

Review of Residential Drug Detoxification and Rehabilitation Services in Scotland.

Background

A review of the availability, decision-making process, use and cost of existing residential detoxification and rehabilitation services in Scotland was carried out to develop a comprehensive picture of the current position across Scotland and to help inform future policy and funding decisions. Alcohol and Drug Action Teams (ADATs) were asked to submit information on their local services.

We received information to the following questions:

1. How many detoxification and rehabilitation beds are there in Scotland?
2. How many people are on waiting lists for residential detoxification and rehabilitation and how long are the waiting lists?
3. How much is being spent in each NHS area on residential detoxification and rehabilitation?
4. Who decides that someone should go into residential treatment and who agrees to funding. Specifically, are there cases in which clinical decisions are subsequently over-ruled for reasons of cost?
5. Are there facilities to help and support drug users and their families whilst they wait to enter residential facilities?

Attention was focused on residential detoxification and rehabilitation services which have a defined goal of making the client drug free. Crisis beds and supported accommodation are outwith the defined scope of this work. A more detailed definition of the services is attached in Annex A. Annex B contains analysis of the information received in graphical format.

1. The number of beds in Scotland for detoxification and rehabilitation

1.1 Main Findings

There are 352 beds available for drug treatment in Scotland, situated across 22 services. Thirty-one beds are dedicated for use by drug misusers only; most are for drugs and / or alcohol misusers.

Almost one-third of the beds and services are located in Glasgow, and all but one of these is available only to Glasgow residents. Eleven of the 15 NHS Board areas have a residential facility and many are available to clients across the country.

Area of residence and age are the main limiting factors in accessing residential services. (Only one service accepts clients under 16.) Mental health, sex, and living arrangements are other limitations on access.

Occupancy rates varied from 36% - 96%. On average, services reported operating at around 80% occupancy, although several were at over 90%. 100% occupancy is not attainable because of clients dropping out of treatment and the flexible nature of residential programmes.

1.2 Other Key Points

- Of the 22 residential facilities, 7 provide both detoxification and rehabilitation services; 8 offer only detoxification services and 7 only rehabilitation.
- The majority of these services (20) treat clients with either, or both, drug and alcohol problems. Only 2 are drug-only services. This reflects the common co-occurrence of drug and alcohol problems, and is reflected in community based services.
- The number of beds per service ranges from 2 - 104. In general the number of beds in any facility is fairly small, most commonly between 2 - 12. Castle Craig, with 104 beds, is the clear exception.
- The duration of residential programmes varies. Detoxification ranges from 1 week – 12 weeks, with around 2 – 3 weeks being most common, short-term rehabilitation lasts from 4 -12 weeks and longer term programmes can run for anything from 3 months up to 18. On average rehabilitation programmes in Scotland last around 6 months.
- Given the desired flexibility in all treatment programmes and the constant risk of relapse, it is extremely difficult to measure the ‘capacity’ of services. However, from the number of beds and the duration of treatment provided by each services it is possible to estimate that there is capacity for 1,679 clients per year to enter residential treatment. Of those, there is provision for 822 clients in detoxification services, 415 in rehabilitation and 442 in facilities which offer both treatment types.
- 1929 clients were actually admitted to residential services in 2005-6. This is above the estimated capacity, suggesting that clients were attending for less than the maximum time allotted for treatment – i.e. they were leaving early. From services which collected the information 22% were reported as repeat presentations.

2. Waiting lists for residential detoxification and rehabilitation

2.1 Main Findings

Approximately 160 individuals were reported to be on waiting lists. Largely this represents a ‘snapshot’ over a short period of time (as at July 2006), as the information is generally not collected by services on an on-going basis. This figure should therefore be treated with caution.

Waiting times for residential services range from nil to over a year. The most common minimum wait for a service is 3 days; the average maximum is just under 7 weeks.

There would appear to be a definite risk of clients being ‘left’ in limbo between community-based and residential services.

2.2 Other Key Points

- Most ADATs claim that any wait to enter residential services is at individual service level since, in the main, once a client is 'ready' for treatment they are referred and 'go' automatically. Any wait from then on, however, is generally not considered an ADAT responsibility.
- Waiting times at individual services do not appear to be taken into consideration when a residential service is chosen.
- Information from the Waiting Times Information Framework suggests that clients who accessed residential treatment most commonly did so within 7 days of being considered 'ready' for that intervention. Although as at March 2006 almost 100 clients had been waiting around a year.

3. Spending on residential detoxification and rehabilitation in each NHS Board area

3.1 Main Findings

A total of £9.08 million was spent on residential detoxification and rehabilitation services in 2005-6. Of this, 68% (£6.1m) came from local authority budgets while 32% (£2.9m) came from NHS Boards.

Residential treatment is considerably more expensive than community-based interventions. Work undertaken by Aberdeen City ADAT found that the average package of care for residential rehabilitation per person per year was estimated at roughly £20,000 as a unit cost, compared to approximately £3,000 per person per year for community rehabilitation.

The highest spending NHS Board is Highland at £0.74m. The largest local authority spender by far was Glasgow City Council which spent some £3.4m on residential services. Indeed Greater Glasgow DAT's total spend accounted for some 48% of the total.

Historically, NHS Boards paid for the detoxification element of residential care while local authorities funded the far longer rehabilitation element. As a result local authority spend is frequently greater than the appropriate NHS partner. This dichotomy largely continues.

3.2 Other Key Points

- Total spend on residential treatment (£9.08m) is above the total dedicated budgets (£7.3m); £5.7m from local authority budgets and £1.6 m from NHS Boards.
- Only 16 ADATs have dedicated budgets within their locality: Angus, Borders, Fife, Midlothian, Western Isles and West Lothian do not, and only in Greater Glasgow is there a dedicated (separate) budget at both NHS and Local Authority level.
- Dedicated budgets are far more common in local authorities (15) than NHS Boards (4).
- Some areas spend only a fraction, if any, of their dedicated budget implying that funding is not a limitation to services, whilst elsewhere only the dedicated budget is spent, suggesting limitations on access. One factor in the variability of spend is clinical

decision-making which can be related to philosophy and individual professional experiences of the relative effectiveness of different treatments.

- Despite the existence of ADATs and the wider Joint Future initiative, there is little evidence of progress towards pooled budgets and truly integrated planning and funding of services. Only 3 ADAT areas (Dumfries and Galloway, Forth Valley and Orkney) have pooled dedicated budgets.

4. Decisions on referral to residential treatment

4.1 Main Findings

There is considerable variation across the country as to who ultimately refers and authorises funding for a client to enter residential drug treatment, from senior social workers to Directors of Public Health. In general terms a more senior authorisation is required from NHS Boards than local authorities.

Almost universally, clients access a residential intervention only after the failure of all community based options. Previous evidence of abstinence, even brief, and a belief in one's own responsibility to change behaviour, are also cited as criteria in some areas.

4.2 Other Key Points

- Clients are referred to residential services from specialist community based services. In the main GP's do not directly refer an individual to a residential facility.
- In the majority of cases (72%) the decision to refer and fund a residential placement is a joint one. Clinical decisions will therefore not be directly over-ruled by financial restrictions.
- Only seven ADATs (Aberdeen City, Forth Valley, Greater Glasgow, Orkney, Shetland, Western Isles and West Lothian) have commonly agreed protocols or criteria in place to determine who should be referred to a residential service. Agreed protocols like this clearly clarify who can attend residential services thereby ensuring fairness.
- In most areas protocols are agreed at agency level, ie. NHS Board or Social Work Department. Whilst protocols appear to be more prevalent within NHS Boards it is more common for Social Work to be in the lead in most areas.
- Some areas only refer clients to services in their own locality, while others prefer to send clients away despite the availability of local services, believing that it is preferable to remove a client from negative relationships and associations. It is also clear that some localities always use the same service. It is not clear whether this is a result of good outcomes or simply continuing past practice.
- There appears to be little communication or partnership working between residential services and community based services. When planning and delivering services most ADATs would not appear to consider the residential option, seeing community based services as their priority, the area that they will make most impact with their local resources.

5. Support to drug users and their families during the wait for residential treatment

5.1 Main Findings

All 22 ADAT areas have support services for clients waiting to enter residential treatment, these are largely specialist community services. Twelve areas have protocols in place to ensure the client receives this support; 6 at ADAT level and 6 at individual agency level. Aberdeen City, Ayrshire & Arran, Dumfries and Galloway, Dundee City, Fife, Highland, Lanarkshire, Midlothian, Moray and Perth and Kinross report no protocols.

Twenty ADAT areas have family support services to help the families of clients waiting for residential services. Aberdeen City and Moray are the only two ADATs who do not. In eight areas there are protocols in place to ensure that family members are aware of, or receive this support if requested: Aberdeen City, Angus, Ayrshire & Arran, Borders, Dumfries and Galloway, Fife, Forth Valley, Greater Glasgow, Highland, Lanarkshire, Midlothian, Moray, Perth & Kinross and West Lothian do not.

5.2 Other Key Points

- From services who collected the information 63% of admissions resulted in a 'successful completion' ie. client remain in treatment for planned duration of programme. In general terms, recorded successful completion rates are higher in rehabilitation services (69%) than detoxification and detoxification / rehabilitation services (44%); this may be the result of data recording issues. There is little monitored progress thereafter.
- Aftercare is crucial to long term positive outcomes. Nineteen ADAT areas have aftercare services in the community for people leaving residential settings: Borders, Forth Valley and Perth and Kinross do not. Ten areas have protocols or guidelines to ensure all relevant clients are referred or signposted onto aftercare: Angus, Borders, Dundee, East Lothian, Fife, Forth Valley, Lanarkshire, Midlothian, Moray, and Perth & Kinross do not.
- There is a considerable body of evidence to suggest that detoxification on its own is unlikely to help clients achieve lasting recovery. Detoxification and rehabilitation should therefore really be considered jointly.

Notes

1. Alcohol and Drug Action Teams were asked to submit local information on residential drug and joint drug and alcohol services in 2005-6. As agreed, and as with previous reviews, this review focuses only on residential detoxification and rehabilitation services, as defined below:

Detoxification

- Aim* Humane withdrawal from a drug of dependence
- Duration* Short – Medium (varying between a few days and a few weeks)
- Interventions*
- Clinically-supervised detoxification;
 - Brief psychosocial intervention (in some cases), usually counselling for relapse prevention
 - Crisis support (in some cases) or practical help with housing, benefits

Rehabilitation

- Aim* - Long-term abstinence and re-integration into society
- Duration* - Medium – Long (varying between 2 or 3 months and 1 year)
- Interventions*
- Clinically-supervised detoxification (in some cases)
 - Intensive psychological support to address issues such as reason for drug use, parenting skills, low self-esteem, physical or sexual abuse
 - Therapeutic interventions may include one-to-one counselling, group therapy, cognitive behaviour therapy.
 - Employability interventions (in many cases), including training in basic skills, social and personal skills, employment preparation

2. Psychiatric hospitals or psychiatric wards in general hospitals which provide drug detoxification have only been included if they have dedicated beds for drug detoxification. All NHS Boards have the ability to clinically detox patients, though this is often not a dedicated facility.

3. Crisis beds and supported accommodation are outwith the scope of this study as both provide very different interventions at a different stage of the clients 'treatment journey'. Specifically, these interventions generally do not have a defined goal of making the client drug free.

4. Although this review is about residential treatment for drug misusers, a lot of the information provided relates to services dealing with both drugs and alcohol. In many cases spend on clients with drug problems could not be separated from spend on those with alcohol problems.

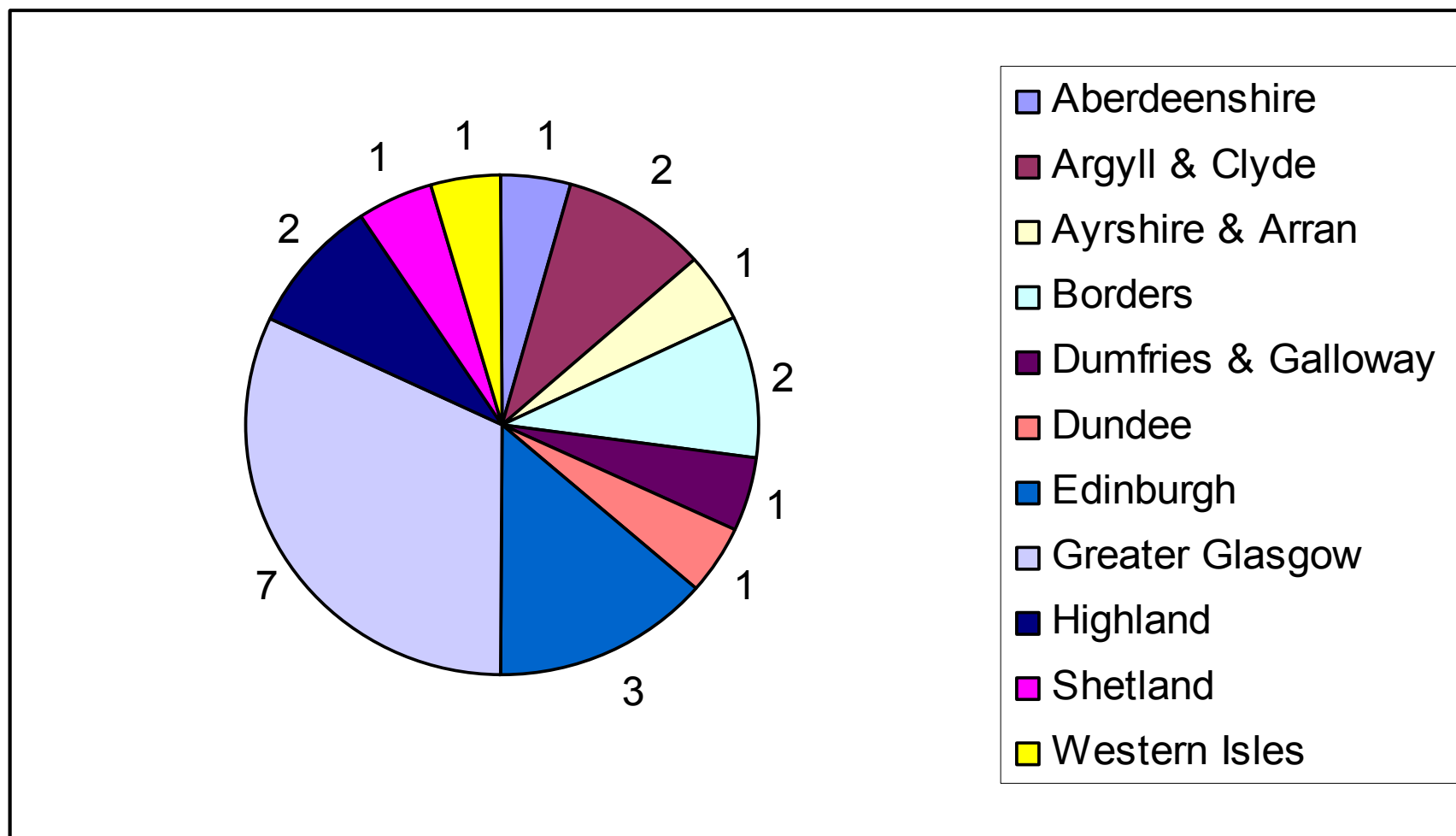
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Number and Location of Residential Services

22 residential services are located in 11 ADAT areas across Scotland.

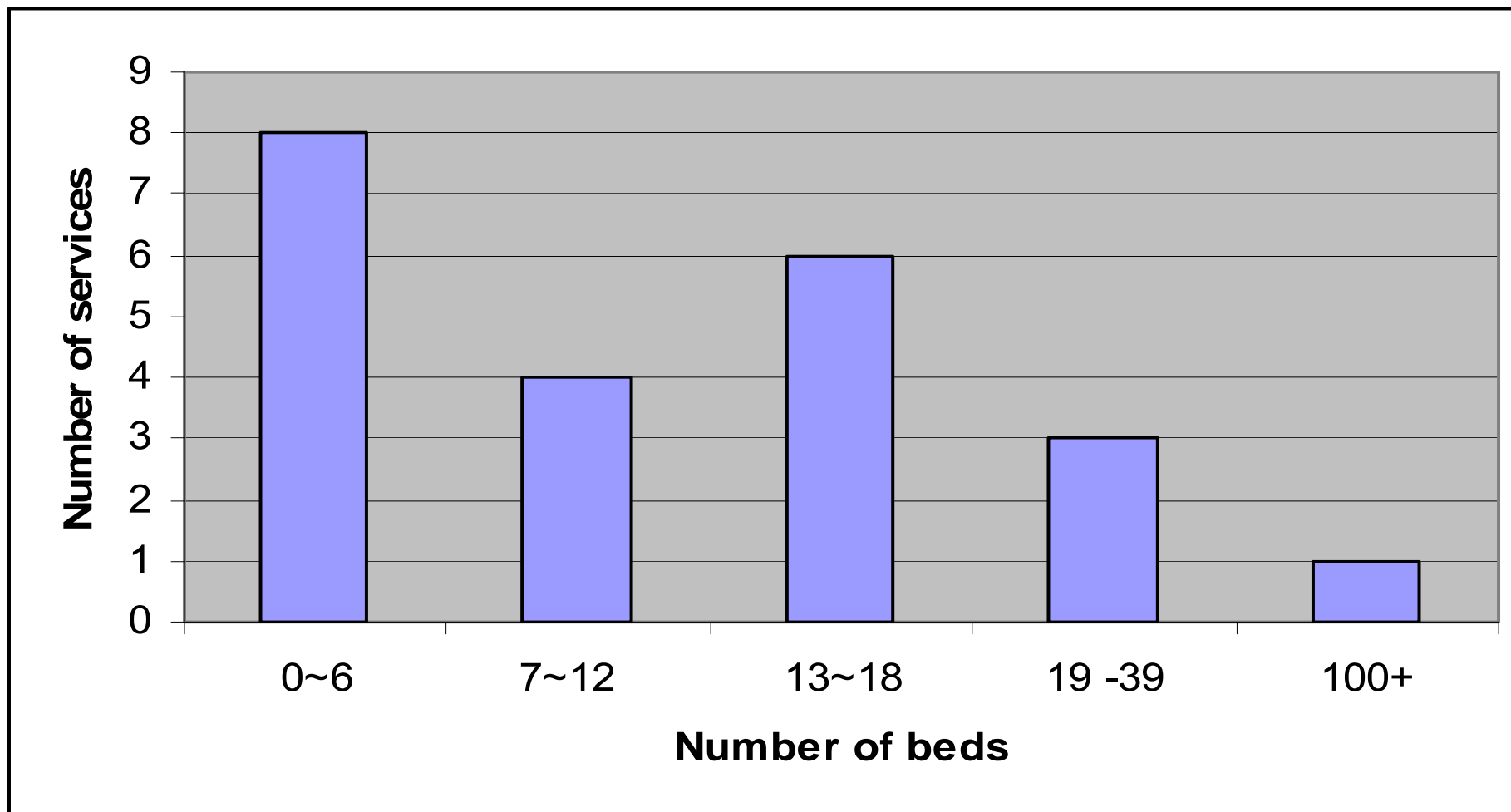
(Information from 22 services)



Size of Residential Services

Most facilities have less than 12 beds, Castle Craig with 104 beds is the clear exception.

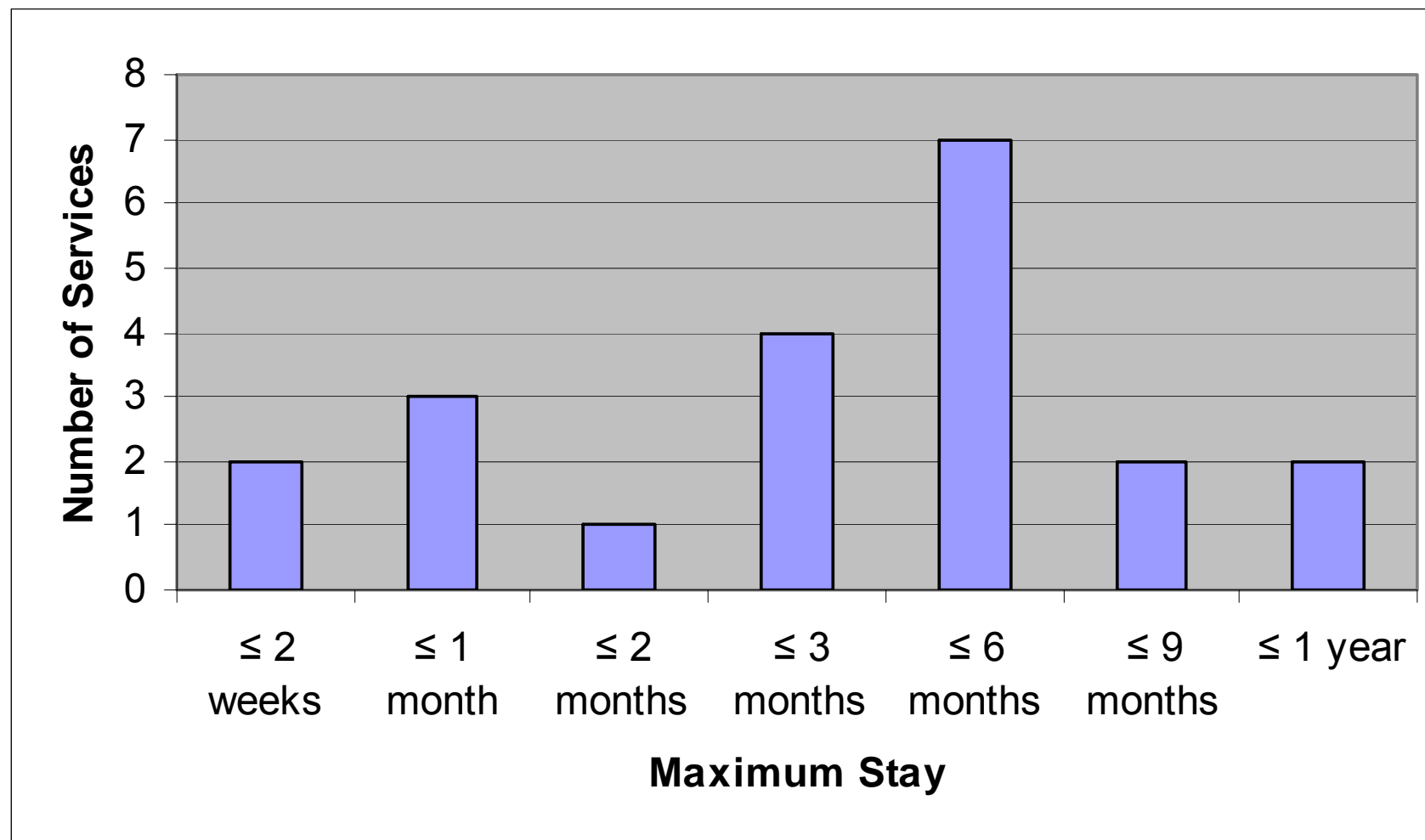
(Information from 22 services)



Length of Residential Treatment

Most services offer treatment for up to 6 months, with a few up to a year.

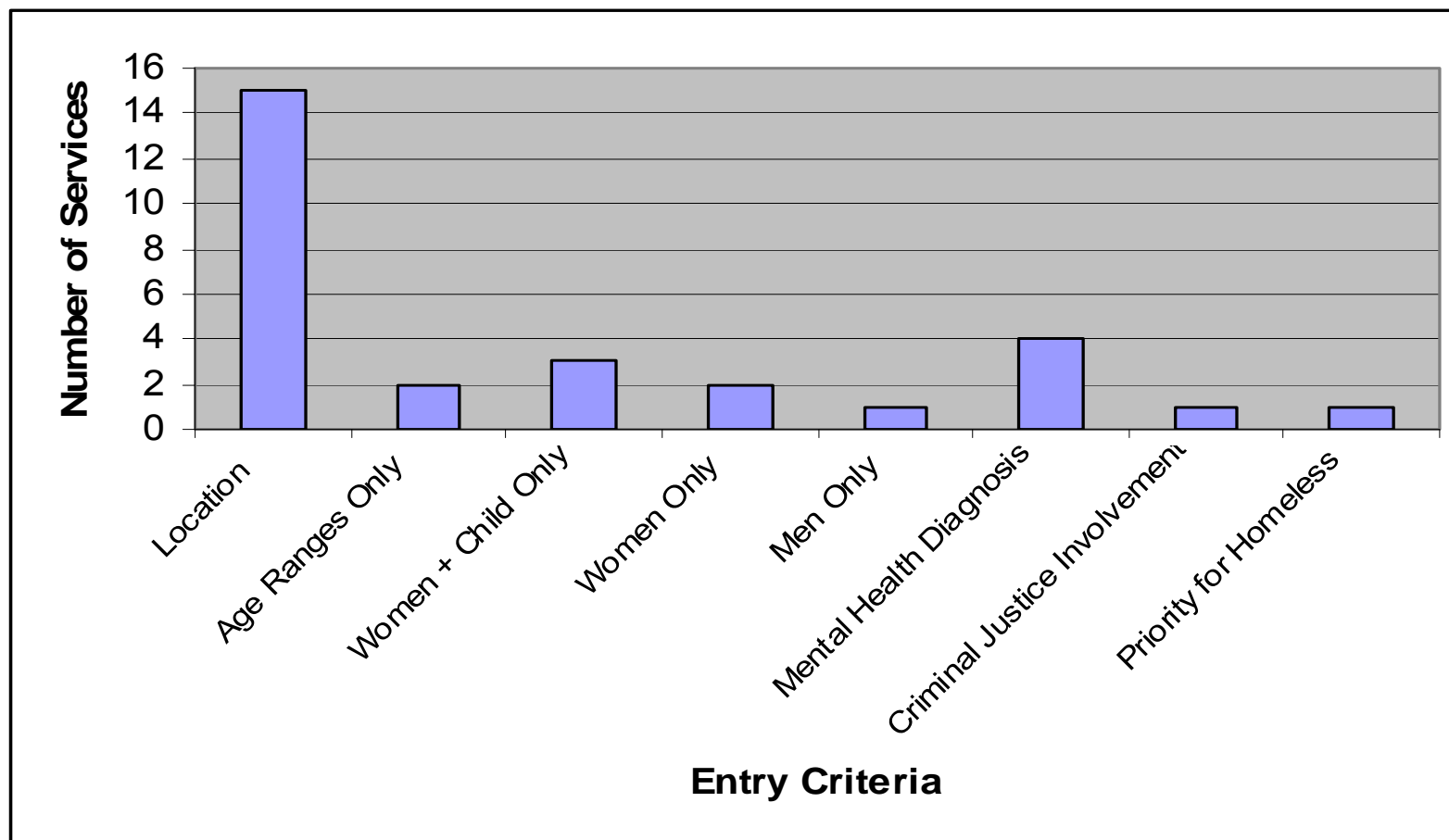
(Information from 21 services)



Entry Criteria for Accessing Residential Services

Where the client lives is the greatest restriction to accessing residential services. Six services have no limitations to access.

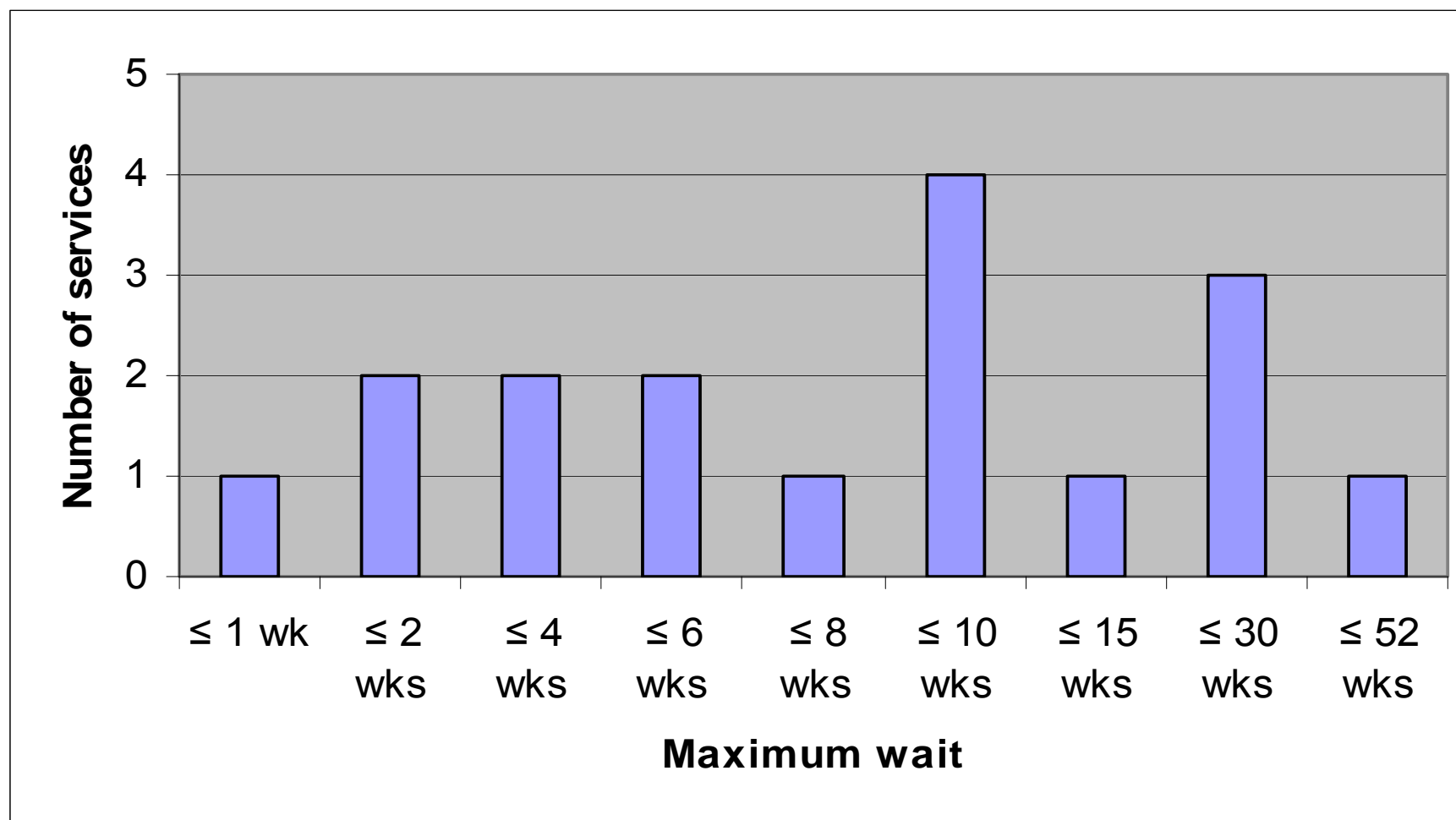
(Information from 22 services; services can have more than entry criteria)



Maximum Waiting Times for Residential Treatment

Maximum waits may be one off incidents. They are not an average.

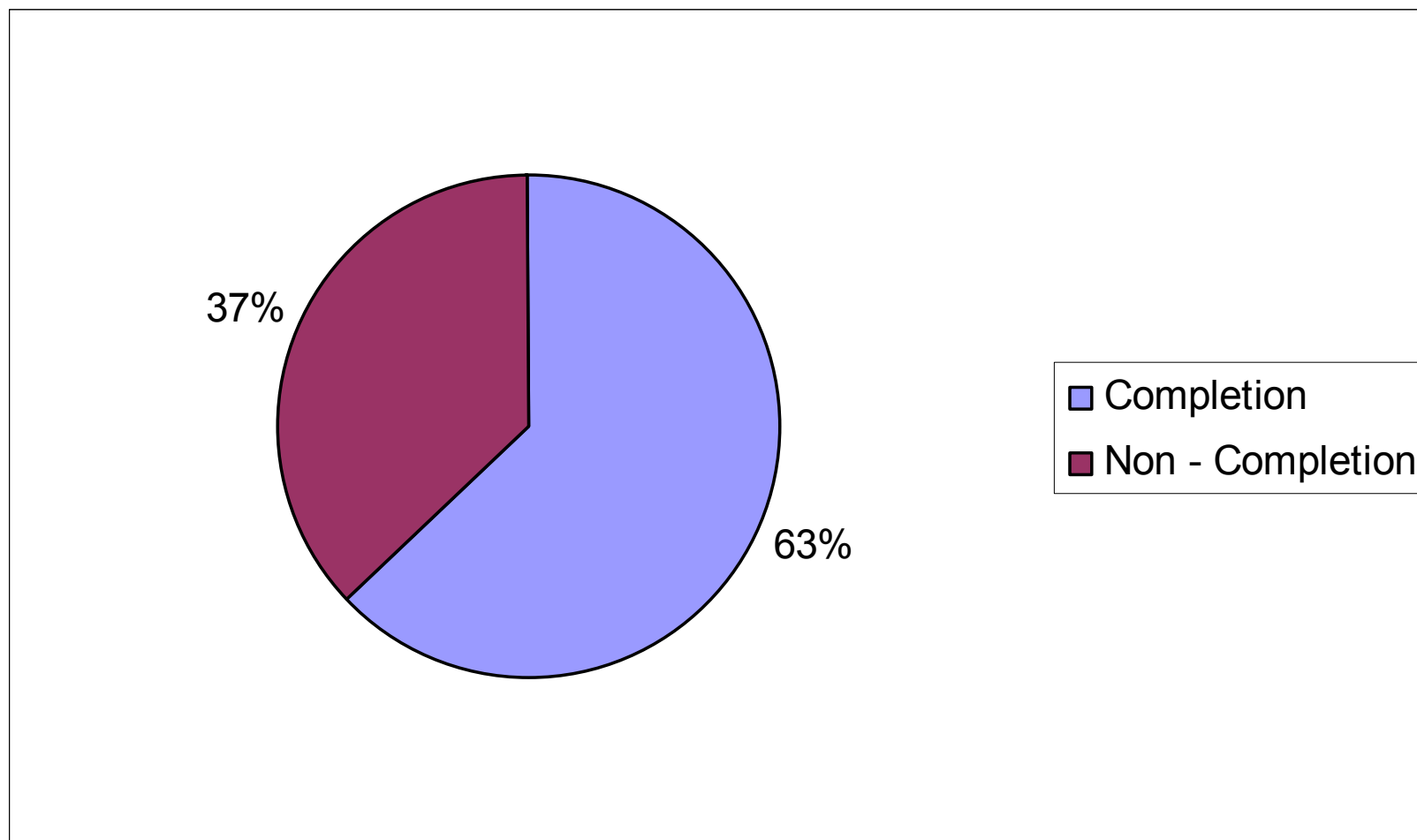
(Information from 17 services)



'Successful' Completion of Residential Programmes

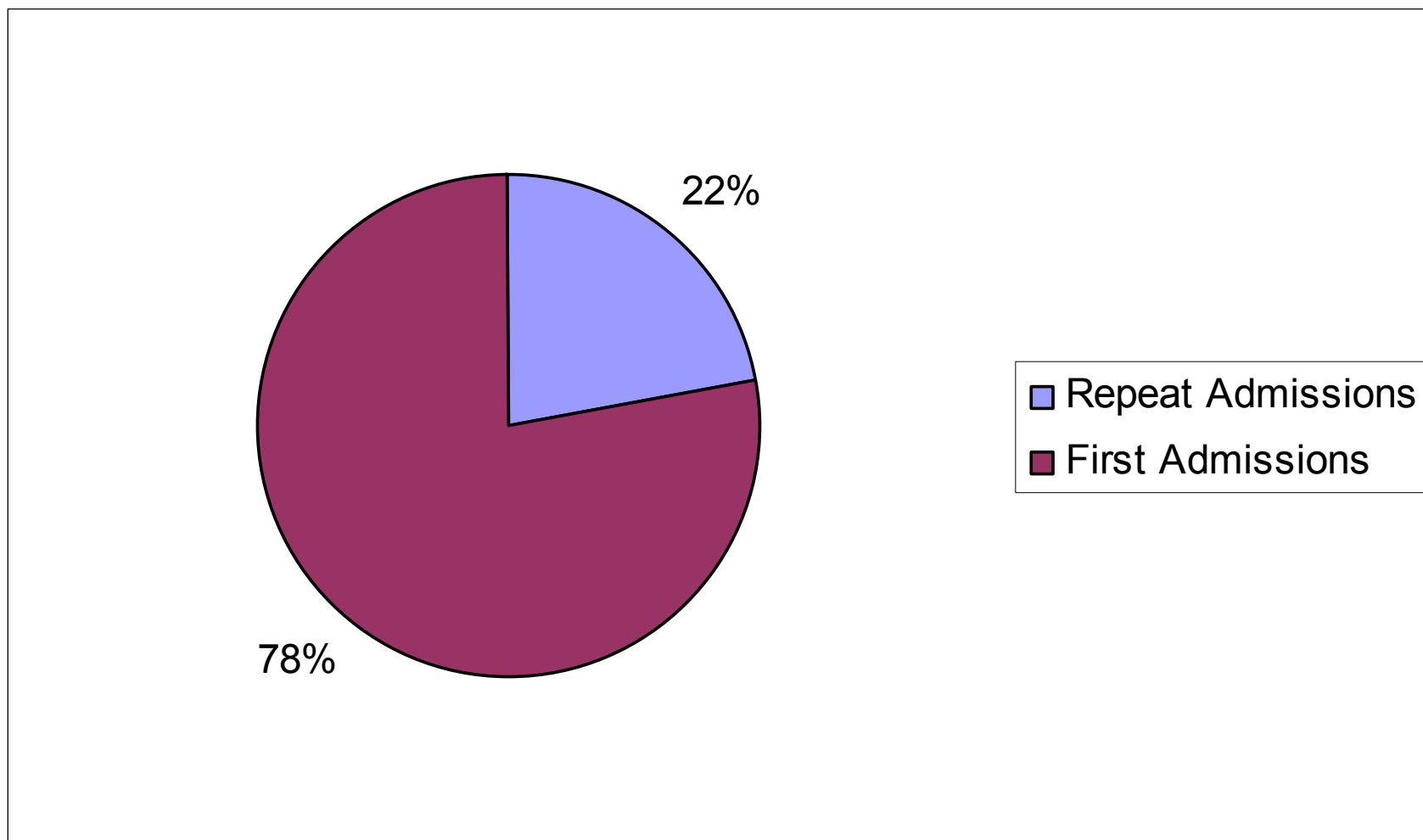
63% of admissions completed their programme of treatment; 37% did not.

(Information from 20 services)



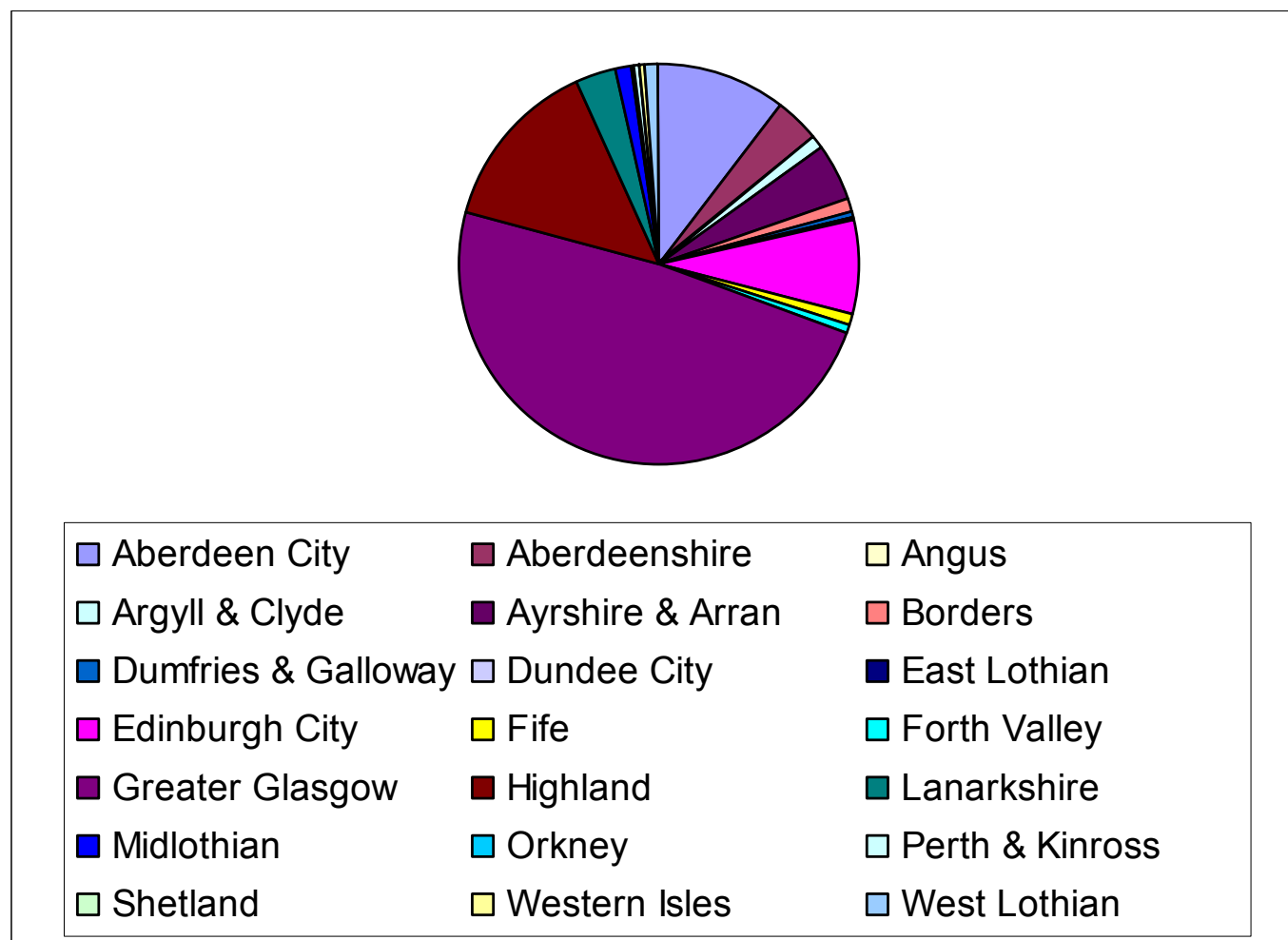
Repeat Admissions at Residential Facilities

22% of admissions are clients entering the same service for a second, or third time.
(Information from 16 services)



Spending on Residential Treatment by Alcohol and Drug Action Team Area (I)

Total spend : £9.08m



Moray ADAT reported no spend in 2005-06

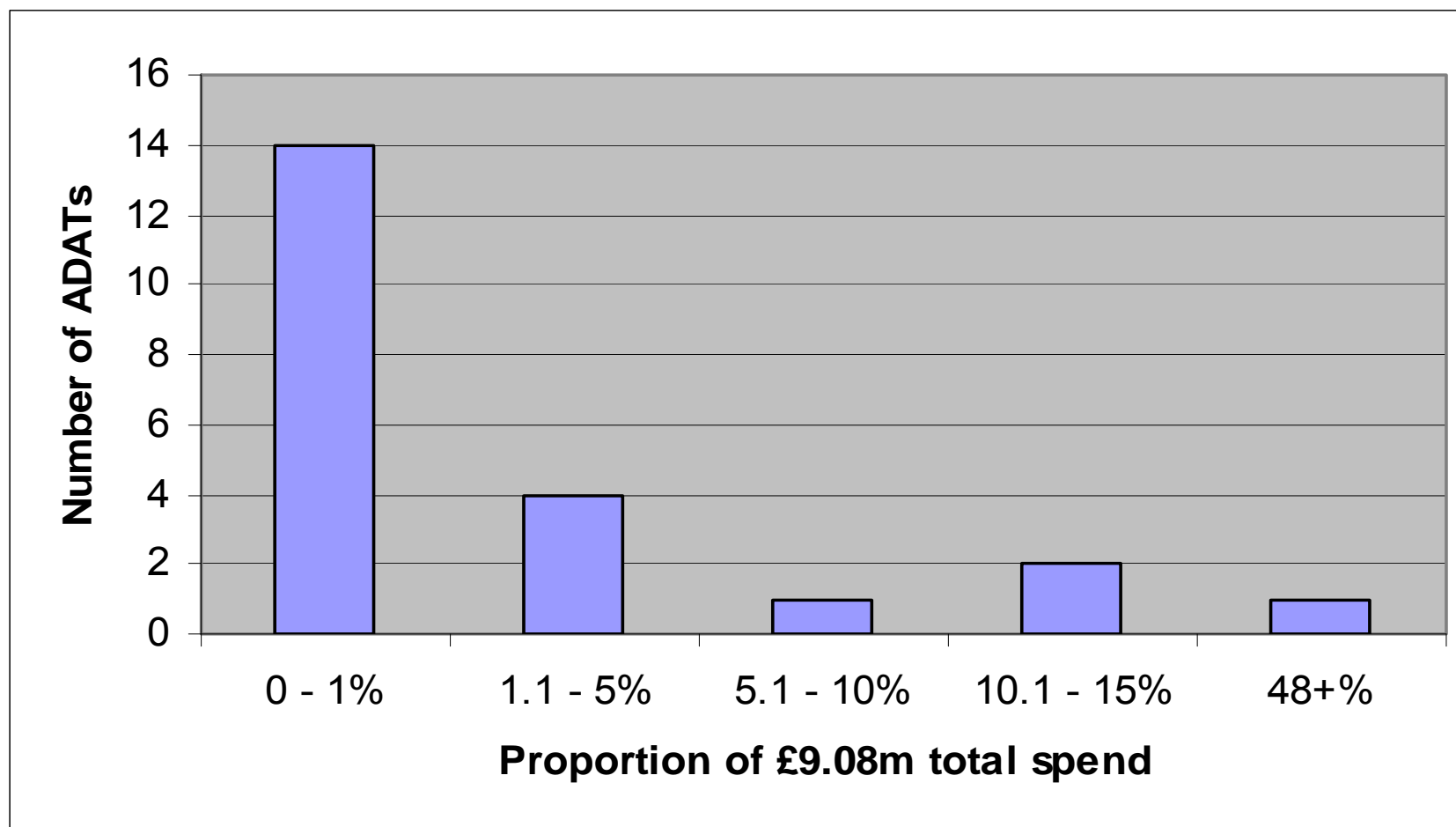
Spending on Residential Treatment by Alcohol and Drug Action Team Area (II)

In ascending order:

Proportion of total spend (Total spend = 9.08m)	ADAT Area	% Spend	Actual Spend (£) (rounded to nearest £1000)
0 – 1%	Moray	0	0
	Shetland	0.01%	8,000
	Orkney	0.1%	10,000
	Angus	0.1%	11,000
	Dundee City	0.1%	13,000
	East Lothian	0.2%	14,000
	Western Isles	0.3%	26,000
	Forth Valley	0.6%	50,000
	Perth & Kinross	0.7%	60,000
	Dumfries & Galloway	0.7%	60,000
	Fife	0.9%	82,000
	Borders	0.9%	85,000
	Argyll & Clyde	1 %	92,000
West Lothian	1%	94,000	
1.1% – 5%	Midlothian	1.2%	111,000
	Lanarkshire	3.2%	288,000
	Aberdeenshire	3.6%	326,000
	Ayrshire & Arran	4.5%	411,000
5.1% – 10%	Edinburgh City	7.5%	677,000
10.1% - 15%	Aberdeen City	10.5%	955,000
	Highland	14%	1,289,000
15+%	Greater Glasgow	48.7%	4,415,000
Total			£9,076,000

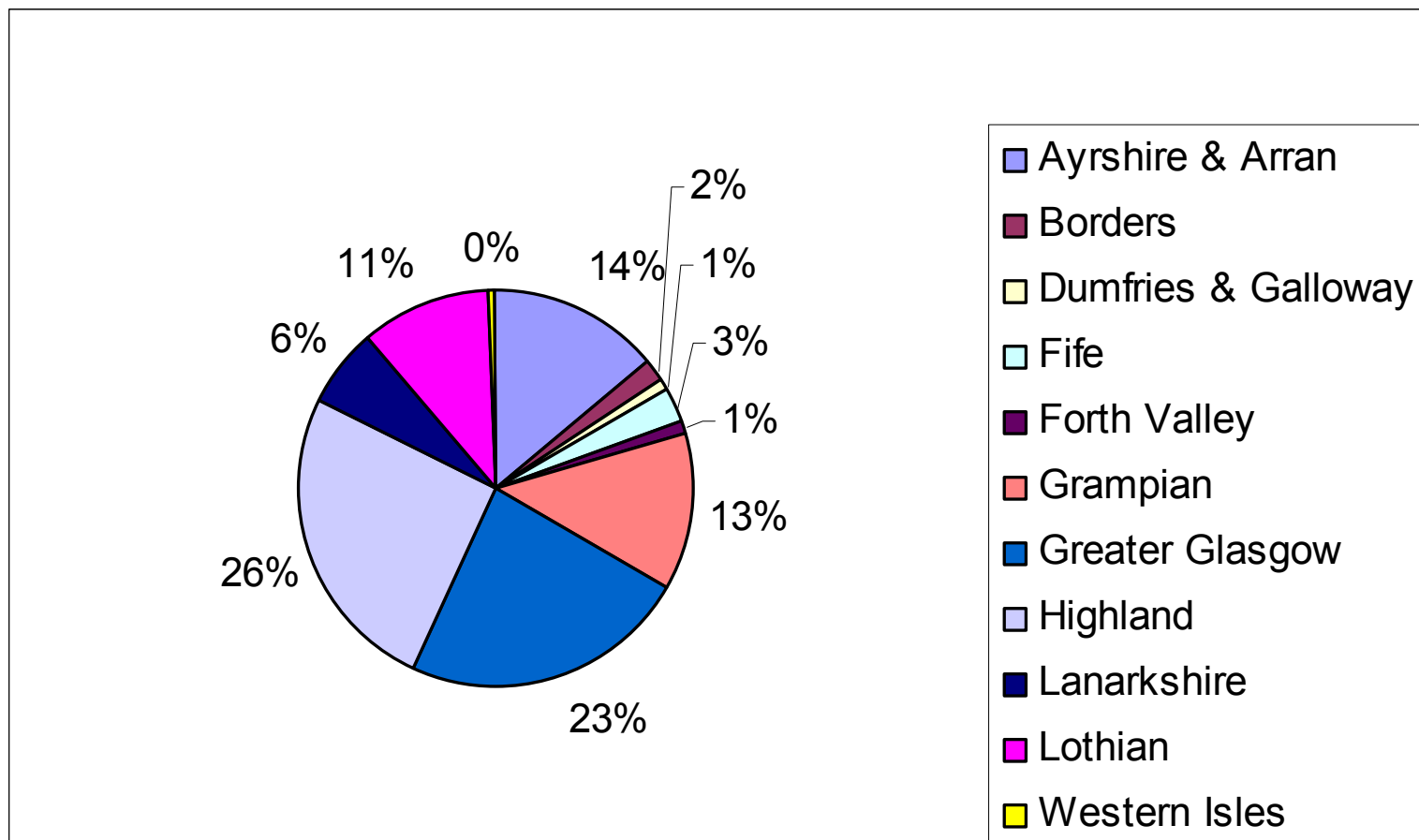
Spending on Residential Treatment across ADAT Areas (III) Differences

Most ADATs spend less than 1% of the Scottish total; Greater Glasgow spends almost half of the total



Spending on Residential Services by NHS Board Area

Total Spend : £2.92m

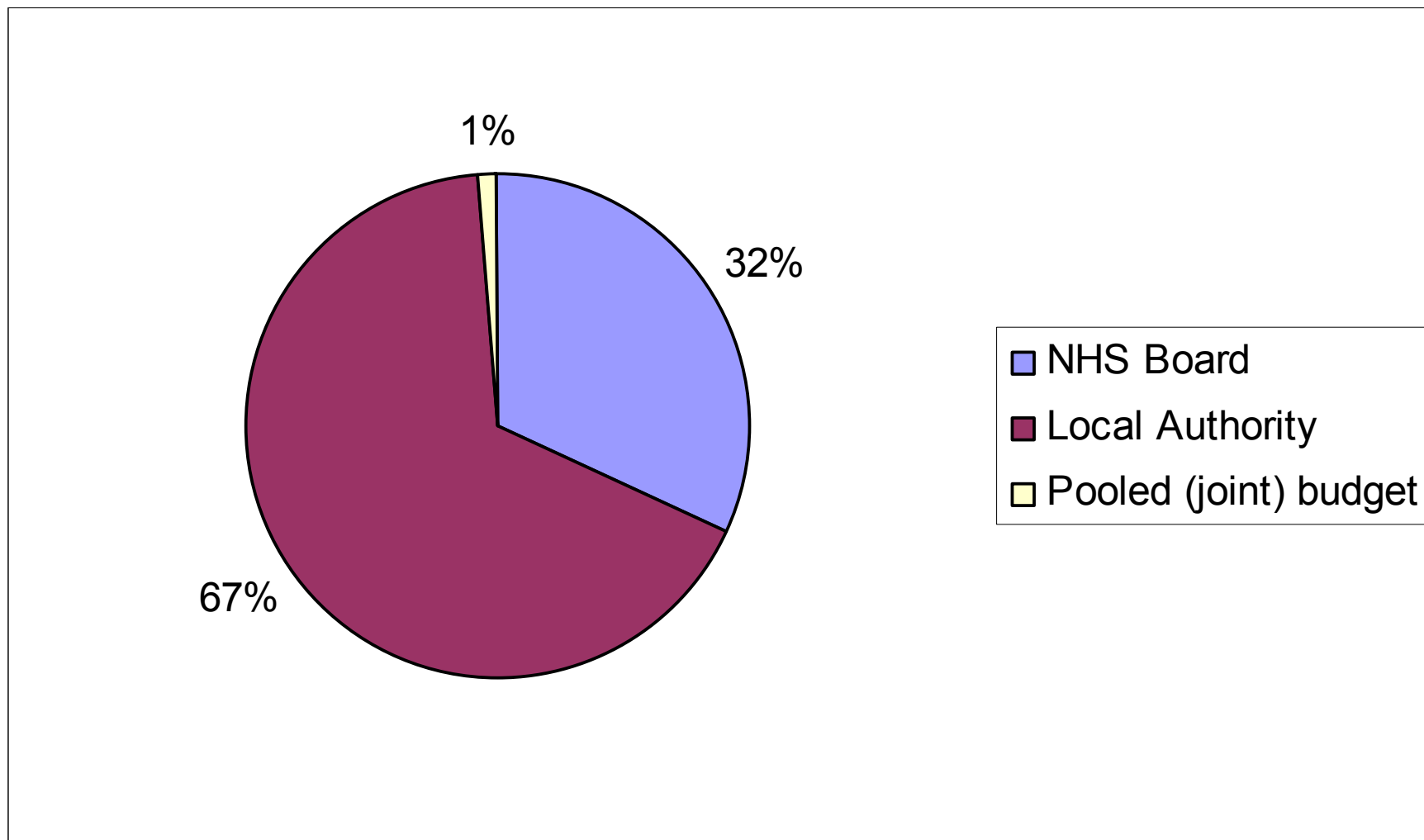


No spend reported from NHS Argyll & Clyde; NHS Shetland or NHS Tayside.

Orkney ADAT has a joint budget with Social Work for residential treatment (£10k), NHS contribution is not known.

Source of funding (I)

Social work budgets are the main source of funding for residential treatment.



Source of Funding (II)

Moray ADAT spent nothing on residential services in 2005-06.

In nine ADAT areas residential treatment is funded from one agency's budget; 2 from NHS funding, 7 from Local Authorities.

100% funding by NHS Board (£)		100% funding by Local Authority (£)	
Ayrshire & Arran	411,000	Angus	11,000
Fife	82,000	Argyll & Clyde	92,000
		Dundee	13,000
		Midlothian	111,000
		Perth & Kinross	60,000
		Shetland	8,000
		West Lothian	94,000

In the 12 remaining ADAT areas funding for residential services comes from both NHS Boards and Local Authorities.

In Orkney the budget is pooled from both the NHS and the Local Authority, no breakdown of this is provided.

The availability of services and protocols to ensure integration between community and residential services for clients and families:

ADAT	Support services for clients waiting to access residential care	Protocols to ensure clients are aware of / receive support	Support services for families whilst client waits for residential care	Protocols to ensure families are aware of / receive support	Aftercare services for clients who complete residential care	Protocols to ensure clients are signposted / referred to aftercare
Aberdeen City	√				√	√
Aberdeenshire	√	√	√	√	√	√
Angus	√	√	√		√	
Argyll & Clyde	√	√	√	√	√	√
Ayrshire & Arran	√		√		√	√
Borders	√	√	√			
Dumfries & Galloway	√		√		√	√
Dundee City	√		√	√	√	
East Lothian	√	√	√	√	√	
Edinburgh City	√	√	√	√	√	√
Fife	√		√		√	
Forth Valley	√	√	√			
Greater Glasgow	√	√	√		√	√
Highland	√		√		√	√
Lanarkshire	√		√		√	
Midlothian	√		√		√	
Moray	√				√	
Orkney	√	√	√	√	√	√
Perth & Kinross	√		√			
Shetland	√	√	√	√	√	√
Western Isles	√	√	√	√	√	√
West Lothian	√		√		√	√