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Good Practice in Abstinence Based Housing Projects Across South Wales

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Contents

Executive summary

Introduction: Little research has explored the effective practices used within abstinence based housing projects. Therefore, this study aimed to identify examples of effective practice used within abstinence based projects. The research also looked to obtain suggestions for service improvements from both residents and staff.

Methodology: In total 29 participants were interviewed (19 residents and 10 staff) from six different projects. All projects visited were based in the South Wales area. A semi-structured method of interviewing was selected, allowing for a consistent yet flexible approach. An interview schedule was designed to guide the interview process. Thematic analysis was used to analyse interview transcripts with the aim of identifying common patterns or themes within the data set.

Findings: Multiple examples of good practice were reported by residents and staff. Participants suggested the individualising of resident care was an essential determinant of the projects success in supporting each person. Effective staff support was also highlighted as a vital component of effective practice. Participants suggested staff should be non-judgemental, respectful and promote independence. Other examples of effective practice identified included the use of individual routines, responding supportively to relapse, communicating with other services, engaging residents in diversionary activities, group work and voluntary work, and promoting training and education. Suggested service improvements included the use of alcohol and drug-testing, increasing in-house activities, improving links with other services, allocating service users to projects away from their usual place of residence, and enhancing the transition of criminal offenders from prison into projects.

Recommendations: A number of recommendations are presented based on a comprehensive consideration of the evidence. Though, the applicability of recommendations should be considered within the context of each projects' individualities.

Conclusions: Overall, the research provides an original insight into the effective practices used within abstinence based projects and offers suggestions for improvements which may be of value to these services.

1. Introduction

1.1. Background

The prevalence of substance use disorders amongst the homeless is significantly higher than the general population (Fazel, Khosla, Doll, & Geddes, 2008; Greenberg & Rosenheck, 2010; National Coalition for the Homeless, 2009). An examination of surveys from North America and Western Europe estimated the prevalence of alcohol and drug dependence in the homeless at 37.9% and 24.4% respectively (Fazel et al., 2008). In contrast, for the general population rates of alcohol dependence are estimated at 5.95% and drug dependence at 1.56% (*based on statistics for the UK and USA*; World Health Organisation, 2004). To further complicate the issue, the rate of mental illness amongst the homeless is also considerably higher than in the general population (Bassuk, Richard, & Tsertsvadze, 2014; Madianos, Chondraki, Papadimitriou, 2013), and greater again in homeless persons with substance use disorders (Brunette, Mueser, & Drake, 2004). Consequently, homeless persons with substance use disorders represent a highly vulnerable population (Drake et al., 1997).

Stable, safe and supportive accommodation has been cited as an essential foundation for the successful recovery and re-integration of homeless persons with substance use disorders (Brunette et al., 2004). Research suggests housing-status is strong predictor of treatment outcomes, with those returning to accommodation following treatment being less prone to relapse than those returning to homelessness (Polcin, 2001). Moreover, homeless persons with substance use disorders do not typically respond well to out-patient based treatment services and adherence rates are usually poor (Drake, Mueser, Brunette, McHugo, 2004), further supporting the need for appropriate housing services.

Studies examining bespoke abstinence based accommodation services for this population are highly supportive of their value. For example, Tuten, DeFulio, Jones and Stitzer (2012) found opioid dependent individuals in abstinence based housing were significantly more likely to maintain abstinence compared with those receiving outpatient support. Abstinence based supportive housing is also likely to reduce the cost of this population to public services. Housing homeless individuals with substance use disorders in supportive housing programs has been associated with marked

reductions in hospitalisations (Martinez & Burt, 2006), ambulance usage, arrests (James, 1998), prison time and detoxification units (Larimer et al., 2009).

1.2. Present study

Despite the multifaceted benefits associated with abstinence-based housing programs for homeless persons with substance use disorders, little research has explored the mechanisms underlying their success. An increased understanding of effective practice from the perspective of both residents and staff, along with the identification of possible gaps or improvements to services would allow projects to make the necessary changes to best support residents in maintaining abstinence. Though, the absence of research in this area restricts the evidenced based development of these services. Consequently, the present study looked to explore effective practices used within abstinence based projects in terms of helping residents to maintain abstinence.

1.2.1. Research aims

The research had two primary aims: [1] To identify and explore examples of effective practice used within the projects in terms of people remaining drug/ alcohol free, and [2] To identify gaps within the support provided, identified by residents and staff. In addition, the research also looked to explore resident and staff views on a number of additional topics such as the use of alcohol and drug testing, involving criminal justice agencies in the service, thoughts on criminal offenders as residents, the location of service, routines, voluntary work, group work, and relapse response.

2. Methodology

2.1. Projects and participants

2.1.1. Projects

In total, six abstinence based projects were visited across six different counties. All projects were managed by the Wallich homelessness charity. Figure 1 displays each of the projects visited, illustrating their location and the number of residents and staff members interviewed at each project.

Figure 1: Map of Welsh counties and projects

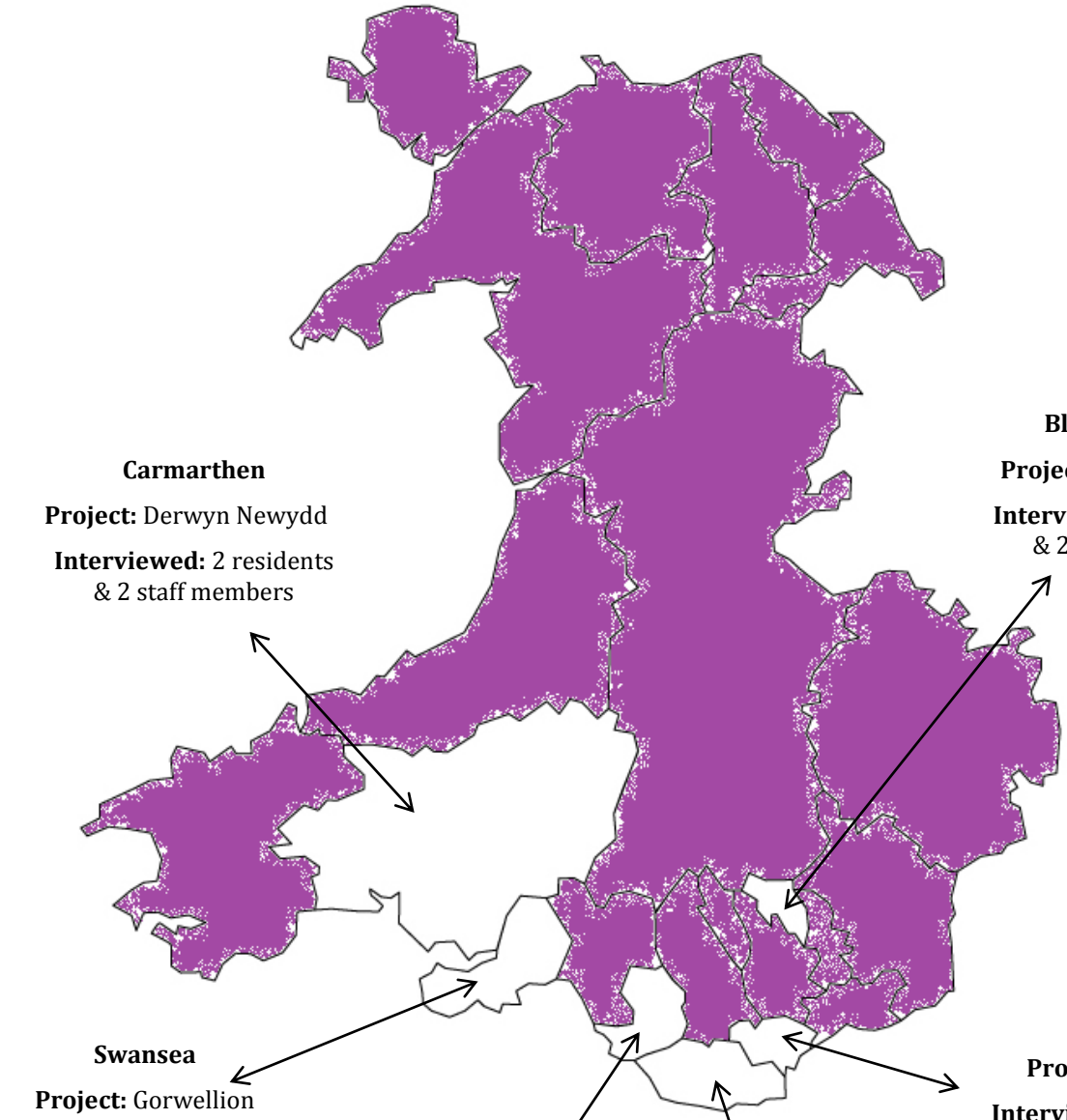


Image source: freeusandworldmaps.com

Derwyn Newydd is an eight bedded project based in Ammanford, Carmarthenshire. Of the eight units, five are designed for long-term residents, while three are emergency units providing short-term housing for those in immediate need. Support staff operate from within the service, offering 24 hour support. Each resident has their own flat with a kitchen, bathroom and living facilities, as well as access to a shared lounge and kitchen facilities. Residents can stay in the project for a maximum of two years.

Gorwellion project is based in Swansea and contains 12 units divided between three houses. Support staff operate from an office based within the core house of the three and offer support during the hours of 8am to 8pm, seven days a week (with floating and on-call support during the night). Gorwellion accepts individuals to the unit with a history of criminal offending, including Prolific and Priority Offenders (PPOs; I.e. individuals responsible for large quantities of crimes). All three houses are located within the city area of Swansea, with two houses located in the same street near the city centre and the third house on a separate street slightly further away from the centre. Each resident has their own flat with a kitchen, bathroom and living facilities, as well as access to a shared communal room. In addition, the core house has a shared lounge and kitchen facilities. Residents can stay in the project for a maximum of two years.

Vesta is a five bedded unit based near the centre of Bridgend. Support staff operate from within the service, offering support during the hours of 9am and 5pm, with an on-call support system operating outside of these hours. Each resident has their own flat with a kitchen, bathroom and living facilities, as well as access to a communal area with kitchen. Residents can stay in the project for a maximum of six months.

Ty Brynhybryd project contains five units and is based in the centre of Ebbw vale, Blaenau Gwent. Support staff operate from within the service, offering support from 9am to 5pm. Outside of these hours a concierge service operates within the project. Each resident has their own flat with a kitchen, bathroom and living facilities, as well as access to a shared communal area with kitchen. Residents can stay in the project for a maximum of one year.

Croes Ffin (Barry) project is based in the centre of Barry and contains nine beds divided between two houses. Support staff operate from an office based within one of

the two houses, offering support from 9am to 5pm. Each resident has their own flat with a kitchen, bathroom and living facilities, as well as access to a shared communal room. Unlike the other projects visited, Croes Ffin Barry provides clients with assured shorthold tenancies; thus residents are expected to demonstrate a level of independence and an ability to live within the community with only a low level of support. Residents can stay in the project for a maximum of two years.

Croes Ffin (Cardiff) project comprises three houses, each with three rooms and located in the suburbs of Cardiff. As with Croes Ffin Barry, these units are designed for individuals capable of living mostly independently in the community, receiving only a low-level support. Support staff are based in the Wallich's central offices based in Cardiff centre, visiting each house daily between the hours of 9am and 5pm. Croes Ffin Cardiff is the only project where residents live in a shared house with no staff presence in any house. Each resident has their own room with shared kitchen, bathroom and living facilities. Residents can stay in the project for a maximum of two years, though are encouraged to move on by nine months.

2.1.2. Participants

A total of 19 residents (13 *male* & 6 *female*; *mean age* = 35.6 years; *age range* = 21 – 50) and 10 staff members (5 *male* & 5 *female*; *mean age* = 41.9 years; *age range* = 28 - 65) took part in interviews. Of the19 residents interviewed, 15 were current residents while four had recently left the project and were living in the community. The length of time residents had been in the projects varied from six weeks to two years, with an average of 9.2 months.

2.2. Interviews

Recognising the diversity between residents and projects, a semi-structured approach to interviews was taken allowing the researcher to ask consistent questions from participant to participant while retaining the flexibility to pursue emerging topics in more depth (Flyan, 2005, p 65). An interview schedule was developed containing standardised questions along with a number of probes used to elicit information and clarify responses. Questions within the interview schedule could be loosely divided into two sections. The first section focused on the two primary aims of the research (i.e. identifying examples of good practice and potential improvements to services). Questions within the second section addressed a variety of topics including the use of

drug and alcohol screening, the location of the service and the involvement of criminal offenders. Resident and staff interview schedules were identical excluding minor wording differences. For example, the question for residents "*How does it impact you when criminal offenders become a resident of the service?*" became "*How do you feel it impacts the residents when criminal offenders come into the service?*" for staff (*see appendix section A & B for interview schedules*).

Interviews with residents and staff all took place within the projects - typically in staff offices or communal areas. All residents were interviewed separately. In three of the four projects where two staff participated in interviews they were interviewed together. Interviews were digitally-audio recorded and transcribed verbatim following the completion of each interview. Interviews ranged between 15 and 90 minutes in duration, averaging approximately 35 minutes.

2.3. Data analysis

Thematic analysis was selected as a systematic method of analysing interview transcripts. Thematic analysis is used in qualitative research to identify, analyse and report themes or patterns within the data (Braun & Clarke, 2006). Guidelines for conducting thematic analysis developed by Braun and Clarke (2006) were followed to enhance the transparency and replicability of the analysis process. The researcher adopted a realist epistemological perspective during analysis due to the objective nature of the research aims. Resident and staff interviews were analysed together allowing for the identification of similarities and differences between groups.

The first stage of analysis, data familiarisation, began with the transcription of each interview and the subsequent thorough reading of transcriptions. Following this the researcher examined the entire data set, developing codes (captions for interesting features in the data) and collating supporting quotations. Next the researcher began the process of identifying overarching themes within codes and gathering all supporting data for each potential theme. Codes also informed the development of sub-themes representing specific features of broader themes. Themes were defined as any patterned response within the data representing meaningful information in relation to the research aims (Braun & Clarke, 2006). Themes were identified at the semantic - as opposed to latent - level, meaning the researcher did not look to explore beyond what participants said, instead organizing and explaining data at the surface level.

Prior to theme identification the researcher developed two categories labelled "Effective practice in abstinence based housing" and "Current gaps in practice" based on the two primary aims of the research. All identified themes were assigned to one of the two preconceived categories. Following initial theme identification all themes were reviewed, removing those with insufficient supporting data and combing like themes where appropriate. With the final themes established, a thematic map was developed to display themes and sub-themes and the relationships between them. Lastly, all themes and sub-themes were reviewed in relation to transcriptions to ensure they accurately represented participants' reports.

Where appropriate, quantitative data was used to supplement the thematic analysis. For example, broad themes that represented views on a particular topic (e.g. criminal offenders) were supported by data displaying the number of people in favour of each contrasting view (i.e. supportive vs. not supportive).

2.4. Ethical considerations

Prior to commencing interviews all participants read and signed a consent form outlining the purpose of the study and their ethical rights (*see appendix section C & D for consent forms*). Resident and staff consent forms differed slightly in wording, though both informed participants of their right to withdraw from the interview at any time, their right to have any or all of the information they provided removed from the findings, and assured participants that the information they provided would be stored confidentially and reported anonymously. Participants were also assured their involvement in the research and the views they expressed on the project would not in any way affect their tenancy; or employment in the case of staff. Following each interview all participants were given the opportunity to ask questions and provided with the contact details of the researcher should they have any further questions regarding the study.

3. Findings

The following section presents the results of the thematic analysis of interview transcripts. The names of all staff and residents are replaced with pseudonyms to protect their anonymity. Organisation and place names are also omitted to further protect anonymity. In total 20 themes and 13 sub-themes were identified within the two categories. Throughout the findings section each theme and sub-theme are assigned a label ("*resident*", "*staff*", or "*resident and staff*") dependent on which participant group (or groups) they apply to.

It is important to note that, although themes represent common patterns within the entire data set, it may not be the case that every theme is applicable to every abstinence based project visited. Each project varied significantly in terms of the residents, the location, and the level and type of support provided.

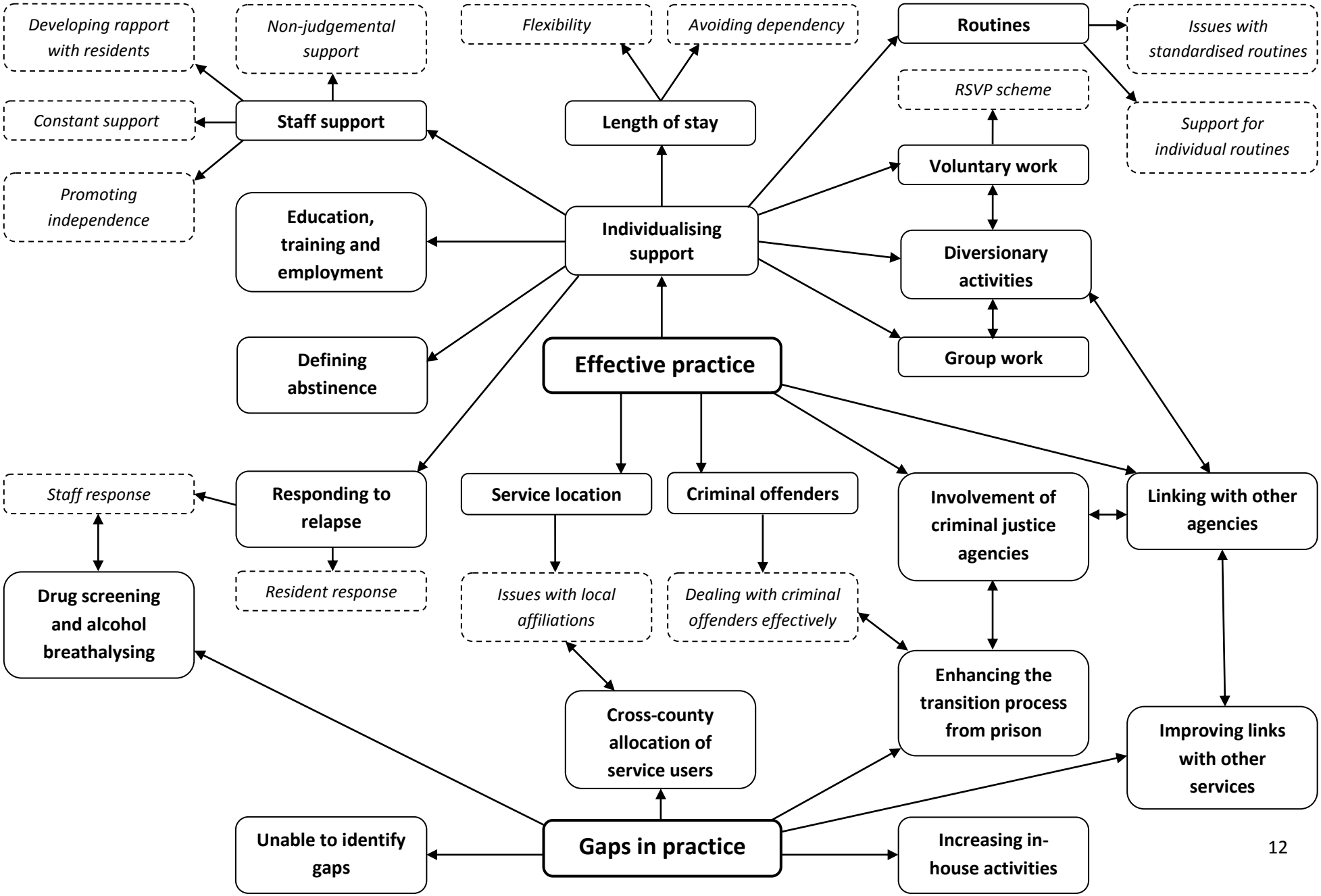
All themes and sub-themes, as well as the complex relationship between them, can be seen in *Figure 1*. Themes are displayed in solid outline text boxes and sub-themes in dashed outline boxes.

3.1. Effective practice

Within the category of "Effective practice" multiple themes were identified representing participants' views on what they felt is effective practice in abstinence based housing projects. Both residents and staff were able to draw on their experiences to report multiple examples of good practice used within the projects. Both groups were also able to make recommendations as to how best support residents in maintaining their abstinence within the context of various topics (e.g. drug screening, responding to relapse). Overall, all residents were highly positive about their experiences within their specific project, being quick to praise staff and the wider organisation:

> *"**Interviewer:*** Okay, so how's it been since you've been here?
>
> *"**Antony (resident):** Fantastic, got to be honest with you"*
>
> *"**Greg:** this is the best thing that's ever happened to me."*
>
> *"**Jack (resident):** To be fairly honest I've seen my support here as excellent"*
>
> *"**Fiona (resident):** at the moment I wouldn't want to be anywhere else"*
>
> *"**Geoff (resident):** it's been absolutely brilliant."*

Figure 1: **Thematic map of findings**



Individualising support *(residents and staff)*

The notion of individualising the support provided to residents was an overarching theme across the entire data set. All staff and several residents referred to the importance of adapting support to each resident based on their individual characteristics, needs and current situation:

> *"**Norman (staff):** I think that is the key and (staff member) and I do talk an awful lot about different ways of working with people and different, adopting different tactics if you like of dealing with somebody, because everybody's so diverse, the clients here are so diverse… the diversity between them is huge… That's also very important because that, that's key, 'here's a set of rules, this is the way we work', it doesn't work because 'you're different, you're different, you're different'… our clients are very, very different in how you talk to them to how you encourage them or what to expect from them is very different."*

> *"**Percy (staff):** I think we're good at recognizing, it sounds an obvious thing, but that all the individuals are different, you have to sort of deal with each person on their individual merits and whatever their characteristics are and the recognition that one approach might work with one client, but it won't work well with another, you can't have a one size fits all sort of philosophy to say."*

> *"**Gail (staff):** It's hard to give blanket answers because every kind of situation is different."*

This theme was linked to several other themes within the category of effective practice. That is, participants often discussed the importance of tailoring support to the individual when discussing other topics such as routines, staff support, relapse response and diversionary activities. Staff cited individual support plans as an essential measure in ensuring personalised care:

> *"**Jennifer (staff):** so what we would do is do a support plan first of all, well do an assessment of all their needs when they first come in, from that we'd devise a support plan, the clients support plan, it's important that it's theirs and has their input, every client is different, so we need to know their particular needs."*

Staff support *(residents and staff)*

The theme of "Staff support" symbolized a vital and multifaceted aspect of effective practice in abstinence based housing. Every resident and staff member referred to the importance of the resident-staff relationship in ensuring the effective

support of residents to maintain abstinence. When questioned regarding the helpful aspects of the project all participants referred to the support they received from staff:

> *"**Daniel (resident):** The staff help; the quality of the care they gave me... the staff really, one to one support, they never gave up on me"*
>
> *"**Scott (resident):** Every staff member here has been brilliant"*
>
> *"**Greg (resident):** he's* (staff member) *excellent, I can't say any more about him, he's brilliant, he's been a life saver to me since I've been here. If it want for him I'd have been back in jail by now, he keeps me on the straight and narrow, he does so much right for me I'd be here all day trying to tell you. He does like, he does everything for me, he's good, he's wicked like."*

Within this central topic four sub-themes were identified, each illustrating a different pillar of effective staff support as suggested by residents and staff. The four sub-themes were labelled "*Developing rapport with residents*", "*Non-judgemental support*", "*Constant support*" and "*Promoting independence*".

Developing rapport with residents (staff)

This sub-theme was identified within staff transcripts and represented the view that developing a strong rapport with clients is a measure of good practice for staff in abstinence based housing. A good rapport with the residents was seen as the foundation staff support, without which the other aspects of support were not possible. Indeed, staff cited the quality of the resident-staff relationship as a key determinant of their ability to support the resident in maintaining abstinence:

> *"**Norman (staff):** "I think the best practice is building a relationship with a client, if you haven't got a relationship then you've got nothing."*
>
> *"**Jennifer (staff):** "I think personally it's down to relationships, so you've got to have a good relationship with the client for anything to work."*
>
> *"**Bob (staff):** It's building the rapport, the rapport I think is especially important, I think* (staff member) *and I are good at building rapports with clients we've had… you build this relationship with them, you've got to have this relationship with them, this working relationship."*

Although this sub-theme was developed based on staff interviews, reports form residents regarding the quality of their relationships with staff corroborated its development:

> *"**Peter (resident):** she was more like a friend, you know, than, than more of like a support worker, I had all of the support I needed. It was just that extra little bit she put in, it just made you feel like… I don't know how to explain it; she just made me feel so comfortable… I talked to her a lot"*

> *"**Greg (resident):*** (staff member) *is the best support worker I've ever, ever had, I class him as a mate as well, he's really, really, he just motivates me"*

Non-judgemental support (staff)

Staff also suggested providing non-judgemental, respectful support to residents was a key component of effective staff support and a significant determinant of a good resident-staff relationship. Typically staff referred to the notion of providing non-judgemental support when asked what it is they do which helps residents to maintain abstinence:

> *"**Georgia (staff):** we do provide a service where we do respect them as individuals, as opposed to thinking "oh yeah they're just an ex druggy or alcoholic" kind of thing. We're not judgmental and I think that's very beneficial in that they're more likely to kind of trust us then, work with us if you know what I mean"*

> *"**Frank (staff):** "You've got the added value on that then, is very much how we work with that person in a very humanistic way, we value that person and recognise the choices that they may take"*

Constant support (residents and staff)

Both residents and staff discussed the importance of staff support being consistent and readily available when residents were in need:

> *"**Katie (resident):** Just knowing that you've got the support, and if you are having trouble you can go to them, even me who will sit there and think 'oh I can't say anything', I feel like I can go to* (staff member) *and* (staff member) *and say 'I think there's a problem'."*

> *"**Frank (staff):** "I guess consistency of support, that's a key stone as well, I think we can offer that"*

> *"**Daniel (resident):** Well, never giving up on me, they had the right to kick me back out, I relapsed a few times, but they never gave up on me, constant support."*

In particular, in projects where staff were present 24 hours a day, the unbroken availability of staff was highlighted by residents and staff as a strong quality of the project:

> ***"Peter (resident):** I think there being someone here at all times has massively helped, obviously they've got the day staff but they've also got the security in the night, but all the security guards are brilliant as well… because when I'm bored in the night, whereas before I would go and think "where's the party?" … So I have liked the support from them, it's good like I said that they are here at night and stuff, because if they wasn't here it would be more chance I could relapse or there'd be more problems, I could be drinking and stuff in here"*
>
> "**Georgia *(staff)*:** *I believe that we're good at in that someone's always here in the project, 24 hours a day, so if someone was in crisis they've got an option then to come to a member of staff, have a discussion or a chat, just let off steam or what have you. So I think that's a massive bonus."*
>
> *"**Ken (resident):** I know there's always somebody here for me to talk to like, that gives you confidence… staff are 24 hour so anytime you want a chat, like I said, the people here are tidy like"*

Where projects did not offer support 24 hours a day some participants suggested this was something they would benefit from:

> *"**Jennifer (staff):** so it would be nice to have a presence, not so much a support worker, but a regular presence in the evenings"*

Promoting independence (residents and staff)

The final pillar or staff support identified was the notion of promoting resident independence. Promoting their independence was frequently reported by residents as a beneficial aspect of the support they had received from staff. In particular, residents suggested they wanted to be guided and supported with tasks such as volunteering and diversionary activities, but not feel pressured or as if staff were doing everything for them:

> *"**Kath (resident):** I wasn't pressured to go, and this is what I mean, because it promotes independence, they were there to hold your hand a little bit, give you a bit of guidance,*

but you're very much taking back control of your life, you know, and it's very empowering"

Staff also addressed the importance of promoting resident independence, particularly with the view of preparing them for life beyond the project:

> *"**Percy (staff):** as support workers, that's our role, to say well 'this is, this isn't somewhere you can just settle now, this is the transitional point whereby, and we're happy to assist in that but it is very much, you know a spring board for independent living.'"*
>
> *"**Frank (staff):** not replicating then the rehab stuff, they've done a couple of years in rehab they come here, they've found their feet and the focus should be on um life skills… You should really be looking at life skills like coping, holistic skills, promoting independence… I think we should be looking at delivering, in whatever we do, developing personal resilience, preparing them for the big bad world again.*

Education, training and employment *(Residents and staff)*

Similar to the sub-theme of promoting independence, but sufficiently distinct to warrant the development of a separate theme, this theme represented resident and staff views on the importance and benefits of staff promoting career progression through education, training and employment. This notion is illustrated well in a short conversation between a resident, Aden, and the interviewer:

> *"**Aden (resident):** she got me in the college, a computer course in the college, it's only a 6 week course, but she got me the course with the college and I done that.*
> ***Interviewer:** Have you done that now?*
> ***Aden:** Yeah completed that, just waiting on my certificate now.*
> ***Interviewer:** How was that?*
>
> ***Aden:** That was brilliant because I didn't have a clue, I could barely switch them on like, but that's great because now, where I'm on JSA now and I've got to do the job search on the computer, I can do all that now on the computer and before I didn't have a clue about it, so I know how to do it now. That's the good thing as well, I have asked them as well that I'd like to get better on my Math's and English, so I've mentioned that to* (staff member), *she's gonna sort out that for me. I'd like to get better because I'm not perfect at reading or writing all the time, but I'd like to get better at that as well."*

Staff often emphasised the promotion of career development as an example of good practice they were currently implementing:

> *"**Norman (staff):** training and education forms a big part of the support plans, to focus on what qualifications and what training clients have had and what they would like, where they would like to be in two years after they've left us? We do try and plug them into training or education"*

> *"**Ryan (staff):** we provide workshops here, um, predominantly we provide workshops that create independent living skills, so budgeting, cooking on a budget, confidence building and things like that."*

Diversionary activities *(staff and residents)*

The use of diversionary activities both within and outside the project was seen as an effective practice in supporting the residents in all projects. Both staff and residents referred to the multiple benefits of such diversionary activities, including keeping busy to prevent boredom, distraction from drug or alcohol related thoughts, increasing self-esteem, and general enjoyment.

> *"**Jennifer (staff):** Um right diversionary activities, that's another thing I forgot to mention, obviously they're a huge thing that we use with clients because that obviously diverts them away from substances using or mixing in social groups. Boredom is probably one of the worst things"*

> *"**Amy (staff):** I try to set up either things within either the Wallich or in the community to keep them busy, um, so boredom isn't a trigger then for that substance misuse. Yeah I'd say that would be one of the major things that we work towards, kind of engaging them in that diversionary activity"*

> *"**Jack (resident):** Activities like we did a quiz, there was the garden, the gardening project that they've done… it was involvement, I think encouragement and actively being involved with other people, because I think one of the biggest knocks you get I think through homelessness is a lack of, a loss of your self-esteem. I don't know if it's self-esteem, confidence if you like, you lose your confidence and I think being encouraged to take part in things, or even just to socialize with other people you know, that starts to bring the confidence back again and I think that was really beneficial."*

> *"**Ian (resident):** Well, it might seem boring to some people, but when you're actually doing it with a group of people that you enjoy the company of, it made for a good day, and then it kept you occupied, and if that was my mind rested for three hours, it wouldn't*

*have rested for an hour normally, so that was pretty good too. Just to get out and do something.***"**

*"**Aden (resident):** we was just all talking out the back having a laugh, they're seeing how we're doing, just a casual laugh having a barbeque out the back, hot sunny day, brilliant like, can't fault it."*

Examples of diversionary activities used within projects included gardening tasks, social cooking events, voluntary work, barbeques, fitness classes, skill building workshops, orienteering, group work sessions, hiking and day trips to local attractions or other Wallich services. Staff also highlighted the importance of residents accessing diversionary activities provided by other services, thus the theme was closely connected with the theme "Linking with other agencies". As with the other aspects of support, staff and residents suggested diversionary activities should be tailored to the individual, as preferences are likely to vary from person to person. This issue gives additional weight to the recommendation of using external services to access diversionary activities, as it is unlikely that a single project can cater for the diverse preferences of all clients.

Voluntary work *(staff and residents)*

Engagement in voluntary work was viewed positively by residents and staff. Within the theme one sub-theme was identified labelled "RSVP scheme", referring to the Wallich in-house volunteering program. Several residents reported that they were currently or had recently engaged in voluntary work while in the project. Other residents stated they had not yet started volunteering, though it was something they wished to do. Voluntary positions were undertaken in a variety of fields including hairdressing, gardening, teaching, supporting youth offenders and recovery related support work. Overall, residents were very positive about their volunteering experiences:

*"**Kath (resident):** I love it, I absolutely love it, and although it's voluntary, it's working towards, I mean I haven't worked in years, you know, since I was very young, and it's given me like experience, it will open up a lot of doors"*

The suggested benefits of volunteering were multifaceted and included developing confidence, giving a sense of purpose, increasing skills and enhancing employability:

*"**Amy (staff):** Um, well I think it's (volunteering) diversionary as I say, gives focus, gives a sense of purpose where people may have spent a lot of time out of employment… gives them confidence to know they can do things they have done previously but they've lost confidence"*

*"**Gail (staff):** "Well it gives them a sense of purpose, a reason to get up in the morning as well"*

The only issue reported with volunteering was by a staff member who stated residents sometimes believed volunteering may negatively affect their benefit entitlement.

RSVP scheme (staff and residents)

The RSVP scheme stands for the Resident Service User Volunteer Program, a within-project volunteering scheme for residents of abstinence based housing projects. Within the larger theme of volunteering the RVSP scheme was a predominant topic.

*"**Frank (staff):** the RSVP scheme it enables people to have just a taster, you know, and that is important you know. It's kind of a massive, all skills base, for whoever comes in, drink, drugs, okay you've got passed that, let's go back to the human person, look at their different skills, what can you do? What can you do for the Wallich? And we can just give them a taster, which can be a weekly thing, it could be a monthly thing, or just a one off, you know. I think people take on board, with a little bit, you know it felt okay, and that can be the cause then of the ultimate goal of employment for people."*

The benefits of the scheme were again multidimensional, including all those stated for general voluntary work, while also having some benefits specific to the scheme. One particular advantage of the internal scheme was that it allowed residents with mental health or confidence problems to volunteer in a safe, familiar environment:

*"**Katie (resident):** Well I just do, I just do mostly based in the project, do I do admin stuff for the office and things like that, because I'm not really able, or physically haven't been able to do voluntary outside so I do admin and I keep the stairs clean, floors clean.*
***Interviewer:** How do you find that?*

***Katie:** Great, oh yeah, it's good to be able to do something because I feel quite left out when everyone's volunteering to do this, volunteering to do that, outside the Wallich, and I can't mentally do that, so they bring it in to me which is great."*

*"**Jennifer (staff):** all clients are offered to do things outside of the Wallich. A lot of them with anxiety issues prefer to stay within their own area if they like"*

Staff also praised the scheme's ability to promote confidence and increase residents' sense of self-worth:

> ***"Ryan (staff):*** *It's a simple thing like (staff member) said, putting information together which is quite simple to do, it's very simple to do. However, we're giving the responsibility to her saying 'can you do this for us? We need this' and she's saying 'Wow, somebody's giving me that responsibility; they must think something off me'. So a simple thing like that is building up her character, building up her self-esteem, and that's what we're here for. She's thinking 'wow, someone thinks something of me for a change.'"*

> *"**Jennifer (staff):** I think it's very useful to have some kind of diversionary activity, it gives people a sense of worth and it helps them show off their skills. So this RSVP's great because I'll say "oh can somebody build me something out there?" and they'll do it, so yeah that's really important.*

Group work *(staff and residents)*

Involving clients in group work was seen as a positive practice by staff and the residents themselves. Most residents reported accessing some form of group-related activity, though the majority did so in external agencies related to drug and alcohol use, recovery or criminal offending. However, some projects did offer group work activities within the project on occasion. Group activities offered included mindfulness sessions, relapse prevention, and those focusing on skill development. In one project, a staff member running a weekly group reported allowing a resident to take over and facilitate the group:

> *"**Jennifer (staff):** I did run a relapse prevention group… some of them loved it and some of them hated it. One of my clients did it once and it was the best, they all told me it was much better than my groups* (shared laugh)*, which is great because that's what it's all about."*

A resident within the same project who was interviewed referred to this particular group, commenting on how enjoyable it had been with a resident running the group:

> *"**Ian (resident):** one of the best sessions we had is when she gave it to one of the clients to do. Where they ran the support group, and obviously there was a bit of a laugh, which there is when* (staff member) *was doing it anyway. But it was just, makes it a bit easier and a little bit better"*

Residents reported multiple benefits of engaging in group work, including benefiting from group feedback, clearing their minds, learning from the stories of others and meeting new people:

> *"**Scott (resident):** Feedback, feedback you know, feedback on how people feel about the centre or what's going on, talking to each other, coming up with ideas sort of thing"*
>
> *"**Aden (resident):** it gets you to talk about your past and that, it helps you a lot because it gets things out… you get to meet new people and that as well, it's really good in the long run because it helps you get everything out and clears your mind, and you're meeting new people as well."*
>
> *"**Jack (resident):** It also develops conversational skills, builds trust up in other people as well, you learn to trust other people in a group situation and of course if there are people there who are on a good solid recovery then that's obviously beneficial to those who aren't, uh because they can identify and relate to the issues that people are going through.*
>
> *"**Kath (resident):** I think groups like that are really important just to remind you 'god it was s**t back then, I really don't want to go there'… and to meet people as well because, for me, I left you know, my friends behind you know, because they were still using and stuff, so it was dangerous for me to, dangerous territory, and so, you know, meeting new people, new friendships based on other things, not drugs or drink."*

Linking with other agencies *(staff and residents)*

Linking and communicating with other agencies involved in the support of residents was cited as being good practice by staff members, particularly in projects with limited staff. Staff believed this allowed the project to have a greater understanding of residents' support network and progress outside of the project. They also emphasised the importance of communication between agencies to ensure the consistent and cohesive support of residents:

> *"**Jennifer (staff):** to make it successful here I think it's, um and obviously with me running it on my own, I rely heavily on networking. Lots of the guys here are prolific offenders or have come from prison so when I start support with the clients I always make sure they have meetings where the client is involved with their wider support network a well, so it might be a community mental health worker, a drug worker, the PPO team or IOM team as their called now, or probation and all that. So um, they feel fully supported right from the beginning and it's easier to keep track then of what's going on. It's about keeping on top of*

things then, making sure we're all linked in together and communicating basically. You know we look out for changes in behaviour and things like that, and try and get on top of things before there are lapses, relapses."

*"**Amy (staff):** "I think a number of our clients come with a lot of community links already set up and whether it's with substance misuse agencies like* (organisation name) *or* (organisation name), *I think trying to establish links with those as well and kind of talk with their probation, with their support, it kind of gives us, it keeps us up with what's going on in the community and you're better able to monitor how they are doing with their abstinence in terms of maintaining it."*

Staff also reported regularly signposting residents to external agencies outside the Wallich. Reasons for linking residents to other services included increasing relapse support and access to diversionary activities, suggesting it resulted in a more comprehensive support system for residents:

*"**Ryan (Staff):** Well we work closely with alcohol and drug providers* (organisation name)*… so we work very closely with them to, firstly it provides a safety net, if they are going to relapse, because relapse is part of the process really, so if they have a relapse they can access there. So they have all the relapse prevention techniques, and a lot of diversionary activities which can be art, cooking you know just things to occupy the mind and take their mind away from it really."*

Residents supported suggestions from staff, stating that they regularly used other services to access groups or diversionary activities and were positive about such experiences:

*"**Ian (resident):** "it was the referrals that were made to the different supporting agencies, and they all helped me but they all helped me with individual problems"*

Routines *(staff and residents)*

During the discussion of routines, residents and staff were questioned about their views on both a standardised routine for all clients and on individual routines for each client. The most prevalent views in the responses to these questions resulted in the development of two sub-themes labelled "*Support for individual routines*" and "*Issues with standardised routines*".

*"**Connor (resident):** Well that's the whole point of doing it isn't it, to get into a decent routine, a normal routine, being normal for once, they help."*

When discussing routine, staff stated they have standardised rules to promote routine and active lifestyles. For example, they always ensured residents were not simply sleeping all day and were instead engaging regularly in activities facilitative to their recovery and independence:

> *"**Ryan (staff):** we don't try to do that where we're going to ring a bell and ask everyone to get up at a certain time. However, we're not going to have everybody staying in bed at 2, 3 o'clock in the afternoon and we leave at 5. That's not good for when they leave here, I don't think that's empowering them at all. However, obviously we're not going to be ringing bells and saying get up and setting fire alarms off."*

> *"**Jennifer (staff):** So yeah, we don't really have anyone sitting around all day, and that's made clear to them when they start their support here, that's not what the project is about, it's about coming here, progressing away from that old lifestyle and getting involved in things."*

Support for individual routines (staff and residents)

Overall, a substantial amount of support was identified for the concept of individual resident routines, supporting the development of this sub-theme. Both residents and staff spoke positively of the use of individual routines within the abstinence based projects:

> *"**Norman (staff):** I think the routine is very important. But I think it's an individual routine... I'm not sure whether that daily routine, on mass is good. We try and work out a routine for each client, I don't think any clients here are not doing something every day."*

> *"**Greg (resident):** That's what I've got, I'll show you now* (goes to get routine planner)*, See start from Saturday, I've got computers with* (staff member)*, then I've got cleaning flats at* (location name)*, tools for recovery with* (organisation name)*, SMART recovery, probation, so that's what I does in a week, I've got something to do every day.*

> ***Interviewer:** And is that helpful?*
> ***Greg:** Yeah of course it is, it's kept me on the straight and narrow. "*

Residents and staff suggested the benefits of individual routines included increasing motivation, providing structure to a previously chaotic lifestyle, keeping residents active, and helping them prepare for life after the project:

> *"**Ryan (staff):** We do it, we do agree with daily routines because we like that structure. If that structures in place it keeps their mind active"*

*"**Georgia (staff):** I think it's good for people who have a tendency to kind of stay in bed most of the time or for people who have never had a routine in their life. So sometimes if they're not used to it and if they were introduced to it they may enjoy it, more of a get up and go in them possibly. So I think it's good for individuals who have no routine, have no oomph in them you know"*

*"**Percy (staff):** Yeah, I mean personally I think that, yeah in many ways it* (routine) *is a good thing and um, obviously the reality of life is that every individual has to conform to some time scale, we have to attend appointments and so forth and I think in that respect, I think to sort of state that the client comes to the project and meets with you once a week, at a specified time, is both good for them and obviously for us as well."*

Issues with standardised routines (staff and residents)

While participants were positive about the use of individual routines, it was clear that the concept of a structured, standardised routine for all residents was viewed negatively by all staff and most residents. The three main issues discussed were residents disliking the "*institutionalised*" nature of a standardised routine, residents not following the routine, and issues with standardising the care for the diverse client group:

*"**Jack (resident):** I think a completely structured day would never work, people are going to rebel against it. Uh, a lot of people if you say you have to get up at this time in the morning there's immediately going to be issues where there's going to be conflict because people will oversleep, people are going to do that. I don't know, I really don't know whether that would work."*

*"**Jennifer (staff):** what you've got to bear in mind is that some people come here with serious mental health issues, some people might not sleep all night so they might stay in bed till midday or whatever, so we have to take all of that into account"*

Staff and residents highlighted how many residents had come from a background, such as prison or rehab, where a shared routine was mandatory, thus abstinence based housing projects should represent the next step in progressing to independent living:

*"**Bob (staff):** It's finding the balance, because you get the routine in prison where they're told basically what time they're going to get up, what time they're gonna have a shower, what time they're gonna eat their food, what time they're going to sleep. They go to rehab where it's a little bit easier, but they still have times where they've gotta be certain places*

doing certain jobs. So you'd like to think it would be a little bit more of a step along the way to their independence by coming to us"

Length of stay *(residents and staff)*

The amount of time residents were allowed to stay in projects ranged from a maximum of six months to two years depending on the project. Two sub-themes were identified from the discussions surrounding length of stay: "*Flexibility*" and "*Avoiding dependence*".

Generally when questioned about the length of time they were allowed to stay in their project residents were happy with the restriction:

*"**Katie (resident):** I think 12 months gives you enough time, the thing is you don't want to be rooted for too long, it seems like an adequate amount of time to me, even though it's just gone so crazily fast."*

However, in projects where the restriction was set at less than a year, two residents and a staff member suggested this may be insufficient:

*"***Interviewer:** is there a limit on how long you can stay here?
***Lewis (resident):** 6 months I think.*
Interviewer: Okay, so how do you feel about that?
***Lewis :** I think it should be longer, if it went to 9 months, know what I mean, coming out of prison it's going to take you a couple of months just to get your head sorted, because my head still hears keys, but if you gave it 9, like say 9 months... So it would be nice if it was like 9 months, 12 months, know what I mean, give the boys time to re-adjust."*

*"**Amy (staff):** it's a 6 to 9 month project... in the time I've been here, I haven't really identified anyone who would be totally ready within 6 months, or even 9 months... So I think 9 months is quite a short time."*

Flexibility (staff)

One common opinion expressed by staff members was that the length of time a resident is allowed to stay in the project should be flexible if needed. That is, residents should not be forced to leave on the exact day their time restriction ends if they are not fully prepared to live independently. Staff believed that, although there should be a time restriction, each resident should be assessed individually and certain circumstances may render it appropriate for them to stay in the project for longer than the maximum

time, while at the same time recognising that some may be ready to leave earlier than others:

> *"**Jennifer (staff):** I mean if somebody needs further support I would ensure that they have adequate support until they moved on, um, but some people, you might have addressed their support needs early on, so keeping them here is not doing them any good at all, it's important to move them out of this environment then to independent living, if they're ready to move on, if they're not they'll stay here until they are."*
>
> ***"Sue (staff):** Obviously the year to date doesn't happen, we don't go 'Right, pack your bags'… Because we have in the past had clients here for 2, 3 months after their leaving dates was.*
>
> ***Ryan (staff):** Yeah because unfortunately we can't imagine up accommodation, it's when they become available really, and the right accommodation for that person.*
> ***Sue:** We wouldn't say 'you have to take that property' because that's going to have a knock on effect then."*

Avoiding dependency (staff)

One potential issue surrounding residents' length of stay highlighted by staff was the possibility of residents developing a dependency on the project. Staff suggested this was pitfall in allowing residents to stay too long inside the project or beyond the recommended time restriction:

> *"**Frank (staff):** I'd say one of the biggest problems I've seen, this is my observation is that, however long people are here, that there's a big risk that they'll develop that dependency on the place, or dependency on a worker, which isn't healthy. When you do have that dependency then you also lose a lot of personal resilience. I think people then who are maybe ready to move on, all of a sudden then a lit drama comes and they're not able to cope with the drama and rely on the project, and then eventually you're going to be in the big world potentially be housed in some housing estate or social housing you know, where you haven't got that kind of comforts of it."*

Service location

All residents and staff were asked to discuss their views on the location of their project. One sub-theme was identified within the discussion of service location labelled "*Issues with local affiliations*". When questioned regarding the service location residents and staff frequently cited being in close proximity to amenities, other support agencies

and travel services as advantage of the location. Thus, being near a town or city centre was viewed positively:

> *"**Peter (resident):** Yeah I think so, yeah, I think it is, I think this building is in quite a good place. It's a good location because if you ever need to go into town shopping, it's quite accessible to everywhere which I think is good, and obviously it's on the main street up that way and a main street up that way, and the main road is down there, so I think it's a good location"*

> *"**Georgia (staff):** I think it's good, location wise, because we're not like centre of town, we're close enough but not too close if you know what I mean. I mean, we're really fortunate in the sense that we're near a bus stop, and there's quite good transport links here. I think it's good to be fair"*

> *"**Daniel (resident):** "It's ideal for the services in (location), they're all within walking distance, and if you're in the criminal justice, abstinence, harm reduction, they're all in one street. It's not far to the police station or the courts either."*

However, staff in one project recognised the issues with one of their projects being near the city centre:

> *"**Bob (staff):** My personal opinion is that we're setting people up to fail straight away, because (project location) is probably the easiest place in (city name) to get drugs, it's the epicentre of drug use in (city name)."*

> *"**Norman (staff):** Clients from here say "please don't send me to* (project location) *because I'll fail"… if that could come out in your report it would be brilliant because we've asked to swap the flats for something somewhere else. It's phenomenal, you can sit in one of the flats, there's a set of stairs running up and you can watch them injecting up there, you can watch them dealing, any time day or night, I could take you down there you could watch it going on."*

Issues with local affiliations (staff and residents)

A common issue raised by residents and staff during the discussion of service location was the problem of residents having local affiliations with persons with whom they had previously used drugs or alcohol with. Residents implied these local affiliations hindered their recovery:

*"**Lewis (resident):** It's okay, with me if I go into the town centre I'll bump into old friends, and that's doing my head in, its causing me a lot of grief you know…. I don't think it's helping, too many old friends and faces."*

*"**Connor (resident):** I was quite lucky because I didn't know anyone around here at first"*

Responding to relapse *(staff and residents)*

In relation to relapse response residents were asked two questions: [1] How they would respond to a peer in the project relapsing, and [2] how they feel staff should respond to relapses. Staff members were only asked the latter of the two questions. These questions resulted in the identification of two sub-themes: "*Resident response*" and "*Effective staff response*".

*"**Ryan (staff):** Relapse is part of recovery and something we work with rather than against."*

Resident response (residents)

Residents' views on how they would respond to relapse varied. Many stated they would try to help the individual, while others believed they would avoid the person to avoid potentially relapsing themselves.

*"**Tim (resident):** So it doesn't bother me really, I'd probably try to help them like, or if they wanted to chat"*

*"**Jack (resident):** it hasn't happened that much, but I have noticed, you spot signs and I've just kept away from it, avoided that person if I've thought there'd be any temptation, I didn't want to be part of it, I wanted that out of my life."*

Residents also commented how relapse can disrupt the project and the recovery of other residents, highlighting the importance of effective staff response to relapse:

*"**Kath (resident):** if it happens again then look towards moving them on somewhere else, because you've gotta think of people who are there and want it right now, who could be a little bit fragile, and it could totally waste, you know, spoil somebody's opportunity"*

*"**Geoff (resident):** Some people blatantly come here shouting their mouth off, come here very late at night, the police cars are picking them up, you know. People don't want that s**t."*

Effective staff response (residents and staff)

Multiple suggestions were offered by participants as to how staff should best respond to relapse within the projects. One common recommendation was that staff should be supportive and not punitive if a resident relapses. Both residents and staff believed the support level should increase during times of relapse and that punishment may lead to further lapses:

> *"**Lewis (resident):** They should be supported, know what I mean, you should be allowed to relapse once, because everybody's going to have a day when they're down, or some shit is going on. Maybe they've just had one relapse and it's just a silly thing, they'll wake up the next day and think "what have I done"*
>
> *"**Ryan (staff):** Well relapse is part of the recovery, so we're not going to be punitive and say "If you relapse here's the door, out you go", you've got to work at then then, like I say it's a part of the process"*

This recommendation was corroborated reports from residents who had experienced relapse while in the projects:

> *"**Antony (resident):** When I've actually lapsed I've said to them, I've told them and they've helped me through it 'Well we're not going to put you out, we'll help you through it', you know and that was a big boost for me, because instead of being worried about being put back on the streets for making a mistake because you're feeling down they'd rather help you, and that was good because it stopped you doing the same thing immediately again"*
>
> *"**Alan (resident):** I think the staff are not completely unaware that people probably have relapses at some point, and they offer support rather than beating you with a stick, which is helpful"*

A second suggestion by both staff and residents was that staff should look to identify the reasons behind the relapse and how to avoid this in the future:

> *"**Amy (staff):** talk with them about what they felt the trigger was for that relapse, and in any way ascertain what the triggers were, whether they want to carry on using, what makes them reluctant to carry on or not, or to feel like they want to withdraw from that. So find out all the information, as much as they're willing to give you"*
>
> *"**Scott (resident):** when someone relapses they shouldn't be angry towards them or anything, then they should try and get them to think positive and say 'right okay you've*

relapsed, let's work out a new structure, getting you back on, back to where you used to be, and find the point where you relapsed, why you relapsed, work on that and move on and rebuild your life again'. People can relapse and lapse, there's always a reason, 99% of people who've had drug and alcohol problems, there's always a way behind it you know, and it's no good having a go at them or making it worse for them when they just need some support."

As with other aspects of resident support, participants suggested each person and each lapse should be assessed and dealt with on an individual basis:

"***Percy (staff):*** *I think you have to take each individual circumstance as well to kind of consider what the action is and sometimes there are really extreme mitigating circumstances which um, um, have to be taken into account, by the same token the consideration always has to be the impact upon others and um, um, if they relapse or if it's habitual then obviously then we have to consider if the person is suitable for the project"*

Eviction was typically seen as a last resort response to relapse:

*"**Jack (resident):*** *there's no way you can solidly enforce "drink and you're out", I think that would be the wrong approach, I think you need to look at why and what could be done to prevent the triggers rising again"*

*"**Sue (staff):*** *I wouldn't want to work in a place where people were thrown out if they relapse. No."*

*"**Tim (resident):*** *Throw em out of here and that's going to make them worse than the situation they came in here with, so no, of course not."*

*"**Ryan (staff):*** *Well relapse is part of the recovery, so we're not going to be punitive and say "If you relapse here's the door, out you go", you've got to work at that then, like I say it's a part of the process, you've got to expect that fall"*

However, all participants noted that eviction should be considered when necessary. Residents and staff believed individuals should be supported during times of lapse, though if a person continually relapsed in the service despite the support efforts of staff then they should be evicted to minimise the negative impact on other residents.

"Scott (resident): *I could go into support worker mode now and say blah, blah, blah, they should do this, they should do that, but they just need to give them support, non-*

judgmental. But if they keep relapsing then they're obviously taking the piss a bit, not taking the piss as such but maybe it's not the right project for them to be in.

"Peter (resident): *if you evict them they're going to be back on the street causing more problems, but if you give them too many chances they're going to walk over the system then aren't they?"*

"Georgia (staff): *we work with them, give them opportunities, you know, we don't say "right you're drinking then you're out", especially the ones that are here maybe long-term. But I don't, I think there's only so many chances you should give someone."*

In one project two residents did, however, feel staff needed to be stricter when responding to relapse. They believed residents should not be given too many warnings as this may affect the recovery of other residents in the project:

"Geoff (resident): *once they come through that door, that's it there's no error, there's not "we'll let you have another chance and let you off this time"… There seems to be more and more chances They should be a bit more strict… so they should be a lot more strict when they come through the door, 1 strike and that's it. We even think you've been drinking, you're back out. Some people just take the piss."*

"Kath (resident): *there was a girl here, that lived here when I moved in and it was quite obvious that she was drinking and, you know, the staff had a little bit of difficulty in proving that at first, and anyway this went on for you know, a good few weeks to be honest, and they gave her, there was too many chances. It was like you get a written warning and then, I can't remember what they're all called, she had about 5 warnings! You know, and not to mention the times that they didn't catch her where she was just sneaking up to her room... I think people should be given a chance, because like I say, relapse is part of it, but I don't think it should be like 1, 2, 3, 4, 5, you know, it just puts other people at risk, ones that are there, that want it right now you know."*

Criminal offenders

All residents and staff were asked how they felt about criminal offenders becoming residents within the service. For purpose of the interview, criminal offenders were defined to residents and staff as individuals with a history of offending who had recently left prison. Participant views on the involvement of criminal offenders are displayed quantitatively in *Table 1*.

***Table 1*: Views on criminal offender involvement in projects**

	Supportive of involvement	Not supportive of involvement	Unsure
Residents	16 (84%)	2 (11%)	1 (5%)
Staff	10 (100%)	0	0
All participants	26 (90%)	2 (7%)	1 (3%)

As can be seen in *Table 1*, participants were predominantly supportive of the involvement of criminal offenders. This was reflected in the analysis of interview transcripts:

> *"**Tim (resident):** Wouldn't bother me, I get on with everyone I do, I've got lots and lots of friends who've been to prison, no judgement, I haven't been, but they've done their crime they've done their time like. Wouldn't bother me like, I'd probably make a really good friend."*
>
> *"**Jack (resident):** "Doesn't bother me at all. No, everybody's entitled to a chance and everybody's, you know, and repeated chances, if somebody's prepared to and wants a fresh start then they should be given all the help to be understood. Where would I be now if people just turned their backs on me or had an attitude towards my drinking and my alcoholism, yeah it's just not, you know, it's like no matter what people deserve the chance to recovery"*
>
> *"**Jennifer (staff):** "I think it works better, if I could have them all straight from prison I would* (laughs)*, a lot of them I think once they've been in prison there's a structure, and what I've done in the past is I've had people who've more or less come straight out and straight into the project, and they're used to that structure aren't they? So coming into the project like this where they're expected to do sort of things, they seem more ready"*

Only two residents were not supportive of criminal offenders being residents, both of whom belonged to the same project, suggesting the type of project may influence the appropriateness of criminal offender involvement:

> ***"Geoff (resident):** It just pisses you off, I can tell straight away that they're gonna be trouble"*

> ***"Kath (resident):*** *it was a bit of a shock like when they said "oh I've just come from prison", not that I had anything against them… But it didn't work, you're not on the same level, do you know what I mean, and he ended up getting kicked out and so did the other one for using, because that wasn't, they didn't come here in that head space, sort of coming here to stay abstinent to find new ways of living life. Obviously a lot of people when they come out of a prison, the first thing they want to do is go and have a drink, celebrate."*

Dealing with criminal offenders effectively (staff)

This sub-theme was not developed for its ubiquity (only two staff members discussed the subject), but rather for its importance to the research aims. The staff who discussed the topic of dealing with criminal offenders worked in a project which specifically looked to house individuals with a history of criminal offending, thus the issue was a pertinent one for both themselves and the project. Both staff members discussed the difficulties in dealing specifically with criminal offender residents and suggested two ways projects could effectively support them. They firstly suggested projects should act quickly to provide the client with support and structure from early on in their time in the project to avoid recidivism or relapse:

> *"**Norman (staff):** we're using a slightly different tactic now, and instead of, as we've allowed in the past, a gradual 'ooh lets go slowly, slowly, slowly' is to attack straight away with idea, not 'let's all get together and have a coffee tomorrow or Tuesday', no 'tomorrow we're going to do this, we're going to do that', and it does seem that if we can get the focus straight away, doing what it is they've told us they want to do, the client wants to do, which is what's happened with* (resident)*, we've taken, we've said 'you told us this that and the other is where you wanted to be', 'right we'll not wait till tomorrow, we're gonna do it today'."*

The second suggestion was to visit prospective residents before they leave prison to assess their support needs and begin to develop a rapport with them:

> ***"Norman (staff):*** *it would help the offender, it would help our client, to focus on what it is they wanted to do. They're going to have time to be thinking that all through. We did start going to prisons actually, one of our colleagues did, and actually finding those guys in prison 6 months down the line, if we're coming in on a monthly basis just having a natter, talking about what you want, start to build up a relationship, 'We'll be there on the doorstep when you come out of HMP, somebody will take you here there and*

everywhere, here's your flat, tomorrow we're going to the treatment agency'. That is the ideal, but that's time consuming and we're dependent on all sorts of things, our time and on the prison service of course too."

Involvement of criminal justice agencies *(residents and staff)*

Residents and staff were also asked to give their views on the involvement of criminal justice agencies in the support of the project. Specfically participants were asked how they felt about the involvement of police officers, police community support officers and probation officers. Views on the involvement of criminal justice agencies for all participants are displayed in *Table 2*. As can be seen, resident and staff views were largely positive on the subject.

***Table 2*: Views on the involvement of criminal justice agencies in projects**

	Supportive of involvement	Not supportive of involvement	No police involvement	Unsure
Residents	14 (74%)	3 (16%)	1 (5%)	1 (5%)
Staff	6 (60%)	2 (20%)	2 (20%)	0
All participants	20 (69%)	5 (17%)	3 (11%)	1 (3%)

In several of the projects visited criminal justice agencies were already involved in the project in some form. This was viewed positively by staff who suggested their involvement was good for the community and the relationship between residents and the police:

*"**Jennifer (staff):** the probation officers come back and for, and it breaks down the barriers then with the clients, you know because the clients have got issues with the police, and sometimes the police can be judgmental towards certain clients, especially if they've been prolific offenders in the past. So it breaks down that barrier I think. Especially when you see them working well and engaging well from both sides, it's that integral contact isn't it."*

*"**Sue (staff):** Yeah they drop in once a week at least, but it's not for punitive measures to see what's going on, it's just to drop in and "everything alright? What's going on?" and*

the community see the police coming in and that creates a safe environment for them as well doesn't it?"

Residents were also positive about their involvement:

*"**Peter (resident):** Yeah I think that would be really good like, I think that would be good, cus I know there's a PCO that comes here, he talks to all the residents in the building as well, and that's quite good actually."*

*"**Katie (resident):** Yeah we have a local police service that comes around, they come in and have a chat on Thursday or Friday.*

Interviewer: How do you find that?

***Katie:** Good yeah they're both lovely, really lovely"*

One resident and two staff members felt police should not be involved in the support of the project, though positively viewed the involvement of other criminal justice workers such as probation officers. The reason offered for this by staff was that residents often have a history of poor relationships:

"**Percy (staff):** *I think possibly the police um, I'd say quite a lot of our clients have a mistrust and prejudice against the police, I don't think they see them as a service that's there to assist, they just think of it as a punitive force that they've always had a bad relationship with"*

This was corroborated by reports from the residents who felt the police or all criminal justice agencies should not be involved in the project:

"Interviewer: How do you feel about police being involved in the support in the project:

***Tim (resident):** No, not for me. I haven't been the best boy all my life"*

*"**Connor (resident):** I don't think police should be here. Probation officers yeah"*

Defining abstinence *(residents and staff)*

All participants were asked to discuss their views on the exact type of abstinence required by residents. That is, should residents be expected to be abstinent from all substances, or only the particular substance from which they are recovering from? Participant views are displayed in *Table 3*.

***Table 3*: Views on level of abstinence**

	Complete abstinence	Abstinence only from problem drug	Abstinence on premises important	Moderate drinking allowed	Unsure
Residents	11 (58%)	1 (5%)	4 (21%)	2 (11%)	1 (5%)
Staff	7 (70%)	0	1 (10%)	0	2 (20%)
All participants	18 (62%)	1 (3%)	5 (17%)	2 (7%)	3 (11%)

As can be seen in *Table 3*, residents and staff were primarily supportive of the view that residents should be completely abstinence from all substances. This was evident during the analysis of transcripts:

> *"**Bob (staff):** It's a conversation we have constantly with the clients, it's all or nothing. You can't play with addiction."*
>
> *"**Peter (resident):** So yeah I think you have to be abstinent from everything"*
>
> *"**Jack (resident):** It's gotta be all substances, pure and straight. You look at switching from one to another with cross-types of drugs, but certainly whether your heroin drugs or alcohol, if you're addicted to one you're addicted to all of them. If you're addicted to one you're addicted to them all"*

Participants commonly believed using one substance may increase the likelihood of a person re-using the substance to which they were previously addicted:

> *"**Antony (resident):** Yes, yeah, problem drugs and everything else, because one thing leads to another"*
>
> *"**Andy (staff):** Once you've had a dependency it's hard to use it recreationally then isn't it? So yeah its complete abstinence isn't it? It has to be."*

Two residents suggested they should be allowed to drink alcohol within moderation, provided it was not an issue for them, though other substances should not be used. Only one participant, a resident, believed residents should be able to use other substances within and outside of the project. However, four residents and one staff member believed that outside of the project it was less important for residents to

remain completely abstinent from all substances, so long as they remained sober while on the premises of the project.

> *"**Jennifer (staff):** We've had people here who might stay abstinent when they're here but might use still in the community, but they, but it's not problematic to them anymore now. So, and some people like to, the guys might have told you, they might want to be abstinent from their problem drug only, so they might use other substances but heroin might be their problem drug and it's important for them to stay away from that, because they might feel that they can control other substances, like they might use cannabis daily."*

3.2. Gaps in practice

A total of six themes were identified within the category of "Effective practice", each representing a commonly reported suggestion by residents or staff concerning potential improvements to the projects. All residents and staff were asked how they thought the project might be improved or what they thought may be missing.

Alcohol breathalysing and drug screening *(residents and staff)*

All residents and staff were asked to express their views on the use of alcohol breathalysing or drug screening within the service. The resultant theme was assigned to the category of "Gaps in practice", as opposed to "Effective practice", as support for the inclusion of such screening measures was overwhelmingly positive, yet no project currently used them. Resident and staff views on the subject are displayed in table 4.

***Table 4*: Views on alcohol breathalysing and drug screening**

	Supportive	Not supportive	Unsure
Residents	18 (95%)	0	1 (5%)
Staff	6 (60%)	2 (20%)	2 (20%)
Total	24 (83%)	2 (7%)	3 (10%)

As displayed in *Table 4*, 60% of staff members interviewed were supportive of using screening measures within the project. It is important to note, however, the reasons for staff supporting screening measures varied from project to project. Staff in

one project were highly supportive of using tools to detect drug or alcohol use in the project, broaching the subject even before the researcher:

> *"**Norman (Staff):** The guy that you met* (resident name)*… he's not been with us very long, we're all getting to know each other trying to build up this relationship, and he said to me this morning 'why don't you do testing?' drugs testing, we've thought about it and there is a huge amount of evidence that it would help us enormously. It might help the clients because they might know then they don't have to lie 'yes I did have a lapse yesterday, help me'. As opposed to pretending it never happened and getting deeper and deeper into trouble."*

The same staff members, along with others, suggested alcohol and drug screening methods would benefit them as it would allow greater confidence in detecting relapses in residents. That is, many staff members stated they often found it difficult to be fully sure whether a resident was using drugs or alcohol, thus screening measures would give them the tools to detect relapses during times of uncertainty:

> *"**Frank (staff):** yes they might lapse, that management of lapse, if you have that confirmatory "you've blown this" or "you pee'd this" it gives us more ammunition then almost to challenge that person. I think when you've got documentary evidence, it does give you a confident answer you know, gives people more confidence you know, and I think it makes us look a lot more professional."*

> *"**Norman (staff):** you get one guy who's rotten in the building, who's doing naughtiness and staying out of harm's way because they're very clever, and everybody else is the rotten apple, the apples in the barrel, everybody else fails, and when that happens it's like a deck of cards a pack of cards. But that is the reason for the testing, because have no, we had no way of being able to know, I never have really felt comfortable, the previous manager would say "if you think that persons been drinking, give them a warning", I have never been confident to rule out everything else, unless they've got a needle hanging out of their arm of course… So I've always been reluctant to draw that conclusion about anyone, even if I'm 90% confident I still wouldn't say anything. It gives you that conviction, it would do, that would help us be stronger in supporting the client and addressing the issue."*

Other staff were supportive of using testing measures, though not for detecting substance use in residents. Instead these staff suggested it would help them to ease the process of admitting prospective residents to the project. This was due to an admission

criterion requiring individuals to demonstrate a period of abstinence prior to entry. Staff stated some individuals often had difficulty in obtaining this proof, thus having the provision for alcohol and drug testing would allow staff to obtain this evidence:

> *"**Sue (staff):** Not for use while they're in here unless we needed to, but sometimes it's very difficult when someone is homeless to engage with some of the services for regular drug testing, so what we thought to help that go along, we could be trained to be able to do that to prove the 6 weeks of abstinence"*

Residents were also positive about the use of screening measures, with 95% (all but one) supporting their use within the service:

> *"**Daniel (resident):** I think it's a must, personally. It would help more because people would be more genuine and when you're signing that contract, and if you're signing it and it says 'you'll be piss tested' mandatory or whatever, and '3 strikes and you're out', that'll be um, I think it's a must really. It's a big issue"*
>
> *"**Alan (resident):** That's probably a very good idea, it's an abstinence program so I would imagine that, especially, certain people like myself, like I just pointed out I don't like to approach people when things are sliding, some people can't take themselves off that slide, so yeah maybe it would be beneficial for staff to have it brought to their attention rather than not knowing."*

One resident even specifically suggested the use of such measures as an improvement to the service:

> "**Interviewer:** So how, if there are any ways, do you think the service could be improved?
>
> ***Fiona (resident):** I think people should be, I wouldn't be saying this if I was doing it myself* (laughs), *I think people should have random drug tests I do.*
>
> **Interviewer:** Okay, why do you think that?
>
> ***Fiona:** Well, because you're in here….You need to sort your life out, you know what I mean? You're in here to sort yourself out, to turn your life around, and I wouldn't be surprised if people are still doing things, and I don't think it's fair on the other people"*

Resident views varied in terms of how exactly they believed alcohol breathalysing and drug screening should be implemented within the project. Only one resident suggested individuals should be tested on a regular basis (i.e. once a week or month).

More commonly residents recommended only using screening tools on a random basis or when staff suspect a resident has been using substances:

> *"**Peter (resident):** People could say on Friday night I'm going out and won't be back till Sunday and while they're out they could take something and wait until it's out of their system. So I think maybe random drug tests would be a good thing, I think the random one's are better than the ones that are weekly because obviously you can't do anything, you can't cheat"*

Staff members who supported the use of testing advocated similar methods of implementation:

> *"**Georgia (staff): "**I think it should be kind of random, it shouldn't be every Monday or nothing like that. Completely random, and more frequently than what it is at the moment. And obviously if we do suspect someone, then definitely."*

While there was significant support for drug and alcohol testing, several residents and staff (including those in supportive of their use) were able to identify potential issues with their use in the projects. Many participants viewed screening tools as "*institutionalised*", while others suggested it may negatively affect the resident-staff relationship:

> *"**Percy (staff):** personally I feel as though, I don't think it would be especially beneficial, I think it would just destroy the trust that we have here, it would be too formalised, too stringent, I think that you have clients really, completely disengaging from the staff, um, it would almost seem like we were policing them and I, personally don't think that's the role of this project"*
>
> *"**Sue (staff):** Yeah we don't want that to be a barrier really because with support work, it's about trust and if you're waving a drug test in front of someone, that doesn't really convey that trust does it?"*

Some staff and residents, recognising both the positive and negative implications of using screening measures, were unable to make a yes or no decision on the subject:

> *"**Jennifer (staff):** I think sometimes it can be useful, especially when we've had somebody who's been in crisis for weeks, you know, we've got their worker saying their clean, they're chaotic here, they're causing problems here. We can issue a warning based on their presentation, but then um, unless they choose to tell you the truth then you can't work with them on that specific issue, so yeah it could be easier from that point of you so you could say 'look you are testing positive for this, is this something you want to*

address? Because we can do that. If it's not that's fine, but we need to look at other options for you now' you know, so it would make that conversation easier I suppose, um, but then would it put a barrier towards you and a client then because they are quite open about other aspects. It's like that what's the word, that kind of authority thing then again, isn't it? Do you know what I mean? Which a lot of them have had a lot of already. So I don't know, I'm kind of on the fence, it would be useful for me but I don't know how it would go down here."

Cross-county allocation of service users *(residents and staff)*

One potential improvement identified by staff was the suggestion service users should be allocated to projects located away from their usual place of residence. Staff recalled how several residents would relapse due to interactions with previous acquaintances from their life before the project. They believed if individuals came to the project with no acquaintances in the area they would be more likely to succeed due to the absence of negative associations and peer pressure. This notion is clearly illustrated in the below conversation between two staff members:

"Norman (staff): *this project would succeed far better if we didn't take anybody from* (project location)*. So nobody, when these guys come in here they don't know everybody on every street corner. We take people from* (location), (location) *takes clients from* (project location)*. The clients will say, their biggest danger, on the support plans, on the assessments, which is very interesting 'oh well I don't want to be out I know everybody here there and everywhere', and the guy that we said didn't last a night, that was exactly what happened, he was walking up wherever it was I met with him going back to probation, met with a mate and they were round the back with needles within hours of being out. Now if that had been somebody from* (location) *who didn't know anybody, you know, and that's one of the big things, but we know it'll never change because of the way the local authorities are funded, but if the local authorities were to get together, they'd save themselves millions of pounds, because there's people in and out of prison the whole time because of the peer pressure. What's the percentage do you think of our guys who go back into offending behaviour or drugs as a result of peer pressure?*
Bob (staff): *I'd say 75%.*

Norman: *Yeah it's a huge amount. But there's nothing we can do about it, we can't say don't talk to anybody."*

Reports from residents corroborated this suggestion. Several residents reported having issues with their local affiliations and even suggested they may be more likely to succeed if they were located away from their usual place of residence:

> "***Peter (resident):*** *When I first moved in I thought 'oh I'm just going to have to ignore my problems that are in* (location name)*'... I would have preferred to, like you know* (resident) *who's in there, he's from* (location name) *so he's out of the way of all of his problems, I wish I was somewhere else, out of the way of all my, because I know too many people in* (location name), *because this is where I grew up. Like I was saying that, in that street up by there, there's a couple of dealers in that street, in the same street as this, as the building is, which isn't quite easy knowing. So obviously I just don't go down that street and ignore the area"*

Increasing in-house activities *(residents)*

Some residents made the suggestion that projects could offer more in-house based activities, or offer them more frequently than they were currently:

> *"***Interviewer:** Okay, so if there are any ways, how do you think that they could change the service or add something to make it better for you?
>
> ***Geoff:*** *They definitely need more activities"*
>
> *"**Daniel (resident):** more diversionary activities, more training opportunities, education or whatever, maybe harm reduction, maybe relapse prevention... More diversionary activities, days out"*
>
> *"**Peter (resident):** we had the 'how to cook on a budget' which I think that's really good I think… But I think by doing stuff like that she was doing it will help, but I just don't think there's been enough of them. Because the last time we had one with her was about a month ago now, there's been nothing since then, so I think sometimes it gives a negative effect then there hasn't been one for so long, then there will be one, then there won't be one for ages.*
> **Interviewer:** So how often would you like it to be?
>
> ***Peter:*** *I think like, I don't know if they could like, but I think every week or every other week at least"*

One resident also considered that staff should organise activities for them in the evenings and outside of their normal working hours:

*"**Peter (resident):** I think with them pushing for us to do things, trying to set things up to keep your mind occupied and stuff like that, I think this good, but it's only a 9 to 5 thing. Obviously there's a lot of hours after when they've left here that you're going to be out doing whatever and stuff like, I think there's, obviously they can't have someone working here all day, like they can't have* (staff member) *working here all day, but I think if they set up thing that were outside hours for people to do and stuff, that might be good"*

Suggestions for in-house activities included social cooking events, team building activities with the staff, and group work sessions. Residents who stated they enjoyed group work were asked whether they would enjoy having such activities within the project. These residents were largely supportive of having groups within the service:

*"**Jack (resident):** I personally would find it useful… now that I attend group therapy on a regular basis, I see the benefit of a group, because a group can help you identify things in yourself as well, and I think by sharing and taking part in a group you're not just trying to self-help, you're getting the help of others.*

*"**Kath (resident):** we did have a few groups here, like I say relapse prevention, mindfulness, things like that, I think there should be more of that, as an opportunity for people to do here you know, just to kind of, people can start to get a little complacent"*

However, many residents stated they already engage in group work sessions facilitated by external agencies and therefore did not need in-house activities as well:

*"**Fiona:** I think we do all do that individually anyway, you know each to their own but I'm fine with what I'm doing I am like."*

Staff also highlighted issues with providing in-house activities:

*"**Norman (staff):** we as an organisation haven't got the time, we used to have time to run in-house programs, us in this building, but we haven't anymore because it's only the 2 of us… so it just doesn't work. We're heavily dependent on external agencies to help us"*

Improving links with other services *(staff)*

A further suggested improvement came from staff who suggested the communication between the projects and the other services involved in the support of residents could be increased:

*"**Percy (staff):** there's all these other agencies and that we seem to work very much in isolation of each other… I'd like to see more coordination between different agencies and have a better understanding of what different organisations do. Although practically, is,*

how difficult is that?... we would need more staff yeah. It's just difficult covering the day-to-day practicalities let alone that. Ideally you could say you could take time out to go and visit (organisation name) *or* (organisation name) *see and understand what they do and have a better understanding of a more holistic approach, but that's easier said than done."*

The importance of good communication between services was a common theme emphasised by staff. They suggested if they were to improve the links between services it may enhance the cohesion of resident care. However, as can be seen from the above quote, several staff suggested they did not have the resources to commit sufficient time to networking with other services.

Enhancing the transition process from prison *(residents and staff)*

One resident and two staff suggested the transition process of individuals from prison to the project could be greatly improved. Participants discussed the idea of a "*seamless*" transition from one service to the next. This theme was closely linked with the sub-theme "*Dealing with criminal offenders effectively*". The resident who discussed this topic supported recommendations by staff who believed individuals should be visited while still in prison. The resident also suggested it would be helpful to meet the individual immediately upon their exit from prison:

*"**Daniel (resident):** Yeah they could do more little trips, meeting them at the gates potentially, as opposed to doing an interview and doing a referral in the jail and leaving them to their own devices, because getting them from that jail to here, they have so many reservations I think in that jail. They come out, get drunk, use drugs, you know, but by meeting them at, there's a window of opportunity that's being missed I think."*

Both the staff and the resident believed by connecting with the individual before they leave prison and developing a clear support plan for their transition from prison they were decreasing the likelihood of the individual re-offending and increasing the likelihood of them successfully being admitted to the project:

***"Norman (staff):** "We've also spoken with, you know PPOs we need to have, before they ever come here, we need to have a plan from prison, so that way at the point of release we can have an involvement with probation, with the PPO, with whoever's in charge so that they've always got a support plan on day one and the guy knows where he is. One of the biggest issues we've had is that guys are being let out of prisons, with their little suitcases and told 'you go up to there now', and they're never seen again, they don't know how to,*

they can't do it, PPOs especially because their life, they've never had a stable life, it's been total chaos from start to finish. But by engaging with them immediately… so we maintain these guys are hard, we need to be putting plans into place to help them, to support them, but it's got to be before they get here, certainly within the first 24 hours of getting out. That would be our, that would be my biggest wish that we had the resources to work with, that would let us do that."

Unable to identify gaps *(residents)*

Although many participants offered suggestions for improvements, one common theme amongst residents was to suggest there were no gaps in the service or possible improvements they could identify. Several residents struggled to answer questions on the subject, stating the project did not need modifying in any way:

*"**Interviewer:** Okay, so is there anything that you think could be improved in the service?*

***Lewis (resident):** Oh god no, because they are so good anyway, so I couldn't say what to change… it's true, because they are so good, they have been good."*

*"**Antony (resident):** Added, um, added, what can you say it's perfect, it's like you just said, it's just like any ordinary house on the street, know what I mean? There's not a lot you can do really, there's support work offered, there's always thing's on the board for people to get involved with, there's plenty of things to get involved with"*

*"**Aden (resident):** No I don't think it could, we don't need anything better really, because we've got everything here that there is like… I like it as it is, can't fault it, stuff to do all the time, which is brilliant, can't fault the place."*

4. Recommendations

Based on the analysis of resident and interview transcripts a number of recommendations are offered. Although each recommendation has been carefully considered based on the available evidence, not all will apply to every abstinence based housing project. All projects are likely to vary substantially in terms of residents and support level and type, thus it is important to consider each recommendations' applicability within the context of each project. Some projects may also already be implementing many or all of the suggestions.

- All care and support provided to residents should be personalised to the individual. An overarching theme within all interviews was the notion of individualising resident support. This notion is directly applicable to all aspects of care, from responding to relapse to developing routines. Staff should develop and follow carefully individualised support plans.
- Staff should invest particular effort to develop good rapport with residents, providing non-judgemental and respectful support.
- Where appropriate, 24 hour support should be made available to residents. This may take the form of support staff working outside of the normal working hours, or a concierge service. This may be less applicable in projects where residents are expected to demonstrate a high level of independence (e.g. Croes Ffin).
- Staff should promote resident independence by supporting them with tasks, while still allowing them to take control of their life and develop independent living skills.
- Engagement in voluntary work should be encouraged by staff. The RSVP and similar internal schemes represent an effective starting point for resident volunteering or for those unable to volunteer externally due to low confidence or mental health problems.
- Staff should also look to engage residents in education, training or employment specific to their goals.
- All projects should seek to engage residents in diversionary activities, whether provided by the project or an external agency. Residents may benefit skill building workshops, social cooking events, gardening, group work sessions,

barbeques, team building activities with staff, and outdoor activities such as orienteering.

- In house diversionary activities will be of particular benefit to clients with anxiety or confidence problems who may find it difficult to access activities outside of the project.
- Where possible and a need is identified, projects should aim to run in-house group work sessions. Suggestions for in-house groups included mindfulness, relapse prevention and additional substance misuse focused groups. Residents may find it helpful and enjoyable to run groups themselves on occasion.
- All projects should look to establish networks with other agencies involved in the support of residents, such as recovery support agencies and criminal justice agencies.
- The use of routines may be beneficial to residents. Some residents may be able to develop and manage their own routines. When developing routines staff should ensure they are specific to each individual and allow some flexibility. Staff should not apply a blanket routine to all residents.
- Staff should encourage residents to adapt a healthy sleep pattern.
- Projects should allow some flexibility in terms of how long residents can stay within the project. That is, although residents should be encouraged to move on within a certain time frame, some may need to stay longer before they are fully ready to move on. Conversely, staff should also recognise when residents are ready to move on from the project and avoid extended stays where possible.
- Staff should be aware of signs of residents becoming dependent on the project. Regularly implementing strategies to promote their independence may help to reduce the risk.
- Abstinence based housing services should be located near local amenities and travel services, typically near a town or city. However, the specific location within that town or city should be carefully chosen based on an in-depth knowledge, avoiding areas known for drug-use and crime.
- Individuals should be allocated to projects outside of their typical area of residence in order to avoid issues with previous affiliates.
- When residents relapse staff should respond by increasing their support, identifying the causes of the relapse and implementing strategies to avoid future

relapses. Staff should also consider the individual circumstances surrounding the relapse.

- Eviction following relapse should be used as a last resort measure. However, if the resident continues to use substances despite the support efforts of staff they should be evicted to avoid their influence negatively affecting other residents.
- Abstinence should be carefully defined to residents in all projects. Staff should encourage individuals to uphold abstinence from all substances to avoid relapses and the negative impact on other residents. However, the individual circumstances of all residents must be considered when considering their substance use.
- Views on criminal offenders as residents within abstinence based projects were largely positive. Thus, it is likely this client group would benefit significantly form involvement in such projects. However, the effective management of such persons is vital to their success. One suggestion is to engage the person in activities and a routine from early in their time in the project to avoid boredom or distraction becoming the cause of recidivism or relapse. Secondly, such persons should be visited in prison to begin the process of developing rapport with this person. Such visits would also allow for the establishment of a support plan for their transition from prison into the project.
- Projects will likely benefit from the involvement of criminal justice agencies such as the police and probation. Some residents may not find this practice beneficial due to negative associations, though it was suggested that the involvement of criminal justice agencies may help to repair negative relationships.
- Staff should be trained in the use of alcohol breathalysing and drug testing and such provision should be made available within projects. Exactly how these measures should be used will likely depend on the specific project. Many participants suggested testing should only be used randomly or when staff suspect a resident has used substances. Regular or routine testing may lead to some objection or negatively impact the relationship between staff and residents.
- Finally, given the emphasis placed on staff support by residents and staff it is essential adequate staffing levels exist to support residents. Additionally, many of the recommendations provided here are dependent on sufficient staffing.

5. Conclusions

The present study aimed to identify examples of good practice in abstinence based housing projects. The research also aimed to identify gaps within the services and make suggestions for how best projects can run. A total of 29 individuals (19 residents and 10 staff) from six projects across South Wales participated in semi-structured interviews.

Multiple examples of good practice were identified within the projects visited. An overarching theme within findings was the concept of individualising resident support; suggesting staff should consider each individual's circumstances when making decisions regarding their recovery support. Effective staff support was also viewed as an essential determinant of resident success. Positive relationships with staff were highly valued by residents. Other examples of effective practice included the use of individual routines, engaging residents in diversionary activities and group work, linking with allied services, responding supportively to relapse, and promoting independence, education, training, employment and voluntary work. Participant suggestions for service improvements included the addition of alcohol breathalysing and drug screening measures, increasing in-house activities, improving connections with other services, enhancing the transition process from prison for criminal offenders, and allocating service users to areas away from their usual place of residence.

Overall, this research has contributed to the limited literature in this area by exploring best practice methods and suggestions from the perspective of both residents and staff. Findings can be used to inform decisions regarding the management and day-to-day running of abstinence based housing projects. However, all findings and their applicability should be interpreted within the context of each individual project and its residents.

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Appendices

Section A: Resident interview schedule

Interview Schedule

Unit:

Name:

Age:

Gender:

Length of stay at the unit:

Instructions for researcher: *blue italics*

- *Generic probes:*

Why has that helped/ would that help you?

Tell me more about…

Why do you feel that?

What about in relation to maintaining your abstinence?

Interview

- *Introductions (developing rapport) – tell person about yourself briefly.*
- **Ask person to read and sign consent form**
- *Start recording*
- *Explain the purpose of the research*

1) First of all, can you tell me a little bit about yourself and your time in (project)?

2) In terms of remaining abstinent, how has this project helped you?
- *Break into:*
  1) Interventions *(probes: group work,* therapy/ abstinence based work? Voluntary work, days out)
  2) Support *(probes: day to day staff support, relationships with staff/ other residents, help with access to other services/ healthcare)*

3) In what ways, if any, could the project better support your abstinence needs? *(Probes: What do you think is missing? Have you ever relapsed whilst in the project? If so, what could have been done to prevent this happening?)*

Check both Dictaphone devices are recording properly

4) Now I'd like to discuss with you several aspects of the service and their impact on residents ability to maintain abstinence.
   Link all of the below to maintaining abstinence
- How do you find the location of the service? *(Probes: Any suggestions on where it might be better located? Why?)*
- How does it impact you when other residents relapse?
- What do you think should happen to those who relapse? *(Probes: punishment? Eviction? Why so/not?)*
- How do you feel your length of stay in the project influences your ability to remain abstinent? *(Probes: do you feel you would relapse if you left? Do you feel you need to move on?)*
- How does it impact you when criminal offenders become a resident of the service?

5) Now I'd like to discuss with you how certain hypothetical changes to the service might impact you as a resident. *Remind that these are simply hypothetical suggestions, not changes that are scheduled to occur.*
- How useful, or not, would you find it to have drug screening/ alcohol breathalysing at the project?
- How helpful would, or not, would you find it to have a set routine implemented in the project? That is, a daily routine/ structure that would be mandatory to follow, such as getting up by 9AM etc.
  If not already covered earlier in the interview:
- How do you feel you would benefit from group work sessions?
- How do you feel you would benefit from engaging in voluntary activities?
- How do you feel you would benefit from involving criminal justice agencies in your support in the project?

6) Finally, is it important for you to maintain complete abstinence, or only from your problem drug? *(Probe: What role should the project play in this?)*

Ask person if they have any questions or anything they would like to add.

Thank person for involvement in the research.

Stop recording

Section B: Staff interview schedule

Interview Schedule

Unit:

Name:

Age:

Gender:

Position:

Instructions for researcher: *blue italics*

- *Generic probes:*

Why has that helped service users?

Tell me more about…

Why do you feel that?

Interview

- *Introductions (developing rapport) – tell person about yourself briefly.*
- **Ask person to read and sign consent form**
- *Start recording*
- *Explain the purpose of the research*

7) First of all, can you tell me a little bit about your role with (project)?

8) In terms of remaining abstinent, how do you feel this service effectively support service users?

- *Break into:*

1) Interventions *(probes: group work,* therapy/ abstinence based work? Voluntary work, days out)
2) Support *(probes: day to day staff support, relationships with staff/ other residents, help with access to other services/ healthcare)*

9) In what ways, if any, could the project better support the abstinence needs of residents? *(Probes: What do you think is missing? What would you do differently to support residents?)*

Check both Dictaphone devices are recording properly

10) Now I'd like to discuss with you several aspects of the service and their impact on you as a resident.

Link all of the below to maintaining abstinence

- How do you find the location of the service? *(Probes: Any suggestions on where it might be better located? Why?)*
- What do you think should happen to those who relapse? *(Probes: punishment? Eviction? Why so/not?)*
- Do you feel there is any relationship between the length of a resident's stay and their abstinence? *(Probes: Do residents improve/ worsen with time?)*
- How do you feel it impacts the residents when criminal offenders come into the service?

11) Now I'd like to discuss with you how certain hypothetical changes to the service might impact the residents. *Remind that these are simply hypothetical suggestions, not changes that are scheduled to occur.*

- How useful, or not, do you think it would be to have drug screening/ alcohol breathalysing at the project?
- How helpful would, or not, do you think it would be to have a set routine implemented in the project? That is, a daily routine/ structure that would be mandatory to follow, such as getting up by 9AM etc.

If not already covered earlier in the interview:

- How do you feel residents would benefit from group work sessions?
- How do you feel residents would benefit from engaging in voluntary activities?
- How do you feel residents would benefit from involving criminal justice agencies in their support?

12) Finally, do you feel the project should promote complete abstinence, or only abstinence from the residents' problem drug? *(Probe: Why?)*

Ask person if they have any questions or anything they would like to add.

Thank person for involvement in the research.

Stop recording

Section C: Resident consent form

Consent Form

The purpose of this research is to explore the effectiveness of housing support provided by the Wallich in terms of people remaining alcohol/ drug free. As a participant in this research you will be asked questions about your experiences of how the Wallich abstinence support has helped you to remain alcohol/ drug free, what could be done differently to better support your needs, and what is missing from this support.

The interview will last between 30 and 45 minutes long. All interview recordings will be stored confidentially in line with the Wallich's confidentiality policy and be seen only be the researcher. Some of the answers you give may be included in the final research report, though your name will be replaced to ensure anonymity. No information you provide will be in anyway traceable back to you. You have the right to withdraw any or all of the information you provide at any time, up to the point of final publication of the research report in October 2015. If you wish to end the interview at any time please state this to the researcher.

If you have any questions regarding the research, or your involvement, please feel free to ask the researcher at any time. If you have read and understood the above information and agree to participate in the research, please sign and date below:

Signed: ……..

Date: ……..

Researcher contact details

Name: Rob Heirene

Email address: rob.heirene@thewallich.net

Section D: Staff consent form

Consent Form

The purpose of this research is to explore the effectiveness of housing support provided by the Wallich in terms of people remaining alcohol/ drug free. As a participant in this research you will be asked questions about your experiences of providing abstinence support to service users, what you think is effective in helping individuals maintain abstinence, and what could be changed to improve the service.

The interview will last between 30 and 45minutes long. All interview recordings will be stored confidentially in line with the Wallich's confidentiality policy and be seen only be the researcher. Some of the answers you give may be included in the final research report, though your name will be replaced to ensure anonymity. No information you provide will be in anyway traceable back to you. You have the right to withdraw any or all of the information you provide at any time, up to the point of final publication of the research report in October 2015. If you wish to end the interview at any time please state this to the researcher.

If you have any questions regarding the research, or your involvement, please feel free to ask the researcher at any time. If you have read and understood the above information and agree to participate in the research, please sign and date below:

Signed: …….

Date: …….

Researcher contact details

Name: Rob Heirene

Email address: rob.heirene@thewallich.net