Scottish Government
Riaghaltas na h-Alba

Stabilisation, detoxification and other crisis support in Scotland: Service mapping and capacity survey 2022/23

HEALTH AND SOCIAL CARE

social research

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Key Findings

Main Survey

• **The mapping exercise identified a total of 38 providers offering a form of stabilisation** based on their reporting offering opioid substitution therapy (OST) and/or benzodiazepines and/or OST optimisation.

• **The majority of stabilisation providers (71%) are statutory organisations** (either NHS hospitals or other statutory organisations). The remaining were residential rehabilitation providers (16%), third sector organisations (8%), a general practice and a private hospital (6%).

• **Around half (53%) of services operated in a community-based or outpatient model and the other half (47%) in a residential or in-patient setting.**

• **Glasgow City has the highest concentration of both residential and community-based stabilisation services (34%).** The other 25 services were spread across 20 local authority areas in Scotland.

• **Of the 29 stabilisation providers that gave an estimate, there was a total of 1,875 people receiving treatment.** This included 272 people attending residential or in-patient services and 1,603 people attending community or out-patient.

• **There is a wide range in the types of substances for which treatment and support is offered, the range of treatment and support offered, and the length of the treatment.** Most stabilisation services also offered some form of detoxification (95%) and behavioural or psychological interventions (92%).

• **Most stabilisation providers (68%) do not operate a waiting list for their services.** Those that did describes waits of between two weeks and up to 12 weeks, with a few noting that this varies depending either on capacity or clinical need.

• **Most stabilisation providers (63%) stated that there are no criteria for exclusion from their service.** Exclusion criteria, where adopted, included the profile of substance use (11%), the existence of a criminal record (8%) or of a specific mental health concern (5%) although some reported that people are assessed on a case-by-case basis and may not result in automatic exclusion from the service.

• **Referrals come from the local ADP or Health Board areas (53%), hospitals (50%), general practices (47%) or through social work (45%).** It is also quite common for people to self-refer.

• **All stabilisation services operate within one or more regulatory frameworks**, including the National Health Service (NHS), Health Improvement Scotland (HIS) and the Care Commission.

• **The most common source of funding is through the NHS or local ADPs. Self-funding for stabilisation is uncommon.**

• **Providers reported that people commonly return home following discharge from residential stabilisation services as opposed to entering residential rehabilitation.** Almost two thirds of residential providers (65%) and three quarters (75%) of community-based providers responding that service users 'rarely' or 'never' move on to this following discharge from their service.

• **A further five providers were identified as providing some form of detoxification, which did not include stabilisation.** They came from a range of organisations, and all also offered behavioural or psychological interventions an active connection to community recovery resources.

• **A further 24 providers were identified as offering another form of crisis support, which did not include stabilisation and/or detoxification**. They are primarily third sector or homelessness services principally operating in community-based settings, offering a range of other treatment and support.

Prison survey

• **All responding prisons (12 out of 15) offer some form of stabilisation for a range of substance use profiles alongside a range of other treatment and support.** These include detoxification, behavioural and psychological interventions, wound care and blood-borne virus testing.

• **Responding prisons reported a patient-centred approach being taken and that there is no maximum capacity.** Instead, treatment and support are delivered based on an assessment of need upon arrival.

Conclusions

• **Services operating in Scotland aimed at supporting people at a point of crisis with regard to their substance use have noted commonalities. However, the findings of this survey suggest an operational definition of "stabilisation" and how this differs from other forms of crisis support is currently lacking.** Based on the results of the survey, a possible broad definition is suggested: "Stabilisation aims to support people to manage their substance use through medication prescription in combination with detoxification and/or psychosocial support as required". This suggested definition will need to be further considered the SCCWG and would benefit from engagement with various stakeholder groups, including people with lived and living experience.

• **The report highlights considerations for further research.** These include further research on providers of stabilisation and detoxification; on other crisis support providers; and into the lived and living experience of current service users, people seeking referral and those supporting them.

1. Introduction

The level of harms from alcohol and drugs in Scotland are 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. In January 2021, Nicola Sturgeon, in her role as First Minister, made a statement to Parliament that set out a National Mission to reduce drug deaths through improvements to treatment, recovery and other support services.

In January 2023, the Scottish Government published a cross-government plan of approach in response to recommendations made by the Drug Deaths Task Force (DDTF). It outlined commitments to increase funding for stabilisation and to explore the options for a national fund to establish and expand stabilisation and crisis services in response to the recommendations made by the DDTF. The Stabilisation and Crisis Care Working Group was established in September 2023 to advise Scottish Ministers on how to meet these commitments. This includes advising on a programme of work on the provision of these services across Scotland and to develop a recognised definition of stabilisation for a Scottish context. The DDTF used this term to refer to harm-reduction services that offer a place of safety in which to provide people with treatment and other support to manage their substance use[1].

To support the work of the working group, analysts from Health and Social Care Analysis developed a survey to map the provision and capacity of stabilisation, detoxification and other crisis support services. The findings from this survey were intended to help inform the working group's recommendations and to gather evidence to help inform a definition of stabilisation.

This report presents the findings from the survey of stabilisation, detoxification and other crisis support providers in Scotland. In addition to seeking to establish the current levels of provision and capacity for each of these services in Scotland, this report presents the findings of the survey with regard to how they are governed and funded; how they operate and how patient outcomes are measured. It concludes by suggesting a possible definition of stabilisation that may serve to inform future work in this area.

[1] Scottish Drug Deaths Taskforce. (2022) Changing lives: our final report. Edinburgh: Drug Deaths Taskforce. https://drugstaskforce.knowthescore.info/wp-content/uploads/sites/2/2022/08/Changing-Lives-updated-1.pdf

2. Methodology

A scoping survey was developed in consultation with the Stabilisation and Crisis Care Working Group (SCCWG) the Residential Rehabilitation Development Working Group (RRDWG) to identify potential providers of services (including detoxification and stabilisation) for people who use alcohol and/or drugs in Scotland. Respondent were asked to provide the name, location and where possible contact details for services they were aware of, and to forward the survey to anyone who may have relevant information. Fieldwork took place in June 2023 and the survey was distributed by email to:

- all residential rehabilitation providers,
- frontline services across Scotland that report via the Drug and Alcohol Information System (DAISy),
- people with lived experience via the Scottish Recovery Consortium (SRC) and the Scottish Families Affected by Alcohol and Drugs (SFAD),
- General Practitioner leads,
- the Scottish Health Action on Alcohol Problems, and
- members of the Residential Rehabilitation Development Working Group (RRDWG).

Subsequent desk research was conducted to verify and supplement the results of the scoping survey. The final list of services was shared with the SCCWG and the RRDWG as a further means to quality assure the results.

A mapping and capacity survey of detoxification, stabilisation and other crisis support providers was developed in consultation with key stakeholders. This was composed of 35 primarily closed-ended questions (see Appendix A), aimed at obtaining information on aspects such as current capacity, types of treatment offered, funding and outcomes. The survey was distributed by email to:

- the list of providers identified as part of the scoping exercise,
- all residential rehabilitation providers in Scotland,
- frontline services that report via the Drug and Alcohol Information System (DAISy),
- Scottish health board leads,
- and members of the Residential Rehabilitation Development Working Group (RRDWG) and the Stabilisation Working Group (SWG), asking them to forward it on to their contacts.

A separate survey, tailored to prison settings, was issued by email to all healthcare managers of the 15 Scottish prisons (see Appendix B). The survey was composed of 12 questions and was also aimed at obtaining information on current capacity, types of treatment offered and outcomes.

Data collection took place between the 27th of October and the 24th of November 2023. The results of the analysis are presented in this report.

3. Results

The main survey received 80 responses. Ten invalid responses were removed and duplicate returns from the same organisation were consolidated into a single response, resulting in a total of 65 responses for analysis.

Responses to the prison survey were received from 12 of the 15 Scottish prisons. As these results cannot be directly compared to those of community-based or other residential services, the findings are reported in the final section of this report.

3.1 Stabilisation

The results of this survey indicate a variation in how stabilisation is understood and interpreted by respondents. Respondents were asked to provide information on the treatment and support they offered.

For the purposes of this survey, providers were classed as offering a form of stabilisation if they reported offering opioid substitution therapy (OST) and/or benzodiazepines and/or OST optimisation. A total of 38 providers were identified as offering these services. It should be noted that 10% (n = 4) of the providers classed as providing stabilisation using this definition did not self-describe as doing so.

3.1.1 Types of providers

Stabilisation is offered across a range of organisation types. Due to the question format in the survey, it is not possible to entirely categorise these as statutory, private and third sector organisations. However, about two thirds of services responding to the survey (71%) were statutory organisations (either NHS hospitals or other statutory organisations), 16% were residential rehabilitation providers[2] and 8% were third sector organisations. The remaining 6% were a general practice and a private hospital.

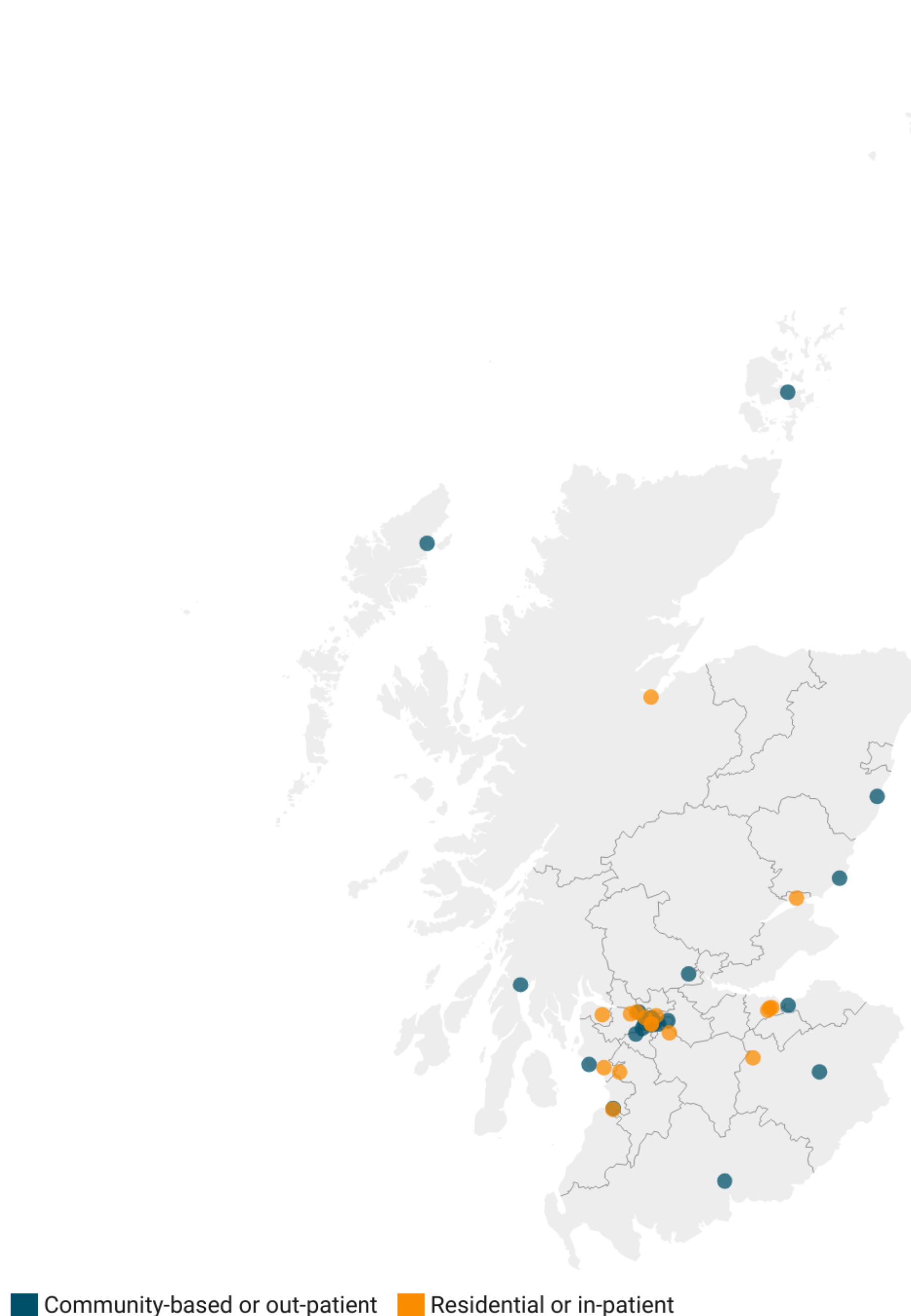
3.1.2 Geographic distribution and model of delivery

There is a fairly even division in the model of delivery for these services. Around half of providers (53%, n = 20) operate a community-based or outpatient model of delivery. The other half of providers operate in a residential or in-patient setting, with one provider describing a hybrid model of community-based delivery with access to specialist NHS acute hospital beds.

Glasgow City has the highest concentration of both residential and community-based services, with around a third (34%, n = 13) located in this local authority area (Figure 1). The other 25 services were spread across 20 local authority areas. Three are in the City of Edinburgh; two each in South Ayrshire, East Ayrshire and the Scottish Borders; and one in each of the following local authorities: Aberdeenshire, Angus, Argyll and Bute, the Western Isles, Dumfries and Galloway, Dundee City, East Lothian, East Renfrewshire, Highland, Inverclyde, North Ayrshire, Orkney, Renfrewshire, South Lanarkshire, Stirling and West Dunbartonshire.

[2] Some residential rehabilitation providers will be private, statutory or third sector.

Figure 1: Location of residential and community-based stabilisation providers in Scotland



Map data: © Crown copyright and database right 2019 • Created with Datawrapper

3.1.3 Capacity estimates

The survey included questions aimed at compiling an estimate of the stabilisation capacity across Scotland. However, analysis indicated that a lack of common understanding or definition of stabilisation and differences observed across the models of delivery make the interpretation of this data challenging. For example, capacity was often reported as having no upper limit and no clear distinction was made between capacity for different types of treatment. This indicates that this question was interpreted as the total number of people a service can accommodate

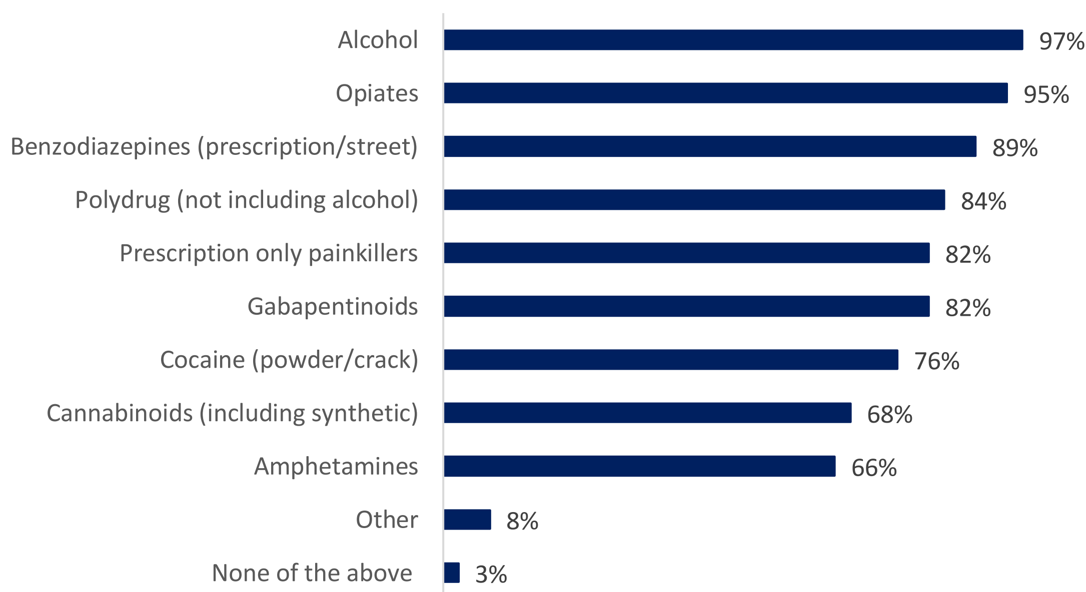
and that resources within an organisation can be flexed to meet demand/ needs of people presenting for treatment. This is indicative of a person-centred approach being adopted across services, such that an assessment of a person's needs determines the type of treatment or support provided. While further research will be required to better understand this, data on the current number of people attending services can provide an indication of current capacity, assuming demand is sufficiently high. It should be noted that this data can only provide a snapshot of the current levels of attendance to these services at the time of the survey.

Of the 29 providers that provided an estimate, there was a total of 272 people attending residential or in-patient services and 1,603 people attending community or out-patient services[3]. The estimates provided varied considerably between 2 and 61 people for residential or in-patient services; and between 10 and 500 for community-based or out-patient services. Nine respondents (primarily from services operating in a community-based or out-patient setting) indicated that they were not able to provide this due to the variation in the number of people using their services month on month, or issues around accessing this data.

3.1.4 Treatment and support

Providers offer treatment for a range of substance use profiles (Figure 2)**.** Most providers are able to offer treatment or support for the use of alcohol (97%), opiates (95%) and benzodiazepines (89%). Other substances mentioned included performance and image enhancing drugs (n = 1) and ketamine (n = 1).

Figure 2: Share of providers reporting offering treatment or support by type of substance



The mapping survey identified a total of 38 services providing some form of stabilisation. The majority of services (74%, n = 28) reported offering OST

[3] One outlier reported 1,268 people currently attending their community-based service. This figure has not been included in the total as the provider has not responded to a follow-up email seeking to confirm the accuracy of this estimate.

prescription, benzodiazepine prescription and OST optimisation. The remaining ten providers offer a single or combination of these three services. When offering just one of these services, this is always in combination with some form of detoxification and/or behavioural or psychological intervention:

- Prescription of OST – 2 providers
- Optimisation of OST – 1 provider
- OST and benzodiazepine prescribing – 4 providers
- OST prescription and optimisation – 2 providers
- Prescription of benzodiazepines – 1 provider

Almost all (95%, n = 36) also offer some form of detoxification. Detoxification from both alcohol and drugs is most common (79%, n = 30), but five are limited to alcohol and one to drugs.

A range of other treatment and support is available across these 38 providers:

- All but one (n = 37) reported providing **naloxone**.
- **An active connection to community recovery resources** (e.g. mutual aid) is offered by 95% (n = 36) providers.
- **Blood-borne virus testing** and **behavioural or psychological interventions** are offered by 92% (n = 35) of providers. Behavioural and psychological interventions included techniques such as motivational interviewing, brief interventions, cognitive behavioural therapy (CBT), Eye movement desensitisation and reprocessing (EMDR), therapeutic community, trauma-informed. An intervention referred to as “safety and stabilisation” was also mentioned by some providers. These interventions were described as ranging from low intensity group interventions (sometimes described as Tier 1) to specialist one-to-one interventions (sometimes described as Tiers 3 and 4) with support from specialised mental health staff (e.g. psychologist, psychiatrist, mental health nurses, key workers, etc.).
- **Provision of alcohol relapse prevention medication** is offered by 87% (n = 33) of providers.
- **Wound care** is offered by 76% (n = 29) of providers.
- **Sexual health care** is offered by 58% (n = 22) of providers.
- **Dental care** is offered by 8% (n = 3) of providers.
- One provider also reported offering injection equipment provision (IEP), and another also reported offering physical fitness related therapies (e.g. yoga).

3.1.5 Duration of treatment

The treatment and support services offered by the stabilisation providers ranged considerably in length from a few days to having no real upper limit, largely depending on the model of delivery. Providers operating in a residential or in-patient setting reported treatment lengths of between 5 days and 10 months, with residential rehabilitation providers generally reporting the longest period of treatment (ranging between 7 days to 10 months). NHS hospital in-patient services tended to have shorter periods of treatment (ranging between 5 days and 3 weeks), although a private hospital reported a length of 6 weeks.

Community-based providers all reported longer treatment times of between 6 weeks and several years. Several respondents indicated that this was largely dependent on the treatment offered, with open-ended support being common for patients on long-term OST.

3.1.6 Waiting lists and waiting times

Most providers (68%, n= 26) do not operate a waiting list for their services. The 12 providers that do have waiting lists described waits of between two weeks and up to 12 weeks, although a few noted that this varies depending either on capacity or clinical need.

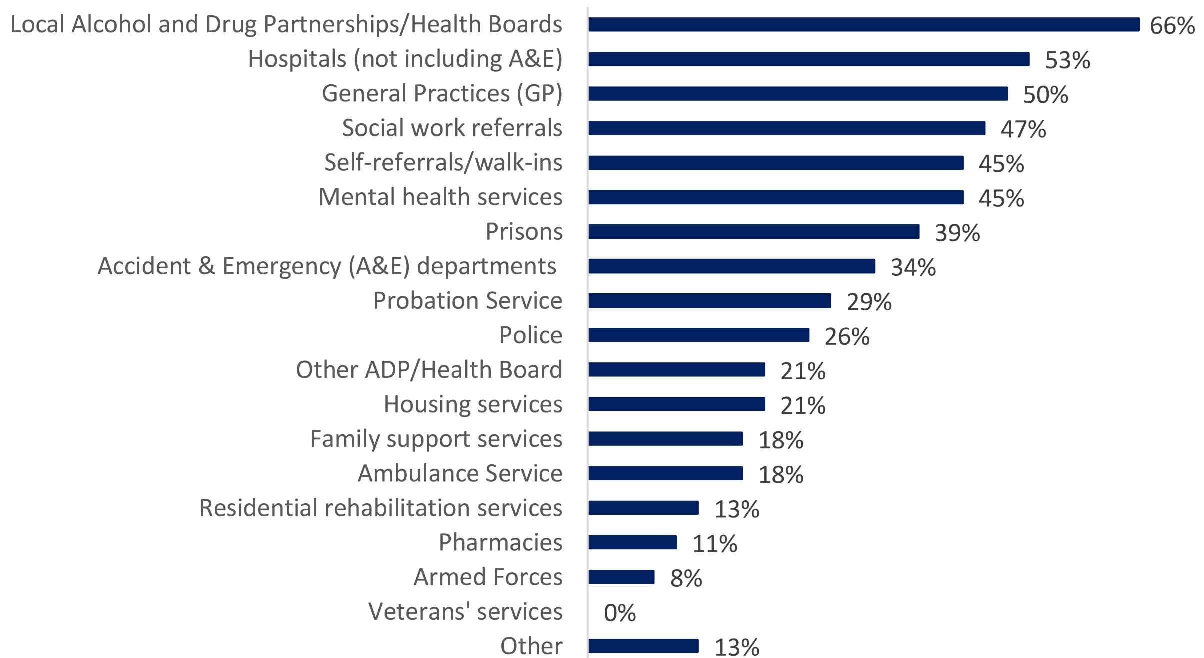
3.1.7 Exclusion and screening criteria

About two thirds (63%) of the respondents stated that there are no criteria for exclusion from their service. Where exclusion criteria were noted, these included the profile of substance use (11%), the existence of a criminal record (8%) or of a specific mental health concern (5%), and an individual not being considered at a point of crisis with regard to their substance use (3%). A few respondents specified that people are assessed on a case-by-case basis and that these criteria might not necessarily result in automatic exclusion from the service. A few respondents also mentioned that people presenting with a mental or physical health condition requiring medical attention or best suited to another service would potentially delay, although not necessarily exclude, someone from admission to their service.

3.1.8 Referral pathways

People arrive at the services via a range of different referral pathways (Figure 3). **Around half of respondents also said people ‘often’ or ‘always’ come from the local ADP or Health Board area (53%), hospitals (50%), general practices (47%) or through social work referrals (45%).** It is also quite common for people to self-refer to the services, with 45% of providers saying this is ‘always’ or ‘often’ the case. Referrals from other ADP or Health Boards, the Ambulance Service, and family support or housing services were less likely.

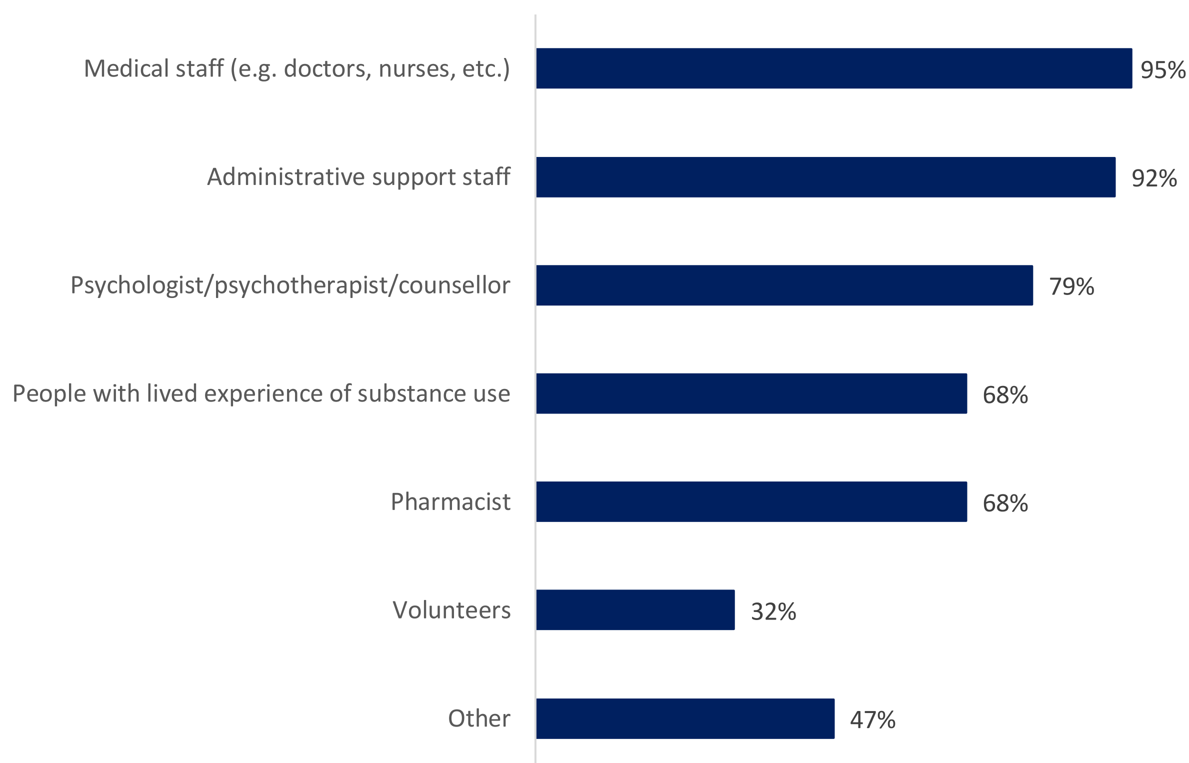
Figure 3: Share of providers responding that their service users 'always' or 'often' arrive to their service by type of pathway



3.1.9 Staffing

The services employ staff across a range of professions (Figure 4)**.** While about a third (32%) of services have volunteers, the majority operate with salaried staff. The most common are medical staff (95%) and administrative support staff (92%) as well as 79% being mental health professionals (psychologists, psychotherapists or counsellors). People with lived experience were reported to be employed by 68% of providers. Other professions employed include occupational therapists, social workers, mental health nursing staff, and support workers.

Figure 4: Share of providers reporting employing different professions (in a paid or volunteer capacity)



3.1.10 Regulatory frameworks

All of the 38 services operate within one or more regulatory frameworks. Most (79%) are regulated by the National Health Service (NHS), about half (47%) are regulated by Healthcare Improvement Scotland (HIS), and about a third (34%) by the Care Commission.

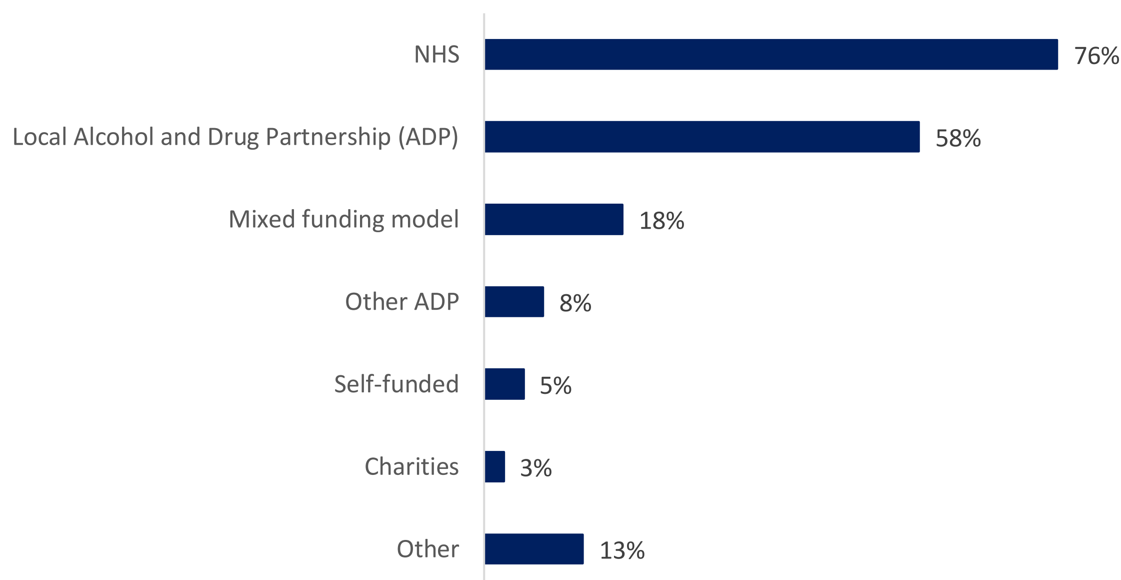
3.1.11 Funding sources

Funding for people using these services comes from a range of sources (Figure 5). **The most common source of funding is through the NHS or local ADPs**, with 76% and 58% of respondents reporting that this is 'always' or 'often' the case. It should be noted that these estimates may have been slightly inflated by the 18% of providers that reported having mixed models of funding.

Most providers reported that self-funding is uncommon, with 84% saying that this is never the case. Other sources of funding mentioned included, local authorities and the Scottish Government[4].

[4] A couple of services noted that the funding coming from local authorities determined who they were able to offer places to.

Figure 5: Share of providers responding that their service 'always' or 'often' receive funding by source of funding



3.1.12 Service user outcomes

Providers were asked how they measured outcomes for people using their services. Outcome Star or DAISy were most commonly said to be used by those who responded to this question, although a few also reported using other questionnaires or surveys. Some providers reported that measuring outcomes is not yet commonplace but is in development.

People are most commonly reported to return home following discharge from a residential service, with 94% of these providers saying this is 'always' or 'often' the case. Hospitals also reported that common routes upon discharge include a move to other wards or a transfer to community services. A move to some form of supported accommodation was also mentioned as being common by residential rehabilitation providers and third sector organisations.

A placement in residential rehabilitation is not a common next step, with almost two thirds of residential providers (65%) and three quarters (75%) of community-based providers responding that service users 'rarely' or 'never' move on to this following discharge from their service.

3.2 Detoxification services

The mapping survey identified a total of 41 services providing detoxification in Scotland, based on having selected 'detoxification from alcohol' AND/OR 'detoxification from drugs' from a list of treatments offered. The majority (n = 36) also offer some form of stabilisation and have been discussed above.

The five remaining detoxification providers identified come from a range of organisations. Three are residential rehabilitation providers, one is a community

alcohol detoxification team, and one is a homelessness service (therefore split between operating on a residential or community-based context).

Three offer both alcohol and drug detoxification, one only drugs and one only alcohol. All also offer behavioural or psychological interventions and an active connection to community recovery resources.

3.3 Other crisis support services

A total of 24 providers were identified as offering another form of crisis support, which did not include stabilisation and/or detoxification. These were primarily third sector or homelessness services principally operating in community-based settings (75%). The majority of providers (71%) reported that all or more than half of their services are specifically dedicated for people at a point of crisis with regard to their substance use.

A range of other treatment and support is available across these providers. Ten of these services describe themselves as offering stabilisation, all had active connections to community recovery resources and 60% offered behavioural or psychological interventions.

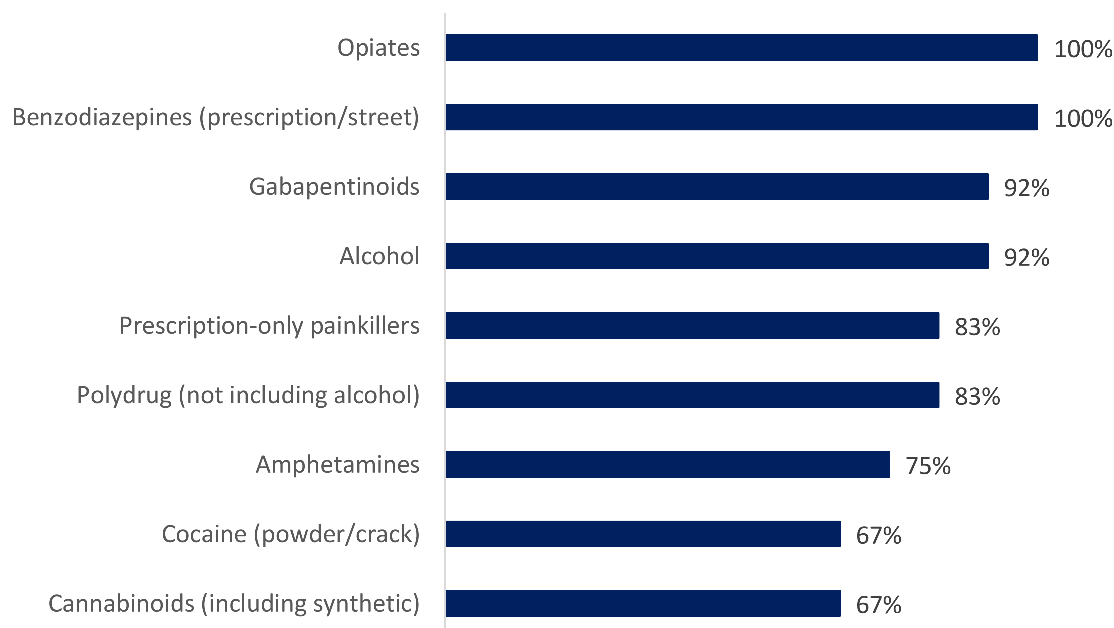
- Most (88%, n = 21) reported providing **naloxone**.
- **An active connection to community recovery resources** (e.g. mutual aid) is offered by 79% (n = 19) providers.
- **Behavioural of psychological interventions** are offered by 58% (n = 14) of providers. The interventions described were generally low intensity psycho-social ones with no mention of specialist mental health staff. They included peer support groups and techniques such as motivational interviewing and cognitive behavioural therapy (CBT).
- **Blood-borne virus testing** is offered by half (n = 12) of providers.
- **Wound care** is offered by about a third (29%, n = 7) of providers.
- **Sexual health care** is offered by 17% (n = 4) of providers.
- Other services also included harm reduction advice or unspecified harm reduction (4 providers); IEP provision (1 provider); wound care, assessment of injecting risk, naloxone and dry blood testing (1 provider); educational activities for young people (1 provider).

3.4 Prisons

3.4.1 Treatment and support programmes

Prisons provide treatment across the range of substance use profiles (Figure 6). All offer treatment for opiates and benzodiazepines and over three quarters (between 75-92% depending on the substance) offer treatment across the rest of the substance use types. Cocaine and cannabinoids are the least common substances for which treatment is offered, however the majority (67%) of prisons still report doing so for both of these.

Figure 6: Share of prisons reporting offering treatment or support by type of substance



All prisons offer some form of stabilisation. Three quarters (75%, n = 9) reported offering OST prescription, benzodiazepine prescription and OST optimisation. The remaining three prisons offer a single or combination of these three services.

- Prescription of OST – 1 prison
- OST prescription and optimisation – 2 prisons

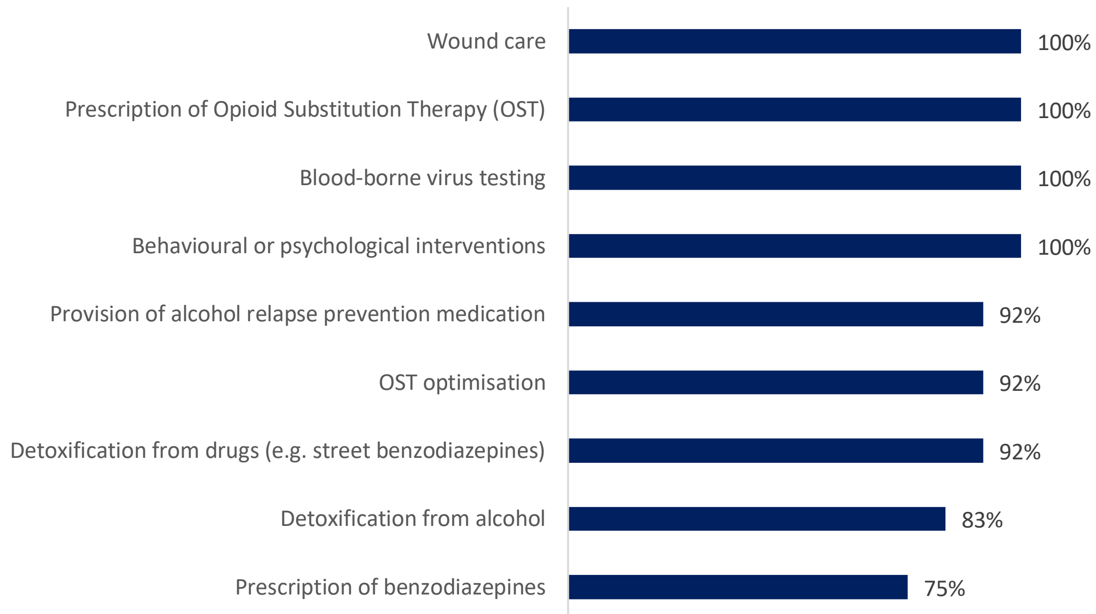
All but one prison (92%, n = 11) also offer some form of detoxification. Detoxification from both alcohol and drugs was most common (83%, n = 10), with one prison only offering detoxification for drugs. A few respondents noted in open-text answers that detoxification is only provided to new arrivals to the prison.

All prisons also reported providing wound care, blood-borne virus testing and behavioural or psychological interventions (Figure 7). Behavioural and psychological interventions included techniques such as motivational interviewing, cognitive behavioural therapy (CBT), relapse prevention and trauma-informed care. An intervention referred to as 'safety stabilisation' was also mentioned by a couple of respondents. These interventions were described as ranging from low intensity interventions with members of the addiction team or nurses to specialist one-to-one interventions (sometimes described as Tier 3), potentially with support from specialised mental health staff (e.g. clinical psychology team).

All but one prison also provides alcohol relapse prevention medication. Follow-up conversations by emails, telephone or Microsoft Teams were held with respondents from four different prisons to clarify how naloxone is used in Scottish prisons. While in prison, naloxone is not distributed to prisoners but is available to members of the prison staff (in its intranasal form) and healthcare staff (in its injectable form) for use

in the event of an overdose. Naloxone is offered to people upon release from prison and respondents described different arrangements for delivering training prior to release and maximising uptake of take-home naloxone upon release.[5]

Figure 7: Share of prisons by type of treatment or support offered



3.4.2 Capacity

As for the general population, while a couple of respondents attempted to provide an estimate for the maximum capacity at their prison, almost all of the respondents to this survey reported that a patient-centred approach is taken and that there is no maximum capacity. Instead, treatment and support are delivered based on an assessment of need when new arrivals to the prison come in.

[5] Respondents were also asked about the provision of sexual health care and dental care in their prison. These results have been removed as follow-up email and telephone conversations with four respondents from different prisons suggests that the question was either misinterpreted or missed.

4. Conclusion

The survey found a total of 65 providers offering some form of detoxification, stabilisation or other support for people at a point of crisis with regard to their substance use in Scotland.

The majority of providers (n = 38) offer some form of stabilisation treatment, usually in combination with detoxification, to an estimated 3,143 people at the time of the survey (based on the 29 respondents who were able to provide an estimate). These services are delivered in both residential/in-patient or community-based/out-patient settings across Scotland (with the highest concentration in Glasgow City health board). Stabilisation was also reported to be provided in prison settings by all respondents to the prison survey and detoxification by all but one. However, it is clear that the delivery of substance use healthcare in prison settings differs significantly from that in the general population, and further research is required to better understand how treatment and support is delivered to the population of people in prison settings.

Self-funding was reported to be uncommon, with 84% of stabilisation providers saying that this is never the case. These services are most commonly funded by the NHS or local ADPs (76% and 58% of providers reporting this, respectively).

Of the 41 services that were identified to provide detoxification in Scotland, the majority (n = 36) were found to offer this in conjunction with some form of stabilisation treatment. The five remaining services came from a range of organisations and offered either treatment for drugs and alcohol or just one of these. All five were found to also offer behavioural or psychological interventions and an active connection to community recovery resources.

A total of 24 providers were identified as offering another form of crisis support, which did not include stabilisation and/or detoxification. These were primarily third sector or homelessness services principally operating in community-based settings (75%) and offered a range of treatment and support.

4.1 Definition of stabilisation

The results of these surveys suggest that providers of services for people at a point of crisis with regard to their substance use do not share a common understanding of how those services are defined. An operational definition of “stabilisation” and how this differs from other forms of crisis support is lacking.

However, a pattern can be identified in the results of this survey, which can be used to suggest a possible broad definition of stabilisation as it is practiced by providers across Scotland. The responses to the survey suggest that stabilisation commonly consists in the provision of medical prescribing treatment (e.g. OST prescription, OST optimisation or benzodiazepines prescription), combined with detoxification and/or psychosocial support ranging from low-intensity interventions to higher intensity ones with specialist clinical staff. These responses can be used as the starting point for developing a broad definition of stabilisation, such as:

“Stabilisation aims to support people to manage their substance use through medication prescription, in combination with detoxification and/or psychosocial support as required.”

This proposed definition will need to be further considered by the SCCWG and would benefit from engagement with various stakeholder groups, including people with lived and living experience.

4.2 Considerations for future research

1. The results of this survey provide a basic understanding of the support available for people at a point of crisis with regard to their substance use. However, further research with service providers is required to better understand the level of need and demand; service-user profiles; pathways into, though and out of services; and differences between residential, community-based and prison-based service delivery of stabilisation and detoxification services in order to better understand how the services are delivered and to identify potential gaps in provision.
2. Further research is required to better understand the provision and definition of other crisis support services available for people who use alcohol and/or drugs in Scotland and how these differ from stabilisation.
3. It would be beneficial to go beyond the insights of providers of detoxification, stabilisation and other crisis support and conduct specific research on the lived and living experience of current service users, people seeking referral and those supporting them. This would enable a better understanding of the needs and barriers of the population of people who would benefit from these services.

Appendix A – Main survey distributed to providers in the general population

Detoxification, Stabilisation and Crisis Care – Mapping and Capacity Survey

This survey is designed to collect information from detoxification, stabilisation and crisis care providers across Scotland on a range of aspects relating to the provision and capacity of these services.

The survey has been developed by the Scottish Government to better understand the support available in Scotland for people who use alcohol and/or drugs and are at a point of crisis with regard to their substance use. We are aware that some of these services may be described as **detoxification**, **stabilisation** or **crisis care** but may also be also have other names and may take place in a range of settings (e.g. residential, community-based, in an in-patient or out-patient capacity). The findings of this research will be used to better understand the range of support available to people who use drugs and/or alcohol in Scotland and will contribute to policy-making. We hope to provide a summary report of the findings in early 2024.

The survey will be live until the 16th of November 2023 and should take about 15 minutes to complete. As we are asking about detoxification, stabilisation and crisis care services within the same survey, we are aware that not all questions may be relevant to you. However, we would be grateful if you could complete the survey to the best of your ability as gathering this information is essential to getting as a full of picture of existing provision as possible. You can also help us by forwarding the link to this survey to any other detoxification, stabilisation or crisis care services that you are aware of.

If your service is split over several sites or buildings, please complete a separate survey for each. You will be asked to provide a postcode for the location and this will allow us to map services across the country.

While the names of services will be listed in the report, findings will be reported on at an aggregate level. Data will be managed in line with data protection protocols. The data may be shared with Public Health Scotland for evaluation purposes and would also be reported on at an aggregate level.

Participation in this research is voluntary and you have the right to stop of withdraw your consent at any point during or after completing this survey. We would ask that you do so by the 16th of December 2023 to allow for analysis and reporting on the data gathered. If you have any concerns about how your data will be processed, please contact DataProtectionOfficer@gov.scot.

Note: questions marked by an asterisk (*) are compulsory

About you
Q1) *Name
[open text]

Q2) *Job title
[open text]

Q3) *Email address
[open text]

About your facility

Q4) *Name of your service
[open text]

Q5) *Type of organisation
[single choice]
- General Practice
- Homelessness service
- National Health Service (NHS) hospital
- Private hospital
- Prison
- Residential Rehabilitation
- Other statutory organisation
- Third sector
- Other private organisation
- Other (please specify)

Q6) Location of your service (postcode). **If your service operates across more than one location, please complete a separate survey for each.**
[open text]

Q7) *What setting is your service delivered in?
[single option]
- Residential or in-patient (i.e. people using the service stay on site)
- Community based (i.e. outreach) or out-patient
- Other (please specify)

Q8) *Please select all substances for which treatment is offered **at your service**.
[multiple choice]
- Alcohol
- Polydrug (not including alcohol)
- Amphetamines
- Benzodiazepines (prescription/street)
- Cannabinoids (including synthetic)
- Cocaine (powder/crack)
- Gabapentinoids

- Opiates
- Prescription-only painkillers
- None of the above
- Other (please specify)

Q9) *Which of the following interventions/treatments do you provide **at your facility**? Select all that apply.
[multiple choice]

- Active connection to community recovery resources (e.g. mutual aid)
- Detoxification from alcohol
- Detoxification from street drugs (e.g. street benzodiazepines)
- Behavioural or psychological interventions
- Blood-Borne Virus testing
- Dental care
- Prescription of Opioid Substitution Therapy (OST)
- OST optimisation
- Prescription of benzodiazepines
- Provision of alcohol relapse prevention medication
- Provision of naloxone
- Sexual health care
- Wound care
- None of the above
- Other (please specify)

Q10) If you selected “behavioural/psychological interventions” in answer to the question above, please specify what these are.
[open text]

Q11) *As a facility, what proportion of the service(s) you offer is specifically dedicated for people who would be considered at a crisis point in relation to their substance use?
[single choice]

- All
- More than half
- Around half
- Less than half
- None
- I don’t know

If you operate in a **residential setting**:

Q12) How many places/beds does your facility provide (i.e. what is your maximum capacity) for **detoxification**?
[single choice; options: “we do not provide detoxification”; 1-30; “other (please specify)”]
Q13) How many places/beds does your facility provide (i.e. what is your maximum capacity) for **stabilisation**?
[single choice; options: “we do not provide stabilisation”; 1-30; “other (please specify)”]

Q14) How many other places/beds does your facility provide (i.e. what is your maximum capacity) not including for **stabilisation and detox**?
[single choice; options: “none”; 1-30; “other (please specify)”]

If you operate in a **community or outpatient model** (i.e. in a non-residential setting):

Q15)What is the maximum number of people that you are able to provide support to per month for **detoxification**?
[single choice; options: “we do not provide detoxification”, 1-30, “other (please specify)”]

Q16) What is the maximum number of people that you are able to provide support to per month for **stabilisation**?
[single choice; options: “we do not provide stabilisation”, 1-30. “other (please specify)”]

Q17) What is the maximum number of people that you are able to provide support to per month (**not including for stabilisation or detoxification**)?
[single choice; options: “none”; 1-30; “other (please specify)”]

Q18) *Thinking about **today**, how many people are currently attending your service?
[single choice; options: 1-30, “other (please specify)”]

Q19) *Thinking about **last month**, how many people attended the service on an average day (this may be the same number as above)?
[single choice; options: 1-30, “other (please specify)”]

Q20) *What is the average length of time people receive treatment at your service before they are discharged (not including unplanned discharges or repeated treatments)?
[open text]

Q21) *Is there a waiting list for your service?
[single option]

- Yes
- No

    [If ‘yes’ to Q21]
    Q22) What is the average length of time that people remain on the waiting list?
    [open text]

Q23) *Which of the following, if any, are specific criteria for exclusion from your service?
[multiple choice]

- Existence of a criminal record
- Existence of a specific mental health concern
- Individual is not at a point of crisis with regard to their substance use
- Profile of substance use
- No exclusion criteria
- Other (please specify)

Q24) *How often do people come to your service from the following sources?
[single choice; options: never, rarely, often, always, I don’t know]

- Local Alcohol and Drug Partnerships/Health Board
- Other ADP/Health Board
- Ambulance Service
- Accident and Emergency (A&E) departments
- Hospitals (not including A&E)
- Pharmacies
- General Practices (GP)
- Residential rehabilitation services
- Mental health services
- Family support services
- Housing services
- Social work referrals
- Armed forces
- Veterans’ services
- Police
- Prisons
- Probation Service
- Self-referrals/walk-ins
- Other (please specify below)

Q25) If you selected “other” in answer to the question above, please specify which and how commonly people come to your service from these sources.
[open text]

Q26) *Which of the following professions are currently employed by your service?
[multiple choice]

- Administrative support staff
- Medical staff (e.g. doctors, nurses, etc.)
- Psychologist/psychotherapist/counsellor
- Pharmacist
- People with lived experience of substance use
- Volunteers
- Other (please specify)

Q27) *Do you operate within any of the following regulatory frameworks? Select all that apply.
[multiple choice]

- National Health Service (NHS)
- Care Commission
- Healthcare Improvement Scotland (HIS)
- Internal/no formal external regulation
- Do not operate within a regulatory framework
- Other (please specify)

Funding

Q28) *How much does your service cost to run on a per person basis?
[open text]

Q29) *How commonly are people attending your service funded by the following sources?
[single choice; options: never, rarely, often, always, I don't know]

- Local Alcohol and Drug Partnership (ADP)
- Other ADP
- NHS
- Self-funded
- Charities
- Mixed funding model
- Other (please specify below)

Q30) If you have selected "other" above, please specify the source of the funding.
[open text]

Service user outcomes

Q31) *How does your facility measure outcomes for people using your services? Please provide details of any specific tools used and follow-up intervals.
[open text]

Q32) *Where do people who use your services typically go when they are discharged from your service?
[single choice; options: never, rarely, often, always and I don't know]

- Return home
- Placement in residential rehabilitation
- Other (please specify)

Q33) if you have selected "other" above, please specify where else people who use your services typically go and how commonly this is the case.
[open text]

Q34) Are there any other comments you would like to make that you feel are relevant to this research?
[open text]

Q35) *Are you happy to be contacted for the purposes of future research?
[single choice]

- Yes
- No

[end survey and thank you message]

Thank you for taking the time to take part in this survey.

Appendix B – Survey distributed to healthcare managers of Scottish prisons

Detoxification, Stabilisation and Crisis Support – Mapping and Capacity Survey (Prisons)

This survey is designed to collect information from Scottish prisons on the provision and capacity of detoxification, stabilisation and other crisis support services being delivered in prison settings.

The survey has been developed by the Scottish Government to better understand the support available in Scotland for people who use alcohol and/or drugs and **are at a point of crisis with regard to their substance use** within Scottish prisons. We are aware that some of these services may be described as detoxification, stabilisation or crisis care but may also be also have other names. A separate survey is being conducted for services outside of prison settings, so **please only provide information on the support/interventions being offered within the prison healthcare setting**. The findings of this research will be used to better understand the range of support available to people who use drugs and/or alcohol in Scotland and will contribute to policy-making. We hope to provide a summary report of the findings in early 2024.

The survey will be live until the 16th of November 2023 and should take about 5 minutes to complete. As we are asking about detoxification, stabilisation and crisis care services within the same survey, we are aware that not all questions may be relevant to you. However, we would be grateful if you could complete the survey to the best of your ability as gathering this information is essential to getting as a full of picture of existing provision as possible.

While the names of services will be listed in the report, findings will be reported on at an aggregate level. Data will be managed in line with data protection protocols. The data may be shared with Public Health Scotland for evaluation purposes and would also be reported on at an aggregate level.

Participation in this research is voluntary and you have the right to stop of withdraw your consent at any point during or after completing this survey. We would ask that you do so by the 16th of December 2023 to allow for analysis and reporting on the data gathered. If you have any concerns about how your data will be processed, please contact DataProtectionOfficer@gov.scot.

Note: questions marked by an asterisk (*) are compulsory

About you

Q1) *Name
[open text]

Q2) *Job title
[open text]

Q3) *Email address
[open text]

About your prison-based services for substance use

Q4) *Name of your prison
[open text]

Q5) *Location of your service (postcode).
[open text]

Q6) *Please select all substances for which treatment is offered within the prison (i.e. in-house).
[multiple choice]

- Alcohol
- Polydrug (not including alcohol)
- Amphetamines
- Benzodiazepines (prescription/street)
- Cannabinoids (including synthetic)
- Cocaine (powder/crack)
- Gabapentinoids
- Opiates
- Prescription-only painkillers
- None of the above
- Other (please specify)

Q7) *Which of the following interventions/treatments do you provide in the prison (i.e. in-house)? Select all that apply.
[multiple choice]

- Detoxification from alcohol
- Detoxification from drugs (e.g. street benzodiazepines)
- Behavioural or psychological interventions
- Blood-borne virus testing
- Prescription of Opioid Substitution Therapy (OST)
- OST optimisation
- Prescription of benzodiazepines
- Provision of alcohol preventative medication
- Substance use related wound care
- None of the above
- Other (please specify)

Q8) If you selected “behavioural/psychological interventions” in answer to the question above, please specify which these are.

Q9) How many people considered to be at a point of crisis with regard to their substance use can you provide treatment/support to per month (i.e. what is your maximum capacity)?
[single choice; options: options none, 1-30, “other (please specify)”]

Q10) How many people can you provide **detoxification** to per month (i.e. what is your maximum capacity)?
[single choice; options: “we do not provide detoxification within a prison healthcare setting”, 1-30, “other (please specify)”]

Q11) Are there any other comments you would like to make that you feel are relevant to this research?

Q12) *Are you happy to be contacted for the purposes of future research?
[single choice]

- Yes
- No

[end survey and thank you message]

Thank you for taking the time to take part in this survey.

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