Inverclyde IADP
Alcohol & Drug Partnership
www.inverclydeadp.org.uk

Inverclyde Residential Rehabilitation Pathway

Principal Author	Kenny Leinster
Responsible Head of Service	Anne Malarkey
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Contents

Inverclyde Residential Rehabilitation Guidance

Introduction

This document has been produced for the staff working within alcohol and drugs treatment services in Inverclyde, to facilitate the consideration and actioning of the residential rehabilitation journey for the people of Inverclyde. This guidance and the relevant papers have been prepared following a series of consultation sessions involving a range of ADP partners. This guidance has attempted to incorporate the advice offered by partners and thanks go to all of the organisations who participated in the consultancy sessions. There is a recognition that most people who request drug and alcohol services will not require to be admitted to residential rehabilitation. Residential rehabilitation is a highly specialised service which provides an intensive service to a small number of people who require this intervention which requires the removal from within their immediate community and is normally abstinence based.

This document will consider the political and organisational drivers around residential rehabilitation, and will consider principles underpinning the Inverclyde approach. Organisational requirements and funding considerations will be outlined. It will then focus on the three key stages of the Inverclyde residential rehabilitation pathway, highlighting the documentation required at each of the three stages:

1. Assessment and preparation
2. Support during the period of residential rehabilitation
3. Multidisciplinary support on return to the community

The document concludes with references and hyperlinks to relevant national policy documents, a flow-chart of processes and templates for all the documentation.

Context and Background

In her statement to the Scottish Parliament on 20th January 2021, the First Minister set out additional investment as part of a National Mission to reduce drug deaths which included an immediate investment of £5 million pounds in the 20-21 financial year. A significant proportion of this is to increase the number of residential placements and associated aftercare to ensure there is capacity to meet demand.

Within Inverclyde there has historically been low numbers of people referred to residential rehabilitation. The current model is unable to evidence a whole system response considerate of individual choice and cognizant of care provided beyond medical model. Unfortunately, this does not provide a structure of assurance aligned to national organisational and strategic position.

Inverclyde ADP is committed to the delivery of services underpinned by the vision of Rights, Respect and Recovery Strategy (SG, 2019):

Scotland is a country where we live long, healthy and active lives regardless of where we come from and where individuals, families and communities:

- *have the right to health and life-free from the harms of alcohol and drugs;*
- *are treated with dignity and respect;*
- *are fully supported within communities to find their own type of recovery.*

People living within Inverclyde who want help to address issues in their life caused by alcohol and substance use should be able to access effective services that are appropriately prepared to be responsive to their specific level of need and support them in their recovery. Inverclyde ADP is committed to delivering a whole system response for people at any stage who are adversely affected by alcohol and drug use, and work with partners across a range of services to ensure people in need have good access to treatment and recovery services, particularly those at most risk. This response is inclusive of individual's right to residential rehabilitation as a care and treatment option. It is a component of Continuum of Recovery response within Recovery Orientated System of Care (ROSC) model.

Care at any point in the system should be underpinned by a trauma informed organisational and strategic structure. Consistent with the strategy and values outlined above, the Five Guiding Principles of Trauma Informed care are; safety, trustworthiness, choice, collaboration, and empowerment (e.g. NHS Education for Scotland (NES). (2021)). All services are encouraged to evaluate how trauma informed they are, and developing a transparent, collaborative pathway for accessing residential rehabilitation is consistent with this aim.

To deliver this intervention equitably and effectively the system needs a robust agreed pathway that will transparently inform individual choice inclusive of balance of risk and potential for unintended harm. This should be inclusive of Realistic Medicine (https://www.realisticmedicine.scot/) approaches which facilitate:-

- Shared decision making.
- Personalised approaches to care.
- Reduces harm and waste.
- Reduces unwarranted variation.
- Manages risk better
- Improvement and innovation.

The Inverclyde guidance is informed by the agendas of trauma-informed practice, realistic medicine and the guidance and protocols issued by the Scottish Recovery Consortium in relation to residential rehabilitation.

Residential Rehabilitation Funding

Until March 2026, Scottish Government has committed to giving all Alcohol and Drug Partnerships additional monies to support the use of residential rehabilitation.

Within Inverclyde a financial oversight process will be established to enable NHS and local authority assurance in relation to the spending on residential rehabilitation.

Timescales and outcomes

The government and policy drivers all indicate that the assessment process, the preparation and the facilitating entry into residential rehabilitation should happen as quickly as is practically possible. This capitalises on the individual's motivation, and minimises the risk that a near-fatal overdose or other physical or mental health deterioration could then interrupt the admission.

There are challenges for putting timescales on this process, as pathways into a request can be variable and unique. Equally, once an individual has been assessed as suitable, availability of placements can vary significantly and result in delays in admission.

As a minimum guide, the Inverclyde Residential Rehabilitation Guidance is suggesting that the period from request to completion of assessment is completed within six weeks. Thereafter, the Project Worker and Manager will oversee the pace of progress.

Common Principles

In developing this guidance there are a number of principles, defined in Scottish Recovery Consortium's Best Practice guidance, upon which best practice is based. These include:

- The practice before, during and after a period of residential rehabilitation should, as far as possible, adhere to or be compliant with existing regulatory frameworks
- A human rights approach putting the individual at the centre of the decision-making process
- Individuals should be offered independent advocacy at the inception of the preparation and assessment process
- A non-stigmatising approach
- Equity of access, provision and delivery of all care
- An understanding of the concepts of care and needs in relation to individuals
- An understanding of the effects of Trauma in determining an individual's behaviour and their use of drugs and alcohol
- The right to advocacy at all times
- The participation of the individual in determining their care and recovery
- Feeling safe, being accepted and valued
- The role of a Recovery Orientated Systems of Care (ROSC) in the long-term recovery outcome
- The integration and collaborative working between community services and the residential sector which accompanies an approach placing the individual at the centre of the continuum of recovery

Workforce Development

An awareness and development programme will accompany this pathway. This will be designed on a tiered basis with the most intensive programme targeted at staff directly involved in the assessment, preparation and support of individuals going through the pathway. There will be a developmental input to the multi-disciplinary support services focusing on their role with an emphasis on the return to the community. In addition, there will be a support session for managers focusing on the new pathway and supporting staff in the introduction and application of the pathway.

1. Assessment and preparation

1. Referral routes

Requests for assessment and consideration of suitability can come via the following routes:-

- An individual already allocated to a worker within treatment services
- An individual not currently involved in treatment services
- An individual identified as at high risk of overdose by professional services within Inverclyde.

2. Initial discussions

All individuals who come into alcohol and drug treatment services should be offered advice on treatment options that are offered within the service. Residential rehabilitation should be discussed along with other options of care that are routinely offered:

- Detox / stabilisation
- Maintenance
- Preventative medications
- Psychosocial support
- Physical health interventions
- Financial support
- Specialist Support (inclusive of Addiction Psychiatry, Psychology and Residential Rehabilitation).

3. Priority groups for Residential Rehabilitation

Existing guidance and research suggest that residential rehabilitation should be available to:

- Those with the most complex needs
- Those who have not previously benefited from previous community-based psychosocial treatment
- Those seeking abstinence and who have significant comorbid physical, mental health or social (e.g., housing) problems

- Those with high-risk factors paired with low recovery capital

4. Residential Rehabilitation considerations

Moving to live in a residential rehabilitation service is a significant and daunting process. The experience is both physically and emotionally challenging. There are issues around stigma, fear of the unknown, fear of failure, all experienced when the individual is at the very earliest stages of recovery. Each residential rehabilitation service is aware of the responsibility they have as providers. While each individual is responsible for their own recovery, residential rehabilitation must keep vulnerable people safe, care for them, look after them 24 hours per day, understand and manage each individual's fears, concerns and anxieties, get to understand them as individuals and enable them to manage their addictions.

The agreement of the most appropriate residential rehabilitation facility should be informed by:

- Individual preference
- Individual need
- Identified risks
- Family and carer inclusivity
- Care Inspectorate approval

Preparation for admission to a residential rehabilitation service will require an initial assessment. The Orange book describes this in some detail and there is a recognition that assessment is an ongoing process that will require to be conducted over a period of time. This assessment should be conducted by the Care Manager. The individual should fully consent and be involved at all times. Other family members or appropriate others can be involved with the individual's consent. A key element of this process is the assessment of risk, both to the individual and others.

During the assessment process, it is important to identify and understand the fears and concerns of the individual. These can include fears of losing accommodation, benefits/income and relationships. SRC's Best Practice guidance defines prompt awareness of some of questions that may be around for individuals:

- Will I have a room of my own?
- Will I need to tell everyone about my feelings?
- What happens if they don't finish, leave early, go back to using drugs?
- Will I have a place to stay when I return?
- What happens if I let people down?
- How will I cope on return?
- Will my family want to see me?

For all individuals requesting residential rehabilitation an exploration and understanding of their substance use, coping mechanisms, change and motivation, mutual aid and recovery network is important. SRC have defined these as including:

- Self-care and nutrition
- Relationships
- Physical health and wellbeing
- Mental health and emotional wellbeing
- Constructive use of time, avoiding boredom
- Offending
- Housing and skills for independent living
- Managing money
- Family relationships

Each of these areas should be explored in detail with the individual through the completion of the outcome starting with acknowledgement made that support may be required to learn and improve their skill level across these areas. This is important in enabling individuals to take control of their lives and manage their behaviours in a way which does not revert to substance use.

5. Decision Making

- The decision that informs residential rehabilitation is essentially the choice of the individual but should be influenced and evidenced by sound clinical and social risk mitigation. Family members should be encouraged to actively participate in the process but should not assume influence beyond the self determination of their loved one.
- A meeting should be arranged and chaired by manager with responsibility for this individual. All colleagues who have contributed to care should be involved as well as the individual, advocacy and their family/carer.
- The meeting will provide an opportunity for the individual, their family and /or carer and all professional colleagues to contribute to decision making process for progression of placement.
- If the individual decides that residential rehabilitation is no longer an option they want to pursue then alternative options to care should be discussed and offered.
- If a decision is made not to support the request the reasons should be clearly explained and written confirmation provided. Alternative options of care should be offered the opportunity for reconsideration of decision if position changes should be advised.
- If there is professional and personal disagreement on decision the reasons should be clearly documented and alternative options discussed and agreed.

6. Dis-engagement from Assessment/preparation for Residential Rehabilitation

   It may be that during this period, the individual dis-engages from the assessment/preparation process and/or dis-engages from the treatment service.

- In the case of an active decision to withdraw from the residential rehabilitation process, the Project Worker should engage with the individual around their reasoning for withdrawal and hear if there are any fears or barriers that could be overcome with assistance with wider services. If the individual indicates clearly that they want to withdraw, then the worker should alert their manager to this decision and record this within their care notes.
- In the case of an individual dropping out of contact with the treatment service, the Project Worker should lead on proactive re-engagement of the individual, primarily in relation to general support and treatment. This should take the form of contacting the individual by phone/letter, and conducting outreach visits to their home if unable to make contact. The Project Worker should discuss the dis-engagement with their manager to consider whether further escalation based on vulnerabilities is necessary before closing the case. Should case closure happen, this should be recorded within the case notes.

7. <u>Final preparation for Residential Rehabilitation</u>

- Project Worker should lead on identifying the range of suitable options, by contacting facilities and matching with the individual‘s needs/risk/geographical considerations and timescales etc.
- The individual (with support of family/advocacy where appropriate) should be supported to decide on which residential facility best suits. Where possible, this should include the individual having direct contact with facilitates, by phone, video call or in-person visiting.

8. <u>Assessment and preparation: Roles and Actions</u>

Project Worker	**Manager**
Highlights request for RR to Manager Explores a referral to advocacy with the individual Offers lower intensity interventions that can be offered locally and evidence of benefits for same advised. Community-based interventions should not be delayed due to ongoing assessment for residential rehabilitation. Family and/or carer should be linked with community-based family supports.	The Manager requests clinical assessment, required prior to admission. At point of request for RR, arranges RR MDT Meeting (no longer than six weeks in advance) to review the completed the RR Assessment.

Project Worker undertakes the assessment incorporating the specific request for residential rehabilitation. Project Worker engages with family. Project Worker engages with Recovery Community.	
Residential Rehabilitation MDT Meeting Chaired by the Manager, this meeting is a forum for reviewing the outcome of the assessment and making a decision about suitability. The meeting should involve: • The individual • Their family/loved one (where applicable) • Their Advocacy Worker (where applicable) • The Project Worker (and any other team member involved in the RR Assessment) • Representation from the Recovery Community	
Approaches Residential Rehabilitation facilities and considers suitability in light of any health/social needs, availability and cost. Explores all available options for residential rehabilitation for the individual so they are fully informed of service options. A decision should be reached about the chosen rehabilitation centre.	If RR MDT concluded in favour of residential rehabilitation, Manager to record and request funding.

2. Support during the period of residential rehabilitation

1. Community links

Whilst in the residential facility, care from treatment services should be ongoing. The Project worker will act as a conduit between the individual, the facility and the community that they will be supported by on discharge. A communication plan will be developed by the residential staff, which will detail the expectations of all parties.

For Inverclyde individuals admitted to residential rehabilitation, Worker should have monthly direct contact with the individual to ensure a sustained meaningful relationship. This is preferably conducted on face-to-face basis, however circumstances may determine that this is delivered over the phone, or using video technology if available. It is crucial for the relation with the worker to continue, as they will be the lead support for the individual when they return to the community, regardless of whether the initial agreed length of stay is completed.

2. Review processes

Regular reviews of an individual's progress are essential to ensure a person-centred approach to planning, and to ensure that contemporaneous information is shared between all parties in order that actions can be taken forward as required.

An initial review will usually take place within a few days of an individual's admission. Thereafter, reviews will be held monthly until point of planned discharge.

The following would normally be considered the core group of attendees for any review:

- The individual
- Keyworker from the residential rehabilitation unit
- The worker from the community team.
- A rep from any relevant community resources (Advocacy, Housing, Justice, ADRS, Employability) (with consent of the individual)
- Family (with the consent of the individual)

The residential facility will document the review, and the minutes of the meeting will be distributed to all relevant parties.

For the roles and expectations of residential rehab facilities, please see SCR's Voluntary Guidance document, embedded in References.

3. Recovery Planning

The Inverclyde Residential Rehabilitation Recovery plan is intended to ensure that each individual has the opportunity to define and set their own recovery goals while they are living within the residential rehabilitation setting. This plan is designed to be flexible in order that recovery goals can be updated and reviewed at appropriate

points following formal reviews. The plan can be used to demonstrate progress during the course of the stay in residential rehabilitation.

A key feature of this plan is the opportunity for the identification of strengths. Many people find it difficult to identify things they do well or have done well. They often find it difficult to identify positive characteristics of their behaviours, either present or in the past.

This Recovery Plan is based around the domains identified within the Outcome Star model. It is intended to be completed with each individual and should be used to indicate progression on the recovery journey. Individuals should retain a copy of each completed Recovery Plan and refer to it on subsequent reviews.

4. Discharge Planning

There is a recognition that the length of stay is time limited and the period in residential rehabilitation is part of the individual's long term recovery journey. There is an acknowledgement within the residential sector that while a period in rehabilitation is important in preparing the individual for a return to the community, this is a vulnerable point of transition. If professionals have an understanding of the needs of individuals returning from residential rehabilitation, they can be best placed to ensure people get the care and support required to meet their needs.

Of the transition points this is the area where the risks are great and the opportunities for breakdown are high. Individuals should be fully involved where possible in determining where they wish to return to, and there are a number of determinants that lead to breakdown at this point. Being aware of these and managing their effects is useful in clarifying both the approach and the actions which indicate best practice. The Project Worker has a vital role in supporting the individual in recovery.

Boredom, trauma and isolation are the enemies of recovery and individuals will face stigma, resistance, relationship issues, fear and anxiety.

The organisational and administration issues involved in organising benefits, accommodation and access to GP and health services are significant. Individuals therefore need to feel supported, valued and be involved in this process.

The effects of trauma can be reignited by a return to previously familiar stimuli.

Role of Project Worker

If professionals have an understanding of the needs of individuals returning from residential rehabilitation they can be best placed to ensure people can get the care and support to meet their needs. There should be a Recovery Plan prepared with the person in recovery which details the responsibilities and requirements for the person in recovery and the role of the Project Worker.

The Project Worker should liaise with all services and organisations to ensure the preparation and coordination of the individual's return is as seamless as possible.

This means as much as possible is done to ensure accommodation is assured, benefits are in place and registration with a GP is completed.

- The individual should be furnished with support from the recovery community and immediately engaged in meaningful activity. This could be volunteering, training or employment.
- There should be the opportunity to engage in trauma specific services to follow from the work already completed in the residential setting.
- There should be regular contact between the community-based staff and the person in recovery.
- The Project Worker should arrange for the person in recovery to be taken from the residential service to their home. Discharge is the recognition of a resident's ability to return to the community and meet the challenges that this entails. Crucial to a positive outcome is liaison and preparation for each individual. This will involve close cooperation with community-based staff to ensure the person in recovery has as seamless a return as possible. This will require detailed planning and preparation.

3. Multidisciplinary support on return to the community

While the role of residential rehabilitation can be a significant factor in the journey of each individual, this can be set within the wider context of the continuum of recovery which also encompasses community-based recovery. Community support should be inclusive of the person's recovery and will involve planned and detailed support by the Project Worker within a range of areas that will be organised and in place prior to return to the community. These include the following:

- Housing
- Benefits
- Primary Care
- ADRS
- Employability, training or meaningful activity
- Recovery Communities
- Family support

References

Rights, Respect Recovery: - Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths (SG, 2018)

Rights, respect and recovery: alcohol and drug treatment strategy - gov.scot (www.gov.scot)

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https://www.realisticmedicine.scot/

Staying Alive in Scotland (SG, 2018)

https://www.sdf.org.uk/wp-content/uploads/2019/11/Staying-Alive-in-Scotland-Digital.pdf

Medication Assisted Treatment Standards, DDTF, 2020

Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)

NHS Education for Scotland (NES) (2021) Trauma-informed practice: toolkit. NHS Education for Scotland

Trauma-informed practice: toolkit - gov.scot (www.gov.scot)

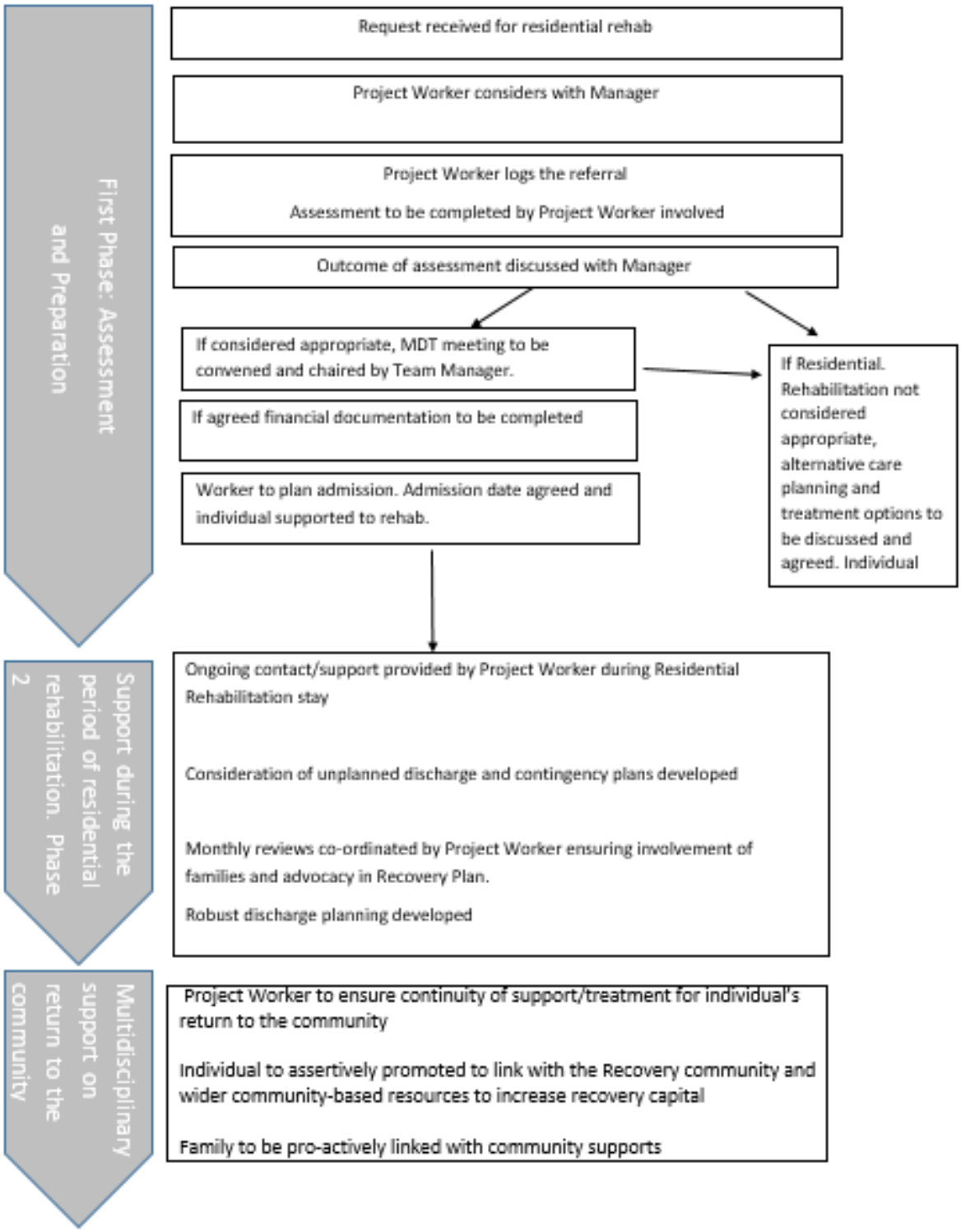
Voluntary Guidance for Best Practice in Residential Rehabilitation in Scotland, Scottish Recovery Consortium, 2021

Residential Rehabilitation Working Group – Scottish Recovery Consortium

Protocol on Transition of prisoners at liberation to residential recovery services across Scotland, SCR, 2020

Residential Rehabilitation Working Group – Scottish Recovery Consortium

Appendix A: Inverclyde Residential Rehabilitation Pathway: Flowchart

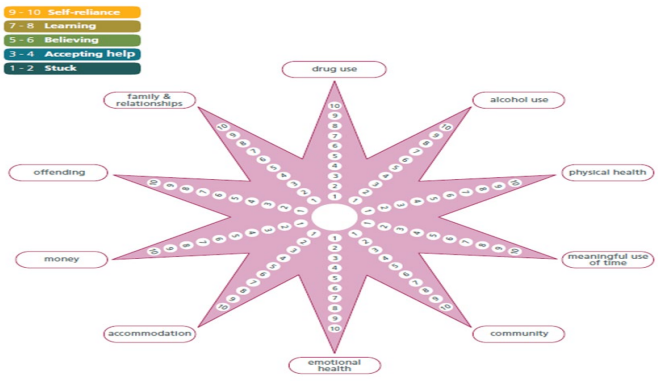


Residential Rehabilitation Flowchart 1

Appendix B: Inverclyde Recovery Plan

1. Individual's details	
Forename: Surname: Address: Postcode: D/O/B Phone number: Chi: SWIS: Consent to share Information? **YES/NO**	GP: Address: Postcode: Phone Number Next of Kin: Relationship: Phone number:
2. Residential Rehabilitation details	
Name: Address: Postcode:	Keyworker(s): Name: Tel No: Email address:
Date rehabilitation started: Planned discharge date:	
3. Project Worker /Team Details	
Name: Team: Tel No: Email address:	

Recovery Plan based on domains of the Drug and Alcohol Outcomes star



4. Recovery Goals	
Drug-use	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Alcohol-use	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Physical health	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	

Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Emotional health	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Family and relationships	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	

When will this goal be reviewed?	
Community	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Meaningful use of time	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Accommodation	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	

Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Money	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	
What is your plan to achieve this goal?	
When will this goal be reviewed?	
Justice	
How will this goal help your recovery?	
What do you need to do to achieve this goal?	
Who do you need to help you achieve this goal?	
How will you know when you have achieved this goal?	

What is your plan to achieve this goal?	
When will this goal be reviewed?	

5. Residential Rehabilitation-additional info and update from last review

6. Views of family/friends/other agencies

7. Conclusions

8. Attendees(s) name and signature	Date