residential rehabilitation accessed and funded? Please provide details (max 200 words).
Click or tap here to enter text.

3.11 Is there currently a waiting list for alcohol and/or drug detoxification in your ADP area?

	Yes	No	Not applicable
Community alcohol detox programme	☐	☐	☐
Inpatient hospital alcohol detox	☐	☐	☐
Community drug detox programme	☐	☐	☐
Inpatient hospital drug detox	☐	☐	☐
Other	☐	☐	☐

If yes for any, please provide details on the average waiting period for each, and the reasons for this waiting period (Max 200 words).

3.12 What was the total number of people from your area who accessed inpatient detoxification in 2019/20 (including those not accessing residential rehabilitation)?

All individuals accessing inpatient detox (alcohol only)	Please select a number
All individuals accessing inpatient detox (drugs/drugs and alcohol)	Please select a number
Individuals specifically referred to inpatient detox prior to rehab (alcohol only)	Please select a number
Individuals specifically referred to inpatient detox prior to rehab (drugs/ drugs and alcohol)	Please select a number
Individuals accessing inpatient detox within res. rehab facility (alcohol only)	Please select a number
Individuals accessing inpatient detox within res. rehab facility (drugs/ drugs and alcohol)	Please select a number

3.13 Of those undertaking detoxification as a specific preparatory step to enter residential rehabilitation, how many of these individuals went on to access rehab?

3.14 On average, how long did individuals wait between completing detox and entering residential rehabilitation in 2019/20?

4. Residential Phase

Relationship with Individuals during Residential Stay

4.1 How do relevant community alcohol/ drug services engage with individuals during their stay in residential rehabilitation? Please provide details on how (and how often) this contact is maintained, the typical purpose of this contact, and any differences in these processes between local and non-local rehab placements (max 300 words).

4.2 Prior to COVID-19, were there any challenges to staying engaged with the individual during their stay in rehab? Please provide details (max 300 words).

4.3 What family support do the ADP or partner organisations fund (through Scottish Government alcohol/drug funding allocated to your ADP) for families of individuals attending residential rehabilitation?

Family Therapy ☐ No specific support provided
Family Support ☐ through this pathway ☐
Other ☐

If other or no specific support provided through this pathway, please provide details (max 200 words)

Exit Planning During Residential Stay

4.4 Are measures taken by the ADP/ partner organisations/ relevant community services to ensure that individuals will have access to appropriate housing tenure upon completion of their residential rehabilitation placement?

Yes ☐
No ☐

Please provide details, including who is responsible for this (max 200 words).

4.5 Are there pathways to supported accommodation for individuals from the ADP area completing residential rehabilitation placements?

Yes ☐
No ☐

If yes, please provide details, including who provides funding for this (max 200 words).

4.6 Are measures taken by the ADP/ partner organisations to ensure that individuals have access to employment/work- placements/voluntary opportunities upon completion of their rehab placement?

Yes ☐
No ☐

Please provide details, including who is responsible for this (max 200 words).

4.7 Is planning for aftercare undertaken by your ADP/ partner organisations during the individual's placement in residential rehabilitation?

Yes ☐

No ☐
Please provide details, including who is responsible for this (max 100 words).

5. After Residential Rehabilitation

Care of Individuals

5.1 Which agencies are responsible for the care of individuals from your ADP area following a residential rehabilitation placement? Please provide details, including whether this differs between local/non-local placements (300 words).

5.2 How soon after individuals exit residential rehabilitation do the ADP/ partner organisations engage proactively in contacting the individual? Please provide details for unplanned and planned exits.

5.3 What are the challenges to engaging with individuals who have been discharged from residential rehabilitation placements? Please provide details (max 300 words).

5.4 What are the main reasons for individuals engaging in an unplanned exit before completion of a residential rehabilitation placement? Please provide details (max 300 words).

Aftercare Services

5.5 What aftercare services are funded by the ADP/ partner organisations for those exiting residential rehabilitation placements?

Individual Therapy ☐
Peer Support ☐
Group Therapy ☐
Peer Mentor/Navigator ☐
Rehab Volunteer Support ☐
Mutual Aid Organisations (eg. 12 step) ☐
Lived experience recovery organisations ☐
SMART recovery organisations ☐
Other ☐

Please provide details, including who provides and/or funds these services (max 300 words).

5.6 How is active linkage to mutual aid and lived experience recovery organisations undertaken? Do you have specific guidance? Is this linkage monitored by the ADP? Please provide details (max 200 words).

5.7 How long is aftercare provided for individuals exiting residential rehabilitation placements by the ADP/ partner organisations? Please provide details (200 words). Click or tap here to enter text.

5.8 What measures are taken to link individuals making unplanned exits to aftercare services? Please provide details (max 300 words).

Harm Reduction and Relapse Pathways

5.9 What harm reduction measures and/or protocols are in place for individuals both during the residential phase and upon leaving their rehab placement? Please provide details, including who is responsible for this (max 200 words).
Click or tap here to enter text.

5.10 Are all individuals returning to the community from residential rehabilitation placements provided with take-home Naloxone kits where appropriate?

All ☐
Specific individuals/groups ☐
None ☐

Please provide details, including who provides and funds these kits (max 200 words).

5.11 Are there specific pathways back into residential rehabilitation for individuals who have relapsed having completed a placement previously?

Yes ☐
No ☐

Please provide details (max 200 words).

5.12 Are individuals who make an unplanned exit from a residential rehabilitation placement considered for another placement in the future?

Yes ☐
No ☐

Please provide details (200 words).

Outcomes

5.13 Does the ADP monitor longer-term outcomes of residential rehabilitation placements for individuals from their ADP area?

Yes ☐
No ☐

If so, please provide details, including the length of time for which outcomes are monitored and how this is undertaken (300 words).

6 General Questions

Standardisation

6.1 Is there a standardised process for residential rehabilitation pathways (including aspects such as funding, referral, assessment, access and aftercare) across the ADP?

Yes ☐
No ☐

Please provide details (max 200 words).

If there is a local policy document or similar, please attach alongside completed survey.

COVID-19 Impact

6.2 What impact has COVID-19 had on these residential rehabilitation pathways (including funding, referral, assessment, access, aftercare) for individuals in your ADP area? Please provide details (max 500 words).

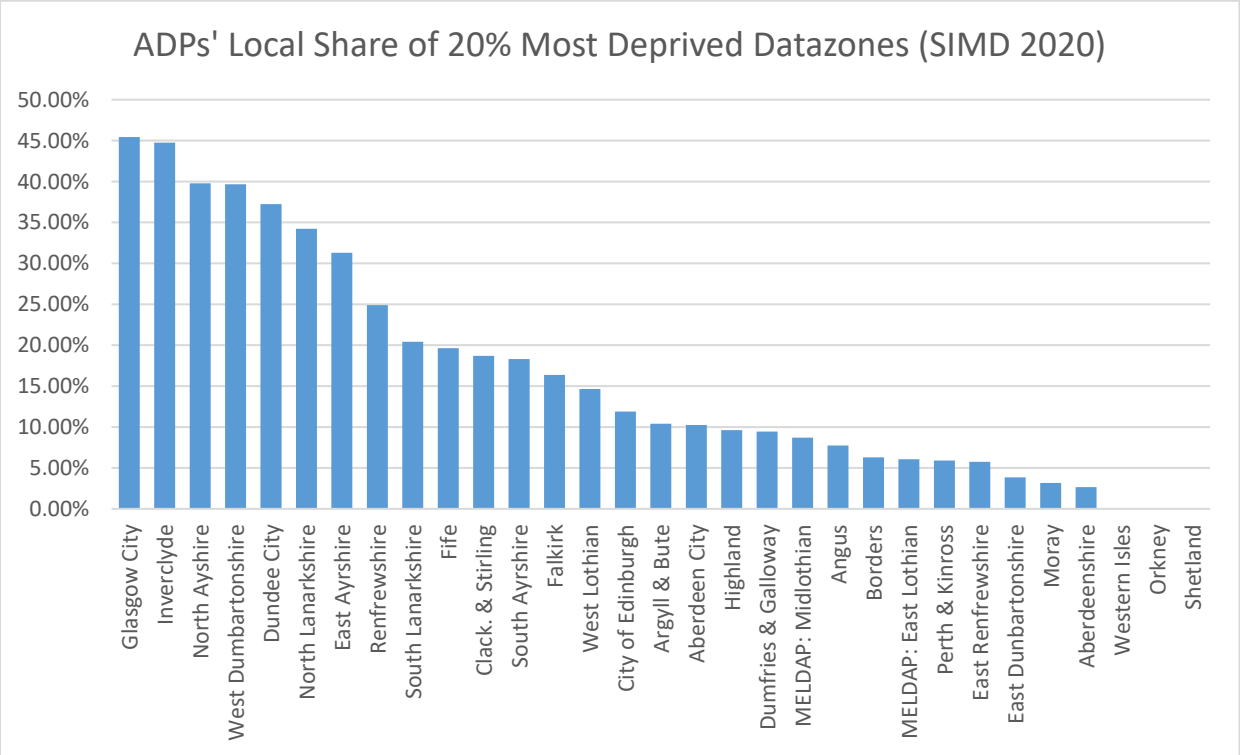
Constraints

6.3 From a strategic planning perspective, what are the determinants which shape the prioritisation/de-prioritisation of the commissioning or resourcing of residential rehabilitation by your ADP/ partner organisations? Please provide details (max 500 words).

General Comments

6.4 What measures would improve access to, and the success of, residential rehabilitation for individuals who experience problem alcohol and drug use? (Max 500 words).

Appendix B – ADP Local Share of 20% Most Deprived Data Zones (SIMD 2020)



Source: Scottish Index of Multiple Deprivation 2020 - gov.scot (www.gov.scot)

Appendix C – Demographic Characteristics of ADP Areas across Scotland

	Percentage (%) Urban/Rural Classification[1]						Mid-Year Population Estimate[2]
ADP	**Large Urban Areas**	**Other Urban Areas**	**Accessible Small Towns**	**Remote Small Towns**	**Accessible Rural**	**Remote Rural**	**Estimated Population**
Aberdeen City	93.4	0.0	5.3	0.0	1.4	0.0	229,060
Aberdeenshire	0.0	30.4	14.4	6.8	35.0	13.4	260,780
Angus	7.6	53.9	11.6	0.0	26.1	0.7	115,820
Argyll & Bute	0.0	17.9	4.2	30.6	4.2	43.0	85,430
Clacks & Stirling	0.0	45.3	29.2	0.0	20.5	3.5	145,370
Dumfries & Galloway	0.0	29.7	17.4	7.7	24.2	20.9	148,290
Dundee City	99.5	0.0	0.0	0.0	0.5	0.0	148,820
East Ayrshire	0.0	42.0	19.1	10.3	20.6	8.0	121,600
East Dunbartonshire	60.1	27.4	7.4	0.0	5.1	0.0	108,750
East Renfrewshire	68.6	18.8	9.1	0.0	3.5	0.0	96,060
Edinburgh, City of	96.2	0.0	2.8	0.0	1.0	0.0	527,620
Falkirk	0.0	90.0	2.0	0.0	8.0	0.0	160,560
Fife	0.0	67.1	15.4	0.0	17.5	0.0	374,130
Glasgow City	99.6	0.0	0.0	0.0	0.4	0.0	635,640
Highland	0.0	31.3	4.2	17.0	9.5	37.9	235,430
Inverclyde	0.0	85.5	12.5	0.0	2.0	0.0	77,060
MELDAP (Midlothian and East Lothian)	11.6	49.45	11.4	7.65	18.95	1.0	201,150
Moray	0.0	36.3	8.2	14.0	29.8	11.8	95,710
Na h-Eileanan Siar (Western Isles)	0.0	0.0	0.0	27.6	0.0	72.4	26,500
North Ayrshire	0.0	72.0	18.8	0.0	4.9	4.3	134,250
North Lanarkshire	1.9	81.6	8.5	0.0	8.1	0.0	341,140
Orkney Islands	0.0	0.0	0.0	34.0	0.0	66.0	22,400
Perth & Kinross	1.2	31.5	10.3	10.9	33.2	12.9	151,910
Renfrewshire	76.0	9.9	9.4	0.0	4.7	0.0	179,390
Scottish Borders	0.0	25.1	22.0	6.0	36.1	10.7	115,240
Shetland Islands	0.0	0.0	0.0	29.6	0.0	70.4	22,870
South Ayrshire	0.0	68.7	4.1	5.7	17.5	4.0	112,140
South Lanarkshire	19.0	59.6	10.7	0.0	9.2	1.6	320,820
West Dunbartonshire	48.2	50.6	0.0	0.0	1.3	0.0	88,340
West Lothian	0.0	82.0	9.7	0.0	8.3	0.0	183,820
Scotland	**34.6**	**36.2**	**8.5**	**3.5**	**11.2**	**5.9**	**5,466,000**

Sources: [1] - Scottish Government Urban Rural Classification 2016 - gov.scot (www.gov.scot) and [2] - Mid-2020 Population Estimates Scotland | National Records of Scotland (nrscotland.gov.uk)

Appendix D – Distribution of Residential Rehabilitation Providers by NHS Health Board and ADP

NHS Health Board	ADP*	Residential Rehabilitation Provider	Sector	Type	Total Capacity (N. Beds)
Argyll & Bute	Argyll & Bute	King's Court, Maxie Richards Foundation	Voluntary/ Not for Profit	Drugs Only	5
Ayrshire & Arran	South Ayrshire	River Garden, Auchincruive	Voluntary/ Not for Profit	Alcohol & Drug	7
	North Ayrshire	Ward 5, Woodland View	Statutory (NHS)	Alcohol & Drug	5
Borders	Borders	Castle Craig Hospital	Private	Alcohol & Drug	110
		Whitchester House, Teen Challenge UK	Voluntary/ Not for Profit	Alcohol & Drug	21
Grampian	Aberdeenshire	Benaiah, Teen Challenge UK	Voluntary/ Not for Profit	Alcohol & Drug	7
		Sunnybrae, Teen Challenge UK	Voluntary/ Not for Profit	Alcohol & Drug	18
Greater Glasgow & Clyde	Glasgow City	CrossReach, Glasgow Residential Recovery Service	Voluntary/ Not for Profit	Alcohol & Drug	17
		Phoenix Futures, Scottish Residential Service	Voluntary/ Not for Profit	Alcohol & Drug	31
		Priory Hospital Glasgow	Private	Alcohol & Drug	9
	Inverclyde	The Haven, Kilmacolm	Voluntary/ Not for Profit	Alcohol & Drug	24
		Jericho House, Greenock (Bank Street)	Voluntary/ Not for Profit	Drugs Only	18
		Jericho House, Greenock (Shankland Rd)	Voluntary/ Not for Profit	Drugs Only	10
	West Dunbartonshire	Alternatives Safe as Houses	Voluntary/ Not for Profit	Alcohol & Drug	36
Highland	Highland	CrossReach, Beechwood House	Voluntary/ Not for Profit	Alcohol & Drug	10
Lanarkshire	South Lanarkshire	Abbeycare Scotland (Abbeycare Group)	Private	Alcohol & Drug	34
Lothian	City of Edinburgh	Bethany Christian Centre	Voluntary/ Not for Profit	Alcohol & Drug	18
		Lothians & Edinburgh Abstinence Programme (LEAP)	Statutory (NHS)	Alcohol & Drug	20
Tayside	Dundee City	Jericho House, Dundee	Voluntary/ Not for Profit	Alcohol Only	12
Western Isles	Western Isles	Hebrides Alpha Project	Voluntary/ Not for Profit	Alcohol & Drug	6

*****All ADPs not included in this table do not have a facility in their local ADP area. A number of these ADPs have reported sending individuals to residential rehabilitation in facilities outwith their ADP area.
Source: Residential rehabilitation: status report on current levels of capacity - gov.scot (www.gov.scot)

How to access background or source data

The data collected for this social research publication:

☐ are available in more detail through Scottish Neighbourhood Statistics

☐ are available via an alternative route

☒ may be made available on request, subject to consideration of legal and ethical factors. Please contact **socialresearch@scotland.gsi.gov.uk** for further information.

☐ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.