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

Results from the Residential Rehabilitation Providers Survey

November 2021

Scottish Government
Riaghaltas na h-Alba
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Executive summary

Overview

- In 2019/20 and 2020/21, there were an approximate total of 1,601 and 1,164 individual placements, respectively, across the 20 residential rehabilitation providers in Scotland identified by previous Scottish Government Mapping and Capacity Reports.

Access, Referrals and Resourcing

- A wait for assessment is typically less than a week, but can be up to a month.
- Three-quarters of people who were formally assessed for residential rehabilitation in 2019/20 were deemed suitable candidates for rehab, with 70% of the total assessed beginning placements.
- The most common reason that individuals are deemed not suitable for rehab are mental health issues; particularly complex or severe and enduring needs.
- Providers reported 425 beds across 20 facilities in Scotland, updating the previous figure of 418 from the Capacity Report in February 2021. Services reported remaining at a lower capacity due to COVID-19.
- On the average day in the month prior to survey, 282 beds (66%) were filled.
- Twelve facilities (60%) accommodate both men and women, another 7 (35%) accommodate only men and 1 facility (5%) only accommodates women.
- The majority of facilities (n=13, 65%) maintain waiting lists to access rehab after assessment, with around 261 individuals waiting at the time of survey.
- Average waiting times in 2020/21 ranged from less than a week to 9 months following assessment, with a median of 3 weeks, although one facility noted wait times were subject to funding confirmation.
- Ten facilities (50%) reported offering in-house detox for alcohol and/or drugs.
- As of 2019/20, in-house detox at the rehab facility was the most commonly reported form of detox prior to residential rehabilitation.
- A total of 534 WTE people work in residential rehabs across Scotland. The majority (n=455 WTE, 85%) are paid, with 79 WTE (15%) volunteers. At least 186 of these WTE workers (35%) have lived experience of recovery.

Individual Placements

- The average cost of a placement in a core programme in rehab in Scotland is £18,112, with placement costs ranging from £6,504 to £27,500 (£350 to £5540 per week). Placements across private providers were typically shorter (5-12 weeks) and more expensive, while third-sector providers were typically longer and less expensive (14-156 weeks).
- In 2020/21 self-funding (35%) was the most common funding source for rehab placements, followed by health-insurance (18%) and ADP funding (14%).
- As of 2020/21, the majority of individual placements in Scotland are at private facilities (54%), with 37% at third-sector and 9% at statutory facilities.
- Rehab is most commonly accessed by those aged 26-35 years old, with a stepwise decline in admission rates among older adult age groups.
- In 2019/20, prior to COVID-19, around 57% of placements came from individuals resident in Scotland, and 43% from those living across the rest of the UK and abroad. In 2020/21, 64% of placements were from Scotland, with 36% from outwith Scotland.

- Around half of rehab placements in Scotland are for alcohol, and half for drugs (either with / without alcohol), with opioids the most common main drug.

Aftercare and Outcomes

- Fourteen providers provided data on placements completed as planned in 2019/20, with three reporting completion rates of between 40-50%, two reporting completion rates between 50-60% and nine reporting completion rates of over 70%. One provider noted that no residents were scheduled to complete their placements until the end of 2021.
- Eighteen (90%) rehabs offer aftercare, with peer support the most common.
- Eighteen facilities (90%) monitor outcomes for individuals who have completed placements, while 11 (55%) do so for unplanned exits.

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 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.

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. This was followed by a report on capacity which found that there were an estimated 418 residential rehab beds/ placements available in Scotland, across the 20 facilities surveyed. 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, 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 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 draws from a survey of residential rehabilitation providers to provides an overview of access, resourcing and provision 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); particularly in the development of a good practice guide on pathways.

2. Methodology

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. The full survey is available in Appendix A. 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.

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

3. Findings

3.1 Demographics and Response Rates

Replies were received from all 20 Residential Rehabilitation Providers in Scotland. These facilities are spread across 13 ADPs. A breakdown of these residential rehabilitation facilities by ADP area and NHS health board is provided in Appendix B. Fifteen (75%) of these rehab facilities are voluntary or not-for-profit, 3 (15%) are privately funded, and two facilities (10%) are funded by the NHS.

3.2 Accessibility of rehab

Identification, Assessment and Referral of Candidates for Residential Rehabilitation

Residential rehabilitation providers reported a wide range of agencies referring individuals to rehab. These included a range of statutory and third-sector organisations. There was substantial variation in the number of agencies referring to each facility. While three providers reported one sole agency referring individuals in 2019/20, others reported multiple (up to 38) different referring agencies. Two providers - one private and one third-sector - suggested that no agencies had referred individuals to their facilities in 2019/20, with all of those starting placements in that year having self-referred.

Eighteen of 20 (90%) residential rehabilitation providers reported that individuals can self-refer for assessment to access residential rehab at their facility. A number of these facilities detailed that the admission and assessment process was similar to that for those who had been referred to the facility by external agencies.

The majority of the individuals who were assessed for residential rehabilitation in 2019/20 began rehab placements at those facilities (Figure 3.1). Of the 2,057 individuals who were assessed for residential rehabilitation in 2019/20 across the 17 facilities for which data was available, around three quarters (n= 1,556, 75.6%) were considered suitable candidates for residential rehabilitation following assessment. Of those who had been deemed suitable for rehab following assessment, 1,430 actually started a placement at this facility; 69.5% of the total who were assessed, and 91.9% of those for whom rehab was deemed suitable at assessment.

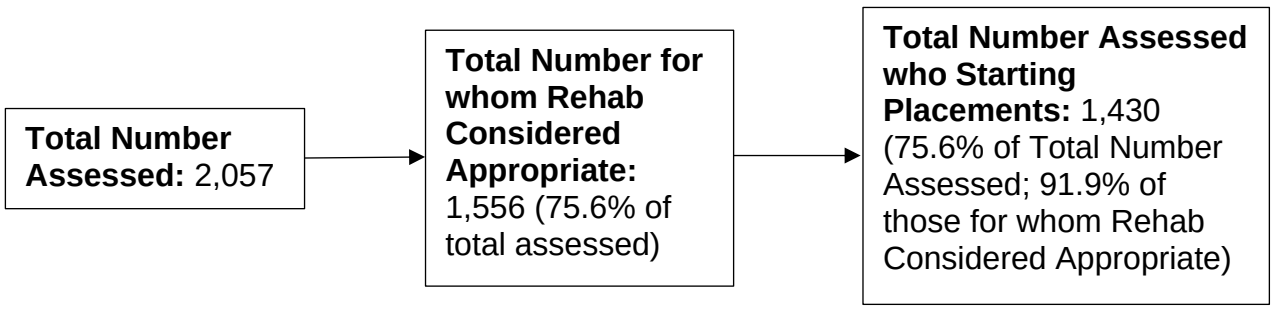


Figure 3.1 – Individuals Assessed, Admitted and Starting Placements at Residential Rehabilitation in 2019/20

Once a person has been identified for assessment, either through self-referral or by external referrers, they typically waited less than a week for assessment. Facilities most frequently suggested that that individuals waited for 3-7 days (n=8, 40%). Others suggested that individuals wait only 1 to 3 days (n=4, 20%). Assessments took two to three weeks across four facilities (20%), while three providers (15%) suggested that they can take up to a month. One facility noted that the length of wait is dependent on the pathway into their facility, with those referred from prison typically taking a few days longer. One highlighted that if there are places available at their facility and the assessment is for an individual in crisis, then the process can be sped up considerably.

Residential rehabilitation providers described wide variation format of assessments. Most facilities described that their main assessments take the form of one-off interviews with the individual seeking access to rehab. A smaller number of others stated that multiple assessments – sometimes on the same day – were undertaken. Some providers highlighted that these followed initial screenings prior to full assessment. Five facilities described using telephone or video calls to undertake initial screenings and/or assessments. **The number and range of individuals who are present at such meetings also varies.** Providers typically described multiple individuals being present at each meeting. These included various constellations of; management staff of the facility; other facility staff; community service key workers; community addictions teams; admissions teams; therapists; psychiatrists; doctors; senior recovery workers; clinical mental health leads; social workers; nurses; occupational therapists, and; family members or carers if chosen. Some facilities described a standardised assessment process for all individuals, while others stated that the constellation of individuals present at each assessment varied by referral route.

<u>Motivation</u>
- Evidence of motivation toward recovery (n=27, 85%);

<u>Medication and Treatment History</u>
- No or non-severe mental health comorbidities' (n=7, 35%);
- Previous history of unsuccessful community treatment (25%, n=5);
- No/limited use of medication (including ORT therapy (25%, n=5);
- Stable on prescription medication (15%, n=3);

<u>Substance Use History</u>
- 'No dependent illicit benzodiazepine use' (30%);
- An extended period of problem substance use (15%, n=3);
- No dependent heroin use (20%, n=4);
- A period of abstinence prior to assessment (5%, n=1);

<u>Criminal Justice History</u>
- No history of specific offences (e.g. arson, violent crime, sexual crime) (15%, n=3);
- No outstanding arrest warrants (10%, n=2);

<u>Housing and Support Networks</u>
- Secure housing to return to (5%, n=1);
- Support network of family and friends (5%, n=1).

Figure 3.2 – Entry Criteria of Residential Rehabilitation Providers in Scotland (n=17)

Providers listed a variety of criteria that must be met for individuals to be deemed suitable for residential rehabilitation at their facility (Figure 3.2). The most common reason that individuals were deemed not suitable for residential rehabilitation were mental health issues; particularly complex or severe and enduring needs. Nearly half of providers (n=9, 45%) noted this as being the foremost reason, with one suggesting that complex mental health needs can prohibit the individual from engaging fully with their therapeutic programme and in the therapeutic community. Another one stated that the most common reason was that they did not accept individuals on anti-psychotic medication. Two facilities suggested that individuals diagnosed as psychotic are only accepted if psychosis is secondary to addiction or trauma, and if mental health professionals are willing to take the person off anti-psychotic or other psychotropic medications. The **inability or unwillingness to evidence motivation –** evidenced by regular phone calls by the applicant, or through a 'readiness' questionnaire – was the next most common issue cited by facilities (n=8). The lack of medical support for detoxification at a number of facilities was also an issue. Some of these stated that **the use of benzodiazepines prior to admission** (n=4) and being on **methadone/prescribed medication** (n=1), as well as those **requiring a high level of medically monitored detox** (n=5) were among the most common reasons. One suggested that, with clinical staff not being on site on a continuous basis, these were undertaken to ensure the safety of the individual and the community. One facility suggests that those using either prescribed or street benzodiazepines would be asked to consult with their doctor about reducing their use before discussing another assessment. Two highlighted that the applicant's **inability to access funding** was the most common reason. A number highlighted that individuals would be signposted towards other options where appropriate, while one suggested that it worked with individuals in order to help make them suitable for admission if possible.

Equality of Access

There was variation in relation to the demographic groups which residential rehabilitation facilities accommodate. Twelve facilities 60%) accommodate both men and women, another 7 (35%) accommodate only men and 1 facility (5%) only accommodates women. One statutory provider which currently only admits men reported being in the process of renovating a building which will allow them to take in female residents. Eight (40%) accepted **pregnant women**, one stating that it did not do so for those who were less than two months from their due date due to not having the facilities to cater for newborn babies. Fifteen facilities (75%) cater for **young adults aged 18 to 25 years**, and fourteen (70%) accept people who are **homeless**. Half of facilities (n=10) cater for individuals with **major mental health diagnoses**.

There was variation in the accessibility of rehab facilities to individuals with specific needs. While just over half of facilities were equipped to admit those requiring the use of a wheelchair, fewer were able to cater for individuals with other specific needs (Figure 3.3). Only a single facility (5%) reported being inaccessible to those with specific needs.

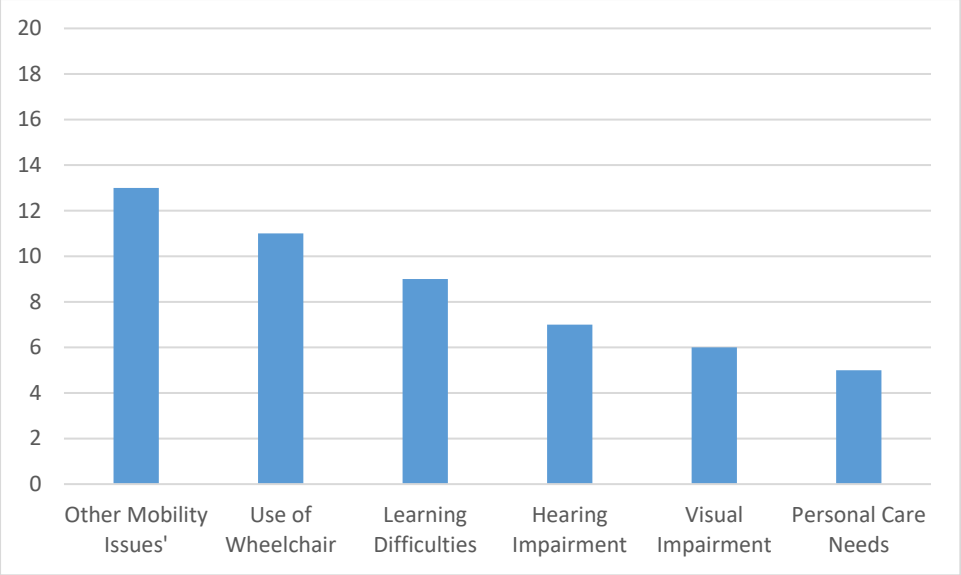


Figure 3.3 – Number of Residential Rehabilitation Facilities Catering for Individuals with Specific Needs (n=20)

Promotional activities

Sixteen facilities (80%) reported undertaking activities (e.g. events/training/wider communication) to promote their facility amongst those working in relevant referring services, while 18 (90%) did so for members of the public who may benefit from residential rehabilitation. Activities included inviting potential referrers and wider recovery organisations to **visit the service** (n=4), other activities mentioned by individual providers were **regular email updates** to referrers. **Presentations to referring agencies**, including prisons, and at **stakeholder conferences.** One highlighted being promoted at NHS Board training sessions and educational materials. Two described being open to **visits from students and young professionals.** One described engaging with church networks, including the distribution of newsletters to church groups. While one holds an engagement event with ADPs, another suggested that they had attempted to engage with ADPs but had been unsuccessful.

Wider promotional work directed at **among members of the public,** providers primarily reported doing so through the maintenance of a **website** (n=18), regular **social media** updates (n=4) and **brochures** (n=6). Others included **annual open days/recovery reunions**, **information sessions**, **drama/musical performances** by those in recovery, and, for one private provider, **radio adverts.** Those that did not engage in promotional work suggested that this was because they were at maximum capacity.

3.3 Resourcing and demand

Capacity and facilities

The survey found a total residential capacity of 425 beds across the 20 facilities in Scotland[1]. These providers reported a median average of 15 beds per facility. The residential capacity across each facility is available in Appendix B. In addition to this residential capacity, there is further capacity for 20 day patients across four facilities. A previous report exploring the impact of COVID-19 on residential rehabilitation capacity found that social distancing measures introduced as a result of COVID-19 had restricted the total residential capacity[2].

Of these 425 beds, facilities reported that at total of 282 beds were filled on an average day over the last month. This equates to two-thirds (66%) of total capacity. This is a slight increase on the 268 beds which providers reported were currently occupied at the time of the capacity survey in February of this year.

Providers reported a total of 316 bedrooms across the 20 facilities in Scotland, with single bedrooms making up around the majority (n=259, 82%) of these rooms (Figure 3.4). Shared rooms were primarily twin rooms, but with a small proportion of trebles. Rooms are allocated on a number of bases; availability; individual needs (including physical mobility); gender; stage of programme (e.g. whether individuals are at a stage where independent living is possible); and, at two facilities, on the basis of a peer-support buddy system. A small number of facilities reported keeping a room available for emergency placements.

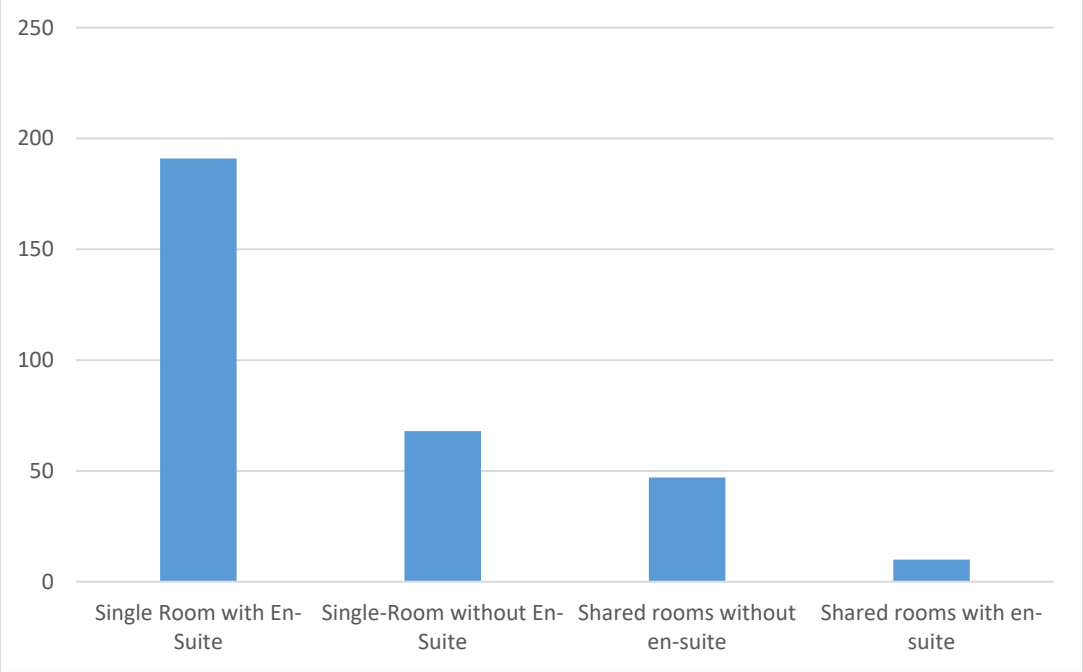


Figure 3.4 – Distribution of Rooms (n=316) Across Residential Rehabilitation Facilities in Scotland

[1] This was an increase of 7 beds from the Scottish Government Capacity Report undertaken in February of this year, with this increase due to a slight increase in capacity across five facilities.
[2] Scottish Government (Feb 2021). Residential Rehabilitation: status report on current levels of capacity. Available at: Residential rehabilitation: status report on current levels of capacity - gov.scot (www.gov.scot)

Individual Placements

Providers reported a total of 1,601 individual placements across all facilities in 2019/20, and 1,164 in 2020/21[3][4]. The lower number of placements reported for 2020/21 reflects both the impact of COVID-19 on placements, as well as the fact that data was only available from 17 services in 2020/21, compared with 18 in the previous year.

There was considerable variation in the number of individual placements across each facility, primarily due to the differing capacity and programme lengths across these facilities. In 2019/20, the greatest number of placements at any one facility was 555, while the fewest was 3. In 2020/21, the greatest number accessing any one facility was 363, while the fewest was, again, 3.

Over half of individual placements in residential rehabilitation across Scotland in both 2019/20 and 2020/21 were at private facilities. Of the total of 1,601 individual placements in 2019/20, 872 (54%) were at private facilities, 588 (37%) were at third-sector facilities and 141 (9%) were at statutory facilities. Of the total of 1,164 placements in 2020/21, 600 (52%) were at private facilities[5], 471 (40%) were at third-sector facilities and 93 (8%) were at statutory facilities.

Around 7 in 10 individuals undertaking placements are male. In 2019/20, 1,107 individuals starting placements were male (69.1%) and 490 were female (30.6%) (Figure 3.5). Four individuals (0.2%) did not identify as the sex assigned at birth. In 2020/21, 821 were male (70.5%) and 343 were female (29.5%) (Figure 3.6).

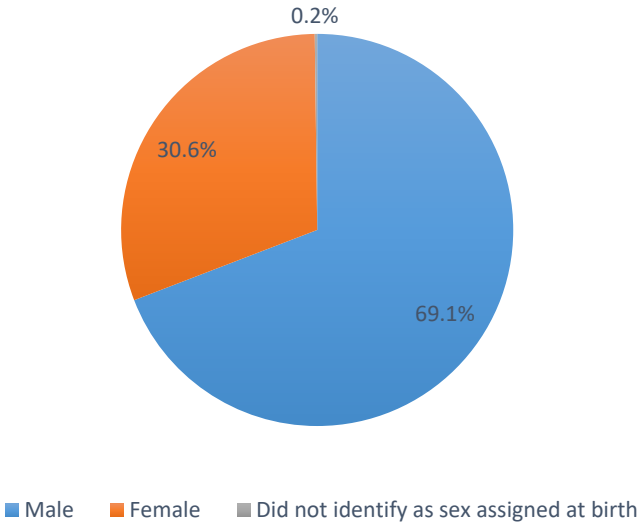


Figure 3.5 – Sex Breakdown of Individual Residential Rehabilitation Placements in 2019/20 (n=1,601)

[3] This report draws on data provided by 18 facilities for 2019/20 and 17 facilities for 2020/21. The figure for 2019/20 is greater than the figure reported previously in the mapping report[3] which only included data from 13 facilities.
[4] For this and subsequent figures throughout this section, CrossReach stated that they had provided the figures for 2019 and 2020, and 2020 and 2021, as opposed to the financial years 2019/20 and 2020/21. For reference, they reported a total of 82 and 84 for these two periods, respectively.
[5] It must be noted that one private facility who reported 60 placements in 2019/20 did not provide data for 2020/21.

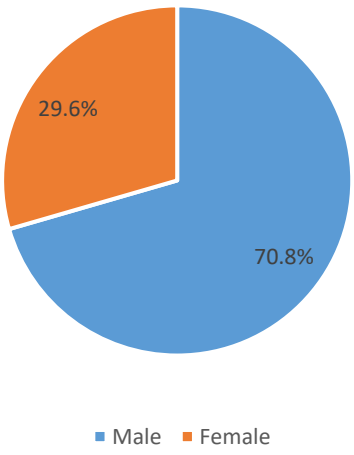


Figure 3.6 – Sex Breakdown of Individual Residential Rehabilitation Placements in 2020/21 (n=1,160)

The most common age category for individuals accessing residential rehabilitation in Scotland is 26-35 years old. Across both years, this was the age-category which contributed the most placements in residential rehab, with a decline in placements across each older-age group in a step-wise manner (Figure 3.7).[6] Across these two years, there was only one individual under the age of 18 years who accessed residential rehabilitation in Scotland.

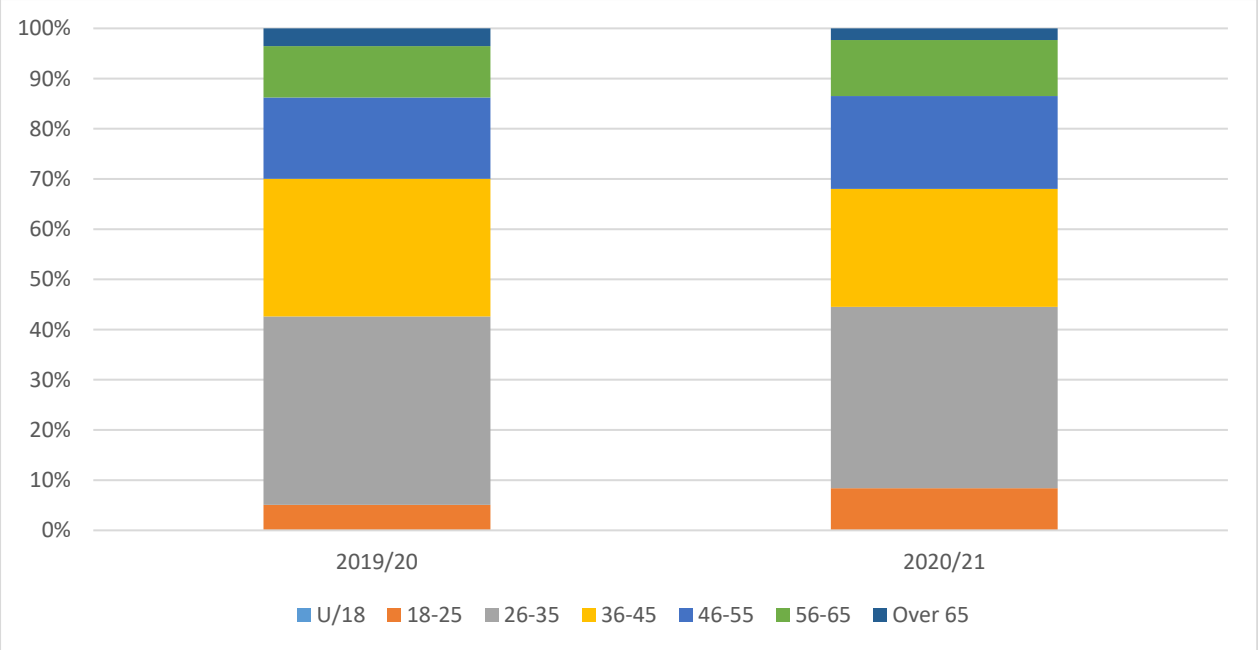


Figure 3.7 – Age Distribution of Residential Rehabilitation Placements in Scotland 2019/20 (1668) in 2020/21 (n=1157).

[6] It should be noted that there were minor inconsistencies between the total number of placements supplied by providers compared with the number of placements broken down by age and residential location.

Residential rehabilitation providers reported that a small proportion of individuals accessing placements at their facilities had physical and learning disabilities (including autism). This amounted to 85 (5%) individuals in 2019/20, and 68 (4%) in 2020/21.

Individuals accessing placements in residential rehabilitation across Scotland come from a range of locations prior to their placement (Table 3.1). For 2019/20, data was available from 18 providers, and for 1,579 (99%) of the total placements across Scotland (Figure 3.8). For 2020/21, data was available from 17 providers for a total of 1,081 (93%) placements (Figure 3.9). It is likely that the reduction in the number of international residents across these two years was due to COVID-19.

Table 3.1 – Previous Residential Location of Individuals Accessing Residential Rehabilitation in Scotland in 2019/20 and 2020/21 (n=2,660)

	Local ADP	Other ADP	**Total Scotland**	Rest of UK	International	**Total Outwith Scotland**	Total
2019/20	479 (30%)	424 (27%)	**903 (57%)**	378 (24%)	298 (19%)	**676 (43%)**	1,579
2020/21	332 (31%)	363 (34%)	**695 (64%)**	259 (24%)	127 (12%)	**386 (36%)**	1,081
Total	811 (30%)	787 (30%)	**1,598 (60%)**	637 (24%)	425 (16%)	**1,062 (40%)**	2,660

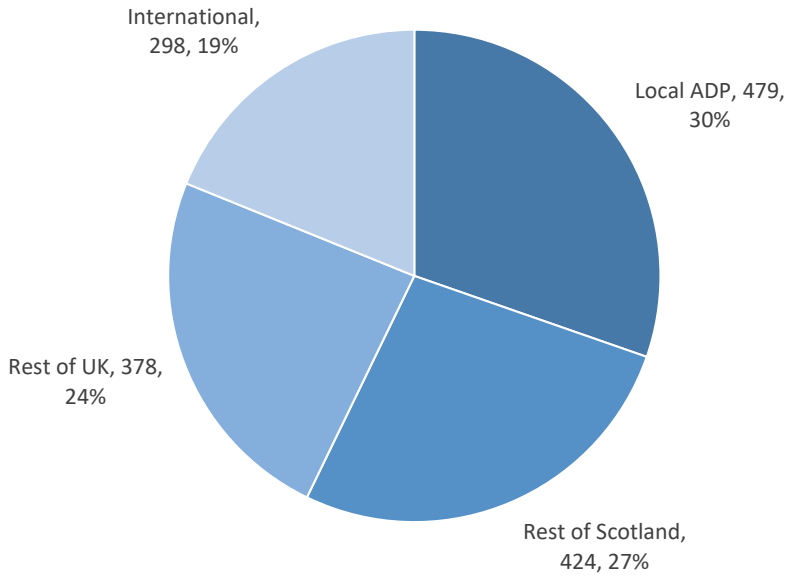


Figure 3.8 – Residential location of individual prior to placement in residential rehabilitation in Scotland (2019/20)

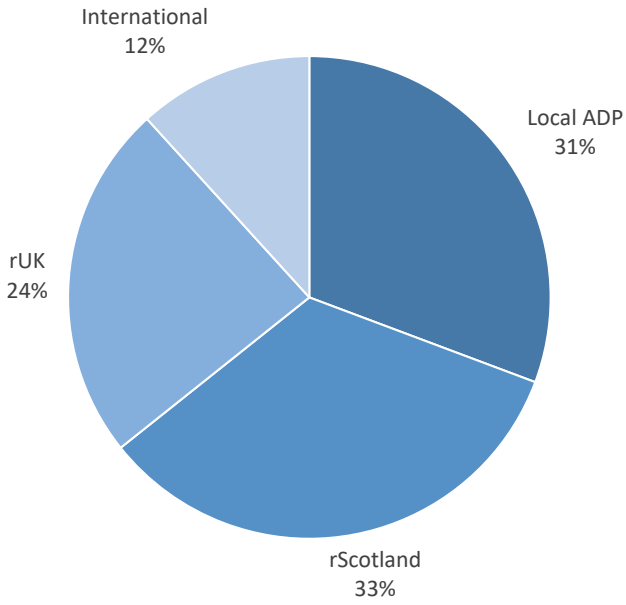
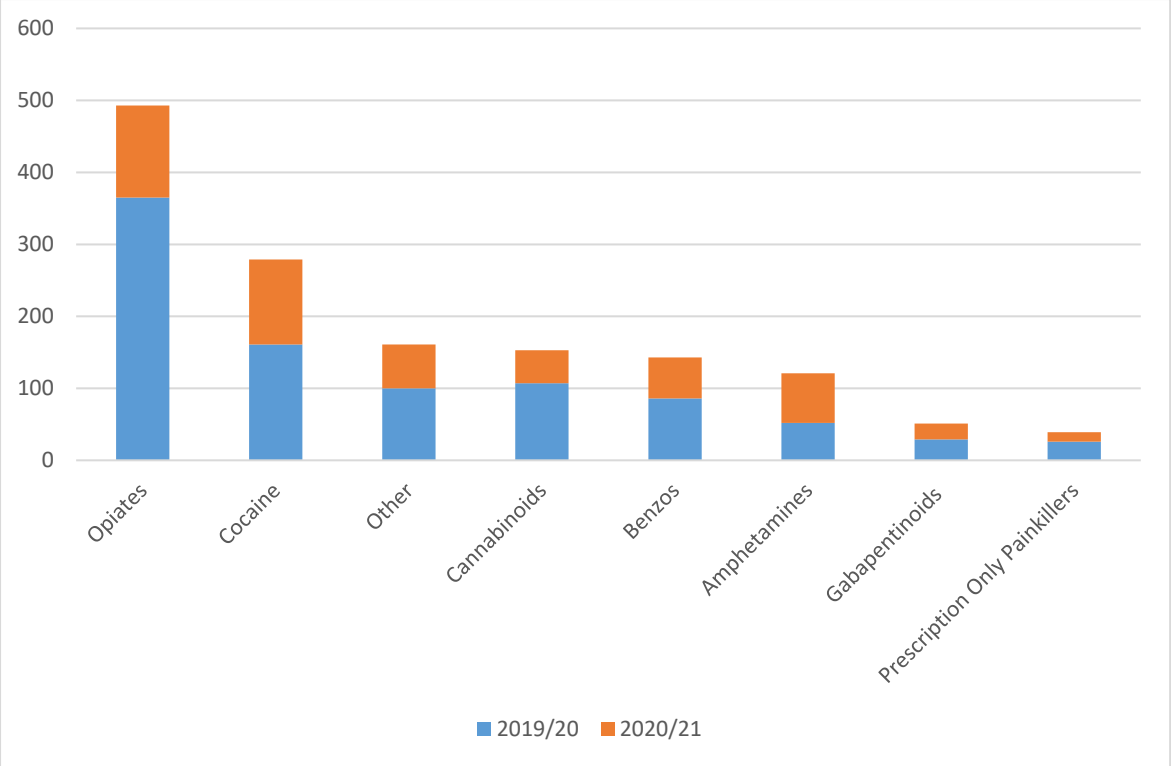


Figure 3.9 – Residential location of individual prior to placement in residential rehabilitation in Scotland (2020/21)

Around half of placements in residential rehabilitation in Scotland are for alcohol only, and around half are for drugs (whether with or without alcohol)[7]. In 2019/20, providers reported on a total of 1892 placements regarding the main substance for which individuals were seeking residential treatment[8]. Of this total, 966 (51%) placements were primarily for **alcohol**, and 926 (49%) primarily for **drugs**. A similar picture was apparent in **2020/21**. For this year, providers reported on a total of 1,266 placements regarding the main substance for which individuals were seeking residential treatment. Of this total, 652 (52%) placements were primarily for **alcohol**, and 614 (48%) were primarily for **drugs**.

Across both 2019/20 and 2020/21, opioids (including methadone) were the most common drug for which individuals were seeking treatment in residential rehabilitation (Figure 3.10). Taking both years together, this was followed by cocaine, 'other drugs' (including anti-depressants, anti-psychotics, ketamine and suboxone/buprenorphine[9]), cannabinoids, benzodiazepines, amphetamines, gabapentinoids, and prescription-only painkillers. One provider noted that, because of polydrug use, these figures may appear misleading; for instance, it may look like benzodiazepine presentation is low, but as a second drug, it was far more common.

[8] [8] While facilities were asked to report on the 'main drug' for which individuals were admitted to their facility, the total number of placements for which the drug was reported was higher than the previous total number of placements provided for both years, suggesting that some had selected multiple categories for some placements, therefore capturing a small proportion of secondary and other drugs which individuals were presenting with. In calculating percentages here, the total number of placements for which a main drug was reported is used; 1,892 in 2019/20, and 1,266 for 2020/21.
[9] From the data provided it was unclear if these individuals were presenting with these as their primary drug.



[1] Other drugs included
[2] Across both years only seven (35%) facilities reported that individuals had started placements with benzodiazepines as the main drug for which they were seeking treatment.

Figure 3.10 – Breakdown of Main Drug Type for which individual seeking residential rehabilitation 2019/20 (n=1,892) and 2020/201 (1,266)

There was a mixed picture across these facilities in terms of the proportion of individuals who were seeking treatment for poly-drug use. While some providers reported that they had seen no polydrug use, others reported that between 80 and 100% of placements in 2019/20 and 2020/21 were individuals with polydrug use (Figure 3.11). Some noted that individuals would commonly have single drug use alongside alcohol. Of those who reported the drugs which were implicated in polydrug use, they noted;

alongside opioids;
- alcohol
- benzodiazepines;
- cocaine (powdered or crack);
- gabapentinoids;
- prescription drugs (including anti-depressants or antipsychotics)
- Methadone and heroin combined;

alongside alcohol;
- benzodiazepines;
- cocaine;
- gabapentinoids;

other drug combinations;
- cocaine and benzodiazepines;
- cannabis with any other drug.

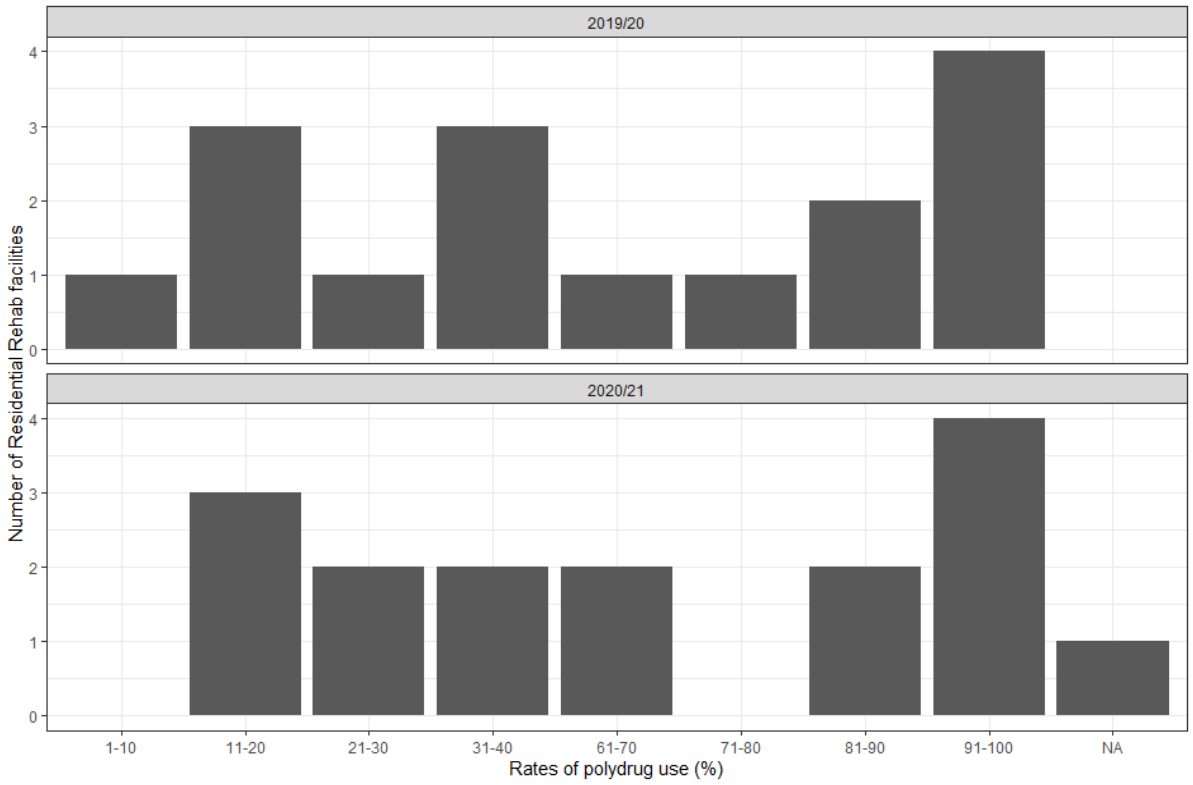


Figure 3.11 – Prevalence of polydrug use among people undertaking placements in residential rehabilitation in Scotland (2019/20 and 2020/21)

Most of the individuals who attend residential rehabilitation in Scotland have previously diagnosed mental health comorbidities. All 20 facilities suggested that mental health disorders were 'common' or 'very common' among those attending their facilities. Of this range of disorders (Figure 3.12), anxiety disorders were most prevalent. Other disorders more rarely seen included eating disorders, and attention deficit hyperactivity disorder (ADHD).

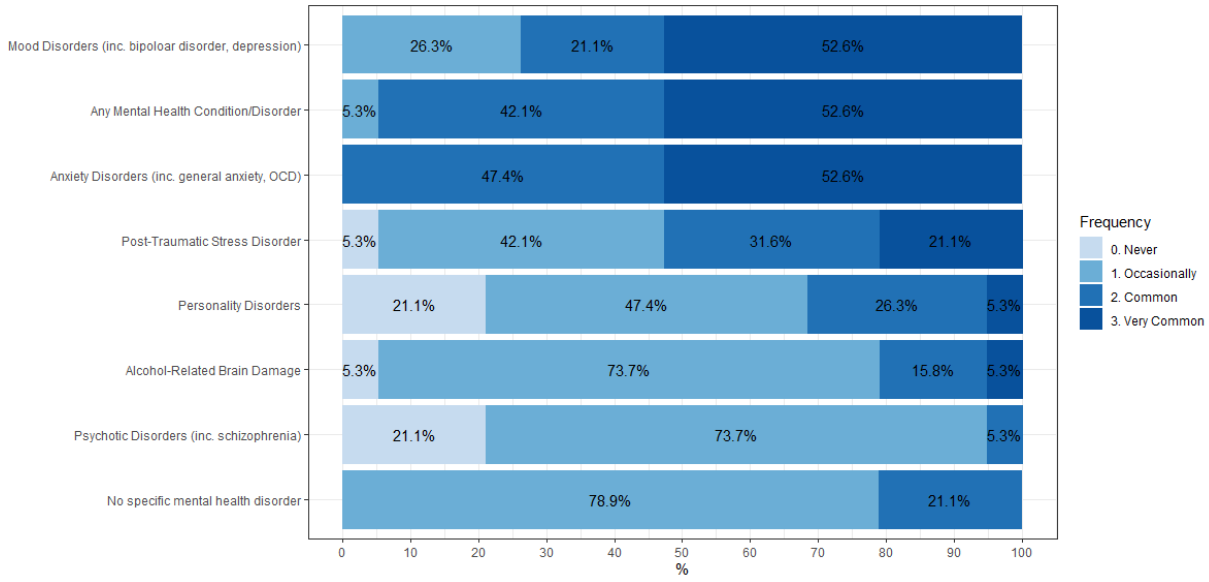


Figure 3.12 – Prevalence of diagnosed mental health comorbidities among individuals undertaking residential rehabilitation placements in Scotland

Funding of Individual Placements

The average cost of a placement in a core programme across the 20 residential rehabilitation providers in Scotland is £18,112. The total core programme cost ranged from £6,504 for 12 weeks at one facility, to around £27,500 for 5 weeks at another. One third-sector facility stated that they operated a social enterprise model within which placements were essentially free, and so did not provide a cost While both of the statutory providers are also free at the point of use to the individual, each of these providers submitted their placement costs (Table 3.2).

Similarly, the length of residential rehabilitation programmes vary substantially across these facilities. The shortest core programme was 4 weeks, while one ran for 156 weeks, or 3 years. The average core programme length across was 23 weeks. Some providers suggested that this was flexible based on individual need. Typically, private providers offered shorter programmes (between 5 and 12 weeks), while third-sector providers offered longer programmes (all over 14 weeks).

Reflecting the differing total placement costs and programme lengths, the weekly cost across these facilities varied widely across Scotland's residential rehabilitation facilities. As well as being shorter in duration, private providers were more expensive, while all third-sector providers were cheaper and offered programmes of longer duration in comparison with the private facilities.

Table 3.2 – Residential Rehabilitation Providers Core Programme Placement Length and Cost (n=19)

Length of Core Programme	Price Per Week	Total Cost
5 weeks	£5,540 (single room), £3,900 (double room)[1]	£27,700 (single room), £19,500 (twin room)
6 weeks	£5,004	£30,024
4 weeks	£4,125	£16,000
12 weeks	£1,332	£15,995
13 weeks	£1,000	£13,010
14 weeks	£840	£11,760
26 weeks	£790	£20,540
26 weeks	£779	£20,254
26 weeks	£745	£19,370
12 weeks	£740	£8,880
26 weeks	£700	£18,200
26 weeks	£596	£15,496
48 weeks	£570	£27,360
40 weeks	£565	£22,600
26 weeks	£557	£14,482
52 weeks	£480	£25,000
52 weeks	£480	£25,000
26 weeks	£364	£9,464
26 weeks	£350	£9,100
156 weeks	£0	£0

[1] This provider reported that lower rates are available for NHS, NHS Practitioners, and Private Insurers

Funding Sources

Providers reported that self-funding remains the most common funding source for placements in residential rehabilitation across Scotland[10]. In both 2019/20 (Table 3.3) and 2020/21 (Table 3.4), self-funding was the most frequently reported funding source, followed by health insurance, with the majority of these placements taking place across private providers. Across these two years, ADPs funded 15% and 14%, respectively, primarily across the third-sector and statutory providers. Other placements were funded by NHS Boards, charitable funding (both through the rehab facilities themselves, and through external charitable organisations and grants), and other sources. These other sources were primarily through **housing benefit,** and a smaller number of **Local Authority** and **Scottish Government Prison to Rehab** and funded places.

Table 3.3 – 2019/20 Funding Sources for Residential Rehabilitation Placements in Scotland for which data was available (17 facilities, n=1,525[1])

	Private Provider (n=3)	**Third-Sector Provider (n=13) [3]**	**Statutory Provider (n=1) [4]**	**Total**
Self-Funded	476	44	0	520 (32%)
Health Insurance Funded	367	0	0	367 (23%)
ADP Funded	8	140	85	233 (15%)
Rehab Provider Funded	4	114	0	118 (7%)
NHS Board Funded	11	61	0	72 (4%)
External Charity Funded	1	2	0	3 (1%)
Other [2]	1	211	0	212 (13%)
Total	868	572	85	1,525

[1] Data on funding was missing funding for 76 (5%) placements

[2] 'Other' includes those funded by Housing Benefit, Local Authority and Scottish Government Prison to Rehab Funding.

[3] Data missing from three third-sector providers

[4] Data missing from one statutory provider

[10] Data on funding was provided by 17 facilities, for a total of 1,525 placements in 2019/20, and 16 facilities for a total of 1,081 placements in 2020/21. Percentages reflect the total number of placements reported previously.

Table 3.4 – 2020/21 Funding Sources for Residential Rehabilitation Placements in Scotland for which data was available (16 facilities, n=1,081[1])

	Private Provider (n=2) [3]	**Third-Sector Provider (n=13) [4]**	**Statutory Provider (n=1)[5]**	**Total**
Self-Funded	371	42	0	413 (35%)
Health Insurance Funded	210	0	0	210 (18%)
ADP Funded	8	132	28	168 (14%)
Other [2]	0	128	0	128 (12%)
Rehab Provider Funded	2	96	0	98 (9%)
NHS Board Funded	11	50	0	61 (5%)
External Charity Funded	0	3	0	3 (1%)
Total	602	451	28	1081

[1] Data on funding was missing funding for 83 (7%) placements
[2] 'Other' includes those funded by Housing Benefit, Local Authority and Scottish Government Prison to Rehab Funding.
[3] Data missing from one private provider
[4] Data missing from two third-sector providers
[5] Data missing from one statutory provider

For funded placements, seven facilities reported that the length of placements was the same across all funding agencies, while six facilities did not have consistent placement lengths agencies. Of those who reported that the placement length was the same across all funders, they reported that the placement length was dependent on the needs of the individual and not linked to funding. Some who stated that the length was different acknowledged that tailoring the length of time to individual need was desirable, but noted that different funders purchase different programme lengths due to their funding limitations. Others reported that some insurers only cover 28 days of treatment.

One voiced their frustration that Local Authorities have not funded placements at their facility. Another highlights that housing regulations can affect the length of a stay. They highlight that if someone is on Housing Benefit in their own tenancy, a joint claim can be made up to a year, after which the individual has to leave, with any subsequent stay being normally around 26 weeks. Housing and DWP can also refuse to sanction another stay in such cases. Similarly, they highlight that Homelessness Services have pressures to reduce figures and those homeless and in residential treatment are still classed as homeless and may need to leave earlier than advised due to homelessness sector pressures to lower numbers.

Just under half (n=9, 45%) of providers reported assisting individuals in accessing funding for placements at their facility. This assistance involved offering guidance to individuals and their families, while a number of other providers described engaging in advocacy work, seeking to encourage potential funders – statutory and third sector – to engage in funding the individual's placement. Facilities who funded individuals to access their service reported a variety of approaches to doing so. These included covering any shortfall in funding, offering 'charity bed' placements, and supporting the extension of placements during COVID-19 lockdown periods.

Half of the residential rehabilitation facilities (n=10, 50%) reported holding block contracts and/or framework agreements with agencies from Scotland or elsewhere. Five providers reported holding block contracts with either one or multiple **ADPs**. Three held a block contract with their **Local Authorities in Scotland**, while another held agreements with **Local Authorities in England**. One facility described a number of **health insurers** holding block contracts; those from the Netherlands and from the US Armed Forces in Europe. Another described currently developing a framework agreement with a local **Health and Social Care Partnership (HSCP)** for two beds. One provider reported that their local **NHS Board** held a block contract with them.

Six facilities (30%) reported that individuals in receipt of housing benefits prior to accessing services opted to *not* take up their place, or engaged in an early exit, due to the risk of losing this benefit. One facility stated that a resident had left the facility partly due to the fear of losing his tenancy and died on an overdose in December 2020. Another facility described that they had to access support from Shelter Scotland to resolve such a case. The Scottish Government has taken action to prevent this through the Dual Housing Support Fund[11].

Funding of Residential Rehabilitation Facilities

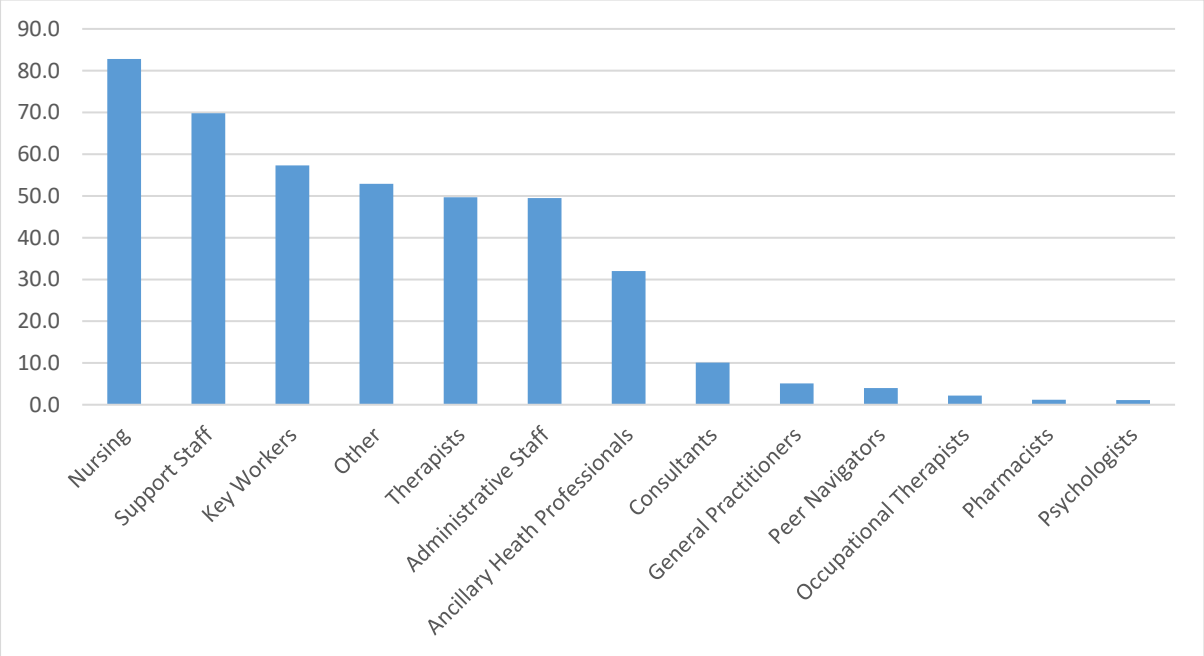
In addition to the income received from individual placements, a number of facilities reported being in receipt of funding from a range of sources. Both of the NHS-run statutory services described received additional funding from three ADPs each. Two received money from the Scottish Government Corra Fund while others mentioned receiving charitable funding from trusts and donors.

Workforce

The total workforce, including both paid and voluntary staff, working in residential rehabilitation facilities across Scotland is around 534.2 Whole Time Equivalent (WTE). The majority of the workforce at these facilities are paid members of staff, amounting to 455.2 WTE overall (85%), with the number of paid workers ranging from 4 to 130 across these providers. An additional 79 WTEs work across these facilities on a voluntary basis (15%), ranging from 1 to 20.

[11] National drugs mission funds: guidance - gov.scot (www.gov.scot)

At least 186 WTE workers (35%) – including both paid and voluntary workers – have lived experience of recovery from problematic alcohol drug use (although several facilities reported not knowing this information). The total WTE with lived experience of recovery ranged across these facilities from 1 to 30. **Facilities employed staff with a range of responsibilities.** Facilities reported employing a range of medical staff, management staff and support staff (Figure 3.13).



[1] 'Other Staff' included executives, management staff, cleaners and chefs.
[2] Data on occupational role was missing for 38 WTE paid staff

Figure 3.13 – Staff Roles across Residential Rehabilitation in Scotland (n=417.2 WTE)

Some facilities do not employ in-house medical and/or nursing staff, and a variety of reasons for this were offered. Financial reasons were the primary reason cited for this. Some providers reported that their model was primarily a **social model rather than a medical model**, and thus had a greater need for other members of staff, including for trained therapists with lived experience. Three highlighted that they primarily operate as (and are classed by the Local Authority as) **supported accommodation**, and therefore both have little need for medical assistance beyond that provided by the local GP practice, and, due to this classification, have insufficient funding through which to develop and run their own in-house clinical unit.

Formal and informal partnerships with a wide range of services were reported by the majority of facilities. Twelve providers (60%) reported having partnerships with **medical services**. These included with Social Care, GP surgeries, NHS Occupational Therapists, consultant psychiatrists, medicine wholesalers, medical practices, pharmacies, NHS detox providers, sexual health nurses and opticians. Nine (45%) worked with a range of **other external partners.** These included Local Authorities (for accommodation), Access to Industry (for employability, training and education), recovery hubs, Housing Agencies, Shelter, advocacy services, food

distribution charities, JobCentres, the non-profit organisation St Vincent de Paul (who provide transport to Mutual Aid meetings), Community Learning and Development services, Street Soccer Scotland. Only 3 providers (15%) reported **no external partnerships**.

All facilities reported that staff members receive a range of training. The most commonly reported was **Health & Safety** training, which every facility that responded to this question confirmed (n=20, 100%). Facilities also reported high proportions of both **drug awareness** and **alcohol awareness** training (n=18, 90%), and **emergency first aid** (n=17, 85%). Three-quarters (n=15, 75%) of facilities undertook **trauma-awareness training**, while a similar number (n=14, 70%) undertook **Naloxone** training. Around half undertook **mental health first-aid** training (n=9, 45%). A number highlighted that individuals could work towards the completion of an **SVQ 3 or 4**. Others mentioned training in relation to a range of aspects of personal development, including in relation to general and specific **physical and mental health**, and a wide range of **training geared towards employability**, **employment skills**.

Regulatory Framework

Fifteen of the 20 facilities (75%) – all of the third-sector providers – are registered charities. Further, all 20 facilities (100%) reported operating within a regulatory framework. Three quarters (n=15, 75%) were registered with the **Care Inspectorate** (including one who was registered with the NHS for the therapeutic programme and the Care Inspectorate for accommodation). Three facilities were registered with the **NHS,** while two were regulated by **Health Improvement Scotland (HIS)**. Two reported being regulated by the **Office of the Scottish Charity Regulator (OSCR)** (one entirely and one in conjunction with the Care Inspectorate). Five facilities also reported that their staff were registered with the **Scottish Social Services Council (SSSC)**.

3.4 Pre-rehab

Waiting Period

Thirteen of the 20 facilities (65%) reported maintaining waiting lists to access residential treatment at the time of survey. A total of 261 individuals across these 13 facilities were on waiting lists at the time of survey. Average waiting times ranged widely across these two years. In 2019/20, average waiting times ranged from less than a week (n=5, 25%) up to 6 months (n=1, 5%). In 2020/21 two institutions reported waiting periods of 8 and 9 months. Waiting lists were primarily maintained due to demand outstripping capacity for residential rehabilitation at these facilities. One provider suggested that individuals can wait while they are undertaking preparatory work in order to meet entry criteria, including reducing medication; one suggested that individuals may have to wait until funding is confirmed; while another suggested that they do not want too many new people at the same time.

Preparation for Residential Rehab (Prior to Detox)

Facilities reported a diverse array of agencies involved in preparing individuals for placement in rehabilitation. Eighteen of 20 residential rehabilitation providers (90%) were involved in this preparatory period themselves, followed by 15 (75%) mentioning **community alcohol/drug services** and 13 (65%) reporting that **prison services** were involved in preparing individuals where relevant. Social Work Services prepared individuals across 12 (60%). By contrast, only 2 (10%) facilities reported involvement from **housing providers**. Across these facilities, **multiple agencies** were involved in the preparation of the individual. Only one facility – a private provider – reported that only self-preparatory work was undertaken.

Preparatory work involved a range of therapeutic and practical activities. Such as attendance at **recovery meetings**, regular contact with project staff, and developing a **recovery plan**. This period of preparatory work also involved work to overcome practical barriers to the individual's placement such as **reduction of drug usage**, sorting out individuals' **financial situation**, **housing, pets, childcare** and other aspects of their life.

One facility offered a 12 week 'Prep for Rehab' programme; and noted that they had seen a **significant improvement in retention and completion rates** since the introduction of this programme of preparatory work.

Detoxification

Ten facilities (50%) reported offering in-house detox for alcohol and for alcohol and/or drugs. These facilities were made up of 5 third-sector providers, all 3 private providers and both statutory providers.

As of 2019/20, in-house detox at the rehab facility was the most commonly reported form of detox prior to residential rehabilitation. This was the case both for individuals seeking residential rehabilitation both for alcohol only and for drugs (whether with or without alcohol) (Table 3.4).

Table 3.4 – Detox Pathways Prior to Placement in Residential Rehabilitation in 2019/20 (n= 1,334)

	In-House Detox at Rehab	**External Inpatient Detox (statutory)**	**External Inpatient Detox (private)**	**Structured Community Detox**	**No Specific Detox**	**Total**
Alcohol Only	523	99	0	57	66	745
Drugs (including alongside alcohol)	386	42	1	55	105	589
Total	909	141	1	112	171	1,334

[1] Data was missing for a relatively large proportion of individual placements (n=267, 17%). The assumption was that missing data was most likely to come from individuals who had not engaged in a specific detox programme. This large proportion of missing data suggests a need for greater link-up between detox services and residential rehabilitation providers.

Rehabs reported a number of different funding pathways for detoxification. Providers highlighted that individuals detoxing prior to access at their facility had done so through funding from the **NHS** (n=11), **private funding** (n=4), **ADPs** (n=3), **Scottish Government Prison to Rehab** funding (n=2), **Turning Point Scotland** (n=2), **prison addiction services** (n=1), and **health insurance** (n=I).

The nine providers who offered in-house detoxification reported that they detoxed individuals from a range of substances. Most commonly, this involved **alcohol** (n=8, 40%) and/or **opioids** (including opioid replacement therapy) (n=8, 40%). Four facilities offered detoxification from **stimulants** (primarily amphetamines and cocaine), four for **benzodiazepines** (20%), while two (10%) offered detox for **gabapentinoids**. Two (10%) noted that they offer support for withdrawal from **cannabis**.

Five of these nine facilities reported having a threshold above which individuals will not be deemed suitable for detoxification. For those on OST this ranged from 30ml to 80ml. These often varied for the same drug between different facilities, and within individual facilities for different kinds of OST.

Two providers who used external inpatient detox facilities reported that there were waiting lists for these detox facilities. These waiting times ranged from **a few days** to **six months for inpatient detox for alcohol and/or drugs**. One reported a waiting list for inpatient detox in Glasgow, although did not state the length of wait. Another reported a **6 month waiting time** for those seeking an inpatient alcohol detox at their local hospital in Glasgow. Another provider highlighted a need to **improve the capacity of clinical detox placements available currently across Scotland.**

Providers who did not have in-house detox provision at their facility utilised a range of inpatient detoxification facilities across Scotland. These included; Kershaw Unit at Gartnavel (NHS), Ward 5 (NHS), Glasgow Drugs Crisis Centre (Turning Point Scotland), Abbeycare Scotland (Abbercare Group), other NHS hospitals, consultant GPs, private GPs, Ritson Clinic in Royal Edinburgh Hospital (NHS).

<u>Drop-Out Prior to Placement</u>

Providers gave a mixed picture regarding whether there were dropouts prior to accessing residential rehabilitation but following successful assessment. Dropouts whilst on the waiting list varied substantially. Thirteen facilities (65%) reported that dropouts occurred ‘hardly ever’ (n=6, 30%) or ‘not very common’ (n=7, 35%), while six (30%) stated that they were ‘common’. Reasons provided for this were that individuals were **unwilling to wait longer**, that their **motivation to achieve abstinence wanes**, that they **lose the stability** that encouraged them to apply in the first place, that their **personal situation changes** (including moving home, being offered work), or thinking that they **do not require rehabilitation** any more. **Dropouts during or following detox were less common, but still occurred across a number of facilities.** Thirteen facilities (65%) reported that dropouts during or after detox were ‘not very common’ (n=10, 50%) or occurred ‘hardly ever’

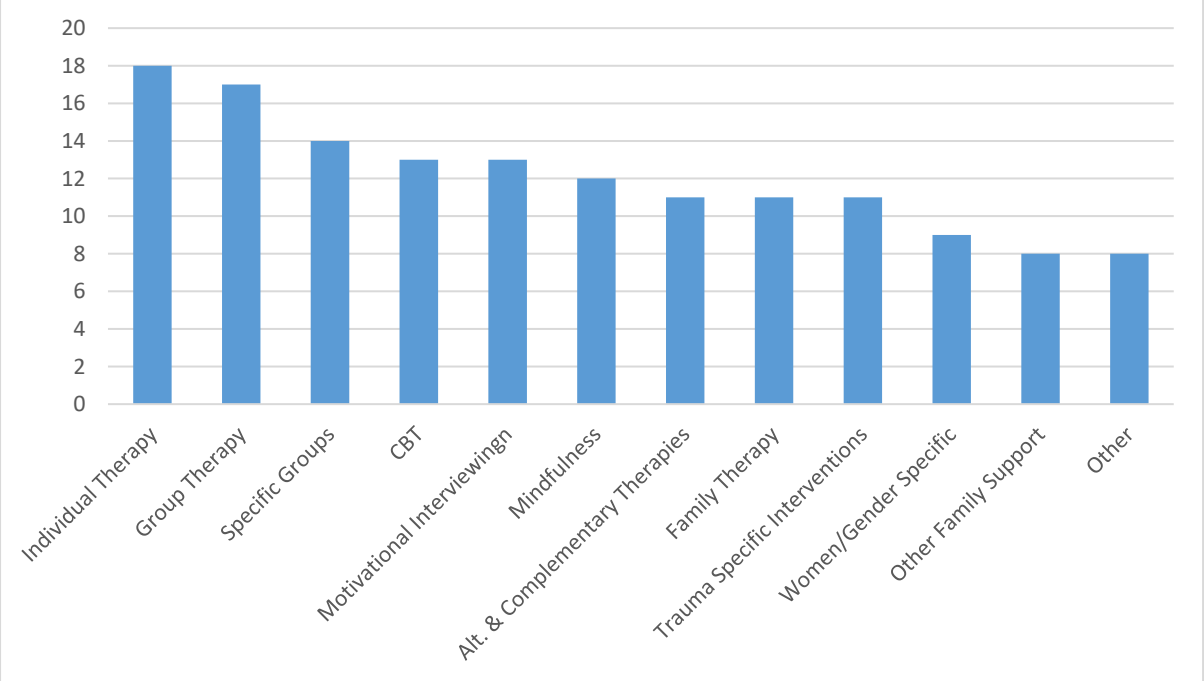
(n=3, 15%). Three providers (15%) suggested that dropouts at this phase were 'common', suggesting that this was particularly the case immediately following detox. This was attributed to a number of reasons; **relapsing**, falsely believing that **detox is the aim** of rehab, **motivation waning**, or the **pressure to deal with their internal feelings being too intense**. Two providers noted that this period is **particularly high risk** due to the reduction in tolerance, and the low barriers towards relapse.

3.5 Residential phase

Programmes offered

Facilities reported offering a wide range of programmes, including a range of individual and group clinical psychological therapies and wider group-oriented activities (Figure 3.14). All facilities offered combinations of multiple activities.

There is substantial diversity across these residential rehabilitation facilities in relation to the models which their provision is guided by. Twelve-step programmes were most common (n=8, 40%), followed by other **faith-based** offerings (n=3, 15%). Two providers stated that they are a **therapeutic community** (10%), one highlighting that they follow all therapeutic community principles as defined by the European Federation of Therapeutic Communities (EFTC). Two others stated that they draw on aspects of the Therapeutic Community approach, while not defining themselves as a pure Therapeutic Community. Others include a model based on **San Patriagno** in Italy, which focuses on peer to peer support, meaningful activity and social enterprise across an extended programme. Two stated that they have **no specific model** but that they offer a suite of programmes tailored towards individuals' needs.



[1] 'Other' included yoga, gardening, football, gym, drama therapy, upcycling, and boat building.

Figure 3.14 – Programmes offered across residential Rehabilitation Facilities in Scotland (n=20)

Relationship with individuals during residential stay

Providers reported a variety of means through which external agencies, such as community alcohol and drug services and ADPs, maintained relationships with individuals throughout the duration of their residential placement. Contact was maintained via phone and/or video calls at a number of providers, while physical visits were undertaken at a greater number of facilities. Again, there was substantial variation in how often contact was undertaken. Some reported weekly phone calls, some suggested that contact was undertaken on a four-weekly basis. Further, there were a number of different purposes reported for such contact; sometimes contact was made for brief, informal catch-ups, while on other occasions, contact took the form of formal reviews. Providers also reported contact with a wide range of agencies; any referral agencies, social work, church groups. The majority of facilities suggested that this contact was tailored towards the individual's needs. A small number of facilities reported no contact with external agencies during the individual's stay.

Sixteen (80%) providers reported that they offer support to the family or carers of the individual while they undergo their residential rehabilitation placement. This primarily involved group support sessions with some facilities offering individual support and therapy. In person visits were permitted by many facilities but generally had to be arranged in advance and were infrequent.
One facility permitted weekends at home if the individual has children, with support plans created for this.

Exit planning during residential stay

All 20 residential rehabilitation providers reported undertaking some form of exit planning with individuals during their residential placement. This exit planning took a number of forms, and occurred at a number of stages of the placement. Where reported, some facilities described identifying all exit needs prior to the individual beginning their placement, while others reported engaging in exit planning at all stages throughout the placement.

Nineteen providers (95%) stated they engaged in exit planning to ensure that individuals have access to appropriate housing tenure upon completion of their placement. A small number of these providers reported engaging in contact with family members in order to ensure that the individual had somewhere to return to (where appropriate). More commonly, facilities linked in with other external housing services, including homeless shelter support, Local Authorities, and housing associations. **Eighteen facilities (95%) described having supported housing or move-on accommodation.** These included the facilities providing accommodation and support to maintain recovery, and to access a tenancy or appropriate accommodation. Others reported having relationships with various external agencies who run supported accommodation locally. One facility described that the council was responsible for supporting patients to suitable accommodation.

Seventeen facilities (85%) reported engaging in planning to ensure that individuals have access to employment/work placements/voluntary opportunities following their placement in rehab. Some of these noted that individuals have the opportunity to secure employment within the project, while others noted that they maintain links to local employers and educational establishments (other facilities may offer these pathways but did not note them here). While a number suggested that these opportunities were available to individuals following the completion of their placement, some began to engage in placements and voluntary opportunities during their placement in order to allow for a smoother transition and to give individuals structure, accountability and purpose in their lives. One offers 'Work-as-Therapy' as part of their Therapeutic Community programme in order to support employability and life skills.

Fourteen facilities (70%) stated that they offer educational and/or training programmes to those undertaking placements. These involved offering **Scottish Vocational Qualifications (SVQs)**, including for cooking, gardening, and a Construction Skills Certification Scheme. **Other training**, included first-aid, food hygiene, community development, mentoring, sports leadership, health and safety, Naloxone, fire safety, manual handling training, money management. Some facilities reported offering **training more specifically targeted towards employability**, including interview skills, self-confidence building, self-assessment, application form work, numeracy and literacy. Some also reported working with residents to identify suitable specialist training in the fields they wish to progress in.

Similarly, every institution reported planning for aftercare during an individual's placement, and 95% said that individuals have discharge plans. Providers reported involvement from a range of people within this process, including of the individual, facility staff, key workers, consultants, therapists, care managers, alcohol and drug recovery service teams, addiction services, and/or any other relevant outside agency. Most described that this was undertaken from early in the individual's placement. One facility highlighted that the only time when it was not possible to develop a discharge plan was when the patient leaves in an unplanned manner without notice One private provider reported that this planning for aftercare was the only form of exit planning which they undertake.

<u>Programme completion and unplanned exits</u>

Providers reported varied completion rates for 2019/20, with nine out of fifteen providers who supplied data reporting that over 70% of individuals completed their placements as planned. Of the fifteen providers who provided data on placement completion, three reported completion rates of between 40-50%, two reported completion rates between 50-60% and nine reported completion rates of over 70%. One provider noted that the residents on placements at the time of the survey were not scheduled to complete their placements until the end of 2021.

Providers reported a range of reasons that individuals would make unplanned exits from their facilities. These included relapses, family and other relationship issues or problems, being home sick, returning to work, not feeling that the programme was right at that time, a challenging detox (often associated with under-reporting prior use), mental health challenges following withdrawal from drugs and/or

alcohol (anxiety noted specifically by one provider), believing that they were healthy and drug free, and being discharged due to non-compliance in the programme (primarily obtaining drugs and, on occasion, attempting to distribute these to others). Three providers highlighted that the isolation period when entering the facility during COVID-19 has been challenging, with one facility reporting that people had left for that reason.

Providers also reported on a number of specific groups who were more likely to engage in unplanned exits. These included; residents who were local to the area; 18 to 25 year olds; those from prison (due to inadequate preparation); opioid users (due to being less likely to endure withdrawal); drug users and, in particular, those who have a long history of problem drug use; those with low recovery capital; those with complex detoxes (particularly those detoxing from several substances); and those with dual mental health and substance use disorder diagnoses. Seven facilities reported that they could not discern any pattern in terms of those who were more likely to make unplanned exits.

These providers also reported on the stages at which unplanned exits typically happen. There were substantial variation in these replies. The most frequently reported were in the **early days and weeks** of placements (n=10, 50%), **midway** through the placement (n=5, 25%), during or immediately following detox (n=3, 15%), or shortly prior to the planned discharge date (n=2, 10%).

3.6 After Residential Rehab

Care of individuals

Providers reported a range of different agencies as being responsible for the care of individuals following placements in residential rehabilitation. The constellation of responsible agencies involved appeared to depend on individual needs, but the primary coordinator of care appeared to depend largely on the area within which the facility was based. This was most commonly reported as being the rehab facility themselves (n=5, 25%), community addiction teams and drug and alcohol services (n=3, 15%), the referring agency (n=2, 10%), church groups (n=1, 5%), Supported Accommodation services (n=2, 10%), Integrated Substance Misuse Team (ISMS) social workers (n=1, 5%). Others reported, depending on need, the involvement of local medical services, the Job Centre, criminal justice agencies, the local authority housing department, and general third-sector organisations including Positive Steps and Christians Against Poverty.

Eleven (55%) residential rehabilitation providers reported engaging in active outreach for patients who do not attend aftercare services, doing so in a variety of ways. This included seeking to maintain contact by phone, and an annual review of progress where possible. One reported piloting a Navigators project with two outreach workers with lived experience to actively seek-out those who had discharged. Another two have community outreach workers in place who can offer support to those who do not have aftercare in place. One suggested that they have a special higher intensity aftercare group for those who relapse. One of the facilities who stated that they did not engage in active outreach highlighted that their links with

local alcohol and drug recovery services who have a proactive engagement policy for all individuals within their remit. Two facilities stated that they do not have the resources to do this, despite knowing that it represents good practice.

A variety of challenges were cited to engaging with individuals who have been discharged from placements. These included relapse, moving to other areas or changing phone number or address, working away, refusal of contact or lack of engagement in appointments. One provider noted that the guilt or shame around relapse is a substantial barrier. Another highlighted the reluctance of certain local authorities to bear any costs among individuals who have attended a placement outwith their area. One provider highlighted that treatment options for those resident in rural areas is an impediment, but that those who have attended the facility still typically make efforts to return for aftercare. Another highlighted that aftercare had been shifted online during COVID-19, which provided a barrier to engagement for a number of individuals. Two highlighted that unplanned exits following withdrawal are particularly risky as individuals have lowered tolerance and there is a greater likelihood of overdose if returning to substance use. Three facilities reported that they were not aware of any such issues.

Aftercare Services

Eighteen (90%) residential rehabilitation facilities reported offering aftercare services, with a wide range of provision. These aftercare services involved a range of programmes tailored either towards the individual or towards recovery groups (Figure 3.15). Other provision included weekly meetings with keyworkers and the ability to visit the rehab facility for a safe environment and support.

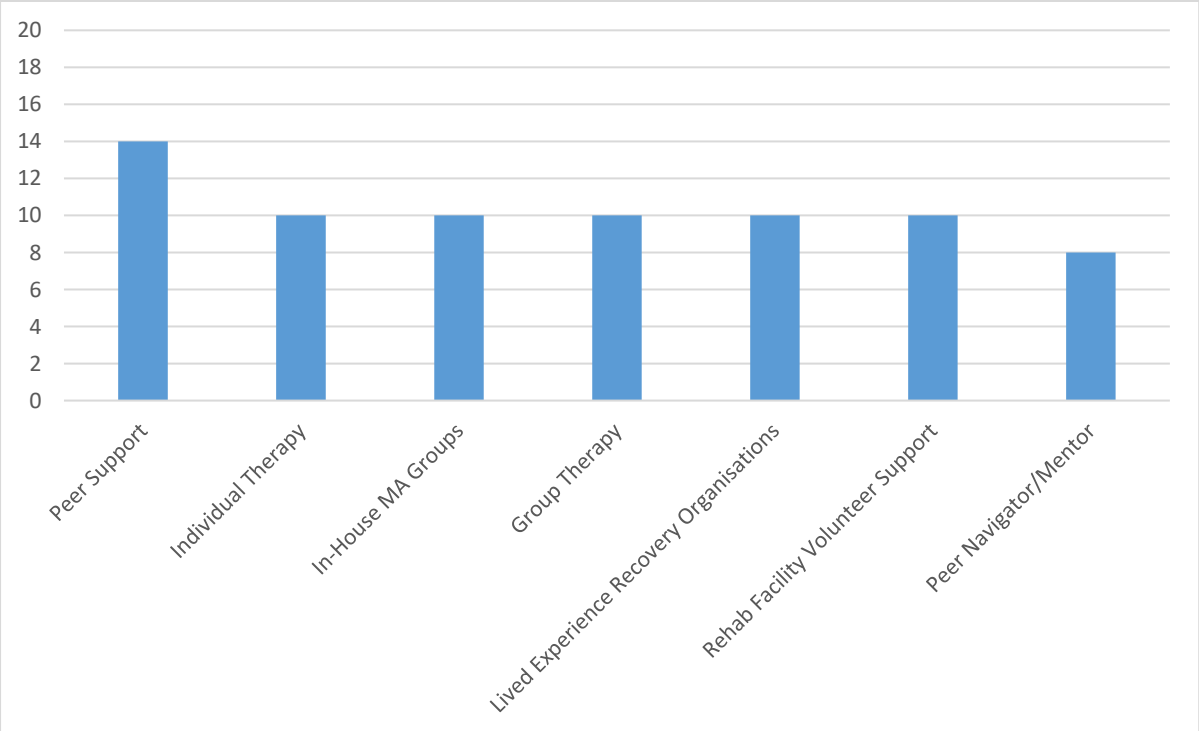


Figure 3.15 – Aftercare Programmes Available at Residential Rehabilitation Facilities (n=20)

Nearly half of aftercare programmes were provided 'for as long as required'. Nine (45%) reported that aftercare was offered on a continuous basis for as long as individuals wish to attend, with no time limit. Two providers highlighted that, they sought to guard against overdependence on this provision. Other durations reported were 24 months (n=1, 5%), 18 months (n=1, 5%), 12 months (n=2, 10%), six months (n=1, 5%) and three months (n=2, 10%).

Fourteen providers (70%) stated that they offer aftercare for those who had made an unplanned exit from their facility. Some noted that this depended on factors including the motivation of the individual, the stage of rehabilitation at which the individual left the programme.

Harm reduction and relapse pathways

Twelve (60%) residential rehabilitation facilities reported offering individuals Naloxone kits. Of these, three rehabs reported offering **all individuals** kits, while nine reported offering them to **specific groups** (noted by some as those who had presented with opioid use or links to those with opioid use). These facilities all highlighted that training would be provided to these individuals in the administering of Naloxone. Some reported that take-up of these kits was high. Eight facilities (40%) stated that they **did not provide Naloxone** kits to individuals at their facility. Nine (45%) provided kits to specific individuals/groups, while three (15%) provided them for all.

All 20 (100%) rehabs reported that individuals who had previously made unplanned exits from their facility would be considered for another placement, with eleven of these facilities (55%) having specific pathways back into residential rehabilitation for individuals who have relapsed. Some of these facilities highlighted that there were conditions behind this access, including whether they had been asked to leave the service for specific reasons (bullying, violence or criminal activity), the time elapsed since exit (including after one month), and whether the individual had used substances since exiting their placement. One facility highlighted that priority would be placed on individuals who are seeking help for the first time.

Sixteen facilities (80%) reported having harm-reduction provision and/or protocols in place for individuals both during the residential phase and upon leaving the placement. This provision included various combinations of; group work on relapse prevention and overdose awareness; counselling; emergency rooms for those who relapse; blood borne virus (BBV) screening; Hepatitis B immunisation; retitration of patients detoxing from opioids back onto their opioid replacement therapy (ORT); and training on BBV issues, women's health issues, men's health issues and Naloxone, tolerance and overdose.

Eighteen facilities (90%) monitor outcomes for individuals who have completed placements, while eleven (55%) monitor of outcomes among individuals who make unplanned exits, where possible. This was undertaken both formally, using a **range of tools** (including Recovery Outcomes Web and Outcomes Star), as well as informally through follow-up contact and documentation. **Outcomes variables** included alcohol intake reduced/ceased; non-prescribed drug

use reduced/ceased; physical health improved, psychological health Improved, social functioning improved. Two rehabs (10%) – one private and one third-sector – **do not monitor outcomes**.

3.7 Impact of Covid-19

Providers noted a number of impacts on their pathways which had occurred as a result of the COVID-19 pandemic and ameliorative policies put into place from March 2020.

Referrals and Assessment

One provider noted an **increase in self-referrals** during COVID, due to drop-in centres and community services closing temporarily and people not knowing where to turn. Similarly, another noted a **negative impact on referrals from agencies/services** for these reasons, as well as from referrers finding out about reduced capacity and longer waiting times at particular services. A large proportion of providers noted changes to the **assessment process**; primarily, a shift towards undertaking the assessment process by telephone or video call. **Admissions were halted** for a period across a number of facilities from March 2020.

Capacity and Workforce

As noted previously, the **intake of residents was limited** due to distancing measures, leading to a reduction in the total number of residents and the total number of day patients. A number noted that the **development of the service was stalled** due to a suspension in fundraising activities. Challenges to **staffing** were also noted, including changes in shifts and increased home working Another noted that staff had to form **bubble groups,** with substantial consequences for working-hours and external activity.

Funding

A number of providers noted a reduced income. One third-sector provider reported £80,000 in **lost revenue** for the first year of COVID-19, stating that this is likely to continue as numbers have been slow to grow.

Pre-Rehab

A number of facilities noted a **substantial increase in waiting lists and waiting times** as a result of distancing measures and the reduction in capacity. One provider, who reported **waiting times of over a year** at the worst point, highlighted that 40% of individuals on the waiting list needed **emergency treatment** in Secondary Care settings (e.g. Accident & Emergency, Hospital Admissions, Acute Mental Health assessments), whereas they typically only have one or two cases happening annually.

Provision

Providers also noted a number of changes in relation to the **programme of activities** available at their facilities. These included limiting the normal programme of activities, and the cancellation of trips to recovery walks, conventions, gym and physical activities. One highlighted a catastrophic service closure followed by loss of their accommodation unit, which was taken over by Public Health and run empty for a year in case of COVID in the homeless population.

Aftercare

Aftercare provision was also impacted, including a shift towards online meetings across a number of facilities. One provider noted a negative impact on **move-on opportunities.**

Outcomes

One facility noted that they have seen a **significant increase in rates of relapse compared to previous years** for both people who have left now (during the pandemic) but also for those who had left in previous years and who with the added stress of COVID now turn back to substance use. Another states that they have had a few **reports of suicide** amongst those requiring rehab which may be due to increased anxiety, their facility being full, other services not being open.

3.8 Suggested Improvements from Providers

When asked what could be done to improve pathways into, through and out of residential rehabilitation in Scotland, most providers gave long and detailed answers, with a range of useful suggestions.

Referrals and Assessment

Two providers suggested that **improved awareness of the value of residential rehabilitation** among professionals would assist in increasing the number of placements. One of these highlights that access is variable depending on how high a profile rehab has in services and whether individual practitioners rate it as a worthwhile intervention. Linked to this, one provider noted that **increasing awareness of actual facilities across all potential referrers** was essential.

Increasing public knowledge about the existence, purpose and role of residential rehabilitation was mentioned by another provider. They suggests that using peers with lived experience as bridges between the community and the rehab can help overcome this. Linked to this, one provider noted that there needs to be careful consideration of public messages in relation to raising **unrealistic client and family expectations** around being able to immediately access residential support of their choice. They highlight that the Scottish Government funding, while welcome, may not be sufficient to meet every client and family member's expectations.

One provider suggests that the **greater flexibility of entry criteria**, with a person-centred approach, would be of benefit.

Capacity and Workforce

A substantial number of providers noted that **increasing capacity** within their facilities and across the sector would be beneficial, given that demand outstrips demand in their experience. Two providers noted an intention to do so, but that they had not been able to access adequate funding.

One provider also suggested that the country could also benefit from **a system where one can easily identify where detox and rehab space is available**. They highlight that there are services which are under occupied while people are still on waiting lists at others (albeit often by choice).

Two ADPs suggested that there is a need to build up **regional capacity** as they feel that those placed locally have greater outcomes.

Funding

A number of providers placed focus on **proper access to funding** as among the main improvements which they would make. A number of these providers described their service as being continually financially precarious, and not being able to engage in medium- to longer-term planning due to this. They also noted not being able to engage in improvements to the quality and capacity of their facilities. One provider suggested that the majority of their core funding comes from non-drug programme funds; foremost, Big Lottery funding and Housing Benefit paid by Housing Services in lieu of residents' benefits.

One residential rehabilitation provider suggests a need for a **more accessible funding stream than through ADPs**. They feel that, from their experience, most ADPs do not understand rehab or how it fits with recovery journeys. They highlight that their service is dependent on engagement and funding from a number of ADPs with different priorities and different levels of communication with them.

A number of ADPs suggested **alternative models of funding**, included national or centralised funding – on either an interim or permanent basis – and **centralised block purchasing** of beds. Another suggested a need for **greater flexibility in the length of ADP/ other statutory funding for stays** based on individual need.

Pre-Rehab

Three providers reported that **access to detox is** among the biggest issues for their services. They suggested that a better pathway for detox would help assist in admitting individuals more quickly into their rehabilitation programmes. Linked to this, another provider suggested that those on **higher doses of drugs** should be able to access rehab to a greater extent than at present. One provider noted that individuals should not be put through **stand-alone detoxes**, but that they should be linked to suitable rehabs as standard.

Residential Provision

A number of providers highlighted that giving **individuals choice regarding treatment types** instead of fitting them into expectations was key.

Developing **new treatment protocols and pathways for polydrug use and higher level opioid replacement prescriptions** was highlighted as a priority by one provider.

Some providers note that there is a **need for services which do not require abstinence as a treatment goal**, given that abstinence will be unachievable for a number of individuals at certain stages in their recovery. One highlights that the evidence is clear that abstinence can take multiple attempts before being achieved and that services should therefore be fluid in their approach to individual's needs.

Another provider was critical of the setting of **prohibitive timescales for success**, stating that person-centred flexibility is required in terms of programme length and follow-up engagement.

One provider notes that **raising hope through the presence of lived experience** in every drug and alcohol service setting would be of benefit.

Aftercare

A number of facilities noted that it is imperative to ensure that **every individual received follow-up care and support**, whether they have completed their placement or not.

One provider suggested that success in the aftercare period will be maximised through **pro-recovery social connections** (contagion of recovery) via mutual aid and LEROs

Outcomes

One facility suggested that service providers require to **improve on how we record data to evidence the efficacy** of residential rehabilitation. including a need to simplify and streamline recording across all residential rehabilitation services.

Relationships, Communication, Sharing Knowledge and Resources

A number of providers stated that there was a need to improve **joined-up, partnership working between all relevant services** at each stage of a person's recovery journey. One provider suggested that this may be coordinated by paid individuals with **lived experience**.

Linked to this, one rehab provider highlighted that **sharing best practice with other providers and statutory authorities** would enable the improvement of pathways and provision. The need for more **creative and collaborative approaches** to funding and pathways was highlighted.

Providers also argued for a need for **greater communication between the Scottish Government and NHS Trusts,** between **ADPs and providers**, and between **ADPs themselves**. A few highlighted that engagement with ADPs had been challenging, and highlighted a lack of coordination at a regional level.

Appendices

Appendix A – Full Survey Distributed to Residential Rehabilitation Providers

1. Access

Identification, Assessment and Referral of Candidates for Residential Rehabilitation

1.1 Please list the names of agencies who referred individuals to your facility for assessment for residential rehab in 2019/20. Where appropriate please give the location of these agencies. If the number of referrals from each agency is known, please state (max 300 words).

1.2 Are individuals able to self-refer for assessment for access to residential rehabilitation at your facility?

Yes ☐
No ☐
Please provide details (max 200 words).

1.3 How many individuals were referred from each ADP area in 2019/20?

Aberdeen City	Please select a number
Glasgow City	Please select a number
Aberdeenshire	Please select a number
Highland	Please select a number
Angus	Please select a number
Inverclyde	Please select a number
Argyll & Bute	Please select a number
Lothian: MELDAP	Please select a number
Borders	Please select a number
Moray	Please select a number
City of Edinburgh	Please select a number
North Lanarkshire	Please select a number
Clackmannanshire & Stirling	Please select a number
North Ayrshire	Please select a number
Orkney	Please select a number
Dumfries & Galloway	Please select a number
Perth & Kinross	Please select a number
Renfrewshire	Please select a number
Dundee City	Please select a number
Shetland	Please select a number
East Ayrshire	Please select a number
South Ayrshire	Please select a number
E. Dunbartonshire	Please select a number
South Lanarkshire	Please select a number
W. Dunbartonshire	Please select a number
East Renfrewshire	Please select a number

Falkirk	Please select a number
West Lothian	Please select a number
Fife	Please select a number
Western Isles	Please select a number

1.4 How many individuals reached the stage of formal assessment for residential rehabilitation at your facility in 2019/20, how many of these individuals were successful in this assessment, and how many of these individuals actually started a placement at your facility?

Formally assessed for residential rehabilitation	Please select a number
Successful in assessment	Please select a number
Actually started placement at your facility	Please select a number

1.5 Once a person has been identified for assessment, how long typically was it until they received this formal assessment? Does the length of time differ for different referrals pathways (e.g. from different referrers, or from the Prison to Rehab programme)?

1.6 How are assessments for your facility conducted? Who is involved in this process? Does this process differ based on who is referring? Please provide details, including whether this process has changed due to COVID-19 (max 300 words).

1.7 What criteria must be typically met for individuals to be deemed suitable for residential rehabilitation at your facility? Please select all options that apply. If selected, please provide details where appropriate.

Previous unsuccessful community treatment	☐	Please provide details
Evidence of motivation towards recovery	☐	Please provide details
Extended period (years) of problem substance use	☐	Please provide details
Opiates or benzodiazepines as primary drug	☐	Please provide details
No history of specific offences (e.g. arson, violent crime)	☐	Please provide details
No unspent/outstanding arrest warrants/criminal charges	☐	Please provide details
No or non-severe mental health comorbidities	☐	Please provide details
Stable on prescription medication	☐	Please provide details
Has secure housing to return to	☐	Please provide details
Has support network of family and friends	☐	Please provide details
Period of abstinence prior to assessment	☐	Please provide details
No dependent heroin use	☐	Please provide details
No dependent illicit benzodiazepine use	☐	Please provide details
No/ limited use of medication (including Opiate Replacement Therapy)	☐	Please provide details
No specific entry criteria	☐	Please provide details
Other	☐	Please provide details

1.8 In the assessment process, what are the most common reasons that individuals are deemed not to be suitable for residential rehabilitation at your facility? What happens to individuals who are deemed unsuitable at the assessment stage? Is there an opportunity to appeal/ review these decisions? Please provide details (max 500 words).

1.9 Does your facility cater for individuals with specific needs/ vulnerabilities?

Men	☐	Men with dependent children	☐
Women	☐	Women with dependent children	☐
Pregnant women	☐	Children (under 18 years)	☐
Young People (18-25 y/o)	☐	Homeless individuals	☐
Major Mental Health Diagnoses (e.g. psychotic illness, personality Disorder, major depression	☐		
Other	☐	No specific measures taken	☐

Please provide details of any specific measures taken to cater for these groups (max 300 words).

Promotional Work

1.10 Does your organisation undertake activities (e.g. events/ training/ other communications) to promote and facilitate referrals to your facility among those working in relevant referring services?

Yes ☐

No ☐

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

1.11 Does your organisation undertake activities (e.g. open days/ leaflets/ posters/ social media posts) to promote your facility to members of the public who may benefit from residential rehabilitation?

Yes ☐

No ☐

If yes, please provide details (max 200 words). If you maintain a website or have a brochure, please copy the url below, and attach the file to your completed survey.

Referrals from Prisons (including Prison to Rehab)

1.12 How do you engage with Scottish Prison Service (SPS) staff regarding the services which your facility offers? How would you describe your facility's relationship with the prison service? Can anything be done to build on/ improve this? Please provide details (max 200 words)

1.13 If your residential rehabilitation facility is not involved in the Prison to Rehab pathway, is this something that you would be interested in?

Yes ☐

No ☐

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

1.14 Since the launch of the Prison to Rehab pathway, how many referrals have you had from prison generally, and, if applicable, through the Prison to Rehab pathway?

Referrals via Prison to Rehab	Please select a number
Other Prison Referrals	Please select a number

1.15 Can you describe the process for arranging the transfer of someone from prison to your facility? Does this differ if the individual is on the Prison to Rehab pathway? How has COVID-19 impacted on these processes? Please provide details (max 200 words).

If your facility is not involved in the Prison to Rehab pathway, please skip to the following section (section 2).

1.16 If applicable, what are the main facilitators and barriers for individuals accessing residential rehabilitation at your facility through the Prison to Rehab pathway? Please provide details (max 300 words).

1.17 If applicable, do you feel the right people were being identified by referrers to join your programme? Is there anything that might improve this process? Please provide details (max 300 words).

1.18 If an individual has been confirmed on the Prison to Rehab pathway, can you describe how the process of securing funding for these individual placements has worked in practice? Please provide details (max 300 words).

1.19 Have you experienced individuals dropping out of the Prison to Rehab pathway at the transfer stage? If so, what were the circumstances? Have you encountered any problems with the transfer process and would you have any suggestion for how it could be improved? Please provide details (max 200 words).

1.20 Have any of the people who entered your programme via the Prison to Rehab pathway left before the end of their treatment programme? Please provide details (max 200 words).

2. Resourcing and Demand

Capacity and Facilities

2.1 What is your maximum placement capacity? If you have a restricted maximum capacity due to COVID-19, please provide this in addition to your total.

	Total (Non-COVID) Capacity	COVID-Restricted Capacity
Residential Patients	Please select a number	Please select a number
Day Patients	Please select a number	Please select a number

2.2 How many bedrooms are there at your facility? Please include all bedrooms including those in offsite residential provision.

Single rooms without en-suite Please select a number
Single rooms with en-suite Please select a number
Shared rooms without en-suite Please select a number
Shared rooms with en-suite Please select a number

Please provide details on how these rooms are allocated (including whether the individual is able to choose). If there are shared rooms of either kind, please provide details on how many beds are in each of these rooms (provide 200 words).

2.3 On an average day in the last month, how many places were filled at your service?

2.4 Is your service accessible for those with the following specific needs?

Use of Wheelchair	☐	Visual Impairment	☐
Other Mobility Issues	☐	Hearing Impairment	☐
Learning Difficulties	☐	Personal Care	☐
Other	☐	Not accessible for those with specific needs	☐

Please provide details (max 300 words).

Individual Placements

2.5 How many individuals started a residential rehabilitation placement at your facility in the following years? (The categories in this question refer to people's sex registered at birth).

	2019/20	2020/21
Total	Please select a number	Please select a number
Male	Please select a number	Please select a number
Female	Please select a number	Please select a number
People who identified as other than their sex registered at birth	Please select a number	Please select a number

2.6 What was the age breakdown of individuals starting a placement at your facility?

	2019/20	2020/21
Under 18	Please select a number	Please select a number
18-25	Please select a number	Please select a number
26-35	Please select a number	Please select a number
46-55	Please select a number	Please select a number
56-65	Please select a number	Please select a number
Over 65	Please select a number	Please select a number

2.7 How many individuals starting a placement your facility had a physical or learning disability (including autism)?

2019/20 Please select a number
2020/21 Please select a number

Please provide details (max 200 words).

2.8 Where were those starting placements at your facility in 2019/20 resident prior to entering rehab?

	2019/20	2020/21
Local ADP/NHS Area	Please select a number	Please select a number
Rest of Scotland	Please select a number	Please select a number
Rest of UK	Please select a number	Please select a number
International	Please select a number	Please select a number

2.9 How many individuals starting a placement at your facility in 2019/20 had each of the following as the main substance for which they were presenting?

	2019/20	2020/21
Alcohol	Please select a number	Please select a number
Amphetamines	Please select a number	Please select a number
Cannabinoids (inc. synthetic)	Please select a number	Please select a number
Cocaine (powder/crack)	Please select a number	Please select a number
Benzodiazepines (presc./street)	Please select a number	Please select a number
Gabapentinoids	Please select a number	Please select a number
Methadone	Please select a number	Please select a number
Opiates	Please select a number	Please select a number
Prescription-only painkillers	Please select a number	Please select a number
Other	Please select a number	Please select a number

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

2.10 Approximately what percentage of people attending the service presented with dependency on multiple (two or more) drugs, not counting alcohol?

2019/20 Choose an item.
2020/21 Choose an item.

Please provide details on the drug profiles which people engaging in poly-drug use commonly present with (max 300 words).

2.11 How common is it that individuals attending the facility have the following diagnosed mental health comorbidities?

	Never	Occasionally	Common	Very Common
No specific mental health disorders	☐	☐	☐	☐
Any Mental Health Condition/ Disorder	☐	☐	☐	☐
Alcohol-Related Brain Damage	☐	☐	☐	☐
Anxiety Disorders (inc. general anxiety, OCD)	☐	☐	☐	☐
Mood Disorders (inc. bipolar disorder, depression)	☐	☐	☐	☐
Personality Disorders	☐	☐	☐	☐
Psychotic Disorders (inc. schiz.)	☐	☐	☐	☐
Post-Traumatic Stress Disorder (PTSD)	☐	☐	☐	☐
Other	☐	☐	☐	☐

If 'other', please provide details on the conditions and how common these are.

Funding of Individual Placements

2.13 How much does a placement at your facility cost? Please provide details, including a breakdown of specific components (e.g. for treatment and accommodation) and different programmes if applicable (max 300 words).

2.14 How long does the core programme at your facility last? Please also provide details on the length of any additional programmes (max 300 words).

2.15 How many individuals were funded by each of the following agencies?

	2019/20	2020/21
Local ADP	Please select a number	Please select a number
Other ADP	Please select a number	Please select a number
NHS Health Board	Please select a number	Please select a number
External Charity	Please select a number	Please select a number
Funded by Facility	Please select a number	Please select a number
Health Insurance	Please select a number	Please select a number
Self-Funding	Please select a number	Please select a number
Other	Please select a number	Please select a number

If other, please provide details, including a breakdown of the number of individuals funded by each of these sources if applicable (max 200 words).

2.16 Is the length of funded placements the same across all funding agencies?

Yes ☐

No ☐

If no, please provide details (max 200 words).

2.17 If your facility funds placements, which individuals receive this funding? How are these decisions made? How does the individual access this funding? Please provide details (max 300 words).

2.18 Do you hold any block contracts/ framework agreements with agencies from Scotland or internationally (e.g. ADPs/ NHS Boards/ Local Authorities/ Health Insurance Providers)?

Yes ☐

No ☐

If yes, please provide details of these arrangements, including the nature of the contract and who they are held with (max 200 words).

2.19 Does your facility assist individuals in accessing funding for a placement at your facility?

Yes ☐

No ☐

If yes, please provide details on how this is undertaken and if your facility has any agreements with external funding bodies (max 200 words).

2.20 Have individuals in receipt of housing benefit prior to accessing your facility ever not taken up a place, or engaged in an early exit from your facility due to the risk of losing this benefit?

Yes ☐

No ☐

Please provide details (max 300 words).

Funding of Residential Rehabilitation Facilities

2.21 What funding does your facility receive (besides money received for individual placements)? Please provide details as to how much funding was received in 2019/20 and 2020/21, all sources which this funding came from, how this funding was accessed and what the funding is used for (max 300 words).

Workforce

2.22 How many staff does your facility employ (whole time equivalent)?

Administration Staff	Ancillary Health Professionals
Consultants	GP
Key Worker	Nursing Staff
Occupational Therapist	(Paid) Peer Navigator/Supporter
Pharmacist	Psychologist
Support Staff	Therapist

Other

Please provide details (max 200 words).

2.23 How many individuals do you employ as paid members of staff and as volunteers?

Total number of paid staff Please select a number
Total number of volunteers Please select a number

2.24 How many of your workforce (both paid staff and volunteers) have lived experience of recovery from problematic alcohol/drug use?

2.25 Do you have a partnership with external agencies for the provision of medical or other services?

Medical Services ☐
Other Services ☐
No external partnerships ☐

If partnerships with external agencies exist, can you describe the nature of these partnerships? Do you hold specific contracts or written agreements with these agencies? Please provide details (max 300 words).

2.26 If your facility does not employ in-house medical and/or nursing staff, what are the reasons for this? Please provide details (max 200 words).

2.27 Have all staff (involved in the care of your residents) received specific training on the following?

Trauma-Informed	☐	Alcohol Awareness	☐
Mental-Health First Aid	☐	Drug Awareness	☐
Naloxone Training	☐	Emergency First Aid	☐
Health & Safety	☐	Other	☐
No specific training undertaken	☐		

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

Regulatory Framework

2.28 Are you a registered charity?

Yes ☐
No ☐

Please provide details (optional) (max 200 words).

2.29 Do you operate within a regulatory framework (e.g. NHS, Care Inspectorate etc.)?

Please provide details, including how this decision made, and if this has changed over time (max 300 words).

3. Pre-Rehab

Waiting Period

3.1 Is there currently a waiting list to access residential rehabilitation at your facility?

Yes ☐

No ☐

If yes, what are the main reasons for individuals being on a waiting list to access residential rehabilitation at your facility? (Max 300 words).

3.2 How many individuals are currently on the waiting list for access to residential rehabilitation at your facility?

3.3 What was the average waiting time for individuals to access residential rehabilitation in 2019/20 and 2020/21? (If possible, please sum the daily waiting times for each year and divide by number of days for which data is available per year).

2019/20 Please select a number

2020/21 Please select a number

Preparation for Residential Rehab (Prior to Detoxification)

3.4 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	☐
Prison Services (if applicable)	☐	Housing Providers	☐
Other	☐		

Please provide details (max 200 words).

3.5 What does this preparatory period of work involve (aside from detox)? Please provide details (300 words).

Detoxification

3.6 How many individuals accessing residential rehabilitation at your facility accessed detox through the following?

	Alcohol only	Alcohol and/or drugs
In-House Detox at rehab facility	Please select a number	Please select a number
External Inpatient Detox (stat.)	Please select a number	Please select a number
External Inpatient Detox (private)	Please select a number	Please select a number
Structured Community Detox Programme	Please select a number	Please select a number
No-specific detox	Please select a number	Please select a number

Please provide details if applicable (max 200 words).

3.7 How is detoxification as preparation for residential rehabilitation placement funded? Please provide details, including whether this is different for those accessing your facility through different pathways (e.g. privately funded, statutory funded, Prison to Rehab etc.) (max 200 words).

3.8 If you offer in-house detox, what substances do you offer detoxification from? Please provide details (max 200 words).

3.9 If you offer in-house detox, do you have a threshold above which individuals will not be deemed suitable for detoxification?

Yes ☐

No ☐

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

3.10 Is there a waiting list for detox at external facilities prior to starting a placement at your facility? Please provide details, including how long people wait, and the reason behind this waiting list (max 200 words).

3.11 If your facility does not offer detox in-house, what detox facilities do you use? Please state the name of the facilities and provide details if applicable (max 200 words).

Drop-Out Prior to Entry

3.12 How common is it for people to drop out while on the waiting list?

Very Common ☐

Common ☐

Not very common ☐

Hardly ever ☐

Please provide details, including the most frequent reasons for doing so (max 300 words).

3.13 How common is it for people to drop out during or following detox?

Very Common ☐

Common ☐

Not very common ☐

Hardly ever ☐

Please provide details, including the most frequent reasons for doing so (max 300 words).

4. Residential Phase

Programmes Offered

4.1 Which of the following specific services does your facility offer? Please only select if you are certain that your facility offers these specific interventions.

Cognitive Behavioural Therapy	☐	If offered, please provide details.
Family Therapy	☐	If offered, please provide details.
Structured Family Support Interventions	☐	If offered, please provide details.
Group Therapy	☐	If offered, please provide details.
Individual Therapy	☐	If offered, please provide details.
Mindfulness	☐	If offered, please provide details.
Motivational Interviewing	☐	If offered, please provide details.
Trauma-Specific Interventions	☐	If offered, please provide details.
Women's/Gender-Specific Support	☐	If offered, please provide details.
Alternative and Complementary Therapies	☐	If offered, please provide details.
Specific Groups (e.g. art, creative writing)	☐	If offered, please provide details.
Other	☐	If offered, please provide details.

4.2 Does your facility follow a specific model (e.g. 12 Step Model/ Therapeutic Community/ faith-based approaches)? Please provide details (max 300 words).

4.3 What is the length of your core and any other programme(s) which your facility offers? How much flexibility is there in this programme length? Please provide details (max 300 words).

Relationship with Individuals during Residential Stay

4.4 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 engagement. If you have good practice examples, or examples where support/engagement is limited, please explain (max 300 words).

4.5 Does your facility provide support for families of individuals attending residential rehabilitation?

Yes	☐
No	☐
Provided by other agency	☐

If yes, please provide details on the support provided. If provided by another agency, please provide details on the support provided and which agency provides this support (max 200 words).

Exit Planning During Residential Stay

4.6 Are measures taken by your facility 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).

4.7 Are there pathways to supported accommodation for individuals completing residential rehabilitation placements?

Yes ☐

No ☐

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

4.8 Are measures taken by your facility 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).

4.9 Does your facility offer educational and/or training programmes?

Yes ☐

No ☐

If yes, please provide details (max 300 words).

4.10 Is planning for aftercare undertaken during the individual's placement in residential rehabilitation?

Yes ☐

No ☐

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

4.11 Do all individuals have a discharge plan?

Yes ☐

No ☐

Please provide details, including who is involved in this process? (Max 200 words).

Programme Completion and Unplanned Exits

4.12 How many individuals completed programmes as originally planned in 2019/20 and 2020/21? Please provide details (max 200 words).

4.13 What are the main reasons for individuals making unplanned exits from your facility? Please provide details (max 300 words).

4.14 Are there any specific groups who are more likely to engage in unplanned exits? Please provide details (max 200 words).

4.15 At what stage do unplanned exits typically happen? Please provide details (max 200 words).

5. After Residential Rehabilitation

Care of Individuals

5.1 Which agencies are responsible for the care of individuals following a residential rehabilitation placement at your facility? Please provide details (300 words).

5.2 Does your facility engage in active outreach for patients who do not attend aftercare services?

Yes ☐

No ☐

Please provide details (max 200 words).

5.3 If applicable, what are the challenges to engaging with individuals who have been discharged from residential rehabilitation placements? Please provide details for both planned and unplanned exits (max 300 words).

Aftercare Services

5.4 What aftercare services are provided by your organisation for those exiting residential rehabilitation placements?

Individual Therapy	☐	Peer Support	☐
Group Therapy	☐	Peer Mentor/Navigator	☐
Rehab Volunteer Support	☐	In-House Mutual Aid Groups	☐
Lived experience recovery organisations	☐	Other	☐

If other, please provide details (max 300 words).

5.5 How long is aftercare provided for individuals exiting residential rehabilitation by your facility? Please provide details (200 words).

5.6 Are aftercare services provided for individuals making unplanned exits from your facility? Please provide details (max 300 words).

5.7 Is specific or targeted aftercare available to individuals who are identified as needing particular attention? Please provide details (max 200 words).

5.8 How does your facility actively ensure that individuals are linked to mutual aid and lived experience recovery organisations? Is take-up of this linkage monitored by your organisation? Please provide details (max 200 words).

Harm Reduction and Relapse Pathways

5.9 Are all individuals attending residential rehabilitation at your facility provided with Naloxone kits where appropriate?

All ☐

Specific individuals/groups ☐

None ☐

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

5.10 Are there specific pathways back into residential rehabilitation at your facility for individuals who have relapsed having completed a placement previously?

Yes ☐

No ☐

Please provide details (max 200 words).

5.11 Are individuals who make an unplanned exit from a residential rehabilitation placement at your facility placement considered for another placement in the future?

Yes ☐

No ☐

Please provide details (200 words).

5.12 Do you have any other harm-reduction measures and/or protocols in place for individuals both during the residential phase and upon leaving their rehab placement?

Yes ☐

No ☐

Please provide details, including who is responsible for this (max 300 words)

Outcomes

5.12 Do you monitor outcomes of residential rehabilitation placements at your facility?

Individuals who have completed placements ☐

Individuals who have made an unplanned exit (where possible) ☐

No monitoring of outcomes ☐

Please provide details, including the length of time for which outcomes are monitored, how this is undertaken, and note any specific tools which are used (e.g. SURE or Outcomes Star) (300 words).

5.13 Would you be willing to share this outcomes data with ADPs/Scottish Government?

Yes ☐

No ☐

If yes, and if you are willing to share this data, please either provide in the box below (max 500 words) or attach any documentation to your completed survey. This data will be presented in aggregate form and individual providers will not be identifiable

6 General Questions

COVID-19 Impact

6.1 What impact has COVID-19 had on these residential rehabilitation pathways (including funding, referral, assessment, access, service provision, aftercare) at your facility? Please provide details (max 500 words).

Funding Impact

6.2 What impact has the recent new funding from Scottish Government had on these residential rehabilitation pathways (including funding, referral, assessment, access, aftercare) for individuals accessing your facility? Please provide details (max 500 words).

6.3 Have any new relationships been established in 2021 as a result of the new funding announcements?

Yes ☐

No ☐

Please provide details (max 300 words).

6.4 How many referrals were made to your facility between Feb 2021 and April 2021?

6.5 Out of these referrals between February 2021 and April 2021, how many placements were funded by ADPs? Please provide details on which ADPs referred individuals to your facility, and how many individuals were referred by each (max 300 words).

6.6 How many of these individuals started placements at your facility between February 2021 and April 2021?

6.7 Has your facility experienced a change in the number of referrals as a result of the additional funding announced in February 2021?

Increased ☐

Decreased ☐

Stayed the same ☐

Please provide details (max 300 words).

6.8 Have any people enquired about residential rehab but have been unable to access local funding pathways between February and April 2021? What areas were these individuals from? Please provide details (max 300 words).

General Comments

6.9 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 – 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	115
		Whitchester House, Teen Challenge UK	Voluntary/ Not for Profit	Alcohol & Drug	23
Grampian	Aberdeenshire	Benaiah, Teen Challenge UK	Voluntary/ Not for Profit	Alcohol & Drug	7
		Sunnybrae, Teen Challenge UK	Voluntary/ Not for Profit	Alcohol & Drug	12
Greater Glasgow & Clyde	Glasgow City	CrossReach, Glasgow Residential Recovery Service	Voluntary/ Not for Profit	Alcohol & Drug	18
		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	37
Highland	Highland	CrossReach, Beechwood House	Voluntary/ Not for Profit	Alcohol & Drug	12
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	22
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

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.