DUNDEE ALCOHOL AND DRUG PARTNERSHIP

RESIDENTIAL AND REHABILITATION RECOVERY MODEL

JUNE 2022

DUNDEE ALCOHOL & DRUG PARTNERSHIP (ADP) – RESIDENTIAL REHABILITATION MODEL

SUMMARY

Background: Following the Scottish Government's announcement of a 'national mission' to reduce alcohol and drug related deaths and associated harms in January 2021, a proportion of the £50 million per year investment of funding was provided to the Dundee Alcohol and Drug Partnership (ADP) to improve the pathways for clients accessing residential rehabilitation.

A unique model has been developed in Dundee focussing on the essential *before* and *after* support components provided alongside a stay at a residential rehabilitation establishment. The model is intended to work in harmony with pre-existing facilities, thus not treating rehabilitation as a separate part of the recovery journey.

Within the Dundee Health and Social Care Partnership (HSCP), it is usually the role of social workers to assess and refer individuals to residential rehabilitation. However, historically there was not an agreed formal pathway for individuals to access residential rehab and then be supported to return to the community. Consequently, individuals would be at a risk of relapse on their return to Dundee, with a with a lower tolerance and heightened risk potential for overdose. More generally, feedback from individuals with lived experience indicated a lack of support and communication from local services throughout the process of accessing residential rehab. It was clear that a more extensive preparation/assessment period, focusing on individuals' readiness, physically and mentally, to embark upon the challenging commitment of residential rehabilitation was required.

A 12-week model: Following a consultation with partner agencies and organisations, including the third sector, residential rehabilitations establishments and those with lived experience (carers, peer workers and clients) the Dundee ADP have been able to design a 12-week model of rehabilitation. This model will:

- Focus on individuals' needs;
- Follow a whole family approach;
- Be client-led; and
- Provide a wrap-around of supports extending the journey of recovery into the community post-rehabilitation and beyond.

Consultations indicated that for various individualised reasons, including vulnerabilities/ trauma/ mental health and personal commitments, recovery in the community should involve an alternative pathway. With similar 'post' community supports already on offer, this could also act as a contingency plan for those who may end rehabilitation early, enabling them to be quickly supported and reduce such risks discussed.

In order to continue developing and begin fully implementing our unique and ambitious recovery and rehabilitation model, and to meet our goals of building on Dundee's recovery community, front line staff staff require the ongoing support of specialised and dedicated workers to deliver the work described. Further investment of funding will be allocated to support the implementation of this model.

INTRODUCTION

The Dundee ADP have adopted a Person-Centred Approach to our residential rehabilitation model by offering alternative routes to recovery within the local community. This is in recognition that residential rehabilitation will not be right for everyone. Primarily the ADP's task was to improve Dundee's pathways to accessing residential rehabilitation, therefore the model proposed will primarily focus on this at the interim stage. The ADP want to provide an inclusive approach allowing everyone the chance to begin their recovery along a path which meets their own individual needs. Throughout this report, both elements of the pathway will be referred to as either 'alternative community recovery pathway' or the 'residential rehabilitation' route.

A 12-week model of residential rehabilitation is being offered, which will centre around a pre and post continuum of recovery, thus not treating rehabilitation as a separate entity. A large focus of further development will be on pre-admission and post-admission support. These stages are considered as equally important in giving individuals the best possible chance in sustaining their recovery journey, based on a holistic assessment of need.

Consultations have been aided by Dundee Drugs and Alcohol Recovery Service (DDARS) colleagues, third sector agencies, rehabilitation staff and peer volunteers, carers of individuals with substance use, other local authority HSCP and service users of residential rehabilitation.

BACKGROUND AND LEARNING

Previously, in Dundee we have followed a 6-Month Model of care in a known and used residential rehabilitation facility, where the individual would receive in-patient care in a facility to aid their recovery from alcohol and/or substances. Historically, staff within Social Work had the lead role in identifying and facilitating a residential placement. There is no specific protocol or criteria in place to decline or accept referrals, rather an expectation to simply progress. Workers have identified this as a gap in the assessment stage which requires development. By not screening referrals or arriving at a multi-agency decision regarding whether residential rehabilitation is suitable for the individual, the process currently lacks a person-centred planning and could potentially cause inconsistencies regarding the criteria individuals need to progress to rehabilitation and service users experience.

FEEDBACK FROM CLIENTS, CARERS, PEER WORKERS AND AGENCIES ON PREVIOUS MODEL

Sending people to residential rehabilitation without the knowledge of an individual's differing needs and background, may endanger setting clients up to fail. Colleagues have felt that without the comprehensive assessment and preparation currently being proposed this may have been an influencing factor in recent cases where individuals unfortunately did not complete or left residential rehabilitation early.

With some clients being sent to different local authorities, we must also be mindful of the implications of being away from crucial supports including support in the community, as well as from family and friends. Cases also arose where individuals would continue using lower class/unprescribed 'over-counter' substances, and on occasion relapse back to illicit, illegal substances following crisis in the

facility. In addition, sometimes there is confusion around the medication's individuals can take when entering the facility and whether these were indeed prescribed. These issues relate back to a lack of support and effective communication from services and could be rectified where a more extensive preparation period with a GP/Health assessment is provided.

Throughout the majority of these cases, staff and service user feedback indicated both a lack of service user's preparedness and readiness to change, making the demands of a 6-month rehabilitation programme much less sustainable or effective. Additionally, although staff would conduct an ad-hoc assessment for rehabilitation at the time, this was not extensive enough and there was little capacity to conduct proper assessments.

Early discharge from residential rehab also placed service users in a vulnerable state, potentially leading to feelings of failure and/or a return to substance use, with the associated risks of low tolerance and overdose. We know that to mitigate early discharge, a proper preparation/assessment period and better communication between the rehabilitation agency with the client and local social work/ other agencies could have increased the client's resilience or concluded that rehabilitation was not appropriate at that time.

By proposing a more person-centred, holistic approach with an understanding of recovery, partnership working and knowledge of available services, both of residential rehabilitation and in the community, we can better meet individual needs and give people the best chance at a sustained recovery.

NEW PROPOSED PATHWAY

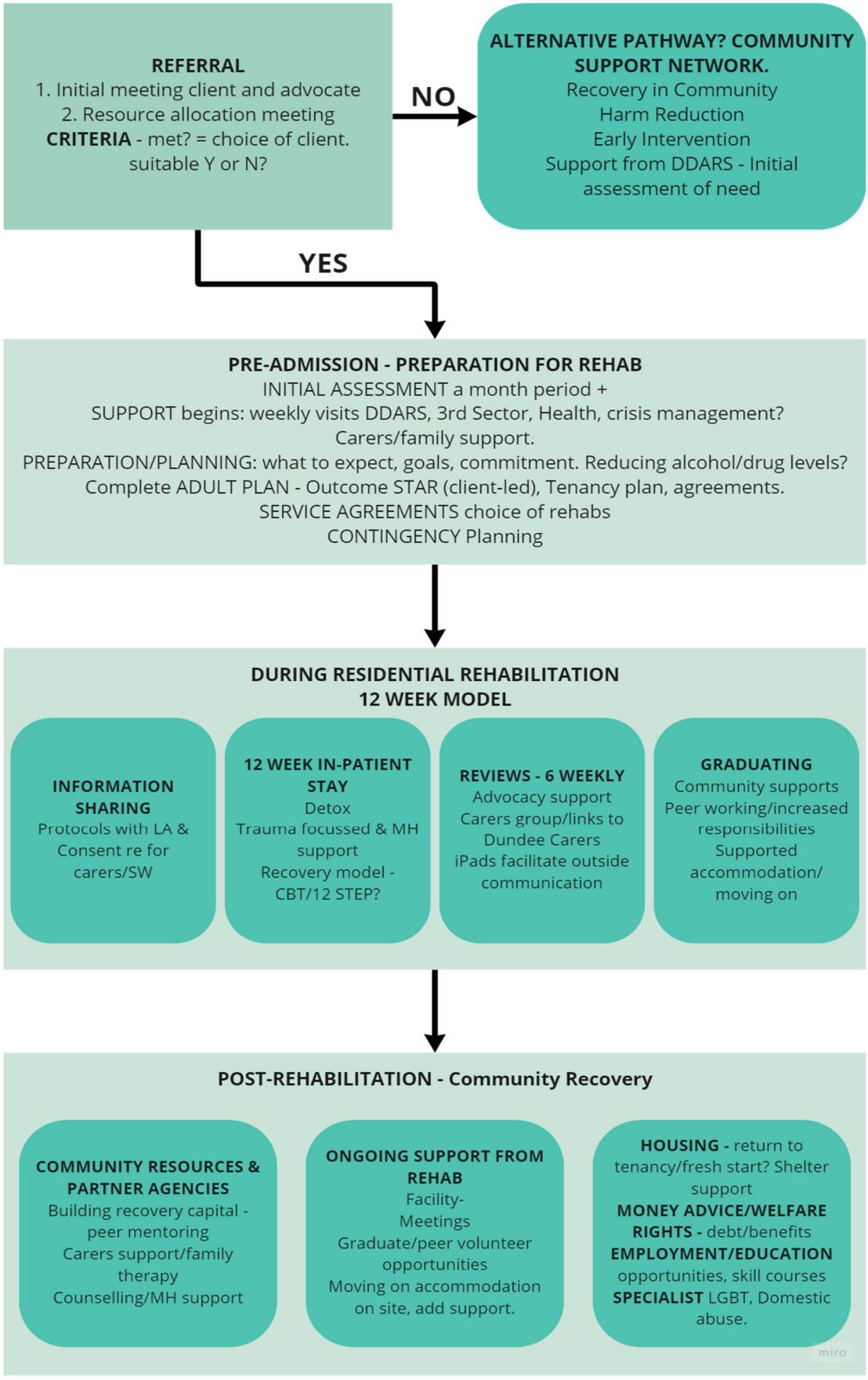
PREPARATION/INITIAL ASSESSMENT STAGE:

The majority of private and third sector residential rehabilitation organisations complete their own assessments of need upon admission. In terms of the initial stages of being considered for rehabilitation treatment from health/social care, the current processes of initial assessment are more limited. A more extensive initial assessment and preparation stage is crucial, and this is equally required to ensure a clear focus on post-rehabilitation supports. This will allow workers and service users to work together to identify whether residential rehabilitation is appropriate for an individual, provide extensive preparation and ensure individuals are aware of the challenges involved in attending a rehabilitation facility. Preparedness is an essential element of the process and ensures individuals have the best opportunity of success.

DURING AND POST-RESIDENTIAL REHABILITATION:

The inpatient element of rehabilitation is a small, albeit important part in an individual's road to recovery. Individuals require a wrap-around model of support to sustain and build on their recovery capital within their community. Our proposal warrants investment around the pre/post-admission supports, designed to work in harmony with the treatment model offered by the rehabilitation facility and in collaboration with other agencies involved throughout the 12 weeks in rehabilitation. Supports shall be led using a holistic/person-centred/whole systems assessment of individual need.

DUNDEE ADP PATHWAY TO COMMUNITY BASED RECOVERY AND RESIDENTIAL REHABILITATION



BREAKDOWN OF THE RESIDENTIAL REHAB COMMUNITY-BASED PATHWAY

Pre-admission

Step	Pre-admission	
1.	Referral Form	
2.	Initial Meeting	Client and advocacy worker (DIAS). Worker to provide client with initial overview regarding what residential rehabilitation will entail and process of assessment to facilitate informed choice.
3.	Resource Allocation Meeting/Discussion	With Social Worker/Specialist Rehab worker, Health Rep, Referrer, 3rd Sector Rep (development of 3rd sector multi-agency working group), Advocate (DIAS) and client if they wish.
		Advocate to support client to express their views, discussion of their goals re recovery.
		Criteria considered: Clients readiness to change, commitment, any preparation so far. Client taking as much responsibility as viably possible considering their current use and barriers.
		Other Factors: Current drug/alcohol use, risks to self/others, commitments, family, Community Justice involvement, MAPPA, outstanding trials etc.
4.	Yes or No? Progression to Rehabilitation Referral or Alternative Pathway	Yes: Discussion on rehabs with availability and which meet individual needs i.e. considerations for physical or mental health, learning disability, domestic abuse vulnerabilities etc. No: Referral to voluntary agency/ongoing DDARS support, complete an initial assessment (to be further developed). Identify supports required i.e. harm reduction/early intervention work, community recovery. Safety planning i.e. any domestic abuse. All at the client's choice.

Assessment & preparation stage

Stage lasts two or more months. This stage of the pathway adopts a person centred, whole systems approach that promotes choice and resilience.

Step 5: Initial Assessment	
Support begins	Weekly visits/meetings with key worker, nurse and advocate or other key individuals as appropriate. Additional crisis management support via voluntary sector during assessment process if required. Mental health support and Harm Reduction.
Potential referral for Carers support	Linked to Dundee Carers Centre. In the form of 1:1, group work and/or family groups. Early Intervention family support from 3rd sector if required.
Assess commitment	The client's readiness to change and goals are discussed. Alternative community recovery is still available and/or option of rehab after undertaking further work in the community.
Wider support needs and wishes	Ecology needs and goals: family/friends/community supports, physical health assessment from GP, educational desires, health and lifestyle support, funding/access to community resources, bus pass, full benefits check, any gender-based issues etc.
Choice of rehabilitation facility	Facility options are explained: NHS, Statutory, funded Residential Rehabs and charities. Established connections and service agreements, continue spot purchasing where required. Agree and plan placement with provider. Agreed length of programme required. Discuss the clients work and family commitments.
	If detox is required, purchase additionally at rehab facility or plan for Perth, Kinclaven Unit (NHS).
Step 6: Preparation	
Virtual day in rehab/discussion with peer worker dependant on rehab type	i.e. 12-step peer, Residential Rehabilitation. What the client is to expect of the programme.
Discuss challenges individual will likely face	Develop a contingency/support plan with client.

and the supports available	
Support to reduce alcohol/drug levels (health colleagues)	Ongoing support in relation to OST. Alcohol/drug consumption diaries.
Agreed contingency plan	This is discussed with client/advocacy and only applied if issues arise. In the event of early exit, supports will be available to resume recovery in the community.
Support client to complete rehab's pre-assessment	Reassurance and support to revisit information, adopting a sensitive and trauma informed approach. Incorporate rehabilitation questions in initial assessment.
Tenancy/homelessness	Will there be any issues where the client is attending rehabilitation? Are there any negative associates and if so does the client need to move?

During residential rehabilitation

Intense 12-week programme at agreed facility.

Step 7: Residential Rehabilitation	
Detox	Planning required, again what the client is to expect: i.e. support on offer, expectation of total abstinence. Prior communication with GP to establish medication. If detox (is required) elsewhere smooth planning in transfer to rehab.
Trauma focussed & Mental Health support/LD/Dual Diagnosis	Availability of professionals on site, delivering tailored therapeutic support. Trauma/gender- based groups. Working through stages of recovery, earning trust and assuming responsibilities/peer working. Framework agreement to be developed.
Recovery Model	Daily groups and timetable. CBT/DBT, 12-steps, Behavioural role play. Increased responsibilities in house over time.

Therapeutic Activities	Building positive hobbies with health benefits. Creative art/writing, sport/gym, walking groups. 1-1 counselling and group work.
Reviews	4/6 weekly dependant on programme. Client led with support from key worker, advocacy, carer attendance if consent. Adults Plan based on Outcome STAR – forward planning.
Ongoing outside supports	Advocacy and support from established key worker throughout.
Housing	Funds to compliment housing benefit fund – maintenance of home, utilities, preparation for return or application to access new council tenancy/moving on accommodation.
Carers group/links to Dundee Carers	Development of a monthly group, carers/family of individuals in rehab. Ability for client to attend supported by worker. If not face-to-face online to begin with.
Information Sharing	Protocols established with Health & Social Care Partnership and Rehab. Consent agreed to pass information to workers and carers.

Post rehabilitation – Community Recovery:

Step 8: Post-Rehabilitation – Community Recovery	
Graduating	Supported accommodation/moving on in collaboration with rehab. Opportunities for volunteering and peer work. OR support to return to Dundee/tenancy.
Counselling/Psychology support	Prior referral for ongoing support upon discharge. Community links and agreements. Referral for ongoing mental health treatment and support. Agency providing counselling support.
Ongoing community support	Support for client to continue to develop their own recovery support network within their community, including development around employability, further education and recreational (fun) activities.
Carers/Family support	Ongoing support from Carers agencies, attendance at groups and supporting the whole family in their recovery.

Specialist supports required	Domestic abuse agencies, LGBTQIA+, additional learning needs.
Housing/Financial support	Referral to Money Advice to address any debt issues. Welfare rights for benefits advice/entitlement. Support to meet additional health needs.
Ongoing family/carer support from agencies	i.e. links to family therapy/counselling if required (third sector).
Employment, volunteering, education	Links with skills development. Employability agency for volunteering/work experience. Further educational skills to be developed (reading/writing/numeracy)? Life skills classes i.e. cooking, budgeting. Health/Lifestyle – access to classes/gym.
Ongoing reviews/communication with DDARS	Ongoing reviews to meet the needs of the client.

CLIENT-LED REVIEWS

Client-led reviews will be led by an 'outcomes focussed' assessment. A client's plan will be formed based on their needs and goals and designed by them, ensuring choice and empowerment are facilitated throughout. Individuals' plans will be formulated from the outset at 'Pre', initial assessment stage. This can also be applied to the alternative pathway for community recovery.

Supports received should be tailored to the individual and these should be introduced at initial stages and supported throughout rehabilitation. For example, health, trauma and gender specific issues could be influencing factors in hindering or promoting a person's recovery in rehabilitation and beyond. Tailored plans would include the ongoing support from health colleagues as required from psychology and counselling for example. As services we also need to recognise the vital importance of aspects of support such as educational needs, active and healthy lifestyle and access to appropriate funds/benefits to promote these. For example, a full benefits check/entitlement to Self-Directed Support/debt support should be provided by appropriate agencies and bus passes to attend groups/appointments/leisure activities over the city to promote mental health and wellbeing throughout recovery.

CLIENT ADVOCACY

Every individual being considered for this will be offered advocacy from Independent Advocacy colleagues, and supported throughout the process of assessment – during rehabilitation – post rehabilitation. Dundee Independent Advocacy Service have also recently employed a female worker, alongside their male worker, which meets the requirement for gender specific services (DVAWP 2021). Advocacy support will focus on the needs and wants of the individual, not what carers or professionals may want for them. Individuals being considered for rehabilitation therefore require informed choice throughout this process. This starts with whether they want to be alcohol/drug free and if rehabilitation is for them. It could also extend to them choosing which rehabilitation they wish to attend, even if costlier than what is recommend, if there is a case for this better meeting their needs. The advocacy worker would be an informed worker, briefed on DDARS assessment process, knowledgeable of residential rehabilitation in Scotland and will complement DDARS assessment and reviews.

The advocacy worker will be introduced at the beginning of the individual's pathway, following referral stage. We propose they will meet initially with the client to collect their views and provide further information on options available. They will also support clients at the initial 'Resource Allocation Meeting' or attend on the client's behalf if they wish. This process was proposed from a person-centred point of view and in discussion with current DIAS worker.

Advocacy should also extend from admission and beyond, collecting views and supporting the client throughout reviews and discussion of future planning. Advocacy support would also follow a client if they chose the alternative community recovery pathway.

CARERS WITH LIVED EXPERIENCE OF SUBSTANCE USE

When referring to 'Carers' throughout this report, those involved within the individual's close circle of family and friends, who have a direct role in supporting recovery, taking care of their physical day to day needs as well as practical (i.e. finances and at times advocating on their behalf), are considered. This includes young carers, usually but not limited to the children of service users. As can be seen from the workflow map of the proposed pathway to accessing recovery and residential rehab, carers of service users feature throughout each stage.

As well as the important role they play in supporting the client, we will also endeavour to support carers own needs. We recognise that addiction is a family illness and carers need to be supported themselves to continue carrying out this role. Supporting the principles of the Carers (Scotland) Act 2016, to better support carers more consistently, we have embarked upon partnership working with Dundee Carers Centre, and specifically with their Lifeline Group.

Throughout the design and implementation of our model, we will consider the voices of carers with lived experience and how these can influence what is needed, what has worked and what has not. By jointly working with Carer's Groups as we prepare and implement our proposed model, we will share this with the group for their valued input.

Carer involvement will include participation at the proposed family groups, which we recommend are facilitated whilst the individual is in residential rehabilitation. This will also be designed in conjunction with the facilities, offering both peer support, where appropriate, and an element of family therapy.

Carers will also be offered support, whether the individual embarks upon a residential rehabilitation pathway or community recovery.

WOMEN, FAMILIES, DOMESTIC ABUSE AND RECOVERY

By recognising gender specific needs and issues, in this case women who use drugs and alcohol, we can better promote gender equality throughout the ongoing development of policy, practices and services in Dundee.

Dundee Violence Against Women Partnership (DVAWP), highlighted the prevalence of domestic abuse, which is continuously on the rise in the city. Prevalence unfortunately appears to outweigh the supports and resources in place to tackle the problem, placing pressure on the specialist services (DVAWP 2021). Interconnected with domestic abuse, the DVAWP also acknowledged the additional adversities women with drug and alcohol addictions face. The Partnership have called for a whole systems approach when reviewing their pathways and identifying gaps in services for women affected by multiple disadvantages in Dundee. The importance of merging the interconnected areas of substance and alcohol use with domestic abuse has therefore become clear, as highlighted by both the Dundee Drugs Commission (2019) and DVAWP. Upper management, however, have recognised the struggles and pressure on services to be able to deliver appropriate support and the need for further investment.

Following an assessment of need and applying a whole systems approach, as recommended by DVAWP (2021), we can begin to meet additional needs not in isolation but recognising their interconnectedness by applying trauma-informed practice. Such specialised support, should begin with the involvement of a psychologist within DDARS, who would offer support pre and post admission. Women require specialist groups (DVAWP 2021) to address such needs and this should be available both in the community pre/post admission and during rehabilitation. Some rehabilitation centres offer women's groups as well as a separate wing for women to reside in. This follows a trauma informed approach to vulnerable women's experiences and protects such vulnerabilities where needed offering them a better sense of safety and security when becoming abstinent from substances.

COMMUNITY RECOVERY AS AN ALTERNATIVE AND A CONTINGENCY

The third sector and local peer-led recovery communities play a vital role in sustaining recovery following post-rehabilitation discharge. Residential rehabilitation is not for everyone however, there may be individuals who's needs indicate that they cannot commit to moving to another locality. For example, they may have care needs, they may not feel physically or mentally able to stay in this setting for a period of time. Instead they could potentially embark on their recovery within the community with the correct supports. Part of our consultation with carers and clients was a query on the quality of the service overall. All individuals should be receiving the supports that are being proposed in the rehabilitation pathways.

The assessment process should therefore also consider an alternative pathway for individuals whom which rehabilitation is assessed as not appropriate at that time, but is not ruled out for the future. The alternative pathway requires further development as and would complement an overall test of change, for service development in future.

A contingency plan should also be considered for those progressing to rehabilitation, in the event a placement is ended early. This parallel planning should be considered with the immediate wrap-around of agencies providing community recovery. Again, this would pave an alternative pathway, and would support the individual to continue with their recovery goals instead of potentially resulting in feelings of failure, which can lead to crisis and high-risk behaviour such as relapse and non-fatal/potentially fatal overdose.

In order to meet our goals of delivering such alternative supports, there is requirement of joint-working and service level agreements between agencies to discuss and inform new processes and protocols, to support individuals. This would include the voluntary support agencies, health professionals.

ONGOING REVIEW, DEVELOPMENT AND REPORTING

Continued development working and reviewing of the service is also proposed to take place via the formation of working groups with local support agencies. We propose a Third Sector Working Group, who once briefed and up and running would send a representative to the initial Resource Allocation Meetings, looking at support in and out of rehabilitation and support the alternative pathway.

CONCLUSION

This new model is now being implemented in Dundee and will continue to develop and grow. Progress will continue to involve all partners, including individuals with lived experience, families, carers and our local communities. Special focus will remain on communications, ensuring individuals and their families know how to access the pathway and utilise it to progress to full recovery.

We envisage the wider positive impact of this extensive model will have on the services and support received by individuals and carers in terms of promoting recovery for families.

Our model is ambitious but designed collaboratively in partnership with all the relevant stakeholders. We believe it will improve outcomes and support the Scottish Government's initial goal in promoting recovery through better access to residential rehabilitation. The model will continue to improve and evolve to ensure the best possible support is available for individuals to recover from the impact of substance use.

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