Perceptions of residential rehabilitation among referrers

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1 Glossary

ADP (Alcohol and Drug Partnership): partnerships between local authorities, the NHS, police, and other community organisations that work together to develop and implement strategies to prevent and reduce drug and alcohol use issues, improve treatment and recovery services, and support individuals and families affected by addiction.

Clients: individuals who have received support for their substance use issues

Opioid replacement therapy (ORT): a treatment whereby a client is prescribed a pharmaceutical substitute for illicit drugs. The aim is that psychosocial (talking) therapies will be used alongside this, to stabilise the client on the replacement opioid, and then enable them to make changes to their lives, so they can reduce and recover from their drug use. It is most used for illicit heroin use.[1] It is also sometimes called opioid substitution therapy (OST).

Referrer: any professional who can refer clients to residential rehabilitation, either directly, or to an assessment for consideration for residential rehab.

Residential rehabilitation: a structured residential programme which offers psychological and other types of support to help people recover from problem substance use.

Substance use issues: use of substances such as illicit drugs and alcohol to the extent that it is having a negative impact on one's life.

The National Drugs Death Mission (National Mission): a Scottish Government programme designed to reduce drug-related deaths and harms through the implementation of fast and appropriate access to treatment and support. While the National Mission focuses on drugs, the Residential Rehabilitation programme focuses on drugs and alcohol.

2 Executive summary

Introduction

The National Drug Deaths Mission was launched in January 2021 to reduce drug-related deaths and harms. One aspect of this is the increased capacity and use of residential rehabilitation to ensure this is available for everyone who wants it and for whom it is deemed to be clinically appropriate.

To go to residential rehabilitation, clients with substance use issues need to be referred. This is often by a professional involved in their care, but in some areas self-referral is possible. The process of referral, and who can make them, is different in different geographical areas.

Although residential rehabilitation has been shown to be a beneficial treatment option, perceptions vary across referrers. Historically, there has been some scepticism and reluctance among professionals to refer to residential rehabilitation services. Views remain mixed as to whether prioritising investment in such services represents the best approach to generate positive outcomes and value for money for service users.

Residential rehabilitation is at times viewed as an expensive treatment option that may only be valid for a small number of people, either because of eligibility criteria or the client's circumstances. The negative perceptions of residential rehabilitation may be rooted in a lack of knowledge or experience of residential rehabilitation, or persistent beliefs about its efficacy as a treatment option from beliefs built up before the launch of the National Mission.

This research focuses on current referring practices, and views of those who can make referrals.

The research had three key aims:

1. Explore referrers' attitudes and perceptions towards residential rehabilitation.

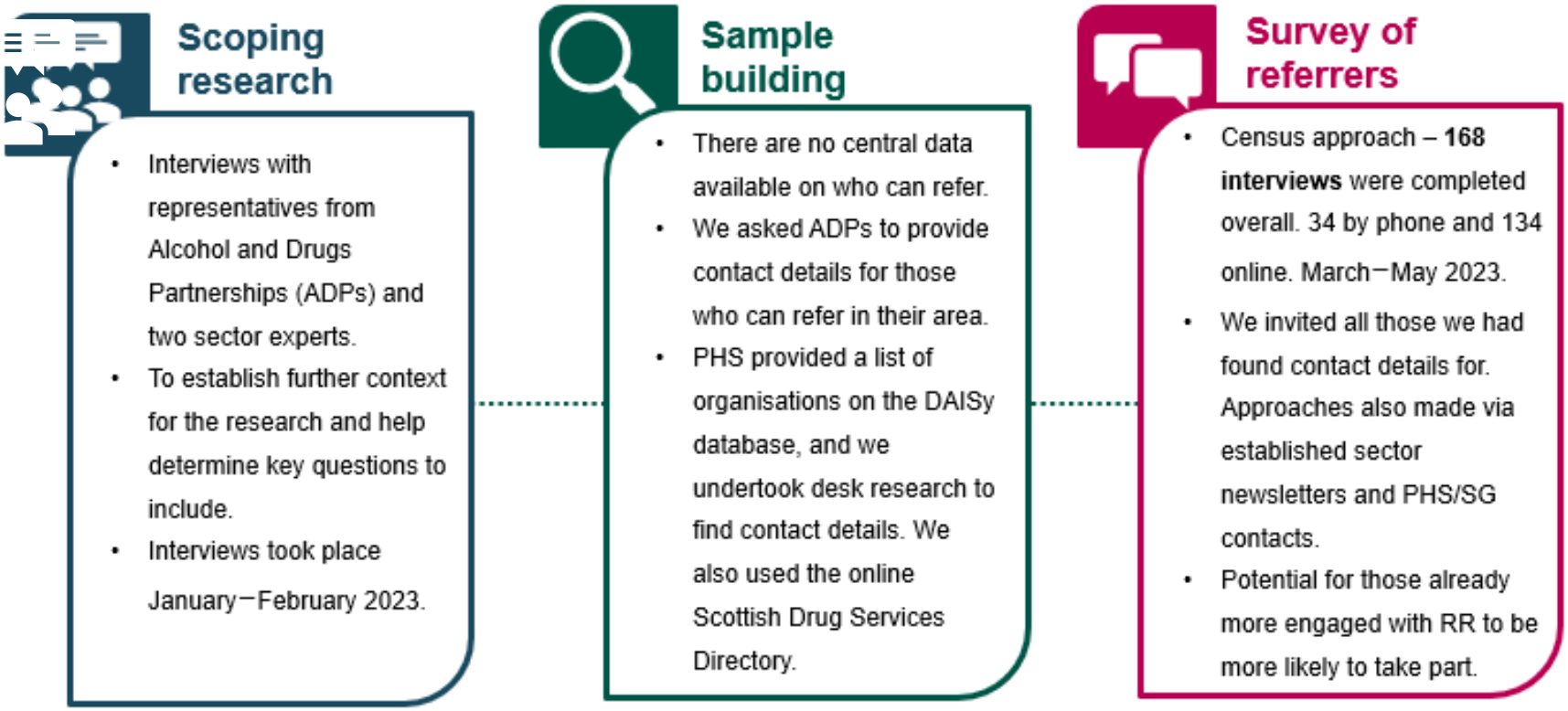
2. Understand how often residential rehabilitation is discussed with clients, and how often this results in a referral.

3. Assess any early impacts of the Scottish Government's Residential Rehabilitation programme.

This research is part of Public Health Scotland's (PHS's) wider evaluation of the Scottish Government's Residential Rehabilitation programme.

Sampling approach

The research involved three key stages:



DAISy: Drug and Alcohol Information System. SG: Scottish Government. RR: Residential Rehabilitation.

Most participants we spoke to worked at statutory or third sector drug and/or alcohol services. A smaller proportion worked for criminal justice services or other organisations.

It is important to note that our results should be treated with caution as this was not a representative sample and there is not a fully populated database of organisations that can refer to residential rehabilitation. We approached all organisations we found details for. However, it is likely that those who are more interested in or engaged with residential rehabilitation are more likely to have taken part.

Awareness of residential rehabilitation

Participants expressed a high level of general awareness and understanding about residential rehabilitation, including:

- who may be likely to benefit (83%)
- what treatment provision is offered (77%)
- being able to explain to clients what residential rehabilitation involves (77%)
- what support is needed before, during and after a residential rehabilitation placement (75%)
- who can be referred to residential rehabilitation (72%)

Referral practices

Participants were generally positive about residential rehabilitation as a treatment option – but views were nuanced, with almost half of participants having concerns about the increased vulnerability of their clients following a placement, including the risk of overdose. Participants also often referred clients to other forms of treatment – especially recovery groups, counselling and medication. Detox services were also referred to, which could become a precursor to residential rehabilitation.

A greater level of experience referring to residential rehabilitation is connected with more favourable views of it as a treatment option, suggesting that there may be a

process of reinforcement occurring that makes future referrals more likely. Conversely, participants who had less experience of referral were then less likely to consider residential rehabilitation.

To summarise:

- More than nine in 10 (92%) participants had discussed residential rehabilitation with at least one of their clients with substance use issues in the three months before the survey. Just over half (54%) of participants had made at least one referral.

- However, fewer than one in three clients with substance use issues (31%) had an opportunity to discuss residential rehabilitation and only 4% of all the clients with substance use issues seen by participants in the last three months were referred for residential rehabilitation. This suggests that while residential rehabilitation is on the agenda for most participants (i.e. those able to refer), it is not being considered for the majority of clients.

- Slightly more participants agreed that residential rehabilitation is only a valid option for a small proportion of people (43%) than disagreed (35%). In total, 18% said they neither agreed nor disagreed, and 4% were unsure, indicating the range of feelings around this.

- The most common reason, given by three in 10 (31%), was that most people do not meet the criteria for a place in residential rehabilitation. This was followed by the attitude or willingness of the client (22%), the high cost and/or lack of funding (19%), and limited places available (17%).

- Participants were also less likely to consider referral where the client's current lifestyle could be described as chaotic. Participants in rural areas were more likely to consider referral for clients whose lifestyle could be described as chaotic, compared to participants in urban areas.

- Those who felt residential rehabilitation was easily accessible discussed it with 47% of clients on average, compared with 26% who did not feel it was easily accessible.

- Participants who agreed that residential rehabilitation was only valid for a small number of people discussed it as a treatment option with fewer than three in 10 (25%) of their clients on average, while those who disagreed with this sentiment discussed it with nearly four in 10 (39%) on average.
- On average, over half (54%) of those who had visited a centre saw no clients placed into residential rehabilitation, but this increased to almost eight in 10 (78%) for those who had not visited a centre.
- In addition, participants with 10 or fewer years of experience in the sector had discussed residential rehabilitation with a higher proportion of clients on average (38%), compared to those with more than 10 years' experience (27%).

Confidence in residential rehabilitation as a treatment method

Almost six in 10 (59%) agreed that previous clients had benefitted from residential rehabilitation, while only 17% disagreed. In total, 18% neither agreed nor disagreed, and 6% said they were unsure.

Around two-thirds of participants agreed that residential rehabilitation is grounded in an evidence base (67%), and provides a person-centred approach (65%). This was higher for third sector organisations than statutory organisations.

Just over a third (38%) of participants agreed residential rehabilitation offered value for money, with almost as many saying they neither agreed nor disagreed (35%), and 16% disagreeing, suggesting much more mixed views about this aspect of it as a treatment option.

Accessibility and connection with other services

Over half of participants (57%) disagreed that residential rehabilitation was easily accessible, while only a quarter agreed it was (24%), suggesting this is a concern for participants.

While 45% of participants agreed that residential rehabilitation is joined up with other local services, three in 10 (30%) disagreed, indicating a mix of experiences.

Barriers

A) Structural barriers

The most common structural barriers were the capacity of residential rehabilitation providers, leading to a lack of rehabilitation spaces or long waiting times for spaces. In terms of the process itself, 80% of participants reported **long waiting times were a barrier** at least sometimes and 21% said it was always a barrier to making a referral. There were related concerns about the waiting time for detoxification services that may be a pre-requisite for treatment.

A number of other related barriers were identified in terms of the wider system of support for residential rehabilitation:

- Lack of time or resources to help prepare clients for rehabilitation was reported as a barrier at least sometimes by 60% of participants. Of the other barriers that participants identified, the long and complicated assessment processes were explicitly mentioned by 16%.

- Six in 10 participants said lack of funding for rehabilitation placements (60%), and lack of resources to assess clients for rehabilitation (52%) were barriers at least sometimes.

- Not having a rehabilitation facility close enough to where clients live was also commonly identified as a barrier to at least some extent by more than half of the participants. Interestingly, this was identified as a barrier to the same extent by those with a facility within their ADP area and those without (58% for both groups).

- Participants working in third sector alcohol and drug services were more likely to identify lack of space or long waiting times as always a barrier (31%). This group were also more likely to report that the long waiting time for detoxification was always a barrier (81%) compared to 53% of

participants in NHS services. This suggests that pathways to detoxification services may be easier to access for NHS participants.

- Those who lived in a rural area more commonly identified not having a rehabilitation facility close enough as a barrier to some extent compared to those in an urban area (77% vs 53%). Lack of resources to assess clients was also more commonly identified as a barrier by those who did not have a rehabilitation facility in their ADP area (19% vs 7%).

B) Client barriers

Participants reported the main client barrier was a lack of interest in or loss of motivation during the process. Clients lacking understanding or not meeting requirements were also common.

The work required to prepare a client for residential rehabilitation was commonly identified as a barrier to making a referral because of a lack of capacity or resources to support clients to do this work.

- Readiness for residential rehabilitation was a common barrier in terms of engaging with preparatory processes: 85% reported that clients not engaging in the preparatory processes necessary for a referral was a barrier at least some of the time, and approximately two-thirds (67%) said clients found the assessment or referral process complex.

- The vast majority of participants reported that clients losing motivation or lacking interest (93%), lacking understanding or having misconceptions about residential rehabilitation (96%), was a barrier at least sometimes. Not meeting specific abstinence requirements was a barrier at least sometimes for 89% of participants.

- There were also various perceived concerns from participants about the nature of the residential rehabilitation services they referred to. More than half of the participants identified unease at least to some extent about the faith-based element of residential rehabilitation (59%) and concerns about the availability of aftercare (58%), which might impact their willingness to

refer. Unease about the faith-based element was a major barrier for almost a quarter of participants (24%), while one in five (20%) said their concerns about aftercare availability were a major barrier to referral.

Suggestions for improvements

Most suggestions for addressing these barriers to referral are related to increased funding or capacity across different aspects of the system. Greater funding in aftercare, more funding to expand the residential rehabilitation bed capacity and greater capacity to support preparatory work were all listed as key areas of focus to overcome some of the perceived barriers. Three in 10 said more information and guidance would be more helpful specifically.

At least two-thirds of participants suggested greater investment would improve the availability of placements, as well as capacity for wrap-around support: more funding to expand bed capacity (72%), greater capacity to support with preparatory work (70%), and investment in aftercare and post-rehabilitation support (73%).

Many participants also called for increased provision for specific groups such as women-only rehabilitation provision (65%), family rehabilitation facilities (60%), and in specific areas so there is a local rehabilitation facility option (61%).

Better access to evidence and information about residential rehabilitation among referrers and clients (69%) and more widely or easily available information on the outcomes of individual rehabilitation centres (65%) were also commonly identified by participants as mechanisms to address barriers.

When asked what would be most useful to overcome barriers, just less than a third of participants said that access to more information and guidance would support them to make referrals (31%). This was more common among those who reported there was no tradition of referring to residential rehabilitation in their area (46%) and those who had not referred any of the clients they had seen in the past three months (41%).

Impact of the National Mission

In terms of the perceived impact of the National Mission, there are some early indications of positive movement. Almost half of the participants agreed that, since the launch of the National Mission in 2021, there was more funding available for placements (49%) and that referrers were discussing residential rehabilitation more often as a treatment option (48%). Interestingly, for those participants who felt that residential rehabilitation was easily accessible, around three-quarters agreed with these two statements. More than four in 10 participants also agreed that referrers are more knowledgeable about residential rehabilitation, more referrals are being made and referrers are more supportive of residential rehabilitation since the launch of the National Mission.

However, an area of potential concern is around waiting times, where very few had seen progress. Just 17% agreed that waiting times are shorter with more than double (42%) disagreeing this was the case.

Views were also very mixed about residential rehabilitation having become more joined-up with other services, with similar proportions of participants disagreeing (36%), being unsure (33%) and agreeing (30%) that there had been progress.

More than half of the participants were unsure (54%) if there was an increase in positive outcomes following rehabilitation since the launch of the National Mission, while one-quarter agreed (24%) and one-fifth disagreed (22%).

Conclusions

Participant views towards residential rehabilitation could be highly nuanced. Most said it was a safe treatment option and recognised a number of benefits including providing respite for families of people who use substances and improving the quality of life of people who use substances. However, while many also believed it could reduce both substance use and substance-related mortality, there were concerns that residential rehabilitation may increase the risk of overdose or leave people more vulnerable following a placement.

There is a complexity of factors that go into practitioners' consideration of referring to residential rehabilitation. This is evidenced by the relatively low number of clients with substance use issues considered or referred to residential rehabilitation. However, there is evidence that increased exposure to residential rehabilitation is linked to more favourable views of it as a viable treatment option. Work towards increasing awareness of the evidence base alongside sharing good practice, and information around the referral pathway may therefore help increase referral rates overall.

- The general awareness of facilities and treatment provision was high and this is something that can be built on, but was lower for specific support such as women-only or family-focused facilities.
- Only a small proportion of clients seen had an opportunity to discuss residential rehabilitation as a treatment option (fewer than one in three), with even fewer then being actively referred (fewer than one in 10).
- There were more participants who felt residential rehabilitation was only suitable for a small number of clients than those who disagreed with this statement within our research. This suggests work may be needed to provide greater clarity and evidence around the benefits and who is eligible.
- Clients losing motivation or lacking interest was the most common barrier to referral, as well as the client's understanding and clients not meeting the abstinence requirements of the facilities. Lack of space and long waiting times – for rehabilitation and related services such as detox – were also common challenges. It is likely that these two barriers may interact and reinforce one another.
- Participant suggestions for overcoming barriers included greater provision of aftercare, increased funding and resourcing, and more information and guidance.

Considerations and recommendations

- Continued work on the foundations of the residential rehabilitation and referral system is needed.
    - Improved information-sharing mechanisms with referrers to build their knowledge and ability to access support.
    - Increased capacity – especially for specific groups such as women and families – and improved ease of access for those without a facility in their ADP area.
    - Exploring options for a national framework of common standards in referral. This could streamline processes and help referrers feel more confident in their decision-making while reducing the potential for historical biases against residential rehabilitation as a treatment option.
- There should be a collaborative effort to simplify the referral process to enhance the accessibility of residential rehabilitation.
    - If there is an intention to increase referral rates overall, work is needed to explore how to simplify the referral process, make it more consistent and more effectively engage referrers who have less experience with residential rehabilitation.
- There is a need to address practical barriers in the system – structural and those specific to those with substance use issues.
    - Waiting times for assessments for residential rehabilitation and the detoxification required by many facilities can put off clients and referrers alike. Reducing these times is necessary if the aim is for more clients to go to residential rehabilitation.
    - There are also concerns over the lack of availability of aftercare when an individual completes their residential rehabilitation treatment. Some participants were hesitant to send clients to a facility, knowing that there

may not be sufficient aftercare to support the transition out of rehabilitation.

- Strict eligibility criteria at rehabilitation facilities were also a practical barrier, such as requiring total abstinence including any prescription drugs, or not permitting ORT. Participants reporting this as a barrier were concerned this might destabilise their clients, and therefore be counterproductive. Some participants also reported the faith-based nature of some facilities to be a barrier, either to the client or themselves. There is a need to acknowledge that these are barriers for some.

- Working to ensure there are sufficient facilities available to suit a variety of needs will enable more people to consider residential rehabilitation, and provide greater choice for clients.

Recommendations for further research

- A systems mapping exercise of how referring works across each area.

  - Mapping the different stages of the process, who can refer, and how it operates in practice. These different approaches could be evaluated to identify opportunities to simplify or standardise aspects of the process, with options to allow for local flexibility. Including workforce mapping would facilitate further research with referrers, as well as identifying any gaps in provision. This could build on the residential rehabilitation pathway development work currently undertaken by Healthcare Improvement Scotland which is exploring existing pathways and the scope for improvement.

- Additional research on factors determining the likelihood of referral.

  - This could include looking at client circumstances such as stage in their recovery journey, drug use profile, personal circumstances and key demographics, as well as looking at eligibility criteria set by providers.

- Research with clients and residential rehabilitation providers.

Examining the referral process from their point of view would further understanding of barriers, and potentially identify areas for more joined-up working. Existing research with clients with substance use issues or who have been to residential rehabilitation could be built on by speaking with clients who were referred but did not go, and those who discussed or considered it but decided on alternative treatment. This could build on the other work streams already undertaken within PHS's evaluation of the Scottish Government's Residential Rehabilitation programme, including qualitative research with a small number of residential rehabilitation providers, and research about perceptions of rehabilitation among those with experience of using drugs.

3 Background

Drug and alcohol use is a serious public health issue in Scotland. There continues to be a drug death rate higher than in any other country in Europe, and also five times higher than in England.[2] Many factors can predispose people to high-risk drug use, including unemployment, involvement with the criminal justice system and family breakdown. Many individuals who use alcohol and drugs have multiple and complex support needs, including challenges surrounding poor physical and mental health, poverty and unstable housing.[3]

The 2018 ‘Rights, respect and recovery’ strategy set the foundations to reduce drug deaths and improve the lives of those impacted by drugs.[4] This was followed by the launch of the Scottish Government’s National Mission (January 2021) to tackle drug-related deaths and harms as a national priority.[5] One of the aims of the National Mission and the Scottish Government’s Residential Rehabilitation programme is to increase the capacity and use of rehabilitation services, with a particular focus on drug and alcohol residential rehabilitation services.[6]

Residential rehabilitation offers clients person-centred, evidence-based support for as long as they need it. There is relatively robust evidence to suggest that residential rehabilitation leads to improved outcomes, including reduced substance use and improved health and quality of life.[7] Recent research, including surveys with ADPs and residential rehabilitation providers, has added to this evidence base by quantifying available support in Scotland, and building an understanding of the barriers and facilitators to accessing support.[8]

Evidence suggests that there are a number of factors that need to be in place to support referrals to residential rehabilitation, namely ease of access, high-quality treatment and available aftercare.[9] Wrap-around services are also key to enabling clients to undertake preparatory work, manage expectations, and provide a community for recovery with other people with lived experience of residential rehabilitation. This pre- and post-rehabilitation support enables clients to build ongoing relationships with staff and also provides continuity of support, which aids recovery.

Although residential rehabilitation has been shown to be a beneficial treatment option, perceptions vary across referrers. Historically, there has been some scepticism and reluctance among professionals to refer to residential rehabilitation services. Views remain mixed as to whether prioritising investment in such services represents the best approach to generate positive outcomes and value for money for service users. It is, at times, viewed as an expensive treatment option that may only be valid for a small number of people, either because of eligibility criteria or the client's circumstances.[10] The negative perceptions of residential rehabilitation may be rooted in a lack of knowledge or experience of residential rehabilitation, or persistent beliefs about its efficacy as a treatment option from beliefs built before the launch of the National Mission.

Work is ongoing to support ADPs in developing residential rehabilitation pathways and standardising contractual arrangements to help remove some of the complexities in the referral process and reduce some of the barriers faced by referrers.[11]

However, other barriers persist for referrers, namely the waiting times for assessment and beds in residential rehabilitation facilities, in part, due to lack of funding and resources. Others include the fragmented support offer across Scotland; the lack of integrated and joined-up support from statutory and third sector organisations (and across a range of specialisms, including mental health, justice, and housing); and inequalities in accessing support (women, young people and those with severe mental health issues face particular challenges).[12]

To meet the aims of the Scottish Government's National Mission and reduce drug deaths through greater use of residential rehabilitation, the barriers to making referrals and improving residential rehabilitation provision need to be better understood. This research will explore the current position and the potential need for improvements to support organisations and individuals who can refer to be better informed and engaged with the Scottish Government's direction of travel on residential rehabilitation. It will also provide a baseline of perceptions and understanding of residential rehabilitation as a treatment option, which can be measured as the National Mission programme progresses.

Research aims

This research aims to support the programme of work by PHS by:

- **adding to the evidence base and filling a key evidence gap** around views towards residential rehabilitation services by those who can refer to them (e.g. those working in NHS alcohol and drugs services, primary care and hospital services, social work services and criminal justice services)
- **providing an important opportunity to baseline referrer attitudes and perceptions** towards residential rehabilitation, explore current use and any additional support needed to encourage referrals and overcome barriers, and identify any early impacts of the Scottish Government's work
- **feeding into the PHS residential rehabilitation evaluation** and providing a valuable source of information to assess impacts and determine future developments to work to tackle drug harms

Research questions

The primary questions that this research aims to address are:

- What are the attitudes of referrers towards residential rehabilitation?
- What are their perceptions and expectations around residential rehabilitation?
- How are conversations around residential rehabilitation approached and often are referrals made?
- What are the challenges to referral and what would help to facilitate referral more easily?
- What, if any, has been the early impact of the Scottish Government's Residential Rehabilitation programme?

4 Methodology

Overall approach

The research used a mixed-methods approach to meet the objectives. Qualitative interviews were used to undertake an initial scoping phase with ADP leads to provide background context and support the development of an effective research tool.

The survey was developed in collaboration with PHS based on existing understanding of the context, the research questions and the information provided by ADP leads. Qualitative cognitive interviewing was used to test the survey as well as a soft launch to get additional feedback. The sample was drawn from a range of sources and individuals were invited to take part in the survey online or by telephone.

Scoping interviews

Scoping interviews were undertaken to explore ADPs' perceptions of the existing attitudes towards residential rehabilitation in their area based on their connections with relevant referral services. The interviews added to the understanding of key issues, facilitators, and barriers, as well as any gaps in knowledge, which helped to enhance the precision of the survey tool developed.

Sample

The contact details for ADPs were publicly available online[13] and made up the sample for the scoping interviews. Interviews were recruited through initial email invitations and follow-up telephone recruitment, with recruiters making up to five attempts to contact individuals (including email reminders and voicemails).

Some difficulties were experienced trying to make contact and arrange interviews with ADP representatives due to phone numbers not being available/the listed number was not recognised/available, and lack of response following email/voicemail or indirect contact with a colleague. The challenges faced in

recruiting representatives for interviews likely reflect the competing pressures on ADP coordinators' time.

Interviews were conducted with five ADP leads or co-ordinators, one sector expert and one member of the Scottish Government. Views from six ADP areas were represented, all of which were primarily urban areas but only half had residential rehabilitation providers within their area.

Interview guide

The scoping interviews lasted approximately 45 minutes and asked questions about the interviewee's experience working in an ADP, their understanding of the residential rehabilitation referral process, their perception of residential rehabilitation and the perceptions of other people within the ADP, and their input into the design and dissemination of the survey.

The findings of the scoping interviews were presented in a written report delivered to PHS and provided the basis for the development of the survey.

Survey of referrers

A survey was used to establish a baseline of service providers who can refer individuals who use alcohol or drugs to residential rehabilitation. One of the main aims of the survey was to provide an estimate of the prevalence of referrals to residential rehabilitation, which was previously unavailable. The survey also captured the existing attitudes, perceptions and expectations of residential rehabilitation among those able to make referrals at the early stages of the National Mission. The survey was designed to be replicated in future research to enable comparison of perceptions over time and inform discussion about the likely impact of the National Mission programme.

Sample

An opportunity sampling approach was taken. As a database of individuals who can refer to residential rehabilitation did not exist, the sample was established through various routes:

- ADPs were asked to provide a list of referrers in their area through an online form. The form was completed by individuals in four ADP areas, and contact information was provided for seven referrers. Contact details for 15 referrers were provided by email from some ADPs.

- The Drug and Alcohol Information System (DAISy) is a national database of specialist drug and alcohol services in Scotland. The list of organisations (not individuals) using the database was shared by PHS and included 212 organisations and desk research was used to identify contact details for 187 organisations.

- The Scottish Drug Services Directory[14] is an online directory which provides details of agencies in Scotland that can help with drug treatment and care. The database included contact details for 192 residential/in-patient and community-based organisations.

- Survey respondents were asked at the end of the survey to identify any referrers they knew who would be interested in completing the survey. The contact details of 20 referrers were provided.

A sample was compiled from these sources, and invitation emails were sent to individuals and followed up with up to three reminder emails.

An open link to the survey was sent to ADP leads with a request that they share it with referrers in their area, and the link was also publicised through contacts in PHS's network. These included:

- sending to primary care managers within Lothian and Lanarkshire who agreed to share the link throughout their primary care network; the substance use primary care teams in Edinburgh and Glasgow; and the primary care Local Intelligence Support Team (LIST) group who circulated the link

- reporting in the NHS Lanarkshire primary care newsletter

- reporting in the Drugs Research Network Scotland (DRNS) newsletter and a separate email announcement
- follow-up communication from PHS to ADPs encouraging them to share the link with referrers
- sharing with the Primary Care Evaluation Network, and a network of prison staff
- sharing the survey link via a staff intranet for referrers who are part of the criminal justice system working in prisons
- sharing with The Golden Lions Group, which is a group of GPs and mental health practitioners

Survey design

The survey explored respondents' perceptions and expectations of residential rehabilitation, their experiences of referring individuals, and any early impacts of the Scottish Government's Residential Rehabilitation programme.

Following an introduction about the research, respondents were asked for background information including their ADP area, type of organisation, and role as a referrer to residential rehabilitation. The question about their role was intended to establish whether the individual could personally make referrals or recommendations to an organisation that will assess the client for referral to residential rehabilitation, compared to individuals who worked in an organisation where other people can do so.

The following report refers to all respondents as participants; however, it should be noted that some questions were only asked of individuals who identified that they personally could make referrals.

Participants were also asked to provide their professional background, years of experience, and whether they had lived experience of substance use and services. The remaining questions were designed to answer the five primary research questions as outlined in Table 4.1.

Various response scales were used in the survey to gauge the degree of respondents' answers (e.g. level of agreement, likelihood, frequency). For this report, the upper and lower ends of the scales were grouped. For example, on a five-point Likert scale: strongly disagree, disagree, neither agree nor disagree, agree, strongly agree. The findings are presented for disagree (strongly disagree and disagree combined), and agree (strongly agree and agree combined).

Table 4.1: Survey questions and associated research questions

Research question	Survey questions
What are the attitudes of referrers towards residential rehabilitation?	Agreement with statements regarding their awareness of residential rehabilitation such as: 'I am aware of the residential rehab options available for people in my area', 'I have a good understanding of what treatment provision is offered in residential rehab', and 'I understand who can be referred to residential rehab' on a five-point Likert scale from 'Strongly disagree' to 'Strongly agree' and a 'Don't know' option. Awareness of specific residential rehabilitation facilities and if they had visited a residential rehabilitation facility. Agreement with statements related to individuals' attitudes towards residential rehabilitation such as: 'Residential rehab is easily accessible', 'Residential rehab provides a person-centred approach', and 'Residential rehab improves social outcomes' on a five-point Likert scale from 'Strongly disagree' to 'Strongly agree' and a 'Don't know' option.
What are their perceptions and expectations around residential rehabilitation?	Likelihood of referring people from different groups or in different circumstances to residential rehabilitation (e.g. women, people with children, client's current lifestyle could be described as chaotic) on a 10-point scale of 'Not at all likely' to 'Extremely likely' and 'Don't know' and 'Not applicable' options.

Research question	Survey questions
How are conversations around residential rehabilitation approached?	Estimations of how many individuals with substance use problems they had seen in the past three months, how many they discussed residential rehabilitation with, referred to residential rehabilitation, and were successfully placed in a facility. Whether discussions about residential rehabilitation are raised by the client or referrer. Frequency that referrals are made to other treatment options such as counselling, medication, or community-based detox services on a four-point scale of ‘Never’ to ‘Often’ and a ‘Don’t know’ option.
What, if any, has been the early impact of the Scottish Government's Residential Rehabilitation programme on referrers?	Which changes referrers have experienced since the launch of the National Mission such as: ‘Referrers are more knowledgeable about residential rehab’, ‘There is more funding available for placements’, and ‘Waiting times are shorter’. Respondents could select as many as applied.

Research question	Survey questions
What are the challenges to referral and what would help to facilitate referral more easily?	How often factors are a barrier such as: 'Lack of rehab spaces or long waiting times for spaces', 'Lack of resources to assess clients for rehab', and 'Client(s) lack motivation/lose interest' on a five-point Likert scale from 'Never' to 'Always' and a 'Don't know' option. The extent to which factors are a barrier such as: 'There is no tradition of referring to residential rehab in my area', 'Paperwork for making referrals to rehab is complex or inefficient', and 'Unease about the faith-based element of residential rehab' on a four-point Likert scale from 'No barrier at all' to 'A major barrier' and a 'Don't know' option. Which factors could help address barriers experienced by referrers such as: 'Better access to evidence and information about residential rehab among referrers and clients', 'More funding to expand the rehab bed capacity', and 'Increasing capacity to make assessments for residential rehab'. Respondents could select as many as applied.

Cognitive testing

Cognitive testing was used to avoid any measurement error that would affect the validity and accuracy of the survey. Observation, think aloud (when the participant is asked to explain the thought processes they go through when answering the questions), and probing techniques were used to explore:

- understanding of the terms used in the question or the question as a whole
- how accurately people can recall the information needed to answer the question

- how easily people can make appropriate judgements about which information to include in their answer
- if they can fit the answer they want to give into the answer categories or format provided

The cognitive interview was undertaken with one researcher from IFF Research with survey design expertise. Owing to the unavailability of referrers or ADP representatives to engage in the cognitive interviews, it was not possible to test the survey with the intended audience. However, further testing of the survey was carried out through a soft launch as described in the next section.

Survey implementation

The survey was hosted online by IFF Research. Participants were invited to take part online (15–20 minutes) via email invitation, or by phone using computer-assisted telephone interviews (approximately 40 minutes). The communications sent to participants used various techniques to maximise the response rate.

- Emails were co-branded as PHS and IFF Research to reassure recipients about the validity of the research and referenced details of the Scottish Government's policy and the project.
- Communications included contact information for the team at IFF Research in case any recipients had further questions about the research.
- Where emails were sent to a known, named contact the email was directly addressed to that individual.

Before the mainstage fieldwork, a soft launch was conducted in March 2023 whereby a randomly selected subsample of 50 participants were invited to test the survey. A copy of the survey was also shared with ADPs with a request to share their feedback. This ensured the questions and design of the survey were accurate and allowed for a period of feedback before launching the survey more widely. Minor

changes to the wording of questions and question types were made as a result of the soft launch feedback from three participants and two ADP representatives.

The mainstage fieldwork was conducted over seven weeks between March and May 2023. Following the initial invitations and follow-up calls, a targeted approach was taken to engage audiences where there was a lower response rate such as prison and criminal justice, mental health services, and homelessness services.

Survey analysis

Before the analysis of the survey data, coding of open-ended responses or 'other' responses was conducted to categorise responses into groups that are sufficiently aligned to the research questions while remaining an accurate representation of the data.

Data tables presenting the survey analysis were produced based on the coded dataset. The survey data was not weighted as the overall population of referrers was not known. The tables included an analysis of the key subgroups.

- Type of organisation (statutory alcohol or drug service, third sector alcohol and/or drug service, criminal justice services including prison services, other organisation).
- Working in a rural or urban area type.
- Respondent had a residential rehabilitation facility/facilities within their ADP area.
- Respondent had visited a residential rehabilitation facility or not.
- Respondent had lived experience of substance use, residential rehabilitation, or other alcohol or drug support services.
- Whether respondents had a tradition of referring to residential rehabilitation in their area. This was defined by participant responses to whether 'There is no tradition of referring to residential rehab in my area' was a barrier to

making referrals. Those who said it was a major barrier or a barrier to some extent are reported as not having a tradition of referring in their area, while those who stated it was no barrier at all or not really a barrier are reported as having a tradition of referring in their area.

- Respondent's length of experience in the sector (comparison only possible at broad level categories: those with over 10 years' experience and those with 10 years or fewer).
- Professional background (comparison only possible at broad level categories: those with a healthcare background and those with an addiction support or counselling background).

Significance testing was undertaken to explore differences within subgroups and compared to the overall distribution, referred to as 'average'. All differences that are discussed in this report were statistically significant unless stated otherwise.

The analysis also investigated differences by ADP area, NHS health boards, whether the respondent was personally able to make referrals or not, the number of individuals with substance use seen or referred to residential rehabilitation, awareness of residential rehabilitation options in their area and whether they felt previous clients had benefitted from going to residential rehabilitation. Conclusions could not be drawn based on these subgroups because the sizes of the subgroups were too small (fewer than 30).

Figures 6.1–10.1 in this report present a visual summary of key analyses. Additional details about the data represented in these figures can be found in a separate data annex to this report.

5 Participant characteristics

As evidenced in Table 5.1 and Table 5.2, survey participants (N = 168) worked across ADP and NHS health board areas, with the highest proportion of responses from those working in Lothian (25%), Greater Glasgow and Clyde (15%), and Fife (15%).

Table 5.1: Participant NHS health board area

NHS health board area	Number of responses	Proportion of responses
Lothian	42	25%
Greater Glasgow and Clyde	26	15%
Fife	25	15%
Tayside	19	11%
Lanarkshire	15	9%
Grampian	14	8%
Ayrshire and Arran	11	7%
Highland	11	7%
All other areas	15	9%

Table 5.2: Participant ADP area

ADP area	Number of responses	Proportion of responses
City of Edinburgh	27	16%
Fife	25	15%
Lothian: Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP)	13	8%
Dundee City	11	7%
Inverclyde	11	7%
Aberdeenshire	10	6%
All other areas	106	63%

Overall, the majority of participants worked in an urban area (82%) rather than a rural area (19%), but more than half reported that there was not a residential rehabilitation facility within their ADP area (55%).

The majority of participants worked in either a third sector alcohol or drug service (35%) or an NHS alcohol or drug service (28%), as shown in Table 5.3. The majority of participants were able to make referrals themselves (90%).

More than a quarter of participants had a professional background as a healthcare professional (e.g. nurse, midwife, allied health professional or other non-medical healthcare professional i.e., dentists; 27%), and approximately one in 10 had a background in social work (11%), recovery or rehabilitation (10%), and addiction support or counselling (10%). Nine per cent of the sample reported they worked as a GP, consultant or other medical professional.

Table 5.3: Participant organisation type

Organisation type	Number of responses	Proportion of responses
Third sector alcohol and/or drug service	59	35%
NHS alcohol or drug service	47	28%
Criminal justice services including prison services	20	12%
Council alcohol and/or drug service	12	7%
Other primary care or hospital services	10	6%
Other organisations (including women's support, mental health, homelessness support, social services)	20	12%

As shown in Table 5.4, participants generally had a lot of experience working with people with substance use issues, with 60% of the sample reporting more than 10 years of experience, and 18% reporting 5–10 years.

Table 5.4: Participant years of experience

Years of experience	Number of responses	Proportion of responses
1 year or less	10	6%
1–5 years	24	15%
5–10 years	29	18%
More than 10 years	96	60%

Finally, as shown in Table 5.5, many participants also had lived experience of substance use issues (30%), residential rehabilitation (10%), or alcohol or drug support services (19%).

Table 5.5: Participant lived experience

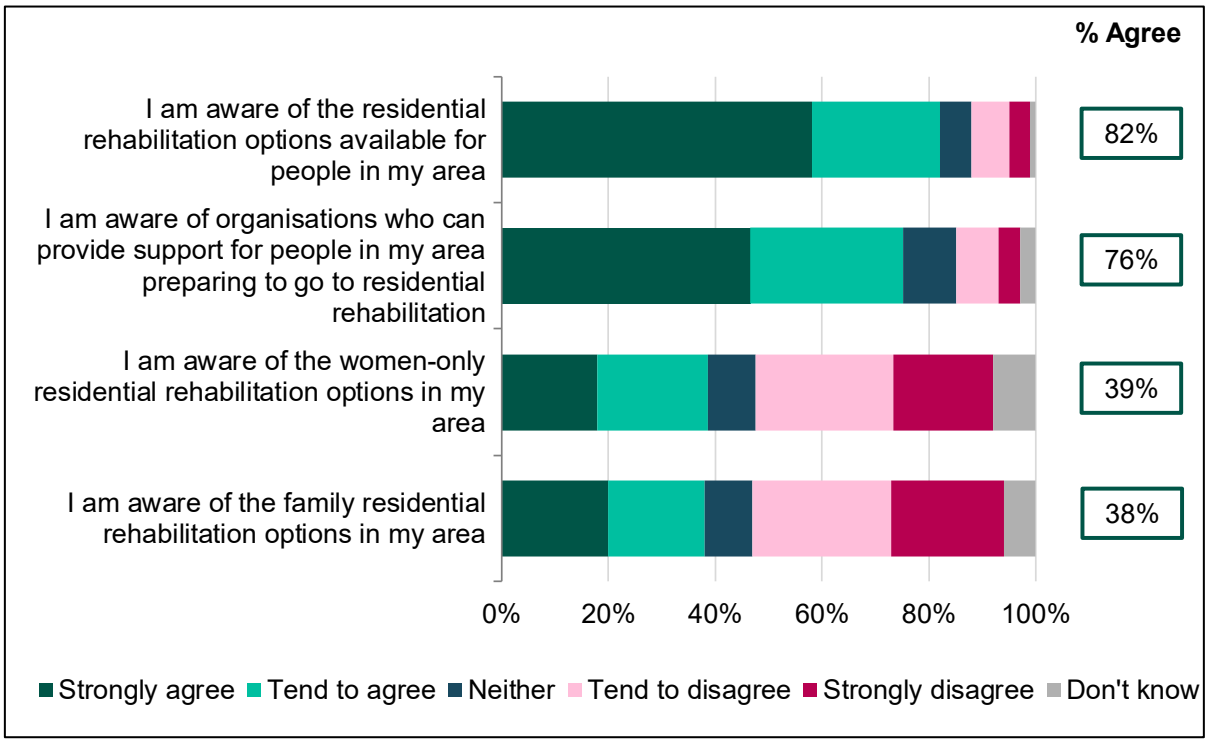
Lived experience	Number of responses	Proportion of responses
Lived experience of problem substance use	50	30%
Lived experience of residential rehabilitation	16	10%
Lived experience of other alcohol or drug support services	32	19%

6 Awareness and knowledge

Awareness of residential rehabilitation options

As evidenced in Figure 6.1, awareness of residential rehabilitation options (82%) and of organisations that provide support was high among participants (76%), while awareness about women-only residential rehabilitation options (39%) and family residential rehabilitation (38%) options was lower.

Figure 6.1: Participant awareness of residential rehabilitation options



Source: IFF Research survey of organisations that can refer to residential rehabilitation. To what extent do you agree: B1-1. I am aware of the residential rehab options available for people in my area; B1-2. I am aware of the women-only residential rehab options, available to women in my area; B1-3. I am aware of the family residential rehab options available to people with children in my area; B1-12. I am aware of organisations that can provide support for people in my area preparing to go to residential rehab. Base: All participants (168).

Most participants were aware of the residential rehabilitation options available in their area (82%). This was more common among those who had previously visited a

residential rehabilitation facility (88%) or who had a tradition of referring clients to residential rehabilitation in their area (92%).

Similarly, the majority of respondents (76%) were aware of organisations that can provide support for people in their local area preparing to go to residential rehabilitation. Agreement was again higher among participants who had previously visited a residential rehabilitation (83%).

Fewer participants were aware of women-only residential rehabilitation options (39%) and of family residential rehabilitation options (38%). Agreement was higher among participants who had previously visited a residential rehabilitation or who had a tradition in their area of referring clients to residential rehabilitation. In terms of awareness of specific rehabilitation facilities:

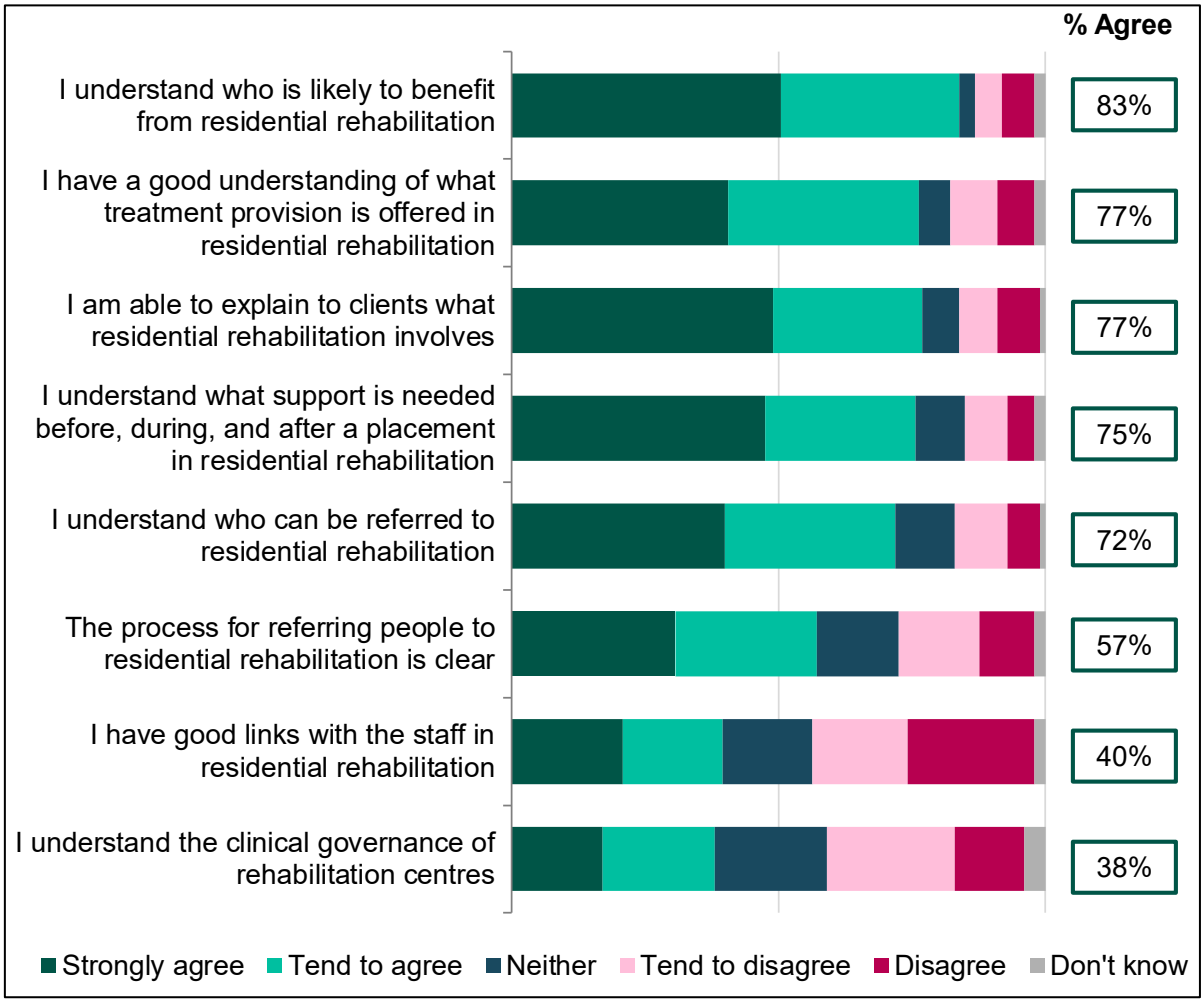
- very few participants (1%) were only aware of one facility
- one in five (18%) participants were aware of 2–3 or 4–5 facilities each
- Four in 10 (37%) participants were aware of 6–10 facilities
- one in five (23%) participants were aware of more than 10 facilities
- one in 50 (2%) participants were not aware of any facilities

It is important to note that this question was asked to online survey respondents only.

Knowledge of residential rehabilitation

As shown in Figure 6.2, knowledge about residential rehabilitation among participants was varied. At least three-quarters of participants had a good understanding of residential rehabilitation in terms of who may be likely to benefit (83%), in terms of what treatment provision was offered (77%), and in terms of being able to explain to clients what residential rehabilitation involves (77%). Participants were least likely to have good links with staff in residential rehabilitation (40%) and to understand the clinical governance of rehabilitation centres (38%).

Figure 6.2: Participant knowledge of residential rehabilitation



Source: IFF Research survey of organisations that can refer to residential rehabilitation. To what extent do you agree: B1-4. I have a good understanding of what treatment provision is offered in residential rehab; B1-5. I am able to explain to clients what residential rehab involves; B1-6. I have good links with the staff in residential rehab; B1-7. The process for referring people to residential rehab is clear; B1-8. I understand who can be referred to residential rehab; B1-9. I understand who is likely to benefit from residential rehab; B1-10. I understand the clinical governance of rehab centres; B1-11. I understand what support is needed before, during, and after a placement in residential rehab. Base: all participants (168).

The majority of participants felt that they had a good understanding of what treatment provision is offered in residential rehabilitation (77%) and that they would be able to explain to clients what residential rehabilitation involves (77%). However, fewer felt that they understood the clinical governance of residential rehabilitation

centres (38%). As shown in Table 6.1, across these three statements agreement was higher among participants who had previously visited a residential rehabilitation facility or who had a tradition in their area of referring clients to residential rehabilitation.

Table 6.1: Participant agreement by whether the participant has visited a residential rehabilitation facility or whether the participant has a tradition of referring clients to residential rehabilitation

Statement	Visited	Not visited	Tradition	No tradition
Agree: I have a good understanding of what treatment provision is offered in residential rehabilitation	89%	51%	89%	71%
Agree: I am able to explain to clients what residential rehabilitation involves	89%	51%	91%	69%
Agree: I understand the clinical governance of residential rehabilitation centres	46%	21%	45%	33%

Source: IFF Research survey of organisations that can refer to residential rehabilitation. To what extent do you agree: B1–4. I have a good understanding of what treatment provision is offered in residential rehab; B1–5. I am able to explain to clients what residential rehab involves; B1–10. I understand the clinical governance of residential rehabilitation centres. Base: all participants (168); respondents who had previously visited a residential rehabilitation facility (115); respondents who had not previously visited a residential rehabilitation facility (53); respondents who had a tradition of referring to residential rehabilitation in their area (97); Respondents who did not have a tradition of referring to residential rehabilitation in their area (52).

Most participants felt that they understood who is likely to benefit from residential rehabilitation (83%) and understood who could be referred to residential rehabilitation (72%). However, these percentages include those who strongly agreed

and those who tended to agree. Only half of the participants (50%) strongly agreed that they understood who is likely to benefit from residential rehabilitation; only two in five (40%) strongly agreed that they understood who can be referred.

A similar proportion (75%) of participants agreed that they understood what support is needed before, during and after a residential rehabilitation placement. Across all three statements, participants were more likely to agree if they had previously visited a residential rehabilitation facility or if they had a tradition in their area of referring clients to residential rehabilitation. Table 6.2 shows this in more detail.

Table 6.2: Participant agreement by response type

Statement	Visited	Not visited	Tradition	No tradition
Agree: I understand who is likely to benefit from residential rehabilitation	90%	70%	90%	79%
Agree: I understand who can be referred to residential rehabilitation	79%	57%	86%	60%
Agree: I understand what support is needed before, during and after residential rehabilitation	83%	57%	84%	69%

Source: IFF Research survey of organisations that can refer to residential rehabilitation. To what extent do you agree: B1–9. I understand who is likely to benefit from residential rehabilitation; B1–8. I understand who can be referred to residential rehabilitation; B1–11. I understand what support is needed before, during, and after a placement in residential rehabilitation. Base: all participants (168); respondents who had previously visited a residential rehabilitation facility (115); respondents who had not previously visited a residential rehabilitation facility (53); respondents who had a tradition in their area of referring to residential rehabilitation (97); respondents who did not have a tradition of referring to residential rehabilitation in their area (52).

Just over half of the participants agreed that the process for referring people to residential rehabilitation is clear (57%), with a quarter disagreeing (26%). Findings from the scoping report with ADPs also suggested a lack of clarity over referral processes (please see Annex A for more detail),[15] with a variety of approaches in different areas. In some areas, there were several layers to the referral process, such as referrers not being able to directly refer clients to residential rehabilitation, but instead being required to refer them to a specific service that would then conduct an assessment. There could be several steps to processes like these. In other areas, referrers could make direct referrals to rehabilitation centres, and self-referral was also mentioned as another viable route by a few respondents. ADPs also indicated there could be differences in process and paperwork for each rehabilitation facility.

Fewer than half of participants felt that they had good links with the staff in residential rehabilitation (40%). Participants were more likely to feel that they had good links with staff if they had previously visited a residential rehabilitation facility (55% agreed they had good links) or if they had a tradition in their area of referring clients to residential rehabilitation (54% agreed they had good links).

Two-thirds of participants in our survey had previously visited a residential rehabilitation facility (68%), while a third had not done so (32%). Of those who had visited a residential rehabilitation facility, the majority had done so before the launch of the National Mission in 2021 (69%).

7 Current referring practices

This chapter discusses data provided by participants able to make referrals about their referring practices in the three months before the survey. This focuses mainly on their use of residential rehabilitation, but the chapter will also briefly discuss participants' use of other treatment options.

Residential rehabilitation as a treatment option

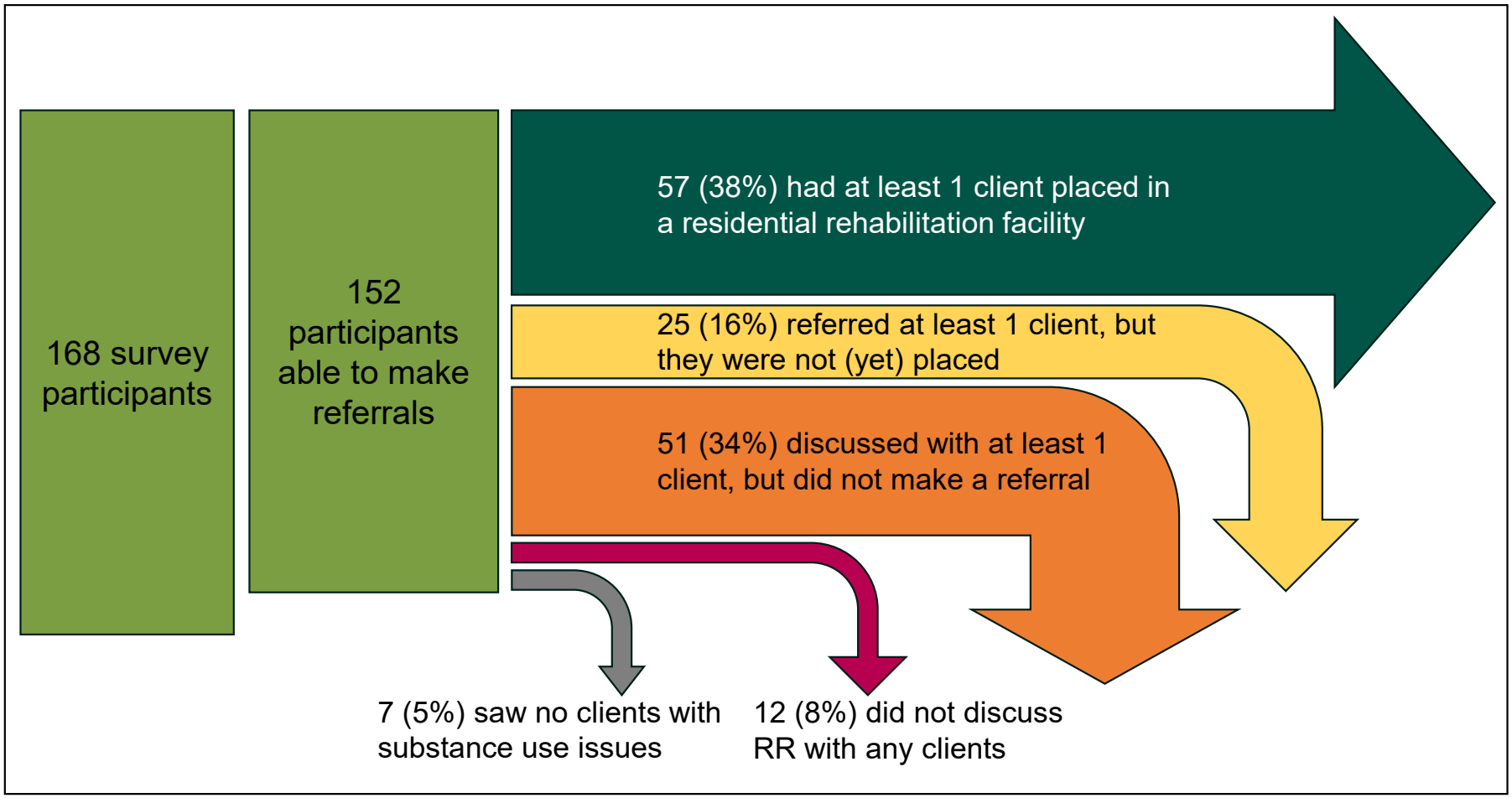
Of the 168 survey participants, 152 confirmed that they were personally able to make referrals to residential rehabilitation or recommend a client to be assessed for residential rehabilitation. These participants were then asked to provide information on:

- the number of clients with substance use issues they had seen in the last three months
- how many of these clients they had discussed residential rehabilitation as a treatment option with
- how many of these clients they had referred to residential rehabilitation
- how many of those who had been referred had been placed in a residential rehabilitation facility

Overall approach

First, looking at the overall outcomes of this, 38% of participants had at least one client placed in a residential rehabilitation facility, as shown in Figure 7.1. A further 16% had referred at least one client but they had not (or had not yet) received a place. Just over a third (34%) of participants had discussed residential rehabilitation with at least one client, but had not made any referrals, while under one in 10 (8%) had not discussed it with any clients. Very few participants (5%) had not seen any clients with substance use issues. Overall, 92% of the 145 participants who had seen clients with substance use issues in the last three months had discussed rehab with at least one client.

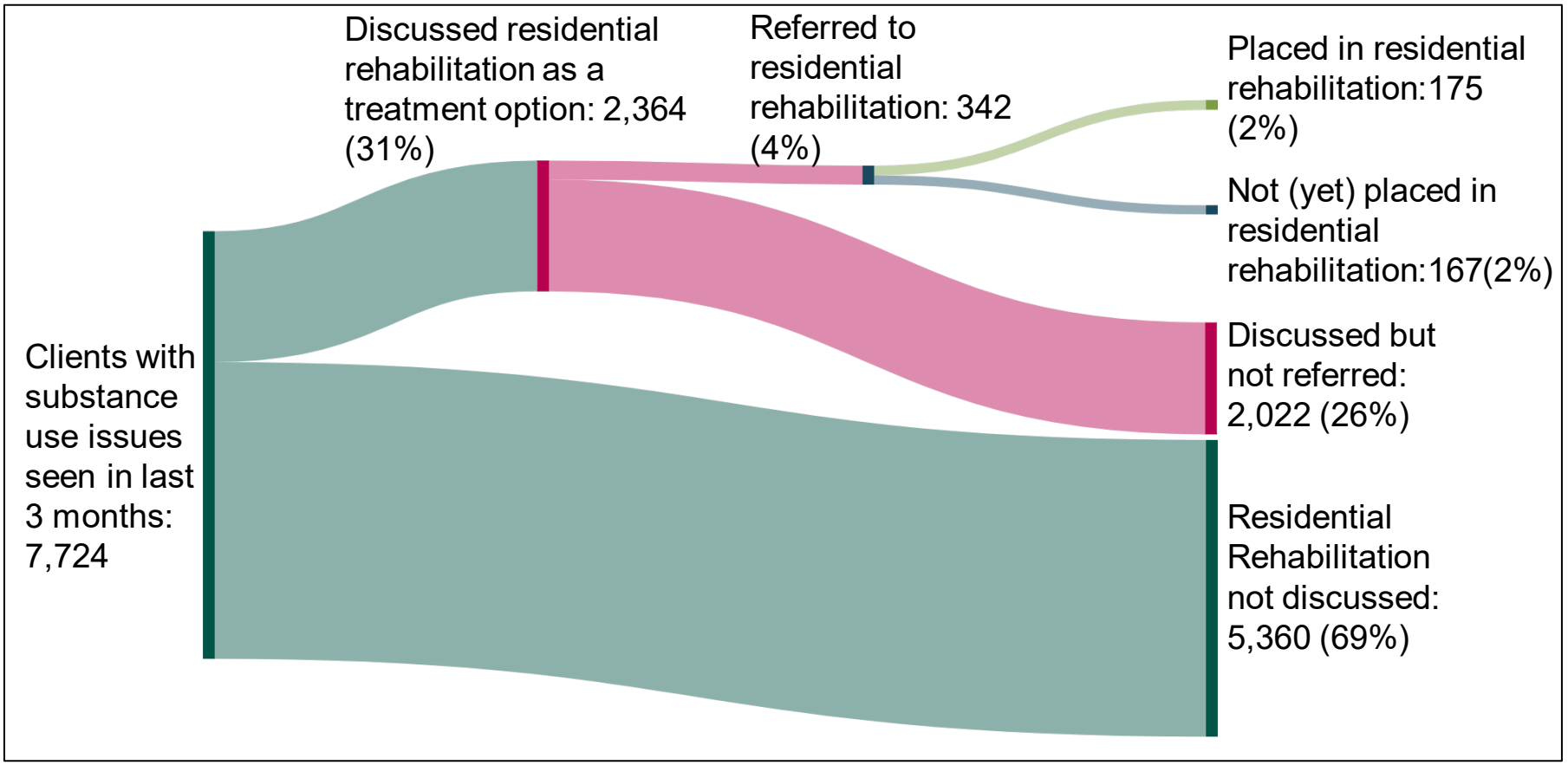
Figure 7.1: Whether participants had discussed, or made referrals to, residential rehabilitation with any clients



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1a. Approximately how many individuals with substance use problems did you personally see in the last three months? C1b. Approximately how many did you discuss residential rehab as a treatment option with?. C1c. How many did you refer to residential rehab? C1d. How many were placed into residential rehab? Base: all participants able to make referrals (152). RR: residential rehabilitation.

In terms of the number of clients they came into contact with, participants had seen a total of 7,724 clients with substance use issues in the three months before the survey. As shown in Figure 7.2, residential rehabilitation was not discussed with just over two-thirds (69%) of clients with substance use issues. For a quarter (26%) of clients, residential rehabilitation was discussed as a treatment option but no referral was made. Two per cent of clients had been referred and placed in a residential rehabilitation facility, and a further 2% had been referred to residential rehabilitation but had not – or not yet – been placed in a facility. Overall, residential rehabilitation was discussed with three in 10 (31%) clients seen. This reinforces the point that while residential rehabilitation is on the agenda for most participants, it is not being considered for the majority of clients with substance abuse issues.

Figure 7.2: Client destinations in the last three months

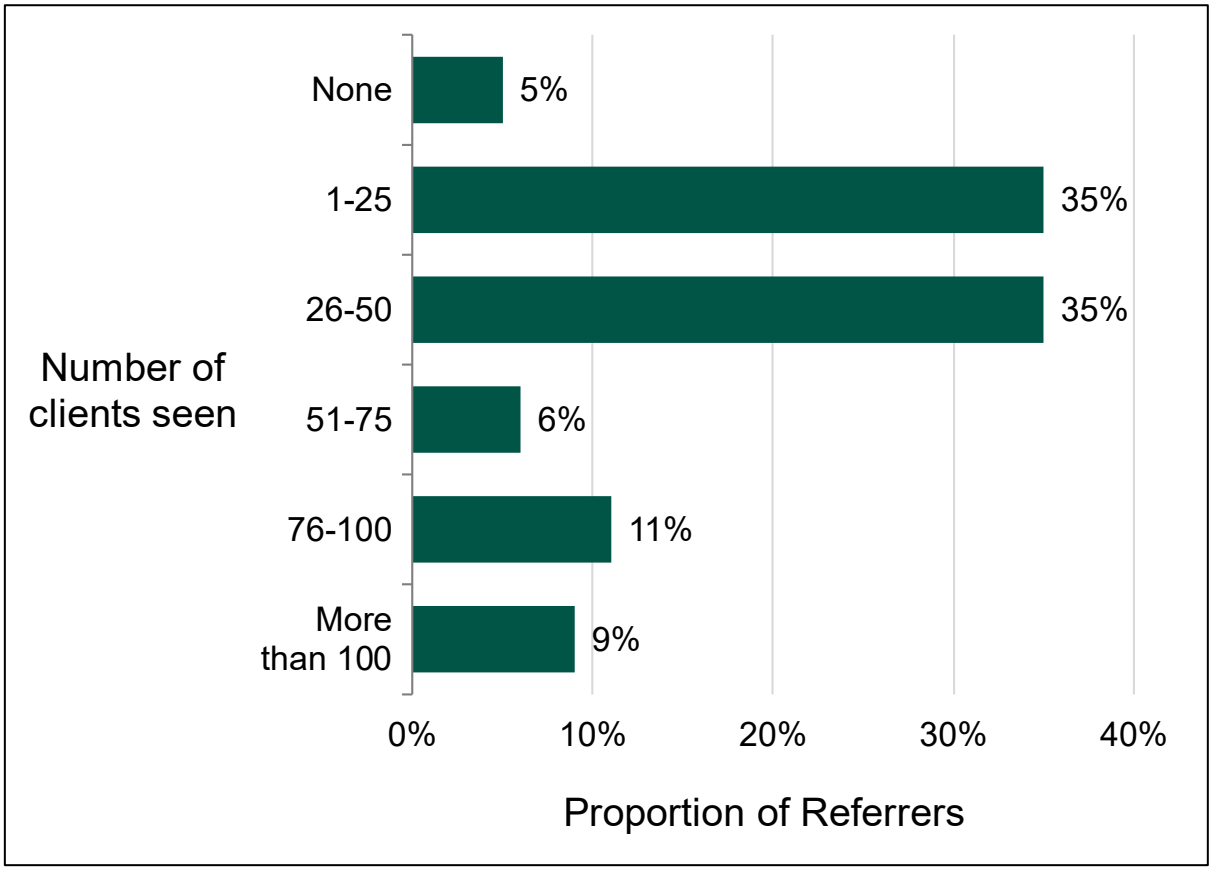


Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1a. Approximately how many individuals with substance use problems did you personally see in the last three months? C1b. Approximately how many did you discuss residential rehab as a treatment option with? C1c. How many did you refer to residential rehab? C1d. How many were placed into residential rehab? Base: all participants able to make referrals (152).

Measures in more detail

The majority (70%) of participants had seen between one and 50 clients with substance use issues in the last three months, evenly split between those seeing 1–25 and 26–50 clients, as shown in Figure 7.3. A total of 6% of participants had seen 51–75 clients, 11% had seen 76–100, and 8% had seen more than 100. One in 20 participants (5%) had seen no clients with substance use issues in the last three months. Across all participants, the median number of clients with substance use issues seen was 30. Median is used here rather than mean due to the presence of outliers in the data.

Figure 7.3: Number of individuals with substance use issues seen by participants in the last three months

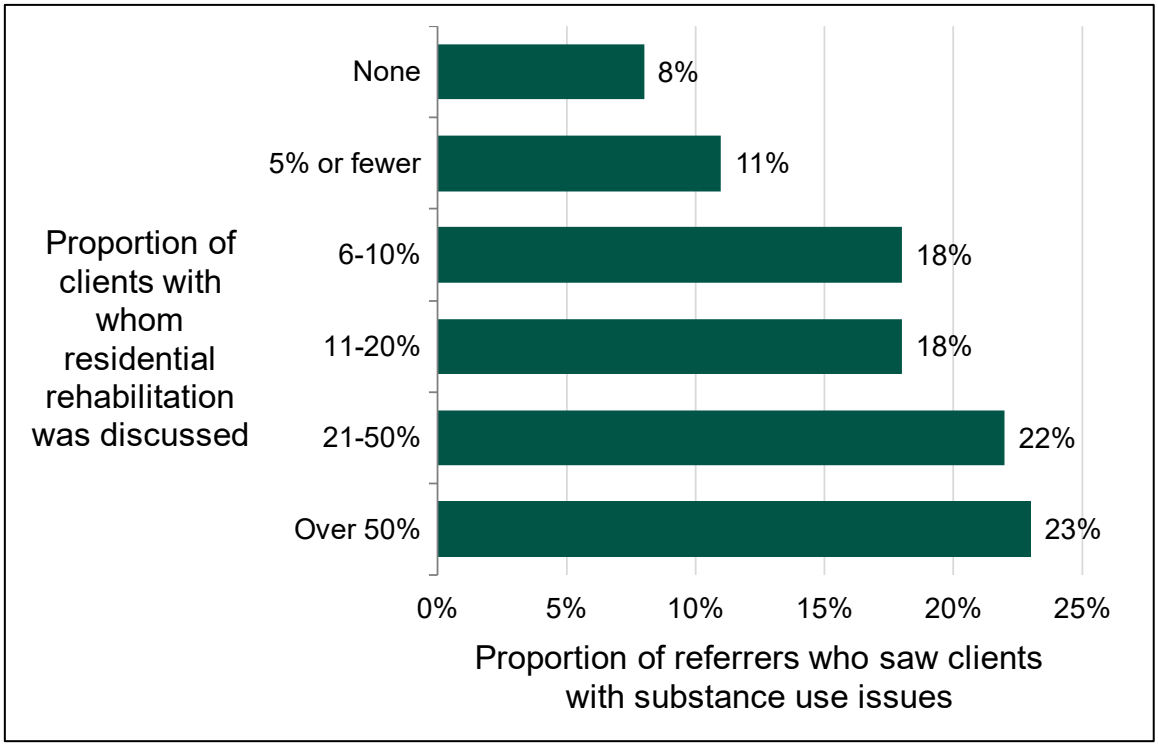


Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1a. Approximately how many individuals with substance use problems did you personally see in the last three months? Base: all participants able to make referrals (152).

Over half (55%) of participants in rural areas had seen only 1–25 clients with substance use issues, they were more likely to have seen this number than participants in urban areas (31%).

Participants who had seen clients with substance use issues were then asked how many clients they had discussed residential rehabilitation as a treatment option with in the last three months. This was then calculated as a percentage of those they had seen. As shown in Figure 7.4, almost one in four (23%) participants who had seen clients with substance use issues had discussed residential rehabilitation with more than half of their clients. A similar proportion (22%) had discussed residential rehabilitation with more than one in five, but fewer than half, of their clients. The others, just over half of all participants who had seen clients with substance use issues, had discussed it with fewer than one in five of their clients. Just fewer than one in 10 participants had not discussed it with any client.

Figure 7.4: Proportion of clients with whom participants discussed residential rehabilitation in the last three months



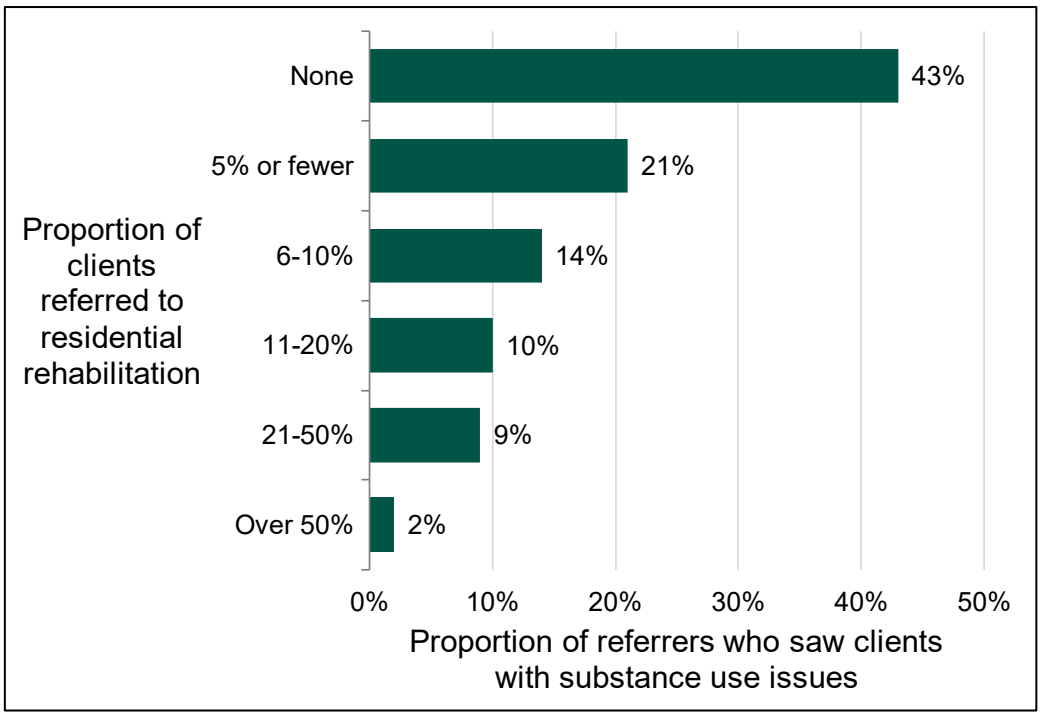
Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1b: Approximately how many did you discuss residential rehab as a

treatment option with? Base: all participants who saw individuals with substance use issues (145).

Participants with 10 years or fewer of experience in the sector had discussed residential rehabilitation with a higher proportion of clients on average (38%), compared to those with more than 10 years' experience (27%). Referrers who had previously visited a rehabilitation facility had also discussed it as a treatment option with a higher proportion on average (35%), compared to those who had not visited one (20%). Participants who reported no tradition of referring to residential rehabilitation in their area had discussed it with a lower proportion on average (22%) compared to those who had a tradition (36%).

Those who felt residential rehabilitation was easily accessible had discussed it with 47% of clients on average, higher than those who did not feel it was easily accessible (26%). Similarly, participants who said the process of referral was clear had discussed residential rehabilitation with a higher proportion of clients on average (37%), compared to those who disagreed that referring was clear (23%). Participants who agreed that they understood the clinical governance arrangements for residential rehabilitation, had discussed it with 38% of clients on average – compared to only 21% of clients on average among those who disagreed. Participants were also asked how many clients they had referred to residential rehabilitation in the last three months, which was again calculated as a percentage of clients with substance use issues they had seen. On average, participants who had seen clients with substance use issues had referred 8% of their clients to residential rehabilitation. Those who had referred at least one client had – on average – referred 11% of their clients.

Figure 7.5: Proportion of clients with substance use issues referred to residential rehabilitation in the last three months



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1c: How many did you refer to residential rehab? Base: all participants who saw individuals with substance use issues (145).

As shown in Figure 7.5, over four in 10 (43%) participants who had seen individuals with substance use issues had made no referrals to residential rehabilitation in the three months before the survey. One in five (21%) had referred 5% or fewer of their clients, followed by 14% who had referred 6−10%, 10% who had referred 11–20%, and 9% who had referred 21–50%. Only 2% of participants who had seen individuals with substance use issues in the three months before the survey, had referred more than 50% of their clients.

Perhaps as expected, participants who had discussed residential rehabilitation with higher proportions of clients had also referred higher proportions of clients: those who had discussed it with over half of their clients referred on average 22% of those they saw, compared to those who had discussed it with 10% or fewer clients, who referred only 1.2% on average. However, participants who had seen fewer clients with substance use issues referred a higher proportion, compared to those who had

seen larger numbers of clients: participants who had seen over 75 clients during the three months referred 2.5% on average, compared to those who had seen 25 or fewer (14% referred on average) or 26-50 (6%).

The following subgroups referred higher proportions of clients on average.

- Participants who had visited a rehabilitation facility (10%), compared to those who had not (4%).
- Participants who agreed residential rehabilitation was easily accessible (13%), compared to those who disagreed (6%).
- Participants who agreed the referral process is clear (11%), compared to those who disagreed (2%).
- Participants who reported no tradition of referring to residential rehabilitation in their area (11%), compared to those who said this was a barrier (4%).
- Participants who disagreed that residential rehabilitation was only valid for a small number of people (13%), compared to those who agreed with this (6%).

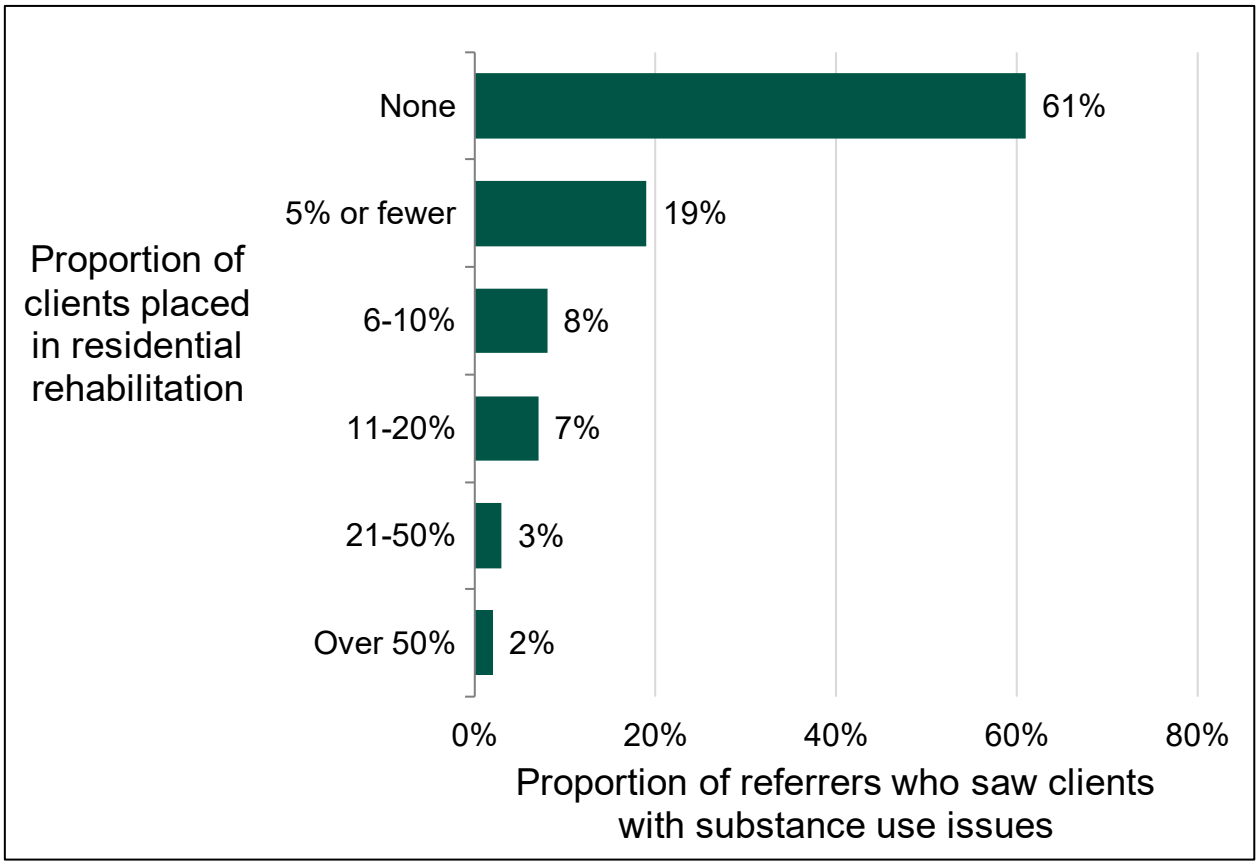
Participants who agreed they understood the clinical governance of residential rehabilitation centres were more likely to have made at least one referral (58%), compared to those who disagreed (30%).

Those who made no referrals to residential rehabilitation tended to be the reverse of the groups listed above, for example almost six in 10 (58%) of participants who had not visited a rehabilitation facility made no referrals, compared to almost four in 10 (38%) of those who had visited.

Participants were asked how many of their clients had been placed in residential rehabilitation in the last three months, which was calculated as a percentage of clients with substance use issues they had seen. On average, participants who had seen clients with substance use issues had seen 5% placed in residential rehabilitation. As shown in Figure 7.6, six in 10 (61%) participants who had seen individuals with substance use issues saw none of their clients placed into residential

rehabilitation. Almost two in 10 saw 5% or fewer of their clients placed in a facility. Smaller proportions of participants saw more than 5% of their clients placed. Only 2% of participants who saw clients with substance use issues saw more than half of their clients placed in residential rehabilitation.

Figure 7.6: Proportion of clients with substance use issues placed into residential rehabilitation in the last three months



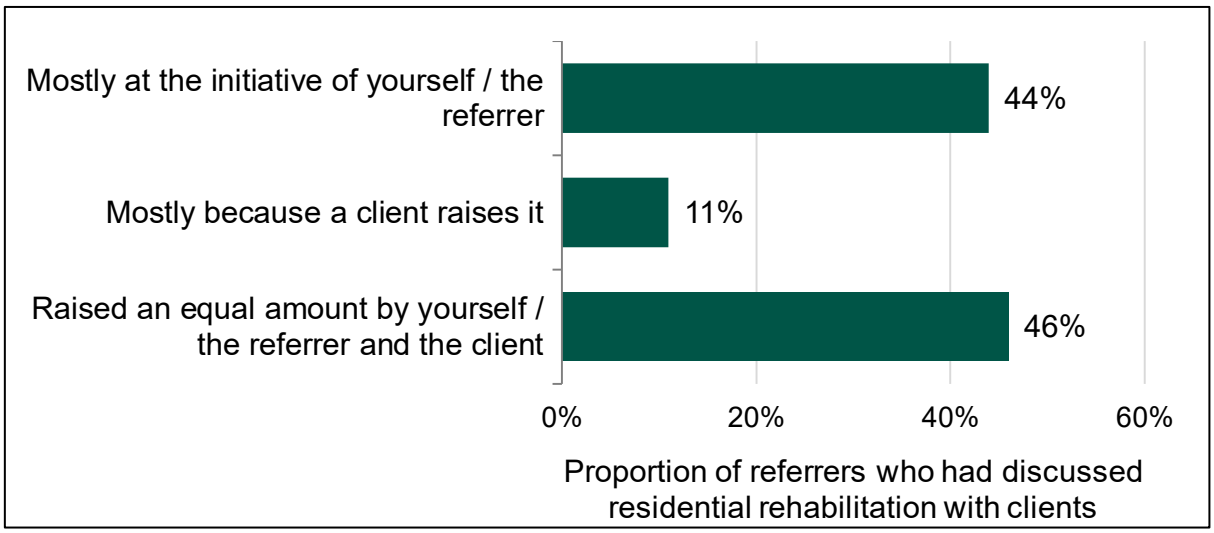
Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1d: How many were placed into residential rehab? Base: all participants who saw individuals with substance use issues (145).

As with referrals, those who had discussed residential rehabilitation with over 50% of their clients saw a greater proportion placed into a facility (14%), compared to those discussing with 10% or fewer (1%). Again, similarly to referral, participants who had seen fewer clients were more likely to see higher numbers placed into residential rehab: those who saw 25 or fewer clients saw one in 10 (10%) placed on average, higher than those who saw 26–50 (3%) or more than 75 (1%).

Discussions of residential rehabilitation

When discussing residential rehabilitation as a treatment option, participants said this tended to be mostly on their initiative/the initiative of the referrer (44%) or raised an equal amount by themselves and the client (46%), as shown in Figure 7.7. Only one in 10 (11%) said it was discussed mostly because a client raised it.

Figure 7.7: How residential rehabilitation is raised as a treatment option



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C2: Thinking about the occasions when you have discussed residential rehab as a treatment option in the last three months, was this... Base: all participants who have discussed residential rehab (133).

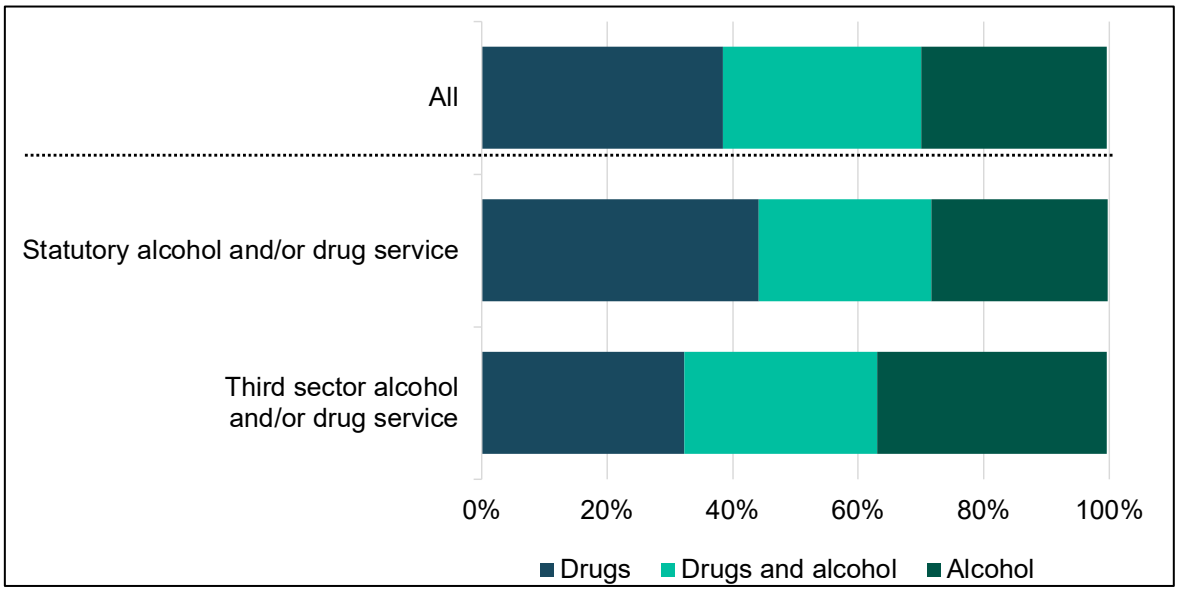
Participants working at a third sector drug and alcohol service were more likely to say residential rehabilitation was mostly raised by clients (19%), compared to average (11%). The following groups were also more likely to say residential rehabilitation was mostly raised by clients.

- Those who did not have a tradition in referring to residential rehabilitation in their area (23%), compared to those who did (5%).
- Those who disagreed that the process for making referrals was clear (28%), compared to those who agreed it was clear (4%).

- Those who disagreed that residential rehabilitation was easily accessible (15%), compared to average (11%).

Participants who discussed residential rehabilitation as a treatment option with clients, were asked what proportions of these clients had issues with drugs, alcohol or both. This was then calculated as a percentage. As shown in Figure 7.8, on average, participants said 38% of the clients had issues with drugs, 30% had issues with alcohol, and 32% had issues with both.

Figure 7.8: Average proportion of clients with different substance use issues



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C1bb Of those people, approximately how many had an issue with…? Base: all participants who have discussed residential rehab (133).

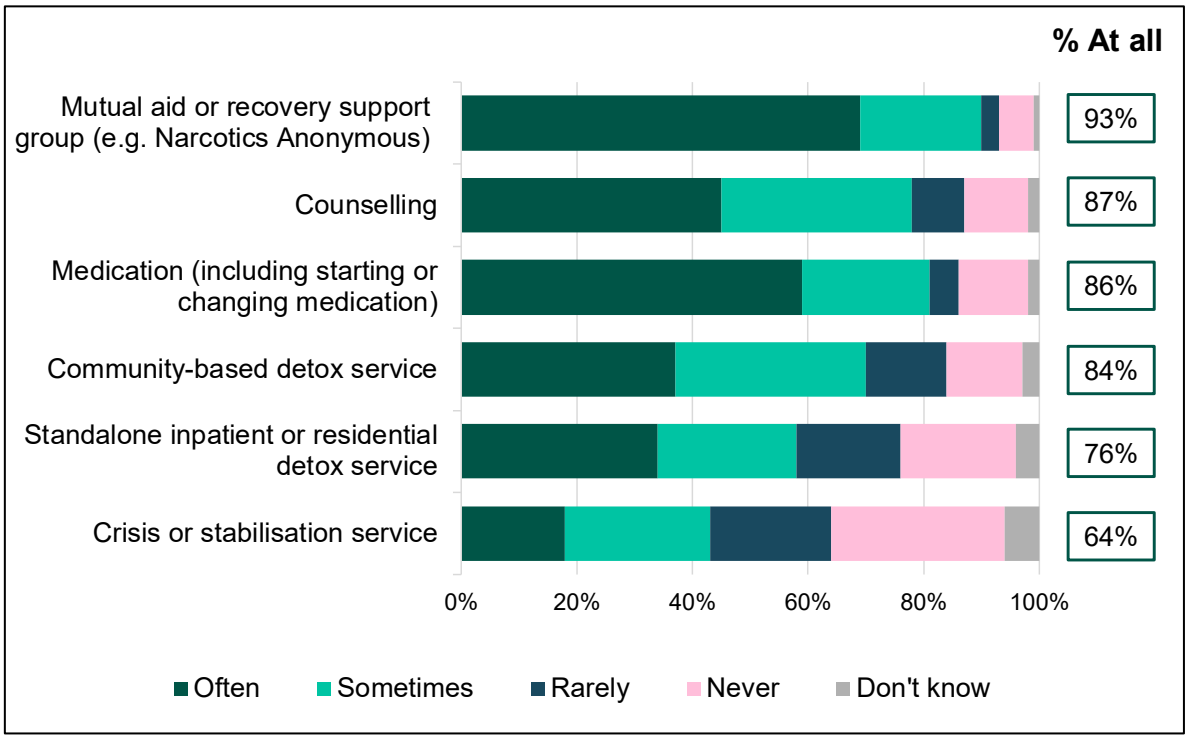
As shown in Figure 7.8, there were some indicative differences in averages between statutory and third sector alcohol and drug services, such as statutory services having seen a higher proportion of clients on average with drug use issues (44%), compared with third sector services (32%).

Other types of treatment

Participants were asked how often they used other types of treatment as an alternative to residential rehabilitation. As shown in Figure 7.9, mutual aid or

recovery support groups, such as Narcotics Anonymous, were the most commonly used, with over nine in 10 (93%) of participants having referred to this type of treatment at some point. This was followed by counselling (87%), medication, including starting or changing medication (86%), and community-based detox services (84%), all used by more than eight in 10 participants. Three-quarters (76%) of participants referred clients to standalone inpatient or residential detox services, while 64% referred clients to crisis or stabilisation services.

Figure 7.9: Frequency of referring to other types of treatment



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C3. How often do you refer individuals to the following types of treatment, as an alternative to residential rehab? Base: all participants able to make referrals (152).

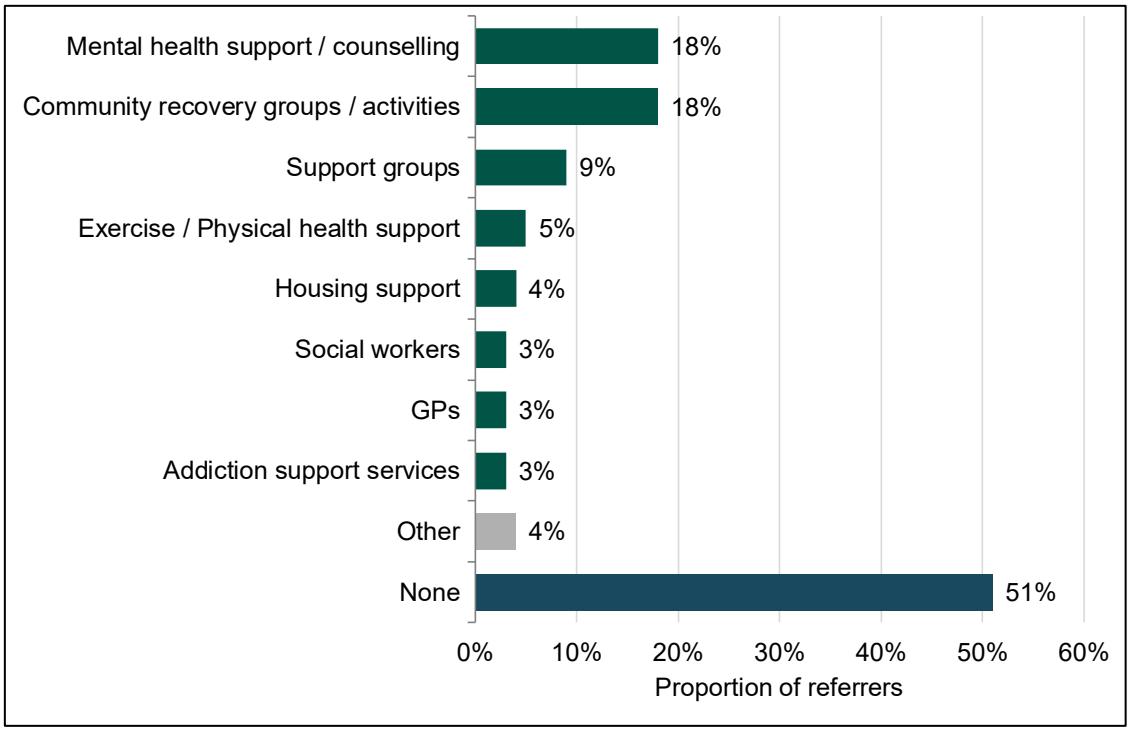
Participants working at statutory alcohol and drug services were more likely to refer clients to medication ‘often’ (74% vs 59% average) but less likely to refer to counselling ‘often’ (32% vs 45% average). However, referring to these treatment options at all was consistent across both service types: around nine in 10 participants from statutory (89%) and third sector (93%) services had referred clients to medication, as well as to counselling (statutory: 85%, third sector: 91%). Those

working at third sector alcohol and drug services were more likely to refer clients to crisis or stabilisation services (76%) compared to average (64%). Participants at statutory alcohol and drug services were more likely to 'never' refer to crisis or stabilisation services (42%) compared to average (30%).

Participants in rural areas were less likely to refer to standalone inpatient or residential detox services (61%) than average (76%). Those with a rehabilitation facility in their local area were more likely to refer to mutual aid or recovery groups (99%), compared to those without (88%). Participants with 10 years' experience or fewer in the sector were more likely to refer to mutual aid or recovery groups often (80%) compared to those with more than 10 years' experience (63%).

Participants were asked if there were any other types of treatment they referred clients to. While half (51%) said there were no other services they referred to, almost a fifth said they had referred to mental health support services and counselling (18%) and community recovery groups or activities (18%) respectively. As shown in Figure 7.10 this was followed by other support groups (9%), exercise and physical health support (5%), and housing support (4%). Three per cent of participants had referred clients to social workers, GPs and addiction support services each. Owing to smaller numbers providing answers to this question, it is not possible to undertake subgroup comparisons.

Figure 7.10: Other types of treatment referrals made by participants



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C3. How often do you refer individuals to the following types of treatment, as an alternative to residential rehab? [Other] Base: all participants able to make referrals (152).

8 Views towards residential rehabilitation

This chapter examines participants' views and opinions on residential rehabilitation. Firstly, it looks at views towards various aspects of residential rehabilitation as a treatment option. Then it explores the likelihood of those able to refer to consider referrals for different client groups.

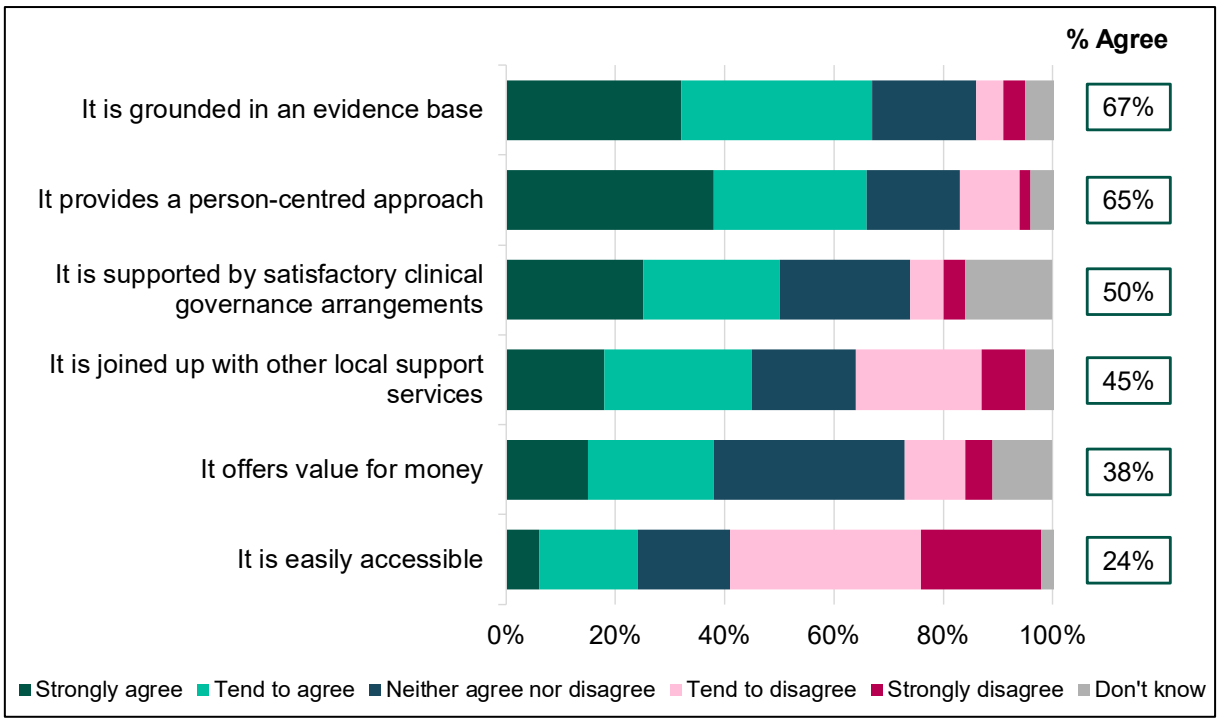
Overall views

All participants were asked the extent to which they agreed with several statements about residential rehabilitation. As shown in Figure 8.1, around two thirds of participants agreed that residential rehabilitation is grounded in an evidence base (67%), and that it provides a person-centred approach (65%). Only 8% and 13% disagreed respectively. Half (50%) of participants agreed that residential rehabilitation is supported by satisfactory clinical governance arrangements, a quarter (24%) neither agreed nor disagreed and one in 10 (10%) disagreed. A relatively high proportion (16%) of participants said they 'didn't know', suggesting a knowledge gap in this area.

While 45% of participants agreed that residential rehabilitation is joined up with other local services, three in 10 (30%) disagreed, indicating a mix of experiences. Just over a third (38%) of participants agreed that residential rehabilitation offers value for money, while almost as many reported they neither agreed nor disagreed (35%), and 16% disagreed.

The only statement where disagreement was higher than agreement was whether residential rehabilitation is easily accessible. Over half of participants (57%) disagreed that it was easily accessible, while only a quarter agreed it was (24%), suggesting this is a concern for participants.

Figure 8.1: Extent to which participants agree with statements about residential rehabilitation



Source: IFF Research survey of organisations that can refer to residential rehabilitation. D1. To what extent do you agree or disagree that residential rehab is…? Base: all participants (168), except 'offers value for money' (160; added post-pilot).

Differences by service type

Participants from third sector service alcohol and drug services were more likely to agree that residential rehabilitation is grounded in an evidence base (80%) than average (67%). Those working at statutory services (20%) were less likely than average (32%) to say they 'strongly' agreed it was grounded in an evidence base, and more likely to say they neither agreed nor disagreed (29% vs 19% average).

Participants at statutory alcohol and drug services (27%) were less likely to say they 'strongly' agreed residential rehabilitation provides a person-centred approach than average (38%). They were also more likely to disagree overall (17%) and 'strongly' disagree (8%) that residential rehabilitation is supported by satisfactory clinical governance arrangements, compared to average (overall: 10%; strongly: 4%). Those at third sector services were less likely to 'strongly' disagree (0%).

In terms of whether residential rehabilitation is joined up with other local services, participants from statutory alcohol and drug services (41%) and other organisations (47%) were more likely to disagree than average (30%), while those from third sector organisations were less likely to disagree (15%.) These higher levels of disagreement were driven by higher levels of 'strongly' disagree (14%) among participants from statutory services and higher levels of 'tend to' disagree (40%) from those at other organisations, compared to average (strongly: 8%; tend to: 23%). Participants from third sector services were less likely to 'tend to' disagree (12%).

Almost half of those working at third sector alcohol and drug services agreed (48%) that residential rehabilitation offers value for money. This was more than average (38%), driven by higher proportions saying 'tend to' agree (35% vs 23% average). Meanwhile, participants at statutory alcohol or drug services were less likely to agree (24%) and more likely to disagree (24%) than average (agree: 38%; disagree: 16%), driven by higher levels of 'tend to' disagree (19%) than average (11%). At least a third at both organisation types said neither agree nor disagree (statutory: 41%; third sector: 35%).

Other differences

Participants who had visited a residential rehabilitation facility were more likely to agree that:

- residential rehabilitation is grounded in an evidence base (75%), compared to those who had not visited (49%). Those who had not visited were more likely to have reported that they did not know (15%) compared to those who had (2%)
- it provides a person-centred approach (70%), compared to those who had not visited (55%)
- it is supported by satisfactory clinical governance arrangements (57%), compared to those who had not visited (36%). A quarter (25%) of those who had not visited said they did not know if residential rehabilitation was supported by satisfactory clinical governance, higher than those who had visited (12%)

- it offers value for money (47%), compared to those who had not visited (17%). Again, a quarter (25%) of those who had not visited said they were unsure if residential rehabilitation offers value for money, compared to only 5% of those who had previously visited a facility

- it is easily accessible (32%), compared to those who had not visited (6%). For this statement, a greater proportion of participants disagreed than agreed in both groups, though this was more likely among those who had not visited (70%), driven by high levels of 'strongly' disagree (32%). This compared to half (50%) of those who had made visits disagreeing, and 17% 'strongly' disagreeing. There were several other differences including:

    - participants in urban areas were more likely to disagree that residential rehabilitation is supported by satisfactory clinical governance arrangements (12%), than those in rural areas (0%)

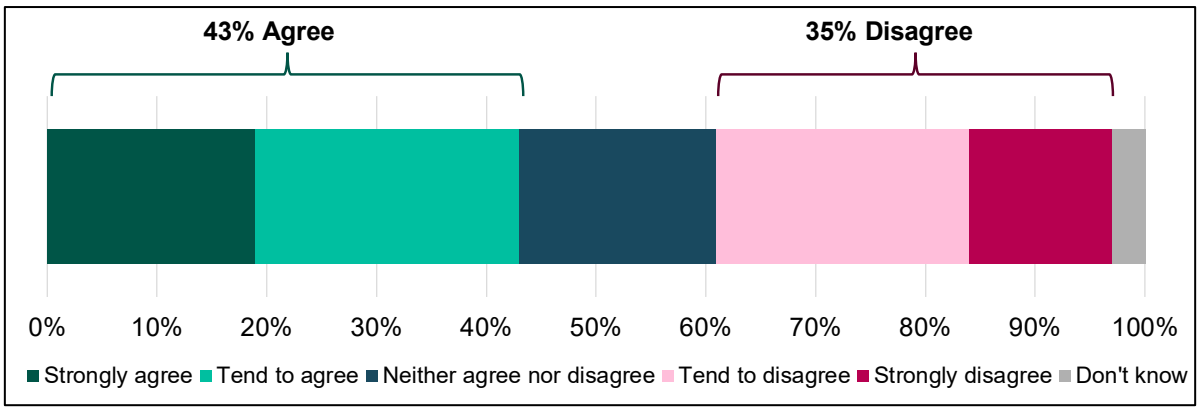
    - participants with more than 10 years' experience in the sector were more likely to disagree that residential rehabilitation is joined up with other local support services (40%), compared to those with 10 years' experience or fewer (19%)

    - participants with a background in addiction support work and counselling were more likely to agree residential rehabilitation offers value for money (51%), compared to those with a healthcare background (23%). Those with a background in healthcare were more likely to disagree that residential rehabilitation is joined up with other local support services (38%), compared to those with a background in addiction support work and counselling (15%)

Only valid for a small number of people

Another statement put to participants was 'residential rehab is only a valid option for a small proportion of people.' Slightly more participants agreed that this was the case (43%) than disagreed (35%), as shown in Figure 8.2. A total of 18% said they neither agreed nor disagreed, and 4% were unsure.

Figure 8.2: Extent to which participants agree or disagree that residential rehabilitation is only valid for a small proportion of people



Source: IFF Research survey of organisations that can refer to residential rehabilitation. D1-2. To what extent do you agree or disagree that residential rehab is only a valid option for a small proportion of people? Base: all participants (168).

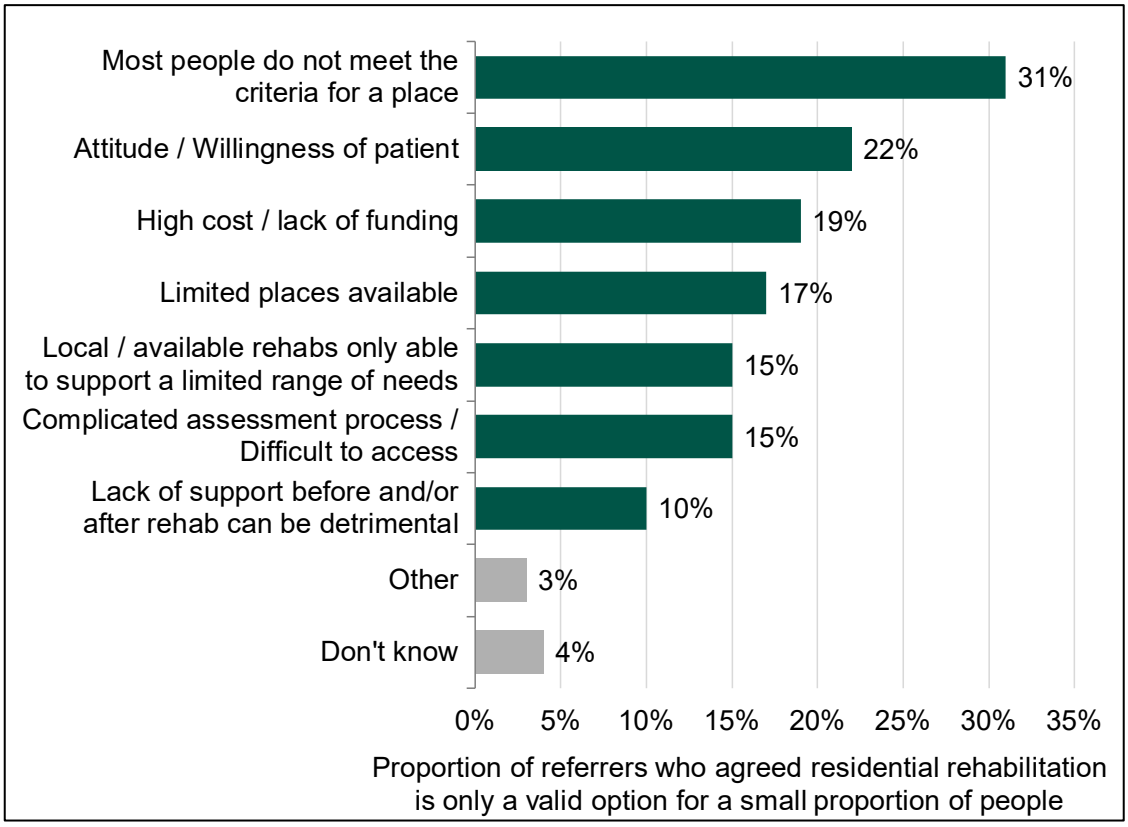
Participants who had previously visited a rehabilitation facility were more likely to disagree (41%) that residential rehabilitation is only valid for a small proportion of people than those who had not visited (23%). Those who had not visited a facility were more likely to 'strongly' agree (30%) that it was only valid for a small proportion of people, and also more likely to say they did not know whether this was the case (11%), compared to those who had visited (strongly: 14%; don't know: 0%).

More than half (58%) of participants who reported no tradition of referral agreed with this statement, compared to just over a third (35%) of those who reported a tradition of referring in their area.

Participants who agreed that residential rehabilitation was only valid for a small proportion of people were asked why they felt this was the case. This was asked as a free-text question, and responses were coded to common themes. The most common reason, given by three in 10 (31%), was that most clients do not meet the criteria for a place in residential rehabilitation, as shown in Figure 8.3. In several cases, this referred specifically to criteria set by residential rehabilitation facilities, but others did not specify the source of the criteria. This was followed by the attitude or willingness of the client (22%), the high cost and/or lack of funding (19%), and limited places being available (17%). Other reasons given included that local or

available rehabilitation facilities are only able to support a limited range of needs (15%), and a complicated assessment process or other difficulties accessing places (15%). One in 10 who felt residential rehabilitation was only valid for a small proportion of people said that the lack of support before and/or after rehabilitation placements can be detrimental (10%).

Figure 8.3: Reasons participants agreed that residential rehabilitation is only valid for a small proportion of people



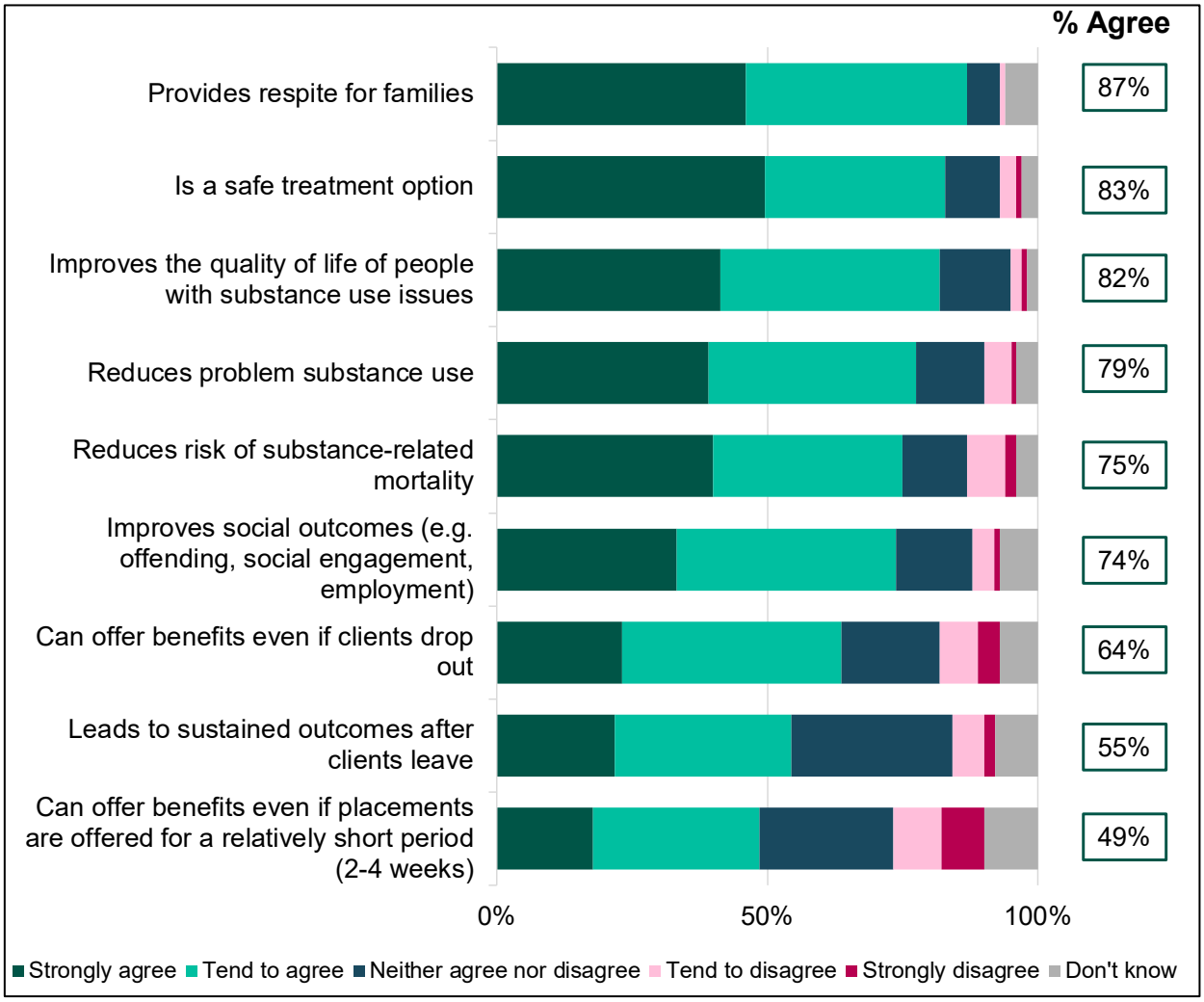
Source: IFF Research survey of organisations that can refer to residential rehabilitation. D2 You said that you agree that residential rehab is only a valid option for a small proportion of people, why do you say that? Base: participants who agreed residential rehab is only a valid option for a small proportion of people (72).

Participants who said that there was no tradition of referring to residential rehabilitation in their area (23%) were more likely to cite a complicated assessment process, compared to those who had a tradition of referral (6%). There were no other significant differences for this question, as due to the base size most subgroups were too small.

Views on aims and benefits

Participants were asked to what extent they agreed with various statements about the aims and potential benefits of residential rehabilitation as a treatment option. The majority of participants agreed that the residential rehabilitation provides respite for families (87%), is a safe treatment option (83%), and improves the quality of life of people with substance use issues (82%), as shown in Figure 8.4. Agreement was also high for the statements that residential rehabilitation reduces problem substance use (79%), reduces the risk of substance-related mortality (75%), and improves social outcomes such as offending, social engagement and employment (74%). Proportions 'strongly' agreeing with these statements were markedly lower.

Figure 8.4: Participant views on the aims and benefits of residential rehabilitation



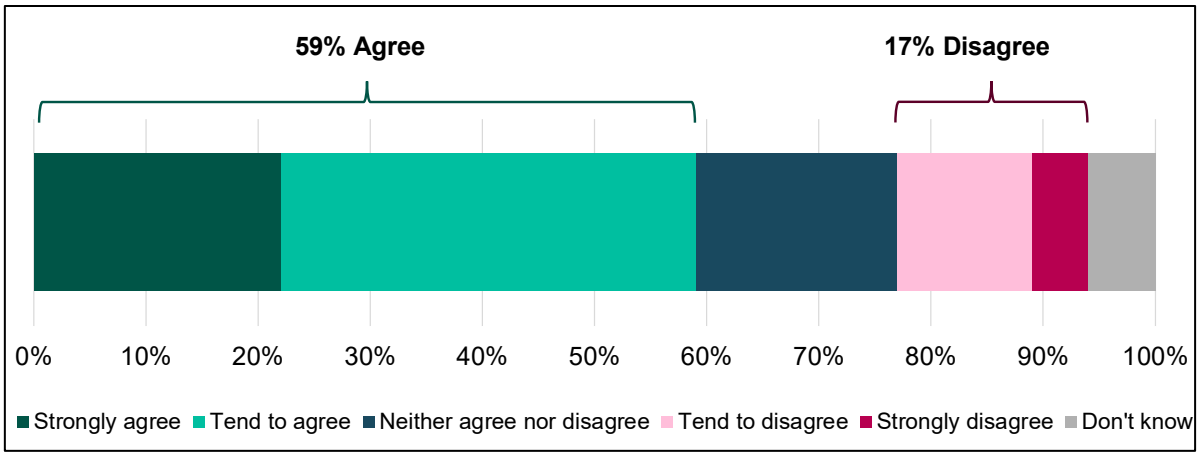
Source: IFF Research survey of organisations that can refer to residential rehabilitation. D3 To what extent do you agree or disagree that residential rehab…? Base: all participants (168), except 'can offer benefits even if placements are offered for a relatively short period (2-4 weeks)' and 'provides respite for families' (145, initially all participants, reduced to online only post-pilot).

Almost two-thirds (64%) agreed that residential rehabilitation can offer benefits even if clients drop out, while just over half (55%) agreed that it leads to sustained outcomes after clients leave. For this measure, three in 10 (30%) said they neither agreed nor disagreed. Just under half (49%) agreed that residential rehabilitation can offer benefits even if placements are offered for a relatively short period of 2–4 weeks. However, only 17% disagreed, with a high level of neither agree nor disagree (25%) responses, and one in 10 (10%) being unsure.

Previous clients

Participants were asked whether most of their previous clients who had gone to residential rehabilitation had benefited from doing so. As shown in Figure 8.5, almost six in 10 (59%) agreed that their previous clients had benefitted from residential rehabilitation, while only 17% disagreed. A total of 18% neither agreed nor disagreed, and 6% said they were unsure.

Figure 8.5: Whether participants agree most of their clients who have been to residential rehabilitation have benefitted from doing so



Source: IFF Research survey of organisations that can refer to residential rehabilitation. D4 To what extent do you agree with the following statement? 'Most of

my clients who have gone to residential rehab, have benefitted from doing so.' Base: all participants able to make referrals (152).

Differences by service type

Participants working in third sector alcohol and drug services were more likely to agree with several of the statements:

- residential rehabilitation is a safe treatment option (98%), compared to 83% on average
- residential rehabilitation improves the quality of life of people with substance use issues (90%), compared to average (82%)
- residential rehabilitation reduces problem substance use (88%), compared to average (79%)
- reduces the risk of substance-related mortality (90%), compared to average (75%)
- residential rehabilitation leads to sustained outcomes after clients leave (69%), compared to average (55%)
- residential rehabilitation can offer benefits even if placements are only for a short period (67%), compared to average (49%)

Participants working at statutory alcohol or drug services were less likely to agree that residential rehabilitation is a safe treatment option (73%), compared to average (83%). They were also less likely less likely (33%) than average (49%) to agree that residential rehabilitation can offer benefits even if placements are only for a short period.

There were also some differences for participants working for other organisations – other organisations included primary care or hospital services, social care services, mental health services, integrated services, homeless shelters and services, women's support services and services for children and young people. These participants were less likely to agree that residential rehabilitation leads to sustained

outcomes after clients leave (33%) compared to average (55%). They were also more likely (17%) than average (7%) to say they were unsure whether residential rehabilitation improves social outcomes.

Other differences

Participants who had made a referral to residential rehabilitation in the last three months were more likely to agree than average with all measures, apart from providing respite for families. Across almost all the measures, participants who had previously visited a residential rehabilitation facility were more likely to agree, as shown in Table 8.1.

Table 8.1: Proportion agreeing with aims and benefits of residential rehabilitation, by whether the participant has visited a rehabilitation facility

Aim and benefit	Visited a residential rehabilitation facility	Not visited a residential rehabilitation facility
Provides respite for families	92%	77%
Is a safe treatment option	87%	74%
Improves the quality of life of people with substance use issues	88%	68%
Reduces problem substance use	88%	58%
Reduces risk of substance-related mortality	81%	62%
Improves social outcomes (e.g. offending, social engagement, employment)	80%	60%
Can offer benefits even if clients drop out	73%	43%
Leads to sustained outcomes after clients leave	63%	36%

Can offer benefits even if placements are offered for a relatively short period (2–4 weeks)	57%	33%

Source: IFF Research survey of organisations that can refer to residential rehabilitation. D3. To what extent do you agree or disagree that residential rehab…? Base: Visited a residential rehabilitation facility (115), Not visited a residential rehabilitation facility (53), except 'can offer benefits even if placements are offered for a relatively short period (2-4 weeks)' and 'Provides respite for families' (Participants who completed the survey online: Visited: 97, Not visited: 48).

Participants who had visited a rehabilitation facility were also more likely to agree that most of their previous clients who had gone to residential rehabilitation had benefited from doing so (65%), compared to those who had not visited a facility (40%). Those who had not visited a residential rehabilitation facility were more likely to say they neither agreed nor disagreed (29%) or were unsure (17%), compared to those who had visited (15%; 2%).

Participants with no tradition of referring to residential rehabilitation were less likely to agree that residential rehabilitation can offer benefits even if clients drop out (56%), compared to three-quarters (76%) of those with a tradition. They were also less likely to agree that residential rehabilitation leads to sustained outcomes after clients leave (42%), compared to those with a tradition (65%).

In addition, participants with lived experience of substance use issues were more likely to agree that residential rehabilitation reduces the risk of substance-related mortality (85%), compared to those without lived experience (70%).

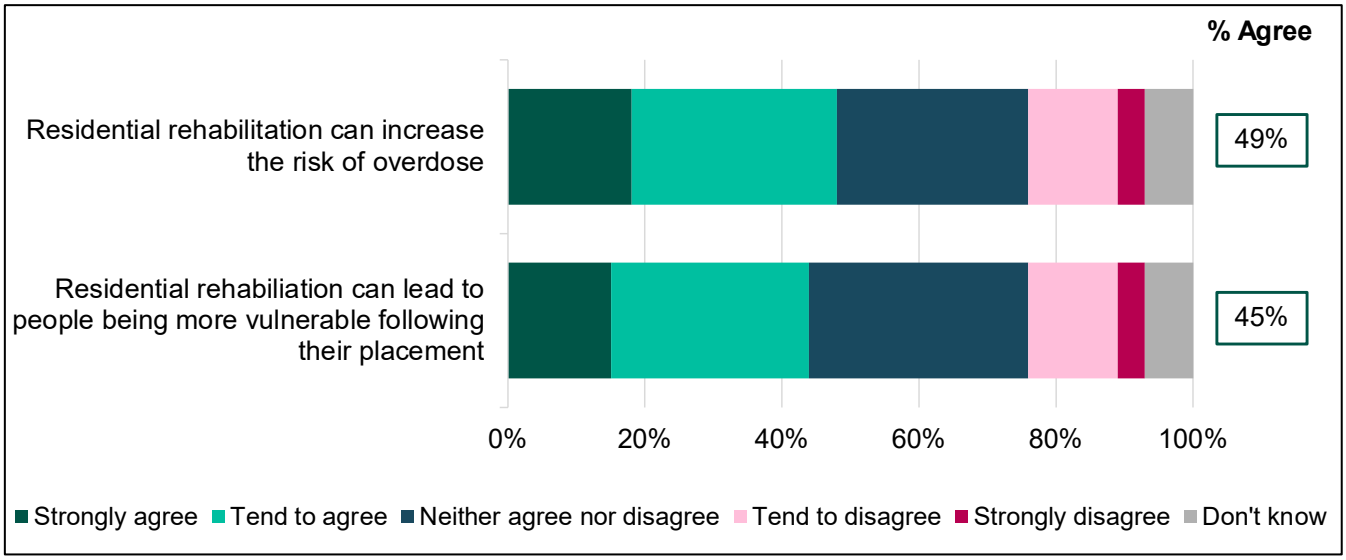
Views on risks

Participants were also asked to what extent they agreed or disagreed with a couple of statements about potential risks related to residential rehabilitation. Just under half (49%) of participants agreed that residential rehabilitation can increase the risk of overdose, as shown in Figure 8.6. Over a quarter (28%) said they neither agreed nor disagreed, 17% disagreed, and 7% were unsure.

Forty-five per cent agreed that residential rehabilitation can lead to people being more vulnerable following their placement, followed by 32% who neither agreed nor disagreed, 16% who disagreed, and 7% who were unsure.

This shows that participant views were highly nuanced, given the high proportion of participants who agreed residential rehabilitation is a safe treatment option (83%).

Figure 8.6: Extent to which participants agree with statements on potential risks



Source: IFF Research survey of organisations that can refer to residential rehabilitation. D3. To what extent do you agree or disagree that residential rehab…? Base: all participants (168).

As perhaps expected, participants who agreed with one of the statements were more likely to agree with the other.

The following groups were more likely to agree that residential rehabilitation can increase the risk of overdose.

- Participants who worked at statutory alcohol and drug services (63%) compared to average (49%). Participants with over 10 years' sector experience (56%), compared to those with 10 years' experience or fewer (40%).

- Those who reported a tradition of referring in their area (59%), compared to average (49%).
- Those who had discussed residential rehabilitation with over half of their clients (70%), compared to average (49%).
- Participants who disagreed that residential rehabilitation was only valid for a small proportion of people (59%), compared to average (49%).
- Participants where more than half of their clients had issues with drugs only (65%), compared to average (49%).

Likelihood of considering referral for different groups

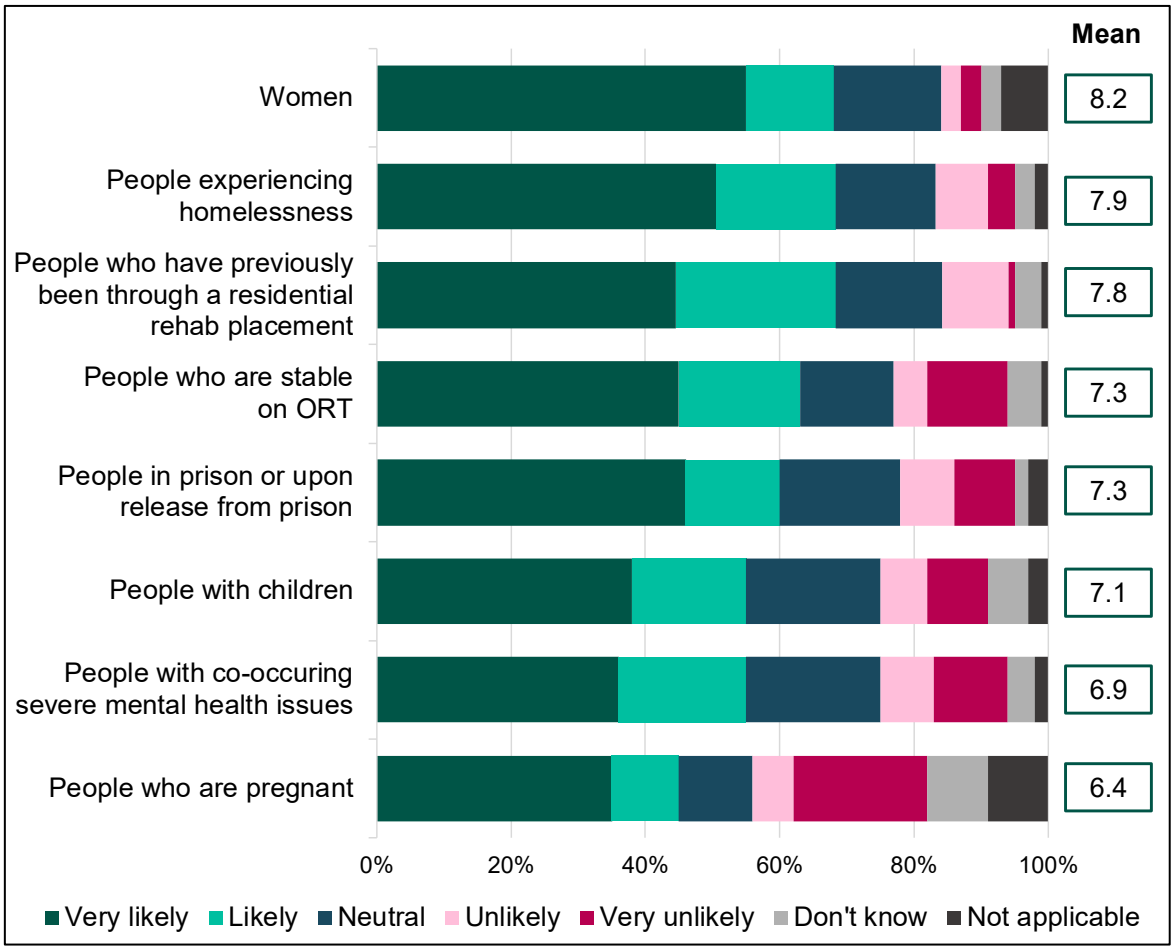
Participants who said they could make referrals were asked how likely they would be to consider referring people from several different groups. Their answer was given on a scale from one to 10, with one being 'Not at all likely', and 10 being extremely likely. Overall averages (means) have been calculated, as well as being consolidated into five measures as follows in Figure 8.7:

- Very unlikely (1–2).
- Unlikely (3–4).
- Neutral (5–6).
- Likely (7–8).
- Very likely (9–10).

On average, participants said they would be most likely to consider referring women (8.2), people experiencing homelessness (7.9), and people who have previously been through a residential rehabilitation placement (7.8). This is followed by people who are stable on ORT (7.3), people in prison or on release from prison (7.3), and people with children (7.1). On average, participants gave lower likelihood scores for people with co-occurring severe mental health issues (6.9) and people who are pregnant (6.4). It is worth noting the small subgroups of participants who reported

that they were ‘very’ unlikely to consider referral for certain groups, including people who are pregnant (20% of participants were very unlikely to consider referral); people who are stable on ORT (12%), people with co-occurring severe mental health issues (11%) and people with children (9%).

Figure 8.7: Likelihood of participants considering referral to residential rehabilitation for different groups



Source: IFF Research survey of organisations that can refer to residential rehabilitation. C4. How likely would you be to consider referring people from the following groups to residential rehab:…? Base: participants able to make referrals who completed online survey (130), except ‘People with Children’ and ‘People who are stable on ORT’ (152: all participants able to make referrals).

Differences in the likelihood of referral

Participants who had made a referral to residential rehabilitation in the last three months were more likely than those who had not to consider referring all the client groups mentioned in Figure 8.7. This is except for people with co-occurring severe mental health issues.

Unsurprisingly, participants who agreed that residential rehabilitation was only valid for a small number of people were less likely to consider referring all client groups listed in Figure 8.7.

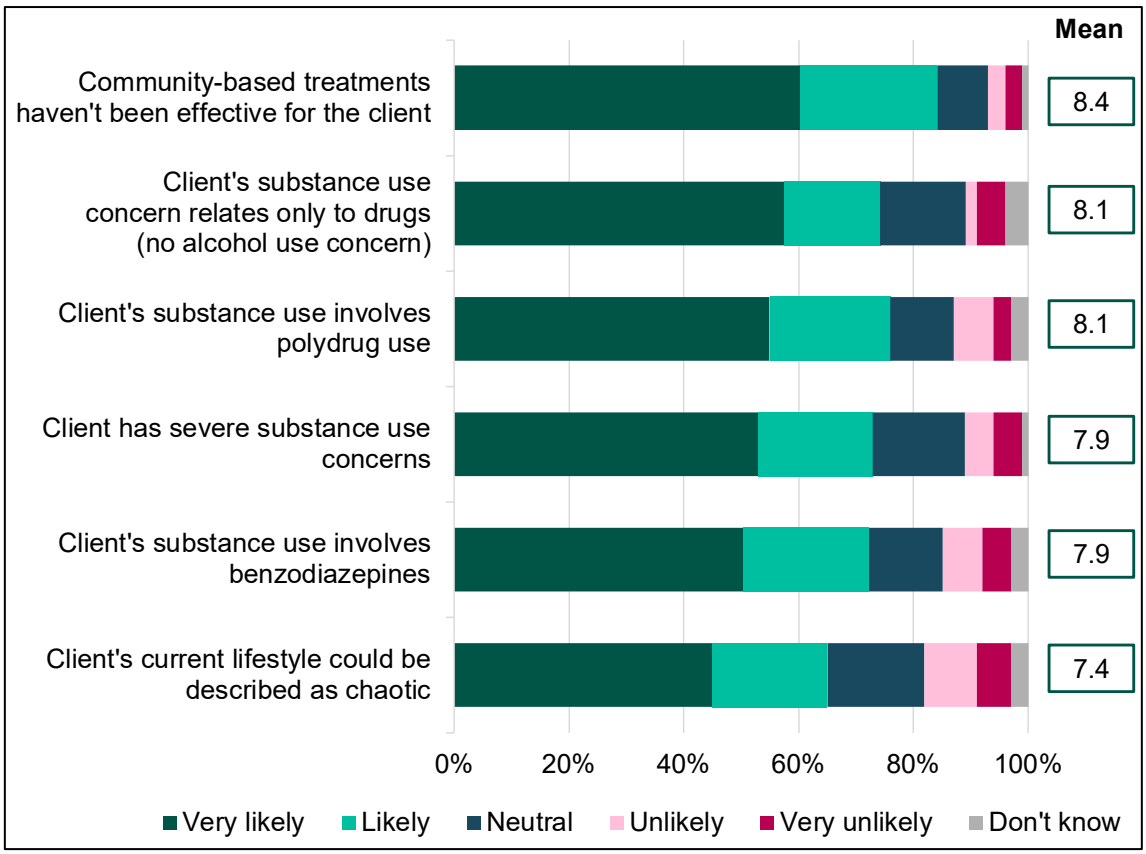
Likelihood of considering referral in specific circumstances

Participants were also asked about their likelihood of considering referring people in different circumstances to residential rehabilitation. As with the previous question, this was given on a scale from one to 10, with one being ‘Not at all likely’, and 10 being extremely likely, with means calculated as well as scores consolidated as follows:

- Very unlikely (1–2).
- Unlikely (3–4).
- Neutral (5–6).
- Likely (7–8).
- Very likely (9–10).

As shown in Figure 8.8, on average, participants were most likely to consider referring clients where community-based treatments had not been effective (8.4), followed by those where the substance use concern was solely drugs (8.1) and those with polydrug use (8.1). This was followed by clients with severe substance use concerns (7.9) and clients whose substance use involves benzodiazepines (7.9). The circumstances where participants were least likely to consider referral on average (7.4), was where the client’s current lifestyle could be described as chaotic.

Figure 8.8: Likelihood of participants considering referral to residential rehabilitation for people in different circumstances



Source: IFF Research survey of referrers. C5. How likely would you be to consider referring people to residential rehab in the following circumstances? Base: all participants were able to make referrals (152), except 'Client's substance use concern relates only to drugs' (130, participants able to make referrals who participated in online survey).

Differences in likelihood

There were a few differences in the likelihood of considering referral between subgroups. Participants who had made a referral to residential rehabilitation in the last three months were more likely to consider referring people in all circumstances listed, compared to those who had not made any referrals.

Participants who agreed that residential rehabilitation is only valid for a small proportion of people were less likely than those who disagreed to consider referral for all client circumstances included in Figure 8.8. This is except for instances where

community-based treatments had not been effective for the clients. Community-based treatment not having been effective was the only circumstance where participants were equally likely to consider referring, irrespective of whether they thought rehabilitation was only valid for a small proportion of people or not.

Participants with lived experience of substance use issues were more likely than those without to consider referring clients with severe substance use concerns (8.5 vs 7.6), due to fewer saying they would be unlikely to consider referral (0% vs 8%). Participants with a background in addiction support or counselling were also more likely to consider referral for clients with severe substance use concerns (8.5), compared to those with a background in healthcare (7.4).

Other differences included:

- Participants in rural areas were more likely to consider referral for clients whose lifestyle could be described as chaotic (8.4), compared to participants in urban areas (7.2). Just over half (52%) of participants in rural areas gave a score of 10, ‘extremely likely’, compared to three in 10 (31%) of those in rural areas.

9 Barriers and overcoming them

Barriers

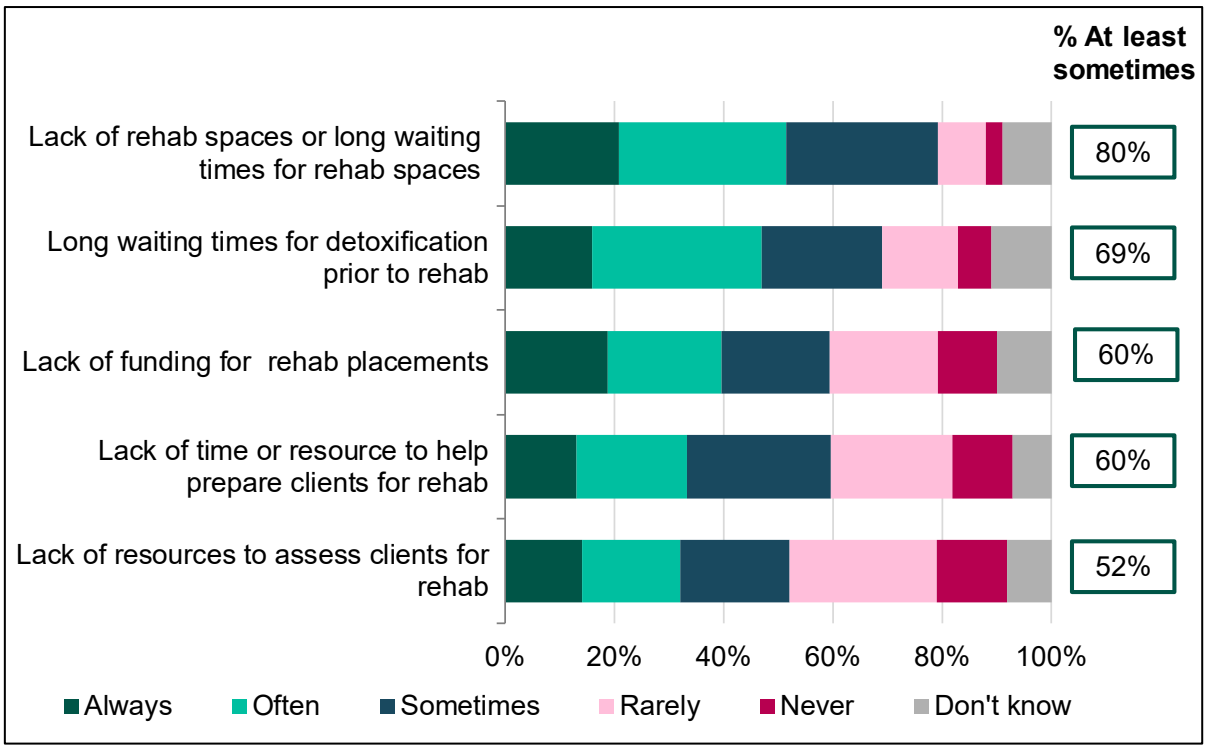
Participants identified various barriers to making referrals to residential rehabilitation that related to structural factors in the process of making a referral; characteristics and considerations of the client; and perceptions and practices of referrers.

Structural factors

As shown in Figure 9.1, the most common structural barriers are related to the following points:

- Capacity of residential rehabilitation providers: a lack of rehabilitation spaces or long waiting times for spaces. 80% of participants reported this was a barrier at least sometimes and 21% said it was always a barrier to making a referral. More specifically, long waiting times for detoxification, a common requirement for clients to meet before entering residential rehabilitation, was a barrier at least some of the time for 69% of participants.
- More than half of participants said lack of funding for rehabilitation placements was a barrier at least sometimes (60%).
- Lack of time or resources to help prepare clients for rehabilitation was reported as a barrier at least sometimes by 60% of participants and lack of resources to assess clients for rehabilitation was a barrier at least sometimes for 52% of participants.
- In addition, not having a rehabilitation facility close enough to where clients live was also commonly identified as a barrier. As shown in Figure 9.2, this was a barrier to at least some extent for more than half of the participants (58%).

Figure 9.1: How often structural factors are a barrier to referring someone for rehab



Source: IFF Research survey of organisations that can refer to residential rehabilitation. E1. How often are the following factors a barrier when you try to refer someone for rehab? Base: all referrers (152).

Differences in the prevalence of structural barriers

The frequency that structural factors in the referral process were identified as barriers varied by organisation type, whether participants had visited a residential rehabilitation facility, and area type. Some differences were also observed based on the locality of a residential rehabilitation facility.

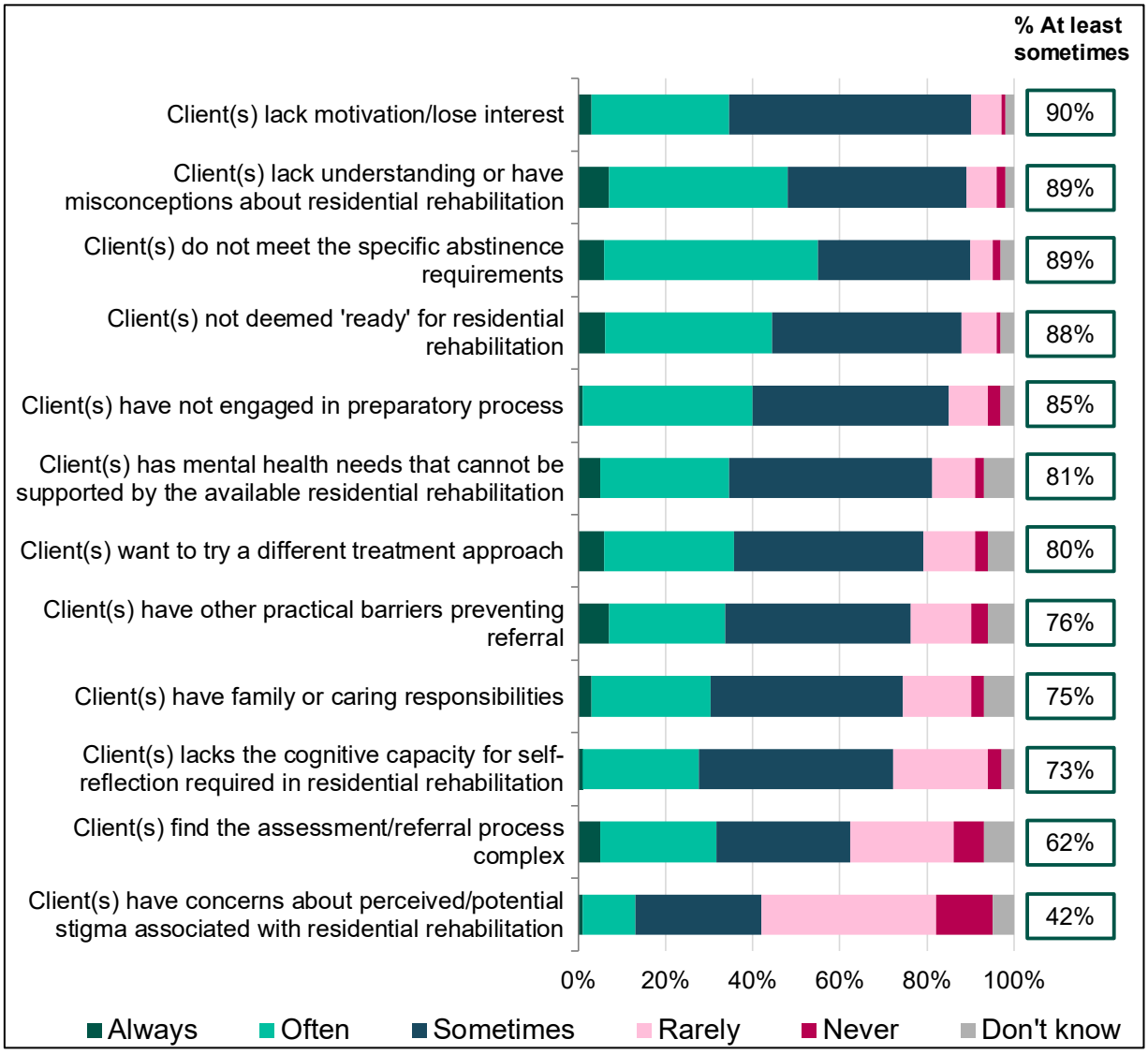
- Participants working in third sector alcohol and drug services were more likely to identify lack of space or long waiting times as always a barrier (31%). This group was also more likely to report that long waiting times for detoxification were at least sometimes a barrier (81%), compared to 58% of participants in NHS services, suggesting that pathways to detoxification services may be easier to access for participants working within the NHS.

- All structural barriers were identified more commonly by participants who had not previously visited a residential rehab centre.
- Those who lived in a rural area more commonly identified not having a rehabilitation facility close enough as a barrier at least to some extent compared to those in an urban area (77% vs 53%).

Client-related factors

Barriers to making referrals that are related to client factors were commonly linked to their understanding or attitude towards residential rehabilitation, their suitability or readiness for residential rehabilitation, or other practical barriers because of the client's circumstances or the requirements of the facility.

Figure 9.2: How often client factors are a barrier to referring someone for rehab



Source: IFF Research survey of organisations that can refer to residential rehabilitation. E2. How often are the following factors a barrier when you try to refer someone for rehab? Base: all participants able to refer personally (152).

The vast majority of participants reported that clients lacking motivation or losing interest (90%; always 3%), or lacking understanding or having misconceptions about residential rehabilitation (89%; always 7%), was a barrier at least sometimes, as shown in Figure 9.2. It was also common for clients to want to try a different approach, and this was indicated to be a barrier at least some of the time by 80% of participants (always 6%). Interestingly, less than half of participants said client

concern about perceived or potential stigma was a barrier at least sometimes (42%; always 1%).

Readiness for residential rehabilitation was a common barrier in terms of engaging with preparatory processes: 85% reported that clients not engaging in the preparatory processes necessary for a referral was a barrier at least some of the time, and approximately two-thirds said clients found the assessment or referral process complex (62%; always 5%). Suitability of clients for residential rehabilitation was also judged by participants in terms of not being deemed 'ready' for residential rehabilitation, (88% at least sometimes; always 6%) or lacking the cognitive capacity for the self-reflection required in residential rehabilitation (73% at least sometimes; always 1%).

Owing to the requirements of some residential rehabilitation facilities or the availability of specialised facilities, practical barriers were also common. Clients not meeting specific abstinence requirements was a barrier at least sometimes for 89% of participants (always 6%), and the clients having mental health needs that cannot be supported in available residential rehabilitation was a barrier for 81% (always 5%). Around three-quarters of participants said that clients had practical barriers such as housing (76%; always 7%), or family or caring responsibilities (75%; always 3%) at least some of the time. Of the other barriers that participants identified in free-text answers, the attitude or lifestyle of the client and facilities being unwilling or unable to take on certain individuals were mentioned by 10% for each.

Differences in the prevalence of client barriers

Some differences in client-related barriers were found based on the type of area participants worked in and the presence of a local rehabilitation facility.

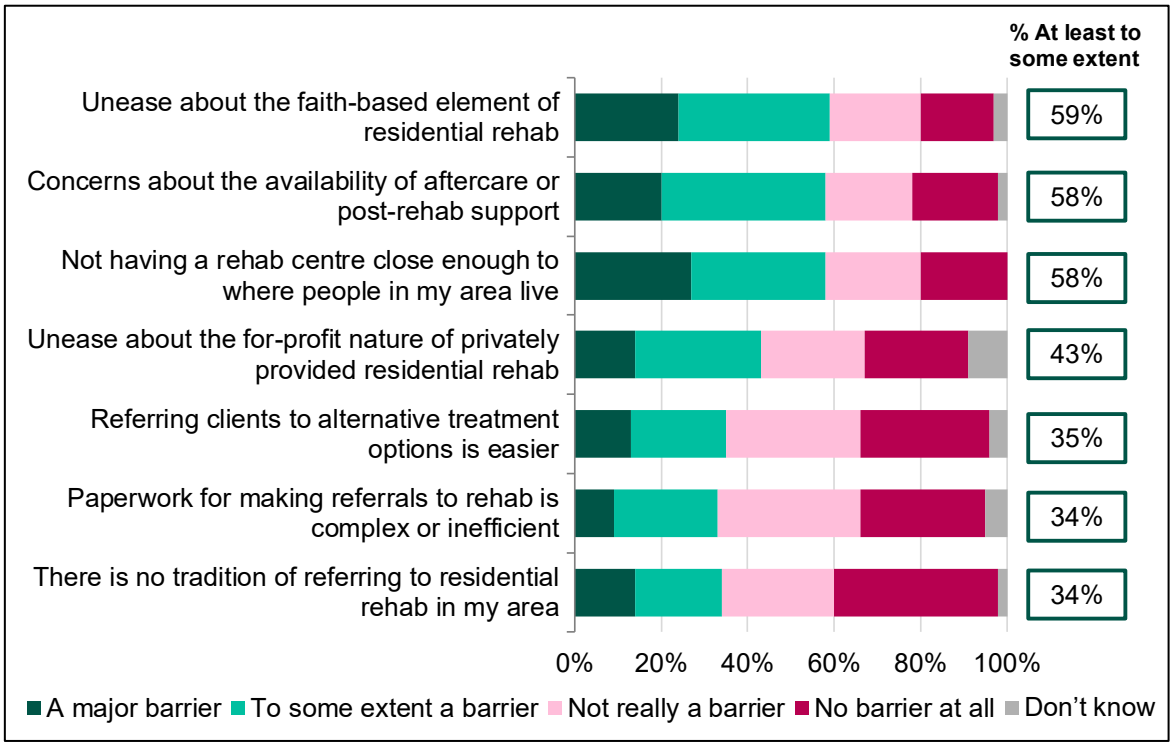
Participants based in rural areas were more likely to say that concerns over stigma (61% vs 37%) was a barrier at least some of the time, compared to those working in urban areas.

Participants in areas without a residential rehabilitation facility were more likely to identify having family or caring responsibilities (82% vs 66%) as being a barrier at least sometimes, compared to those with a local residential rehabilitation facility.

Referrer-related factors

Participants' perceptions of residential rehabilitation were a common barrier to making referrals, as were factors related to individuals' referral practices.

Figure 9.3: How often referrer-related factors are a barrier to referring someone for rehabilitation



Source: IFF Research survey of organisations that can refer to residential rehabilitation. E2a. To what extent are the following factors a barrier to referring for you? Base: all participants able to refer personally (152).

The survey highlighted unease or concern about residential rehabilitation that was reported as a barrier to at least some extent by participants. As shown in Figure 9.3, the most common of these were unease about the faith-based element of residential rehabilitation (59%) and concerns about the availability of aftercare (58%). There was also unease about the for-profit nature of privately provided residential rehabilitation (43%).

Referral-related barriers were also reported to some extent for 34% of participants who said there was no tradition of referring to residential rehabilitation in their area, and 35% of participants who found that referring to other treatment options was

easier. Lastly, 34% of participants perceived that the paperwork for making referrals was complex or inefficient as a barrier to making referrals to residential rehabilitation.

Differences in the prevalence of referrer barriers

The barriers experienced by participants relating to their perceptions and practices varied depending on whether they had a tradition of making referrals in their area or had visited a facility.

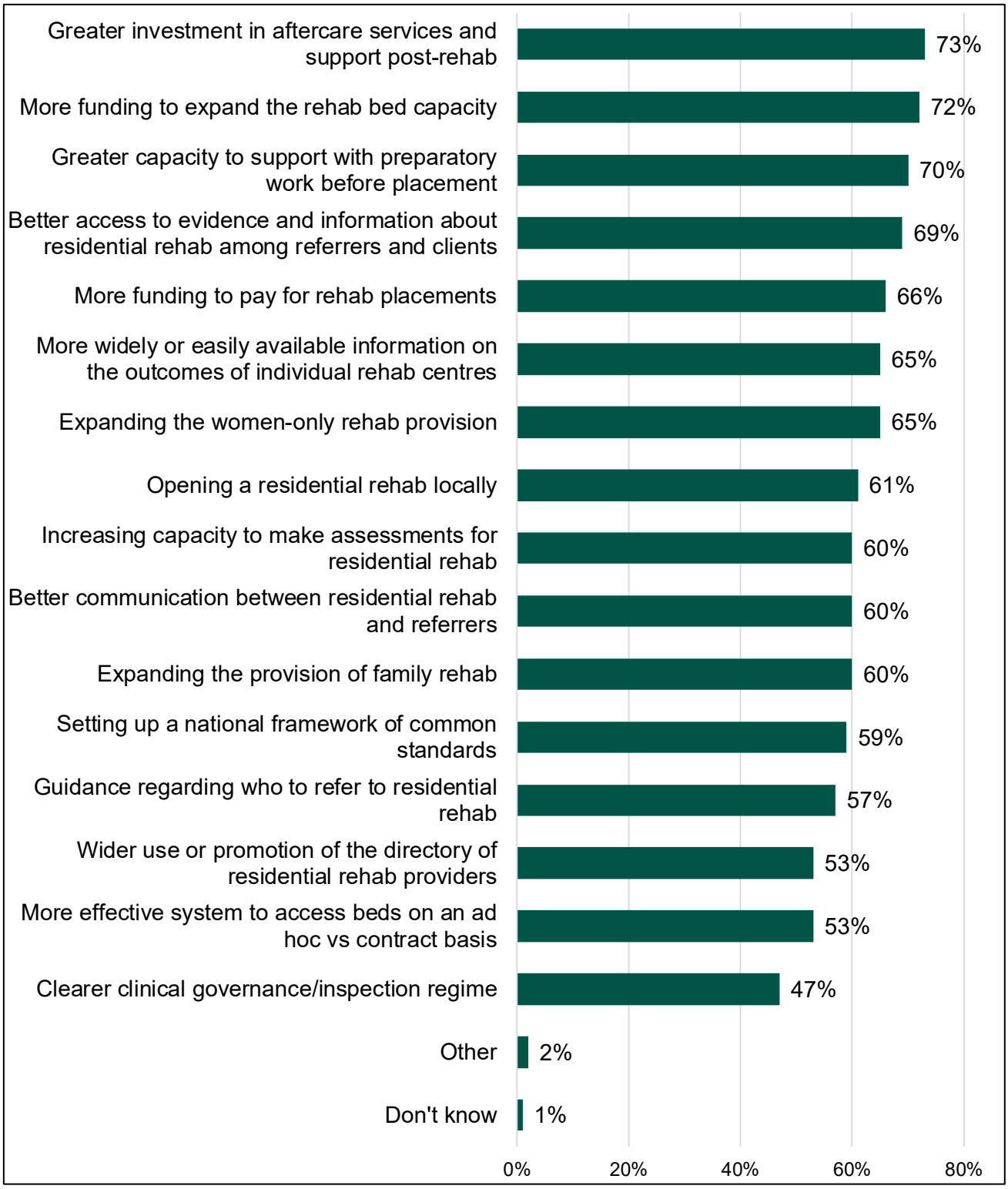
Participants who reported that there was not a tradition of referring to residential rehabilitation more commonly identified barriers relating to paperwork making referrals complex or inefficient (56% vs 22%), concern about the support being faith-based (75% vs 51%) of for-profit (60% vs 34%), and lack of aftercare or post-rehabilitation support available (71% vs 51%), compared to those who did have a tradition of making referrals in their area.

It was more common for those who had not visited a facility to identify the following barriers: making referrals to other treatment options was seen as easier (48% vs 30%), the paperwork for making referrals was seen as complex or inefficient (48% vs 28%), and they reported unease about the faith-based (71% vs 54%) or for-profit nature of treatment (57% vs 37%).

Addressing barriers

Participants identified a number of ways in which barriers could be addressed to support them to make referrals. The most common suggestions from participants to address barriers, as shown in Figure 9.4, focused on increased funding and capacity, and greater availability of information.

Figure 9.4: Suggestions to help address barriers



Source: IFF Research survey of organisations that can refer to residential rehabilitation. E4. What could help address the barriers you experience in referring for residential rehab? Base: all participants (152).

At least two-thirds of participants suggested scope for greater investment: more funding to expand the rehabilitation bed capacity (72%), more funding to pay for rehabilitation placements (66%), greater capacity to support with preparatory work (70%), and greater investment in aftercare services and support post-rehabilitation (73%). Moreover, many participants also called for increased provision for specific groups such as expanding the women-only rehabilitation provision (65%), expanding the provision of family rehabilitation (60%), and opening a residential rehabilitation locally (61%).

Participants also commonly suggested better access to evidence and information about residential rehabilitation among referrers and clients (69%) and more widely or easily available information on the outcomes of individual rehabilitation centres (65%) as mechanisms to address barriers.

Other suggested methods to overcome barriers were also selected by more than half of the participants:

- Better communication between residential rehabilitation and referrers (60%).
- Increasing capacity to make assessments for residential rehabilitation (60%).
- Setting up a national framework of common standards (59%).
- Guidance regarding who to refer to residential rehabilitation (57%).
- More effective system to access beds on an ad hoc vs contract basis (53%).
- Wider use or promotion of the directory of residential rehabilitation providers (53%).

Participants who worked in third sector alcohol and drug services were more likely to choose suggestions that were related to increasing provision. This included more funding to pay for placements (78%), expand bed capacity overall (88%), and for women-only provision (78%), as well as local facilities (76%). This group were also more likely to believe that having a greater capacity to make assessments (71%) and systems to access beds would help (69%). This resonates with some of the

specific barriers being experienced to a greater extent by this group concerning lack of space or long waiting times.

Participants who reported no tradition of making referrals to residential rehabilitation in their area were more likely to report, for almost all the suggestions mentioned, that they would help enhance the referral process, compared to those who did have a tradition of making referrals. In terms of funding and capacity, the majority of participants (81%) with no tradition of referring believed more funding to pay for placements (vs 59%), expanding provision of family rehabilitation (75% vs 53%), or opening a local rehabilitation facility (75% vs 54%) would help, and 83% felt that increasing capacity for assessments (vs 47%) or support with preparatory work (vs 62%) would address barriers. They also more frequently suggested that better access to evidence (90% vs 59%), and guidance regarding who to refer (83% vs 42%) would help overcome barriers, as well as better systems in terms of access to beds on an ad-hoc rather than contract basis (71% vs 43%), communication with facilities (79% vs 48%), and promotion of the directory of providers (65% vs 47%).

Most useful way to address barriers

Participants were asked in an open-text question which of the different suggestions would be most useful to help them to make referrals to residential rehabilitation. Responses indicated that greater information and improved systems for referrals would provide the most support.

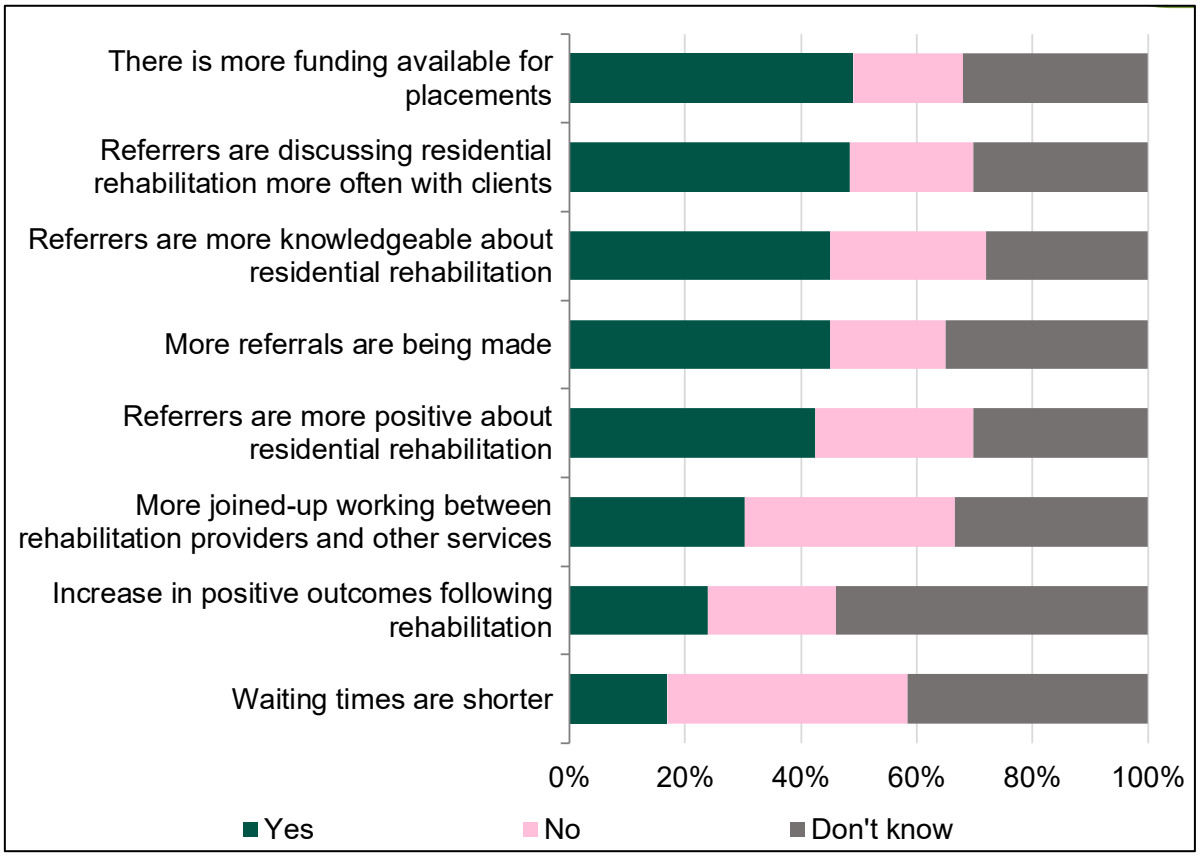
Just less than a third of participants said that access to more information and guidance would support them to make referrals (31%). This was more common among those who reported there was no tradition of referring to residential rehabilitation in their area (46%) and those who had not referred any of the clients they had seen in the past three months (41%).

Other suggestions included a more centralised or standardised system which connects organisations efficiently and provides consistent and accurate information (15%), more before and after rehabilitation support for referrers and clients (13%), and more places available (11%).

10 Early impacts of the National Mission

Participants were asked about any changes they had noticed in the approach to residential rehabilitation among participants in their organisation since the launch of the National Mission in 2021. Figure 10.1 shows participants' views regarding changes in approach.

Figure 10.1: Participant views on suggested changes in referrers' approach to residential rehabilitation since the launch of the National Mission



Source: IFF Research survey of organisations that can refer to residential rehabilitation. F1. Since the launch of the National Mission in 2021, have there been any of the following changes in the approach of referrers in your organisation? Base: all participants (168).

Just under half of participants agreed that there is more funding available for placements (49%), that participants are discussing residential rehabilitation more often with clients (48%), and that more referrals are being made (45%) since the

launch of the National Mission, indicating there was some sense of progress. Across all three statements, agreement was higher among participants who had a tradition of referring clients to residential rehabilitation. Table 10.1shows this in more detail. However, overall there were high levels of uncertainty across these suggested changes, ranging from 28% to 54%, suggesting that perceptions of change were either not being seen widely, or there was a lack of clarity in tying any changes back to the National Mission itself.

Table 10.1: Agreement by whether participants had a tradition of referral in their area

Statement	Tradition	No tradition
Agree: There is more funding available since the launch of the National Mission	58%	35%
Agree: Referrers are discussing residential rehabilitation more often with clients since the launch of the National Mission	61%	31%
Agree: More referrals are being made since the launch of the National Mission	58%	25%

Source: IFF Research survey of organisations that can refer to residential rehabilitation. Since the launch of the National Mission in 2021, have there been any of the following changes in the approach of referrers in your organisation? F1–3. There is more funding available for placements; F1–4. Referrers are discussing residential rehab more often with clients; F1–5. More referrals are being made. Base: all participants (168); respondents who had a tradition of referring to residential rehabilitation (97); respondents who did not have a tradition of referring to residential rehabilitation (52).

Just under half of the participants also agreed that referrers are more knowledgeable about residential rehabilitation (45%) and that referrers are more positive about

residential rehabilitation (42%). Across both statements, agreement was higher among participants who had a tradition of referring clients to residential rehabilitation in their area (53% and 53% respectively).

Most participants disagreed (42%) or were unsure (42%) that waiting times were shorter since the launch of the National Mission, with only one in five agreeing (17%). Third sector alcohol and drug services were more likely to disagree that waiting times were shorter (54%).

Participants were split on whether there was more joined-up work between rehabilitation providers and other services since the launch of the National Mission, with similar proportions of participants disagreeing (36%), being unsure (33%) and agreeing (30%). Participants were more likely to agree if they had a tradition of referring clients to residential rehabilitation in their area (37%), compared to those who did not have a tradition of referring in their area (21%).

More than half of the participants were unsure (54%) if there was an increase in positive outcomes following rehabilitation since the launch of the National Mission, while one-quarter agreed (24%) and one-fifth disagreed (22%).

11 Conclusions and recommendations

Conclusions

Overall, the findings suggest that many participants held the view that residential rehabilitation can be a beneficial treatment option, especially among those who had previously had greater exposure and engagement with residential rehabilitation. The evidence also provides examples of some of the barriers and basis for negative perceptions of residential rehabilitation, which facilitate the development of recommendations for action that could be considered by PHS.

It is important to note that conclusions about the perceptions of the wider referrer population should be drawn with caution. The sampling approach used was not representative, since we did not have access to a fully populated database of organisations that can refer to residential rehabilitation. The distribution of the survey through ADPs and other drug and alcohol service networks and the use of a census approach means it is possible that those who are more interested in residential rehabilitation and potentially hold more positive beliefs about it may have been more likely to respond to the survey, risking response bias. For example, two-thirds of the participants in our survey had previously visited a residential rehabilitation facility, while a third had not done so.

Nevertheless, the findings provide an informative baseline of referrer perceptions of residential rehabilitation. Generally, it was clear that greater exposure and engagement with residential rehabilitation had a positive impact on participants' views and made them more likely to consider residential rehabilitation as a treatment option in various circumstances. The perceived ease of access to residential rehabilitation seems to be linked to the likelihood of referring. Participants who perceived it as being more accessible were more likely to have discussed residential rehabilitation with clients and more likely to have referred individuals.

Conversely, this meant participants with less exposure and experience of residential rehabilitation were less likely to make referrals and reported greater concerns about residential rehabilitation as a treatment option. They also tended to believe there were more barriers to making referrals. Increasing engagement with and exposure to

residential rehabilitation may increase referring rates among those with less experience of it and may lead to changes in perceptions of residential rehabilitation. For example, this may be achieved through education, visits to rehabilitation centres, or building networks with colleagues who have more experience of clients going to residential rehabilitation.

Awareness of residential rehabilitation facilities in general was high, as was awareness of treatment provision available and who could benefit from residential rehabilitation. However, this needs to be considered alongside the finding that more participants agreed residential rehabilitation was a valid treatment option only for a small proportion of people than disagreed with this statement. Similarly, although there was a strong level of understanding of who could benefit from residential rehabilitation, evidence suggests that on average less than one in three people with substance use issues would be considered for referral.

Where overall awareness of treatment provision was lower it tended to relate to specific support facilities, such as for women or families, and the clinical governance of rehabilitation centres. Many participants identified issues with the clarity of the process for referring to residential rehabilitation. This was highlighted in the scoping interviews with ADPs, who emphasised that referral processes vary widely across ADP areas and residential rehabilitation providers and can be complex to navigate. While difficulties with the process of making referrals could prove a practical barrier to increasing referrals, the perception of the referral being a complex process could create an attitudinal barrier, leading to other treatment options being seen as simpler to refer to. Indeed, referral for other types of treatment such as recovery support groups, counselling and medication was common.

Only a small proportion of individuals seen by participants were referred to residential rehab. The evidence suggests an even smaller number are placed, although it is important to note that participants were asked about individuals they had seen in the past three months (so the proportion of successful placements may be higher but take longer than three months to materialise). Those with more exposure to residential rehabilitation, participants who had visited a residential

rehabilitation and those whose area had a tradition of referring, referred more individuals on average.

Even though the number of referrals made was relatively low, the majority of participants reported that they believed residential rehabilitation had several benefits for clients including providing respite for families of people with substance use issues and improving the quality of life of substance users. Many participants also agreed that residential rehabilitation is a safe treatment option and reduces both substance use and substance-related mortality. However, concerns that residential rehabilitation may increase the risk of overdose or leave people more vulnerable were also prevalent, giving a sense of the complexity of views that go into its consideration as a treatment option.

Participants had mixed views about whether they would consider clients for referral based on certain demographics or life circumstances. When asked about who they would consider referring to residential rehab, the likelihood of considering an individual for referral was particularly low for a number of identified groups. These included people who were pregnant, people who were stable on ORT, people with co-occurring severe mental health issues, and people with children.

Views of the evidence base for residential rehabilitation and its overall efficacy varied too. Few thought it was easily accessible and this often appeared to be a factor in shaping wider views of its suitability as a treatment option. Perceptions of whether it represents value for money and provides person-centred treatment were also mixed and likely complicated by the nuanced sense of possible outcomes from residential rehabilitation, but were balanced towards a more positive than negative assessment overall.

Some unease was also identified about the faith-based nature and, to a lesser extent, the for-profit nature of some rehabilitation facilities. The issue around the faith-based nature of some rehabilitation facilities was also uncovered during the scoping phase of research and emerged as being a widespread issue among participants from the survey responses. Whether this has an impact on the likelihood of referral itself and how this barrier can be overcome may be an issue worth considering in greater depth. Overall, it was evident that those who worked in the

third sector had greater confidence in the processes and approaches utilised by residential rehabilitation providers, compared to statutory providers.

Beyond the perceptions and views of residential rehabilitation held by referrers, a number of structural and client-related barriers were also prevalent. Lack of spaces or long waiting times, availability of places, and clients losing motivation or interest were prominent barriers to referral, as were lack of client understanding, clients not meeting abstinence requirements or being considered ‘ready’ for residential rehabilitation.

The most common suggestions from participants to address the barriers discussed focused on three areas: greater support for preparatory and aftercare services, increasing funding and capacity, and greater availability of information. More information and guidance was most commonly identified as a factor that would help facilitate more referrals. The need for information aligns with the findings that referrers with lower exposure and engagement with residential rehabilitation tend to hold more reservations about residential rehabilitation and are less likely to make referrals to it.

Lastly, in terms of changes since the beginning of the National Mission in 2021, the findings of this survey provide early signs that some attitudinal changes may be in progress, such as participants discussing residential rehabilitation with clients more, and being more positive about it as a treatment option. However, there were high levels of uncertainty about any changes, suggesting it may either be different across localities, too early to identify changes, or there is uncertainty about attributing the changes observed. Very few participants said waiting times were shorter, echoing concerns raised about waiting times being a barrier. This suggests waiting times may be a more persistent issue that could take longer to address.

The associated findings around waiting times for detoxification services being a concern; mixed responses about how well joined-up residential rehabilitation services are; and requests for greater levels of information and aftercare services, indicate a holistic approach to improving the residential rehabilitation system that may be required for it to function more effectively. The issue of improving the accessibility of aftercare may be a particularly relevant issue in light of widespread

concerns around increased vulnerability following a residential rehabilitation placement and the perceived increased risk of overdose.

Recommendations

Our recommendations cover policy-related actions and suggestions for future research.

Policy

- Mixed views around the evidence base, efficacy, and accessibility of residential rehabilitation are likely to impact the probability of discussing it as a treatment option and making referrals, representing key barriers that need to be overcome to improve equality of access for clients.
- Focus should be placed on making it clearer what residential rehabilitation achieves through improved communication between different services and providers. This will improve confidence in its efficacy as a treatment option.
- There is also a need to improve how joined-up residential rehabilitation and other support services are. In particular, the need for better connectivity with aftercare services may be an important area to focus on.
- More effective communications around the evidence base and value-for-money of residential rehabilitation could be supported by the adoption and implementation of national standards that would serve as an over-arching framework. This would help organisations to navigate a multitude of considerations when making referrals and support a more consistent referral process.
- Establishing a network of best practice between referrers and providers that showcases outcomes achieved from residential rehabilitation could support more active take-up, as exposure to residential rehabilitation and positive experiences of its outcomes is a critical feature of confidence in its efficacy and application. This may be an important means of expanding the number of organisations actively considering referral.

- The perceived accessibility of residential rehabilitation is likely to have a big influence on the likelihood of referral. Work around improving waiting list times and the process of referral is likely to be an important means of shifting views around referral.

Overall, we therefore recommend:

- Further work to establish the foundations for the residential rehabilitation system and making referrals. There is some uncertainty around who is most appropriate to refer and how to make referrals, as well as concerns over waiting times, places, and funding. Suggestions that could improve the foundations of the system include:
    - Improve mechanisms for information sharing among referrers to support their understanding of what services exist, how to access them, and how to make referrals in their area. This could also include information on capacity in the system, guidance on who to refer, and who to contact with queries.
    - Build capacity for referrals to turn into placements, for example increasing the number of beds, increasing the number of beds for specific groups such as women-only or family-based facilities, and making access to existing beds more straightforward for those without a facility in their area.
    - Explore options for a national framework of common standards in referral to residential rehabilitation, with room for flexibility at a local level. This could help referrers feel more confident in their decision-making, lessen any remaining historical biases, and streamline processes. This is linked to our first suggestion for future research, which would assist in understanding the current practices across different areas.
- Our research shows that those referrers who have had more engagement with residential rehabilitation are more likely to make referrals, suggesting that first-hand knowledge and experience lead to a more positive view.

Communicating the evidence basis for residential rehabilitation more widely may help, as doubts about this remain a barrier for some. Sharing outcomes for those who go to residential rehabilitation may also help, as well as encouraging referrers to visit a residential rehabilitation facility, to gain first-hand knowledge.

- Ensuring the infrastructure and capacity within the referral system and among rehabilitation facilities is in place is critical to address to support referrals to residential rehabilitation. Practical barriers that can prevent individuals from taking up their place, or being referred initially:
    - Waiting lists for assessments, residential rehabilitation itself, and the detoxification required by many facilities can prevent both referrers and clients from pursuing residential rehabilitation for treatment. In fact, the top barrier that participants reported that clients lacked, or lost interest or motivation, may be partly connected to the result of long waiting times.
    - Strict eligibility criteria at rehabilitation facilities were also a common practical barrier, such as requiring total abstinence. Scoping research suggested that this could include not permitting any prescription drugs, or individuals already stable on ORT. A review of these criteria could be undertaken to ensure they do not create any unnecessary barriers, as well as ensuring there are sufficient facilities available to suit a variety of needs.

Future research

Our recommendations also focus on areas for further research and development to help address knowledge gaps and guide future decision-making for the range of associated agencies within the referral and rehabilitation system.

- We recommend undertaking a systems mapping exercise of how referring works in each area, including the different stages of the process, who can refer, and how it operates in practice. These different approaches could then be evaluated to identify opportunities to simplify or standardise aspects of

the process while recognising the need for flexibility locally. There would be an additional benefit if this exercise included workforce mapping, in terms of understanding who is making referrals or can make referrals. This would facilitate future research with referrers, as well as identify any gaps in provision. For example, in our research it proved difficult to find anyone in children's services who was able to refer – this could be because very few people in that sector have the authority to refer or because of the lack of provision for those aged younger than 18. This could build on the residential rehabilitation pathway development work currently undertaken by Healthcare Improvement Scotland which is exploring existing pathways and scope for improvement.

- Further exploration of the factors determining the likelihood of referring, and the impact of this on referrals made would also be beneficial. For example, looking at client circumstances such as stage in the recovery journey, their drug use profile, wider personal circumstances, as well as key demographics. Examining the relationships between referrers, clients and residential rehabilitation providers would also be valuable. For example understanding how the eligibility requirements such as abstinence impact decision-making around referral, and whether features of the rehabilitation facility itself such as whether they are a faith-based facility, for-profit, or offer aftercare provision, impacts likelihood of referral.

- Relatedly, further research may also be required to understand the perceived benefits and risks of residential rehabilitation and how the process for assessing clients may lead to it only being considered appropriate for a small number of people. This understanding may help to identify specific perceptions that act as barriers to referral and feed into the development of national standards.

Lastly, the present research assessed referrer views and experiences of residential rehabilitation, but conducting research with clients and residential rehabilitation providers will aid understanding of the referral process from their perspective including understanding of barriers to referrals and any potential

gaps in provision, and opportunities for establish more joined-up working. We would recommend conducting research with clients with varied experiences of residential rehabilitation including those who were successfully placed in residential rehabilitation and those who were not, as well as with clients who considered residential rehabilitation but decided to pursue an alternative treatment, or did not end up with a placement for other reasons. This could build on the other work streams already undertaken within PHS' evaluation of the Scottish Government's Residential Rehabilitation programme, including qualitative research with a small number of residential rehabilitation providers, and research about perceptions of rehabilitation among those with experience of using drugs.

12 Appendix A: Key findings from scoping interviews with ADPs

We interviewed several ADPs and sector experts to aid our understanding of current practices and views of residential rehabilitation, and to inform the design of the survey for referrers. The following is a summary of our findings from these interviews, which have fed into our survey design.

How referrals work

- The way the referrals process worked, and who was involved, varied across different areas. In some areas, various organisations or professionals could refer individuals to be assessed for residential rehabilitation. These included GPs, primary care staff, social workers, and those working within drug and alcohol services, housing services, and the voluntary sector. In several areas, there was also an option for the individual to self-refer, but other areas did not allow this.

- In contrast, some areas had only one organisation that could refer to residential rehab, with service users needing to be under the care of, or be referred to, that organisation first. A team member or case manager from this organisation would then discuss the various options with the individual and assess their needs to decide the appropriate course of treatment – this could be residential rehabilitation, or another approach. In one organisation, all referrals went through one member of staff.

- Several ADPs reported that multidisciplinary teams were involved in assessing suitability for residential rehab, or in determining the appropriate treatment. One said that while case managers would undertake the assessment, they would get advice from the multi-disciplinary team and other professionals.

- In some areas, individuals were referred to the social work team or a social worker for this assessment to take place – in some instances this was seen

as an advantage as they could also provide support for other needs including family, housing and mobility. However, the high workload in the social work sector, and the individual being taken on 'as a case' long term could lead to longer waits and delays in the process, as they had to wait for a space in the caseload to become available. One ADP where this approach was used described it as a 'bottleneck.'

Common themes

Several themes emerged from our discussions as follows:

- Perceptions of residential rehabilitation.
- Practicalities around the process.
- The role of abstinence.
- Other factors needed alongside residential rehabilitation that influence its success.

Perceptions of residential rehabilitation

- In some areas there remains a perception that residential rehabilitation is limited and expensive, and is therefore only for a small number of people. One ADP said that ORT and counselling were still usually considered first, with residential rehabilitation being the third option that 'isn't high enough up on the list.' Another felt that residential rehabilitation was sometimes seen as 'an ethereal thing that doesn't exist' because of the history, and misconceptions around cost and what it entails. They said organisations know their budget is small so they worry they cannot send everybody, potentially acting as a barrier to referral. But the reality is they can send anyone who is assessed as needing to go. Another said that consultant psychiatrists would not tend to regard residential rehabilitation as a core part of their work – they felt the perception persists from several years ago when residential rehabilitation was a 'last chance saloon' for individuals at very high risk of drug-related death.

- One ADP noted that they had seen similar misconceptions about cost among individuals – that residential rehabilitation was something for rich people, so they had not realised it might be an option for them. They felt there was a lack of knowledge about residential rehabilitation among individuals using drugs and alcohol. Another ADP said they were working hard to debunk the perception among both referrers and individuals that residential rehabilitation is hard to get into, as more funding and spaces had become available.

- Another ADP felt that social work had not adjusted to the increase in funding and beds for residential rehabilitation – they found a persistent attitude among social workers that residential rehabilitation is limited, and that only a small number of people need it. In their area, social workers had not integrated with the local alcohol and drug service.

- In one area with an active recovery community, the ADP felt most referrers were positive, because they could see the results residential rehab had had for these individuals – they felt this connection with the local community was an important factor in referrers' perceptions.

- There was a concern among some that individuals and their families, as well as some referrers, can see residential rehabilitation as almost a 'silver bullet' or 'cure all'. They suspect these views may come from the media or social media. Going in with such high expectations can be damaging if they have a poor outcome from their stay – it can feel like a real set back or make the individual more vulnerable.

- Several ADPs mentioned individuals living chaotic lives, and the differing views among organisations in the sector about whether residential rehabilitation should be considered for them. One ADP mentioned that there was a misconception among some organisations that residential rehabilitation was particularly for those with more chaotic lives, who need to be removed from their situation. They felt that this needed to be pushed back on, as residential rehabilitation 'is not a jolly holiday.' Another ADP

stated that residential rehabilitation was not actually suitable for individuals with chaotic lives.

- One ADP felt residential rehabilitation was being ‘given a status it doesn’t necessarily deserve in terms of efficacy’, that other treatment options needed to be considered, and that it was not an approach that would work for everyone.

- There was also a perception among some that residential rehabilitation is not joined up with other services – there are some examples of practicalities that indicate this could be the case in some areas.

- An ADP mentioned that those on ORT would be less likely to have residential rehabilitation discussed with them because they were perceived as stable so were ‘parked’.

- In terms of individuals themselves, fear of the unknown, about what residential rehabilitation will be like was often seen by ADPs. There were also fears about the impact on relationships and family, as well as concerns about stigma and discrimination. All these were potential barriers for individuals to accessing residential rehabilitation treatment.

Practicalities around the process

- Waiting times and lists were identified as a key barrier. In some cases, this was due to availability of beds, but in other areas, the process of referral and assessment itself was seen to be creating the delays. Long waiting lists could sometimes lead to referrers being reluctant to refer individuals to residential rehabilitation.

- One ADP stated the waits between referral and assessment in the local process led to large dropout rates, as individuals lost motivation, or their circumstances changed. They felt the assessment by a social worker in their area created a bottleneck, and said that the local drug and alcohol service would be undertaking more assessments, as they focused more specifically on admissions, rather than the wider remit of social workers.

- The time and complexity of the referral and assessment process was not just a concern in terms of timely outcomes, but its impact on the wider wellbeing of individuals seeking help. One ADP felt the length of the process in their area meant individuals had to 'jump through hoops'.

- ADPs mentioned their size and locality in relation to bed arrangements. For example, a larger ADP was able to contract a specific number of bed spaces with a provider, whereas a smaller area had tried to contract a certain number of beds but did not make enough referrals. This meant it was not financially viable, and they have to work on an ad-hoc basis, meaning it can be challenging to find beds. Another aspect of location is whether there is a residential rehabilitation facility within the ADP area. Again, the larger ADP had a local residential rehabilitation facility, and felt this meant they could work more efficiently with them, and provide a more joined-up service. Some ADPs do not have any residential rehabilitation providers in their area, making it harder to build these relationships, as well as meaning individuals would have to travel further for treatment.

- One ADP mentioned the difficulty of referral paperwork being different for each residential rehabilitation provider. They try to contact the provider for this ahead of time but do not always get a response, which adds time and work. They would also prefer wider paperwork to be more transparent – for example they received a new brochure, but it included no prices and was unclear about what services were provided. Another found the communication with residential rehabilitation providers patchy, with responsiveness varying. They would expect regular contact and reviews about individuals who had been referred, but this is not as consistent as they would like.

- In one area, workloads and difficulty recruiting staff means that services could not always undertake the necessary preparation work to stabilise individuals so they are ready for residential rehabilitation – they felt they were more in a 'firefighting' mode, keeping people away from crisis.

- Other concerns include difficulties placing those with children or family due to a lack of suitable facilities. Reaching individuals experiencing homelessness or coming from the criminal justice system also proved challenging. Knowing how to time things with prison release was difficult, plus prisons had their own assessment team which were unable to refer out of area. They were also unable to refer directly to the local assessment programme for residential rehabilitation.

- In terms of individuals themselves, there were often concerns over what a stay in residential rehabilitation would mean for the practical aspects of their lives, such as housing, finances, benefits. Depending on the distance of the rehabilitation facility from home, there were also sometimes concerns over travel, the associated costs, and the potential to damage relationships if it is too far for visits. Some also had concerns over the cost of residential rehabilitation itself.

12.1 In one area, individuals previously had to contribute towards the cost, but the ADP had started funding the full cost as this contribution proved to be a barrier.

The role of abstinence

- ADPs had varying perceptions about the role of abstinence in treatment, especially in relation to residential rehab. One ADP said they saw residential rehabilitation as abstinence-based recovery for several months, to ‘get clean.’ Another described a need to define what rehabilitation is, as there was a difference between abstinence from illicit substances and ‘pure abstinence.’ Another said non-abstinence residential rehabilitation was sometimes referred to by people in the sector as ‘pretend rehab’, though they disagreed with that characterisation themselves. Some indicated there was also a mix of attitudes among referrers and individuals seeking treatment.

- Some ADPs felt abstinence was a barrier to some individuals getting support through residential rehabilitation and associated services. For example, one

ADP said that abstinence is a very intensive treatment method, so not suited to all, and that some individuals are not interested in it. The abstinence-based approach of 'no mind-altering substances' also includes mental health medication, which ADPs raised as a 'hidden barrier' for some individuals to access residential rehab. In another area, the ADP said their recovery community, often used as a source of support post-rehab, was 'quite rigid in terms of being abstinence based', and was therefore not suited to all. They were aiming to diversify their post-rehabilitation support to make more options available. In another example, the residential rehabilitation facility was 12-step, and the ADP said some organisations did not want to refer to 12-step.

- Safety was mentioned a handful of times. For example, one ADP said there were concerns around the safety of abstinence, though felt it could be mitigated through continued care. Another said that before their role there had been a lot of failures in residential rehabilitation, as the only option was a faith-based rehabilitation which did not offer detox, an approach they did not feel was safe.

- Another raised the need to measure outcomes in other ways, not just by abstinence, for example, by improvements to physical and mental health, or family respite.

Other factors needed alongside residential rehab, or that influence its success

- Several ADPs discussed wider support and care that they felt could contribute towards good outcomes for individuals – either alongside residential rehab, or before and after the stay. However, several did caveat that it was hard to predict who would do well in residential rehab.

- In one area, the ADP described wrap-around care before, during and after the residential rehabilitation stay, and felt this had a positive impact. Ahead of their residential rehabilitation stay, the individual would receive 'pre-hab' support services, who worked with them and their family to manage their expectations. The individual would also have a case manager, who

remained in touch with them throughout their stay, and would work with them afterwards with ‘post-hab’ support. This consistent person meant that the individual was already linked up to recovery services upon leaving residential rehabilitation. In contrast, another ADP felt they had a gap in aftercare – but they felt similarly about how important it was. They planned to review their aftercare services and offer different forms of support.

- One ADP had a very active ‘recovery community’ of people who have been through treatment including residential rehab. They felt this community was a strong asset in supporting individuals seeking treatment, as people considering residential rehabilitation could easily talk to someone who had previously been through it.

- In another area, the ADP felt the relationships staff could build with the individual had a big impact on achieving a positive outcome of residential rehab.

- Another ADP discussed the need for the individual to be in the right headspace for residential rehabilitation to be successful – they felt the individual needed to ‘have a degree of cognitive insight’ to undertake self-reflection.

Suggested items to include in the survey or further research

To conclude each interview, we asked ADPs and sector professionals what they felt ought to be included in our survey, or further research. The ideas they shared were as follows:

- Which individual referrers would or would not refer.

- What would make referrers more confident to refer.

- Barriers to residential rehabilitation.

- How accessible people find services.

- How to measure demand for residential rehabilitation.

- Consistency between providers; contact between providers and referrers – is this continued throughout placement, enabling referrers to address any issues.
- Waiting list averages.
- Attitudes to abstinence.
- How are individuals affected by dropouts or short-notice placements.
- Measuring outcomes other than just abstinence – the impact on wider health and family life.
- Any instances of residential rehabilitation making an individual more vulnerable.

13 References

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