Summary of Residential Rehabilitation in Scotland

June 2021

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Introduction

This report has been written after researching various sources. These sources are all in the public realm and thanks is given to all sources mentioned within this document.

We write this to give an outline of residential rehabilitation services in Scotland, how they are accessed and funded, with any concerns outlined. It outlines our findings when searching publicly accessible sources and so facts may differ slightly.

If you feel that any information has been misrepresented in this document, or that your information could add to this, then please do not hesitate to contact us.

Background

There is no doubt that we are in the grips of an ever-increasing public health emergency when it comes to deaths related to drug use (Source). These drug deaths continue to rise year on year and have done for around a decade (Source). A 2019 University of the West of Scotland report makes a clear correlation between funding decisions, primarily cuts, and how these can be linked to the increase in drug related deaths – especially among those who cannot afford to fund their own rehabilitation. In December 2020, after the publication of drug deaths, the First Minister appointed a new dedicated Drugs Policy Minister in Angela Constance MSP. Both Nicola Sturgeon and Ms Constance have made a public commitment to not only reduce the deaths, but also improve care pathways for individuals, this includes residential rehabilitation.

Concern regarding the provision of residential rehabilitation in the addictions field is not new. Concerns surround the lack of accessible beds, how people access these and how they get the funding for it, if at all. Despite the effectiveness of residential rehabilitation having been widely evidenced as a viable treatment option there seems to be systemic reluctance from many professionals and local authorities to put in place procedures that would allow service users direct access to residential rehabilitation (Source).

Residential rehabilitation is not to be defined in the same context as a detox centre or stabilisation unit. These types of services offer placements for a few weeks and allow a place where someone can either detox from drug/alcohol use or stabilise onto prescription replacements – but these services will not necessarily treat the underlying reasons as to why someone will use these substances habitually. Given the lack of detox only beds often someone will leave these short-term services stabilised on some form of prescription medication (MAT, OST etc) with very little option of going somewhere longer term from this service. Residential rehabilitation is for a period of usually around 3 to 12 months where they will be offered counselling, physical/ mental health support and various other offers designed to ensure that they can be supported to make positive life changes. Offers could also include a range of support such as moving on support, housing and throughcare, education and skills training although individual services may offer some or all of these dependent on their own programme.

The opportunity to do these in a safe and controlled environment should be an option available to all.

A New Approach

The new drugs Minister Angela Constance has openly discussed the need for a change in approach, recognising that what they have done previously hasn't worked and one of those areas where they "expect real change" is around the provision of, and access to, residential rehabilitation. Upon this announcement the Scottish Government announced additional funding in the addictions field for over 5 years. Of this amount money was to be specifically "ringfenced" on increasing residential rehabilitation and aftercare. Initial funding for this was released in January and returns can be seen at the end of this document in Appendix A . We are unclear in these returns if there was any major increase in capacity, or referrals, to residential placements.

Reform, or a desire to reform, the addictions sector is not new. The Scottish Government have fully recognised the need for multiple issues to be addressed as part of the overall approach to tackle alcohol and drug related deaths. The Fairer Scotland Action Plan (2016) sets out a 50-point plan to deliver a fairer and more prosperous Scotland by 2030. This includes the Fairer Scotland Duty which ensures that public bodies take account of poverty and disadvantage whenever key policy decisions are made. Someone's rights can also be found within international treaties. These are mainly economic, social and cultural rights but include rights relating to employment, housing, health, education and adequate standards of living. In Scotland, civil and political rights are protected by the Human Rights Act 1998 and in the Scotland Act 1998.

The Scottish Government also go on to state that "everybody has a right to health and making help available is an essential part of respecting a person's rights and dignity" and that their aim is to empower more people to seek support and ensure that support is consistent, flexible and effective. Access to services should be faster and services should stick with the people they support. The government will ensure that staff and resources are in place to provide the required levels of high quality, person-centred treatment and support and recognise the importance of ensuring funding is used effectively by Alcohol and Drug Partnerships (ADP) so people can be offered a complete range of treatment or recovery options including residential recovery rehabilitation (Source).

Despite this accessing rehabilitation services continues to be problematic.

"Gatekeeping"

Getting access to residential rehabilitation is not the reality for many who may need it, even if they request it. Access comes in many forms and with many barriers. Many people are not informed of rehabilitation as a treatment of option and, in some areas, there has been little to no rehabilitation placements in decades, if at all. This is despite these areas displaying high numbers of drug deaths per-capita (Inverclyde for example). People in these funding "deserts" are likely to be on some form of medication for decades and/or have to seek out charitable rehabilitation routes that are often 12 step or faith-based services.

As mentioned above it has also been the case since this funding was announced that some local authority ADP's have continued the stance that there is no demand, or need, for residential rehabilitation. This is despite some frontline workers reporting that they are told that *"rehab is not an option"* for their clients and so not to mention, or offer, this. There are also reports that people are actively placed on a Methadone amount, called the therapeutic dose, that automatically exceeds the amount some funded rehabs can take, only a few services have the facility to *"detox"* off high amounts and yet these are primarily not funded. So, the person seeking rehabilitation is often caught between a *"rock and a hard place"*.

Despite there being general duties, and also the rights mentioned above, placed upon Local Authorities to provide services to those seeking help with drug/alcohol issues, there is no statutory right that can be challenged if someone doesn't get a particular type of service. So basically, left in a "you will get what I say you will get" situation. People then often feel lost and with no voice or often feel that their wishes are ignored, creating a vacuum of hope for many.

Regulation

The responsibility for the planning, designing and commissioning of alcohol and drug services is delegated to Integration Authorities and despite evidence of its effectiveness in treating addiction, residential rehabilitation is a non-existent provision in many local areas. There are “deserts” across Scotland & the rest of the UK regarding this provision and, as mentioned above, often voluntary sector rehabilitation is the only option for clients.

Integration Authorities issue directions to NHS Boards and local authorities as well as other statutory providers of alcohol and drug services. These directions should set out the intention, expected delivery, financial resource and desired outcomes of its services. The Integration Authority is required to review the delivery of these directions as a part of its approach to performance management. The Scottish Government should then work with Integration Authorities and Alcohol and Drug Partnerships to strengthen their governance and accountability. These delegated services are thus held accountable for how well they fulfil these directions given to them by the Integration Authority. Given that each area is autonomous, how they administer these services is down to them and there seems to be no unification overall and so someone’s experience in a place like Inverclyde is vastly different to someone in Midlothian, and so forth.

There is no independent, or outside, scrutiny of this process at this stage of the process.

For the services themselves there are two regulatory agencies with statutory enforcement powers which scrutinise alcohol and drugs services, both created though the Public Services Reform (Scotland) Act 2010. Section 44 of the Act established Social Care and Social Work Improvement Scotland (commonly known as the Care Inspectorate) and section 108 amended the National Health Service (Scotland) Act 1978 to establish Healthcare Improvement Scotland. These agencies do not regulate the Integrated Authorities, ADP’s or Health Boards.

Services such as residential rehabilitation services have to be registered by law and so most are regulated and inspected by the Care Inspectorate. This can be likened to other services such as support services, supported accommodation etc. The rest, and services provided through the NHS, are regulated and inspected by Healthcare Improvement Scotland. Details of the inspection of care, hospitals and other NHS non-hospital inspections responsibilities of HIS can be found here. Similarly, each service inspected by the Care Inspectorate can be found on their site.

Although these two regulatory bodies assess each service regularly, ensuring that they comply with their guidelines of work, they don’t asses the referral pathways to these services nor do they regulate the process in any way.

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Funding Decisions

The decision on who receives funded rehabilitation seems to be wide and varying – with no set principles or practices across regional areas or Scotland overall. Having contacted multiple services there also does not seem to be a standard assessment criteria and certainly no standard paperwork could be produced, so the service a person receives in Glasgow will completely differ from the experience of someone from West Dunbartonshire for example. The lack of any "uniformed" policies and guidance on this matter causes alarm.

There also seems to be an element of *'gatekeeping'* of this funding and also a *"postcode lottery"* on which areas actually provide this funding at all. Workers in some areas allegedly *"scoff"* or *"laugh"* at someone asking for funding, with some workers forming their own opinions that *"rehab doesn't work anyway"* and so not using this as a treatment option. Reports, even in areas that do fund residential rehabilitation, service users are told to *"go away and show commitment"* before they will consider applying for funding, often placing them on some form of medication at that point. One female reported that she had "begged for rehab", only to be advised to attend a community based recovery group to reduce her drug intake as a form of showing her "commitment" – this was despite advising she was placing herself at risk to earn money to pay for her addiction.

Having spoken to people across 5 areas, feedback of how people access funding seems to follow a general method in which a person will approach their *"worker"* and discuss what treatment they believe is best for them (Source). At this point residential rehabilitation is identified and, upon some form of assessment, they are then "*put forward"* for residential rehabilitation to a senior member of staff – or complex needs team – sometimes referred to as a Multi-Disciplinary Team or MDT. This person/ panel does not meet the person directly but then decides if they will get this or not, on many occasions ignoring the recommendations of the *"worker"*. The very staff who work directly with the service user are often discouraged from applying in the first instance.

But there does not seem to be any specific legal duty to do this in any formal way and the only specific attempt at pushing specific legal provisions on accessing rehabilitation and treatment seems to have been the Drug Treatment and Rehabilitation (Scotland) Bill which was rejected. The rights of someone in this area seems to be formed from multiple pieces of legislation instead.

To note though that most areas do not do this at all and there is evidence that some have never funded rehabilitation, for those who do there seems to be the above general process.

Despite workers in residential services being qualified and experienced in assessing prospective residents they take no formal part in the process until the client is referred, if indeed they ever are.

Outline of Residential Drug or Alcohol facilities in Scotland

Residential rehabilitation was defined, as per the mapping report (updated in December 2020 to include additional "missed" units), as *"facilities offering programmes which aim to support individuals to attain an alcohol or drug-free lifestyle and be re-integrated into society, and which provide intensive psychosocial support and a structured programme of daily activities which residents are required to attend over a fixed period of time"*.

Using this report, and concluded our own shorter version search for residential rehabilitation services in Scotland we found the following services:

- **Voluntary/3rd Sector** – Benaiah, Teen Challenge; Hebrides Alpha Project; Jericho House, Dundee; Jericho House, Greenock (Bank Street); Jericho House, Greenock (Shankland Road); The Haven; Phoenix Futures Scottish Residential Service; Safe as Houses Project; The King's Court, Maxie Richard's Foundation; Sunnybrae, Teen Challenge; River Garden and Whitchester House, Teen Challenge; Beechwood, Rainbow House, Crossreach; Bethany Christian Centre*
- **Private Sector** - Abbeycare Scotland, The Priory Hospital and Castle Craig Hospital;
- **Statutory Service** - Ward 5, Woodland View and Lothians and Edinburgh Abstinence Programme (LEAP) - (in the form of a partnership between the NHS, City of Edinburgh Council and the third sector).

The total number of beds available is estimated to be 418 and at the end of 2020, start of 2021, providers reported that a combined total of 268 beds were occupied and so, at the time of survey, were running at around 69% of capacity.

Looking at Healthcare Improvement Scotland (HIS) and the Care Inspectorate sites for each service all show a non-standardised approach to operating with varying registration types including "hospitals", "housing support services" and "care homes for people with drug and alcohol misuse problems". Upon conversation with many of these services, we were unable to conclude why this is the case but can surmise that representatives from services we contacted assume it was due to available funding at the time of registration as this can affect what funding you are eligible for.

Due to this each service also seems to operate a different funding pathway to the next, although many are similar if they sit roughly within the three sub-headings above. Even within this the cost of each service can vary dramatically despite many operating the same model and/or programme.

Funding

Although facilities reported that existing funding is a significant issue in reaching their capacity this predominantly seems to be an issue isolated to those services reliant upon residents receiving funding. Those funded through housing benefit report not being able to "meet demand" due to reaching capacity consistently and thus operating a "waiting list". Looking at "supply and demand" in this way shows a truer form of demand for residential rehabilitation and questions remain as to why one form is under-subscribed and the other is over-subscribed.

Most of these facilities report that due to the issue of funding they are often running "hand to mouth" and that actual facilities and staffing were requiring investment to meet any drive to increase access and/or capacity. Two charity run units reported an annual operating loss in excess of £30,000, which was being met by the wider charity funds or external grants, without which they would be forced to close.

Another service, a Christian based programme in the Scottish Borders area, has advised that they claim HB at the elevated rate but do not receive anything additional to this. They advise that around a decade ago they did receive this from the local authority but that this ceased when the service refused to remove the Christian aspect from their service, based purely on the religious aspect to their programme as opposed to its high success rates. They add that this relationship is also a barrier to applying for the recent funding, administered by the Corra Foundation, as support from a "local ADP" is required. This additional funding (removed 10 years ago) has been described as "supporting people" money by staff and is commonly known as this, "care component" or similar. Another 12-step based service advise this additional money also removed by their local authority some years ago and now only paid when they place residents of that Council are resident in the service, a loss that accounts to their annual shortfall.

There seems to be no reasoning for the removal of this locality-based support money, especially in the middle of a national crisis, other than authorities not paying for "their own residents".

As stated above funding streams for each service varies, dependent primarily on which sector they exist, the fact they were a commissioned service by the NHS/ Local Authority, or their registration type as mentioned above. Some local authorities have been approached to pay this regardless of what area the service is in, as long as the resident is from their area, some have agreed to look at this and some have refused – again highlighting that there is no actual issued guidance or policy governing this work across the country, something drastically needed.

But having looked at each service online, or called them directly (where available) main funding streams are all follows (this is an estimate as many can operate discretionary

too):

Unknown (possibly funded by work-based income streams in the community/area).

- Hebrides Alpha Project.
- River Garden Residential Centre.

Funded through ADP/HSPC/NHS budgets (dependent on area) as commissioned service.

- Phoenix Futures Scottish Residential Service
- Beechwood, Crossreach
- Rainbow House – Crossreach.

Housing Benefit (sometimes complimented with support component).

- Benaiah, Sunnybrae, Whitchester House - all Teen Challenge.
- The Haven Kilmacolm.
- Jericho House, Dundee, Greenock (Bank Street) and Greenock (Shankland Road).
- Safe as Houses Project.
- The King's Court, Maxie Richard's Foundation.
- Bethany Christian Centre

**Additional support component only payable for residents from the local area where unit is based, if at all.*

Private funding/Insurance/NHS only.

- Abbeycare
- The Priory
- Castle Craig (reports a high % of residents are foreign nationals).

NHS

- Ward 5
- LEAP – *(report partial funding available through Housing Benefit for 13 weeks).*

Self-funding contributed over a third (36.8%) of placements. Around a quarter (27.4%) were funded by Social Security payments like HB and charitable funding, while private insurance is used to fund around one in five (22.0%) places. ADPs funded little more than a tenth (13.2%) of those accessing beds across the surveyed facilities (Source).

The amount of funding each receive also differs not just between "funded" or "private" services, but even the HB rates received by each. This can often differ due to the facility itself and overall final costs are dependent upon the duration of each programme. Some offer shared rooms with shared facilities and others offer "self-contained" flats.

These amounts can roughly be broken down to the following approximations.

Housing Benefit

Payments differ from around £200 per person per week to around £380, dependent on accommodation type.

Where it has been mentioned, the locality-based support payments are an additional £180 to £240 per person per week, where eligible.

Funded

Prices vary and seemingly vary based on type of service received at the time.

The costs of these are met by local authority or NHS departments who have a contract set up with these services, often called "commissioned".

One service reports a cost of around £700

per week per person while another reports a fluctuating cost of approximately £1400 per week per person per week while “on detox” to around £1000 per person per week afterwards. Some of these services will also require a resident to hand over their own benefit money to pay for their “keep” there too.

This ‘client contribution’ is quite common and often at the request of the commissioning contract, so essentially the local authority is stating that clients have to pay a contribution. FAVOR UK are certain that most services would drop this approach if they were able to received appropriate funding to cover costs. We find the practise to be a clear sign of discrimination in that people would not normally be expected to contribute financially towards their standard health care. Obviously, people do for private care, but in the case of state funded care we have a situation where someone can access a community drug treatment programme at no cost, but if that programme doesn’t work for them due to their multiplicity or complexity of need, they have to part fund their own treatment in a residential setting. This seems to be a clear discrimination against people who have multiple need i.e., homelessness, Mental health and substance use.

The provision of enhanced care for more acute needs is very common within healthcare i.e. intensive care units, whilst in addiction treatment the approach seems to be that people should accept a level of care that is not appropriate for treating their health condition, or they have to pay for their own treatment. The fact that access to rehab (the equivalent of intensive care) is blocked for so many with need of intensive support seems to us to represent institutional discrimination.

Private

We were only able to seek one services costs on this and these costs seem to be easily changed dependent on the client, service and length of stay. These services can also employ medical staff and allow a detox from higher doses.

Costs can be around £3600 per person per week. These funds are usually met by the client privately as most statutory services will not fund this, based on cost alone. There is no clear reason as to why these costs are so high other than these services being businesses, although these services do seem to be equipped for clients on really high doses of medication and a medically assisted detox is available alongside inhouse medical teams.


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Housing Benefit payment issues

As mentioned above, fully funded rehabilitation is dependent on what seems to be a “postcode lottery” for most. Most local authority areas do not send referrals to any of these services and thus do not actively pay for these from a set health budget.

When a person doesn’t get this funding and needs to enter residential rehab to support them with their addiction, there is only the option of those funded by Housing Benefit. Services where they can self-refer without the input of any statutory service and where in fact it has been evidenced that ADP workers will “close” someone’s case if they do enter one of these services. Without this HB payment the rehabs would not be able to operate and provide the services they do.

These are the rehabilitation units seem primarily to be those registered as “housing support services” and thus seem to be recognised in a similar fashion to services operated for homeless people, or people in other forms of supported accommodation for example.

The issue arose for people when they have a tenancy and need to continue claiming HB for this tenancy when they enter rehab, and thus don’t lose their home.

It seems there has been a mixed picture on when dual HB awards are being made in these situations. Some Local Authority HB departments have historically allowed dual HB payments and this seems to have been because LA departments did not talk to each other and the only time this was always disallowed was when the LA in question administered both applications for HB (so the person had a tenancy in the same area as the rehab unit). One local authority pursued a case through to tribunal, where it was concluded that dual housing benefit (HB) claims for 3rd sector rehabs are not allowed, as these 3rd sector rehabs are not included in the [1] housing benefit regulations 2006. Therefore, HB payments cannot be made for these rehabs and the person’s home. This is not to be confused with the temporary absence from home rule that someone would be entitled to for one claim of HB whilst away for specific reasons..

Scottish Government Drug Policy team advised

initially that dual HB payments can be made in these occasions. On discussion it seems that Lothian Edinburgh Abstinence Project (LEAP) was cited as evidence of this. Having investigated this, and discussed with LEAP, we looked at the following.

LEAP seems to be a partnership between the NHS and the Local Authority. They are registered with Healthcare Improvement Scotland but from there we are confused as to the eligibility. They may be either registered as a "medically approved" service and so contained within the regulations for dual HB or, according to LEAP, have an agreement in place with the local DWP to allow payment for someone's rent for a 13-week period. Their own website confirms this partially as follows:

> "If you have a tenancy, housing staff will try and find a way to help you maintain the rent on this whilst living in our accommodation. If you are not entitled to housing benefit, there may be an accommodation cost levied".

On the 19th March, in response to the issue raised above, the Scottish Government announced a. £5m recovery and rehabilitation fund. This fund, which will start on the 31st May 2021, and will ensure that people don't have to make an impossible choice between their tenancy and their recovery journey. We do not have the guidance on this as yet but can surmise this is a short-term solution to the issue, a welcome solution of course, but one where a longer-term solution to funding is required, including inserting this type of service into the Housing Benefit regulations or by the Scottish Government introducing a more up-to-date funding stream.

Now that this is allowed, we could see a growing number of service users attempt to access these services and thus should give a clear indication of numbers, given that they were dissuaded from applying at the application stage due to this issue.

We do not think the cost will be prohibitive at this point, as unfortunately many of the people who enter rehab are homeless and do not need to claim dual HB. However, if Housing First is to be rolled out nationally, with more people with addiction being supported into homes first, and often residential rehab will be required to ensure they recover, then we would have a situation where more people will have to choose between their housing first home and residential rehab.

The concern now focusses on the long term. All the recent funding announcements give everyone some space to consider a longer term "fix" in this sector.

Benefits/Funding Considerations

A longer-term solution to benefit funded is a DWP one as unless a permanent solution is found then this solution only exists during the lifetime of the fund. HB/UC legislation could and should be amended under the two homes rule so anyone needing to temporarily reside in residential rehabilitation paid by HB, whilst having a permanent tenancy, were put on a par with the same grounds as those needing to do so for fear of violence (6 months for UC and 12 months for HB if intention is to return) (Source).

Superseding all of the asks here is that the Scottish Government needs to be focussed on why there is a need for benefits funded services in the first instance. They should look at how it funds residential rehabilitation overall, possibly as a health or social care need, and overhaul a dysfunctional registration and funding system. A comparative sector for example here would be where someone with physical disability is required to go into temporary rehabilitation/respite care accommodation. As far as we can find, this funded out of a local authority's social care budget or from NHS funding if it involves medical care.

The Scottish Government has published further documents where addressing health inequalities is a priority. In their document, Public Health Priorities, the document that to improve Scotland's health and wellbeing they need to work together to shift focus toward preventing ill health, reducing inequalities and to work more in partnership. They advise on success being measured against relevant matters such as "significant and persistent health inequalities" and "unsustainable pressures on health and social care services".

The Scottish Government and COSLA has already agreed six Public Health Priorities in June 2018. These were intended to reduce health inequalities in our communities. One focus, accepted by the Scottish Government was "A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs".

Since this, Public Health Scotland has since been established and again has set the drug death crisis as one of its priorities within the document "A Public Health Approach to Drug Use in Scotland".

So, the Scottish Government seems to be open to changing the sector and thus should look to consider all of the facts, ensuring that the funding for these sectors is equal for all and so is how people access such services. This should not be allowed to be left to chance, depending on your postcode.

Recommendations

As mentioned previously there is no specific legislation governing access to drug/alcohol residential treatment services, but instead there are many that the need for such services can be taken from. A common one cited within advocacy projects is the Patient Rights (Scotland) Act 2011, where section 3 advises on a person's rights when receiving healthcare, we are advised that advocacy services often have to back this with arguments on Human Rights and/or Equality Act. Specific legislation with points of law that can be argued, for example homeless rights that can be enforced through the Housing (Scotland) Act 1987, should be afforded to anyone seeking drug treatment. This could be in the form of its own "Act" or even inserted into an existing "Act" like the National Health Service (Scotland) Act 1978, but we must take steps to do so if we are serious about taking a rights-based approach to access. This would ensure that anyone, in any part of the country, knows what they are entitled to and decision makers held to account if this is not the case.

It should also be desirable that all local authorities issue unified practice, policies and guidance in this sector. This will also ensure that local authorities no longer work in a "siloed" fashion when it comes to the provision of residential rehabilitation and thus ensures all areas work to the same guidelines when it comes to assessing people for, or funding for, such provisions.

Despite the lack of legislation in this field the UK does look to use various sources of rights to embed the right to health. This includes World Health Organization Constitution where "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions". The UK also adheres to the Universal Declaration of Human Rights, where Article 25(1) advises "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, and medical care and necessary social services."

The International Covenant on Economic, Social and Cultural Rights, which the UK joined in 1976, does go so far as to define the "Right to health" specifically includes creating conditions to ensure equal and timely access

to medical services for all and goes so far as to state that the right to health is an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health.

The Scottish Government advise that taking a human rights based approach means that they will consider the PANEL principles when making decisions on health. These principles are:

- Participation – people should be able to voice their experiences and take part in decision-making. Policies and practice should support people to participate in society and lead fulfilling lives.
- Accountability – organisations and people should be accountable for realising human rights. There is a floor below which service standards must not fall, but above that human rights should be understood as a progressive journey towards fulfilling the full potential of every human being.
- Non-discrimination – everyone has the same rights regardless of their ethnicity, gender, income, religion, etc.
- Empowerment – people, communities and groups should have the power to know and claim their rights in order to make a difference.
- Legality – all decisions should comply with human rights legal standards.

As a set of internationally agreed rights, human rights should at least provide a framework on which to build the case for public health initiatives that are inclusive and work for everyone.

Taking a human rights-based approach to health should involve:

- Ensuring the fair and equitable distribution of the social determinants of health
- Thinking about how resources are allocated to ensure decisions about policy and spending are not contributing to health inequalities or making them worse
- Working with people to understand the factors that undermine their right to health and together identifying actions to make improvements
- Taking action to tackle economic and social inequalities alongside actions which specifically focus on disadvantaged groups and deprived areas.
- Ensuring services are planned and delivered in proportion to need
- Ensuring services are available, accessible, appropriate and of equal quality.

It would therefore be a recommendation that these guidelines, rights and principles detailed above would be a good starting point when enshrining someone's rights into a dedicated legal system or when issuing standardised guidelines, or codes of practice, in this field.

Our final but critical point is that with regards to assessing for, and accessing residential treatment, the UK's drug treatment clinical guidelines seem to be routinely ignored

They are here "Drug misuse and dependence UK guidelines on clinical management"

For example, the guidelines say the following

"3.7.4.2 Early recovery phase: enhanced care

Services may wish to consider extended

recovery support programmes beyond treatment for some individuals. Those who have had multiple previous failures at sustaining abstinence may fall into this category. A combination of psychosocial interventions (e.g. cognitive behaviour therapy and medications for relapse prevention supported by contingency management for abstinence) can be helpful at this stage. Some individuals will opt for, and engage very successfully in, time-limited programmes of intensive recovery support either in a residential setting or in a community day programme, to prepare themselves for sustaining their recovery long-term (the programmes typically supporting abstinent recovery only). Pathways to, and entry criteria for, accessing such programmes should be as clear as possible to staff and drug service users.

Residential treatment and structured day programmes Residential rehabilitation programmes are one of the longest established forms of treatment for drug dependence. The evidence base is mixed, with methodological problems inherent in studying or comparing this intervention. While those who complete residential treatment, programmes have better outcomes than those who do not complete, cost-effectiveness still needs to be formally assessed in research. Despite this, residential rehabilitation may be an important option for some people requiring treatment for drug dependence. Many of those who choose to pursue residential or intensive day treatment will have previously engaged in community interventions and come to a point where they feel such options are now appropriate for them and they are ready to engage.

The best outcomes are seen for those who complete full programmes. Where abstinence from opiates is the goal, service users need to be made aware of the danger of relapse and overdose. Strategies should be in place to warn clearly of the risks and to mitigate these. This includes take-home naloxone training. Pathways to early reengagement with community treatment services need to be in place for those who do not complete treatment or who relapse after completion. The decision to pursue an abstinence based approach should be voluntary and the benefits and risks of this approach, as for any other treatment option, should be discussed openly and supportively to help patients make informed choices.

The range of therapeutic approaches employed in residential treatment makes some programmes especially suitable for those with the most complex needs and for those who “have not benefited from previous community-based psychosocial treatment” (NICE 2007). However, there will be some people who desire to go directly into residential treatment and some may benefit from doing so. Such decisions will need to rely on a best clinical judgement. Although most residential settings are focused on abstinence from illicit and prescribed medication, there is emerging evidence from outside the UK of benefit for service users receiving OST and residential treatment simultaneously. However, at present there is insufficient evidence to make a recommendation for this approach. Structured day programmes normally require service users to attend four or five days a week during the day. Programmes are typically of finite length and are structured with a compulsory rolling schedule of activities, which often includes group work. The aim is to improve social functioning and to help service users achieve their goals focusing on community rehabilitation. These programmes may suit those with greater recovery capital or social support and can be comparable to residential programmes in terms of effectiveness although they have significantly higher drop-out rates,

particularly for those dependent on opiates"

Page 118 reference to detox

"The choice of setting for detoxification: Staff should routinely offer a community-based programme to all service users considering opioid detoxification. Exceptions to this may include service users who:

- have not benefited from previous formal community-based detoxification
- need medical and nursing care because of significant comorbid physical or mental health problems
- require complex polydrug detoxification, for example, concurrent detoxification from alcohol or benzodiazepines
- are experiencing significant social problems that will limit the benefit of community-based detoxification.

The following point is supplementary to NICE's guideline:

- there are cases in which detoxification in an inpatient or residential rehabilitation service might benefit a patient who has not previously attempted detoxification in the community"

Page 38 talks about the need to inform people of treatment options

"It is inappropriate, in providing ethical, evidence-based treatment, for services to create a sense that those opting for OST maintenance are making a poorer choice than those opting for an abstinence-oriented or abstinence-based treatment. Equally, prescribing services should not discourage a patient who wishes to pursue detoxification, but should provide the best information on benefits and risks, and support the patient's considered decision. Staff should convey all the options suitably optimistically and realistically, and with sensitivity to the service user's personal situation and risks."

Page 58 talks about the need for staff to be trained in all areas of patient need.

"Good assessment is essential to the start and continuing care of the patient. Not only can it facilitate engagement in treatment but it can begin a process of change. Clinicians need to be competent to assess all areas of patient need. Assessment also provides an opportunity to provide information about treatment options and the expectations of treatment."

There are lots of other relevant sections but from these it shows the need for clear pathways, trained assessment, informed treatment options etc

As this practise is seemingly routinely ignored it would appear that community services are not working to clinical guidelines with relation to residential care.

This seems to us to be a serious issue in that by not applying guidelines, client safety and therefore their human right to health is routinely compromised.


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50% TIERED
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Appendix A

Local Authority returns on additional residential rehab. This is what the investment was actually spent on

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
NHS Ayrshire & Arran	East Ayrshire	96,294	Residential placements	62,591	Associated aftercare and post placement support	Increased social work resource Increased / improved provision	100,349.8
			Improving access to treatment	18,500	Assertive outreach (including approaches for specific/at risk groups)	Increased nursing resource Increased / improved provision	
			Improved access to harm reduction activities	19,258.80	Increased supply of naloxone	Increased nursing resource Increased / improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
NHS Ayrshire & Arran	North Ayrshire	96,294	Residential placements	62,591	Residential/inpatient detox placements	Increased / improved provision	96,294
					Associated aftercare and post placement support	New and enhanced aftercare support	
			Improving access to treatment	33,703	Assertive outreach (including approaches for specific/at risk groups)	Increased nursing provision	
	South Ayrshire	68,382	Residential placements	35,000		Scoping of demand Increased / Improved provision	68,382
			Improving access to treatment	4,000	Assertive outreach (including approaches for specific/at risk groups)	Increased provision	
				12,000	Same day prescribing and treatment (this may include scoping work)	Test of Change in relation to MAT Standard 1	
			Improved access to harm reduction activities	17,382	Increased supply of naloxone	Skills building Increased / improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
NHS Borders	Borders	49,773	Residential placements	47,773	Residential/inpatient detox placements	Increased / improved provision	49,773
			Improved access to harm reduction activities	2,000	Increased provision of opiate substitute therapy, including Buvidal	Skills building for service staff Increased / improved provision	
NHS Dumfries & Galloway	Dumfries & Galloway	85,129	Residential placements	60,000	Residential/inpatient detox placements	Increased / improved provision	85,000
			Improving access to treatment	11,000	Assertive outreach (including approaches for specific/at risk groups) Non-fatal overdose work with pharmacies to identify high-risk clients for onwards referral	Increased resources Improved provision	
			Improved access to harm reduction activities	14,000	Increased supply of naloxone Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
NHS Fife	Fife	170,727	Residential placements	110,972	Residential/inpatient placements	Increased capacity	170,726

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
			Improving access to treatment	25,609	Assertive outreach (including approaches for specific/at risk groups) Improving access and retention relating to prescribing service	Increased capacity	
			Improved access to harm reduction activities	34,145	Increased supply of naloxone Improved access to BBVT capacity Increased provision of opiate substitute therapy, including Buvidal	Increased provision / capacity	
NHS Forth Valley	Clackmannan-shire & Stirling	83,268	Residential Placements	54,124	Identification of local placement resources	Increased capacity / improved provision	83,268
			Improving access to treatment	12,490	Assertive outreach (including approaches for specific/at risk groups)	Improved access Skills building for service staff	
			Improved access to harm reduction activities	16,654	Increased supply of naloxone	Increased provision of naloxone	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
	Falkirk	179,000	Residential placements	60,000	Recovery workers x 2	Increased staffing resources	179,000
			Improving access to treatment	56,000	Social worker Administrator	Increased staffing resources	
			Improved access to harm reduction activities	63,000	Advance Nurse Practitioner Team set up costs	Increased staffing resources	
NHS Grampian	Aberdeen City	101,876	Residential Placements	66,000	Increase intensive housing support to improve independent living Personalised support Individual assessment	Improvement of service	101,000
			Improving access to treatment	15,000	Assertive outreach (incuding approaches for specific / at risk groups)	Improvement of service Increased capacity	
			Improved access to harm reduction activities	20,000	Increased supply of naloxone	Increased supply / provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
	Aberdeenshire	68,382	Residential Placements	44,000	Residential inpatient detox placements Aftercare / post placement support Scoping work	Increased provision	78,000
			Improving access to treatment	9,000	Assertive outreach (incuding approaches for specific / at risk groups) Same day prescribing	Increased / improved provision	
			Improved access to harm reduction activities	14,000	Increased supply of naloxone Improved access to BBVT Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
	Moray	42,330	Residential Placements	27,514	Residential inpatient detox placements Aftercare / post placement support	Increased nursing provision Increased capacity	42,329
			Improving access to treatment	6,349	Assertive outreach (incuding approaches for specific / at risk groups)	Improved staffing resources	
			Improved access to harm reduction activities	8,466	Increased provision of opiate substitute therapy, including Buvidal	Improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
NHS Greater Glasgow & Clyde	Glasgow City ADP	539,171	Residential Placements	350,461	Residential inpatient placments Pre-admission sessions Digital aftercare packages / phones Recovery aftercare - food and fuel vouchers	Improved / increased provision	539,171
			Improving access to treatment	80,876	Digital engagement services - phones, data Fuel, food and transport vouchers	Improved / increased provision	
			Improved access to harm reduction activities	107,834	WAND rollout (Wound care, Assessment of injecting risk, Naloxone, Dry blood spot testing WAND incentive vouchers Vehicle lease / digital tech BBVT data recording	Improved / increased provision. Promotion / increased uptake of new initiatives.	
	East Dunbartonshire	33,026	Residential placements	21,500	Residential / inpatient placements	Increased provision	33,126
			Improving access to treatment	4,950	Assertive outreach (incuding approaches for specific / at risk groups) Same day prescribing and treatment (this may include scoping work)	Increased / improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
			Improved access to harm reduction activities	6,676	Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
	East Renfrewshire	34,887	Residential placements	34,887	Residential / inpatient placements	Increased provision	34,887
	Inverclyde	81,407	Residential Placements	52,914	Residential / inpatient detox placements Aftercare / post placement support	Increased / improved provision	
			Improving access to treatment	12,211	Assertive outreach (including approaches for specific / at risk groups). Same day prescribing and treatment (this may include scoping work).	Increased / improved provision	
			Improved access to harm reduction activities	16,281	Increased supply of naloxone Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
	Renfrewshire	103,737	Residential Placements	70,000	Residential placements Aftercare, community support and re-engagement	Increased / improved provision	103,737

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
				33,737	Assertive outreach (including approaches for specific / at risk groups)	Improved provision	
	West Dunbartonshire	79,547	Residential Placements	45,847	Residential placements	Increased provision	79,547
			Improving access to treatment	26,200	Development of mobile harm reduction unit Access to wound care / BBVT Increased supply of naloxone Navigator project - further development	Increased / improved provision	
			Improved access to harm reduction activities	7,500	Further investment -Non-fatal overdose pathway	Improved provision	
NHS Highland	Argyll & Bute	44,191	Residential Placements	28,800	Residential placements Aftercare / post-placement support	Increased / improved provision	44,200
			Improving access to treatment	6,600	Heroin assisted treatment / same day prescribing - may include some scoping work	Improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
			Improved access to harm reduction activities	8,800	Improved access to BBVT	Improved provision	
	Highland	68,382	Residential Placements	46,902	Residential placements Resolve bottleneck challenges	Increased provision	68,383
			Improving access to treatment	21,481	Provide funding for staff for multi-agency team, allowing pilot to continue til end of March 2021	Sustain current provision	
NHS Lanarkshire	North Lanarkshire	196,779	Residential Placements	130,000	Residential Placements Associated aftercare and post placement support.	Increased provision	
			Improving access to treatment	30,000	Assertive outreach (including approaches for specific / at risk groups)	Increased provision	
			Improved access to harm reduction activities	40,000	Increased supply of naloxone Improved access to blood borne virus testing	Increased provision	200,000
	South Lanark-shire	146,536	Residential Placements	94,000	Residential placements Aftercare / post-placement support	Increased / improved provision	146,306

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
			Improving access to treatment	8,000	Assertive outreach (incuding approaches for specific / at risk groups) Evaluation of approach	Increased / mproved provision	
			Improved access to harm reduction activities	44,306	Improved access to BBVT	Increased / improved provision	
NHS Lothian	City of Edinburgh	198,640	Residential Placements	129,116	Residential / in-patient placements / detox placement Development work to expand furute capacity	Increased / improved provision	198,640
			Improved access to harm reduction activities	69,524	Increased supply of naloxone Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
	Midlothian	53,495	Residential Placements	34,772	Residential placements	Increased / improved provision	53,495
			Improving access to treatment	8,024	Assertive outreach (incuding approaches for specific / at risk groups)	Increased / improved provision	
			Improved access to harm reduction activities	10,699	Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
	East Lothian	53,495	Residential Placements	34,772	Residential placements	Increased / improved provision	
			Improving access to treatment	8,024	Assertive outreach (incuding approaches for specific / at risk groups)	Increase nursing resources	53,495
			Improved access to harm reduction activities	10,699	Increased supply of naloxone Improved access to BBVT Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
	West Lothian	62,799	Residential Placements	55,649	Residential placements	Increased provision	62,799
			Improved access to harm reduction activities	7,150	Increased provision of naloxone	Increased provision	
NHS Orkney	Orkney	21,861	Improving access to treatment	10,930.50	Assertive outreach (incuding approaches for specific / at risk groups)	Improved Provision	21,861
			Improved access to harm reduction activities	10,930.50	Increased provision of opiate substitute therapy, including Buvidal	Increased provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
NHS Shetland	Shetland	23,722	Improved access to harm reduction activities	23,722.00	Increased supply of naloxone Increased provision of opiate substitute therapy, including Buvidal	Increased provision	23,722
NHS Tayside	Angus	59,077	Residential Placements	38,400	Residential placements Aftercare	Improved Provision	59,076
			Improving access to treatment	8,861	Communication materials to support understanding Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	
			Improved access to harm reduction activities	11,815	Increased supply of naloxone Improved access to BBVT Increased provision of opiate substitute therapy, including Buvidal.	Increased / improved provision	
	Dundee City	153,980	Residential Placements	117,980	Residential placements Improvements to 'Spot Purchasing' framework	Increased / improved provision	153,980
			Improving access to treatment	36,000	Extension of current NFO Pathway Assertive outreach (incuding approaches for specific / at risk groups)	Increased / improved provision	

NHS Board	ADP	Allocation	Area for investment	Amount	Detail of investment	Comment	Total reported spend
	Perth & Kinross	66,521	Residential Placements	43,239	Residential placements / aftercare	Increased / improved provision	66,521
			Improving access to treatment	9,978	Assertive outreach (incuding approaches for specific / at risk groups)	Increased / improved provision	
			Improved access to harm reduction activities	13,304	Invest in communication materials Support recruitment of post within ADP	Increased resourcing Improved communication	
NHS Western Isles	Western Isles	20,000	Residential Placements	14,000	Residential / inpatient detox placements Aftercare and post-placement support	Increased / improved provision	20,000
				1,000	Assertive outreach (incuding approaches for specific / at risk groups)	Improved accessibility	
				5,000	Increased supply of naloxone Increased provision of opiate substitute therapy, including Buvidal	Increased / improved provision	

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