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

Interviews with People with Lived Experience of Accessing Residential Rehabilitation

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Executive summary

Accessibility, Referrals and Funding

- The majority of people interviewed experienced various challenges in accessing residential rehabilitation.
- Participants reported having heard about, accessed, and funded their placement in residential rehabilitation through a range of different pathways.
- Some described how they or their families had exerted considerable effort to try and secure funding for their placement, often having to contact multiple statutory and third-sector providers, but experienced difficulties in doing so.
- Those who had accessed residential rehabilitation through receiving money from their family described the feelings of guilt and shame which this created, and their inability to fund longer placements and aftercare through this means.
- Knowledge of residential rehabilitation and its availability was poor among individuals with problem alcohol and/or drug use, their families and, often, potential referrers.
- Participants reported varying degrees of motivation to attend rehab prior to entry, with some of those who had been less motivated before admission having found rehab an integral part in their recovery.

Pre-Rehab Phase

- Participants detoxed prior to their placement through various means, including self-directed home detox, structured community detox and inpatient detox at the rehab facility.
- Wide variation in preparatory work was reported, ranging from involvement in peer groups with current residents, to reducing intake, to no preparatory work.
- A woman who attended regular peer groups with current residents suggested that this was beneficial in helping to gain an idea of what rehab would involve, smoothing the transition into the programme, and allowing her to develop positive relationships prior to entry.
- One participant had accessed multiple detoxes unconnected to her eventual residential rehabilitation placement, and suggested that she had received no advice or signposting to rehab or other treatment services during or following these.

Residential Phase

- Participants noted a number of aspects of residential rehabilitation which they found particularly beneficial, including through comparison with community alcohol and/or drug treatment services. These included the highly-structured nature of daily routines; the removal from their environment; learning about the nature of addiction; their needs being treated holistically; and the deep relationships formed with staff and peers, particularly those with lived experience.

- Challenging aspects of residential rehab, often acknowledged by participants as having been important to their overall recovery, included the intensive, communal living; the often sharp criticism given by peers in group sessions; and religious aspects of faith-based facilities.

Post-Rehab Phase

- Participants reported a range of substance use outcomes following residential rehabilitation, with some having achieved abstinence after one placement and others reporting up to four placements in residential rehabilitation.
- All of those who had attended aftercare spoke of its importance in helping them to sustain recovery following their placement, suggesting a number of mechanisms through which it did so.
- Importantly, two of those who had returned to problem substance use following their placement highlighted that this had been relatively brief, and that the strategies and tools which they had learnt during their rehab placement had been essential in helping them to quickly reduce and abstain from use.

1. Background

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

To support the work of a working group on residential rehabilitation, chaired by David McCartney, the Scottish Government published a mapping report in December 2020 to better understand the current residential rehabilitation landscape in Scotland, which was followed by a report on capacity in February 2021. The Scottish Recovery Consortium (SRC) also published a report from consultation with a reference group of people with lived experience of having accessed rehab at the direction of the working group. The mapping and capacity reports served primarily as scene setting exercises and highlighted the need to further explore and better understand how people enter, experience and leave residential rehabilitation, and how this varies for individuals across Scotland. The mapping and capacity reports informed a set of recommendations by the working group to the Scottish Government which included that 'The Scottish Government and Alcohol and Drug Partnerships should work together to scope and compare current referral pathways, including referral criteria and inclusions/exclusions.'

The Scottish Government has undertaken a programme of research which has sought to address this recommendation. On the 30th November 2021, a suite of reports placing focus on pathways into, through and out of residential rehabilitation was published on the Scottish Government website:

- Guidance on Good Practice for Pathways (developed by the Residential Rehabilitation Development Working Group);
- Results from the Alcohol and Drug Partnership (ADP) Survey;
- Results from the Residential Rehabilitation Providers Survey;
- Prison to Rehab Pathway Report;
- A bridging narrative which links these reports together.

This report complements this existing research by exploring, in detail, pathways into, through and out of residential rehabilitation across Scotland from the perspective of those with lived experience of having accessed residential rehabilitation.

2. Methodology

Semi-structured, qualitative interviews were undertaken with nine[1] people with lived experience of having accessed residential rehabilitation[2]. Individuals were recruited through a number of third-sector organisations involved in alcohol and/or drugs. These included the Scottish Recovery Consortium (SRC); Restoration Fife; and Lothians and Edinburgh Abstinence Programme (LEAP), a statutory residential rehabilitation provider.

In order to ensure that participants' experiences were as pertinent to current experiences of residential rehabilitation[3] in Scotland as possible, individuals who had accessed residential rehabilitation in the last ten years were included in the sample. It is important to note that the experiences of these individuals primarily predate the recent increase in Scottish Government funding and the development of pathways into residential rehabilitation across Scotland. While such a small sample is not generalizable to the population of all individuals accessing residential rehabilitation across Scotland, effort was taken to ensure that participants were recruited from a broad range of Alcohol and Drug Partnership (ADP) areas and providers, and that the sample was diverse in both demographics and individual experiences – whether positive or negative – of residential rehabilitation[4].

Six men and three women took part in interviews. These participants ranged in age from 38 to 62 years, with an average age of 46 years. Participants were from five different ADP areas; Dundee City (n=1), Edinburgh City (n=2), Fife (n=2), Forth Valley (n=3) and South Lanarkshire (n=1). They reported a range of main substances for which they were seeking residential rehabilitation; primarily heroin (n=4), alcohol (n=3) and benzodiazepines (n=1). The majority (n=6) reported using other substances alongside their main substance, including alcohol, benzodiazepines and cocaine. Three participants used methadone, including one participant who had stopped previous heroin use but was seeking residential rehabilitation specifically to come off methadone. Participants attended a range of residential rehabilitation facilities across Scotland, including private (n=2), statutory (n=2) and third-sector (n=4) providers. Four participants reported more than one placement in residential rehabilitation; three of these having attended twice, and one having attended five times before sustaining recovery for over a decade.

The interview questions (Appendix 1) sought to place focus on aspects of the rehabilitation journey which were also covered in the previous ADP and providers'

[1] Two of these nine interviews are pending transcription by APS Group Scotland - APS website (theapsgroup.com) – and were not available for analysis within the timeframe of this report. Following their transcription, a revision to include these may be published in due course.
[2] One of these individuals was in the process of attempting to access residential rehabilitation through statutory pathways but had not, at the time of interview, gained a referral or access.
[3] 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 that residents are required to attend over a fixed period of time.
[4] Due to specific challenges around recruiting participants still engaged in problem alcohol and/or drug use, it is important to note that the participants interviewed for the purposes of this report broadly reported positive experiences of rehab.

surveys, including the processes of referral and gaining access to funding, the preparatory and residential stage, and aftercare. Within these broad topics, the interviews allowed for flexibility in order to focus on experiences which were deemed of importance to the interviewee.

All data has been anonymised, with pseudonyms given to participants and any potential personal identifiers altered within quotes. APS Group Scotland were used to transcribe these interviews, but no personal information was shared besides the audio files, and a data sharing agreement was in place.

One participant, reflecting on the interview process, noted that they were glad of how this research specifically sought to engage and learn from people with lived and living experience of residential rehab. They mentioned that people with lived experience were often drawn upon by statutory and third-sector organisations across the sector in a tokenistic manner.

Data was collected between the 10th January and 2nd February 2022. All interviews were carried out online via Zoom or Microsoft Teams.

3. Main findings

3.1 Accessibility of Residential Rehabilitation

3.1.1 Hearing about Residential Rehabilitation

Participants were asked about how they had first heard of residential rehabilitation, and at which stage this occurred in their history of problem substance use. The majority reported having first heard of residential rehabilitation as a potential treatment option through word of mouth. Most described that this had happened years – at times decades – after having started using substances problematically. This occurred through family members, friends or acquaintances (including others engaging in problem substance use) who had either been referred to residential rehabilitation themselves, or had suggested to them that they would benefit from it.

> “My big brother had gone through that process, that's how I heard about it”
>
> (John, 51)
>
> “Another guy that I was selling part of my methadone to said that he was speaking to his addiction worker about getting into rehab. I never actually even knew of rehabs until the guy mentioned it to me. It was just by a fleeting conversation and then I asked that my addiction worker, who was from the community addiction team and it was then that they started speaking to me about rehabs.”
>
> (Barry, 41)

One participant highlighted that he had discovered residential rehabilitation as a treatment option through attendance at a 12-step group. His account highlights the relatively poor knowledge of residential rehabilitation among those experiencing problem substance use which discussed further throughout this report.

> “I had never heard of any of them until I started going to fellowship, and I was in a place where could actually hear that stuff. [...] All that previous 18 years, well. Sixteen, 17 years of addiction, I've never heard of any other rehabs except for the Christian ones.”
>
> (John, 48)

Some participants reported having heard of residential rehabilitation as a potential treatment option through professional services. One woman described having heard about residential rehabilitation from her GP, while others suggested that workers at community alcohol and/or drug treatment services had discussed residential rehabilitation with them after an extended period of having attended these services. One participant who had heard of residential rehabilitation through word of mouth noted that those working across the community services that they had previously attended did not appear to either know about residential rehabilitation, or show an interest in referring the individual to residential rehabilitation.

Many of these individuals said they had immediately considered residential rehabilitation an option when they first heard about it, often after having sought recovery through community treatment services for a number of years. Some of these individuals suggested that they would have likely benefitted from residential rehabilitation had they heard about it months or years previously. Contrasting these accounts, two interviewees acknowledged that they had perhaps heard about residential rehabilitation previously but did not take notice due to the nature of their problem substance use, and would likely not have considered attending residential rehabilitation at these times.

> “Up until the point when I started speaking about wanting to go to rehab, all I was wanting from them was my prescription. I would go in there and say what needs to be said to get my prescription and get out the door as quick as I could. So they possibly could have been offered me stuff before that, but I just was not listening. [...] I think I've been very lucky because I went into rehab when I was twenty 21 year old, so it was like a breaker for me.”
>
> (Barry, 41)

For Barry, his attendance at services to receive Medically Assisted Treatment (MAT) in the form of methadone formed the first occasion through which he became aware of wider support.

> “I never really knew of treatment until I started engaging to get a medical prescription.”
>
> (Barry, 41)

3.1.2 Getting Referred

Similar narratives were apparent in relation to the process of getting referred to residential rehabilitation. Across the individuals interviewed there were a range of referral pathways reported, including self-referrals, referrals through statutory services (primarily GPs) and through third-sector organisations. Their accounts highlighted a number of challenges in terms of getting referred to residential rehabilitation. People typically noted that their knowledge in terms of the availability, nature of and access to residential rehabilitation services was poor prior to referral. Reflecting the relatively recent development of this knowledge base through Scottish Government mapping reports, some reported that they were unaware of how many residential rehabilitation facilities there were in Scotland, their location, and how to gain access.

> “I don't even know where they are. I did not know that there was one in Glasgow.”
>
> (Tony, 38)

The interviewees’ accounts also made clear that this lack of knowledge about residential rehabilitation was shared by potential referring services. One participant suggested that their GP in Edinburgh was unaware of the existence of the Lothians

and Edinburgh Abstinence Programme (LEAP), a statutory residential rehabilitation provider in Edinburgh that she later attended.

> “I saw a locum GP that day who happened to do some work up at LEAP on occasion, and she offered it to me and I couldn't make my mind up then. So I phoned back later in the day, spoke to another GP and was told that there was no NHS rehab in Edinburgh. So even within one day, depending on who you speak to, you're getting different stories. But I persevered.”
>
> (Susan, 63)

A number of participants also spoke of a lack of knowledge not only of the availability of residential rehabilitation but of the nature of and drivers leading to problem substance use, particularly among GPs. One highlighted the effect this had on her perceptions of availability of support.

> “When I was about 19 I went to my doctor. I took about four [street Valium] because I was so... Just to try and get the courage to go in and say, ‘I'm addicted to these’. And she just said “oh, you shouldn't take those. That's not good for your anxiety. Do you mind if I ask where you get them?” And that's all she said, and I just left her room in floods of tears thinking, I'm not going to tell her where I get them. And so I didn't really hold any hope with the doctor that they would be able to help me at all.”
>
> (Kirsty, 40)

Another described his experiences when beginning to seek help for alcohol use in 2008. His GP advised him not to attend community forms of support, suggesting that this would lead to him mixing with the ‘wrong type’. The participant attributed this stigmatising advice to the fact that he came from a middle-class background and, as such, did not appear to conform to his GP’s understanding of the ‘types of people’ who experience problem substance use.

> “Although my GP was a very kind and caring woman, she obviously didn't understand addiction at all and had quite a stigmatized understanding of people who suffered from addiction. And I didn't quite fit that, I was somebody who came from a relatively, not well off or anything like that, but, you know, a comfortable family, educated, et cetera, and didn't fit it. So when the conversation came to access some community addiction team support she said no, you don't want to go there, you'll end up mixing with the wrong type. [...] I mean, that is just a shocking piece of advice and she thought she was trying to help me, but was just absolutely rotten.”
>
> (James, 42)

One participant voiced his frustrations at having been unable to access residential rehabilitation despite having spent years requesting a referral from a community service. He described having been asked to continue engaging with a weekly meeting with his drugs counsellor, while being left unaware of his likelihood of accessing residential rehabilitation in the future despite his pleas. He felt that this

was likely due to the fact that he was abstinent from ‘street drugs’ – he had previously been using heroin – and in receipt of Methadone. Highlighting the importance of the attitudes of individuals in shaping the referral process, he also suggested that his manner of communicating had reduced his chances.

The majority of those interviewed had been using substances problematically for years, and some for a number of decades, prior to being referred to residential rehabilitation. Again, all had previously engaged with community alcohol and/or drug treatment services for an extended period of time. A number of participants described how the community services they had accessed had been of limited utility in helping them to achieve recovery.

> “They were comparatively easy to access once you had been honest with your GP. But the very nature of the diseases, we are not honest. ‘Do you drink?’ ‘Yes, a little’, whereas I was actually drinking 3 or 4 bottles of wine a day. But they detoxed you or got you to stop drinking, patted you on the head and said you've just got to not drink. There was no looking at the internal factors.”
>
> (Susan, 63)

Some had previously accessed residential rehabilitation, often on a number of occasions, either for the same or for other substances. Participants typically described that they had found the kind of contact they had with community services inadequate in allowing them to lasting achieve reduction or abstinence from substance use.

> “They’re asking if you have been taking anything or not been taking anything and then letting me go. They are not actually helping me. What is the point in going to see them to talk to them for 20 minutes and away for the next month? They think if you have not been using drugs, you're fine. But that is not the case. [...] It's asking me questions, ‘oh how are you feeling from 1 to 10?’ Then the next week he is going ‘so you said you were a seven last week’, and this is the kind of stuff that I am getting and it is really annoying me. What is this doing for me? [...] I have had nine workers in the last two years. Prior to that I had to phone up to find out who my worker was because I had not heard anything from them in about 16 months. [...] There is no point in having worker after worker because it takes me a wee bit to start opening up to people.”
>
> (Tony, 38)

Some interviewees discussed the process of selecting a residential rehabilitation facility. Few participants described being actively able to choose where to attend residential rehabilitation. Instead they had usually been presented with one choice by referrers, or – for those funded privately – had been limited to facilities which they were aware of.

> “I don't know because I never really knew of anywhere else. I was just some guy that I spoke to [at a community service] and he mentioned it. The first

time we were looking at one [by the same provider] in Liverpool, and it was just by the off chance that we realised there's one in Glasgow."

(Kirsty, 40)

One man described having relapsed after having exited early from his placement in a faith-based residential rehabilitation facility due to his challenges with the faith-based aspects of the programme. He said that he had subsequently attended a non-faith-based facility which he suggested was more suited to his needs. Coupled with findings regarding the low knowledge of what residential rehabilitation entailed and awareness of the different types of residential rehabilitation prior to participants' first placements, this suggests that he may have achieved more positive outcomes had he had more choice over the selection of which facility to attend.

One participant reported that her peer cohort had discussed the relative merits of staying in their local area for residential rehabilitation or going elsewhere, with differences noted among those who were seeking recovery from alcohol and those from drugs.

"Going out of area is more appropriate for somebody who's using illegal drugs, because in a different area they won't know where to get them. Well, I'm sorry, but alcohol, I can find anywhere. So you're not removing yourself from the problem because the problem for me is everywhere. So my peers that were more drug users than alcohol users felt it would be better to be elsewhere because then they wouldn't have known that 'down that street is where my dealer lives'."

(Susan, 63)

3.1.3 Accessing Funding

Participants described having accessed funding through a range of sources. Three had been able to access private funding through family members, while others accessed statutory or third-sector funding sources. Those who had relied on funding from family members typically described how these family members had been unsuccessful in their attempts to secure funding from third-sector and statutory services.

"They phoned around anyone and everyone, third sector organisations, charities... there was just nothing there. [...] Actually making any inroads into any local authority funded support or NHS, there was nothing. [...] All this time that you felt well actually our dear and blessed NHS is a safety net that's going to catch you when you fall, but you just keep on falling."

(James, 42)

A number of participants suggested that if they had not accessed statutory funding, they would not have been able to, or motivated to, access residential rehabilitation. Similarly, one interviewee, whose family had been unsuccessful in their attempts to obtain statutory or third-sector funding, suggested that he would likely have

continued to use substances problematically if he had not been able to access financial support from his family.

> “I am very convinced that had I been born into a different family without the means to afford that money, It is very unlikely I'd still be here today. You know, the trajectory that I was on was horrific.”
>
> (James, 42)

Two interviewees who had relied on financial support from family members due to having been unable to access other sources of funding reported that this had generated further feelings of guilt and shame given the financial burden which this placed on these family members.

> “I'll always feel really indebted to my mum and dad, I will always have that guilt there. [...] I really think there needs to be a better pathway. [...] The girl that I was staying with the day I went to rehab. She didn't have the funds, she's still out there [engaging in problem substance use]. And I think a lot of that as well when I was in rehab, there was a feeling of I'm so lucky to have been given this opportunity and I could not just give up, and it's just horrible.”
>
> (Kirsty, 40)

Kirsty also highlighted how these feelings of placing a financial burden on family members had provided a barrier to accessing appropriate aftercare following her placement.

> “You could pay for more aftercare but I already felt awful that my mum and dad had used a lot of their savings to put me in there in the first place and I didn't want them to pay any more.”
>
> (Kirsty, 40)

3.2 Pre-Rehab Phase

3.2.1 Motivation for Residential Rehabilitation and ‘Rehab Readiness’

Participants often discussed their own perceived state of ‘rehab readiness’ and motivation for residential rehabilitation at the time of referral, with these accounts highlighting the complexity of determining ‘readiness’ for residential rehabilitation. The vast majority of these participants – including those who had sustained abstinence following a single placement – suggested that they would not have identified themselves as having been ready for residential rehabilitation when referred or on entry. Most were unaware of what residential rehabilitation involved prior to their placement.

> “I had no idea what to expect, the second time I did but no, I had no seen really anything of it on the telly or anything and it was bizarre, really.”
>
> (Kirsty, 40)

> “I still thought it would be like the celebrity rehab you read about. I quickly learned that's not the case.”
>
> (Susan, 63)

Reflecting the lack of self-motivation towards rehabilitation, some suggested that they had felt pressured into accepting a placement, typically from family members. James suggested that he was sceptical about the benefits of residential rehabilitation and only accepted a placement due to these family pressures. He described how, within a few days of entering residential rehabilitation, his feelings towards it changed and he became highly motivated to complete his placement.

> “I went in there absolutely convinced it was a waste of time and money and it wasn't going to work. It wasn't like I was desperate to go through rehab at all then. I didn't want to go, but I had no choice, it was that or I was getting kicked out into the street again. [...] But after the first two or three days, once I was able to kind of get up and go downstairs and meet with people, almost upon the first meeting with the therapists there I realised that here were people who understood me intuitively because they had walked that path themselves. [...] My parents remember those first few days like they were yesterday and I said to them, you know, these guys really know what they're talking about and everything within the place had had such a profound impact on me, even within four days, that my whole attitude to the thing changed and I threw myself into the cause straight away.”
>
> (James, 42)

The accounts of a number of those interviewed suggested that they felt that residential rehabilitation was the ‘last option’ open to them in achieving recovery from problem substance use. While reasons for this were not explicitly stated, this may be due to residential rehabilitation typically having been offered after a number of unsuccessful attempts at achieving recovery through community alcohol and/or drug services.

> “I got to the point where suicide was the only other option. So I kept going to the prep for rehab meetings till I got in.”
>
> (Susan, 63)
>
> “Let's say there was a glimmer of hope more than light. I mean, not to be pedantic, but when you go from being suicidal to getting a glimmer of hope, you don't see the light at the end of the tunnel quite yet, but you just think for the first time in years, maybe, just maybe, there's a way out of this.”
>
> (Susan, 42)

Two participants suggested that they had initially entered residential rehabilitation in order to allow themselves to gain control and moderate their substance use, but that education about the nature of addiction which they had gained during their

placement had led them to a realisation that abstinence presented a better option for them.

> “I did kind of go into it the second time thinking that you would still be able to drink and I thought I will I'll get myself signed for six months and after that I will be able to go out and start partying and doing all this wonderful stuff in Glasgow. But it was for the best for me to be honest. The whole thing is a journey and it takes people came to understand what works for them. That is why addiction is such a complex issue. I didn't wake up and decide that I wanted to be abstinent, but I had tried lots of different ways, and eventually I got to a point where I realised that this is the only thing that seems to work for me, and that is what had to be done.”
>
> (Barry, 41)

With a number of interviewees now working in the field in various roles, James drew both on his own experiences of shifting motivation when entering residential rehabilitation and those of people he had supported in order to highlight the challenges associated with determining ‘rehab readiness’.

> “Most addiction therapists that I have worked with are really good at assessing people's motivations, but you never know when it's going to change. People can change motivation in the last week of treatment and you think thank goodness they got it. But sometimes it happens post treatment. [...] It's very difficult to determine when somebody is ready for treatment, which I've just proved by saying had you assessed me prior to it, I would probably have said no, and you would say that you would agree and say you are not ready. But then I was. But what we're doing at the moment is saying, well, it's difficult to figure it out so we're just not going to send anybody because we may get it wrong. But we're getting it wrong, and it's costing people's lives.”
>
> (James, 42)

3.2.2 Waiting Times

Most participants described relatively short waiting times prior to their placement. Two participants described that this had likely been due to the fact that they had relatively few barriers to access due to having been privately funded, and because their relatively chaotic use prior to entry had meant that they were treated as urgent cases.

> “I'd been struck off 90ml of Methadone and I was in dire straits and I couldn't live the way I was living on the streets. So my brother basically put a word into the managers down there and I managed to get away quickly. So there wasn't much of an assessment done at all. It was just a conversation with my brother on my phone. Two days passed and they got back to me and said right, come down this day and we will meet you at the train station, and that’s what I did.”
>
> (John, 51)

> “I was very unwell at the time that was going on so they [his parents] just had to make contact. I had to give permission for my medical records to be made accessible to the [private] rehab and then I got admitted. I think it was next day, because there were only like two or three other patients in their addiction wards at the time I went in.”
>
> (James, 42)

Some participants described how the length of wait was dependent on them displaying motivation through attendance at meetings, or reducing their current usage prior to entry.

> “They wanted me to get to 60 ml or below, and so that was really the only condition. And try and stop the street drugs, you know, if you are on a lot of Methadone it is easy to stop the street drugs.”
>
> (Gary, 51)

Another interviewee now working for a third-sector organisation supporting people to access residential rehabilitation suggested that there remained a need for improvement in the process of referral and access to residential rehabilitation in his area.

> “You've got through all these steps before you go on a waiting list and it's time consuming. People are at the end of their tether. They may have had near fatal overdoses and their lives are chaotic. The pathway for it's very time consuming and admin heavy. [...] That's the feedback that I get from people that are waiting to get to residential rehab. It's not about where they are at and how they are living their life, It's more about if they are engaging with the service or not, before they get decided how far up the waiting list they go or how soon they go away.”
>
> (John, 51)

3.2.3 Detox

Participants had undergone the process of detoxification prior to their placements through a variety of means. Some had undertaken self-directed home detox, some having previously accessed community and inpatient detox, and a number of others had undergone detox in the residential rehabilitation facility. Those who had done so at the facility typically described feeling well supported, although others noted that this was a particularly challenging part of the placement for them and their peers.

One woman suggested that, prior to having undertaken detox in rehab at the start of her placement, she had undertaken both community and inpatient detox for alcohol use on a large number of occasions, but had typically been sent home with no mention of or link-up to other community alcohol and/or drug treatment services or residential rehabilitation services.

> “They detoxed you or got you to stop drinking, patted you on the head and said you've just got to not drink. There was no looking at the internal factors. There was no going to groups that encourage you not to drink like SMART or AA...”
>
> “*So were they not signposting you to any other services at all?”*
>
> “No. they didn’t do that when I was in but I believe some of them do now.”
>
> (Susan, 63)

Another participant highlighted why self-directed and community detoxes had been challenging for her previously.

> “When you detoxing you're so vulnerable to picking up drugs to get rid of the pain and you're so vulnerable to bumping into somebody or somebody contacting you, because I did lots of home detoxes but I always used again.”
>
> (Kirsty, 40)

Reflecting the low knowledge both of what residential rehabilitation offered and the nature of problem substance use prior to their first placement, some interviewees suggested that they had felt that undertaking detox would be all they required in order to cease use of alcohol and/or drugs, but had realised – through learning about the nature of addiction during residential rehabilitation – that this would not be the case.

> “I went over there, but I only lasted through the detox itself and thought I was OK, without doing any work on myself or anything. No, I didn't need the residential rehab at the time. [...] I ended up doing the same things again, you know.”
>
> (John, 51)
>
> “I thought, oh, it's going to cost two thousand pounds, so I'll get a detox and I'll come back out and life will be fine and I won't drink anymore. I thought I just needed detox from alcohol. I didn't know how ill and deluded I was. I thought that a detox would be all right and nobody [outside] would know but it does not work like that.”
>
> (Kirsty, 40)

Kirsty had been engaging in problematic use of Tramadol, and suggested that the third-sector organisation from which she was seeking support had previously encouraged her to purchase more Tramadol online due to the unavailability of detox provision.

> “I went asking for help and I had to wait two weeks for the appointment. So I went back 2 weeks later for the appointment thinking thank goodness I'm going to get help. The appointment was only to take all my information. I went

back to them about a couple of days before my next appointment was due and I was banging on the door saying, 'I am going to run out [of Tramadol], I've not got any money'. [...] And I'm going to rattle, effectively, and their advice to me was go and buy some more online. [...] So I did that but they take days to be delivered. [...] I decided myself, right, I may as well just do it now and I'm going to detox. [...] I did that and my ex-husband supported me. I feel horrible because my kids were there, they thought I was ill. And then [that organisation] works for [a larger third-sector organisation] and they phoned social services because they said that I put my life at risk for detoxing. So that was it with them."

(Kirsty, 40)

3.2.4 Preparatory Work

There was wide variation in terms of preparatory work which interviewees described prior to their placements. Two of those who had undertaken more than one placement, as well as some who are now involved in working in the sector, suggested that there had been improvements made in terms of preparatory work in the time since their first placement.

As touched on previously, three participants suggested that they had been encouraged to reduce or stop their substance use prior to entering residential rehabilitation. Further, a number of participants described being asked to attend regular meetings prior to their placement in order to demonstrate motivation. Susan highlighted the benefit of meeting and developing relationships with existing residents, with this having smoothed the process of adjustment to the demands of her placement.

"They asked you to go to meetings and there's a weekly 'prep for rehab' meeting, which is run by a social worker connected to the rehab and you are you expected to go there every week just to show commitment, and I did. [...] When I went in, I knew a couple of people, only having seen them at sort of hour long meetings, but they weren't all strangers when I went in. And you could ask questions like, 'do I need to take a dressing gown?' Silly questions like that. So, yeah, you are well prepared. And you were told that you always have to be in three's, you were never to be on your own, and all these rules."

(Susan, 63)

The interviewees who had engaged in relatively intensive preparatory work prior to their placement emphasised the importance of this in helping them, and their peers, to engage in the programme from an early stage and in helping them transition more quickly from their previous daily lives to the intensive, structured schedule in residential rehabilitation.

"When you go into a place like that from a place of real chaos and no preparation, it's very difficult for that person to benefit from that. [...] It's easy to understand that with no preparation it's just too much, too much of a shock to the system for that individual to make that change. [...] There's definitely a

benefit in preparing people for residential but we need to think about how we do that, and I think, again, I'm a proponent of the use of lived experience wherever we go because this is what saved my life."

(James, 42)

Reflecting the aforementioned poor knowledge of what residential rehabilitation entailed prior to entry among the majority of participants, one interviewee highlighted the need to made preparatory work standard across residential rehabilitation in order to allow people to mentally prepare for their placement.

"The first time for me, I never had any understanding of what it was. So there needs to be work done with people to understand why they're are going to rehab, what addiction is, what as you're going in there for. You are not going in there to detox, you are going in there to understand addiction. I think it's more about the work that gets done for people to understand what rehab is that's what makes people suitable for it."

(Barry, 41)

3.3 Residential Phase

3.3.1 Mechanisms through which residential rehabilitation generated positive outcomes

Participants were asked what aspects of residential rehabilitation they felt had worked in helping them to achieve their recovery goals. Given that all of the interviewees had accessed community based alcohol and/or drug treatment services, they were also prompted to consider what aspects of residential rehabilitation they had found to be of benefit in comparison with these other services.

The disciplined, structured nature of the daily programme was mentioned by the majority of participants as an important component through which residential rehabilitation allowed them to move towards recovery, with these interviewees often contrasting this regimented daily schedule to their lives prior to their placement.

"It was like really disciplined. And I probably needed that in my life and I felt self-achievement every time I was doing stuff successfully, and going through a month without getting a red ticket and then two months and all that stuff. It came at the right time for me in my life."

(John, 51)

"One thing rehab taught me, and I still do it today, it taught me the benefit of living a structured day. It really did teach you how to get stuff done, whereas before you didn't bother. You were just sitting about. [...] The way that you keep you busy is really good because you're not in your own head, thinking about 'oh, I am no well, I need this and need that'. You're not thinking of it at all through the day."

(Gary, 51)

Among the most frequently cited reasons for why residential rehabilitation had been perceived to be beneficial in producing positive outcomes was the deep and meaningful connections and relationships forged with others who were undergoing similar recovery journeys, and who therefore were experiencing a similar situation.

> “When we’re in active addiction we reject people because they're getting in the way, they're telling us what to do and blah, blah, blah, and it goes against what our addiction is telling us to do. So we reject people and we're also rejected. So you end up disconnected from everything. And that's where you're really in a pickle, because you're just left alone with your addiction and your addiction kills you, because that's basically, that is the end result. And so residential, like I say that very quickly, within half an hour sometimes people create bonds that are stronger than anything they experienced for years.”
>
> (James, 42)

> “I was living in recovery and I started making friendships and building new relationships and taking on board the experience of other people, and the people believing in me before I believe in myself, all that stuff.”
>
> (John, 51)

A number of participants noted that they were compelled – more so in rehab than in other treatment services – to be brutally honest with themselves and others regarding the extent of their problem substance use and the factors which had contributed to it. These participants felt that this was important in terms of generating clarity and self-awareness around the nature of their addiction, and, through discussion with peers with similar experiences of problem substance use, realising that their experiences, thoughts and behaviours were not unique to them but common to others experiencing problem substance use.

> “I was suddenly able to be honest for the first time in my life, because even with people who had been trying to help me, I never told them the truth about the extent of my problem. Never, because I was so ashamed. I was so ashamed of who I had become. So here I was able to really let my guard down.”
>
> (James, 42)

> “I thought I was unique, but the longer I'm in AA and listen to people, everybody thinks they're different. Everybody thinks they're unique.”
>
> (Gary, 51)

Linked to this, a number of participants described the education they received during their placement as having been critical in helping them to sustain recovery beyond their placement. This involved being taught about the psychology of addiction, about factors which sustain use and which lead people to use in the first place, and being given strategies through which to reduce or avoid future problem substance use, including during crisis moments.

> “It was good because it was all about learning how to deal with you as a person. You might not have known that at the time and you may have went in there not really understanding the ethos of what was getting taught to you but you did learn like. I thought addiction was my drug use, but my addiction was not about drug use, drug use was my coping strategy for my addiction. My addiction was me. [...] I’ve still got that wee voice that is like 'you're not good enough. You will never amount to much. You're wasting your time.’ I will always have that little voice but the more I take drugs and stuff like that, that voice becomes louder and the less I take drugs, the more I am around positive people and doing good stuff, the volume turns down very low. I have got coping strategies and friends to speak about stuff. I didn't know or understand any of that when I went into rehab the first time.”
>
> (Barry, 41)

> “It forced me to look at the underlying reasons rather than just putting a Band-Aid on and stopping the drinking. And it encouraged me to alter my habits. ‘When do you drink? Right, what can you do at that time of day that will break that cycle?’ And I think I needed to be removed from the home situation albeit that I live on my own to break that cycle and come back with a new frame of mind.”
>
> (Susan, 63)

As touched on by Susan, above, a number of participants suggested that the isolation from the outside world engendered by the residential nature of the placement was central to its effectiveness. This was reported to allow individuals distance from relationships which had been central to them continuing to engage in problematic alcohol and drug use, as well as time to form new thought patterns and perspectives on their situation.

> “It's definitely the whole experience of being in there with people that are going through the same thing as you, being away from society and the dangerous connections you could make or just the fact that you could just go in and score if you can.”
>
> (Kirsty, 40)

Kirsty suggested that some people attending her residential rehabilitation were allowed home in the evening, as day patients. She suggested that this would not have worked for her, as she would have been tempted to engage in substance use until a relatively late stage in her placement.

Linked to this, a number of participants described how having restricted or no access to their phone, television and other technology forced them to confront their situation as opposed to engaging in avoidance tactics.

> “You're not allowed your phone, you're not allowed books unless they are like the AA big book. You only get to watch the telly on a Friday, Saturday and Sunday night and they put a movie on for you in the library, so you're not distracted at all. [...] I needed the discipline there.”
>
> (Kirsty, 40)

Among the most common theme which emerged across the accounts of the majority of participants was the importance of engaging with staff with lived experience of substance use and recovery, including those who had done so through access to residential rehabilitation. Their accounts highlighted that this worked through a number of mechanisms. Firstly, these individuals provided role models who proved that recovery was possible. Secondly, people accessing residential rehabilitation found that it was easier to be honest with, and open up to, people with lived experience of problem alcohol or drug use, given the fact that they had been through these challenges themselves. One suggested that this also reduced the potential for these conversations to be stigmatising and shame-provoking. Thirdly, they found that staff with lived experience had a greater knowledge of the tactics and manipulation which individuals, often unknowingly, attempted to use as a result of their problem substance use.

> “I was so inspired by these therapists who had clearly had a life very similar to mine and they were not leading that life anymore and it looked so attractive. That was, well, literally life changing.”
>
> (James, 42)

> “He was the first person I ever spoke to that was an alcoholic. And I had been for lots of counselling and all that mental health stuff when I was young and I never, ever told anybody I smoked cannabis, I drank wine or I take drugs because... I felt less than that person, intimidated by that person. That person in rehab said to me ‘well, I know, I know how you feel’ and I was like, ‘no, you don't’. And he said I am an alcoholic and he's standing there in a suit and tie. And I'm like ‘what’? And then you just speak completely differently. It's bizarre. They know you, you can't lie anyway because they know how your head works. The therapist I had there was amazing. She just like ripped me to shreds, basically, she was so sweet and lovely to me for the first week, and then the second week. Bam, bam, bam, how dare you not do this this time for those beautiful children? You know, and I was walking out the room thinking how can she speak to me like that? And then a couple of days and you are thinking, she is right, you know? But she was able to challenge me like that because I'm in a safe, protected environment, and that's what I needed.”
>
> (Kirsty, 40)

3.3.2 Challenging Aspects of Residential Rehabilitation

Participants also noted a number of factors related to their placement which they found challenging, and which they would improve. However, it should be noted that following the placement many of these factors were later acknowledged to have

been important in their recovery. One interviewee suggested that he had left his placement early as he had found it hard to accept the often cutting criticism from his peers in group therapy sessions. This was noted by another participant as a particularly challenging part of their placements, although both of these participants highlighted the benefits of this process.

> “There's a thing called an encounter group, and if you say something out of turn, man, it’s just radge. [...] It's hard to sit and take it then, because if somebody puts a slip in about you, then you're sitting there in this group and there's 29 people getting to have a go at you before you're allowed to say it back. That was hard to take and I did not take it too well. I was in the manager’s face telling him to ram it and I was packing my stuff that Friday and somebody stopped me and talked me out of it. I didn't really want to go. But it was my head telling me that I had to go. [...] Worst mistake of my life I think.”
>
> (Gary, 51)

> “You bare your soul, you're given feedback by your peers and by the therapists, and they don't miss and hit the wall and I could get very angry, and I did get very angry on occasion on. But when I thought about it, they were actually right it and it was having your defects pointed out to you, and learning why, what my motivation for drinking was.”
>
> (Susan, 63)

As noted earlier, John suggested that he had been discouraged from residential rehabilitation on his first placement due to the religious aspects of programme, although again stated that he later found this to have formed an important part of their recovery. Reflecting this, he highlighted the importance of preparatory work to educate and engage individuals in aspects of the programme.

> “When you first go along, you're just hearing words liker higher power and you're thinking where is the kumbaya and all this other stuff. [...] If I had been told that before and maybe start reading the bible before you go and blended yourself in so that it was not so much of a shock, it would have been probably easier to take on board. Because in the 18 months I was working for them, those guys and gals used to come in there and would be leaving after the first week or so saying things like ‘it's too much’. Probably one in every three was leaving because of that situation.”
>
> (John, 51)

While having acknowledged that the intense relationships developed through communal living formed a key component in their recovery and the effectiveness of residential rehabilitation, two participants suggested that they found this challenging.

> “As an addict, at the end it gets really lonely. And you're not used to making conversation and making relationships. So it was quite hard, it was pretty hard for me going and dealing with 30 addicts that were in off the street and at different places.”
>
> (John, 51)

> “There were days when I just wanted to run away and hide, and I found the communal living quite difficult. But it was also very supportive. You have to talk about things within yourself that you thought you would never, ever talk about. You have to be honest and it took me a few weeks to realise that, so I probably didn't get as much from it as I would if I had fully embraced it from the go.”
>
> (Susan, 63)

While having completed his own placement, one participant noted that his peers often left during or immediately following detoxification. He highlighted that this can form a particularly challenging part of the process. He also highlighted other external pressures as forming a barrier to placement completion which is challenging for residential rehabilitation providers to mitigate.

> “It is probably not for everybody. But I think about the times that I was in it, you're probably talking about say maybe a hundred people came in and maybe 30 people actually made it through. Some people maybe coming in and leaving at the end of the detox because they can't handle the detox, or they maybe been in for two or three months and something happens with a partner or their families or something and that makes them leave. And so there are loads of different contributing factors that is not the fault of the rehab and is more to do with us as individuals and circumstances that go on within life.”
>
> (Barry, 41)

One participant noted that there was relatively limited focus on mental health during her placement (as was the case in previous episodes of treatment in community services), and that she felt that residential rehabilitation would benefit from greater integration of focus on mental health for those with mental health comorbidities.

> “The concentration was on your addiction and treatment for that. I have suffered from depression most of my adult life, and there were some comments made to the fact that once I'm not drinking I would not be depressed, because alcohol is a depressant. And so there wasn't really much looking at my mental health, really. On occasions that I pushed it, it was looked at. But it wasn't a main feature.”
>
> (Susan, 63)

3.4 Length of Placement

Those who were interviewed were asked how they felt about the length of their placements. Reported placement lengths ranged from 28 days to 11 months. People typically reported feeling that the length of their placements had been either

adequate, or not long enough, with none suggesting that their placement had been too long. Of those who had felt that they had been adequate, interviewees typically reported that it had been necessary for them to stay for that length of time for various reasons. These included allowing time for new habits, routines and mental patterns to become embedded, and for appropriate attention to be given to forward planning.

> "By the end, I was ready to walk, but it probably needed the 12 weeks to not only break the thought processes, but to put in new sort of pathways. I know a lot of people, when they get half way, they think, well, I've got this and I thought that as well. But all that they've done at that point was stop you from thinking the way you were thinking. But they hadn't started you thinking the new way."
>
> (Susan, 63)

As noted earlier, Kirsty had not been able to secure statutory funding, and relied on financial support from her family to fund her placement in a private facility. She felt that the four-week placement which her family were able to afford was too short and did not allow for adequate continuity of care planning, nor aftercare as noted previously.

> "How you actually plan your return to life and stuff, you know, that requires a lot of time and effort and if you're only in for four weeks because you're paying it yourself, then you don't have a lot of time to do that. And if you're being paid, if you've got funding to be somewhere for 12 weeks, you've got a lot more time to do that and continuity of care planning. [...] I'm quite a lucky person to have gone from where it was to have 28 days to come out the other side and I've never touched anything since, you know?"
>
> (Kirsty, 40)

Another participant highlighted that he would have benefited from a longer placement but, again, his parents were unable to afford to pay a longer placement at the private provider.

> "Yeah, probably. I think if I had funding I would have been really happy to stay in there for 12 weeks, I would have been more than happy. But I was really lucky that my mum and dad managed to put me in for six weeks instead of 28 days."
>
> (James, 42)

3.5 Post-Rehab Phase

3.5.1 Aftercare

Participants were asked about their experiences of aftercare. There were variations in the extent to which participants had received aftercare, with some having not received any – including Kirsty, due to her unwillingness to ask her family for more money – and others having sustained intensive, daily involvement in aftercare

activities for an extended period of time. All participants who had received aftercare following their placement suggested that this was a crucial component of their recovery process.

> “Rehab is a great place. I feel that you also need the aftercare and I think without these two things [preparatory work and aftercare], rehab does not work on its own.”
>
> (Barry, 41)

A number of participants spoke of the process of planning for aftercare during their placement. There was variation in terms of how this was undertaken, with some noting that they were actively involved in the collaborative development of an aftercare plan, while others had plans written up for them by workers at the residential facility. As noted previously, some suggested that longer placement lengths allowed greater scope for aftercare planning.

Those who had attended aftercare following their placement had done so through a range of means. These included attendance at lived experience recovery organisations and 12-Step meetings, as well as group therapy sessions, and returning to volunteer at the facility. Some had attended aftercare provided by the residential rehabilitation facility, while others attended those provided by other third-sector organisations. One participant who had been attending aftercare for two years following her placement noted that this aftercare had been intensive and time consuming, but that she felt that this was necessary for her.

> “When I came out, you can take as many days off from recovery as your addiction took off while you were drinking. It didn't. So they recommend 90 meetings in 90 days. I was doing actually two meetings a day before lockdown, and then after lockdown I was doing four or five Zoom meetings a day. I've cut back now, as I'm more solid in my recovery. I now do five, maybe six meetings a week.”
>
> (Susan, 63)

Reflecting Susan’s account, another participant who had returned to residential rehabilitation on two occasions reflected the need for regular aftercare support, suggesting that the provision of support on a weekly basis following his first placement had not been enough for him to sustain abstinence.

Those who had engaged in aftercare suggested a number of mechanisms by which it helped them to meet their recovery goals. All these participants highlighted that it allows for the continuation of the kind of close-knit relationships which had been formed during the residential placement and which were central to its benefit. Further, exposure to others who had either sustained recovery or who had relapsed, as well as to individuals who had not yet attended residential rehabilitation and were engaging in problem substance use, was noted as providing a constant reminder of the importance of sustaining recovery.

> “I had three suicide attempts. I don't want to go back there. I know if I drink again, my daughter will not be in my life ever. She will just walk. She gets married in June. I didn't think I'd be going to the wedding, but I am, and these are things that keep me going and I also have very good friends. It's a small circle of friends in AA but it's a very close circle of friends and I just keep in touch and talk and my sponsor has been sober for 34 years. So there's very little that I can say that they go 'I’ve never heard that before' they usually go yeah, yeah, yeah. [...] I really enjoy it, and it's good for me because the step one group in particular reminds me that I don't want to go back there. You know, my life was completely out of control and unmanageable.“
>
> (Susan, 63)

A number of those interviewed described undertaking work in a variety of different roles – whether paid or voluntary – across the sector. While often couched in terms of ‘giving something back’ to the services which had helped them to move beyond problem substance use, their accounts also highlighted that they benefited in a number of ways from such work, including providing them with a sense of purpose and routine, as well as connection to other people with lived experience of recovery.

Participants who had not received aftercare support, including John who had engaged in an unplanned exit from a previous placement, suggested that they had found the period following rehab particularly challenging due to this. One described that he had returned to problem substance use due to a combination of personal circumstances and the lack of follow up support following his placement.

> “There was a bit of preparation in there before I went home. [...] I went home, but there was no aftercare. I was going home to the same house and street and the same people, so I ended up doing the same things again, you know. [...] My son's got disabilities and Downs Syndrome so he got a date to go in for open heart surgery, so I came home. All the stress of that, back to the same house, no aftercare, nothing. But the stress and to watch my son on life support machines and all that... That was all big green lights for me to use, and sad as it is, that was the way it was.”
>
> (John, 51)
>
> “When I was a patient probably there wasn’t very much focus on it. And that’s why sometimes we get that, there’s the cliff edge. You've got this really wrapped up in a ball of cotton will kind of experience and then you are the door and then it's like, right go fend for yourself. [...] I think places are getting a lot better at figuring out, right, how do we support people? Everybody understands that if you've got an opiate patient, day of discharge is red alert, high risk.”
>
> (James, 42)

3.5.2 Outcomes

The people interviewed had diverse experiences following residential rehabilitation placements. As noted previously, a number had returned to rehab, either at the

same or other facilities, between one and four times. Most participants described having accessed a different residential rehabilitation facility following their initial placement. One participant who had left a placement early reported that he had attempted to regain access to the same facility, but that this had not been an option due, as he perceived, to the residential rehabilitation facility's staff's frustrations with his disruptive behaviour during his placement. He also suggested that his referrers and funders did not engage him in aftercare due to their frustrations at having left his placement.

> "I started feeling really guilty and start using again, I tried to get back in but it was not happening. I don't know why it didn't happen. [...] And no aftercare from [his referrers]. None at all. They were fuming because I walked out, fuming, were not happy at all, yet there's people that I know that have walked out... There was a guy from a couple of miles down the road. He walked out and he still does stuff with them to this day."
>
> (Gary, 51)

Others described having sustained abstinence after a single placement. Despite the variety in experiences following residential rehabilitation which were reported, a theme emerging across a number of interviews was that people had often relapsed following their placement, but had quickly reversed this and managed to reduce and abstain from use, attributing this to the skills, coping mechanisms and knowledge which they had learnt during their placement in residential rehabilitation. Given that such relapses would likely be documented statistically as a 'failure' of treatment, this forms an important consideration for the measurement of outcomes from residential rehabilitation.

> "I had drunk again and it wasn't for long, but it just proved to me that was I learnt at LEAP was right. And when I stopped drinking at that point, I have not wanted to drink again. And I wouldn't recommend relapsing after treatment, but it's what my journey was and treatment had given me the tools to be able to put the drink down again quite quickly and get back on track."
>
> (John, 51)

4. Conclusions

4.1 Overview

This report has drawn on qualitative interviews with people with lived experience of having accessed residential rehabilitation to explore, from their individual perspectives, the pathways into, through and out of residential rehabilitation across Scotland. As noted, this report complements the suite of reports published by the Scottish Government in November 2021 which explored these pathways through surveys of ADPs and residential rehabilitation providers.

While these accounts cannot be assumed to be representative of experiences across the sector given the small sample size, they provide a valuable insight into important aspects of residential rehabilitation. It is again important to caveat the accounts provided by noting that the majority of accounts relate to experiences of pathways into, through and out of residential rehabilitation prior to the recent increase in Scottish Government funding for residential rehabilitation across Scotland.

We would like to explicitly thank the people who kindly gave their time to share their experiences with us. We would also like to acknowledge the important role of the Scottish Recovery Consortium, Restoration Fife, and Lothians and Edinburgh Abstinence Programme (LEAP) for facilitating the link between the research team and individual people with lived experience of having accessed residential rehabilitation for the purposes of this research.

4.2 Considerations

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

A number of considerations were made in the report summarising the pathways surveys undertaken with ADPs and residential rehabilitation providers, published in November last year. A number of these considerations are also relevant to the findings of this research:

- **A need to develop standards regarding the pathways around access, assessment, referrals, funding, and aftercare** – The ADP survey found substantial variation in the pathways into, through and out of residential rehabilitation across ADPs, and an appetite for greater guidance around pathways. The experiences which participants shared through interviews demonstrated the substantial barriers which they faced in getting referred to, and accessing, residential rehabilitation placements. The implementation of standards across each ADP, alongside guidance, would allow for the

development of these pathways and the minimisation of geographic inequalities in access to rehab and aftercare.

- **A need to minimise structural barriers which reduce equity of access** – While it is necessary that certain entry criteria and person-centred clinical judgement are in place to ensure the safety and efficacy of rehab for the individual and others attending these facilities, the ADP and providers surveys highlighted that current referral and entry criteria sometimes include unnecessarily prohibitive barriers. Financial barriers are also apparent, as well as wide variation in funding mechanisms for individual placements. Such barriers were reflected in the accounts of participants interviewed for this report. These findings highlight a need to ensure clearer pathways and greater access to statutory funding for rehab placements across all areas, with specific work needed across the nine ADPs identified as having underdeveloped pathways.

- **A need to establish a centralised list of approved rehabs** – The ADP and providers surveys identified that only a few ADPs maintain a list of preferred rehab providers, and that there is more general need to improve communication between ADPs and providers. Interviews with those with lived experience of accessing rehab highlighted a lack of awareness of residential rehabilitation facilities among both individuals and families affected by problem alcohol and drug use, and among potential referrers. Further, some described the rehabilitation facilities which they initially attended as having not been appropriate for a number of reasons, but having benefited from subsequent placement in more suitable programmes. A centralised list of approved residential rehabilitation providers, made available both online and in physical form, could assist in raising awareness among ADPs and potential referrers of the specific offerings of rehab providers. This centralised list would help to inform choice regarding individual placements.

- **A need to develop specific preparatory programmes** – The ADP and providers reports highlighted significant variation in preparatory work for residential rehab, both in terms of programmes offered and the agencies responsible for this preparatory work. Participants' accounts here reflected this variation, and demonstrated the importance of preparatory work in allowing individuals to gain benefit from their placements. These reports have also highlighted an opportunity to learn from and share best practice, and to develop standards around preparatory work across Scotland.

- **A need to establish structured links to detox** – Poor access to detox forms a barrier to accessing rehab, particularly for those seeking recovery from benzodiazepine use or those who otherwise require complex detox. The providers survey highlighted that less than half of rehab facilities offer in-house detox, that there are long waiting times for external detox facilities, and that many of those accessing rehab detox without medical assistance, or through unknown pathways. The interviews reported on here similarly highlight wide variation in experiences of detox prior to placement. There is a need to increase detox provision, and for greater alignment with rehabs.

Specific pathways for people taking high doses of benzodiazepines or engaging in complex poly-drug use may be beneficial.

- **A need to ensure robust exit planning and continuity of care** – Those who had been able to access aftercare highlighted its importance in helping to sustain recovery following a rehab placement. While the previous surveys found that most providers offer aftercare, and that aftercare is available in most ADP areas, they also demonstrated a lack of clarity around who is responsible for aftercare, particularly for non-local placements. This could heighten risk, particularly for those making unplanned exits. It is also vital to improve clarity around options to return to rehab. Evidence-based guidance regarding if and how re-admittance should be arranged would support decision making.

In addition to these considerations, the interviews undertaken with people with lived experience have led to the development of a number of further considerations, as follows:

- **A need to further understand person-centred suitability for referral –** The interviews captured a range of experiences prior to referral, with prior levels of motivation – on which referral and admission often hinges – at times seemingly unrelated to people's engagement with the programme, and subsequent outcomes. These findings highlight a need to further understand the concept of 'rehab readiness' in order to explore who may benefit from rehab, and at what time.

- **A need for further research to explore what aspects of rehab work for different people –** These interviews identified a number of aspects of residential rehabilitation which participants felt had been useful in helping them to sustain recovery during and following their placement. While those interviewed formed a relatively representative sample of those accessing rehab across Scotland, the small sample size makes extrapolating these findings to particular population groups challenging. Further research may explore what aspects work for particular population groups.

- **A need to improve knowledge and choice in relation to different rehab programmes –** Findings here demonstrated that participants sometimes found aspects of rehab programmes unsuitable for them, while gaining greater benefit from their placement at other facilities. These findings highlight a need for greater access to knowledge of different rehab programmes involve prior to referral in order to ensure that individuals and referrers work together to identify facilities which are suitable for the individual.

- **A need for development of knowledge of residential rehabilitation across potential referrers –** The accounts of some of those interviewed highlighted a poor and variable knowledge of residential rehabilitation facilities among potential referrers, including both primary care providers, and drug and alcohol services. These findings highlight a need to develop this understanding among potential referrers in relation to the availability of

residential rehabilitation services are available across Scotland, and of how to identify individuals as potentially suitable for potential referral.

- **A need to further explore the impact of rehab placements, and which specific outcomes measures to use –** Participants described a wide array of positive outcomes following their placement. Some of the people who took part in interviews suggested that they had briefly returned to problem substance use following their placement, but that the tools which they had learned during their placement had allowed them to keep these periods of use relatively brief. These findings highlight a need to further understand the short- to longer-term outcomes for individuals following placements, and how to measure these in a way which captures this complexity.

5. Appendices

5.1 Interview Topic Guide

Introduction

- We are trying to gather as much information as possible on residential rehabilitation for alcohol and drugs across Scotland. We have carried out surveys with rehab facilities, and with Alcohol and Drug Partnerships (the government funded organisations who coordinate alcohol and drug services locally).
- While these have been useful, we think it's particularly important to explore the experiences of people who have actually been through rehab in order to find out what the experience is like, so that these can inform ongoing improvements.
- This interview is designed to gather information on your experiences of your journey of going through residential rehabilitation from start to the present day. It has a few questions on your life and substance use before accessing rehab, questions asking how you came to be referred to, and accessed and funded your placement in rehab, on what the day-to-day process of attending rehab was like, and on the journey out of rehab towards aftercare and your life following your placement. It tries to focus on what worked well, and aspects of the journey which you would improve.
- You'll have seen this in the Participant Information sheet and Consent Form, but just to emphasise, if you do not feel comfortable answering any questions, you are under no obligation to answer them. You can ask us to skip particular questions, and are free to stop the interview at any time without giving us a reason. All of your responses will be made anonymous and made as confidential as possible (unless you inform us of risking harm to yourself or others).

Personal/Background

- Age
- Gender
- Ethnicity
- What rehab(s) did you go to and when?
- Which area did you live before accessing rehab? Where area do you live now?
- Employment status
- Housing status
- Any involvement with criminal justice history?

Experience of Alcohol/Drug Use

Substance use profile

- What substances were you using?
- What was the main substance for which you were seeking recovery?

Access

Previous experience of treatment/recovery services

- Did you have a history of accessing other treatment/recovery services before rehab?
- Why did you feel that these services had not worked for you?

Identification

- How long had you been using for, and attempting to recover before rehab was presented as an option?
- How did you come to hear about or consider rehab as an option?
- Who was the main person/agency who referred you in the end?
    - Did you think that people in these services were helpful in terms of helping you access rehab?
    - Why did you prefer the idea of residential rehabilitation in comparison with other treatment/recovery services?
    - What did you hope to get out of rehab?
    - Did you consider yourself to be in recovery before accessing rehab?

Assessment

- Can you tell us about the assessment?
    - Who was involved?
    - What kinds of questions did they ask?
    - How did you find the experience? How did it make you feel?

Funding

- Can you talk us through the process of accessing funding for your placement?
    - How easy was it to get funded?
    - Did the providers help you in the process of securing funding?
    - Had you approached anyone else for funding?
    - What would you have done if you hadn't accessed funding through that pathway?
    - Did you try and access statutory funding at all?

Selection of Facility

- How much of a say did you get in relation to choosing a facility?

- Did you feel then that the choice was the best one for your needs at the time?

Pre-Rehab

Waiting Period

- After being accepted for a placement, did you have to wait to enter rehab?
  - How long did you have to wait?
  - What were things like for you during this waiting period? Did your motivation wane at all? Were you ever considering changing your mind?

  - IF P2R – What was the process of transfer like?
  - IF P2R – Did you go straight from prison or did you have a short stay outside of prison before going into rehab?
  - IF P2R – Did you feel the prison staff/rehab were working well together to organise

Preparatory Work

- What kind of preparatory work did you have to do before entering rehab?
  - Who was involved in this period of work?
  - Did you feel well-prepared for residential rehabilitation when you started your placement?
  - Did you feel you knew exactly what to expect from your placement, and the benefits and challenges?

Detox

- Did you have to undertake detox beforehand?
  - Where did this take place?
  - How long did you have to wait?
  - (If going to a facility) How was this funded?
  - Did you have to wait at all between detox and rehab?
  - Did you feel well supported?

Residential Phase

Engagement with external services

- How much engagement did you have with community-based services/ADP while in your rehab placement?
- Engagement with FAMILY and wider relationships during placement.

Success of programme

- What was your experience of being in rehab like?

- Was there anything that would have made your experience of rehab better or improved your likelihood of recovery?
    - [If having sustained recovery] What do you think it was about rehab that helped you towards success in recovery?
    - Why was rehab different to other kinds of treatment or recovery service?
    - [If not having sustained recovery] What do you think it was about rehab that was limited in helping you towards success in recovery? What did you feel disrupted their recovery or caused them to begin taking substances again?
- If you had mental health issues at the time, how were these addressed? Did you feel they were adequately dealt with? Who was involved in this?
- Did you feel that the staff at the rehab were competent? Informed? Sensitive in dealing with issues of trauma etc?
    - Were there any gaps in terms of staff that you would have liked to have been there?

Completion of Placement

- How long did your rehab placement last? Was this longer/ shorter than planned?
    - Did you ever leave and come back/ have multiple stays in rehab?
    - [If unplanned exit] What were the factors which led to you leaving rehab early?
    - (If having sustained recovery) What made the last stay a success?

Aftercare

Planning for Aftercare/Post-Rehab

- What kind of planning was undertaken for finishing rehab? In terms of housing? Employment/Training? Relationships?
    - Was planning for accessing aftercare undertaken during your placement? Can you tell us a bit about this?
    - Did you link in with other services/recovery communities etc?

Post-Rehab

- Can you talk a bit about the process of adjusting to life following your placement?
    - Did you feel ready for life after rehab? Life skills? Relationships?
    - How well supported did you feel at this time?
    - Who was involved in providing support to you throughout this process?

Aftercare Experiences

- If having accessed aftercare…
- Can you describe how you came to access aftercare following your placement?
- What aftercare services did you/have you been attending?

    - And for how long? how long do you think you will keep going?

- If not having accessed aftercare:
- Why did you feel you did not need to, or were not able to, access aftercare?

Readmission (if applicable)

- Can you tell us a bit about returning to residential rehabilitation?
    - Was the possibility of going back discussed at all with you and at what stage?
    - What was the process of gaining access again like?

General Questions

Suggestions for improvements

- What would have improved your journey into, through and out of residential rehabilitation?

General Comments

- Do you have anything you wish to add that was important about your experience of residential rehabilitation that we've not covered?

Findings from the ADP and Provider surveys

- Barriers for benzos
- Mental health comorbidities
- Workforce

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