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Research Report

Exploring demand for, and perceptions of, Residential Rehabilitation amongst people who experience problems with drugs across Scotland

Perkins, A., Craig, F., Dumbrell, J., Gardiner, K., Horne, A., Livingston, W., Richardson, J., Schofield, J. and Steele, S.

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Public Health Scotland

Exploring demand for, and perceptions of, Residential Rehabilitation amongst people who experience problems with drugs across Scotland

Final report

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Study conducted on behalf of Public Health Scotland as part of a wider evaluation of Residential Rehabilitation that Scottish Government has commissioned Public Health Scotland to lead.

13 February 2024

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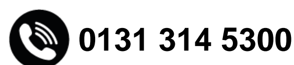

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Keywords

Access, Awareness, Demand, Drugs, Informed, Interest, Perceptions, Preference, Residential Rehabilitation, Substance Use

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Declaration of interests

The Principal Investigator of the study (Andy Perkins) managed Residential Rehabilitation programmes in the south of England between 1995-2004.

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List of abbreviations

The following table describes various abbreviations and acronyms used throughout this report. The page on which each one is defined or first used is also given.

Table 1: List of abbreviations and acronyms

Abbreviation /Acronym	Description	Comments	Page
IQR	Interquartile range	The interquartile range (IQR) measures the spread of the middle half of a dataset (between the 1st and 3rd quartiles).	37
PHS	Public Health Scotland	–	13
RR	Residential Rehabilitation	The Scottish Government define residential rehabilitation as: ‘Residential rehabilitation was defined 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.’	12
SURE	Substance Use Recovery Evaluator measure	SURE is a 21 items (five factors) psychometrically valid, quick and easy-to-complete outcome measure, developed with substantial input from people in recovery. It can be used alongside, or instead of, existing outcome tools.	21
WP	Work Package	–	16

Executive summary

Introduction

The level of harms from drugs in Scotland is high in comparison to the rest of the UK and Europe, and causes avoidable damage to people's lives, families and communities. Tackling the high level of drug related deaths in Scotland is a stated priority for the Scottish Government.

Public Health Scotland [PHS] have been asked by the Scottish Government to evaluate the Residential Rehabilitation [RR] programme element of its National Mission to reduce drug deaths, covering the period until March 2026.

This is the final report of a two-part study and explores (1) ‘demand for’, and (2) ‘perceptions of’ RR amongst people who experience problems with drugs across Scotland.

Study aim and objectives

The overall study aim was to better understand demand for, and perceptions of, RR services amongst people who experience problems with drugs across Scotland.

The research objectives of the study were to explore, amongst people who experience problems with drugs: awareness of RR services; experience of trying to access RR services; perceptions of RR; levels of interest in RR; and interest in RR relative to other treatment options (treatment preferences).

Work packages

The study comprised of three distinct and overlapping work packages [WPs] which incorporated primary quantitative and qualitative data collection from people who use drugs and who are engaged with services and organisations across Scotland who support people with drug use issues. A total of 367 survey responses were collected across WP1 and WP2.

Participant characteristics

It is important to be aware of the risk of selection bias in this study. First, those with an interest in RR will have been more likely to participate in a survey advertised specifically

as about RR. Second, the recruitment strategy was primarily dependent on support from community-based, third-sector support services. Those who do not utilise these services may not be fully represented in the study findings. Third, there are indications that those further along in their recovery journey may be overrepresented.

Study participants were resident in twelve out of the fourteen Scottish territorial Health Boards and thirty out of the thirty-two Local Authority areas. Almost three quarters (74%) of participants were aged between 30 and 49 years, nine per cent were under 29, and sixteen per cent aged 50 and above. Almost two-thirds of participants (65%) identified as male. The majority (97%) identified as being of White ethnicity, predominately White Scottish or Other British.

Participants were asked to indicate which drug(s) they currently experience problems with. The most common substances noted were benzodiazepines / hypnotics (64%), opioids (64%), stimulants (56%), cannabinoids (43%) and alcohol (40%). The median number of currently problematic substances per person was three, and half of participants had problems with between two to four drugs. Just thirty-five participants (10%) reported experiencing problems with a single substance.

Just over half of participants (52%) were currently accessing NHS drug services and almost forty per cent accessing third sector drug services. The median number of service types per participant was two with half of all participants being engaged with between one to three service types.

Key findings

Work package 1 (WP1) results

Study findings highlight participants' diverse engagement with drug treatment options over the past two years, including high levels of engagement with ‘support for recovery’, harm reduction, and NHS specialist prescribing, with a smaller percentage having accessed RR. Geographic location, substance challenges, and living conditions influenced participants' likelihood of undergoing RR, pointing to demographic and situational barriers to accessing these services, for some.

Awareness of RR amongst participants was generally low, with many citing lack of information or direct offers for RR as major barriers to access. Despite this, satisfaction amongst those who had attended RR in Scotland was high. However, a significant number

of participants were either uninformed about RR's benefits or faced personal circumstances that hinder their ability to pursue such treatment, underlining the need for increased awareness and accessibility of RR services to address drug-related issues more effectively.

Just under half of participants reported that they were not actively considering a stay in a RR service either now or in the future. Just under half expressed a degree of interest in going to RR.

For a full set of key findings from WP1 please see **Chapter 5** in the main report.

Work package 2 (WP2) results

In the study, participants rated various treatment options, with 'support for recovery' and detoxification receiving high importance, whilst harm reduction, GP support, and RR received lower ratings. RR showed a polarised view amongst participants, being rated as either the most or least important treatment option for substantial subgroups, a pattern also observed for detoxification.

Participants were generally more optimistic about their own likelihood of completing an RR programme than they were about the broader population's chances. Despite personal confidence, there was a common belief that many community members would drop out of their first RR programme and that multiple stays might be necessary for effective treatment. The majority viewed RR as an effective treatment option, indicating a positive perception of its potential benefits.

Factors such as secure tenancy, funding availability, choice of RR facilities, and proximity to services were deemed essential for committing to an RR stay. Information sources about RR, and the range of treatment options, were mainly personal contacts and drug services, highlighting the importance of firsthand experiences and professional guidance in shaping treatment decisions and perceptions.

For a full set of key findings from WP2 please see **Chapter 6** in the main report.

Synthesis of qualitative findings from all three work packages

Information about RR often came from informal networks and personal research, suggesting a gap in formal communication from specialist services. Perceptions of RR's activities varied, with some participants holding clear views on aspects like detoxification

and therapy, whilst others were unsure about the programmes’ structure, especially those who had never participated in RR.

Accessing RR involved navigating systemic barriers, with many relying on personal networks for inspiration, guidance, and support. The importance of accessible, and comprehensive aftercare to support improved treatment and recovery outcomes was also noted. Motivation for applying to RR was driven by urgent personal needs, including health crises, the desire for abstinence or recovery, family reunification, and the need to escape from negative environments.

More in-depth discussion about the effectiveness of RR elicited mixed responses, from positive endorsements of its transformative potential to scepticism, largely influenced by individual or secondary (family or friends) experiences and outcomes. Participants' confidence in completing RR varied, affected by their personal motivation, past successes, and the perceived benefits of the programme. However, the anticipated journey through RR included emotional, familial, and health-related challenges with potential to lead to early exits, whilst participants additionally expressed concern over post-treatment risks like relapse and reintegration difficulties.

For a full set of key findings from the synthesis of qualitative findings from across all three work packages (WP1, WP2, and WP3), please see **Chapter 7** in the main report.

Discussion

Awareness and understanding of RR and implications for assessing demand

The study highlights a critical gap in awareness and understanding of RR amongst individuals facing drug-related issues, affecting the ability to forecast demand for RR services accurately. Low levels of knowledge and the limited promotion of RR have led to misunderstandings about its availability and benefits. The findings suggest that better awareness could help manage demand by ensuring choices are based on comprehensive information rather than misconceptions.

Participant insights reveal that knowledge about RR primarily comes from personal or community experiences, rather than through formal channels. This lack of targeted information dissemination may contribute to uneven access across different regions. The study advocates for more effective diffusion of RR information, to empower individuals with

the necessary tools to make informed decisions about their recovery paths, aligning with Scottish Medication-Assisted Treatment [MAT] Standards.

The need for increased awareness and understanding of RR is emphasised as essential for informed healthcare choices. Future strategies should focus on improving the promotion of RR services and conducting further research to address knowledge gaps. Enhancing the visibility and understanding of RR can lead to better access and more accurate assessments of demand, ensuring individuals are well-informed about their treatment options.

Experiences relating to RR

The experiences of individuals with RR were explored in detail, emphasising systemic barriers to access, such as gatekeeping and unclear pathways, and the reliance on personal and community networks for information. The research highlights the critical roles of aftercare and recognises a community view of 'readiness' as important in RR success. Efforts to get into RR are shown as often motivated by urgent health crises and the aspiration for change.

Participants identified housing stability and financial support as vital considerations for RR, with a significant emphasis on the need for secure tenancy as a prerequisite for application. This underscores a gap in awareness about supports like the Dual Housing Support funding provided by the Scottish Government. The availability and quality of aftercare were again seen as pivotal in influencing post-RR outcomes, especially for individuals returning to low-support environments. Acknowledgement of the need for pre and post RR care were noted.

The findings suggest that improving service accessibility, streamlining information dissemination, and ensuring comprehensive aftercare are crucial steps toward optimising the effectiveness of RR interventions.

Wider treatment system considerations

The study underscores a preference for community-based support. 'Support for recovery', the highest rank option, was defined in the survey questionaire as, for example, recovery communities or recovery groups or cafés. Recruitment strategies may have skewed data towards those already inclined towards such options, however. This identified preference may not fully capture the varied needs of those seeking recovery, who do not access these

community-based options. High satisfaction with non-residential community-based options, evidenced by the popularity of recovery cafes amongst those with prior RR experience, highlights their significance for maintaining abstinence-based recovery. This preference suggests that community interventions could lessen the need for more intensive and costly treatments.

Treatment preferences were described as evolving, influenced by individual recovery journeys. The preference for community-based support, whilst strong, may not entirely reflect the broader population's needs, with factors like service availability and individual differences in treatment-seeking behaviours playing a crucial role. This calls for a nuanced understanding of treatment preferences, considering the diversity of needs and the potential impact of various factors on the effectiveness of community-based options.

Generally, the study points to the need for a comprehensive approach in evaluating treatment options, ensuring that the diverse needs of the recovery-seeking population are adequately addressed.

Conclusions

In conclusion, the study highlights a strong preference for community-based support amongst participants, whilst acknowledging potential biases that may affect the generalisability of these findings. It underlines the importance of considering the dynamic and individual nature of treatment needs, and the impact of recruitment strategies and local factors on the perceived effectiveness and preference for community-based options.

The study provides, through the eyes and experiences of people who use drugs, a comprehensive overview of the state of RR services in Scotland, highlighting the crucial need for increased awareness, accessibility, and the significance of community-based options in the recovery process. It underscores the challenges in quantifying demand for RR services and points to the necessity for further research to understand these complexities better.

The findings have significant implications for policymakers, service providers, and the wider community in shaping effective and accessible drug rehabilitation services. The findings will need to be considered alongside the range of other research studies being conducted as part of the RR evaluation portfolio (managed by Public Health Scotland) to identify and develop the next stages of development for the RR sector across Scotland.

Considerations for research, policy and practice

Priority needs to be given to addressing the findings in this study regarding low and varying levels of awareness and informedness amongst the broad population of people who use drugs across Scotland. This should be progressed as a co-produced work plan to ensure that all relavant stakeholders are fully informed about the current landscape in order to then contribute reciprocally in developments to raise awareness for people who use drugs.

Particular attention should be paid to helping people who use drugs understand the differences and expectations between the broad range of RR centres across Scotland, so that informed choices are able to be made. This could be improved by utilising a greater degree of public-facing evaluation and research regarding different types of RR programmes.

Further research will be required over the coming years to revisit the baseline findings of this study in order to identify and measure how demand for RR changes over time once further investment and development (such as raising levels of awareness amongst people who use drugs) have taken place.

Chapter 1: Overview of the research study

1.1 Introduction

This is the final report of a two-part study exploring (1) 'demand for', and (2) 'perceptions of' Residential Rehabilitation [RR] amongst people who experience problems with drugs across Scotland.

In this report we begin in **Chapter 1** by outlining where this study sits within the wider RR evaluation portfolio and the Scottish Government's National Mission to reduce drug deaths and improve the lives of those impacted by drugs. We then outline in **Chapter 2** the research design and methods used to conduct the research, followed by an exploration of the study strengths and limitations in **Chapter 3**. In **Chapter 4** we describe and summarise the characteristics of those who participated in the research. **Chapters 5 and 6** then present respectively the key findings in relation to the two primary work packages [WP1 and WP2] which were designed to explore questions of 'demand for' and 'perceptions of' RR amongst people who use drugs across Scotland. A synthesis of our analysis of qualitative findings from across all three work packages [WP1, WP2, and WP3] is laid out in **Chapter 7**. Finally, our discussion of the key findings of the study along with a set of considerations for research, policy, and practice are presented in **Chapter 8**.

1.2 Background

The level of harms from drugs in Scotland is high in comparison to the rest of the UK and Europe, and causes avoidable damage to people's lives, families and communities. Tackling the high level of drug related deaths in Scotland is a priority for the Scottish Government. On 20th January 2021, the First Minister made a statement to Parliament which set out a National Mission to reduce drug deaths through improvements to treatment, recovery and other support services. One of the five priorities is to increase capacity and improving access to RR. RR is also included in the August 2022 Scottish Government's National Drugs Mission Plan 2022-2026.

The Scottish Government's RR programme has three core components:

- The provision of funding to improve access to RR - £100 million over a five-year period (to March 2026);

- Support to Alcohol and Drug Partnerships to develop pathways in and on from RR (delivered through Healthcare Improvement Scotland);
- Support around commissioning of RR placements – Scotland Excel were asked to develop national arrangements to support commissioning.

The Scottish Government has set itself two targets in relation to RR:

- An increase in the number of RR beds in Scotland by 50% to 650 by 2026; and,
- An increase in the number of people publicly funded to go through RR per year by 300% to 1,000 by 2026.

Public Health Scotland [PHS] have been asked by the Scottish Government to evaluate the RR programme covering the period until March 2026.

1.3 Study aim and objectives

The overall study aim was to better understand demand for, and perceptions of, RR services amongst people who experience problems with drugs across Scotland. The former includes developing:

- a quantitative estimate of levels of demand for RR; and
- a more in-depth insight into what 'demand' for RR services entails.

The research objectives of the study were to explore, amongst people who experience problems with drugs:

- Awareness of RR services;
- Experience of trying to access RR services;
- Perceptions of RR;
- Levels of interest in RR; and
- Interest in RR relative to other treatment options (treatment preferences).

The research questions of the study were as follows:

- What proportion of individuals with drug use issues are **aware** of rehabilitation services? How have they become aware of RR? How well informed about RR do they feel?
- What proportion of individuals with drug use issues have previously tried **accessing** RR? What has been their experience of trying to gain access?
- How do individuals with drug use issues **perceive** RR? What do they think RR might involve (e.g. abstinence requirements, active engagement in therapy, involvement in chores)? To what extent are they aware of the challenges involved in securing positive outcomes (e.g. risks involved, non-completion, relapse)?
- What proportion of individuals with drug use issues would be interested in **participating** in RR? Under which circumstances or conditions would they be interested? What benefits would they expect to gain? To what extent is their interest in RR (partially) the result of unrealistic expectations?
- What proportion of individuals with drug use issues would **prefer** RR to other treatment options for drug use issues? How would they rank different treatment options – and where would they rank RR?

For the purpose of this study 'demand for RR' was interpreted as levels of interest in RR amongst individuals who are currently using drugs or individuals who have used drugs within the last two years.

1.4 Language considerations

The world of substance use treatment is full of jargon and abbreviations. We have purposely chosen to use 'people-first' language (e.g. 'people who use drugs'), which emphasises the individuality, equality, and dignity of people rather than defining people primarily by a problem or issue. We want to emphasise the importance of language in helping to challenge and reduce the pervasive stigma that is still attached to being a person who experiences problematic substance use.

In this report, we have opted to use the term 'substance(s)' to encompass the use of both illicit and prescribed drugs, as well as alcohol. Scotland exhibits a notable prevalence of poly-substance use. Whilst our evaluation primarily concentrates on RR for individuals who

experience problematic substance use, it is crucial to acknowledge that this may stem from the use of both illicit and prescribed drugs, and potentially include alcohol.

Chapter 2: Project design

2.1 Introduction

A full description of the research methods for recruitment, data collection, and preparation of data for analysis is provided in **Appendix A** and we provide a short summary below.

The study comprised of three distinct and overlapping work packages [WPs] which incorporated primary quantitative and qualitative data collection from people who use drugs and who are engaged with services and organisations across Scotland who support people with drug use issues.

The WPs used a range of research designs and methodologies to address the two broad areas of interest ('demand for' and 'perceptions of' RR) and the key research questions outlined in **section 1.3** above. In summary:

- WP1 consisted of a short (5-10 minutes) quantitative, online survey, for completion by anyone across Scotland who experiences problems with drug use, focusing on the issue of 'demand for' RR.
- WP2 consisted of a detailed, structured survey for use in face-to-face interviews (30-45 minutes) with members of the Figure 8 Lived Experience research team, focusing on 'perceptions of' RR. This work package was set up to engage individuals across the following agreed set of sub-categories:

    1. Those individuals who have never considered RR.
    2. Those individuals who have never been offered RR.
    3. Those individuals who have been offered or considered RR but have declined or never pursued a referral, or have been unable to pursue an application due to personal circumstances.
    4. Those individuals who have been through an RR programme (since the Scottish Government RR programme was initiated).
    5. Those individuals who are considering or planning to access RR in the near future.

6. Those individuals who think they may require a period in RR at some point in the future, but are not actively considering it just now.

- WP3 consisted of a small number of online individual and group interviews recruited from across the six sub-categories of individuals noted above in WP2. The focus groups were used to: (1) sense-check the early findings from analysis of survey returns in WP1 and WP2, and (2) aid the research team to help interpret responses to the question about whether individuals are interested in RR and the expectations that underpin their responses.

2.2 Contribution of work packages

WP1 contributes primarily to the quantitative 'demand for' RR question as well as gathering information about participant characteristics and some limited qualitative responses. Additionally, the WP1 question set was embedded within the WP2 survey.

WP2 and WP3 contribute to both the 'demand for' and the 'perceptions of' RR questions as gathering information about participant characteristics and more extensive qualitative responses.

Each WP informs the others throughout the research process (e.g. design, analysis, interpretation).

2.3 Recruitment and sampling

For WP1, the aim was to reach a broad sample of individuals who use drugs across all areas of Scotland to explore and estimate current/future demand for RR.

For WP2, the aim was to reach a representative sample of individuals who use drugs across all areas of Scotland to explore, via in-person interviews with a member of the lived experience research team, perceptions of RR.

For WP3, the aim was to engage with a small number of individuals from across the six sub-categories noted above who had participated in WP2 to explore (qualitatively) in greater detail the early findings from WP1 and WP2 regarding 'demand for' and 'perceptions of' RR.

To be included in the study participants had to acknowledge that they are either currently experiencing problems with drugs, or have experienced problems with drugs within the

past two years. Participants were also able to identify if they are currently experiencing problems with alcohol (or have done within the last two years). However, if they were not able to acknowledge a current or recent problem with drugs then they were not invited to complete the full suite of questions within WP1 and WP2. Only those who participated fully in WP2 were then invited to take part in WP3.

A summary of study methods, recruitment, sampling and activity completed is presented in the table below. Fieldwork activities took place between June and December 2023.

Table 2.2: Summary of study methods, recruitment, sampling and activity completed

Method	Description	Number
WP1 Quantitative survey	WP1 consisted of a short (5-10 minutes) quantitative, online survey, via JISCs Online Surveys (formerly British Online Surveys), focusing on the issue of 'demand for' RR for completion by anyone across Scotland who experiences problems with drug use. The survey link was shared extensively across a wide range of services (both specialist and non-specialist drug services), other community networks, and social media platforms.	**170**
WP2 Mixed methods survey	WP2 consisted of a detailed, structured survey (again using JISCs Online Surveys) for use in face-to-face interviews (30-45 minutes) by members of our Lived Experience research team, focusing on 'perceptions of' RR. The survey was set up to target samples of individuals across all Health Board areas of Scotland (see **Table B1**, **Appendix B**).	**197**
WP3 Individual and group interviews	WP3 consisted of a small number of online individual and group consultations with participants recruited from those who took part in WP2.	**8 individuals across 4 consultation sessions**

2.4 Analysis

A summary of the approach to data analysis, both quantitative and qualitative, is presented below. A full description is provided in **Appendix A**.

2.4.1 Quantitative data analysis

Quantitative data collected via the in person and online surveys were downloaded from the survey platform as comma separated value files and imported into R[1]. Both the **WP1** and **WP2** surveys included a common set of questions on participants' demographics, their previous experience of RR, and their current / potential demand for RR services. Responses to these questions were combined into one dataset for analysis. The second dataset consisted of responses to the unique questions in the **WP2** survey.

The data management and analysis methods of the quantitative data were designed to ensure that accurate and meaningful tables and charts could be generated to help address the study's research questions, including data cleaning, and presentation of descriptive statistics and figures.

Several quantitative questions in the surveys provided a free text box for participants to provide additional information on their response. For example, after being asked to rate their awareness of RR services in Scotland on a scale of 0 (not at all informed) to 10 (fully informed), participants were invited to describe how they arrived at the score they had entered. Illustrative quotes were selected to give a broadly representative indication of respondents' answers.

2.4.2 Qualitative data analysis

The analysis methods utilised for the qualitative component of this study were designed to address the complexities inherent in analysing elements drawn from across the various work packages. A number of considerations informed the approach taken to ensure robustness and accuracy within the analysis. These are discussed in **Appendix A**.

Stringent measures were implemented to safeguard the anonymity and confidentiality of participants regarding their free text responses. Names, service names, locations and any other identifiers, were systematically omitted and replaced with generic names or descriptors and placed in square brackets. For example, '…[service in northern England]…'. Additionally, the data collection process was designed to prevent any

inadvertent disclosure of individual identities. The research team employed secure data storage and handling practices, restricting access to authorised personnel only. These precautions were undertaken to uphold ethical standards and created a secure and confidential environment, where participants could share their experiences and opinions candidly.

2.5 Ethics

Ethics approval for the project was received from Wrexham University Research Ethics Committee (ID540, dated 18/01/2023).
Additionally, confirmation was received from the West of Scotland NHS Research Ethics Service on 7th September 2023 that distribution of WP1 survey details to NHS drug services did not require ethical approval.

Chapter 3: Strengths and limitations

3.1 Introduction

This is the largest study to date in Scotland exploring demand for, and perceptions of, RR amongst people who use drugs.

3.2 Limitations

Whilst a potential limitation of the study is that those with interest in RR will be more likely to participate in a survey advertised specifically as about RR, we have attempted to mitigate this by the following means:

- Providing clarity and emphasis on the study criteria (i.e. anyone who currently experiences problems with drugs, or has experienced problems with drugs within the last 2 years) in all communications.
- Identification of sub-groups has allowed for a better understanding when advertising the surveys/interviews.
- Distribution of the study surveys and recruitment via a broad set of services where people who use drugs present (e.g. homelessness and mental health services), rather than just drug treatment services.

Despite these mitigations, the sample achieved in this study is noted as including a higher per centage of individuals who have previously experienced RR than would be found within a general drug treatment population.

Relatedly, the recruitment strategy for the study (particulary for WP2 and WP3) was primarily dependent upon support from community-based, third-sector support services. This means that the perspectives of the broad population of individuals who experience problems with drugs across Scotland, and who do not utilise these services, may not be fully represented in the study findings.

There are further indications of potential selection bias within the WP2 results, where participants were asked to complete the validated Substance Use Recovery Evaluator [SURE] (Neale J, et al., 2016)[2] as part of their interview. Out of a possible score range of 21-63 (with higher scores indicating more advanced stages of recovery), the range of

responses noted by participants was 27-63, with a median value of 54. This median value indicates an overall sample of individuals who are further along in their recovery journey than might be expected if a fully representative sample of the broad population of people who use drugs had been engaged in the study.

A small amount of duplication is noted within the combined WP1 and WP2 dataset (3.7%) with **13** of the individuals taking part in the WP2 survey noting that they had already completed the WP1 survey. Due to the anonymity of completion of WP1 via an online weblink, it was not possible to identify and/or remove the duplicate responses, so they are included in the full dataset. In conducting the WP2 interviews with these 13 individuals, the researchers noted that a number of them had indicated that they had previously completed a WP1 survey, however, they then clarified that they 'thought' they might have completed the WP1 survey and weren't completely sure that they had. On this basis, and given that it is a small number of duplications (maximum 13, but likely to be less), it was decided to leave any possible duplications in the dataset as they wouldn't unduly skew the overall results with being so low in number.

3.3 Strengths

A key strength of our approach was to make extensive efforts to gather responses (particuarly to the WP2 survey) from across all areas of Scotland. This was achieved in the main by regular communications with all thirty-two ADPs across the country as well as a wider set of communications to all drug services utilising the publicly available databse of drug services hosted online by the Scottish Drugs Forum[4]. Although low numbers of responses were received across the Highlands and the Islands, the extensive communication work has led to a geographically diverse sample included within the research (see in particular **Chapter 4 'Participant Characteristics'** and **Table B1**, **Appendix B** for further detail).

Another key strength of our approach has been the purposeful deployment of a team of experienced researchers with lived experience to complete the study fieldwork, in recognition that such researchers have a likely stronger rapport with interviewees from the outset due to their lived experience. Consequently, they are able to elicit a greater degree of accuracy and depth when working with individuals face-to-face to complete surveys that explore the perceptions and attitudes of those being studied. We believe that this has been all the more important for this study design given the aspirations of the Scottish Government's National Mission on Drugs which says, 'We want to see lived and living

experience at the heart of the conversation about tackling this problem – at local, national and international level.'

A significant investment was made regarding quality control of the researchers recording 'free text responses' in a consistent manner in WP2. This involved two training sessions prior to data collection, led by the Principal Investigator of the study (Andy Perkins) and the Quality Assurer (Professor Jo Neale). Additionally, the researchers engaged in conducting 'pilot' WP2 interviews with each other prior to data collection starting. Finally, our approach to quality assurance also involved the research team having regular meetings throughout the data collection window to compare notes and experiences of completing the WP2 surveys in order to check consistency of approach.

It is also noteworthy to highlight the active engagement and willingness of participants to offer additional perspectives and feedback through the use of free text questions in WP2. When 'other' free text options that were linked to some of the quantitative questions in WP2 are excluded, a total of ten specific free text questions were asked within the WP2 dataset. There questions received 1583 individual responses across the 197 participants, which indicates that a majority of participants contributed input to a significant proportion of the free text boxes. In both WP1 and WP2, participants provided valuable insights beyond the standard questions, with a total of nine 'other' boxes populated with 102 responses. The findings from this extensive combined set of free text responses, along with the qualitative data from the WP3 individual and goup interviews, are presented in **Chapter 7** of this report.

Chapter 4: Participant characteristics

- Participants were resident in twelve out of the fourteen Scottish territorial Health Boards and thirty out of the thirty-two Local Authority areas.
- Almost three quarters (74%) of participants were aged between 30 and 49 years, nine per cent were under 29, and sixteen per cent aged 50 and above.
- Most participants (65%) identified as male including, fewer than five who were assigned female at birth and who now identify as male.
- The majority (97%) identified as being of White ethnicity, predominately White Scottish or Other British.
- Just over half (51%) reported having no religion or faith and thirty-eight per cent identified as some denomination of Christianity. Amongst those responding 'Other', thirteen described a general sense of spiritualty, four provided other Christian denominations, and four described atheist or agnostic positions.
- Just under two thirds of participants (64%) were in some form of stable accommodation (e.g. owned / rented) whilst twenty-seven per cent were either homeless or living in unstable accommodation (e.g. friend's place, hostel, shelter/refuge).
- Just fifteen per cent of participants were in work, training, or education. Three quarters of participants were not working, predominantly due to temporary or long-term sickness or disability.
- Participants were asked to indicate which drug(s) they currently experience problems with. The most common substances noted were benzodiazepines / hypnotics (64%), opioids (64%), stimulants (56%), cannabinoids (43%) and alcohol (40%).
- The median number of currently problematic substances per person was three, and half of participants had problems with between two to four drugs. Just thirty-five participants (10%) reported experiencing problems with a single substance.
- Just over half of participants (52%) were currently accessing NHS drug services and almost forty per cent accessing third sector drug services. Almost one quarter were accessing NHS mental health services (24%) with just over one in five accessing other

non-specialist NHS or Local Authority services (22%). Just nine per cent were in contact with a third sector mental health service.

- The median number of service types per participant was two with half of all participants being engaged with between one to three service types.
- Participants completing the WP2 survey were asked to complete the validated Substance Use Recovery Evaluator [SURE]. Out of a possible total SURE score range of 21-63 (with higher scores indicating more advanced stages of recovery), the range of responses noted by participants was 27-63, with a median value of 54.

4.1 Introduction

This chapter presents the participant characteristics for all survey participants – i.e. the combined results from both the **WP1** and the **WP2** surveys. Unless specified, **N=367** participants in all tables and figures.

Throughout this chapter, statistical disclosure control techniques have been applied to participant characteristics data to reduce the risk that an individual would be identified as having participated in the survey. This is because of the sensitive nature of the topic area (substance use). Suppressed data have been denoted by an asterisk (*). The asterisk indicates numbers that are less than five or any percentage which reflects fewer than five participants.

4.2 Location

Participants were resident in twelve out of the fourteen Scottish territorial Health Boards and thirty out of the thirty-two Local Authority areas.

Table 4.1: Number and proportion of participants by Health Board

Health Board	n	%
Grampian	35	9.5%
Tayside	29	7.9%
Highland	10	2.7%
Forth Valley	17	4.6%
Western Isles	*	*
Dumfries and Galloway	13	3.5%
Ayrshire and Arran	29	7.9%
Greater Glasgow and Clyde	91	24.8%
Lothian	56	15.3%
Fife	20	5.4%
Lanarkshire	34	9.3%
Borders	14	3.8%
Missing	-	-
Total	**367**	**100.0%**

Note: The number of missing responses has not been included in **Table 4.1**. Otherwise, it would have been possible to calculate the number of responses from NHS Western Isles.

Table 4.2: Number and proportion of participants by Local Authority

Local Authority	n	%
Aberdeen City	11	3.0%
Aberdeenshire	21	5.7%
Angus	7	1.9%
Argyll and Bute	8	2.2%
Clackmannanshire	5	1.4%

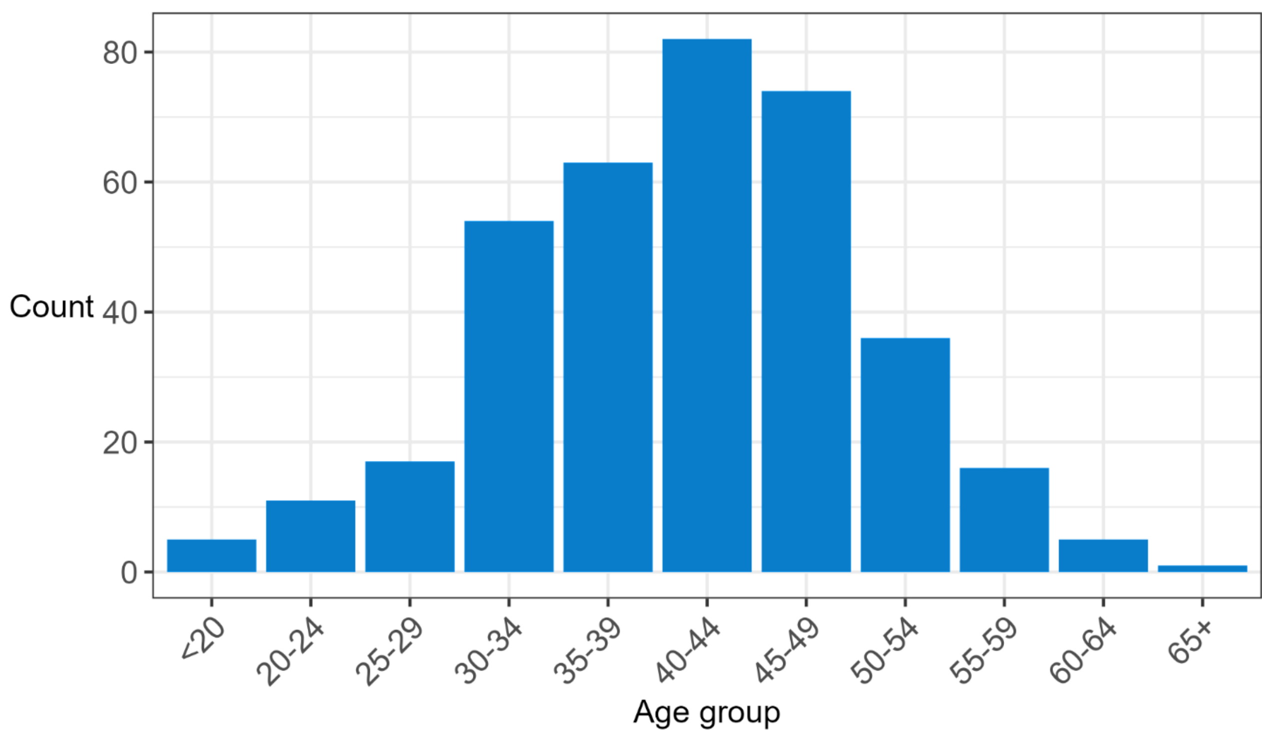
Local Authority	n	%
Dumfries and Galloway	13	3.5%
Dundee City	15	4.1%
East Ayrshire	13	3.5%
East Dunbartonshire	*	*
East Lothian	5	1.4%
East Renfrewshire	9	2.5%
Edinburgh City	32	8.7%
Eilean Siar (Western Isles)	*	*
Falkirk	7	1.9%
Fife	20	5.4%
Glasgow City	61	16.6%
Highland	*	*
Inverclyde	6	1.6%
Midlothian	9	2.5%
Missing	18	4.9%
Moray	*	*
North Ayrshire	7	1.9%
North Lanarkshire	12	3.3%
Perth and Kinross	7	1.9%
Renfrewshire	7	1.9%
Scottish Borders	14	3.8%
South Ayrshire	9	2.5%
South Lanarkshire	22	6.0%
Stirling	5	1.4%
West Dunbartonshire	6	1.6%

Local Authority	n	%
West Lothian	10	2.7%
Total	**367**	**100.0%**

4.3 Age group

Almost three quarters (74%) of participants were aged between 30 and 49 years, nine per cent were under 29 and sixteen per cent aged 50 and above.

Figure 4.1: Age distribution



N = 364

4.4 Sex and gender

Most participants (65%) identified as male, including three who were assigned female at birth and who now identify as male.

Table 4.3: Sex distribution

Sex at birth	n	%
Female	126	34.3%

Sex at birth	n	%
Male	237	64.6%
Missing	3	0.8%
Total	**367**	**100.0%**

4.5 Ethnicity

The vast majority (97%) identified as being of White ethnicity, predominately White Scottish or Other British.

Table 4.4: Ethnicity distribution

Ethnic group	n	%
African, African Scottish, African British	*	*
Black, Black Scottish, Black British	*	*
Mixed or multiple ethnic groups	*	*
White - Scottish	324	88.3%
White - Other British	26	7.1%
White - Irish	*	*
White - Gypsy/Traveler	*	*
Other ethnic group	*	*
Missing	9	2.5%
Total	**367**	**100.0%**

4.6 Religion / belief

Just over half (51%) reported having no religion or faith whilst thirty-eight per cent identified as some denomination of Christianity. Amongst those responding ‘Other’, thirteen described a general sense of spirituatly, four provided other Christian denominations, and four described atheist or agnostic positions.

Table 4.5: Identified religion / belief

Religion or belief	n	%
Buddhist	*	*
Christian - Church of Scotland	58	15.8%
Christian - Roman Catholic	64	17.4%
Christian - another denomination	17	4.6%
Pagan	*	*
None	186	50.7%
Prefer not to say	13	3.5%
Other	21	5.7%
Missing	5	1.4%
Total	**367**	**100.0%**

4.7 Housing

Just under two thirds of participants (64%) were in some form of stable accommodation (e.g. owned / rented) whilst twenty-seven per cent were either homeless or living in unstable accommodation (e.g. friend's place, hostel, shelter/refuge).

Table 4.6: Current housing situation

Current housing	n	%
Caravan	*	*
Friend's place	5	1.4%
Hostel	39	10.6%
House / flat that I own / am buying	23	6.3%
House / flat that I rent privately	42	11.4%
No usual residence / homeless	11	3.0%
Parents' / family's place	28	7.6%

Current housing	n	%
Partner's place	*	*
Shelter / refuge	12	3.3%
Social housing	170	46.3%
Other	20	5.4%
Missing	13	3.5%
Total	**367**	**100.0%**

Amongst those responding 'Other', ten indicated that they stay in supported accommodation, four in council or housing association accommodation, two in either RR or recovery housing, one was sleeping on the streets and one serving a prison sentence.

4.8 Employment / training and caring responsibilities

Just fifteen per cent of participants were in work, training, or education. 75% were not working, predominantly due to temporary or long-term sickness or disability.

Table 4.7: Current employment status

Employment status	n	%
In paid employment or self-employment: Full-time (35+ hours per week)	28	7.6%
In paid employment or self-employment: Part-time (regular hours)	18	4.9%
Full-time student	5	1.4%
In paid employment or self-employment: Part-time (irregular, casual)	*	*
On a government scheme for employment training	*	*
Sub-total (In work / training / education)	**56**	**15.3%**
Long-term sick or disabled	206	56.1%
Unemployed (Seeking work and available to start in 2 weeks or waiting to start a job already obtained)	35	9.5%
Intending to look for work but prevented by temporary sickness or illness	26	7.1%
Looking after home or family	*	*

Employment status	n	%
Retired	*	*
Sub-total (Not working)	**274**	**74.6%**
Other	29	7.9%
Missing	8	2.2%
Sub-total (Other/missing)	**37**	**10.1%**
Overall total	**367**	**100.0%**

Amongst those responding 'Other', fifteen indicated they were unemployed (including one 'unemployed / student' and one 'universal credit'), five reported having voluntary work (including one 'volunteer worker and part-time college student'), two described caring responsibilities, and one was in prison.

Twenty-seven per cent of participants indicated they look after, or give help and support to a family member, friend, or other person(s) due to their age or a long-term health condition.

Table 4.8: Current caring responsibilities

Caring responsibilities	n	%
Yes	100	27.2%
No	261	71.1%
Missing	6	1.6%
Total	**367**	**100.0%**

4.9 Problematic substance use

Participants were asked to indicate which drug(s) that they currently experience problems with. The most common substances noted were benzodiazepines / hypnotics (64%), opioids (64%), stimulants (56%), cannabinoids (43%) and alcohol (40%).

When asked to identify the single substance causing the most problems, the most common responses were opioids (27%), stimulants (25%), and benzodiazepines / hypnotics (23%).

Twenty-two participants (6%) did not answer this question indicating that the surveys were successful in reaching individuals who are currently experiencing problems with drugs.

Table 4.9: Drugs currently causing problems for participants

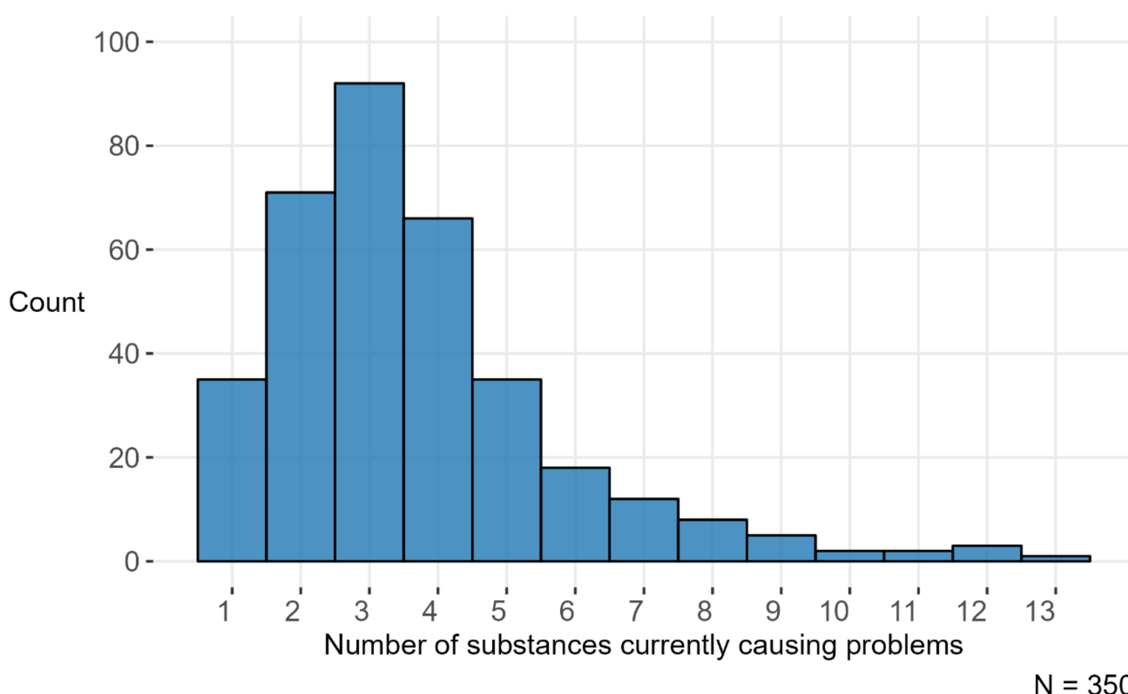
Drugs you currently experience problems with (select all that apply)	n	%
Alcohol	146	39.8%
Benzodiazepines/hypnotics	233	63.5%
Cannabinoids	156	42.5%
Dissociatives	24	6.5%
Empathogens	25	6.8%
Gabapentinoids	122	33.2%
Novel psychoactive substances	17	4.6%
Opioids	236	64.3%
Over the counter	45	12.3%
Psychedelics	29	7.9%
Solvent/inhalants	22	6%
Stimulants	207	56.4%
Synthetic cannabinoids	22	6%

Table 4.10: The drug type causing the most problems currently

Category causing most problems currently	n	%
Alcohol	41	11.2%
Benzodiazepines /hypnotics	85	23.2%
Cannabinoids	16	4.4%
Empathogens	*	*
Gabapentinoids	9	2.5%
Opioids	98	26.7%
Stimulants	93	25.3%
Synthetic cannabinoids	*	*
Missing	22	6.0%
Total	**367**	**100.0%**

The median number of currently problematic substances per person was three, and half of participants had problems with between two to four drugs. Just thirty-five participants (10%) reported experiencing problems with a single substance.

Figure 4.2: Number of substances currently causing problems



4.10 Treatment and support services currently accessed

Participants in WP2 were asked to indicate the types of services they were currently attending or in receipt of treatment / support from. 'Non-specialist' services were defined as included housing, homelessness, criminal justice etc.

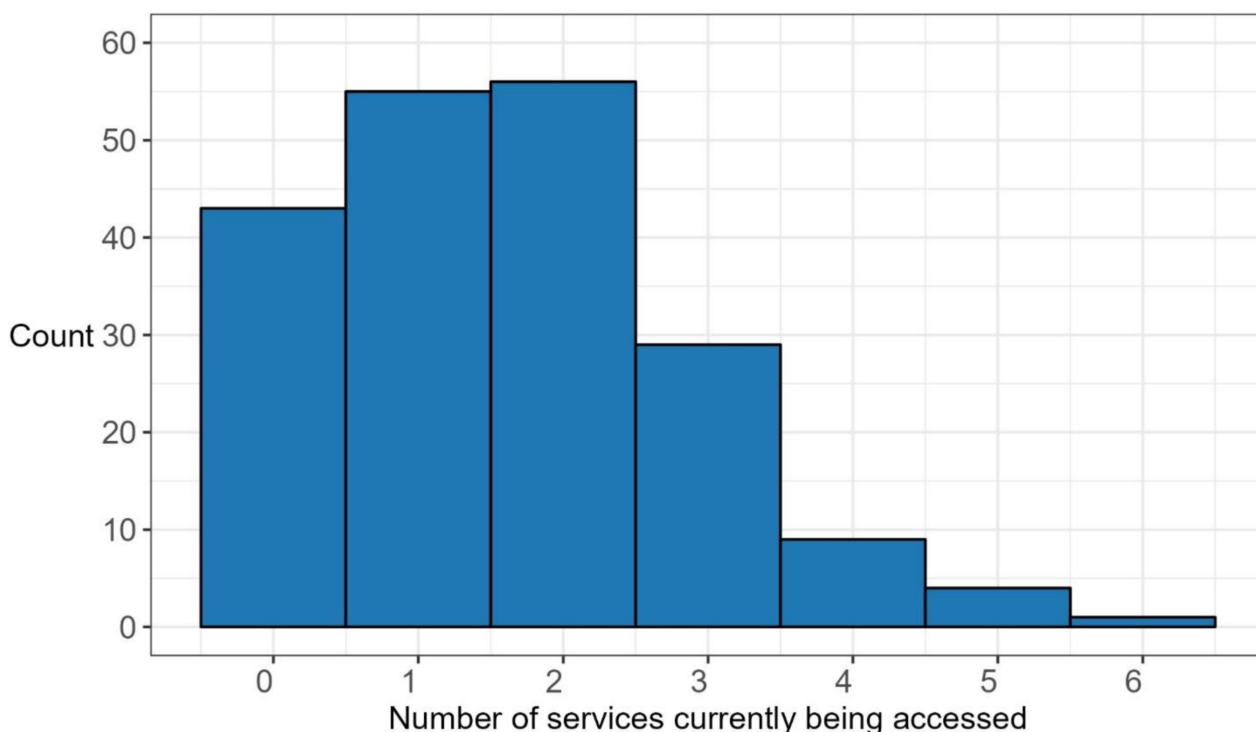
Just over half of participants (52%) were currently accessing NHS drug services and almost forty per cent accessing third sector drug services. Almost one quarter were accessing NHS mental health services (24%) with just over one in five accessing other non-specialist statutory services (22%). Just nine per cent were in contact with a third sector mental health service.

Table 4.11: Services currently being accessed

Currently accessing (select all that apply)	n	%
NHS drug service	102	51.8%
Third sector drug service	77	39.1%
NHS mental health service	48	24.4%
Any other non-specialist statutory service	44	22.3%
Any other non-specialist third sector service	28	14.2%
Third sector mental health service	17	8.6%

The median number of service types per participant was two with half of all participants being engaged with between one to three service types.

Figure 4.3: Number of services currently being accessed



4.11 Stage of recovery

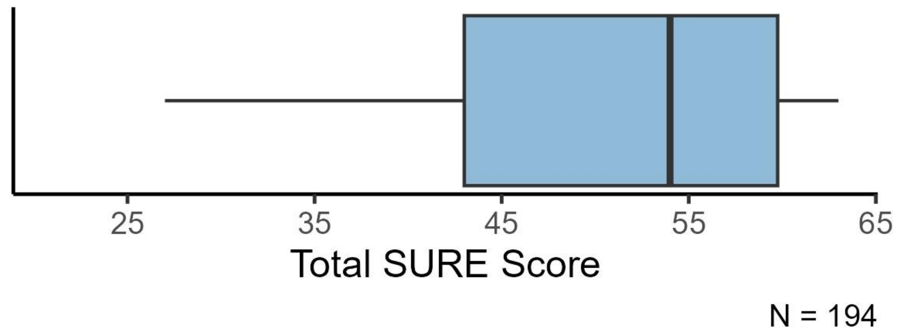
Finally, participants completing the WP2 survey were asked to complete the validated SURE questionnaire, which scores their recovery under five domains and provides a total score (with higher scores indicating more advanced recovery). **Table 4.11** below summarises participant scores for each domain and the total score.

Table 4.12: Substance Use Recovery Evaluator [SURE] – participant scores (n=194)

SURE domain	Possible score range	Min.	Median	IQR	Max.
Drink and drug use	6-18	6	16	11-18	18
Self-care	5-15	5	12	8-14	15
Relationships	4-12	4	12	10-12	12
Material resources	3-9	3	8	7-9	9
Outlook on life	3-9	3	8	5-9	9
Total	**21-63**	**27**	**54**	**43-59.8**	**63**

Notes: IQR = interquartile range, the spread of the middle half of the data. So, half of the participants had a total SURE score between 43 and 59.8.

Figure 4.4: Substance Use Recovery Evaluator [SURE] total score distribution – interquartile range



Chapter 5: Work package 1 (WP1) results

KEY FINDINGS:

- Participants were asked which drug treatment options they had used or received over the previous two years for drug-related issues. Most (over 50%) had accessed support for recovery (defined in the survey questionnaire as, for example, recovery communities or recovery groups or cafés), harm reduction, group work, NHS drug service prescribing, and individual counselling. Just under one quarter (23%) reported using RR in the previous two years. This compares to a total of thirty-nine per cent of participants who have experience of RR at some point in their lives.
- On a scale of zero (not at all informed about RR), five (moderately informed) through to ten (fully informed), almost half of all participants (47%) responded zero to three (0-3), thirty-two per cent replied four to six (4-6), whilst almost one in five (19%) responded seven or above. The median score was four and half of all participants responded between one and five.
- The proportion of participants who had experienced RR was broadly similar by sex and appeared to increase by age. Participants living in Greater Glasgow and Clyde, Lothian, Grampian, and Fife were most likely to report experience of RR (all 45% or greater), whilst those in Tayside and Lanarkshire were least likely to report experience of RR (both less than 30%). Those experiencing the most problems with opiates, alcohol, and benzodiaxepines/hypnotics were most likely to have had a stay in RR, whereas those experiencing most problems with cannabinoids were least likely to have had a stay in RR. Those living in hostels (77%) and privately rented accommodation (74%) were least likely to have ever had a stay in RR.
- Participants were invited to select the statement that best described why they had never had a stay in RR before. Almost half (49%) reported they had either never been offered the option of attending or they did not know how to access a place in RR. Personal circumstances were a barrier for fifteen per cent of participants.
- Thinking of their only or most recent stay, almost all (92%) had attended a service in Scotland and most (53%) had attended since the start of 2020. Most attendances were to services in the central belt of Scotland.

- Participants rated their level of satisfaction with various RR service elements. Satisfaction was high (very satisfied or extremely) with respect to most elements.
- Just over half (55%) of those who had experienced RR indicated whether they completed their most recent programme. Of these, most (61 out of 78) reported that they had completed the programme.
- Just under half of the sample (43%) reported that they are not actively considering a stay in a RR service either now or in the future. Twenty-nine per cent think they may benefit from a period of time in RR but either think this is something they would actively consider in the future (13%) or are currently facing barriers in their personal circumstances that prevent them from going (16%). Just over fourteen per cent are actively considering RR and are either waiting to be admitted to an already-agreed place (4%) or would like to apply for a stay within the next 6 months (10%).

5.1 Introduction

This chapter presents a descriptive analysis of the results from the WP1 question set, which was also embedded within the WP2 question set. This means that the results in this chapter are based on the total study sample (**N=367**).

Throughout this chapter, statistical disclosure control techniques have been applied to participant characteristics data to reduce the risk that an individual would be identified as having participated in the survey. This is because of the sensitive nature of the topic area (substance use). Suppressed data have been denoted by an asterisk (*). The asterisk indicates numbers that are less than five or any percentage which reflects fewer than five participants.

In the main, the WP1 survey was designed to explore the nature of ‘demand for’ RR amongst the target population. However, there is some overlap and interpretation with the ‘perceptions of’ RR data which, in the main, is presented subsequently in **Chapter 6**.

5.2 Experiences of treatment and support

Participants were asked which drug treatment options they had used or received over the previous two years for drug-related issues. Most (over 50%) had accessed support for recovery (defined in the questionnaire as, for example, recovery communities or recovery groups or cafés), harm reduction, group work, NHS drug service prescribing, and

individual counselling. Just under one quarter (23%) reported using RR in the previous two years. This compares to a total of thirty-nine per cent of participants who have experience of RR at some point in their lives.

Table 5.1: Treatment and support options received

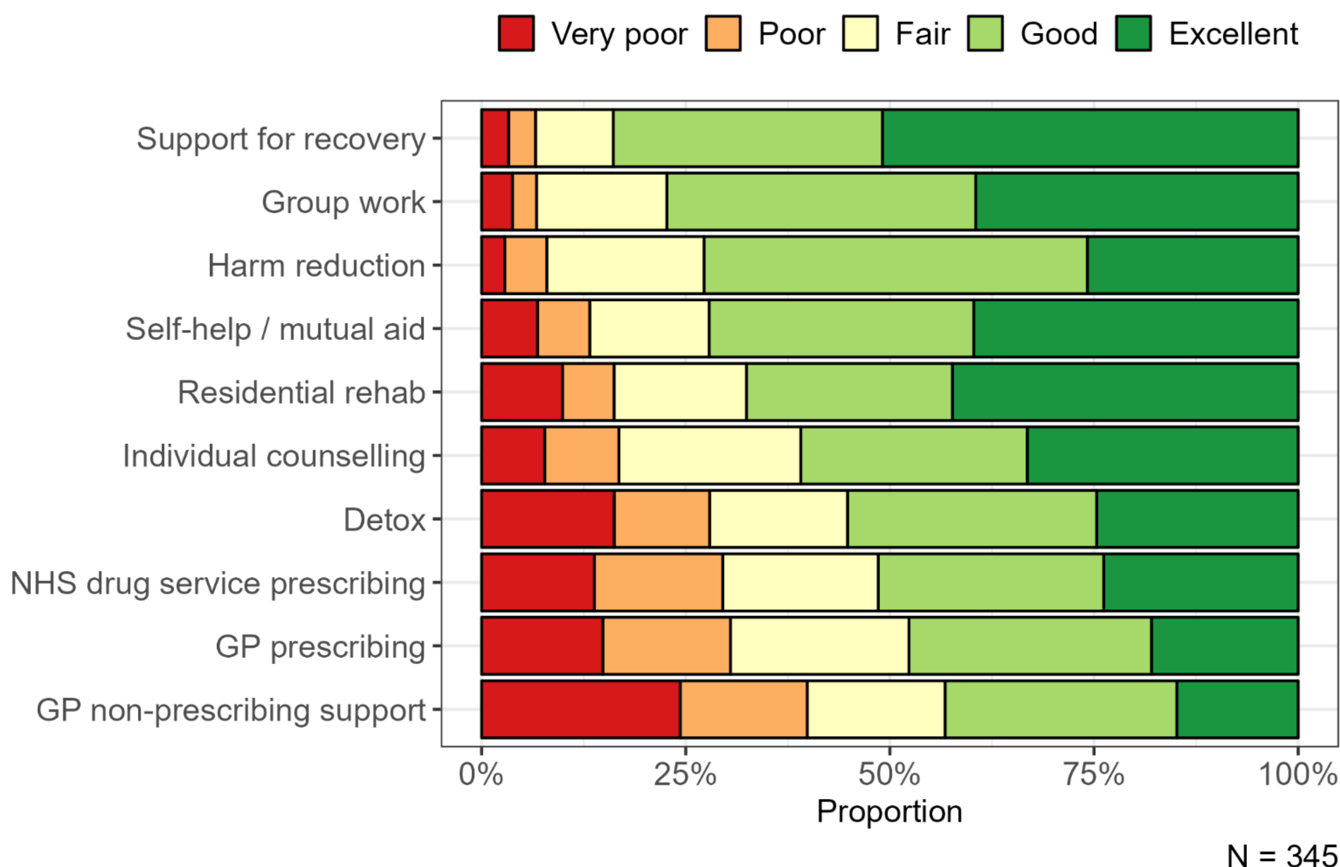
Treatment / support	n	pc
Support for recovery	206	66.0%
Harm reduction	174	55.8%
Group work	170	54.5%
Prescribing from NHS drug service	170	54.5%
Individual counselling	166	53.2%
Self-help / mutual aid	150	48.1%
Detoxification	109	34.9%
Non-prescribing support from GP	101	32.4%
Prescribing from GP	90	28.8%
Residential rehabilitation	71	22.8%

Participants were asked to rate the quality of the support they had received from each treatment and support option they had accessed.

Treatment and support options with the most positive ratings were: support for recovery (84% rated as Good or Excellent), group work (77%), harm reduction (73%), self-help / mutual aid (72%), and RR (68%). Self-help / mutual aid was defined in the questionnaire as, for example, 12 Step Fellowship or SMART Recovery.

Prescribing from NHS drug services (51%) and GPs (48%) and GP non-prescribing support (43%) had the lowest proportion of Good or Excellent ratings.

Figure 5.1: Rating the support received from treatment options



5.3 Definition of residential rehabilitation

Participants were asked to rate the accuracy of the following definition of RR, which was adapted from that used by Scottish Government:

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

[Note: The definition used is a shortened version of the definition that the national Residential Rehabilitation Working Group agreed with the Scottish Government, as published in 'Pathways into, through and out of Residential Rehabilitation in Scotland.' Scottish Government (November 2021) [3]. The full definition is: 'Residential rehabilitation was defined 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.']

Most (62%) thought the statement was accurate (somewhat / very / highly), but over one-fifth (22%) felt they did not know enough about RR to rate the statement.

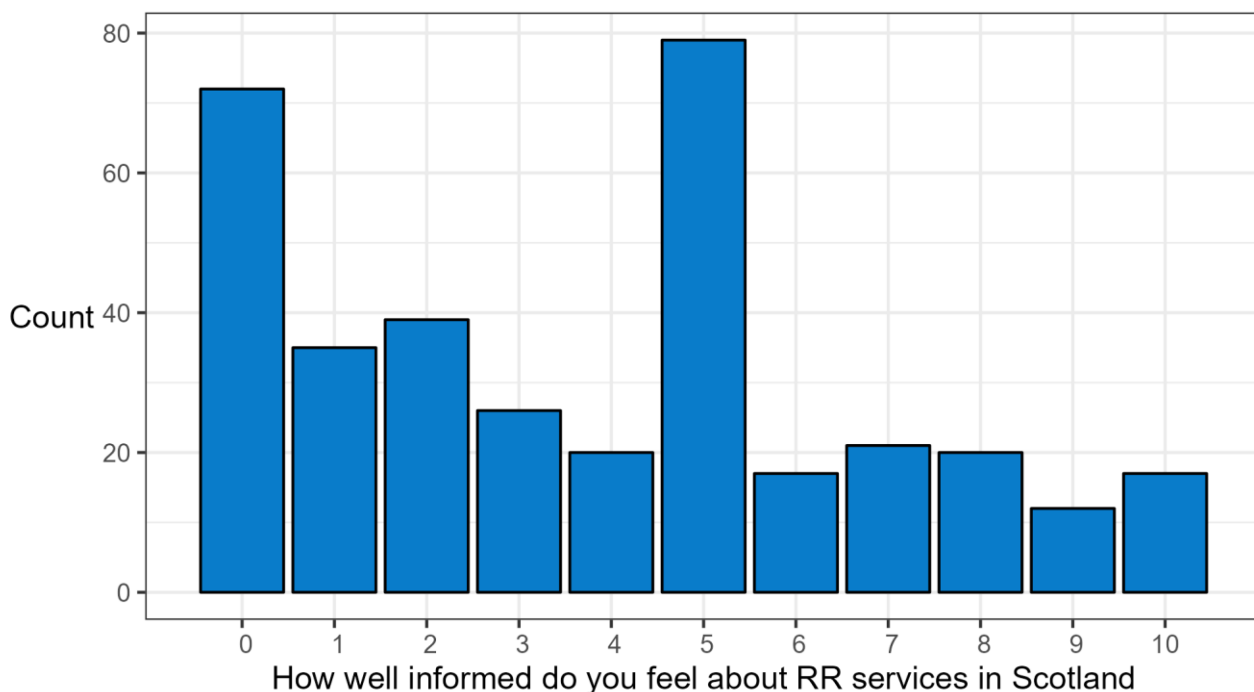
Table 5.2: Rating the accuracy of the given definition of RR

How accurate do you think this definition is?	n	%
Highly accurate	42	11.4%
Very accurate	87	23.7%
Somewhat accurate	100	27.2%
A little accurate	33	9.0%
Not accurate at all	20	5.4%
I don’t know anything (or enough) about RR to comment	80	21.8%
Missing	5	1.4%
Total	**367**	**100.0%**

5.4 How informed are you about residential rehabilitation services in Scotland?

On a scale of zero (not at all informed about RR), five (moderately informed) through to ten (fully informed), almost half of all participants (47%) responded zero to three (0-3), thirty-two per cent replied four to six (4-6), whilst almost one in five (19%) responded seven or above. The median score was four and half of all participants responded between one and five.

Figure 5.2: Rating of how well-informed participants felt regarding RR services



N = 358

A small selection of illustrative quotes that describe how people arrived at scores of between 0-2, the median score 4, and between 8-10 are presented in the table below. The full set of free text responses to this question are included within the analysis contained in **Chapter 7**.

Table 5.3: Illustrative quotes regarding how well informed individuals felt about RR

Score	Comments
0 to 2	• I have asked about rehab but I only hear about rehabs that are religious. • People have only mentioned rehab to me twice despite having been in and out of problem drug use for 20 + years. • If there had been a rehab close I would know more, but there's nothing. The only rehabs I knew of were down south [England] and they were about £12,000.

Score	Comments
4	• Because it's not advertised - I knew it existed but didn't know processes. The only reason I know anything is because I move in recovery circles. • I know about a rehab in [northern England] which my support worker has told me about. I'm about to apply. • Because I don't really ken. I've never to one I know folks who've been to one and they were out two weeks and back on it. There's a van that comes to [town near Edinburgh] but all we've done is read leaflets.
8 to 10	• My dad has been in rehab. I have not been, but I know of and about them through friends and family. • It's through lived experience and me asking those questions, by asking the right questions to the right people I was able to get the info I needed to find treatment. Then when I got the info pack from rehab it informed me everything. • I didn't have a clue before I went in, but I do now.

5.5 Ever had a stay in residential rehabilitation?

Less than half of participants (39%) had ever experienced RR.

The proportion of participants who had experienced RR was broadly similar by sex and appeared to increase by age. Participants living in Greater Glasgow and Clyde, Lothian, Grampian, and Fife were most likely to report experience of RR (all 45% or greater), whilst those in Tayside and Lanarkshire were least likely to report experience of RR (both less than 30%). Current caring responsibility was not associated with having been to RR. Those experiencing the most problems with opiates, alcohol, and benzodiaxepines / hypnotics were most likely to have had a stay in RR, whereas those experiencing most problems with cannabinoids were least likely to have had a stay in RR. Those living in hostels (23%) and privately rented accommodation (26%) were least likely to have ever had a stay in RR.

Table 5.4: Experience of RR

Ever had RR	n	%
Had RR	143	39.0%
No RR	220	59.9%
Missing	4	1.1%
Total	**367**	**100.0%**

Table 5.5: Ever had RR by sex

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Female	46	78	2	126	36.5%
Male	97	140	0	237	40.9%
Missing	0	2	2	4	0.0%
Total	**143**	**220**	**4**	**367**	**39.0%**

Table 5.6: Ever had RR by age group

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
<20	*	*	*	*	*
20-24	*	*	*	*	*
25-29	*	*	*	*	*
30-34	20	33	1	54	37.0%
35-39	27	36	0	63	42.9%
40-44	32	50	0	82	39.0%
45-49	33	41	0	74	44.6%
50-54	15	21	0	36	41.7%
55-59	7	9	0	16	43.8%
60-64	*	*	*	*	*

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
65+	*	*	*	*	*
Missing	0	1	2	3	0.0%
Total	**143**	**220**	**4**	**367**	**39.0%**

Table 5.7: Ever had RR by carer status

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Yes	38	60	2	100	38.0%
No	103	158	0	261	39.5%
Missing	2	2	2	6	33.3%
Total	**143**	**220**	**4**	**367**	**39.0%**

Table 5.8: Ever had RR by Health Board

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Ayrshire and Arran	11	18	0	29	37.9%
Borders	*	*	*	*	*
Dumfries and Galloway	*	*	*	*	*
Eilean Siar (Western Isles)	*	*	*	*	*
Fife	9	11	0	20	45.0%
Forth Valley	*	*	*	*	*
Grampian	16	19	0	35	45.7%
Greater Glasgow and Clyde	44	46	1	91	48.4%
Highland	*	*	*	*	*
Lanarkshire	10	23	1	34	29.4%
Lothian	27	29	0	56	48.2%
Missing	6	10	2	18	33.3%
Tayside	7	22	0	29	24.1%

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Total	**143**	**220**	**4**	**367**	**39.0%**

Table 5.9: Ever had RR by main problem drug

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Alcohol	18	23	0	41	43.9%
Benzoidiazepines / hypnotics	36	48	1	85	42.4%
Cannabinoids	*	*	*	*	*
Empathogens	*	*	*	*	*
Gabapentinoids	*	*	*	*	*
Opioids	44	54	0	98	44.9%
Stimulants	27	65	1	93	29.0%
Synthetic cannabinoids	*	*	*	*	*
Missing	13	7	2	22	59.1%
Total	**143**	**220**	**4**	**367**	**39.0%**

Table 5.10: Ever had RR by housing status

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Caravan	*	*	*	*	*
Friend’s place	*	*	*	*	*
Hostel	9	29	1	39	23.1%
House/flat that I own/am buying	10	13	0	23	43.5%
House/flat that I rent privately	11	30	1	42	26.2%
No usual residence/homeless	*	*	*	*	*
Parents’ / family’s place	11	17	0	28	39.3%
Partner’s place	*	*	*	*	*
Shelter/refuge	*	*	*	*	*

Ever had RR	Had RR	No RR	Missing	Total	% Had RR
Social housing	74	96	0	170	43.5%
Other	11	9	0	20	55.0%
Missing	2	9	2	13	15.4%
Total	**143**	**220**	**4**	**367**	**39.0%**

5.6 Reasons for not having experience of residential rehabilitation

This section describes responses from those who reported no prior experience of RR (N = 220).

Participants were invited to select the statement that best described why they had never had a stay in RR before. Almost half (49%) reported they had either never been offered the option of attending or they did not know how to access a place in RR. Personal circumstances were a barrier for fifteen per cent of participants.

Table 5.11: Reasons for having not experienced RR

Why you have never had a stay in residential rehabilitation before	n	%
I have never been offered the option of applying for a place in a RR service	83	37.7%
I have never considered going to RR	29	13.2%
I wanted to go to RR but was refused a place	11	5.0%
I was offered RR, but I declined	13	5.9%
I am aware that RR programmes exist, but I have no idea about how to go about accessing them	24	10.9%
I think I would benefit from a period of time in RR, but my personal circumstances have prevented me from going	33	15.0%
I am currently waiting to go to RR for the first time	10	4.5%
Other	17	7.7%
Total	**220**	**100.0%**

Those replying ‘Other’ generally indicated that they had engaged in other (non-residential) treatment and recovery methods. Some described having faced barriers that prevented

them from attending RR including the duration of a long-term programme, childcare, long waiting time, and perceived stigma. Two perceived that their drug problems were not severe enough to warrant a RR stay.

5.7 Most recent stay in residential rehabilitation: where, when and how funded

The following sections describe responses from people reporting they have experienced RR (**N = 143**).

Thinking of their only or most recent stay, almost all (92%) had attended a service in Scotland and most (53%) had attended since the start of 2021. Most attendances were to services in the central belt of Scotland, predominately in / around Glasgow and Edinburgh, with some elsewhere in Scotland (Peeblesshire). Over half (56%) were unable to confirm how their stay had been funded and one quarter (26%) reported their stay had been approved and funded by a drug service. Those responding 'Other', indicated that their stay was funded by their local council (n=2), their housing benefits (n=2), or by a charity (n=1).

Table 5.8: Where most recent RR stay was funded

Details of most recent stay in RR	n	%
In Scotland	132	92.3%
Outside Scotland	11	7.7%
Total	**143**	**100.0%**

Table 5.9: When most recent RR stay was funded

Details of most recent stay in RR	n	%
Since 01/01/2021	76	53.1%
Before 31/12/2020	55	38.5%
Missing	12	8.4%
Total	**143**	**100.0%**

Table 5.10: How most recent RR stay was funded

Details of most recent stay in RR	n	%
Funding approved and paid for by drug services	37	25.9%
I don’t know/recall	15	10.5%
Funding approved and paid for by other services	11	7.7%
Self-funded (or from family)	9	6.3%
Other	5	3.5%
Employer	1	0.7%
Missing	65	45.5%
Total	**143**	**100.0%**

Table 5.11: RR service attended at most recent stay

Which RR service did you attend?	n	%
Abbeycare [Erskine, Renfrewshire]	12	8.4%
Alternatives/Safe as Houses [Clydebank, West Dunbartonshire]	8	5.6%
Calderglen House [Blantyre, South Lanarkshire]	*	*
Castle Craig Hospital [West Linton, Peeblesshire]	10	7.0%
Crossreach Residential Recovery [Glasgow]	*	*
Haven Kilmacolm [Horsecraigs, Inverclyde]	*	*
Jericho House [Greenock]	*	*
LEAP (Lothians and Edinburgh Abstinence Programme) [Edinburgh]	11	7.7%
Phoenix Futures Residential Service [Glasgow]	12	8.4%
Turning Point Crisis Service [Glasgow]	*	*
Turning Point Stabilisation Service [Glasgow]	*	*
Turning Point (Turnaround) [Paisley]	*	*
Turning Point (308) [Glasgow]	*	*

Which RR service did you attend?	n	%
Other	8	5.6%
Missing	65	45.5%
Total	**143**	**100.0%**

'Other' services noted by participants, and which were considered by said participants to be RR services, were:

- Blue Triangle Housing Association [services across Scotland]
- North East Addictions, [Tyne and Wear]
- Steps to Hope [Edinburgh]
- Inpatient detox at Kershaw Unit [Glasgow]
- Anne Hope House [Edinburgh]
- Gartnavel and Levendale [Glasgow]
- Safe as houses [Clydebank]

Amongst those reporting ever having attended a RR service in Scotland, most (62%) had one stay, seventeen per cent had two stays, and twenty-two per cent reported three or more stays. Amongst those reporting having attended RR outside Scotland, sixty-nine per cent had one stay, seventeen per cent two stays, and just under seven per cent reported three or more stays.

Table 5.12: Number of stays in RR – in Scotland

Number of RR stays	n	%
1	82	61.7%
2	22	16.5%
3+	29	21.8%
Total	**133**	**100.0%**

Table 5.13: Number of stays in RR – outwith Scotland

Number of RR stays	n	%
1	20	69.0%
2	5	17.2%
3+	2	6.9%
Missing	2	6.9%
Total	**29**	**100.0%**

5.8 Satisfaction with residential rehabilitation

Participants rated their level of satisfaction with various service elements. Satisfaction was high (very satisfied or extremely) with respect to most elements: environment, accommodation, living arrangements (71%), staff support (70%), peer support (66%), group (64%) and individual (62%) therapy / support, programme structure/rules (59%), service model or approach (59%), and food, diet, nutrition (56%).

Satisfaction was slightly lower for family contact and support (55% very satisfied or extremely), and medical support (45%), and leisure activities (44%).

Figure 5.3: Satisfaction with service elements from most recent stay in RR

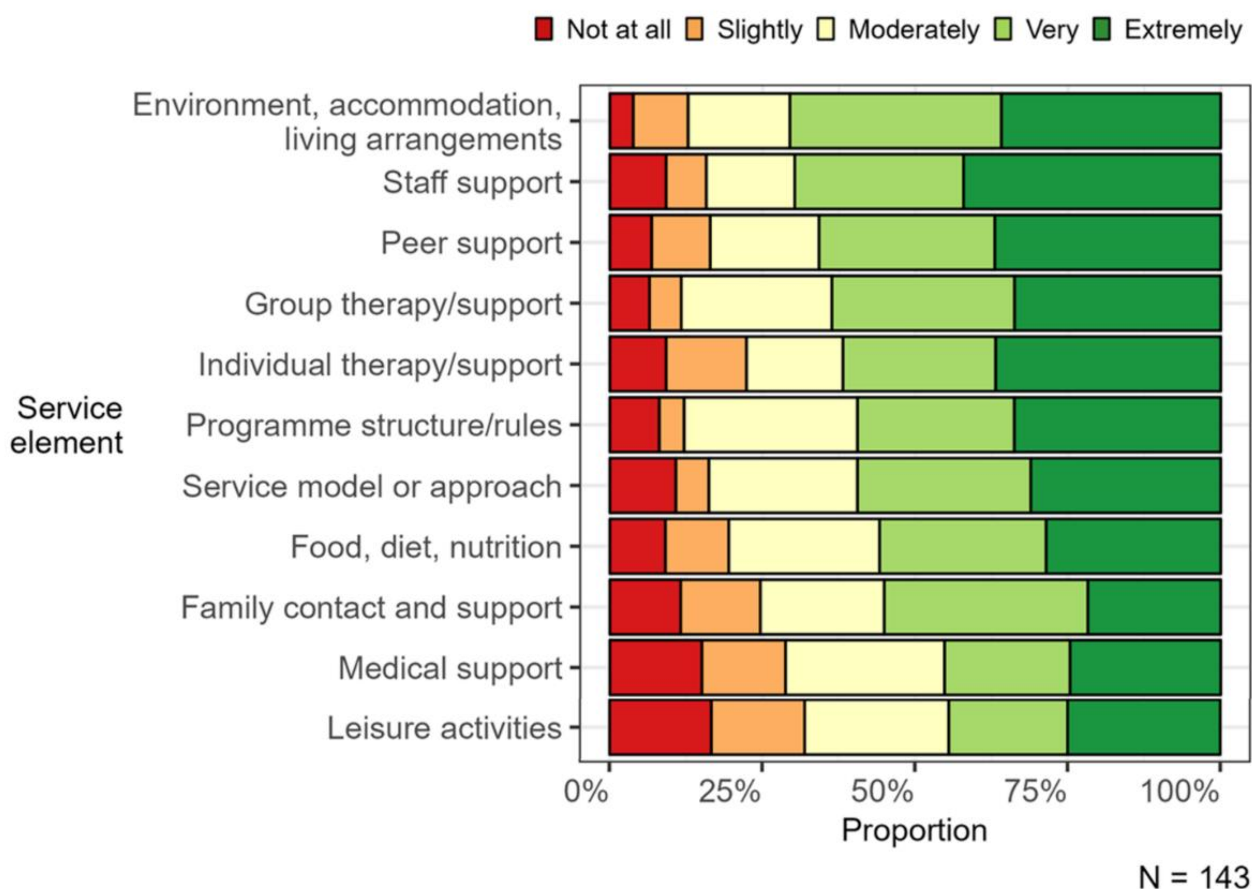
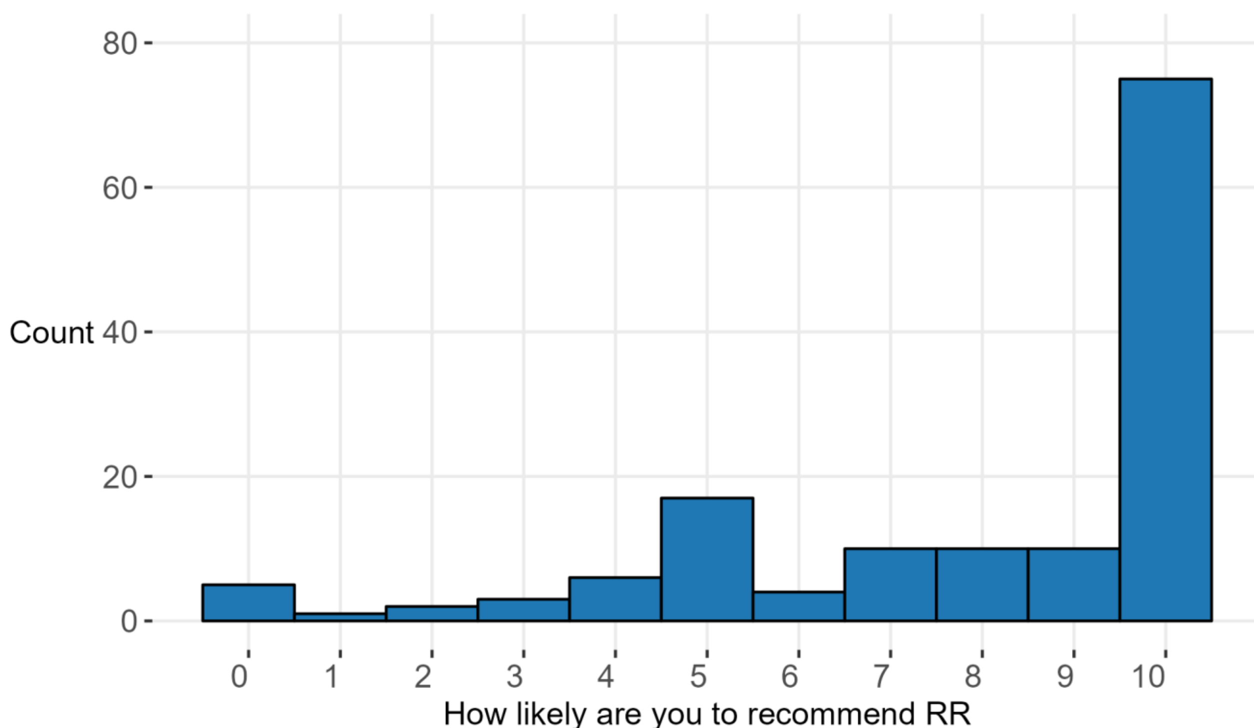


Figure notes:

- Service elements are sorted by proportion of 'very' or 'extremely satisfied' responses (descending).
- Excludes 'don't know' (low number of D/K responses: four for family contact, three each for medical support and service model, and two for programme structure) and 'missing'.
- Examples of 'service model or approach' were provided in the survey: '(e.g. 12-Step, CBT, Faith-based, Therapeutic Community)'. Examples of 'medical support' provided were: '(e.g. GP, dentist, optician)'.

Considering their previous experience(s), participants were very likely to recommend RR to other people who experience problems with drugs on a scale of zero (not at all likely) to ten (extremely likely). The median score was ten and half of participants scored between six and ten.

Figure 5.4: How likely are you to recommend RR to other people with a drug problem (0 = Not at all likely to 10 = Extremely likely)



5.9 Completing residential rehabilitation

Just over half (55%) of those who had experienced RR indicated whether they completed their most recent programme. Of these, most (61 out of 78) reported that they had completed the programme.

Table 5.14: Completion of most recent RR programme

Did you complete the RR programme?	n	%
Yes	61	42.7%
No	17	11.9%
Missing	65	45.5%
Total	**143**	**100.0%**

Amongst the seventeen people who did not complete the programme, seventy-one per cent indicated the decision to leave early was wholly or partly theirs.

Table 5.15: Reason for non-completion of previous RR programme

Was it your decision to leave the programme early or were you asked to leave by the service?	n	%
It was my decision to leave	9	52.9%
The RR service asked/told me to leave	5	29.4%
Both of the above	3	17.6%
Total	**17**	**100.0%**

5.10 Intentions and barriers

The following sections describe responses from all participants (n=367).

Just under half of the sample (43%) reported that they are not actively considering a stay in a RR service either now or in the future. Twenty-nine per cent think they may benefit from a period of time in RR but either think this is something they would actively consider in the future (13%) or are currently facing barriers in their personal circumstances that prevent them from going (16%). Just over fourteen per cent are actively considering RR and are either waiting to be admitted to an already-agreed place (4%) or would like to apply for a stay within the next 6 months (10%).

Table 5.16: Current intentions and situation regarding RR

Actively considering RR? Which of the following best describes your current situation	n	%
No – I do not feel that I need to go to RR either currently or in the future.	158	43.1%
Maybe – I think I would benefit from a period of time in RR, but my personal circumstances are preventing me from going.	60	16.3%
Maybe – I think I might require a period of time in RR at some point in the future, but I am not actively considering it, or applying for it, just now.	46	12.5%
Yes – I am actively considering applying to go to RR in the near future (i.e. within the next 6 months).	38	10.4%

Actively considering RR? **Which of the following best describes your current situation**	**n**	**%**
Yes – I have been offered a place in a RR service and am currently waiting to be admitted.	14	3.8%
Other	46	12.5%
Missing	5	1.4%
Total	**367**	**100.0%**

Those responding ‘Other’ gave a range of additional information. Around half reported that they were well-established in their own recovery, including some who had experienced RR previously, and no long felt that they needed a stay. Others described views under two broad groupings: (1) those who do not currently feel the need for RR, but who would be interested if they relapsed or experienced other difficulties that affected their current recovery, and (2) those who experience barriers that prevent them pursuing their interest in exploring a stay.

The tables below (5.17-5.23) provide crosstabulations of ‘actively considering RR’ against age group, sex, carer status, Health Board, drug causing most problems, current housing, and ever had RR. The denominator used for these crosstabulations does not include the ‘other’ or ‘missing’ categories that are presented in Table 5.16 above.

Participants aged under 30 were more likely to indicate their active interest (Yes) compared with those aged 30 and over (28% vs 18%), as were Males (18%) versus Females (13%).

People with current caring responsibilities were less likely to be actively interested in RR (8%) compared to those without caring responsibility (20%).

There did not appear to be a strong relationship between the drug causing people most problems, their current housing situation, or their prior experience of RR and active interest in RR.

Table 5.17: Active interest in RR (No/Maybe/Yes) by age group

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
<20	*	*	*	*	*	*
20-24	*	*	*	*	*	*
25-29	*	*	*	*	*	*
30-34	23	14	8	45	31.1%	17.8%
35-39	20	22	10	52	42.3%	19.2%
40-44	37	27	9	73	37.0%	12.3%
45-49	35	23	9	67	34.3%	13.4%
50-54	*	*	*	*	*	*
55-59	*	*	*	*	*	*
60-64	*	*	*	*	*	*
65+	*	*	*	*	*	*
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

Table 5.18: Active interest in RR (No/Maybe/Yes) by sex

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Female	65	33	15	113	29.2%	13.3%
Male	92	73	37	202	36.1%	18.3%
Missing	1	0	0	1	0.0%	0.0%
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

Table 5.19: Active interest in RR (No/Maybe/Yes) by carer status

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Yes	59	23	7	89	25.8%	7.9%
No	98	80	45	223	35.9%	20.2%
Missing	1	3	0	4	75.0%	0.0%

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

Table 5.20: Active interest in RR (No/Maybe/Yes) by Health Board

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Ayrshire and Arran	*	*	*	*	*	*
Borders	*	*	*	*	*	*
Dumfries and Galloway	*	*	*	*	*	*
Eilean an Siar (Western Isles)	*	*	*	*	*	*
Fife	*	*	*	*	*	*
Forth Valley	*	*	*	*	*	*
Grampian	*	*	*	*	*	*
Greater Glasgow and Clyde	30	32	16	78	41.0%	20.5%
Highland	*	*	*	*	*	*
Lanarkshire	*	*	*	*	*	*
Lothian	19	21	8	48	43.8%	16.7%
Tayside	11	8	8	27	29.6%	29.6%
Missing	4	7	2	13	53.8%	15.4%
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

Table 5.21: Active interest in RR (No/Maybe/Yes) by main problem drug

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Alcohol	18	10	5	33	30.3%	15.2%
Benzoidiazepines / hypnotics	40	28	11	79	35.4%	13.9%
Cannabinoids	*	*	*	*	*	*
Empathogens	*	*	*	*	*	*
Gabapentinoids	*	*	*	*	*	*

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Opioids	38	27	14	79	34.2%	17.7%
Stimulants	34	35	16	85	41.2%	18.8%
Synthetic cannabinoids	*	*	*	*	*	*
Missing	14	0	1	15	0.0%	6.7%
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

Table 5.22: Active interest in RR (No/Maybe/Yes) by current housing

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Caravan	*	*	*	*	*	*
Friend's place	*	*	*	*	*	*
Hostel	8	20	8	36	55.6%	22.2%
House/flat that I own / am buying	*	*	*	*	*	*
House/flat that I rent privately	14	12	8	34	35.3%	23.5%
No usual residence / homeless	*	*	*	*	*	*
Parents' / family's place	*	*	*	*	*	*
Partner's place	*	*	*	*	*	*
Shelter/refuge	*	*	*	*	*	*
Social housing	82	43	22	147	29.3%	15.0%
Other	*	*	*	*	*	*
Missing	5	3	1	9	33.3%	11.1%
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

Table 5.23: Active interest in RR (No/Maybe/Yes) by experience of RR (ever had RR)

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Yes	64	35	17	116	30.2%	14.7%
No	92	71	35	198	35.9%	17.7%

Interest in RR by characteristic	No	Maybe	Yes	Total	% Maybe	% Yes
Missing	2	0	0	2	0.0%	0.0%
Total	**158**	**106**	**52**	**316**	**33.5%**	**16.5%**

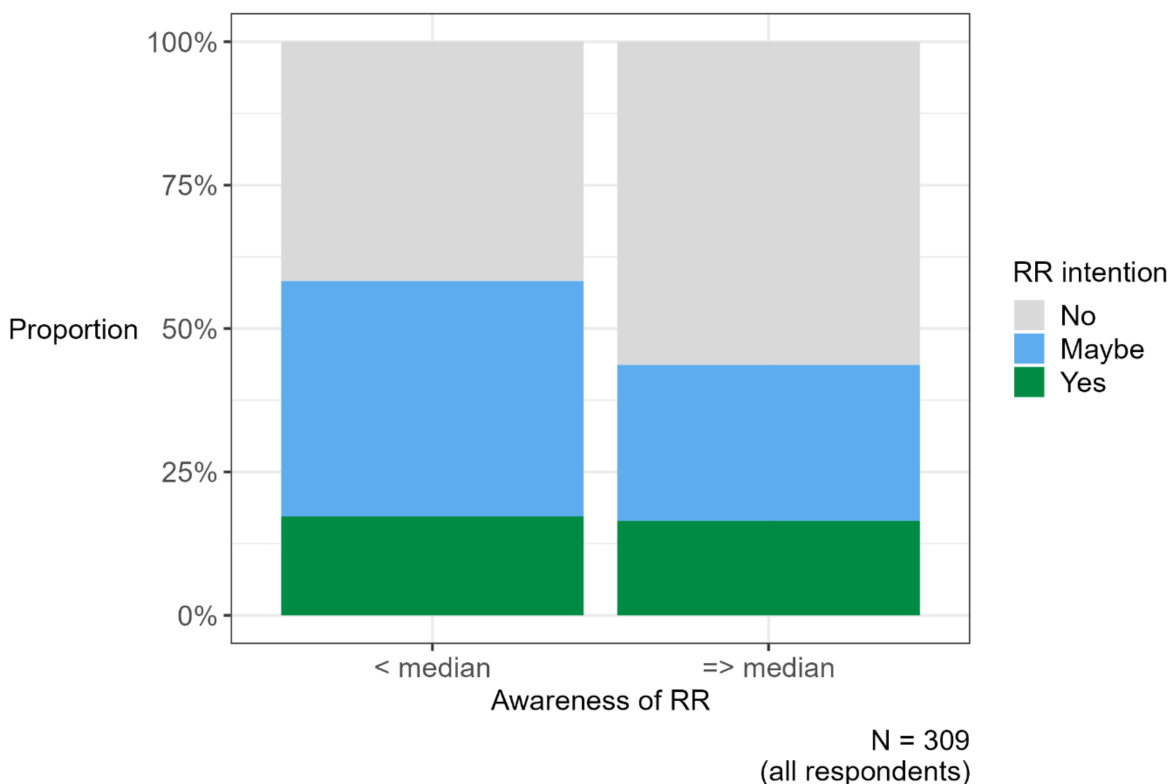
The figures and tables below provide crosstabulations of 'actively considering RR' against 'level of informedness of RR'.

Feeling well informed about RR does not affect a positive intention to attend RR in the future, but does reduce less firm intentions and increases the likelihood of stating 'I do not feel that I need to go to residential rehabilitation either currently or in the future'.

Table 5.24: Intention for RR (No/Maybe/Yes) by informedness of RR (scale of 0-10) – all participants

Intention for RR by informedness – all participants	No	Maybe	Yes	Total	% Maybe	% Yes
Less than median	63	62	26	**151**	41.1%	17.2%
Median or greater	89	43	26	**158**	27.2%	16.5%

Figure 5.5: Intention for RR (No / Maybe / Yes) by informedness of RR (scale of 0-10)

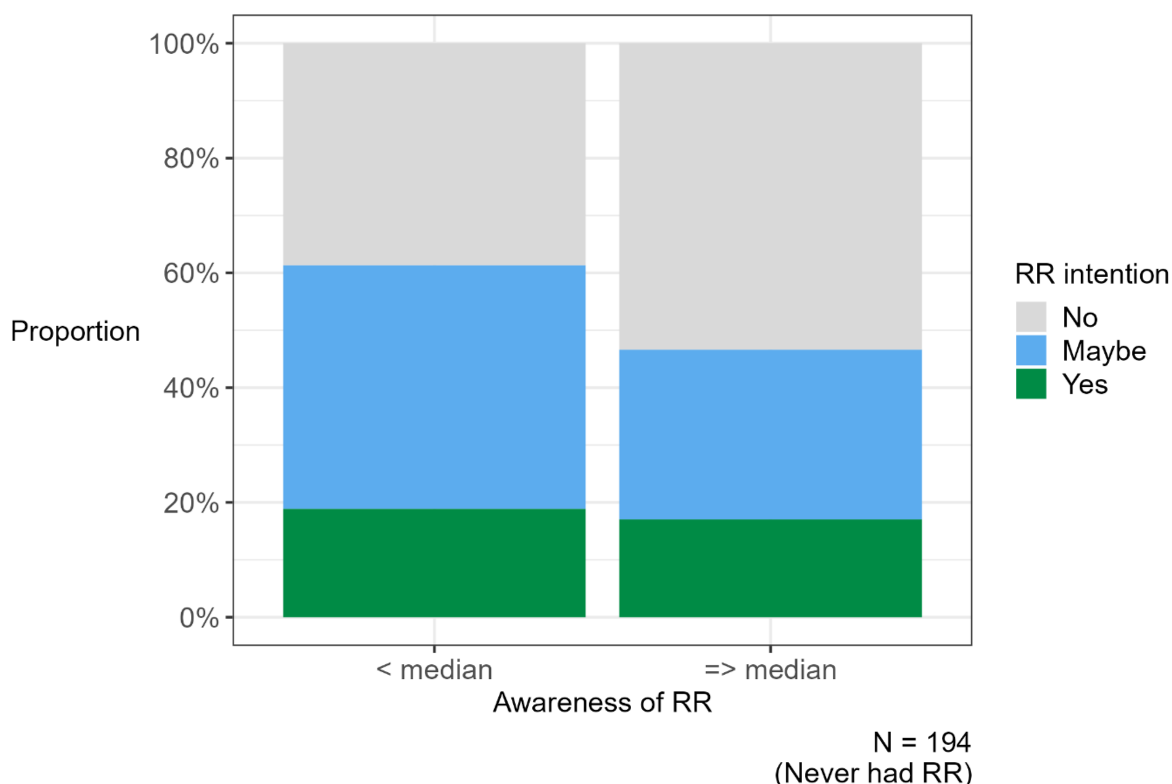


The picture is almost identical when just looking at people who have never been to RR.

Table 5.25: Intention for RR (No/Maybe/Yes) by informedness of RR (scale of 0-10) – respondents who have never been to RR

Intention for RR by informedness – never been to RR	No	Maybe	Yes	Total	% Maybe	% Yes
Less than median	41	45	20	**106**	42.5%	18.9%
Median or greater	47	26	15	**88**	29.5%	17.0%

Figure 5.6: Intention for RR by informedness (amongst RR naïve participants)



Amongst those reporting an interest in attending RR but who feel their personal circumstances are a barrier the majority (80%) cited health reasons (physical / mental health issues and medications, including learning disabilities), just over half (53%) social factors (such as finances, housing, and employment), and forty per cent family reasons (childcare / pets / other caring responsibilities). Just over one in five (22%) reported the lack of a suitable local service was a barrier. Forty-one per cent gave other reasons, including stigma (13%) and cultural/religious reasons (2%). A breakdown of response numbers from all the available category options is presented in the table below.

Table 5.26: Circumstances stopping participants from actively considering or pursuing a place in RR

Circumstance (select all that apply)	n	%
Mental Health issues	26	43.3%
Housing situation	24	40.0%
No suitable RR service locally	13	21.7%
Mental Health medication	11	18.3%
Pets	10	16.7%
Childcare responsibilities	8	13.3%
Stigma	8	13.3%
Caring responsibilities	6	10.0%
Finances	6	10.0%
Physical health issues or disabilities	6	10.0%
Pain medication	4	6.7%
Employment	2	3.3%
Learning Disability	1	1.7%
Cultural or religious	1	1.7%
Other	16	26.7%

Participants answering ‘Other’ generally described barriers relating to their health and medications (especially ORT related), and family and caring responsibilities. Two participants expressed concerns regarding abstinence and one person replied ‘court situation [and] curfew’.

Chapter 6: Work package 2 (WP2) results

KEY FINDINGS:

- Participants were asked to rank the importance of ten treatment options from most (1) to least (10) important. Support for recovery was the most highly rated (median 3) followed by detoxification, group work, individual counselling, NHS drug service prescribing, and self-help / mutual aid services (median 5). The lowest rated were harm reduction (median 6) followed by prescribing and non-prescribing support from GPs, and RR (all median 7).
- Notable proportions of participants rated RR as the most (rated 1) or least (rated 10) important option. No other option was rated 10 (least important) by over 40 participants. Out of the ten treatment options, only detoxification had a similar distribution of scores with the largest peaks at ratings 1 and 10.
- Participants appear to be more optimistic about their own chances of being able to complete an RR programme compared to their perceptions of the chances of the wider population of people who use drugs in completing a first RR programme. Almost three quarters (74%) thought that they personally would be likely or extremely likely to complete an RR programme, whereas fewer than one in ten participants thought that more than sixty per cent of people attending RR for the first time would be likely to complete the programme.
- Just over one-quarter of participants (27%) thought that at least 4 out of 5 people would drop out of their first RR programme early with three-quarters of participants believing that it would be likely or extremely likely that an individual would require more than one stay in RR.
- When asked ‘how effective do you think RR is as a treatment option for people who need or want it in Scotland?’, fifty-six per cent of participants responded positively (very or extremely). Seven per cent had more negative views on its effectiveness (slightly or not at all effective). Fifteen per cent were unable to answer this question.
- Just under two thirds of people (64%) would need to know that their tenancy was secure in order for them to be able to commit to a stay in RR. Almost one half (46%) would need to be able to access funding to cover the costs of their stay, over one

quarter (28%) would need a better choice of RRs and a similar proportion (26%) would need to be able to access a service within a reasonable distance of the area of their residence. Twenty-one per cent would need to secure the support of their employer. Caring responsibilities for children (15%) or pet dog (13%) would need to be accommodated to others to engage.

- Most participants obtained their information on RR from people they know who have personal experience of RR (57%) or via drug services (49%). Substantial proportions had either done their own research (26%) or visited one or more RR services (26%).

6.1 Introduction

This chapter presents a descriptive analysis of the results from the WP2 interviews (**N=197**), minus the WP1 question set results (which were embedded within the WP2 survey and that have been presented already in **Chapter 5** above).

In the main, the WP2 survey and interview were designed to explore the nature of 'perceptions of' RR amongst the target population. However, there are also some participant characteristic data included within the question set (which should be considered alongside the data in Chapter 4).

6.2 Treatment and support services – relative importance

Participants were asked to rank the importance of ten treatment options from most (1) to least (10) important. The median ratings ranged from 3 to 7, and the interquartile ranges [IQR] were between 4 and 6, suggesting a wide range of views amongst participants.

Based on these summary statistics, support for recovery was the most highly rated (median 3) followed by detoxification, group work, individual counselling, NHS drug service prescribing, and self-help / mutual aid services (median 5). The lowest rated were harm reduction (median 6) followed by prescribing and non-prescribing support from GPs, and RR (all median 7).

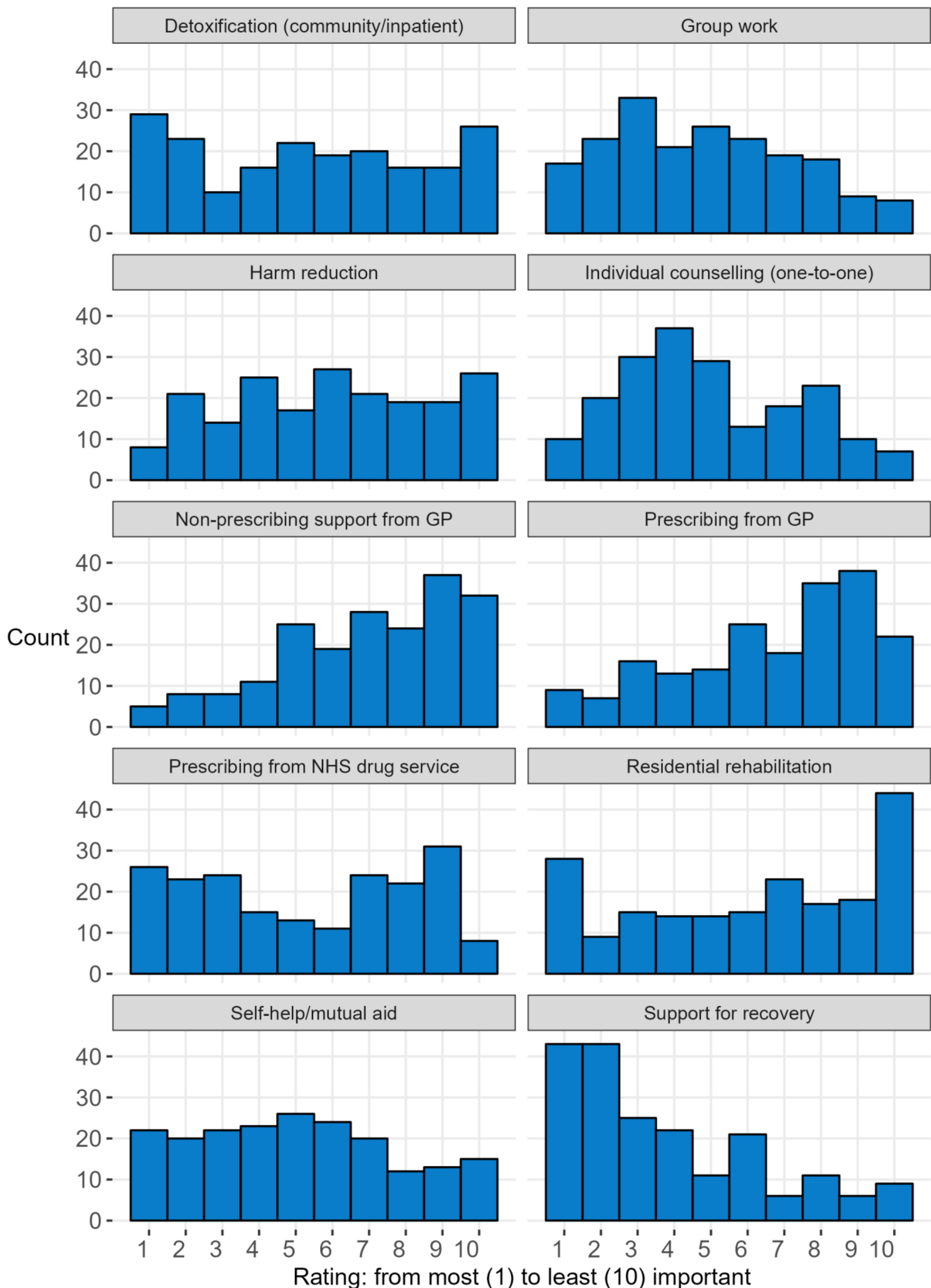
Table 6.1: Rating the importance of treatment options (summary statistics)

Treatment option	Median rating	IQR rating
Support for recovery	3	2-6
Detoxification (community/inpatient)	5	2-8
Prescribing from NHS drug service	5	3-8
Group work	5	3-7
Individual counselling (one-to-one)	5	3-7
Self-help/mutual aid	5	3-7
Harm reduction	6	4-8
Residential rehabilitation	7	3-9
Non-prescribing support from GP	7	5-9
Prescribing from GP	7	5-9

Note: IQR = interquartile range, the spread of the middle half of the data, e.g. half of the participants rated RR between 3 and 9.

The following figure provides histograms that describe the distribution of ratings across these treatment options. This confirms the wide range of scores across the sample and indicates that notable proportions of participants rated RR as either the most or least important option.

Figure Error! No text of specified style in document.**.1 Rating the importance of**



treatment options (histograms)

6.3 Residential rehabilitation programme completion

Participants generally thought most people attending RR for the first time would be unlikely to complete the programme. Sixty-two per cent of participants believed that 0-40% of individuals would complete the programme, whilst thirty-one per cent thought that 41-80% would do so. Only a small fraction (1.5%) were optimistic that 81-100% would complete.

Table 6.3: Perception of others' likely completion rate for first RR

Estimated proportion completing RR	n	%
0-20% of people likely to complete their first stay in RR	53	26.9%
21-40%	69	35.0%
41-60%	46	23.4%
61-80%	15	7.6%
81-100%	3	1.5%
Don't know	11	5.6%
Total	**197**	**100.0%**

In contrast, almost three quarters of participants (74%) thought that they would be 'likely' or 'extremely likely' to complete the programme if they were to attend RR.

Table 6.4: Perception of own likelihood of completing RR

How likely that you would complete RR	n	%
Extremely likely	91	46.2%
Likely	54	27.4%
Neutral	19	9.6%
Unlikely	7	3.6%
Extremely unlikely	9	4.6%
I don’t know	14	7.1%
Missing	3	1.5%
Total	**197**	**100.0%**

Views expressed by participants regarding their likelihood of completing an RR programme are presented in **Chapter 7**.

6.4 Reasons someone might leave residential rehabilitation early

Participants were asked to review a list of several factors that may be reasons why someone would leave RR before they had completed the programme, and to rate these from (1) extremely likely to cause a person to leave early through to (5) extremely unlikely.

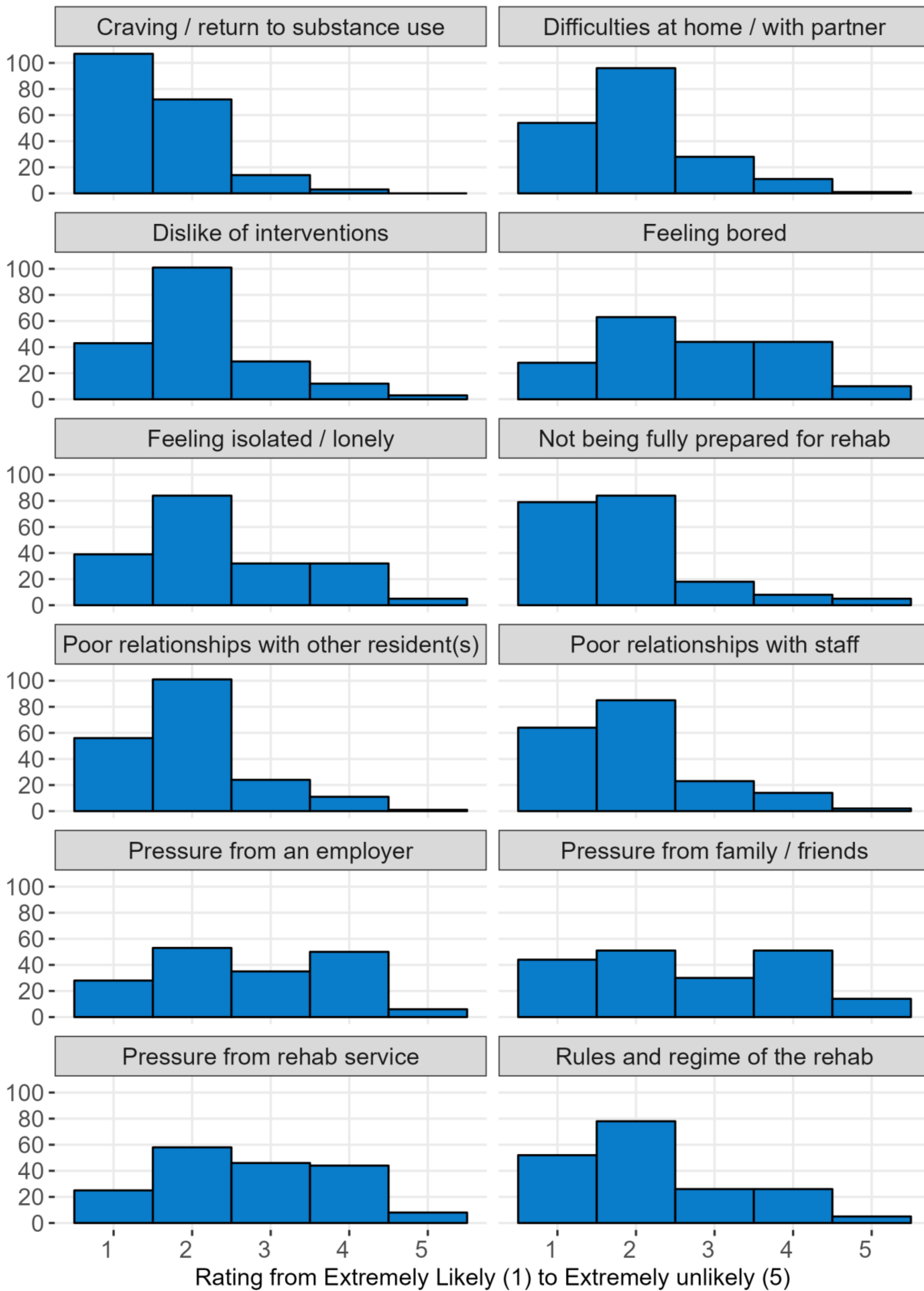
In general, participants thought that lapse or relapse into substance use was extremely likely to be a reason for someone leaving RR early whilst pressure from RR staff to stay longer than needed and pressure from employer to leave early had the lowest median scores (neutral). All other possible reasons had a median score of 2 (likely).

Table 6.6: Summary statistics for scoring of reasons someone might leave RR early (where 1 = Extremely likely and 5 = Extremely unlikely)

Reason	Minimum	Median	IQR	Maximum
Craving / return to substance use	1	1.0	1-2	4
Dislike of interventions	1	2.0	2	5
Difficulties at home / with partner	1	2.0	1-2	5
Not being fully prepared for RR	1	2.0	1-2	5
Poor relationships with other resident(s)	1	2.0	1-2	5
Poor relationships with staff	1	2.0	1-2	5
Rules and regime of the RR	1	2.0	1-3	5
Feeling isolated / lonely	1	2.0	2-3	5
Pressure from family / friends	1	2.5	2-4	5
Feeling bored	1	3.0	2-4	5
Pressure from an employer	1	3.0	2-4	5
Pressure from RR service	1	3.0	2-4	5

Note: IQR = interquartile range, the spread of the middle half of the data, e.g. when thinking about whether craving / return to substance use might casue someone to leave RR early, half of the participants rated the likelihood as either 1 or 2.

Figure Error! No text of specified style in document.**.2 Likelihood of reasons causing someone to leave RR early**



When asked to identify 'Other' reasons that someone might leave a programme early, participants suggested a range of factors related to:

- 'within the person', such as processing underlying trauma, fluctuating motivation, and familial challenges;
- 'within the RR service', such as drugs being brought into the RR service, rules and regime requirements, and approach of staff; and
- 'external to the person and/or RR service', such as financial and legal reasons.

6.5 Number of stays in residential rehabilitation

Three quarters of people thought it was likely or extremely likely that someone would require more than one stay in a RR unit.

Table 6.8: Perception of likelihood of a need for more than one RR episode

How likely someone would require more than 1 stay in RR	n	%
Extremely likely	79	40.1%
Likely	68	34.5%
Neutral	23	11.7%
Unlikely	7	3.6%
Extremely unlikely	1	0.5%
I don't know	18	9.1%
Missing	1	0.5%
Total	**197**	**100.0%**

6.6 Perceived effectiveness of residential rehabilitation

When asked 'how effective do you think RR is as a treatment option for people who need or want it in Scotland?', fifty-six per cent of participants responded positively ('very' or 'extremely'). Twenty-one per cent perceive RR to be 'somewhat' effective, whilst seven per cent had more negative views on its effectiveness (slightly or not at all effective). Fifteen per cent were unable to answer this question.

Table 6.9: Perception of effectiveness of RR for those who need or want it

How effective	n	%
Extremely	43	21.8%
Very	68	34.5%
Somewhat	42	21.3%
Slightly	10	5.1%
Not at all	4	2.0%
I don't know	17	8.6%
Not easy to say	12	6.1%
Missing	1	0.5%
Total	**197**	**100.00%**

6.7 Accessing residential rehabilitation

Just under two thirds of people (64%) would need to know that their tenancy was secure in order for them to be able to commit if they felt they needed a stay in RR. Almost one half (46%) would need to be able to access funding to cover the costs of their stay, just over one quarter (28%) would need a better choice of RRs and a similar proportion (26%) would need to be able to access a service within a reasonable distance of the area of their residence. Twenty-one per cent would need to secure the support of their employer. Caring responsibilities for children (15%) or pet dog (13%) would need to be accommodated to allow others to engage with RR.

Table 6.10: Pre-conditions required for individuals to consider applying for RR

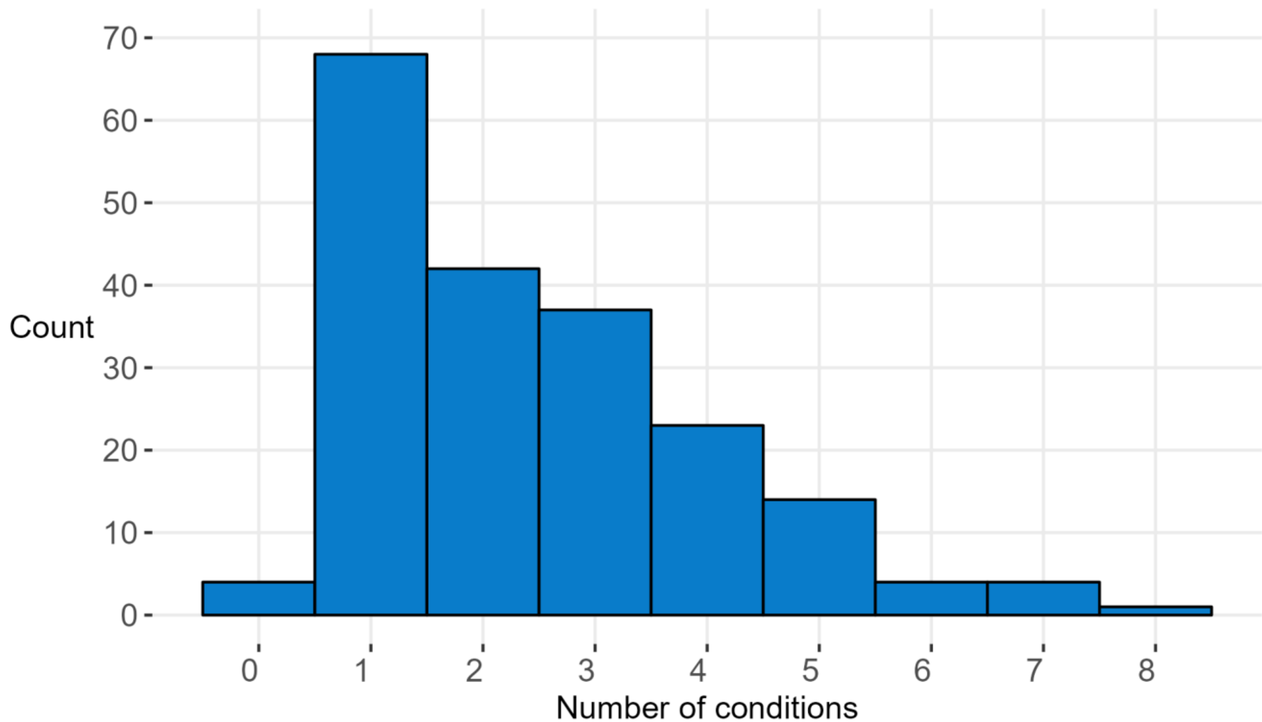
Condition / circumstance (select all that apply)	n	%
Not having to give up my tenancy in order to apply	126	64.0%
Ease of funding	91	46.2%
Greater choice of RR programmes	55	27.9%
Access to a RR programme that is not too far away from where I normally live	51	25.9%
Support of my employer (e.g. allowing me time off work)	41	20.8%
Access to a RR programme that allows me to take my child(ren)	30	15.2%
Access to a RR programme that allows me to take my dog	26	13.2%
Not having to give up my study (education) in order to go to RR	16	8.1%
Other	49	24.9%

Those who responded 'Other' were invited to provide additional detail. Their answers included supplementary information on the options listed above plus identification of a range of other barriers to accessing RR which are summarised as those to do with:

- 'self', such as the individual's state of mind and their mental health status;
- 'family', such as visiting arrangements for family members, childcare and caring responsibilities; and
- 'external factors', such as those that would need to be addressed to support their engagement with RR, for example financial and housing stability outside of the RR programme.

Just two per cent of participants indicated that they had no pre-conditions that would need to be addressed before they could commit to a place in RR. Thirty-five per cent reported one condition whilst fifty-two per cent reported between two and four conditions. Twelve per cent indicated that they had five or more conditions that would need to be resolved.

Figure Error! No text of specified style in document.**.3: Number of pre-conditions that would need to be addressed in order to commit to a place in RR**



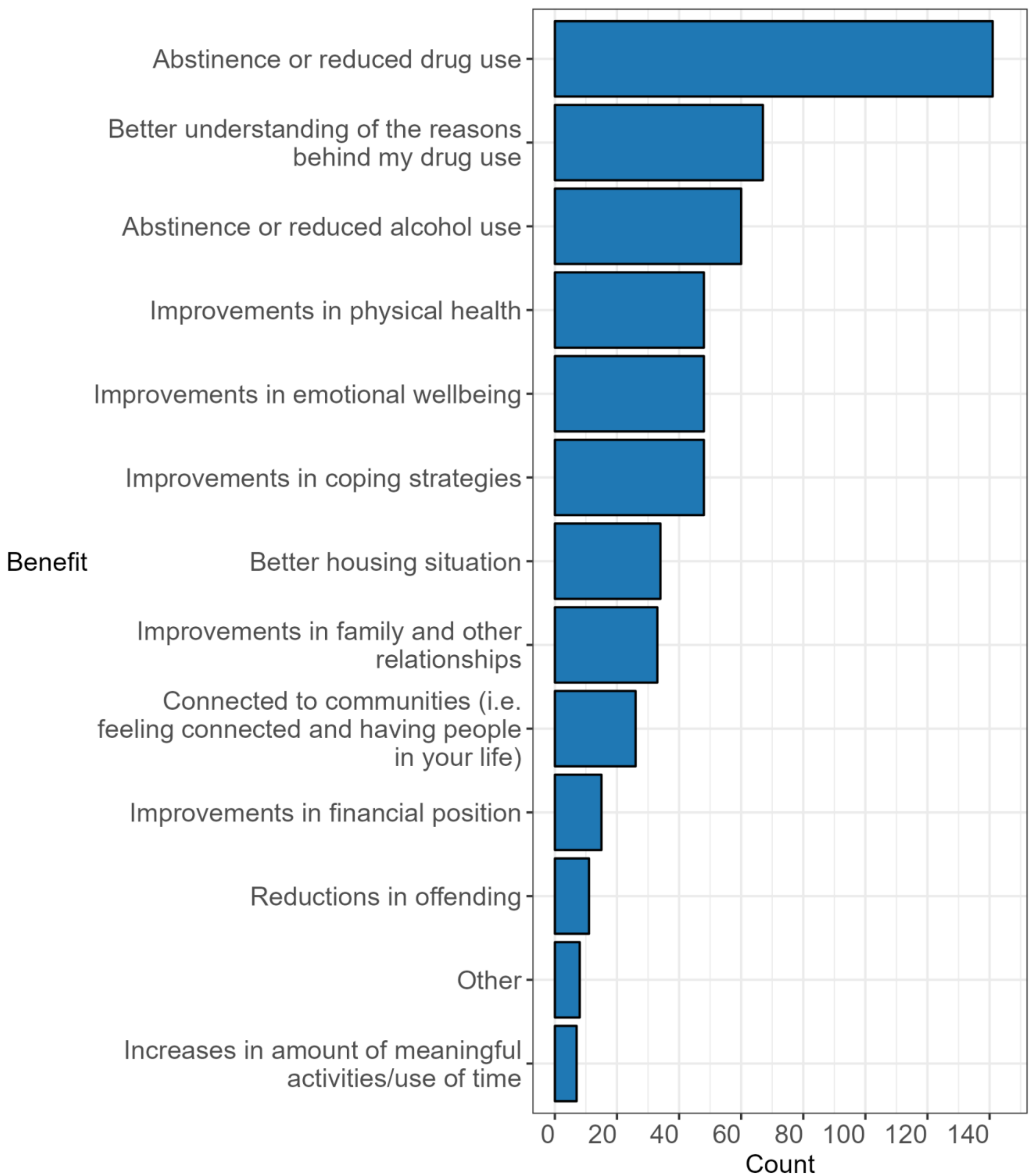
6.8 Anticipated benefits of residential rehabilitation

Participants were asked to select the three most important benefits they would expect to gain from a potential future stay in RR.

Almost three-quarters (72%) identified abstinence or reduced drug use as a key benefit, followed by improved understanding of the reasons behind their drug use (34%) and abstinence or reduced use of alcohol (30%). Just under one quarter (24%) indicated improvements in emotional wellbeing, coping strategies, or physical health.

Improvement in their housing situation and family/interpersonal relationships were both selected by seventeen per cent, whilst improved community connections were selected by thirteen per cent. Fewer people identified an improved financial position (8%), reduced offending (6%) or meaningful activities (4%).

Figure Error! No text of specified style in document.**.4: Anticipated benefits of RR (select the three most important)**



6.9 Sources of information on residential rehabilitation

Most participants obtained their information on RR from people they know who have personal experience of RR (57%) or via drug services (49%). Substantial proportions had either done their own research (26%) or visited one or more RR services (26%).

Table 6.12: Sources of information that have informed current knowledge of RR services in Scotland

Source of information (select all that apply)	n	%
A family member, friend or other person I know who has been to RR	113	57.4%
Drugs worker and/or service	96	48.7%
Own research	52	26.4%
Visit(s) to RR	51	25.9%
Other worker or service	30	15.2%
Someone else's research	7	3.6%
Other	16	8.1%

Those replying 'Other' provided additional detail on personal experience, that of friends, and information from drug-related and other services, details of which are presented in **Chapter 7**.

Chapter 7: Synthesis of qualitative findings from all three work packages

KEY FINDINGS:

- **Awareness and understanding of RR:** Participants' knowledge about RR varied widely, with many relying on informal networks and personal research for information, highlighting a gap in formal dissemination from specialist services.
- **Perceptions of RR activities:** Many participants, particularly those who had never been in RR, had mixed perceptions about its activities, ranging from specific understandings of detoxification and therapy to significant uncertainties about the programme's structure.
- **Reasons for applying for RR:** Key motivators for seeking RR included urgent health crises, the desire for abstinence/recovery, family reunification, and escape from harmful environments, underscoring the varied factors driving individuals towards RR.
- **Early exits and post-treatment risks:** The decision to leave RR early was influenced by emotional, familial, and health-related challenges, with post-treatment risks such as relapse and reintegration difficulties being major concerns.
- **Perceived effectiveness of RR:** Opinions on RR's effectiveness ranged from highly positive, citing its transformative impact, to scepticism and uncertainty, reflecting diverse personal experiences and observed outcomes.
- **Likelihood of completing RR:** Participants' beliefs about their likelihood of completing RR were influenced by factors such as personal confidence, past successes, motivation for personal growth, and their understanding of the benefits of RR.
- **Considerations about accessing RR:** Decisions to enter RR were shaped by a range of factors including family connections, personal health, housing and financial stability, and the readiness for the commitment to RR. Gaining access to RR services often involved overcoming systemic barriers, with many participants depending on personal networks or chance encounters, and emphasising the importance of supportive aftercare post-RR.

- **Treatment preferences:** Treatment preferences were largely shaped by personal experiences, with participants favouring options based on their effectiveness, and highlighting the importance of community support and structured, holistic, and sequential recovery approaches.

7.1 Introduction

This chapter combines qualitative data gathered from a total of 1694 free text box responses spanning across WP1 and WP2,along with data derived from eight individuals across four individual and group consultations (WP3). The analysis of these data complement the findings in **Chapters 5** and **6**, and adds participants' 'voices' onto the previously presented quantitative data.

In the main, these 'qualitative' data functioned to:

- sense-check the early findings from analysis of survey returns in WP1 and WP2; and
- aid the research team in assessing levels of interested in RR, the expectations that underpin survey responses, and participant perceptions and attitudes in relation to RR as a treatment option for addressing problematic substance use.

Thus, textual data drawn from the free text box responses and the individual and group consultations was mapped against the key research questions of the study (as detailed in **Table 2.1** in **Chapter 2**). The results are presented in **Sections 7.2 – 7.7** below.

A small selection of illustrative qualitative examples are included under each heading/subheading below, with a fuller sample of examples provided in **Appendix C**.

7.2 Awareness and understanding of residential rehabilitation

Participants' collective awareness and understanding of RR gave rise to six thematic categories, with each reported below with a representative quotation. Knowledge and awareness of RR was extremely limited amongst some participants, fragmented amongst others and typically came from community networks than focused information dissemination efforts from specialist services. Rather, community learning emerged as a primary method through which information was obtained about RR. In the absence of this, many individuals felt underinformed, especially regarding RR access and eligibility.

Personal research filled this gap for some, highlighting the importance of proactive information seeking to gain an awareness and understanding of RR. Direct experiences with RR and/or engagement with service workers also impacted individual knowledge levels.

Many individuals reported possessing a complete lack of information or knowledge about RR services. These responses typically directly stated or implied that the individual had had no exposure to, or discussions about, RR programmes. Some responses collated under this theme identified this as a failure in information dissemination amongst specialist services.

> ‘All I have ever heard is alcohol rehabs, and not drugs rehabs, not in [name of City] anyway.’ [WP2 Participant #05, male]

A related yet distinct theme emerged from a proportion of responses which revealed misconceptions or a limited understanding of RR. These responses often came from individuals who had some awareness of the existence of RR but possessed incomplete or incorrect information, potentially leading to misguided perceptions.

> 'I've never been spoken to about rehab. I've heard of it through friends and I know there is rehab out there, I know it from Trainspotting.’ [WP2 Participant #78, male]

The perceived lack of proactive information dissemination from specialist services about RR often necessitated individual effort in seeking information. For example, many who felt underinformed, despite typically being in close contact with services, resorted to personal research to gain knowledge of RR.

> ‘I had to go out and find info about the rehabs myself – they weren't very well advertised.’ [WP2 Participant #42, male]

Others learned about RR through interactions with professionals in health or social care roles, or through organisational resources such as informational sessions, leaflets, or recovery groups. This type of awareness, though somewhat less common than community derived knowledge, tended to be more structured and possibly more accurate.

> 'I didn't hear about anything that whole time [25 years] up until three years ago... It was the mental health team drug and alcohol team that came in and made me aware of a rehabilitation centre.' [WP3 Participant 01, female]

Peer and community learning emerged as a primary channel through which people became aware of and felt informed about RR. The sharing of direct or indirect experiences and knowledge of RR within peer groups and community settings provided insights and practical information about residential treatment, significantly more often than formal channels.

> 'I have learned from people in this group who have went to rehab.' [WP2 Participant #02, male]

Direct experience with RR was the final theme through which knowledge and awareness of residential treatment was gained. Under this theme individuals reported having firsthand knowledge of the access procedures and inner workings of RR services and programmes. Their insights were based on personal experiences with at least one RR programme, which permitted higher confidence in their perceived informedness.

> 'I've been to rehab so I know a fair bit about how it works.' [WP2 Participant #48, male]

7.3 Perceptions of residential rehabilitation

The following section delves into the perceptions, attitudes, and experiences of individuals concerning RR treatment for substance use. It explores participants' understandings of the different regimes and the activities involved in Scotland's various programmes, the reasons behind applying for RR, the perceived risks post treatment, and the overall effectiveness of these programmes.

7.3.1 Perception of the activities that take place in residential rehabilitation amongst those who have never been

The analysis of responses regarding expectations of RR programmes reveals a diverse range of perceptions and assumptions. Whilst some individuals demonstrated an understanding of specific elements like detoxification, therapy, and structured routines, a significant number expressed uncertainty or lack of knowledge about what these programmes entail.

Participants frequently expressed a lack of certainty or admitted they had little to no knowledge about RR programmes.

> ‘I don't know.’ [WP2 Participant #72, gender not indicated]

Participants frequently mentioned detoxification and medication management as integral parts of RR processes.

> ‘Detox, medication, counselling.’ [WP2 Participant #35, male]

Participants anticipated that counselling, group work, and therapeutic activities would be key elements in the RR process.

> ‘Therapy, meetings AA, life skills.’ [WP2 Participant #90, male]

Participants expected a structured daily routine, including regular meals and activities, as part of RR.

> ‘I would be given a structured day with breakfast, lunch etc., but that's just a guess.’ [WP2 Participant #06, female]

Some participants anticipated behavioural changes and mental health work, such as addressing the underlying reasons for their substance use and learning coping mechanisms.

> ‘Figure out problems that caused drug use and mental health.’ [WP2 Participant #57, female]

A few participants mentioned the inclusion of spiritual or religious elements in RR programmes.

> ‘Spirituality - 12 step, health and wellbeing, mental health work.’ [WP2 Participant #55, female]

Support services, including help with reintegration, were seen as part of the RR process.

> ‘Reintegration work, back to work courses, Place to live, job assistance.’ [WP2 Participant #69, male]

The dynamics of group therapy and social interactions within the RR setting were expected by some participants.

'Group work, smart meetings, withdrawal/detox.' [WP2 Participant #40, female]

These themes represent a mix of specific ideas and general uncertainties about the RR process, reflecting varied levels of understanding amongst individuals without direct experience with these programmes.

7.3.2 Leaving residential rehabilitation, reasons for early exits and post-treatment risks

This analysis delves into the survey responses related to participants perceptions of why individuals might leave RR early, and the perceived immediate risks following treatment completion back into the community. The findings shed light on the factors expected to influence early departure and the potential risks in the aftermath of leaving RR.

The **decision to leave RR** early was identified by survey participants as influenced by a myriad of factors. These themes not only highlight the intricacies of RR, but also the diverse challenges faced by those who undergo treatment.

A significant theme emerging from the responses revolved around emotional and familial ties and responsibilities. The longing and concern for children whilst undergoing treatment in RR was acknowledged as a profound factor likely leading to early departure. Similarly, the influence of partners or significant others was notable. Bereavement was also anticipated to influence the commitment of individuals to stay in residential treatment. These emotional and family-related factors highlight understanding of the intricate balance between personal recovery and family commitments that many must strike for RR viability.

'Missing children – extremely likely.' [WP2 Participant #01, male]

'Partner wanting them to come back.' [WP2 Participant #10, male]

'A death in family.' [WP2 Participant #96, female]

Concerns around detoxification and cravings/withdrawal, formed another critical theme. For those individuals who had experienced leaving an RR programme early, several of them noted an inability to cope without substances as the major prompt for their decision to leave RR.

Moreover, the process of withdrawal and detoxification, especially when not properly managed or supported within the RR setting, was expected to pose significant challenges, with the potential to precipitate premature departure from a programme.

> ‘The most likely reason is not fully understanding or being prepared to face withdrawal or thinking that being in rehab wouldn’t require you to face any of this.’ [WP2 Participant #21, male]

The treatment from staff and a disregard for authority amongst some participants, seemed to play a notable role in decisions around early exits. Additionally, cultures perceived to be authoritative, were also anticipated to negatively impact completion rates. Importantly, a notable proportion of responses referenced a community-level distrust of authority, a feeling which may be readily exacerbated where service cultures and staff lack sensitivity.

> ‘Staff not behaving professionally.’ [WP2 Participant #19, male]

> ‘Disregard for authority.’ [WP2 Participant #43, male]

Notions of readiness, social dynamics within the RR setting, and personal behavioural challenges, also emerged as potentially influential in decisions to leave early. Internal conflicts about readiness for recovery, exemplified by making excuses, reflect the anticipated psychological battle some individuals may face. Possibly a reflection of client readiness, the formation of romantic relationships within the RR environment, was expected to lead to a shift in focus, with potential to influence exit decisions. Likewise, several participants noted the triggering effect of finances on RR completion, especially the impact of unexpected windfalls. These factors, relating to (un)readiness highlight anticipated challenges both within and external to the RR setting, which may significantly impact exit decisions.

> ‘Just not ready and making excuses.’ [WP2 Participant #23, male]

> ‘Getting in a relationship and leaving with that person.’ [WP2 Participant #34, female]

> ‘Coming into money. People get claims sorted while in rehab and having that could make someone go out early.’ [WP2 Participant #17, male]

The reasons for leaving RR early are diverse, encompassing emotional, familial, health, environmental, and social factors. Each theme sheds light on the different challenges anticipatedly faced by individuals in RR.

The **perceived risks following RR** for individuals recovering from problem substance use were multifaceted, encompassing relapse, overdose, reintegration challenges, and social and personal factors arising in the course of life post residential treatment.

A predominant theme was the perception of heightened risk of relapse and overdose, particularly due to a reduced tolerance for substances following a period in RR. Participants frequently underscored the likelihood of falling back into substance use and the increased danger of overdose due to altered physical tolerance levels.

> ‘Relapse would be the main thing.’ [WP2 Participant #01, male]

> ‘Overdose - they still think they can take what they could before rehab.’ [WP2 Participant #04, female]

The difficulty in reintegrating into previous environments and navigating old social circles was another significant concern. Participants noted the challenges faced through shifting associations with existing acquaintences and the potential for these environments to trigger a relapse.

> ‘Old habits. Being in there [RR] in a bubble is all very well, coming back out is the real hard bit. Very hard.’ [WP2 Participant #100, male]

> ‘Falling back in with old crowd and your old ways.’ [WP2 Participant # 101, female]

Participants expressed concerns about how individuals might manage in the absence of a structured approach to reintegration through aftercare and specialist support.

> ‘Relapse, if they come without an exit plan.’ [WP2 Participant #18, male]

These quotes reflect participants’ understandings of the need for ongoing support post residential treatment and the risks associated with insufficient attention to and engagement with structured aftercare.

Analysis revealed a spectrum of perceived risks post-RR, emphasising relapse, overdose, reintegration challenges, and the influence of social and personal factors.

7.3.3 Perceived effectiveness of residential rehabilitation

The following analysis unveils diverse perceptions regarding the effectiveness of RR for treating problematic substance use in Scotland. Structured around themes derived from participants' ratings of effectiveness, the findings reflect the nuanced views of the study sample towards residential treatment.

A dominant theme amongst those rating RR as **extremely or very effective** was its transformative role in changing individuals' lives for the better. Participants spoke of significant personal growth, lifestyle changes, and the opportunity for focused recovery through the provision of time and structure. They described RR as a crucial juncture for introspection and reshaping one's life, emphasising its role in facilitating a concentrated effort on personal healing and recovery.

> 'It's the best chance you get to look at yourself. To get your life back on track. Get your family back in your life.' [WP2 Participant #36, gender not indicated]

Participants also reflected on the capacity of RR to remove individuals from detrimental environments and contexts, facilitating mechanisms such as time and feelings of safety to support effectiveness. Furthermore, the specific needs of certain demographics, such as women and children were also acknowledged. Others argued for the extension of RR to the broader community who likewise stand to benefit.

> 'Getting away from their community.' [WP2 Participant #09, female]

> 'It's desperately needed for women and children.' [WP2 Participant #29, female]

> 'There is such a high per centage of drug users a lot of people do want help but don't know where to go or how to get it.' [WP2 Participant #65, female]

For those **uncertain about RR's effectiveness**, themes revolved around a lack of personal experience and the complexities of RR outcomes observed amongst others. The responses indicated a hesitation amongst participants to make definitive judgments due to limited firsthand knowledge. Uncertainty was also linked to participants' recognition of personal choice and the individualised nature of recovery and complexity in treatment outcomes.

> 'I don't know enough about rehabs.' [WP2 Participant #41, male]

> 'It's difficult to answer because not everyone wants rehab. It seems in Scotland rehab is pretty poor.' [WP2 Participant #80, female]

Participants who viewed RR as **slightly or somewhat effective** discussed their mixed experiences of the treatment option, whilst some others suggested improvements to the treatment landscape.

> 'Putting people with the same problems [in RR setting] causes problems.' [WP2 Participant #50, female]

> 'Think it could be done better e.g., heroin assisted/benzo-assisted treatment.' [WP2 Participant #13, female]

A small group of individuals viewed RR as **not at all effective**, citing high relapse rates and questioning its overall suitability. Their scepticism was rooted in observations of individuals who fail to sustain recovery post-RR and concerns about whether RR addresses the varied needs of those who experience problematic substance use.

> ''There are people who have made it through and are still clean but also know people who have relapsed.' [WP2 Participant #14, female]

The effectiveness of RR in Scotland for treating problemematic substance use was perceived through a multifaceted lens, with ratings ranging from highly effective to ineffective. Whilst many participants emphasised its transformative potential and its capacity to provide safe and supportive environments, others expressed uncertainty or highlighted mixed outcomes, which some identified with the individualised nature of treatment. These findings highlight the complexity of addressing problem drug use and the varied impacts of RR on individuals' journeys towards recovery.

7.3.4 Perceived likelihood of completion of residential rehabilitation

This section delves into the participants' perceptions surrounding the likelihood of their completing an RR programme. Themes reflect a blend of personal convictions, past experiences, and external influences, each playing a crucial role in shaping individuals' beliefs about their ability to successfully navigate through the RR process.

A theme of **self-confidence and determination** was prevalent amongst participants who rate themselves as **extremely likely** to complete a RR programme. These individuals exhibit a strong sense of agency and self-assuredness in their ability to succeed.

'I'm the type of person that if I start something I make sure that I finish it." [WP2 Participant #05, male]

Amongst those participants who rated themselves as **extremely likely** to complete an RR programme, it can be seen that **past experiences and learned skills** are considered and experienced as being instrumental in navigating any future episodes of RR.

'I've done it twice and lasted extremely hard detoxes. If I put my mind to it and wanted it I'd 100% do it.' [WP2 Participant #23, male]

Many participants who believed they would be **extremely likely** to succeed in RR cited **personal growth, motivation, and a desire for change** as their driving forces. This theme underscores the role of personal aspirations and life goals, such as improving family relationships or achieving personal development, in fostering a readiness and motivation for completing RR.

'Something has changed in my head. I'm scunnered with it. I want my family in my life, to be there for my kids, holidays.' [WP2 Participant #40, female]

Similarly, many of those participants who believed they would be **extremely likely** to succeed in RR demonstrated in their responses a good understanding of the benefits and process of RR, and what to expect from it. This theme suggests that an **informed understanding of RR** can significantly bolster confidence in one's ability to navigate its challenges.

'I know the benefits and what to expect. And, I had a great experience whilst there.' [WP2 Participant #70, male]

Participants who feel they are **unlikely or extremely unlikely** to complete the programme often cited **personal barriers or current life circumstances**. This theme highlights the impact of individual challenges and personal limitations on the perceived ability to succeed in a RR setting.

'The way my head is at the moment I don't think I'd last a week.' [WP2 Participant #69, male]

'I hate being told what to do or feeling controlled.' [WP2 Participant #62, female]

A **lack of knowledge about RR or uncertainty about its suitability** contributed to lower ratings of likelihood to complete the programme. This theme reflects the impact of informational gaps and uncertainties on individuals' perceptions of their capability to undergo RR successfully.

> ‘I don’t know enough about rehab.’ [WP2 Participant #45, male]

Individuals who rated themselves as **likely**, **neutral**, or **unsure** often discussed the importance of **readiness and the right timing** in their ability to complete RR. This theme captures the idea that personal readiness and situational factors play a crucial role in determining preparedness for RR amongst a proportion of the sample.

> ‘If I was given the chance I think I would complete it but because of my epilepsy none will accept me.’ [WP2 Participant #92, female]

The influence of **external factors, such as the quality of the programme and the presence of support systems**, was more frequently mentioned by those who are 'Likely', 'Neutral', or 'Unsure' about completing the programme. The significance of the external environment and existing support networks was noted by multiple participants as central in shaping beliefs about their ability to succeed in RR.

> ‘Because of the support I’m receiving now and where I am at with my addiction, I would be pretty confident I could complete.’ [WP2 Participant #64, female]

These themes collectively illustrate the intricate factors that influence participants' perceptions of their likelihood to complete a RR programme. From internal attributes like self-confidence and motivation to external influences such as support systems and programme quality, a range of elements contributed to shaping these perceptions.

7.4 Experiences related to residential rehabilitation services

This section explores the nuances of accessing RR, the reasons/motivations individuals seek RR and the diverse paths they take. Both personal and systemic challenges/barriers were noted and the crucial need for continued support post RR was highlighted. Many participants, despite being engaged with specialist services, reported a reliance on personal connections, coincidental encounters, or self-referral due to the absence of formal channels.

> 'It took me three months and they still didn't do anything. So basically I had to phone this rehab myself and refer myself.' [WP3 Participant #02, male]

Participants reported encountering barriers when attempting to access RR, such as extended waiting times, unattainable criteria, and perceived insensitivity from service providers. These challenges, along with complex and unclear access pathways, compounded the difficulties for individuals seeking help, with some feeling that services hindered their access to preferred treatment options.

> 'I'm not being put around; this is my life it's important to me not you.' [WP3 Participant #03, female]

Post-RR challenges such as maintaining recovery and the often reported lack or unsuitability of continued support were highlighted. Going further, the transition from RR back into the community was identified as a crucial phase which posed significant risks and challenges.

> 'See I would think that's the most important bit... what you're going to do after you leave rehab so you need that support once you leave.' [WP3 Participant #04, male]

In summary, learning about and accessing RR services was described as heavily reliant on informal networks and personal initiative. Participants reported challenges at each stage of the process, including dealing with limited information prior to actively seeking access, negotiating complicated referral processes, and the availability and quality of aftercare post-RR.

7.5 Reasons for applying for residential rehabilitation

The present analysis delves into the primary reasons survey participants cited for applying for RR. Their responses illuminate a spectrum of motivations, ranging from severe health crises to the desire for a stable, substance-free life. The themes emerging from these responses provide additional insights into the diverse and often profound factors that drive individuals towards seeking RR.

Many participants highlighted life-threatening situations and a sense of desperation as their primary motivators for seeking RR. This theme reflects the acute crises that often preceded the decision to enter RR.

'Avoiding death. Sheer luck I'm still here.' [WP2 Participant #22, female]

This theme speaks to there being a critical point at which individuals decided to seek help, often as a last resort in life-threatening situations.

A substantial number of participants sought RR with the goal of achieving abstinence/recovery and reuniting with their families. This theme underscores the importance of personal relationships and family in the recovery journey.

> 'I wanted to get my health back and do it for my mum and myself.' [WP2 Participant #37, male]

The decline in physical health was cited as critical reasons for applying for RR, emphasising the long-term impacts of substance use on health and the need for comprehensive treatment.

> 'My addiction was so severe that I was taking seizures. My physical health was terrible, I was nearly at death's door. I wanted to live.' [WP2 Participant #68, female]

This theme reflects the severity of health issues arising from prolonged substance use and the desperation for a solution.

Experiences of inadequate support from existing community-based services and previous failures in other forms of treatment emerged as a common theme. These responses point to the limitations of other treatments and the search for more effective alternatives for achieving abstinence.

> 'I had tried everything else, self-detox and this was the only option I had. Rehab was my last option or it could have been my life.' [WP2 Participant #78, male]

The need for a safe space and escape from harmful environments associated with long-term substance use was another recurring reason for seeking RR. This theme reflects the necessity of a secure environment, such as that offered in residential treatment, for both recovery and protection from external threats.

> 'I got attacked in my village and nearly broke my neck - needed to get a safe place to escape to.' [WP2 Participant #58, male]

> 'To get away from the 30 year lifestyle of methadone - was sick of it. Change life.' [WP2 Participant #76, male]

The pursuit of safety and a respite from dangerous environments were significant factors for some in the decision to seek RR.

Constraints on access were also discussed amongst participants with experience of RR. This theme highlights certain external pressures and limitations that might impact access to and the decision to enter RR, such as geographical, legal and funding constraints.

> 'They weren't going to let me in my last rehab because I had firearms convictions previously (from 25 years ago).' [WP2 Participant #84, male]

> 'There are no treatment centres here, they all require funding which is not an option unless you want to go to religious treatment.' [WP1 Participant #02, female]

These responses offer insight into the complex interplay of factors that can either impede or facilitate access to RR services.

These themes collectively illustrate the complex and multifaceted reasons that led individuals to seek RR. From immediate life-threatening situations to long-term struggles with substance use and the desire for a safe and supportive environment, the motivations for entering RR were as varied as the individuals themselves.

7.6 Factors influencing decisions to enter residential rehabilitation

Analysis in this section explores the various considerations and concerns participants have regarding entering RR and specifically, their personal circumstances and things that would need to be in place to make residential treatment a viable option. Adding detail to the quantitative analysis in **Chapter 6**, these insights highlight aspects related to the decision-making process in choosing treatment options, considering factors from health and family dynamics to personal readiness and financial concerns.

Maintaining contact with family and loved ones during RR was a significant consideration for many. The ability to stay connected and ensure care for those they are responsible for plays a crucial role in their decision to commit to RR and their intentions for future treatment options.

> 'I would need to be sure I could have contact with my family.' [WP2 Participant #60, female]

Addressing personal health issues, particularly mental health, was a key factor allowing individuals to confidently commit to RR. Participants indicated that ensuring their mental and physical health needs were met is critical for their readiness to engage in the residential treatment process.

> 'My mental health issues.' [WP2 Participant #07, female]

The need for stable and secure housing, as well as arrangements for pets and dependents, was another prominent concern. Stability in these areas is seen as essential for creating a conducive environment for recovery.

> 'Stable and secure housing.' [WP2 Participant #26, female]

> 'Help looking after a pet.' [WP2 Participant #38, female]

Being in the correct mindset and feeling ready for the commitment to RR is highlighted as vital. Participants stressed the importance of mental and emotional preparedness for the RR journey.

> 'Correct mindset.' [WP2 Participant #33, male]

The necessity of having robust support systems, both during and after the RR process, was emphasised. This included aftercare services, which are considered essential for sustained recovery and preventing relapse.

> 'Support when leaving and aftercare.' [WP2 Participant #93, male]

Preferences for the RR location, including considerations like being out of the current living area or having a child-friendly environment, were important for some. These preferences reflected the desire for an RR setting that aligns with individual needs and circumstances.

> 'It would need to be out of area.' [WP2 Participant #75, male]

> 'A rehab that allows my daughter to visit me in a 'children's environment'. [WP2 Participant #94, female]

Concerns about handling financial matters or debts whilst in an RR programme were significant for many participants.

> 'Help with any accrued debt/reintegration issues.' [WP2 Participant #70, male]

As reflected in Chapter 6, a large proportion of participants expressed no need or interest in accessing an RR service. Qualitative open text box and focus group responses complemented this finding, adding that this was either due to already being in recovery or having a lack of interest or confidence in the approach. This highly common perspective on intentions in relation to RR highlights the diverse pathways to recovery expressed amongst this sample, and the fact that RR, whilst a sought after treatment option was seen neither as a one-size-fits-all solution or a silver bullet.

> 'I am in recovery without the help of a rehabilitation service.' [WP1 Participant #01, male]

7.7 Treatment preferences

This section adds detail to the survey responses in **Chapter 6** by exploring the factors underlying treatment option preference. Personal treatment experiences, across the range of options described in chapter 6, guided participants' treatment preferences. Such experience included community-based and residential options, both of which were noted for their efficacy in supporting the attainment of individual treatment goals. Participants described a preference for structured, holistic and sequential approaches in the treatment and management of substance use.

Personal experience was the largest theme emerging through content analysis of survey responses to the question of why participants ranked treatment options as they did. Captured within were various articulations of the idea that treatment preferences were arrived at through experience. Alongside succinct statements such as 'through experience', additional context was often provided, such as duration markers, or descriptions of the successes and challenges experienced with the various treatment options.

> 'Through my experience of rehab, it's been things that have been suggested to me to do.' [WP2 Participant #73, male]

Treatment experiences, both positive and negative, shaped participants' answers in the ranked-response question regarding treatment option preferences. Responses under this subtheme reflect participants' perceptions of treatment option efficacy in managing problemematic substance use. Thus, preference aligned directly with the perceived efficacy (or lack thereof) of treatment options.

> 'My first 3 options were what actually worked for me.' [WP2 Participant #22, female]

Concurrently, difficulties and challenges faced during, often prolonged treatment episodes were described as influencing treatment preferences. Negative personal experiences, limited availability, and systemic barriers were highlighted as factors guiding the preferences of many individuals.

> 'I feel the support from groups is not important right now and group support brings me down and I want to be brought up.' [WP2 Participant #66, male]

Central to treatment option preference for many was the **role of community and group settings** in providing a platform for empowerment, personal growth, and the maintenance of recovery from problemematic substance use. Participants expressed how engaging with others who have shared similar experiences offered a rare pathway to improved lives and personal development. Shared wisdom, feelings of safety, and the facilitation of honest relationships within communities and groups were acknowledged to enhance recovery outcomes and thus, shape the preferences of many participants.

> 'Fellowships meetings are where I found my home, a new set of friends, be honest and feel safe.' [WP2 Participant #78, male]

Moreover, the structure, reliability, and accessibility of community support emerged as a significant theme. Several participants noted that regular community support and recovery cafe drop-ins provided them a needed sense of purpose and structure and that they were more reliable and accessible than support from formal statutory services.

> 'The recovery options are at the top because I draw on the connection of others in recovery - I can drop into these services and they're there all the time. Statutory services are not as reliable or focused on aftercare community organisations.' [WP2 Participant #89, male]

Furthermore, content analysis of responses comprising this theme show that preference was directly influenced by the nurturing and supportive environment provided within recovery communities. Participants frequently commented on the positive and encouraging nature of these spaces, which offered safety, respect, and understanding, felt experiences sometimes absent in other areas of their lives.

> 'I'm asked my views here at the recovery cafe. They genuinely want to listen to me to make things better for the future.' [WP2 Participant #24, male]

Community and group settings offered not only essential resources and a sense of belonging but also played a crucial role in fostering personal growth, providing reliable support, and creating nurturing environments argued by several individuals to facilitate individual recovery. It is important to note thought that the recruitment strategy for the study (particulary for WP2 and WP3) was primarily dependent upon support from community-based, third-sector support services, meaning that this theme may not be fully representative of the broad population of individuals who experience problems with drugs across Scotland.

The concept of **structured holistic support** also emerged through analysis, reflecting a general preference amongst a proportion of participants for a combination of medication-assisted treatment [MAT] and community-based psychosocial support. Responses were further organised into three sub-thematic areas.

Participants detailed how a combination of prescribed medication and engaging in group activities played a crucial role in managing their recovery journeys.

> 'Without my script things would fall apart. I attend groups and get a lot of support from cafes and group work," [WP2 Participant #76, male]

This illustrates the symbiotic relationship between medical treatment and community support and its role in treatment preference for some participants.

Participants expressed a desire for more organised and focused recovery strategies.

> 'I need structure, focus and support on getting me through. Prescriptions haven't been important for my use (…) treatment is too prolonged and not structured enough.' [WP2 Participant #88, female]

Alongside recognition of the value of structured holistic support, some responses added nuance, highlighting the challenges faced in accessing and navigating the healthcare system. Responses collated under this sub-theme, and reflected in treatment preference in **Chapter 6**, outline frustrations with the limited support received from general practitioners and the broader healthcare system.

> ‘Prescription is really important because it changes the depths of your addiction - reduces desperation - helps you make better choices (…) GPs have opted out of supporting people with drug issues.’ [WP2 Participant #58, male]

Adding further insight into the factors underlying treatment preference, responses formed the theme **first things first**, which reflects participants’ recognition of an inherent order in the treatment and recovery process. Three central sub-themes emerged.

Analysis highlighted the emergence of a structured treatment and recovery pathway concept. For example, participants acknowledged the importance of following a specific sequence in their recovery journey, with some placing in-patient options as the primary step.

> ‘Rehab is number one because I know from other how it worked. If you want to cut down then detox is number two.’ [WP2 Participant #79, male]

Regardless of the starting point, all responses gathered under this theme noted the achievement of treatment goals as a sequential process.

Several others highlighted the need for stability through MAT before progressing further in the recovery process. Participants expressed, for example, the necessity of achieving a stable state before considering additional steps like detox and counselling.

> ‘I need to get stable and life back on track - currently awaiting MAT, I want to get stable and then consider detox and counselling for trauma etc.’ [WP2 Participant #75, male]

Finally, the significance of a comprehensive and sequential approach in recovery was highlighted. Responses indicated that each step in the recovery process builds upon the previous one, leading to a more successful outcome.

> ‘I fell through the net. If I had harm reduction then getting support, moving into detox / rehab would have been the next step.’ [WP2 Participant #68, female]

These themes underscore the understood importance of a methodical and well-structured approach to achieving treatment goals.

The preceding discussion underlines the complex interplay of personal experiences, and future goals in shaping substance use treatment preferences, highlighting the centrality of community-based, holistic support, structured approaches, and individual choice in facilitating desired outcomes amongst the study sample.

Chapter 8: Discussion and considerations for future research, policy and practice

8.1 Discussion

8.1.1 Awareness and understanding of RR and implications for assessing demand

This study identified limited awareness and understanding of RR amongst the national sample, revealing significant implications for assessing future demand for RR services. It explores the complex relationship between awareness levels and the intention to seek RR, alongside the implications of personal and community-derived knowledge on access disparities and informed decision-making.

The limited awareness and understanding of Residential Rehabilitation [RR] amongst participants in this study has significant implications for assessing future demand for RR services for people who use drugs across Scotland. Half of participants reported low awareness levels (0-3 out of 10), with a similar proportion suggesting limited knowledge or never having been offered the option of RR as reasons why they had never experienced RR. The limited knowledge and experience of RR, evident through both self-reported 'informedness', and participants' diverse expectations around RR programming, suggest insufficient promotion of treatment options.

The relationship between awareness and demand is nuanced and study findings should be interpeted cautiously. The inverse association between awareness and intention to apply for RR appears to indicate that enhancing awareness about RR could paradoxically serve as a mechanism to regulate its demand. This insight may offer reassurance to both funders and providers concerned about the potential surge in demand following heightened awareness. However, the association found between increased awareness and a decreased likelihood to seek RR may be confounded by individuals with RR experience who might be better informed and/or perceive no need for further intervention. Nonetheless, by equipping individuals with a thorough understanding of RR, including its challenges, expectations, and common misconceptions, they can be empowered to make informed decisions about their prefered treatment pathways. In either case, awareness raising around treatment options will serve to align interest with perceived need and suitability, rather than an underinformed intrigue with the concept.

Those with higher perceived informedness typically had personal or indirect experiences with RR. Knowledge of RR tended to be community-derived, with interaction amongst community members rather than systematic promotion by specialist services, playing key roles. Consequently, in the absence of targeted promotional efforts from treatment providers, regions with minimal community exposure to RR services are likely to experience continued disparities in access. Additionally, a significant proportion (around a quarter) of participants stated that their own research had informed their knowledge of RR. Whilst underscoring the need for proactive dissemination efforts from specialist services, this finding has implications for those lacking capacity and/or resources to undertake their own research. Awareness raising aligns with the fundamental principle of empowering people to make educated choices about their care, and this may be particularly important amongst populations of individuals lacking resources with complex health and social care needs. The findings underscore the challenge of accurately estimating demand for RR services due to widespread unawareness and misconceptions about RR amongst participants. Future efforts should focus on enhancing awareness and understanding of RR, emphasising the need for more research and targeted promotional strategies to empower individuals with informed choices about their treatment options.

Taken together, attempts to accurately quantify demand for RR services, are hindered in contexts of low awareness and understanding of the treatment method and more research is needed to unpick some of these complexities. This study provides a baseline on which to build future research into the question of understanding demand for RR.

Beyond assessing demand, low levels of awareness indicate limited opportunities amongst the study sample to make informed decisions around their treatment. This clear finding reflects a gap in implementation of the Scottish Medication-Assisted Treatment (MAT) Standards, which advocate that individuals should be “clear about what choices are available to them throughout their journey through services and are aware of their right to make their own decisions about their care plan”[5].

The findings underscore the challenge of accurately estimating demand for RR services due to widespread unawareness and misconceptions about RR amongst participants. Future efforts should focus on enhancing awareness and understanding of RR, emphasising the need for more research and targeted promotional strategies to empower individuals with informed choices about their treatment options.

8.1.2 Experiences relating to RR

This section examines the experiences related to RR amongst the present sample and the implications for the wider treatment-seeking population. It covers systemic barriers to accessing RR, the role of personal and community networks in information dissemination, and the importance of aftercare and readiness for RR. Additionally, it discusses participants' motivations for attending RR, their satisfaction with various programme elements, and the implications of these findings for extending RR access.

As already outlined above, a key theme from this report is the lack of information regarding RR amongst communities of individuals with experience of problematic drug use. Of note, the present sample is likely to be more community-engaged than the wider population, and thus having greater access to knowledge of RR. Despite this, we found that those actively seeking information or attempting to gain access to RR services were often met with systemic barriers, including gatekeeping (of information and referral-making), lacking pathways, long waiting lists and high thresholds for access, particularly in relation to medication.

Amongst those who had attempted to access information about or to seek access to RR, a proportion noted the insufficiency of efforts made by specialist services to ensure individuals were appropriately informed of their treatment options. The study shows that information is more readily transmitted and received through communities rather than through systematic dissemination from specialist services. Likewise, personal research, self-referral, and support from wider services, such as criminal justice, and social work were productive channels for access to RR. This may speak to gatekeeping as well as the existence of pathways to RR additional to more typical routes through drug and alcohol recovery services. Some participants reported the need to self-refer, in spite of close relationships with, and repeated requests of, specialist services to facilitate RR access. Gatekeeping may be a consequence of service staff's beliefs around RR and client fit, managing limited availability, or poor pathways. Participants reported that Local Authority areas are limited to a certain number of spaces, which gives rise to client selection based partly on economic considerations and perceptions of likely success. Importantly, this practice contradicts with client choice (i.e., MAT standards) and individuals' rights to the highest attainable quality of healthcare, soon to be enshrined in Scottish Law. An immediate consequence of gatekeeping is that only the more resourceful can self-refer

and manage intake expectations and processes, whilst those with more complex needs, who may stand to benefit most, will remain beholden to specialist services.

One of the most striking findings from the study data was that almost two-thirds of participants (64%) identified ‘not having to given up my tenancy in order to apply’ as being a pre-condition for them to be able to consider applying for RR. This pre-condition was noted significantly more so than any of the other of the identified pre-conditions, with ‘ease of funding’ coming in second in the list, noted by just under half (46%) of participants. This finding is particularly interesting against the backdrop of the Scottish Government having made available dedicated Dual Housing Support funding to cover when RR units are asking people for their housing benefit to contribute to their accommodation costs: ‘This fund will support individuals who want to keep their tenancies whilst in rehab services which are funded by social security payments. Funds will be made available to local authorities to ensure that when an individual accesses rehabilitation their housing payments on their core residence do not stop for the time that they are in treatment.’[6]

The availability of this funding may not be known, or understood sufficiently across the Scottish population of people who use drugs who are considering whether they should attend RR for their problematic drug use.

Another crosscutting theme was the importance placed on aftercare, particularly by individuals with RR experience, with negative post-RR experiences such as relapse attributed to inadequate aftercare provision. In addition to these reported experiences, a substantial number of participants recognised the (un)availability of aftercare services as a crucial factor influencing the risks encountered following RR. This may be especially true where individuals return to areas with low levels of recovery activity and limited community access to RR services. Particular consideration needs to be given to individuals’ personal circumstances, including their area of residence, when determining appropriate aftercare packages.

With consequences for service accessibility, survey participants identified multiple factors anticipated to influence early departure from RR, including emotional and familial responsibilities, health concerns, and the RR environment. Prominent issues included family separation, substance use and withdrawal challenges, and negative staff interactions. Addressing these concerns through family-inclusive approaches, comprehensive medical and psychological support, and improved staff training for a more empathetic approach could enhance RR retention rates and accessibility. Sensitivity to

community distrust, particularly amongst socially excluded individuals like those experiencing homelessness, is also an important consideration for wider access.

The theme of readiness for RR was a consistent thread intersecting participants' experiences and perceptions. The study data suggests that particpants expect individuals to exhibit 'readiness' for RR through proactive engagement and action. In practical terms, 'readiness' often manifested as individuals actively attempting to access RR services, in spite of barriers such as gatekeeping and limited information from specialist services. This perceived readiness requirement, raises important considerations on the role of services in preparing individuals for RR. The role of services in facilitating this is complex but fundamentally starts with ensuring that individuals are well-informed about their options and are meaningfully involved in treatment planning.

Most survey participants who had attended RR in Scotland recently, were motivated by health crises, a desire to stop using substances, and/or family reunification. Where data were provided, over half of individuals reported completing their latest programme, with high satisfaction across all service elements. There was however a noted need for improved aftercare, especially for individuals with caring responsibilities or residing in areas with less recovery infrastructure and support.

The presence of recent and first-time attendees observed in this study is promising, potentially signifying the effectiveness of initiatives aimed at broadening RR access. However, this observation could be influenced by selection bias. Recent attendees, with their RR experiences more vivid in their memory or possibly still active in recovery community groups, might have been more aware of or inclined to participate in the survey.

The satisfaction levels reported for various RR programme elements were notably high, covering aspects like environment, accommodation, family involvement, nutrition, therapy (group and individual), leisure activities, medical and peer support, programme structure, service model, and staff assistance. This information is particularly valuable in enlightening RR-naive individuals who have limited understanding of RR, offering insights into both the typical programming of Scottish RR services and the high satisfaction levels experienced by participants who have undergone these programmes.

The study has highlighted the challenges in accessing RR and the presence of systemic barriers and information gatekeeping, whilst underscoring the critical role of aftercare and personal readiness in the success of RR. It also revealed high satisfaction levels amongst

RR attendees and the promise of recent efforts to broaden access to RR across Scotland, suggesting the need for continued and improved approaches in service provision and information dissemination.

8.1.3 Wider treatment system considerations

This section addresses considerations of the wider treatment system, focusing on the distinct preference for community-based support amongst study participants. Potential biases are also explored which may lead to overestimates of the preference for such support. The section also refects upon the influence of past treatment future treatment preferences, the dynamic nature of treatment needs over time, and the implications of these findings for the broader population.

Study data show a distinct preference amongst partipants for community-based support, with 'support for recovery' proving the most popular option. Though a resounding preference, recruitment methods may have introduced selection bias into the dataset through the overrepresentation of individuals already engaged with and who may have had more positive views of community-based support. This could skew the findings towards a more favorable opinion of such treatments. Paticipants broadly conceptualised ‘support for recovery’ as including non-statutory drop-in services and recovery cafes, as well as the various activities and provisions offered within them. Given this broad interpretation, the ranking of preferences might be seen as having overlapping and repetitive options.This ‘conceptual bias’ may have induced conflation of different types of support into a single preferred option. This wide interpretation could mask variations in preference for specific types of support within the category, leading to an oversimplified understanding of participant preferences. Importantly, recipients of these non-statutory community-based options were frequently also in structured drug treatment from NHS specialist services. Thus, comprehensive community support, often complemented with MAT, met the needs of a substantial sub-population of participants, thereby ranking highly in their preferences, with this overlap in options potentially skewing results..Taken together, these potential biases could result in an overestimation of the preference for community-based support and structured support, potentially overlooking the diversity of needs and preferences amongst the wider population seeking recovery from substance use.

Furthermore, recovery cafes, which are largely abstinence-based, and often emerge amongst communities with RR experience[7], necessarily comprised a higher proportion of individuals with prior RR experience who continued their treatment and recovery through

this community-based option. This trend indicates the effectiveness of community-based approaches in supporting long-term recovery. Additionally, psychosocial support, group work, and structured treatment approaches were highly valued for their effectiveness in addressing the present needs of participants. The support offered within RR and through aftercare services, which encompasses these elements, suggests that RR has a similar capacity to meet the needs of individuals who benefit from structured environments, peer support, and group work.

Not surprisingly, participants' past treatment experiences have shaped the perceived effectiveness of, and preferences for, future treatment options. Many participants who had utilised community-based services and 'support for recovery' after a stay in RR indicated that successful experiences in RR reduced the perceived need for additional stays, underlining a lasting impact of effective RR.

The dynamic nature of needs and circumstances also means that interest in treatment options may change over time. Participants perceived treatment as a sequential process, often progressing from drug treatment initiation, stabilisation, concurrent psychosocial support, detoxification, and RR, followed by continued psychosocial support and potential relapse, leading back to drug treatment. This characterisation of treatment as a fluid, ever-changing process highlights the variable nature of individual preferences and interest when asked at different stages in their own journey.

The study's recruitment methods which utilised, as one of the main strategies, engagement of participants actively engaged in 'support for recovery' from services like recovery cafés and crisis centre drop-ins, revealed a notable preference for these types of community-based psychosocial support. This preference, however, might not fully represent the broader population from which the study sample was drawn. The high satisfaction rates reported for 'support for recovery' and similar services could be attributed to a bias introduced by these recruitment methods. Additionally, this apparent preference may also be influenced by local factors such as the availability of drop-in psychosocial support options, the visibility of recovery communities, and individual or group differences in seeking community treatment options. Accessibility of these community options is difficult to determine without hearing from individuals who do not attend. It is important to consider these factors as they might skew the perceived effectiveness and preference for these services (a point which is acknowledged in the 'limitations of the study' section in **Chapter 3**).

8.2 Conclusions

In conclusion, the study highlights a strong preference for community-based support amongst participants, whilst acknowledging potential biases that may affect the generalisability of these findings. It underlines the importance of considering the dynamic and individual nature of treatment needs, and the impact of recruitment strategies and local factors on the perceived effectiveness and preference for community-based support.

The study provides, through the eyes and experiences of people who use drugs, a comprehensive overview of the state of RR services in Scotland, highlighting the crucial need for increased awareness, accessibility, and the significance of community-based options in the recovery process. It underscores the challenges in quantifying demand for RR services and points to the necessity for further research to understand these complexities better.

The findings have significant implications for policymakers, service providers, and the wider community in shaping effective and accessible RR services. The findings will need to be considered alongside the range of other research studies being conducted as part of the RR evaluation portfolio (managed by Public Health Scotland) to identify and develop the next stages of development for the RR sector across Scotland.

8.3 Considerations for research, policy and practice

Priority needs to be given to addressing the findings in this study regarding low and varying levels of awareness and informedness amongst the broad population of people who use drugs across Scotland. This should be progressed as a co-produced work plan to ensure that all relavant stakeholders are fully informed about the current landscape in order to then contribute reciprocally in developments to raise awareness for people who use drugs.

Particular attention should be paid to helping people who use drugs understand the differences and expectations between the broad range of RR centres across Scotland, so that informed choices are able to be made. This could be improved by utilising a greater degree of public-facing evaluation and research regarding different types of RR programmes.

Further research will be required over the coming years to revisit the baseline findings of this study in order to identify and measure how demand for RR changes over time once

further investment and development (such as raising levels of awareness amongst people who use drugs) have taken place.

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Appendix A – Research methods

Introduction

The Table below maps out the contribution (partial, highlighted in amber, or full, highlighted in green) that each WP provides to each of the research questions.

Table A.1: Contribution of work packages to areas of interest

Research questions	WP1	WP2	WP3
What proportion of individuals with drug use issues are **aware** of rehabilitation services? How have they become aware of residential rehabilitation? How well informed about residential rehabilitation do they feel?	Amber	Green	Amber
What proportion of individuals with drug use issues have previously tried **accessing** residential rehabilitation? What has been their experience of trying to gain access?	Amber	Green	Amber
How do individuals with drug use issues **perceive** residential rehabilitation? What do they think residential rehabilitation might involve (e.g., abstinence requirements, active engagement in therapy, involvement in chores)? To what extent are they aware of the challenges involved in securing positive outcomes (e.g., risks involved, non-completion, relapse)?	–	Green	Amber
What proportion of individuals with drug use issues would be **interested** in participating in residential rehabilitation? Under which circumstances or conditions would they be interested? What benefits would they expect to gain? To what extent is their interest in residential rehabilitation (partially) the result of unrealistic expectations?	Amber	Green	Amber
What proportion of individuals with drug use issues would **prefer** residential rehabilitation to other treatment options for drug use issues? How would they rank different treatment options – and where would they rank residential rehabilitation?	Green	Green	–

Work Package 1

For WP1, the aim was to reach a representative sample of individuals who use drugs across all areas of Scotland to explore and estimate current/future demand for RR.

Following a rigorous design phase, including multiple draft versions of the WP1 survey being constructed, the final draft version was piloted with a number of people with lived experience of drug use. The final version was signed off by PHS and went live on 30th May 2023.

Multiple methods have been utilised to raise awareness of the survey, including:

Table A.2: Awareness raising methods for WP1

Method	Notes
Email communications with ADPs	First round of emails was sent to all ADP leads across Scotland on 30th May 2023. Regular communications were then sent out across the course of the fieldwork, particularly trying to engage those ADP areas from where no/few responses to the survey have been received.
Email, phone and Teams communications with services	Following acknowledgement from ADPs, bespoke communications were then sent to Third Sector/Local Authority services, with communications continuing on a regular basis. Phone and Teams calls have been utilised to engage services with the research.
Face-to-face visits from Figure 8 researchers to Third Sector services	During June and July 2023 a range of visits from members of the Figure 8 research team were conducted across Third Sector services who offered the opportunity. This led to a good number of surveys being completed.
Distribution of poster across all services with QR code link to survey	A poster was designed and distributed across services from mid-June 2023 onwards to help services promote the survey. The poster included a QR code to enable individuals to easily link to the online survey via a Smartphone or tablet device.

Method	Notes
Email to all NHS drug treatment services with details of survey	Following confirmation from the West of Scotland NHS Research Ethics Service on 7th September 2023 that distribution of the survey details to NHS drug services does not require ethical approval, emails were sent to all such services across Scotland.
FaceBook and Reddit advertising	Two rounds of FaceBook/Reddit advertising were conducted during August and September 2023. The primary objective was to entice users to click on a link that led them to a survey about the need for RR. **1st advertising (August 2023)** – Over a span of 14 days, we executed a targeted advertising campaign, launching 6 distinct ads across Facebook. Reach: Total unique users who saw our advertisement: 42,874 Impressions: Total number of times our advertisement was displayed: 70,692 This indicates that on average, each user was exposed to our advertisement approximately 1.65 times. Engagement: Total clicks leading to our survey: 632 **2nd period of advertising (September 2023)** – Over a span of 7 days, we executed a targeted advertising campaign, launching 4 distinct ads across both Facebook and Reddit. **FaceBook analysis** Reach: Total unique users who saw our advertisement: 16,523 Impressions: 50,958 Engagement: 530 clicks leading to our survey, resulting in an engagement rate (clicks/impressions) of approximately 0.01 **Reddit analysis** Impressions: 50,890 Engagement: 140 clicks leading to our survey, resulting in an engagement rate (clicks/impressions) of approximately 0.28%.

Method	Notes
Recovery Walk Scotland	The Figure 8 team hosted a stall at this year's Recovery Walk in Greenock on 23rd September 2023 and distributed hundreds of small leaflets with details of the survey and the QR code on.

The first survey return was received on 1st June 2023 and the survey was closed for completion on 1st December 2023. A total of **170** individuals from across **twenty-eight** out of the thirty-two Local Authority areas of Scotland completed the WP1 survey.

As will be noted below, a further **197** individuals completed the WP2 survey, which includes the WP1 survey, meaning a combined total of **367** responses were received to the WP1 questions.

Work Package 2

For WP2, the aim was to reach a representative sample of individuals who use drugs across all areas of Scotland to explore, via in-person interviews with a member of the lived experience research team, perceptions of RR. Following another rigorous design phase, including a number draft versions of the WP2 survey being constructed, the final draft version was piloted with a number of people with lived experience. The final version was signed off by PHS and following set-up and 'road testing' on the Online Surveys software, the survey went live on 14th August 2023.

A plan for targeting balanced numbers across all Local Authority areas was put together (based on population size) and implemented by the research team with a methodical approach adopted to contact services and arrange for visits across as many areas of Scotland as possible. Progress was slow to get going as more time was required to raise awareness of the interviews and agree arrangements, but week on week the numbers increased.

In the main, interviews were conducted face-to-face. Where distance or location prohibited in-person interviews, the researchers made arrangements (via services) to complete the survey via Zoom. No recording of the interview was necessary as the survey was completed by screen-sharing over Zoom, meaning that the participant saw, and was able to check, exactly what the researcher was completing for each question.

Participants were offered a £20 bank payment at the end of their interview as a thank you for their time.

A total of **197** individuals from across **twenty-nine** out of the thirty-two Local Authority areas of Scotland completed the WP2 interview (survey).

The full breakdown of results, by Local Authority area, is presented in **Table B.1** in **Appendix B**.

Work Package 3

At the end of WP2, individuals were provided with the opportunity to express interest in taking part in one of six follow-up WP3 online group interviews – one group interview to focus on individuals from each of the six sub-categories of RR experience noted in **Section 2.1** in **Chapter 2**.

Sixty-two individuals noted their interest via completion of a separate 'engagement' survey that was made available to participants via a link at the end of the WP2 survey. The research team made contact with all these individuals to (1) verify their interest, (2) confirm which sub-group the individual considered themselves to be in, and (3) confirm that the individual would be able and confident to engage in an online focus group. Following this process, a total of **twenty-four** individuals agreed to participate in one of six WP3 online group interviews in late November 2023. However, only **eight** individuals across the following four sub-categories joined on the day of their respective session.

Participants were offered a £20 bank payment at the end of their interview as a thank you for their time.

Table A.3: WP3 Focus Group recruitment and participation

Sub-category	Number
1. Those individuals who have never considered RR.	0
2. Those individuals who have never been offered RR.	1
3. Those individuals who have been offered or considered RR but have declined or never pursued a referral or have been unable to pursue an application due to personal circumstances.	2

Sub-category	Number
4. Those individuals who have been through an RR programme (since the Scottish Government RR programme was initiated).	2
5. Those individuals who are considering or planning to access RR in the near future.	3
6. Those individuals who think they may require a period in RR at some point in the future but are not actively considering it just now.	0

A further five individuals who could not access online meetings were contacted to see if they would participate by telephone. Of the five contacted, three did not respond and two declined to participate.

Analysis

Quantitative data analysis

Quantitative data collected via the in person and online surveys were downloaded from the survey platform as comma separated value files and imported into R (R Core Team, 2023). Both the **WP1** and **WP2** surveys included a common set of questions on participants' demographics, their previous experience of RR, and their current / potential demand for RR services. Responses to these questions were combined into one dataset for analysis. The second dataset consisted of responses to the unique questions in the **WP2** survey.

The data management and analysis methods of the quantitative data were designed to ensure that accurate and meaningful tables and charts could be generated to help address the study's research questions. Our approach included:

Data cleaning – Data were cleaned to ensure that:

- missing data were correctly coded as "missing",
- date and time variables were in the correct format,
- responses to Likert-type questions were recoded from e.g. "Strongly Disagree," "Disagree," "Neutral," "Agree," and "Strongly Agree" to 1, 2, 3, 4, 5.

Descriptive statistics were generated including:

- **Frequency tables** to report the number and proportion of responses to categorical questions, e.g. the number (%) of participants in each age group.
- **Crosstabulations** to describe the relationship between two categorical variables, e.g. the number (%) of participants in each age group split into those who had experienced RR versus those who had not.
- Measures of

Figures were generated to provide visual representation of descriptive statistics including:

- **Histograms** to represent the distribution of responses to categorical questions. For example, the number of different rug types that were causing problems for participants.
- **Stacked bar charts** to illustrate responses to Likert-type questions. For example, rating support received from services under five levels of satisfaction from "Very poor" to "Excellent".

Several quantitative questions in the surveys provided a free text box for participants to provide additional information on their response. For example, after being asked to rate their awareness of RR services in Scotland on a scale of 0 (not at all informed) to 10 (fully informed), participants were invited to describe how they arrived at the score they had entered. Illustrative quotes were selected to give a broadly representative indication of respondents' answers.

Qualitative data analysis

The analysis methods utilised for the qualitative component of this study were designed to address the complexities inherent in analysing elements drawn from across the various work packages. The following considerations outline informed the approach taken to ensure robustness and accuracy within the analysis:

- **Delineation between cohorts:** The research initially aimed to establish whether there were any clear narratives for different cohorts across work packages. However, early manual analysis identified a dominance of overlapping rather than distinct narratives between the cohort groupings.

- **Cross tabulation analysis:** Pilot investigations were made to demarcate qualitative findings by participants' experiences with or intentions towards residential rehabilitation (RR) through cross tabulations. This analysis revealed that the findings were near-identical across different cohorts, limiting the utility of this approach.

- **Challenges encountered in analysis:** The analysis was further complicated by several factors:

- Missing data: Gaps in the data presented challenges in drawing comprehensive conclusions.
- Incomparable sample sizes: Variations in the size of different cohort groups questioned the validity of any direct comparisons.
- Geographical and other variations: Differences in geographical locations and other dimensions added layers of complexity.
- Non-mutual exclusivity of cohort groupings: The overlapping nature of cohort groups made it challenging to isolate distinct narratives or experiences.

- **Thematic analysis of open text box data:** A strict thematic analysis was initially conducted on the open text box data without referencing the quantitative findings. However, this approach revealed some misleading findings, which had implications for the conclusions drawn from the study.

- **Adopting an inductive-deductive approach:** To address these challenges, the study employed a two-fold approach:

- Inductive coding: The qualitative data was first approached inductively, allowing cross-cutting themes to emerge organically from the data. This method facilitated the identification of themes that were not initially apparent.
- Deductive thematic framework: Following the inductive phase, a deductive method was applied, where the research questions served as a meta-thematic framework. This framework was used to organize and interpret the themes identified in the inductive phase.

Stringent measures were implemented to safeguard the anonymity and confidentiality of participants regarding their free text responses. Names, service names, locations and any other identifiers, were systematically omitted and replaced with generic names or descriptors and placed in square brackets. For example, '…[service in northern England]…'. Additionally, the data collection process was designed to prevent any inadvertent disclosure of individual identities. The research team employed secure data storage and handling practices, restricting access to authorised personnel only. These precautions were undertaken to uphold ethical standards and created a secure and confidential environment, where participants could share their experiences and opinions candidly.

Appendix B – WP2 sampling framework

Table B.1: Full breakdown of WP2 target and actual interview numbers by ADP area

ADP Area	Population (000s)	% of Scottish population	WP2 target numbers	Numbers completed
Aberdeen City	227	4.14%	9	6
Aberdeenshire	263	4.80%	10	8
Angus	116	2.12%	5	3
Argyll and Bute	86	1.57%	3	3
Clackmannanshire and Stirling	145	2.64%	6	8
Dumfries and Galloway	149	2.72%	6	7
Dundee City	148	2.70%	6	7
East Ayrshire	122	2.23%	5	6
East Dunbartonshire	109	1.99%	4	1
East Renfrewshire	97	1.77%	4	6
Edinburgh	526	9.59%	20	20
Falkirk	161	2.94%	6	3
Fife	375	6.84%	14	13
Glasgow City	635	11.58%	24	26
Highland	239	4.36%	9	1
Inverclyde	77	1.40%	3	3
MELDAP	205	3.74%	8	8
Moray	96	1.75%	4	3
North Ayrshire	134	2.44%	5	5
North Lanarkshire	341	6.22%	13	9
Orkney	23	0.42%	2	0

ADP Area	Population (000s)	% of Scottish population	WP2 target numbers	Numbers completed
Perth & Kinross	154	2.81%	6	6
Renfrewshire	180	3.28%	7	4
Scottish Borders	116	2.12%	5	7
Shetland Islands	23	0.42%	2	0
South Ayrshire	112	2.04%	4	5
South Lanarkshire	323	5.89%	13	16
West Dunbartonshire	88	1.60%	3	3
West Lothian	186	3.39%	12	10
Western Isles Na h-Eilean Siar	27	0.49%	2	0
TOTAL SCOTLAND POPULATION	**5483**		**220**	**197**

Appendix C – Qualitative themes and examples

Table C.1: Awareness and understanding of RR – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples
• 'Before I went to rehab, I didn't have …clue about it. Going to 12 step meetings I met a lot of different people and got my knowledge up as I was talking to people from different walks of life.' [WP2 Participant #81, male] • 'I have heard of people accessing other rehabs, but you're always told you won't get funding for rehab.' [WP2 Participant #80, female] • 'I got leaflets last week as I've started the process of applying into rehab.' [WP2 Participant #82, male] • 'I feel that no one ever speaks to me about rehab, even when I have asked. They haven't got the information there.' [WP2 Participant #85, female] • 'Lack of information displayed in drug services.' [WP2 Participant #11, male] • 'Nobody goes out of their way to tell you about rehab.' [WP2 Participant #16, male] • 'I heard about it on this survey.' [WP2 Participant #21, male] • Because I have learned through talking to others at meetings about rehab.' [WP2 #99, male]

Table C.2: Perceptions of RR activities – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Perceptions of RR activities
• 'Detoxification and therapy for the cause of the addiction.' [WP2 Participant #27, female] • 'Group sessions, keep to a regimented structure.' [WP2 Participant #54, male] • 'Help with health, mental health, therapy.' [WP2 Participant #71, male] • 'Counselling, confidence building to return to their community.' [WP2 Participant #44, female] • 'I don't know anything about rehab.' [WP2 Participant #47, female]

Illustrative (qualitative) data examples – Perceptions of RR activities
• 'Controlled prescription/detox. Control benefits. Attend support meetings and other activities. Help to reintegrate, housing support/welfare.' [WP2 Participant #43, male] • 'Not sure but I think they work on people's triggers (as to why they use drugs).' [WP2 Participant #60, female] • 'Detox and then other activities and courses which you would get the choice of. Counselling would be mandatory.' [WP2 Participant #67, male] • 'You get taught or retaught how to live, structure and tools to help keep you clean.' [WP2 Participant #74, male]

Table C.3: Reasons for applying for RR – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Reasons for applying for RR
• '[I] was nearly dead.' [WP2 Participant #09, female] • 'I was scared. I was determined to get into a secure (rehab). There was nothing available in my area and I could not get access to funding. I funded rehab myself.' [WP2 Participant #86, male] • 'To be drug free. And to get my family back.' [WP2 Participant #26, female] • 'Been on methadone for 17 years and wanted to get off it so they offered a detox.' [WP2 Participant #61, male] • 'I was at my wit's end – this was my only way out. Essential to be removed from current circumstances.' [WP2 Participant #59, male] • 'Overdosing five times and leaving my family just after I'd lost my mum. Poor life decisions.' [Participant #48, male] • 'I was fucked, in 30 year of addiction, I was broken. Near dead.' [WP2 Participant #93, male] • I felt like I was going to die. I wanted my life back.' [WP2 Participant #86, female] • 'I wanted to be free from going to the chemist everyday…I know I deserve better. I wanted rehab to get the tools to live a better life.' [WP2 Participant #63, female]

Table C.4: Early exits and post-treatment risks – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Early exits and post-treatment risks
• 'Authoritative staff.' [WP2 Participant #31, female] • 'Revisiting old traumas and having to speak about your past may make some people leave early. Also hearing feedback from group therapy' [WP2 Participant #63, female] • 'If people are not ready, they won't stay.' [WP2 Participant #12, male] • 'If my mental health could not cope with it and was not supported.' [WP2 Participant #39, female] • 'At more risk of overdose because lower tolerance levels.' [WP2 Participant #20, male] • 'If you have to give up your house to go to rehab then leave early and could end up homeless.' [WP2 Participant #08, male] • 'Going back to the same situation, same area etc., you're more likely to use again.' [WP2 Participant #28, male] • 'Triggers and relapse.' [WP2 Participant #56, male]

Table C.5: Perceived effectiveness of RR – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Perceived effectiveness of RR
• 'It would be different for every person.' [WP2 Participant #49, female] • 'Unless you are desperate and very sure it is for you it is not effective.' [WP2 Participant #12, male] • 'I have never done rehab so don't know how effective it is.' [WP2 Participant #51, female] • 'For some, it's effective and for others it is not. Like methadone, effective for some and not others.' [WP2 Participant #67, male] • 'My mum and dad went to rehab, and it worked for them.' [WP2 Participant #03, male]

Illustrative (qualitative) data examples – Perceived effectiveness of RR
• 'I have now recovered from my substance abuse; not interested.' [WP2 Participant #19, male] • 'I've seen many people go to rehab and come back and they are back on drugs within a few months at least.' [WP2 Participant #04, female] • 'It wasn't for me, but it did work for others.' [WP2 Participant #91, male] • 'From my interactions with people, I know people who have been several times, and it has not worked.' [WP2 Interview Participant #91, male]

Table C.6: Likelihood of completing RR – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Likelihood of completing RR
• 'I am a man of my word, if I say I'll do it, I'll do it, but I have too much to lose by going.' [WP2 Participant #01, male] • 'Having been in residential treatment, I'm now in recovery, clean off all drugs and prescription medications so now I'd fly through treatment.' [WP2 Participant #46, female] • 'I've not too long completed rehab.' [WP2 Participant #95, male] • 'Likely now as I am older now, and I have been to rehab when I was younger.' [WP2 Participant #85, female] • 'I can't do it myself and would take that opportunity with both hands.' [WP2 Participant #06, female] • 'I don't want to set myself up to fail.' [WP2 Participant #16, male] • 'I just want the chance.' [WP2 Participant #30, female] • 'I've heard it's hard and that the regime is challenging and busy.' [WP2 Participant #32, male]

Table C.7: Considerations about accessing RR – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Considerations about accessing RR
• 'I just resigned to the fact that I was just going to do meth (…) I met somebody through [name of RR service] (...) that's the beginning of how I got into rehab.' [WP3 Participant #05, male] • I am epileptic.' [WP2 Participant #92, female] • 'I want to get clean and have a detox, to get and feel normal. Rehab is not an option due to losing tenancy.' [WP2 Participant #53, male] • 'Currently homeless, so might need housing stability to consider properly.' [WP2 Participant #35, male] • 'Clear guidance on the withdrawal process and support.' [WP2 Participant #50, female] • 'I would go anyway, no matter what.' [WP2 Participant #25, male] • 'I need one I can access alongside partner.' [WP2 Participant #13, female] • 'I care for my mother so there would have to be care in place for her before I could consider rehab.' [WP2 Participant #51, female] • 'I need counselling and support for past trauma.' [WP2 Participant #87, female]

Table C.8: Treatment preferences – selection of illustrative (qualitative) data examples

Illustrative (qualitative) data examples – Treatment preferences
• 'Rehab was the safe place I had to go…removed from society.' [WP2 Participant #42, male] • 'Detox and rehab are my top priority. I feel I am ready, and I'll keep banging on the door.' [WP2 Participant #52, male] • 'I'm interested in coming to understand the experiences of others through recovery community and mutual aid. Rehab doesn't seem to meet my needs at the moment.' [WP2 Participant #33, male] • 'I find it hard to categorise as a lot of these options are not open to me.' [WP2 Participant #39, female]

Illustrative (qualitative) data examples – Treatment preferences
• 'Support depends on where people are in recovery and their mindset.' [WP2 Participant #15, male] • 'As much as recovery is mostly self-aided, the initial steps need support and assistance before, and addict can begin to want to help themselves.' [WP2 Participant #27, female] • 'Had to get support for complex needs so still not getting the help I need.' [WP2 Participant #97, male] • My life would be in chaos if I was not prescribed methadone.' [WP2 Participant #98, male]