Action in Partnership

Tackling **Drugs** in Scotland

Residential detoxification and rehabilitation services for drug users: A review

research

Effective Interventions Unit

SCOTTISH EXECUTIVE

Scottish Executive
Effective Interventions Unit

Remit

The Unit was set up in June 2000 to:

• Identify what is effective – and cost effective – practice in prevention, treatment, rehabilitation and availability and in addressing the needs of both the individual and the community.

• Disseminate effective practice based on sound evidence and evaluation to policy makers, DATs and practitioners.

• Support DATs and agencies to deliver effective practice by developing good practice guidelines, evaluation tools, criteria for funding, models of service; and by contributing to the implementation of effective practice through the DAT corporate planning cycle.

Effective Interventions Unit
Substance Misuse Division
Scottish Executive
St Andrew's House
Edinburgh EH1 3DG
Tel: 0131 244 5117 Fax: 0131 244 3311
EIU@scotland.gsi.gov.uk
http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

Effective Interventions Unit

Residential detoxification and rehabilitation services for drug users:

A review

November 2004

WHAT IS THE AIM?

To provide a brief review of the existing evidence on residential detoxification and rehabilitation services for drug users.

WHAT IS IN THIS REVIEW?

- a definition of the aims of residential detoxification and rehabilitation services
- a summary of the evidence on the effectiveness of those services
- a list of residential services in Scotland
- a description of the way in which residential services are being used in Scotland.

WHO SHOULD READ IT?

Anyone interested in commissioning, planning, developing or delivering services for drug users, and anyone interested in undertaking further research on residential services.

WHO PREPARED THE REVIEW?

Dawn Griesbach from the Effective Interventions Unit (EIU) conducted and wrote the review with assistance from Patricia Russell (EIU), Linsey Duff (EIU / Information Services, NHSScotland), Karin O'Brien (EIU), Chris Rich (EIU) and Sally Thompson (Scottish Executive Substance Misuse Division).

Contents

Executive Summary		**1**
Introduction		**3**
Chapter 1:	**Description of residential detoxification and rehabilitation**	**5**
Chapter 2:	**Effectiveness of residential detoxification and rehabilitation**	**9**
Chapter 3:	**Residential detoxification and rehabilitation services in Scotland**	**15**
Chapter 4:	**Conclusions**	**23**
Appendix 1:	**List of residential detoxification and rehabilitation services in Scotland**	**25**
Appendix 2:	**Residential admissions, by DAAT area in 2002 – 2003 and 2003 – 2004**	**29**
References		**33**

Executive Summary

This review provides information about **residential detoxification and rehabilitation services** for drug users. It includes:

- a description of the aims of residential detoxification and rehabilitation services and the interventions provided by them;
- a summary of the evidence on their effectiveness;
- a mapping of these services in Scotland; and
- brief details of how Scottish residential services are used.

The review does not consider the effectiveness of residential services for alcohol users, nor does it compare the effectiveness of residential and community services. Such a comparison is actually quite difficult because the **immediate aims, duration and interventions** associated with residential and community services are **different**.

Description of residential detoxification and residential rehabilitation

Residential detoxification and residential rehabilitation are **not the same**. The primary aim of residential detoxification is to provide the means for **safe and humane withdrawal** from a drug of dependence. Detoxification is not so much a form of treatment for drug misuse, as a **gateway to treatments** that are aimed at long-term abstinence.

Residential rehabilitation programmes, on the other hand, aim to support individuals to attain a drug-free lifestyle and be re-integrated into society. They provide **intensive psychosocial support** and a **structured programme of daily activities** which residents are required to attend over a fixed period of time.

Not all residential rehabilitation programmes are alike. Residential rehabilitation programmes differ markedly on the basis of their **underlying philosophy** and in the details of the programme structure, intensity and duration.

Effectiveness of residential detoxification and residential rehabilitation

Completion rates for residential detoxification programmes are very high — around 75-80%. However, lapse or relapse following residential detoxification programmes is common. Detoxification programmes will result in **better long-term outcomes** if they are followed up by some form of **structured aftercare**.

The four main factors that impact on and influence the effectiveness of residential rehabilitation programmes are — **time in treatment, retention, client characteristics and provision of aftercare**. More specifically:

- Residential rehabilitation programmes of **at least three months duration** are more effective than shorter programmes.
- Those who **complete** residential rehabilitation programmes have significantly better long-term outcomes than those who leave prematurely. Unfortunately, residential rehabilitation programmes have **high drop-out rates**. Studies have shown that one-quarter of clients leave within two weeks of entry and 40% leave within three months.

- Clients with less severe problems are more likely to be retained in treatment. However, even clients with very severe problems, including co-morbid psychiatric problems, can achieve similar outcomes to those with fewer difficulties if more intensive individualised services are made available to them.

- Following completion of a residential rehabilitation programme, **community aftercare is necessary** to sustain the good outcomes achieved.

Residential detoxification and rehabilitation services in Scotland

There is currently **no comprehensive directory** of residential detoxification and rehabilitation facilities in Scotland. Therefore, as part of this study, we undertook to map all residential detoxification and rehabilitation units in Scotland — and to answer basic questions about each service such as: (i) its location (ii) the number of beds available in the facility and (iii) the duration of the programme.

We identified **21 residential detoxification and rehabilitation units** in Scotland, with 329 beds for adult drug users. This figure does not include residential crisis services or supported accommodation services, although many supported accommodation services are similar to residential rehabilitation in terms of their aims and interventions.

Nine of the 21 units are based in the west of Scotland — six of these are in Glasgow. A number of facilities give priority to clients from particular geographical areas, thus reducing the number of beds available to clients from outside those areas.

Based on available data, an estimated 905 Scottish drug users were admitted to a residential treatment facility between April 2002 and March 2003, and an estimated 1,294 were admitted between April 2003 and March 2004. Because of inconsistencies in the data sources, **these figures can only be considered to be very rough estimates. The actual numbers are likely to be greater.**

Residential treatment is expensive. On average, the cost of a week in a residential rehabilitation programme ranges **between £310 and £425 per week**, although some facilities cost considerably more than this. The cost of residential detoxification may be twice as much (or more) because of the clinical input provided.

Most non-NHS residential treatment facilities receive self-referrals, and in such cases the client is usually also self-funded. However, many referrals to residential programmes are also made by statutory services. In most areas of Scotland, funding for residential rehabilitation is managed by social work departments, whereas funding for residential detoxification is managed by NHS Boards. Only a few areas of Scotland currently have arrangements for joint funding of residential treatment for drug users.

In addition, it would seem that only a few areas in Scotland have developed criteria for determining when a client's needs can best be met through a residential service. In many areas, practitioners **will not usually consider referring a client to a residential service until community services have been tried and exhausted**.

Conclusion and possible areas for further research

Residential detoxification and rehabilitation programmes should not be seen as stand-alone interventions, but rather as components of an integrated package of care. Adequate preparation and after-care provided in community settings are key to the success of residential treatments.

Further research in this area may focus on undertaking a more detailed mapping of residential services in Scotland, improving retention rates and investigating models of good pathways of care between community and residential services.

Introduction

There is a wide range of services available to drug users for treatment, care and support. Among these are services which are provided to individuals in a residential setting. This review provides information specifically about **residential detoxification and rehabilitation services** for drug users. It includes:

- a description of the aims of residential detoxification and rehabilitation services and the interventions provided by them;
- a summary of the evidence on their effectiveness; and
- a mapping of these services in Scotland; and
- brief details of how Scottish residential services are used.

This review does not consider the effectiveness of residential services for alcohol users and it is likely that different factors impinge upon the outcomes of residential treatment for primary alcohol and primary drug misuse. It is worth noting, however, that most residential programmes for drug users in Scotland also provide services to alcohol users, although the reverse is not necessarily true — that is, not all residential services for alcohol users also provide services to drug users.

This review is intended to provide a basis for further research on the subject of residential and community rehabilitation for drug users, to be funded under the Scottish Executive's Drug Misuse Research Programme in Spring 2005. Therefore, the concluding chapter of the review makes some tentative suggestions about possible future research in this area.

Methods

In addition to a brief review of the literature on residential services for drug users, this review draws on information gathered from a number of other sources, including:

- a Directory of Specialist Drug Treatment Services in Scotland, available from the Scottish Drugs Forum (SDF) website
- the Drug and Alcohol Action Team (DAAT) Corporate Action Plan returns for 2002-04
- the Scottish Drug Misuse Database for the years 2002-04.
- a report of a qualitative investigation of residential services in Scotland undertaken in 2001/2002 as part of the Drug Outcomes Research in Scotland (DORIS) study
- the results of a survey of social workers' use of residential detoxification and rehabilitation services, undertaken between January and May 2004 by the Association of Directors of Social Work (ADSW) sub-group on Substance Misuse
- brief telephone interviews with a selection of practitioners, local authority budget holders and DAAT officers across Scotland undertaken in October 2003.
- A brief telephone survey of providers of residential services in Scotland, carried out between March and September 2004.

It became clear during the process of gathering evidence that this subject provokes strong views from practitioners, service providers, commissioners and researchers alike. We hope this review will provide a useful contribution to the on-going discussions and debates taking place in many areas of Scotland about the role that residential services have in relation to community services in providing integrated care to drug users.

THANK YOU

The EIU would like to thank all those who have provided information for this review. In particular, we are grateful to the members of the ADSW sub-group on Substance Misuse for allowing us access to the results of their survey, and to those practitioners, DAAT officers and managers who agreed to speak to us about this important topic.

Chapter 1: Description of residential detoxification and rehabilitation

Residential detoxification and residential rehabilitation are very different in terms of their aims, duration and interventions. The main differences are summarised below. It is important to note that in the context of residential rehabilitation services, "abstinence" usually means free of all illicit and prescribed drugs, including methadone.

RESIDENTIAL DETOXIFICATION	RESIDENTIAL REHABILITATION
Aim Humane withdrawal from a drug of dependence	**Aims** Long-term abstinence and reintegration to society
Duration Short - Medium (varying between a few days and a few weeks)	**Duration** Medium - Long (varying between 2 or 3 months and 1 year)
Interventions provided 1. Clinically-supervised detoxification 2. Brief psychosocial intervention (in some cases), usually counselling for relapse prevention 3. Crisis support (in some cases) or practical help with housing, benefits, etc.	**Interventions Provided** 1. Clinically-supported detoxification (in some cases) 2. Intensive psychosocial support to address issues such as reasons for drug use, parenting skills, sexual or physical abuse, prostitution, low self-esteem, family relationships, etc. Therapeutic interventions may include one-to-one counselling, group therapy, relapse prevention, motivational interviewing and cognitive behaviour therapy. 3. Employability interventions (in many cases), including training in basic skills, social and personal skills, and employment preparation.

This review does not include information about residential crisis services or supported accommodation, although both of these may also have a role in the treatment, care and support of drug users at different stages in their recovery.

In Scotland, it is actually quite difficult to distinguish between some types of supported accommodation services and residential rehabilitation. Many supported accommodation services also have abstinence as an aim and they similarly provide a structured daily programme of activities for their residents. This point will be discussed in further detail in Chapter 3.

Residential detoxification

The primary aim of residential detoxification programmes is to provide the means for **safe and humane withdrawal from a drug of dependence**. Detoxification programmes may also provide individuals with a period of respite from drug use and its consequences, and, therefore, they give clients an opportunity to think clearly about their drug use and whether to seek further help. Detoxification is not so much a form of treatment for drug misuse as a gateway to treatments that are aimed at **long-term** abstinence (Robertson and Wells, 1998).

The nature of a detoxification programme will vary according to the drug or drugs of dependence. The symptoms of acute opiate withdrawal are unpleasant and often severe, but not life-threatening. The need for clinical intervention in residential detoxification programmes largely relates to moderating these symptoms and encouraging an individual to continue with the process. In contrast, detoxification from benzodiazepines and other sedatives / hypnotics and from alcohol requires careful clinical management, since sudden withdrawal may produce symptoms such as delirium and fits, which can result in sudden death. Withdrawal from stimulants such as cocaine does not usually result in visible physical symptoms, but may include severe depression, extreme fatigue, vivid and unpleasant dreams, agitation, and intense craving for the drug. Again, with stimulant withdrawal, the need for intervention by a detoxification service largely relates to ameliorating these symptoms and supporting and encouraging the individual to persevere.

Information

The period following acute opioid withdrawal is often characterised by symptoms such as fatigue, depression, poor tolerance of stress and craving for drugs.

Mattick & Hall, 1996

For most drug users, the acute withdrawal period is followed by a longer period of general malaise which may last for months. It is during this period that the risk of relapse is greatest.

Because residential detoxification programmes must be tailored to the nature of a person's drug use, the duration of residential detoxification programmes is often variable. In the UK, different programmes last between a few days and a maximum of 12 weeks. **In-patient Rapid Opiate Detoxification (IROD)** programmes, such as Detox5 in Harrogate and the Green Door Clinic in Falkirk, involve the sedation of the patient under general anaesthesia for a period of 2-3 days, so that he / she does not consciously experience the acute symptoms of withdrawal (Rae, Matheson & Bond 2001). IROD programmes are ordinarily followed by a short period of maintenance prescribing with an opioid antagonist, such as naltrexone.

Other residential detoxification programmes provide detoxification over a slightly longer (but still relatively short) period of time through **a programme of reduced prescribing.** Such programmes may also provide support to the drug user through respite, crisis intervention, counselling in relapse prevention, or one-to-one counselling. They might also include practical support, through linking the client to other services such as supported housing or long-term rehabilitation. Depending on the client, some programmes may focus more on stabilising an individual's drug use rather than detoxification alone.

Residential rehabilitation

In contrast to residential detoxification programmes, residential rehabilitation programmes provide **intensive psychosocial support and a structured programme of daily activities** which residents are required to attend. It is important to note that residential rehabilitation programmes are **not all the same**. Programmes differ markedly on the basis of their underlying philosophy and in the details of programme structure, intensity and duration of treatment. The National Treatment Outcomes Research Study (NTORS) identified three distinct types of programmes in England:

1. 12-step / Minnesota Model programmes

2. Therapeutic communities

3. Christian houses

A fourth category, referred to as "General houses", included all those programmes that did not fit neatly into one of the other three categories (Stewart *et al,* 2000; Gossop, personal communication). This same classification may also be used for programmes in Scotland (Saville, personal communication). However, a comprehensive directory of residential rehabilitation programmes in England and Wales suggests that, in reality, programmes may use a combination of approaches.[1]

The published research literature provides information about 12-Step / Minnesota Model Programmes and Therapeutic Communities, but not about Christian houses.

- **12-step / Minnesota Model** programmes provide information to residents about the disease model of addiction (i.e. that chemical dependency is a chronic illness affecting one's physical, mental and emotional well-being) while combining professional care with **instruction** in 12-Step principles. The **main therapeutic mechanism is provided through group work**, namely fellowship in Alcoholics / Narcotics Anonymous. (Castle Craig in West Linton is an example of a 12-Step residential programme.)

- **Therapeutic communities** emphasise social learning, behavioural and cognitive-behavioural approaches to achieving a healthy pro-social lifestyle characterised by abstinence (Lang & Belenko, 2000). Therapeutic communities promote change by **developing self-worth and personal responsibility, challenging** individual attitudes and behaviour and **encouraging the development of life and social skills** through engagement in daily work and activity routines. Structured group work uses Cognitive Behavioural Therapy methods. Residents pass through three distinct programme stages, which are designed to help them prepare and plan for an independent lifestyle before moving back out into the community. (Phoenix House in Glasgow is an example of a therapeutic community.)

Residential rehabilitation programmes may be either short-term (varying from 6-12 weeks) or long-term (usually lasting 3-12 months). Some programmes also provide facilities for opiate detoxification, usually using methadone. The length of the detoxification stage may vary between 3-28 days, depending on the programme. Since abstinence is the aim of all residential rehabilitation programmes, drug use by residents is considered to be grounds for ejection, and routine drug-testing is a feature of most programmes.

---

[1] See the NTA's Directory of Residential Treatment Services, which provides detailed information about the philosophy and programme of care provided by residential services in England and Wales: http://www.nta.nhs.uk/residentialdirectory/index.html.

Summary

- Residential detoxification and residential rehabilitation are **different** in terms of their aims, duration and interventions.
- The primary aim of residential detoxification is to provide the means for **safe and humane withdrawal** from a drug of dependence.
- Detoxification is not so much a form of treatment for drug misuse, as a **gateway to treatments** that are aimed at long-term abstinence.
- Residential rehabilitation programmes provide **intensive psychosocial support** and a **structured programme of daily activities** which residents are required to attend.
- Residential rehabilitation programmes differ markedly on the basis of their **underlying philosophy** and in the details of the programme structure, intensity and duration.

Chapter 2: Effectiveness of residential detoxification and rehabilitation

The significant cost of residential services compared to community services may lead DAATs and partner agencies with responsibility for commissioning services to want to compare residential and community services, in order to answer the question, **"Which form of treatment is most effective in treating addiction?"**. While it may be natural to ask this question, a straight-forward comparison is actually quite difficult for several reasons.

1. **The immediate aims and duration of residential and community treatments for drug misuse are different**.

   The ultimate aim of both residential and community drug services is the same — namely the attainment by the client of a sustainable drug-free lifestyle. However, many community programmes will seek, in the first instance, to stabilise an individual's drug use — usually through methadone maintenance prescribing and basic education about harm reduction, before moving on to support clients towards a lifestyle free of all drugs. **The key to attaining this will be the ongoing assessment of the client's needs, wishes and circumstances.**

2. **The interventions provided by community and residential programmes are different.** Residential programmes provide a highly structured programme of intensive psychosocial support over a clearly defined period of time. In contrast, different types of community services provide different types of interventions. Most community programmes provide only low intensity psychosocial interventions, and NTORS found that the majority of community methadone services did not have a planned treatment duration (Stewart et al, 2000), although many community rehabilitation programmes do have more structured interventions with defined durations.

3. **The characteristics of clients entering community services are often quite different than those entering residential services**. NTORS found that clients entering residential services in England had more serious problems than clients entering community methadone services. The reasons for this relate to complex processes of self-selection and referral. In order to truly compare the effectiveness of community and residential services, individuals would need to be randomly allocated to both treatment modalities. It is questionable whether such a random allocation would be possible, or ethical.

EVIDENCE

NTORS found that, compared to clients entering community services, those entering residential services were:

- Older
- Had a longer history of heroin use
- Were more likely to have shared injecting equipment
- Were regular users of stimulants (especially cocaine)
- More likely to be heavy drinkers
- More likely to be actively involved in crime
- Arrested more frequently

Gossop et al, 1998

In addition to the practical difficulties of making a fair comparison between community and residential treatments, the question of comparable effectiveness is perhaps not helpful for another reason. Namely, the question implies that community and residential treatments are mutually exclusive options. **Residential detoxification and rehabilitation programmes are not stand-alone interventions.** These interventions must be seen as components of an integrated package of care, with community services actively involved in the client's **preparation** for residential admission and **aftercare** following the client's completion of the programme.

This chapter presents evidence on effectiveness of residential detoxification and residential rehabilitation. Our review of the literature was **not a systematic review** — that is, no particular criteria were used to inform decisions about including or excluding certain studies. Instead, an effort has been made to include a wide range of studies, and to refer as much as possible to research from the UK. Inevitably, however, in a review of this type, reference is also made to the sizeable literature from the US.

Most of the studies described here do not compare residential and community treatments; instead they compare residential treatment with no treatment. Some also compare clients who complete residential programmes with those who do not.

Before presenting the evidence on the effectiveness of residential detoxification and rehabilitation programmes, it is perhaps worth mentioning briefly the subject of waiting times. Sixty percent of the residential programmes that participated in the NTORS study had a waiting list, but for the majority of these programmes, waiting times were only 1-2 weeks (Stewart et al, 2000). Contrary to what might be expected, there is some evidence to suggest that clients who experience delays prior to entering a residential programme **do not** have poorer outcomes as a result (Christo 1998).

Effectiveness of residential detoxification

No one method of detoxification is effective for all clients. Methods will and should depend entirely on the characteristics of the individual and the nature of their drug use.

Since the primary aim of a detox programme is removal of all illicit chemical substances from the body, completion of the programme is very important. Completion rates for residential (or in-patient) detoxification programmes are high — around 75-80% — and in fact, are considerably higher than those for community detoxification programmes, which vary between 20 – 53% (Marsden & Farrell 2002; Mattick & Hall 1996). Severity of drug use immediately prior to treatment is associated with early drop-out from residential detoxification programmes (Ghodse et al 2002).

Despite the growth in recent years of **rapid opioid detoxification** services, it is not clear that there is any benefit from detoxifying a client over a number of days rather than over a number of weeks. In-patient rapid detox is a very expensive way of providing relief from the symptoms of withdrawal. The use of general anaesthesia adds a small risk of death during the detoxification process (Mattick & Hall 1996).

The evidence indicates that **even successful detoxification is often followed by lapse or relapse** (Robertson & Wells, 1998). Relapse is so common that many addiction service providers would not consider it to be a sign of treatment failure, since the majority of drug users will have to make a number of attempts at detoxification (assisted or unassisted) before they can successfully live a drug-free lifestyle.

EVIDENCE

Ghodse et al (2002) found **no difference** in 12-month outcomes between clients who dropped out of a six-month detoxification and recovery programme and those who completed the programme but who had no aftercare. In contrast, clients who completed the programme and then went on to spend at least six weeks in a recovery or residential rehabilitation unit had significantly better one-year outcomes in terms of drug use, health, and criminal activity.

Ghodse et al, 2002.

However, **the evidence strongly suggests that detoxification programmes will result in better long-term outcomes if they are followed up by some form of structured aftercare** or supportive counselling (Inkster et al, 2001; Ghodse et al 2002; Best Practice Working Group 2000). It is also important to keep in mind that the risk of drug-related death is very high in the period immediately following detoxification because of an individual's reduced tolerance (Strang et al 2003). This fact alone makes it absolutely vital that support and aftercare is provided to drug users following detoxification.

Effectiveness of residential rehabilitation

The explicitly stated goal of all residential rehabilitation programmes is the client's **long-term abstinence from illicit and prescribed drugs**. Therefore, this must be the primary outcome against which the effectiveness of these programmes is assessed. However, a number of research studies have also measured other types of outcomes from residential rehabilitation and good outcomes could also be considered to include:

- ✓ longer periods of abstinence
- ✓ shorter periods of relapse
- ✓ less severe drug / alcohol use
- ✓ less involvement in crime
- ✓ movement towards employment
- ✓ improvements in physical and mental health
- ✓ less involvement in risk behaviours such as injecting or risky sexual behaviour.

There are four main factors that impact on and influence the effectiveness of residential rehabilitation programmes. These are:

Time in treatment

Retention in treatment

Client characteristics

Provision of aftercare

Each of these factors is explored in further detail below.

Time in treatment

Time in treatment is the single most important predictor of good outcomes from residential rehabilitation programmes. **The longer an individual is in treatment, the better the outcomes.** For residential rehabilitation programmes, **three months** appears to be a significant threshold. Programmes that are at least three months long result in better outcomes for clients than shorter programmes (Gossop et al 1999; Christo 1998; McCusker *et al* 1997). There may be some further benefit from programmes lasting six months, but programmes lasting longer than six months may not necessarily result in further improvements (McCusker et al, 1997). On the other hand, there is some evidence that **programmes of one year or longer may result in better outcomes for patients with more severe symptoms** at intake, including patients with severe psychiatric co-morbidity (Brunette et al 2001).

EVIDENCE

NTORS found that 75% of clients entering residential programmes (including in-patient, short-term and long-term programmes) had used heroin in the past 90 days. At one-year follow-up, only 50% of these same clients reported that they had used heroin in the past 90 days.

However, those clients who spent more than a **"critical time"** in residential treatment had **significantly better outcomes** than those who spent less than the critical time.

At one-year follow-up, 64% of those who were in treatment for **less** than the critical time reported using heroin in the past 90 days, whereas only 29% of those who spent **more** than the critical time in treatment reported using heroin.

Gossop et al, 1999

Retention in treatment

Because of the clear, consistent and strong association between time in treatment and outcomes, **it is therefore crucial to retain clients in treatment**. Programme completers are consistently more likely to have good long-term outcomes than those who leave prematurely. And indeed, a number of research studies of residential programmes use treatment retention as a proxy measure for good client outcomes.

EVIDENCE

A study of residential care placements in one London borough found that only 5% of those who left residential rehabilitation prematurely had good outcomes at six months, whereas 79% of programme completers had good outcomes.

Christo 1998

Unfortunately, residential rehabilitation programmes have **high drop-out rates**. Studies commonly show that 25% of clients leave within two weeks of entering a programme and 40% by three months (Marsden & Farrell 2002). Some UK research studies have reported early discharge rates as high as 70%. There is some evidence to indicate that the majority of early discharges are due to client self-discharge, rather than ejection from the programme for drug use or behaviour problems. One study of residential care placements in London found that 15 out of 21 premature discharges were the result of clients leaving the programme early against staff advice (Christo 1998). The evidence also suggests that the majority of these early discharges occur shortly after detoxification (Saville, unpublished report; Keen *et al,* 2001; Christo 1998).

However, those who leave prematurely cannot necessarily be considered to be treatment failures. Research has suggested that even a short time in a residential programme can have long-term beneficial outcomes for clients, even if these fall short of complete abstinence (Gossop *et al* 1999).

There is no clear evidence about which *types of programmes* (i.e., which programme philosophies) result in better client retention. Instead, research studies generally try to explain client retention in terms of client characteristics.

Client characteristics

In general, clients with more severe problems at treatment entry are at greater risk of premature drop-out (Christo 1998; Lang & Belenko 2000). There is some evidence to suggest that those who are in contact with services prior to their entry to residential

EVIDENCE

Lang & Belenko found that residential programme completers — compared to programme drop-outs — reported (at treatment entry) more close friends, a higher degree of social conformity, no history of psychiatric illness, fewer previous convictions for drugs offences, less severe drug use, less risk-taking behaviour, and a longer employment history.

Lang & Belenko, 2000

A study of 138 residents in a Phoenix House centre in Sheffield, found that those who successfully completed the one-year programme were more likely to have been drug-free at entry, whereas those who left the programme prematurely had required detoxification upon entry.

Keen et al 2000

Homeless substance users with mental health problems were randomly allocated to either a residential therapeutic community or a community treatment programme in New York City. The community programme was specially designed to treat both substance misuse and major mental illness. Those clients allocated to the residential treatment programme showed better ability to engage with treatment.

Nuttbrock et al, 1997

rehabilitation may have better outcomes than those who are not (Christo 1998). Similarly, being drug-free prior to programme entry may also result in better outcomes. As mentioned above, it appears that the majority of drop-outs from long-term residential programmes leave shortly after detoxification.

At first glance, these findings may seem to suggest that clients with fewer, or less severe problems are more likely to succeed in residential rehabilitation programmes. However, it must be remembered that the **clients who get referred to residential rehabilitation programmes are generally more likely to have more severe problems than drug users accessing community services**. As mentioned above, the NTORS study found that clients entering residential programmes had greater problems, in terms of drug use, physical and psychological health, criminal behaviour and drinking behaviour, than clients of community methadone programmes. However, these same clients also made some of the greatest treatment gains.

In addition, a number of studies have shown that, if identified early, even individuals with very severe problems, including dual diagnosis, can achieve similar outcomes to those with less severe difficulties, if more intensive, individualised services are made available to them (Carroll et al, 1994; Hoffman et al, 1994; McKay et al 1997; Nuttbrock et al 1997).

Residential services may be particularly appropriate for individuals dependent on cocaine. The needs of these clients often relate to inadequate housing, serious crime, severe psychiatric problems and low levels of support. Residential rehabilitation may significantly improve outcomes for these individuals (NTA 2002; Seivewright *et al* 2000).

Provision of aftercare

To sustain the good outcomes achieved following completion of a residential rehabilitation programme and to prevent relapse, some form of community aftercare is often necessary. NTORS found that the provision of aftercare was more common following residential rehabilitation programmes than either in-patient or methadone services (Stewart *et al*, 2000). Aftercare may take many forms including on-going counselling, participation in Narcotics Anonymous (NA), residence in a supported housing scheme and involvement in an employability or training programme. In the US, it is common for individuals to attend NA meetings following completion of residential programmes. These meetings are seen to provide an important source of support and on-going encouragement for recovering drug users. The evidence indicates that those who attend NA meetings are more likely to remain drug-free than those who do not.

EVIDENCE

A study of 489 ex-prisoners who took part in a therapeutic community treatment programme in the Delaware correctional system found that those programme graduates who participated in aftercare programmes were more likely to be drug-free and arrest-free 42 months after completion of the programme than those who did not.

Inciardi, Martin and Surratt, 2001

Sacks et al (2003) compared homeless mentally ill substance users who completed a residential rehabilitation programme with those who completed the programme and then went on to a therapeutic community-oriented supported housing programme. Good outcomes were achieved by both groups. However, significantly better outcomes were achieved by those who participated in the supported housing programme.

Sacks et al, 2003

There is little information available in the research literature about the role that aftercare can play for clients who **drop out** of residential rehabilitation programmes.

The next chapter will look in more detail at residential services in Scotland, and how these services are currently used.

Summary

- **Completion rates for residential detoxification programmes are very high** — around 75-80% — and in fact, are considerably higher than those for community detoxification programmes.
- Detoxification programmes will result in **better long-term outcomes** if they are followed up by some form of **structured aftercare**.
- The four main factors that impact on and influence the effectiveness of residential rehabilitation programmes are: **time in treatment, retention, client characteristics and provision of aftercare**.
- Residential rehabilitation programmes of **at least three months duration** are more effective than shorter programmes. Longer programmes may be appropriate for those with more severe problems.
- Residential rehabilitation programmes have **high drop-out rates**. Studies commonly show that about one-quarter of clients will leave within two weeks of entry.
- **Community aftercare is necessary** to sustain the good outcomes achieved following completion of a residential rehabilitation programme.

Chapter 3: Residential detoxification and rehabilitation services in Scotland

There is no comprehensive directory of residential detoxification and rehabilitation facilities in Scotland such as the on-line directory available for England and Wales provided by the National Treatment Agency. Therefore, as part of this study, we undertook to map all residential detoxification and rehabilitation units in Scotland — to answer basic questions about each service such as:

- Where is it located?
- How many beds are available in the facility?
- What is the duration of the programme?
- Is the facility available only to specific population groups? — i.e., women with children, clients from a particular geographical area, etc.

For this purpose we drew on a number of sources of information including: (i) a short telephone survey of residential detoxification and rehabilitation services in Scotland; (ii) the annual Drug & Alcohol Action Team Corporate Action Plans (CAPs)[2]; (iii) the *Directory of Specialist Drug Services in Scotland* compiled by the Scottish Drugs Forum; and (iv) the findings from an unpublished survey of social workers conducted in January 2004 by the Association for Directors of Social Work (ADSW) sub-group on substance misuse.

We also attempted to explore the way in which residential services are currently used in Scotland, and sought to answer the following additional questions:

- How many placements are made to residential services in Scotland each year?
- How are these placements funded?
- How are clients referred to these services?
- How do practitioners make decisions about which service to refer a client to?

To answer these questions, we consulted the annual CAPs, the Scottish Drug Misuse Database,[3] and the findings from the ADSW survey. We also spoke directly to a selected sample of practitioners and service managers.

---

[2] The annual Corporate Action Plans provide detailed information about the way in which each DAAT area intends to address national and local priorities. The CAPs also provide details of each area's contribution towards targets set by the Scottish Executive in the National Drug Strategy. For further information, see http://www.drugmisuse.isdscotland.org/dat/cap/dat.htm).

[3] The Scottish Drug Misuse Database is managed by Information Services, NHSScotland (formerly known as the Information and Statistics Division). Information is collected on all new clients presenting to drug treatment services in Scotland. This is reported to the database using a standard proforma, called an SMR24 form.

Mapping Scottish residential detoxification and rehabilitation services

This study identified **21 residential detoxification and rehabilitation units for drug users in Scotland**. These are listed in Appendix 1 of this document.[4] The particular services included in this list all met the following criteria:

- The Unit Manager or Charge Nurse described the facility specifically as a residential detoxification and / or rehabilitation unit for drug users — or said that it was able to provide detoxification or rehabilitation.
- The service had dedicated beds for this purpose.

As mentioned earlier, for the purposes of this review, we have focused only on residential detoxification or rehabilitation services for drug users. Therefore, Appendix 1 does not include other types of residential services, such as residential crisis services (for example, Glasgow Drug Crisis Centre and the Links Project in Edinburgh). The aim of these services is generally the stabilisation of chaotic drug use, rather than helping the client to become drug-free.

We have included in Appendix 1 psychiatric hospitals or psychiatric wards in general hospitals which provide drug and alcohol detoxification, but only if they have dedicated beds for drug detoxification. Some psychiatric hospitals only provide detoxification to patients with dual-diagnosis, but will not provide detoxification to drug users who do not also have a co-morbid psychiatric problem. These hospitals **are** included in the list in Appendix 1.

Red Towers in Helensburgh is primarily a respite service for drug users. Many of the clients who enter this service will not be drug-free upon leaving. Similarly, many of the residents of 218 in Glasgow and the Shield Centre in Lanarkshire will be stabilised on methadone, rather than free of all illicit and prescribed drugs upon leaving the service. These services **have** been included in Appendix 1, since all of them also offer detoxification and / or short-term rehabilitation to their clients.

We have **not** included supported accommodation services in Appendix 1 (for example, the Whiteinch Project in Glasgow and the Rankeillor Initiative in Edinburgh), although it became clear during our investigations that **the distinction between residential rehabilitation and many supported accommodation services is difficult to make**. There are a sizeable number of supported accommodation services in Scotland for recovering drug or alcohol users. Many of these are provided by small, independent charitable or church organisations and have intensive programmes similar in nature and duration to a residential rehabilitation service. Nevertheless, managers of supported accommodation units whom we spoke to were invariably clear about describing their service as supported accommodation and **not** residential rehabilitation.

Further investigation found that the distinction is probably based on the classification of "care" services and "support" services made by the Scottish Care Commission. Residential rehabilitation units in Scotland are generally registered with the Care Commission as "care homes", and are therefore required to meet the National Care Standards for residential care facilities. "Support" services are not required to meet these same standards. In addition, many "supported accommodation" services receive core funding from the Scottish Executive Supporting People programme. Supporting People is an integrated policy and funding framework for housing support services introduced in April 2003. It aims to enable vulnerable people to live independently in

[4] We believe that this is a comprehensive list of all residential detoxification and rehabilitation facilities in Scotland, but we regret if we have inadvertently omitted any facility.

the community in all types of accommodation and tenure.[5] Services that are registered as care homes are not eligible to receive Supporting People funds. Finally, the distinction between supported accommodation and residential rehabilitation is also apparently made in the funding of placements. At least in some areas of Scotland, it would appear that social work funding which is earmarked for rehabilitation may not be spent on placements in supported accommodation. Therefore, it is likely that the distinction between some supported accommodation units and residential rehabilitation facilities appears to be based at least partly on the requirements of funding streams and the need to meet standards, rather than on the basis of actual programme content.

Within the 21 residential facilities identified by this study, **there are 329 adult beds for detoxification and rehabilitation**. In general, the number of beds available in any one facility is small — seventeen of the 21 facilities listed in Appendix 1 have fewer than 16 beds. Castle Craig, with 104 beds, is the exception to this rule. The next largest facility in Scotland is Phoenix House in Glasgow which has space for 39 clients in the main building. The smallest facilities are based in NHS hospitals. Some of these have only two beds available for clients undergoing drug detoxification.

Nine of the 21 residential facilities are located in the west of Scotland; six of these are based in Glasgow. In many cases, because of funding arrangements (i.e., contract purchasing of beds), priority is given to clients from particular areas, and beds are not always available to clients from outside that area.

Information

- We identified 21 residential detoxification or rehabilitation units in Scotland.
- Altogether there are 329 adult beds available for detoxification or rehabilitation in Scotland.
- Just under half of residential detox and rehab units are located in the West of Scotland, and due to the practice of contract purchasing of placements, many facilities give priority to clients from certain geographical areas.
- The duration of residential detox programmes in Scotland vary from a few days to a few weeks. Rehabilitation programmes vary in length from one month to one year.

In general, detoxification facilities based in NHS hospitals are only available to their local area population. For example, Loudon House in Ayr is a 12-bedded dual-diagnosis service which gives priority to drug-using clients with mental health problems in Ayrshire & Arran. The Orchards in Glasgow has two beds for drug detoxification, but these are only available to clients from the North of Glasgow. Ruthven Ward at New Craigs Hospital in Inverness is only available to drug users in Highland.

Only three services in Scotland — Brenda House (in Edinburgh), Aberlour and the No. 1 Project (both in Glasgow) — also provide facilities for the children of drug users.

The duration of residential detoxification programmes in Scotland varies from a few days to a few weeks. Rehabilitation programmes range in length from one month to one year. Longer rehabilitation programmes, such as those provided by Phoenix House, may include a period of re-entry to the community which involves a stay in supported accommodation.

[5] For further information about the Supporting People initiative, see http://www.scotland.gov.uk/housing/supportingpeople/.

How are residential detoxification and rehabilitation services used in Scotland?

Number of placements

Anecdotally, service providers report a great demand for residential detoxification and rehabilitation services by drug users and their families. The reasons for this include:

- a desire by the drug user to get away from the people, circumstances and issues that support his or her drug use;
- a desire by the drug user to be drug-free, and a failure to achieve this goal through community services.

The annual CAPs provide information from the DAATs about the number of individuals who were admitted to residential services in the previous year. Using this information, and information from the Scottish Drug Misuse Database, it is possible to get a rough estimate of the number of individuals from each area who have been admitted to residential detoxification and rehabilitation facilities. However, it is important to note that both the CAPs and the Scottish Drug Misuse Database provide only a partial (and probably overlapping) picture of the **actual** number of Scottish drug users who are admitted to residential detoxification and rehabilitation units each year. Neither of these sources of data are able to provide precise information on residential admissions for the following reasons:

- The CAP asks DAATs for information about: i) total number of admissions to all residential services in their area and ii) the total number of clients who received treatment in a residential service outwith the DAAT area. However, returns are inconsistent. Some have provided only partial information, some combine figures for drugs and alcohol admissions and some include information on self-funded places while others do not.
- The Scottish Drug Misuse Database reports on the number of **new clients** presenting for treatment services — where "new" is defined as a first-time presentation, or a presentation after a six-month absence. It is evident that not all residential facilities in Scotland are currently submitting data to the database. In addition, SMR24 forms are completed when clients first attend a service. Not all first attendances necessarily result in admissions.

With these caveats in mind, Appendix 2 of this report provides a very rough estimate of the number of clients from each DAAT area who were admitted to a residential detoxification or rehabilitation facility in the last two years. It may be seen from this data that:

- The majority of placements from across Scotland were made to only a handful of residential facilities. These were: Phoenix House in Glasgow, Ronachan House in Tarbert, Castle Craig in West Linton, and Red Tower in Helensburgh. These are the four largest facilities in Scotland.
- Nearly 10% of Scottish residential admissions in 2002-2003 and 6.3% in 2003-2004 were made to programmes in England and Wales. The facilities from south of the border used most frequently were the Phoenix House facilities in South Shields, Sheffield, Brighton and Wirrall.

Information

Based on available data, between April 2002 and March 2003, an estimated 905 Scottish drug users were admitted for residential treatment. Another 1,294 were admitted between April 2003 and March 2004.

Of these, approximately 9.5% in 2002-2003 and 6.3% in 2003-2004 were admitted to facilities in England or Wales.

Note that these figures should be seen as rough estimates only.

What are the costs of these services and who provides the funding?

Residential services are expensive, and the cost of programmes in Scotland varies considerably. On average, the weekly cost of a residential rehabilitation programme in Scotland ranges between £310 and £425. In general, residential detoxification programmes are more expensive than rehabilitation programmes because of the additional medical / clinical input often required. In some private facilities, the cost of a week's detoxification may be as much as twice the cost of rehabilitation in the same facility. Rapid Opiate Detoxification is particularly expensive, with 5-day programmes costing several thousand pounds.

Most residential programmes will accept self-referrals and self-funders. However, where an individual is referred by a statutory agency, there will also usually be an application for funding. At present, only a few areas in Scotland have joint budgets for detoxification and rehabilitation. In most areas of Scotland, funding for detoxification (including detoxification in residential rehabilitation units) is managed by Health Boards, whereas local authorities (Social Work) manage the funding for rehabilitation. Thus if an individual has been referred to a single residential unit for both detoxification and rehabilitation, it is conceivable that he / she may have to wait to take up the place if either the Local Authority or Health Board has exhausted their respective budgets for the current financial year.

The availability of rehabilitation funding may also depend on whether individuals currently in residential programmes leave prematurely. Rehabilitation funds that had previously been budgeted for one individual may be made available to someone else, if the first individual leaves the programme prematurely.

The recent ADSW survey of social workers (mentioned above) found that some areas in Scotland have a dedicated budget for residential detoxification and rehabilitation, while others do not. The size of these budgets varies considerably, and it is not clear the extent to which annual budgets and expenditure are determined consistently across Scotland on the basis of a local area needs assessment. The problem of establishing the level of **local need** (as opposed to demand) for a residential service is a difficult one, and one which the National Treatment Agency in England is currently engaged in.

What is the process by which clients get referred to residential services?

As mentioned above, many residential services will receive self-referrals. However, where funding is required from statutory services, the client is generally referred by a health or social work practitioner.

In general, the process of referral involves **an initial assessment of the client**. There is variation across Scotland in whether the initial assessment is undertaken by a specialist drug / alcohol worker (or not), whether it is conducted jointly by staff in social work and health (or if it involves staff in only one agency), and the extent to which staff in voluntary agencies may make referrals to residential services. Some areas of Scotland have specialist addiction teams, comprising both health and social work practitioners. Where these exist, the initial assessment is usually carried out by a member of that team.

There is also variation across Scotland in what happens after this initial assessment. In general, where a referral to a residential rehabilitation service is sought, the **client's care plan** must then be ratified or approved by a senior social worker or team leader. In some areas, this individual may also be able to authorise release of funding for the placement; in other areas, authorisation may need to be sought from a third individual — i.e., a service manager or locality manager. Where a referral for detoxification is

sought, this must usually be ratified or approved by a senior medical practitioner or consultant psychiatrist and authorised by the Health Board.

In some parts of Scotland, it was reported that GPs occasionally referred patients directly to residential detox or rehabilitation units, without first seeking authorisation from the relevant funding body. This causes difficulties when the social work department or Health Board is billed by the residential unit. It is not clear how common this practice is, but it suggests a need to agree clear protocols for referral at a local level.

Many residential agencies also have their own pre-admission assessment, although the rigour of this process is variable. In some cases, it involves nothing more than the completion of an application form. In others, the client may be expected to attend a number of pre-admission assessment interviews (Saville, unpublished report).

How is client eligibility for residential services determined?

In principle, a client's eligibility for residential services should be determined on the basis of an assessment of the individual's need. Practitioners were often keen to point out, however, that the client assessment is not an assessment for **a particular type of service**. That is, the client is not assessed **for residential rehabilitation** or **for residential detoxification**. Rather, the client's assessed needs may be met in a number of ways. For some clients, those needs can be met in a community setting, and for other clients, those needs are best met in a residential context.

However, it appears that very few local areas in Scotland have developed a standard set of criteria for determining when a client's needs can best be met through a residential service. When asked how they determine a client's eligibility for a residential rehabilitation service, practitioners invariably say that the client must show evidence of having attempted to engage with community services in the past. In many areas, **residential services are not considered until community services have been tried and exhausted**. The exception to this rule is likely to be when a client or their family is prepared to fund their residential placement. This partly explains the NTORS finding that clients entering residential treatment were older, had a longer history of heroin use, and generally had more problems than those entering community services. (See page 9 above.)

There were, however, a few areas that did have well-developed criteria for determining when a client's needs could best be met by residential services. Some of these are shown in the box to the right.

Criteria used by some areas to inform referral to residential services

- Previous experience of becoming abstinent
- Previous experience of stabilising drug use, but difficulties in maintaining this in the community due to other factors and needs in the client's life
- Evidence of client willingness to engage with a community drugs worker or other structured intensive support to change their lifestyle
- Evidence of an "internal locus of control" — that is, a willingness to change and to see change as a personal responsibility
- A commitment to an active process of reduction in drug use, including a reduction in methadone use to 40ml or less
- A significant risk to the client and / or to their children, which cannot be adequately addressed in a community setting
- Having substance-related mental or physical health problems requiring intensive support (i.e., severe psychiatric co-morbidity and severe dependence with poly-drug use)
- Homelessness

It is also worth mentioning that, in the last year or two, a small number of areas in Scotland have developed local policies **not to use residential services**, but rather to **support drug users through community services**. The reasons for this appear to be related to cost, and a perception that residential services are not effective.

How are decisions made regarding which services are used?

This decision about which particular residential service to use is usually taken by a client's keyworker in discussion with the client. Very often, a client has a strong view about where he / she wants to go, or does not want to go. These views may be based on word-of-mouth recommendation, or having known people who successfully completed a particular residential programme. In other cases, the keyworker will have knowledge of a particular service based on previous experience, and so will suggest that service to the client. Some practitioners said they attempt to match clients to the right service for their particular needs, but many expressed the view that there are actually very few options available. A number of practitioners said that they visited the service with their client before he / she was admitted, but it is not clear how common this practice is.

The number of services listed in Appendix 1 — and the limitations on the availability of some services to clients from certain geographical areas — does seem to corroborate the perceptions of practitioners that there are limited choices for clients seeking a placement in a residential service in Scotland. However, **it was also clear that many practitioners did not feel they had enough information about what residential services were available, where they were located, and what they offered.**

Summary

- There is currently **no comprehensive directory** of residential detoxification and rehabilitation facilities in Scotland.
- This study identified **21 Scottish residential detoxification and rehabilitation units** in Scotland. Between them, these units have 329 beds for adult drug users.
- Nine of the 21 units are based in the west of Scotland — six of these are in Glasgow. A number of facilities give priority to admissions from particular geographical areas, thus reducing the number of beds available for residents from other areas.
- Based on available data between April 2002 and March 2003, an estimated 905 Scottish drug users were admitted to a residential treatment facility, and an estimated 1,294 were admitted between April 2003 and March 2004. **These figures can only be considered to be rough estimates. The actual numbers are likely to be greater.**
- On average, the cost of a week in a residential rehabilitation programme ranges **between £310 and £425 per week**. Residential detoxification is more expensive than residential rehabilitation.
- In most areas of Scotland, funding for residential rehabilitation is managed by social work departments, whereas funding for residential detoxification is managed by NHS Boards. Only a few areas of Scotland have arrangements for joint (local authority and NHS) funding of residential treatment for drug users.
- Most non-NHS residential treatment facilities receive self-referrals, and in such cases, the client is also often self-funded.
- Where a client seeks a referral from a statutory agency (either health or social work), residential services are not usually considered until community services have been tried and exhausted. Only a few areas in Scotland have developed criteria for determining when a client's needs can best be met through a residential service.

Chapter 4: Conclusions and Future Research

This review was undertaken to inform further research to be commissioned on the effectiveness of residential rehabilitation under the Scottish Drug Misuse Research Programme. Existing research evidence makes it clear that drug users will achieve better outcomes the longer they remain in treatment. This review indicates that residential detoxification and rehabilitation services may have an important role to play for clients whose aim is to be drug-free. Residential detoxification and rehabilitation are undoubtedly effective in the treatment of drug misuse. However, this statement comes with some caveats:

- Residential detoxification must be seen as only a first step in the process of becoming drug-free.
- Residential rehabilitation programmes should be at least three months long.
- Clients must be retained in the programme.
- Appropriate aftercare should be included as part of the treatment.

Unfortunately, residential rehabilitation programmes have high drop-out rates. Roughly half of clients who enter a residential rehabilitation programme will leave prematurely. The majority of these clients will leave within the first few weeks of entry. **Further research in this area may focus on ways of increasing client retention**.

In terms of future research, **it may also be beneficial to undertake a more detailed** mapping of residential rehabilitation services than was possible for this review. Such an exercise would not only clarify the differences between residential rehabilitation and supported accommodation, but would also provide community practitioners with greater information about the range of options available to their clients.

Despite the good outcomes that can be achieved through residential treatment, this review is not suggesting that residential services are appropriate for **all** drug users. A comprehensive assessment of an individual's needs and social circumstances, and a clear understanding of his / her aims and aspirations, are the best basis upon which to make a decision about his / her suitability for residential treatment. However, there is some evidence to suggest that, at least in some areas of Scotland, further work needs to be done on developing clearer referral processes and establishing criteria for deciding when an individual's needs can best be met through placement in a residential service. In addition, some areas would undoubtedly benefit from having joint (health and social work) management and joint funding of budgets for drug detoxification and rehabilitation. Given the aims of the Joint Future agenda, many local areas are already beginning to move in this direction.

The findings of this review show that residential services cannot be seen as stand-alone services. Residential detoxification can only be considered as a first step in the process of becoming drug-free, and even long-term residential rehabilitation programmes need to be followed up by continued support in the community. Adequate preparation and after-care provided in community settings are key to the success of residential treatments. Residential services should be considered as only one aspect in an integrated package of care for drug users. **Future research could examine existing pathways into residential treatment and pathways out following successful completion to identify models of good practice and factors that help to sustain the benefits achieved.**

	Project Name	Type of service: D=detox R=rehab	Town/City	Programme Duration	Number of beds	Comments
West of Scotland						
1	218	D (respite / crisis)	Glasgow	12 weeks max.	14	The project works with women drug users going through the criminal justice system and aims to reduce illegal drug use and offending behaviour. An initial residential component is offered to those women who have no alternative housing. Abstinence is an aim only in so far as the client want this; some clients are instead stabilised on methadone.
2	Aberlour Child Care Trust (Scarrel Road)	D/R	Glasgow	6 months, can be extended	6 women and 12 children	Beds are for Glasgow area residents only.
3	No. 1 Project	R	Glasgow	6 months	6 women and 12 children	Priority given to clients from Glasgow City. Service is also able to accept women who are pregnant.
4	Phoenix House	D/R	Glasgow	1 year (incl. 6 months re-entry in supported accommodation) Additional aftercare / support available as needed.	39 (main house) + 12 re-entry flats	Twelve of the 39 beds in the main house are allocated for women only. Able to provide detox prior to rehabilitation.
5	Rainbow House	R	Glasgow	6 months	14	Expecting to move premises in late summer 2004. New premises will have provision for detoxification.
6	The Orchards (part of North Glasgow Substance Misuse Service)	D (in-patient)	Glasgow	7-14 days (avg)	2	Detox and assessment service for problem drug / alcohol users. Has 6 beds in total, but only 2 are available to drug users. Beds available only to patients in North of Glasgow. Moving in summer / autumn 2004 to a 15-bed unit with day patient unit to be available to Northeast of Glasgow.

	Project Name	Type of service D=detox R=rehab	Town/City	Programme Duration	Number of beds	Comments
West of Scotland (cont.)						
7	Red Tower Drug Project	D, short-term R & respite	Helensburgh	12 weeks	23	The service accepts both drugs and alcohol clients. Priority is given to Glasgow residents.
8	Loudoun House Dual Diagnosis Residential Rehabilitation Unit, Ailsa Hospital	R (in-patient)	Ayr	4 weeks	12	Majority of clients are from Ayrshire & Arran. Service is available at cost to clients from outside Ayrshire & Arran. Accept clients with mental health problems ranging from low mood and anxiety to schizophrenia.
9	Ronachan House	R	Tarbert	6 months	21	The service accepts both drug and alcohol clients.
Southeast and Central Scotland						
10	Shield Centre	R & support	Wishaw	16 weeks	2	This is a social work-sponsored service, which provides short-term rehabilitation and support to problem drug and alcohol users in North Lanarkshire. A large proportion of clients are homeless. Abstinence is an aim only in so far as the client want this; some clients are instead stabilised on methadone. Accepts referrals from both social work and health. Located next to a counselling project.
11	Bethany Christian Centre	R	Edinburgh	Initial 15-week programme, may be extended to 1 year.	16	
12	Brenda House	D/R	Edinburgh	6-9 months	6 women and 12 children	
13	Green Door Clinic	D	Falkirk	5 days	8	Provides medically-supported rapid opiate detoxification.
14	Malta House	R	Edinburgh	6 months	12	Clients should be detoxed before entry. The facility has a gym and workshop on the premises.

	Project Name	Type of service D=detox R=rehab	Town/City	Programme Duration	Number of beds	Comments
Northeast Scotland, Highland and Islands						
15	Alexander Clinic	D/R	Old Meldrum (Moray)	42 days, may be extended to 12 weeks	13	Detox lasts for 7-14 days.
16	Beechwood House Rehab	R	Inverness	Offer a 4-week and a 10-week programme	15	
17	Ruthven Ward, New Craigs Hospital	D	Inverness	Maximum 3 weeks	6	The beds in this in-patient ward are available for both drugs and alcohol detoxification to patients in Highland.
18	Papa Stour Project	R	Shetland	1 year (avg)	2	Currently has 2 beds, but hopes to expand to 4. Programme is geared towards individual needs. Clients must detox prior to entry. The service is based on Christian principles and there is an emphasis on restorative justice.
19	Western Isles Acute Psychiatric Unit	D	Stornoway, Isle of Lewis	2-3 weeks	6	The Unit provides detoxification to drug and alcohol users who also have co-morbid mental health problems. The service is primarily for local residents, but is also used by patients from mainland Scotland who come to detox.
Borders						
20	Castle Craig Clinic	D/R	West Linton	4-6 week primary programme may be followed by 6-month extended care programme.	104	A registered private hospital. Intensive 24-hour medical input available.
21	Huntlyburn House	D	Melrose	10-14 days	2	Based in an acute psychiatric hospital. Beds are available to both alcohol and drug users – no dedicated beds for drug users.

Appendix 2: Residential admissions, by DAAT area, in 2002 – 2003 and 2003 – 2004

This table below presents estimated residential admissions for drug users in 2002-2003 and 2003–2004 by DAAT area. This information has been collected from two data sources: (i) the annual CAPs submitted to the Scottish Executive by each DAAT area; and (ii) data taken from the Scottish Drug Misuse Database for the same period on first attendances at residential services. Both of these sources provide only a partial picture of the use of residential services in Scotland, and so the numbers presented below must be seen as estimates only.

Bold print indicates that the service is based in England or Wales.

DAAT Area	Service	Clients Admitted in 2002-2003	Clients Admitted in 2003-2004
Aberdeen City	Alexander Clinic, Old Meldrum	0	29
	Detox 5, Harrogate	**32**	**11**
	Castle Craig, West Linton	7	11
	Phoenix House, Glasgow	8	8
	Green Door Clinic, Falkirk	0	6
	Phoenix House, South Shields	**11**	**3**
	Pierpoint, St Anne's on Sea	**0**	**2**
	Red Tower, Helensburgh	3	2
	Brenda House, Edinburgh	6	1
	Total	67	73
Aberdeenshire	Alexander Clinic, Old Meldrum	0	15
	Phoenix House, Glasgow	13	4
	Castle Craig, West Linton	3	5
	Detox 5, Harrogate	**1**	**1**
	Phoenix House, South Shields	**0**	**1**
	Brenda House, Edinburgh	2	0
	Deeford, Aberdeen (closed in 2003)	1	0
	Red Tower, Helensburgh	1	0
	Green Door Clinic, Falkirk	0	1
	Phoenix House, Brighton	**1**	**0**
	Total	22	27
Angus	Phoenix House, Glasgow	4	3
	Red Tower, Helensburgh	1	0
	Brenda House, Edinburgh	1	0
	Phoenix House, South Shields	**1**	**0**
	Phoenix House - Family Unit, Sheffield	**1**	**0**
	Total	8	3
Argyll & Clyde	Ronachan House, Tarbert	0	19
	Castle Craig, West Linton	2	32
	Phoenix House, Glasgow	15	14
	Red Tower, Helensburgh	14	13
	Brenda House, Edinburgh	5	1
	Aberlour Childcare Trust, Glasgow	1	0
	Hebron House, Norwich	**1**	**0**
	Middlegate House, Lincolnshire	**1**	**0**
	Phoenix House, South Shields	**1**	**0**
	Total	40	79

DAAT Area	Service	Clients Admitted 2002-2003	Clients Admitted 2003-2004
Ayrshire & Arran	Loudon House, Ayr	1	189
	Phoenix House, Glasgow	2	2
	Brenda House, Edinburgh	0	1
	Red Tower, Helensburgh	1	0
	Castle Craig, West Linton	3	0
	Total	7	192
Borders	**Tunstall Unit, Sunderland, Tyne & Wear**	**1**	**10**
	Castle Craig, West Linton	3	7
	Ronachan House, Tarbert	1	1
	Phoenix House, Glasgow	1	0
	Brenda House, Edinburgh	1	0
	Huntlyburn House, Melrose	22	0
	Total	29	18
Dumfries & Galloway	Phoenix House, Glasgow	4	3
	Ronachan House, Tarbert	0	1
	Brenda House, Edinburgh	2	0
	Total	6	4
Dundee	Total	0	0
East Lothian	Brenda House, Edinburgh	1	2
	Malta House, Edinburgh	—	1
	Castle Craig, West Linton	2	0
	Phoenix House, Glasgow	1	0
	Total	4	3
Edinburgh	**Phoenix House, South Shields**	0	**25**
	Malta House, Edinburgh	0	22
	Castle Craig, West Linton	10	17
	Phoenix House, Glasgow & **Wirrall**	13	14
	Brenda House, Edinburgh	23	14
	Ronachan House, Tarbert	11	4
	Phoenix House, Hampshire	0	**3**
	Ley Community, Oxford	0	**3**
	Red Tower, Helensburgh	1	1
	Beechwood House, Inverness	1	0
	Total	59	103
Fife	Castle Craig, West Linton	2	1
	Phoenix House, Glasgow	0	1
	Brenda House, Edinburgh	1	1
	Red Tower, Helensburgh	1	0
	Total	4	3
Forth Valley	Malta House, Edinburgh	2	3
	Ronachan House, Argyll	3	2
	Castle Craig, West Linton	1	0
	Brenda House, Edinburgh	1	0
	Total	7	5

DAAT Area	Service	Clients Admitted 2002-2003	Clients Admitted 2003-2004
Greater Glasgow	Red Tower, Helensburgh	120	133
	Castle Craig, West Linton	66	84
	Phoenix House, Glasgow	63	83
	Rainbow House, Glasgow	6	35
	No. 1 Project, Glasgow	16	19
	Aberlour Childcare, Glasgow	12	19
	Brenda House, Edinburgh	1	1
	Ronachan House, Argyll	8	0
	Total	292	374
Highland	Ruthven Ward, New Craigs Hospital, Inverness	162	189
	Beechwood House, Inverness	64	62
	Castle Craig, West Linton	1	1
	Ty Gwyn, Wales	**1**	**0**
	Brenda House, Edinburgh	1	0
	Total	229	252
Lanarkshire	Castle Craig, West Linton	53	89
	Shield Centre, Wishaw	3	17
	Red Tower, Helensburgh	12	6
	Ronachan House, Argyll	1	5
	Phoenix House, Glasgow	13	2
	Rainbow House, Glasgow	2	1
	Phoenix House, South Shields	**0**	**1**
	Detox 5, Harrogate	**0**	**1**
	Brenda House, Edinburgh	0	1
	No. 1 Project, Glasgow	1	0
	Total	85	123
Midlothian	Brenda House, Edinburgh	4	4
	Castle Craig, West Linton	1	3
	Phoenix House, South Shields	**3**	**3**
	Detox 5, Harrogate	**2**	**0**
	Total	10	10
Moray	Green Door Clinic, Falkirk	0	1
	Total	0	1
Perth & Kinross	**Phoenix House, Wirrall**	**15**	**11**
	Diana, Princess of Wales Treatment Centre, Norfolk	**9**	**6**
	Castle Craig, West Linton	1	0
	Total	25	17
Shetland	Ronachan House, Tarbert	**0**	1
	Aquarius, Northampton	**1**	0
	Clouds, Wiltshire	**1**	0
	Turning Point, Whitley Bay	**1**	0
	Total	3	1

DAAT Area	Service	Clients Admitted 2002-2003	Clients Admitted 2003-2004
Western Isles	Acute Psychiatric Unit	0	1
	Total	0	1
West Lothian	Phoenix House, Glasgow	1	4
	Castle Craig, West Linton	1	0
	Malta House, Edinburgh	3	0
	Brenda House, Edinburgh	1	1
	Kenward Trust, Yalding, Kent	**1**	**0**
	Phoenix House, South Shields	**1**	**0**
	Total	8	5
	TOTAL ADMISSIONS	**905**	**1,294**
	of which, number (percent) admitted to facilities outside Scotland	**86** (9.5%)	**81** (6.3%)

References

Best Practice in Alcohol and Other Drug Interventions Working Group (2000) A summary of the evidence based practice indicators for alcohol and other drug interventions.

Christo G (1998) Outcomes of residential care placements for people with drug and alcohol problems. An evaluation of Hammersmith & Fulham Social Services. London, Hammersmith & Fulham Social Services.

Ghodse AH, Reynolds M, Baldacchino A, Dunmore E, Byrne S, Oyefeso A, Clancy C, Crawford V (2002) Treating an opiate-dependent inpatient population: a one-year follow-up study of treatment completers and noncompleters. *Addictive Behaviors*, 27: 765-778.

Gossop M, Marsden J and Stewart D (1998) NTORS at One Year. Changes in substance use, health and criminal behaviour One Year after intake. Department of Health, London.

Gossop M, Marsden J, Stewart D, Rolfe A (1999) Treatment retention and 1 year outcomes for residential programmes in England. *Drug & Alcohol Dependence*, **57:** 89-98.

Gossop M, Marsden J, Stewart D, Kidd T (2003) The National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. *Addiction*, 98: 291-303.

Inciardi JA, Martin SS, Surratt HL (2001). Therapeutic communities in prisons and work release : Effective modalities for drug-involved offenders. In B Rawlings and R Yates (eds.) *Therapeutic communities for the treatment of drug users. Therapeutic communities 4*, Jessica Kingsley Publishers Ltd, Philadelphia, PA, pp. 241-256.

Inkster K, Matheson C (2001) A qualitative evaluation of the process and outcomes of Grampian opiate / opioid dependent patients seeking in-patient rapid opiate detoxification (IROD). Aberdeen, University of Aberdeen.

Keen J, Oliver P, Rowse G, Mathers N (2001) Residential rehabilitation for drug users: a review of 13 months' intake to a therapeutic community. *Family Practice*, 18: 545-548.

Lang MA, Belenko S (2000) Predicting retention in a residential drug treatment alternative to prison program. *Journal of Substance Abuse Treatment*, 19: 145-160.

Marsden J and Farrell M (2002) Research on what works to reduce illegal drug misuse. Appendix 5 of *Changing Habits. The commissioning and management of community drug treatment services for adults.* Audit Commission, London.

Mattrick RP and Hall W (1996) Are detoxification programmes effective? *The Lancet,* 347: 97-100.

McCusker J, Bigelow C, Frost R, Garfield F, Hindin R, Vickers-Lahti M, Lewis B (1997) The effects of planned duration of residential drug abuse treatment on recovery and HIV risk behavior. *American Journal of Public Health*, 87: 1637-1644.

National Treatment Agency (2002) Commissioning cocaine / crack treatment. 1b, 1-8. Hannibal House, Elephant and Castle, London SE1 6TE. Research into Practice.

Nuttbrock LH, Ng-Mak DS, Rahav M, Rivera JJ (1997) Pre- and post-admission attrition of homeless, mentally ill chemical abusers referred to residential treatment programs. *Addiction*, 92(10): 1305-1315.

Rae K, Matheson C, Bond CM (2001) General Practitioners' referral for In-patient Rapid Opiate Detoxification (IROD): An exploration and rating of the factors involved in decision making. Aberdeen, Department of General Practice and Primary Care, University of Aberdeen.

Robertson R and Wells B (1998) Detoxification and achieving abstinence. In Robertson R (ed) *Management of Drug Users in the Community: a practical handbook*. Arnold.

Sacks S, DeLeon G, Sacks JY, McKendrick K, Brown BS (2003) TC-oriented supported housing for homeless MICAs (mentally ill chemical abusers). *Journal of Psychoactive Drugs*, 35(3): 355-366.

Saville (2003, unpublished) Drug Outcome Research in Scotland: A Qualitative Investigation of Drug Treatment Services in Scotland. Centre for Drug Misuse Research, University of Glasgow.

Seivewright N, Donmall M, Douglas J, Draycott T, Millar T (2000) Cocaine misuse treatment in England. *International Journal on Drug Policy*, 11: 203-215.

Simoens S, Matheson C, Inkster K, Ludbrook A and Bond C (2002) The effectiveness of treatment for drug users: An international systematic review of the evidence. Effective Interventions Unit, Scottish Executive, Edinburgh.

Stewart D, Gossop M, Marsden J, Strang J (2000) Variation between and within drug treatment modalities: Data from the National Treatment Outcome Research Study (UK). *European Addiction Research*, 6: 106-114.

Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S, Gossop M (2003) Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *British Medical Journal,* 326: 959-960.

Scottish Executive Effective Interventions Unit Dissemination Policy

1. We will aim to disseminate the right material, to the right audience, in the right format, at the right time.

2. The unit will have an active dissemination style. It will be outward looking and interactive. Documents published or sent out by the unit will be easily accessible and written in plain language.

3. All materials produced by the unit will be free of charge.

4. Material to be disseminated includes:

- Research and its findings
- Reports
- Project descriptions and evaluations
- Models of services
- Evaluation tools and frameworks for practitioners, managers and commissioners.

5. Dissemination methods will be varied, and will be selected to reflect the required message, and the needs of the target audience.

These methods are:

- Web-based – using the ISD website 'Drug misuse in Scotland' which can be found at: http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

- Published documents – which will be written in plain language, and designed to turn policy into practice.

- Drug Action Team channels – recognising the central role of Drug Action Teams in developing effective practice.

- Events – recognising that face-to-face communication can help develop effective practice.

- Indirect dissemination – recognising that the Unit may not always be best placed to communicate directly with some sections of its audience.

6. This initial policy statement will be evaluated at six-monthly intervals to ensure that the Unit is reaching its key audiences and that its output continues to be relevant and to add value to the work of those in the field.

ISBN 0-7559-3849-6

Astron B38325 11-04

9 780755 938490

w w w . s c o t l a n d . g o v . u k