Dochas Service Evaluation

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Acknowledgements

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List of Abbreviations

A&E	Accident and Emergency (services)
ADP	Alcohol and Drug Partnership
ASB	Anti-Social Behaviour
AUDIT	Alcohol Use Disorders Identification Test
B&B	Bed and Breakfast (hotel)
CPN	Community Psychiatric Nurse
EIU	Effective Interventions Unit
FTE	Full-Time Equivalent
FEANTSA	European Federation of National Associations Working with the Homeless
GP	General Practitioner
HA	Housing Association
HHP	Hebridean Housing Partnership
LA	Local Authority
LHA	Local Housing Allowance
PRS	Private Rented Sector
RSL	Registered Social Landlord

Executive Summary

Background and service description

Operated by Crossreach and funded by the Western Isles Alcohol and Drug Partnership (ADP), the Dochas[1] service offers practical support and advice to adults (aged 16+) who are seeking recovery from substance use and at risk of homelessness on the Isle of Lewis in the Outer Hebrides, Scotland. It supports around 20 individuals at any one time and has a staff team of three part-time support workers. The staff work primarily on an outreach basis but have an office base in Stornoway. The vast majority of service users are resident (in either temporary accommodation or independent settled housing) within Stornoway.

The Dochas service aims to prevent homelessness by helping clients to sustain their own tenancy or prepare them for taking up new or short-term tenancies, whilst also helping them address problematic relationships with substances and wider issues in liaison and via joint working with other relevant (statutory and voluntary sector) agencies. The service has been commissioned to provide both emotional and task-based support to enable clients to maintain recovery from substance use and sustain their tenancy. Its remit has evolved in recent years to incorporate a preventative focus as well as an assertive and non-time-limited approach to support delivery in the vein of the principles of Housing First.

This summary report outlines the key findings of an independent evaluation of the Dochas service. The evaluation was conducted by the Institute for Social Policy, Housing and Equalities Research (I-SPHERE) at Heriot-Watt University and was funded by Crossreach. It aimed to gain insight into any potential 'difference made' to the lives of people the Dochas service supports with a view to informing its future operation and Crossreach's response to the client group more generally. It involved a review of literature regarding the effectiveness of assertive outreach services (including but not limited to Housing First) in rural or island contexts, and in-depth interviews with Crossreach staff (n=4), service users (n=7), and external stakeholders (n=6).

Alignment with Housing First principles

The Dochas service exhibits a high degree of adherence to the relevant Housing First principles, that is, those governing support delivery (rather than housing provision). Strong commitment to non-time-limited and person-centred support, extending beyond that relating to housing and/or recovery, is clearly evident. Service users are able to exercise substantial choice and control over the remit and location of support received. Active engagement, harm minimisation, and a strengths-based philosophy shape day-to-day support delivery in tangible ways.

Limits to the capacity of the small team of part-time posts does nevertheless limit the degree of flexibility that can be employed as regards the intensity of support. Specifically, individual caseloads (which are higher on a full-time equivalent basis than is the case for most Housing First projects in Scotland) and the part-time nature of support workers' roles restrict the extent to which staff can flex up support at short notice without compromising the regular support of other service users or exceeding their contracted working hours.

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[1] 'Dóchas' is Gaelic for 'hope'.

Difference made to service users' lives

The Dochas service has been very positively received by service user and stakeholder interviewees. The nature of outcomes identified varies substantially at the individual level but tends to include some combination of: a reduction in risk of repeat homelessness, greater engagement with (non-emergency) healthcare services, improved mental health, better management of finances, and reduction in social isolation. Impacts on substance use were variable, with some service users reporting little or no change, but others noting that the accountability provided by Dochas had contributed to the stabilisation or a reduction in substance use.

A number of service characteristics were identified by interviewees as having contributed to these positive outcomes. Key amongst these were staff members' commitment, non-judgementalism, and trustworthiness; so too their expertise in operationalising a trauma-informed and person-centred approach. The flexibility, stickability, and longevity of support were also widely deemed critical to Dochas' success in achieving positive outcomes for service users. Further to this, the emphasis placed on advocacy, especially as regards facilitating access to health-related services, was highlighted as a key enabler. This was particularly valued given the challenges encountered when brokering access to some other services.

Delivery challenges and opportunities

The Dochas service is positively regarded by key stakeholders in the housing and criminal justice sectors locally and benefits from constructive collaborative working relationships with a number of associated services. Its relationship with the health sector is weaker, however, due in part to recent turnover of staff in health services and reduced opportunities for in-person relationship building as a consequence of the covid pandemic. Facilitating client access to mental health services has proven to be especially challenging, as is true for many other services supporting a similar client group across Scotland and elsewhere in the UK. Dochas' emphasis on advocacy is regarded as a particular strength for this reason, given its pivotal role in helping service users overcome these barriers.

There is a clear scope and appetite for awareness raising activities regarding what the Dochas service does and whom it supports going forward. Whilst a formal demand mapping exercise has not been conducted, there is a widespread belief that levels of need (and likely demand) exceed the current scale of provision for the target group on Lewis and Harris (and potentially further afield). The Dochas service has a reputation for delivering support flexibly, but the scope for support workers to be responsive to service users' needs is restricted by the part-time nature of their roles, and this should be borne in mind should the service be scaled up or replicated elsewhere.

The context in which Dochas operates shapes delivery and service user experiences in notable ways. The time absorbed by travel to support clients living outside Stornoway, limited public transport options on the island, and limited availability of specialist health and social care services present significant challenges. The small population and reportedly 'close-knit' social networks on the island mitigates social isolation for some service users whilst simultaneously increasing risks of exclusion from other services because of either: a) reputations based on past misdemeanours; b) heightened concerns about confidentiality; and/or c) elevated perceptions of stigma. The Western Isles' unique religious context adds an additional layer of complexity: enhancing levels of support for some service users, whilst exacerbating concerns about stigma associated with substance use for others.

Conclusion

The Dochas service makes a very positive difference to the lives of the individuals it supports. It acts as an important safety net which reduces burden on other (statutory) services and is valued by service users and external stakeholders alike. It aligns with the relevant principles of Housing First (i.e. those governing support delivery rather than housing provision) and has showcased the benefits of assertive, flexible, and non-time-limited support for the target population.

The emphasis on advocacy is considered a key strength and is especially important given the island's small population and service network which, together, heighten the risk that clients may be known to and excluded by external service providers on grounds of past misdemeanours. Other notable strengths include Dochas' staff members' non-judgemental approach and the 'stickiness' of support offered. The main identifiable limitations or weaknesses relate to the service's geographical reach, and limits to the flexibility that staff can exercise given their part-time roles. Both are artefacts of capacity limitations.

Factors which have facilitated service delivery include the high level of qualifications, expertise and commitment of staff, together with the positive relationships established with key stakeholders in the housing and criminal justice sectors. Factors which have inhibited service delivery include the part-time nature of support worker roles, time absorbed by travel to support clients living outside Stornoway, inability to refer clients directly into detox services, and recent reduction in capacity and responsiveness of mental health services.

The unique context in which Dochas operates presents a number of challenges and opportunities. The distances involved in delivering support beyond Stornoway raise substantial resourcing implications. The island's rural and 'religious' character simultaneously enhances social support and treatment opportunities for some individuals with a history of misusing substances whilst creating additional barriers to support for others (via active exclusion by a small pool of housing and support providers and/or self-exclusion given elevated concerns regarding confidentiality or stigma).

Crossreach may want to consider the following recommendations when reflecting on the delivery of Dochas or other services targeting a similar client group going forward:
- Develop a publicity campaign to promote the service, informing new (and reminding long-standing) staff in relevant stakeholder agencies (including GP practices) of Dochas' remit, aims and referral processes.
- In parallel with the above, aim to proactively build relationships with relevant staff in relevant health care roles. It may be appropriate and potentially beneficial for the Alcohol and Drug Partnership to play a role in facilitating this endeavour.
- Reflect on the relationship between Dochas and the council's Housing First project so as to avoid duplication, whilst also reinstating joint meetings with the Housing Department regarding shared clients.
- Consider employing staff in full-time roles if the service should be scaled up or replicated elsewhere in the future so as to increase support workers' capacity to respond flexibly to changes in client needs.

1. Introduction

1.1 Background

Operated by Crossreach, the Dochas[2] service offers practical support and advice to adults who are seeking recovery from substance use on the Isle of Lewis in the Outer Hebrides, Scotland. This report documents the findings of an independent evaluation of the Dochas service. The evaluation was conducted by the Institute for Social Policy, Housing and Equalities Research (I-SPHERE) at Heriot-Watt University and was funded by Crossreach[3].

1.2 Service description

When first developed slightly more than a decade ago, Dochas was a floating support service targeting formerly homeless people with alcohol and/or drug issues, particularly those moving on from the Western Isles Council's Acres hostel. It only had one member of staff at the time but has since grown slightly in scale (see below). Historically, Dochas support tended to be provided on a time-limited basis and eligibility was conditional on service users actively engaging with the support offered, as is typical of most mainstream floating support services. The Dochas service's remit has evolved in recent years to incorporate a preventative focus as well as a more assertive and non-time-limited approach to support delivery.

This shift in orientation was inspired, in large part, by compelling international evidence regarding the effectiveness of Housing First for homeless people experiencing complex needs, that is, the co-occurrence of substance use and/or mental health problems (Mackie et al., 2017). In this vein, the Dochas service aims to operationalise many of the core principles of Housing First, and in particular a person-centered 'assertive outreach' service based on a trauma-informed and harm minimisation approach, flexibility regarding when and where support is delivered, and relative absence of behavioural conditions (e.g. no requirement that clients exhibit a commitment to engaging to remain eligible for support).

The current target group comprises adults (aged 16 years and above) with a history of substance use (alcohol and/or drug issues) who are at risk of homelessness. Dochas always has and continues to be resourced via grant funding from the Outer Hebrides Alcohol and Drug Partnership (ADP). Referrals come from a range of sources, including homelessness, health and criminal justice services, and via self-referral. Its geographical remit officially encompasses the Western Isles, but in practice is at present confined to the Isle of Lewis. Most current service users are resident in Stornoway, with only a minority living in villages in surrounding areas.

The Dochas service aims to prevent homelessness by helping clients to sustain their own tenancy or prepare them for taking up new or short-term tenancies, whilst also helping them address problematic relationships with substances and wider issues in liaison and via joint working with other relevant (statutory and voluntary sector) agencies. The service has been commissioned to provide both emotional and task-based support to enable clients to maintain recovery from substance use and sustain their tenancy. It is expected that the focus of support will vary according

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[2] 'Dóchas' is Gaelic for 'hope'.
[3] It should be noted that the evaluation was originally designed and commissioned in 2019, prior to the pandemic and development of other services such as the Western Isles Council's Housing First project. It was postponed until 2022 when restrictions on social contact were relaxed to the extent that conducting research fieldwork in person was permissible.

to individual client needs, including but not limited to, for example, support regarding housing, recovery, mental health, community integration, and/or employability. Support planning is aided, and individual outcomes recorded across a range of areas, via the Recovery Star[4].

Dochas' staff team comprises three part-time support workers, each working overlapping two (or for one staff member three) day shifts per week. One team member has a lower caseload and focusses on particularly 'difficult to engage' clients. Day-to-day oversight of and pastoral care for Dochas staff is provided by the Lewis Street project manager, whilst Crossreach's Head of Services for Mental Health provides accountability supervision and oversees the strategic direction of the service. Overall service capacity is not set rigidly, but Dochas typically supports around 20 individuals at any one point in time whilst concurrently 'remaining connected' with former clients.

The staff team work primarily on an outreach basis (see below) but have an office base in Crossreach's Lewis Street supported accommodation service in Stornoway. Dochas is officially staffed between 9am and 5pm Monday to Friday, but there is some flexibility around these core hours. All clients have a named worker, albeit that a few who have particularly high support needs are shared between two staff members. No out of hours support is formally provided, but Dochas staff do operate with a degree of flexibility outwith standard office hours (see Chapter 3).

At the time of data collection (late autumn / early winter 2022), the Dochas service was supporting 20 individuals, three quarters (n=15) of whom were men and one quarter (n=5) women. Their ages ranged from 27 to 66 years, but most were in the middle age range with an average (mean) age of 48 years. All were White British.

The nature of substance use issues for current clients at the time were described in service records as relating to alcohol (only) for slightly more than half (n=12) individuals, both alcohol and drugs for one quarter of clients (n=5), and drugs (only) for a minority of service users (n=3). In terms of housing status, two were in homeless temporary accommodation, 17 in a social rented tenancy, and one was an owner occupier.

The length of time current clients had been receiving support from Dochas at the point of data collection varied considerably. Of the 20 clients being supported at the point of fieldwork, four individuals had been involved for less than one year, four for 12-23 months, another four for 24-35 months, six for 36-59 months, and two for five years or longer.

1.3 Evaluation aim and methods

This evaluation aimed to gain insight into any potential 'difference made' to the lives of people the Dochas service supports with a view to informing its future operation and Crossreach's response to the client group more generally.

It was underpinned by the following research questions:
1. To what extent does the service share and/or depart from the operational principles of Housing First?
2. How is the service experienced and perceived by service users and other key stakeholders?
3. What are the service's key strengths and weaknesses?

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[4] The Recovery Star is a tool commonly used in one-to-one keywork or services which support individuals with a wide range of short and long-term mental health difficulties – see https://www.outcomesstar.org.uk/using-the-star/see-the-stars/recovery-star-4/.

4. What if any challenges and/or opportunities does Dochas' unique context present for service delivery and outcomes?
5. What if any other factors facilitate or inhibit service operation and outcomes?
6. What if any recommendations might be made regarding the future delivery of the service and/or provision for its target group more generally going forward?

A qualitative approach was adopted, and two key methods employed. Initially, a review of international academic and grey literature was conducted to appraise the (limited) existing evidence regarding the effectiveness and/or operational challenges associated with assertive outreach services (including but not limited to Housing First) in rural or island contexts. This was conducted to inform the development of research instruments and set evaluation findings into context.

The literature review was followed by a series of semi-structured in-depth interviews with the following people:
- Crossreach staff including both support workers responsible for frontline delivery of support (n=2) and individuals in senior strategic or management roles (n=2)
- Individuals receiving support from the Dochas service (n=7)
- External stakeholders including representatives of relevant housing, health, and criminal justice services, as well as service users' wider family (n=6).

The majority of interviews (n=12) were conducted in person during a fieldwork visit to the service in October 2022, either in office premises or (in the case of most service users) in their homes. The others were subsequently conducted via videoconference (n=2) or by telephone (n=3). Shopping vouchers to the value of £20 were given to all service users who contributed to interviews as a gesture of thanks for their involvement and to counter potential non-response bias.

All interviews (with one exception[5]) were recorded with the permission of participants and transcribed verbatim. Pseudonymised[6] interview transcripts were analysed thematically using NVivo qualitative data analysis software. Where quotations are used in later chapters, limited detail is provided in attributions to preserve participant anonymity. No profile of service users' demographic or other identifying details is provided for the same reason. Quotation text has been edited very slightly in places to remove details that might identify individual staff members (e.g. names and references to gender).

An assessment of the extent to which the service adheres to the core principles of Housing First was integrated into interviews and analysed with the aid of a proforma designed by Homeless Link and used in the evaluation of Scotland's Housing First Pathfinder (Johnsen et al., 2022) and major city region pilots in England (MHCLG, 2021).

Ethical approval for the study was obtained from the School of Energy, Geoscience, Infrastructure and Society (EGIS) Research Ethics Committee at Heriot-Watt University prior to data collection.

1.4 Report outline

The report consists of five further chapters. Chapter 2 reviews literature on rural homelessness and substance use, and issues relating to service delivery in rural and remote contexts. Chapter 3

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[5] Notes from the unrecorded interview were analysed along with transcript data form other interviews via NVivo qualitive data analysis software.

[6] Pseudonymisation involves the removal of details that could be used to identify a person. Pseudonymised data cannot be linked to its source without the use of a 'key' accessible only to designated authorities.

assesses the extent to which the Dochas service adheres to relevant core principles of Housing First. Chapter 4 documents narrative accounts of the difference that Dochas makes to service users' lives and factors that contribute to these effects. Chapter 5 reflects on the challenges and opportunities encountered in Dochas delivery, including but not limited to those pertaining to its unique geographic context. Chapter 6 draws together key conclusions from the evaluation and presents recommendations for future service delivery.

2. Literature Review

This chapter summarises the findings of a review of existing evidence regarding homelessness and substance use in rural and island contexts, together with what is known about the operational challenges associated with delivering assertive outreach type services (including Housing First) in these areas. This is used to provide a backdrop to and contextualise the evaluation findings reported in subsequent chapters. The literature review draws on both academic and grey (non-academic) sources. The review was international in scope, but the discussion below focuses predominantly on UK-based evidence where this is available.

Seven key themes are drawn from the extant literature, including: the (limited) volume of evidence on rural homelessness, substance use, and service use; the lesser visibility of rural homelessness and associated challenges; the relative prevalence of substance use in rural vis-à-vis urban areas; risk factors for substance use issues in rural contexts; rural cultures and public perceptions of substance use; availability and accessibility of support services in rural contexts; and operational lessons learned via the delivery of housing-led (including Housing First) services in rural locations.

2.1 Limited evidence on rural issues

A key finding is that there is surprisingly little published research on homelessness and substance use in rural contexts. The lack of attention devoted to rural homelessness is particularly striking, especially in the UK, and that which has been conducted appears to have focussed exclusively on England and/or is largely dated (e.g. Cloke et al., 2002). A number of studies do quantitatively assess the relative prevalence of substance use (drug and/or alcohol) issues in rural as compared with rural urban areas, and/or investigate qualitatively the different experiences of people misusing substances in these contexts, but few such studies consider the UK (Burt, 1996; Loewen-Friesian et al., 2022). Furthermore, the lack of clarity and consistency in definitions of rurality across the existing evidence based (Loewen-Friesian et al., 2022) makes it difficult to discern which existing research is most relevant, especially as regards the design of responses.

The volume of evidence regarding the effectiveness of, and /or lessons learned in the development of, housing-led or assertive outreach-based services targeting people experiencing or at risk of homelessness is extremely limited indeed. Only a handful of papers and reports were identified, and none of these focusses explicitly on such initiatives in the UK (but rather North America or other parts of Western Europe). These are nevertheless reviewed below as at least some of the lessons highlighted are likely to have some resonance within the Scottish context.

It is notable that where studies draw evidence from across a number of (inter- or intra-national) rural contexts, they typically emphasise that whilst these share characteristics differentiating them from urban locales, their characteristics and needs can still be diverse. MacDiarmid (2020) for example argues that the needs of Scotland's island communities are particularly distinctive given added challenges around extreme weather and limited public transport to mainland Scotland or to main towns on the islands where services are typically based. For these reasons, Loewen-Friesian et al. (2022) emphasise the value of qualitative research which can offer insights into complex sociocultural factors associated with alcohol use behaviours and service use in rural contexts.

2.2 Visibility of rural homelessness

A core theme running through the (limited) literature on rural homelessness is that whilst it occurs for many of the same reasons in rural as urban areas, homelessness tends to be less visible in rural

areas than it is in cities (Burt, 1996; Cloke et al., 2002; FEANTSA, 2013; Tunaker et al., 2023; Waegermakers Schiff and Turner, 2014). Drawing on general population survey data, Bramley and Fitzpatrick (2017) confirm that the risk of experiencing homelessness is significantly lower in rural as compared with urban areas of the UK. Furthermore, local authority records in England indicate that the rural households are disproportionately less likely than those in urban areas to be accepted as statutorily homeless and estimated rough sleeper headcounts are lower in rural areas (Snelling, 2017). Tunaker et al. (2023) nevertheless recently reported a widespread perception amongst representatives of organisations supporting homeless people in rural areas that levels of rural homelessness have increased in the past five years.

Research on rural homelessness within the UK suggests that at least some cases go undetected or unreported (Cloke et al., 2002), with individuals more likely to bed down in alternative countryside locations such as outhouses, barns, tents, and cars (Snelling, 2017). Tunaker et al.'s (2023) qualitative research in four English local authority areas indicated that levels of tolerance of rough sleeping and/or the use of outbuildings on farms or in other rural settings can be widely variable. On this, they noted that some farmers had developed positive relationships with homeless people residing on their land and responded compassionately; others had however experienced aggression or violence from trespassers in the past and thus reported the presence of people sleeping rough to the police or local authorities (Tunaker et al., 2023).

Snelling (2017) notes that some characteristics of rural areas can (in at least some contexts) exacerbate the challenges faced by people experiencing housing insecurity, such as lower levels of housing affordability, shortages of appropriate tenure options, and high prevalence of second and/or holiday homes. Cloke et al. (2002) note that there is a tendency for some rural authorities and residents to deny the existence of homelessness in their locality given that it is anathema to idealised constructs of rural idyll.

Echoing the conclusions of research conducted in other European and North American contexts (e.g. FEANTSA, 2013; Waegermakers Schiff and Turner, 2014), Snelling (2017) concludes that the peculiarities of rural areas in the UK can make delivering services to prevent and relieve homelessness particularly difficult. Examples of such challenges include: balancing economies of scale; a lack of specialist services; overcoming travel distances and limited public transport options; difficulties reaching isolated groups; commissioning in two-tier council structures; limited availability of alternative accommodation options; and falling local authority budgets (Snelling, 2017).

2.3 Prevalence of substance use issues in rural areas

A recent and rigorous international review of academic evidence on the prevalence of hazardous alcohol use and alcohol-related harms in rural and remote communities concluded that most (but not all) studies have found that rural, relative to urban, residence is associated with an increased likelihood of hazardous alcohol use and alcohol-related harm (Loewen-Friesian et al, 2022). Furthermore the authors concluded that this rural-urban disparity appears to have worsened in the last 20 or so years; also that it varies between geographic regions, age groups, and outcome types (being highest in Australia, among young age groups, and for more severe alcohol-related harms).

Expanding on the latter point, Loewen-Friesian et al. (2022) report that the association between rurality and adverse alcohol outcomes also becomes more pronounced when increasingly hazardous and harmful patterns of drinking are considered. By way of example, a report by Davis et al. (2016)

found that rural residents were more likely than urban residents to have an AUDIT-C[7] score of more than 8, which is indicative of 'higher risk' of alcohol-related harm.

In contrast, after reviewing existing evidence to support the development of services for drug users in rural and remote areas, Scotland's Effective Interventions Unit concluded that while there was a level of under-reporting in rural areas, problematic drug use was less prevalent in rural than in urban areas (EIU, 2004). Alcohol use and its attendant problems were said to far outweigh problems relating to illegal drug use in the four rural and remote areas in Scotland that were involved in the study (EIU, 2004).

2.4 Risk of experiencing substance use issues in rural areas

Loewen-Friesian et al.'s (2022) international evidence review identified numerous risk factors for hazardous alcohol use and alcohol-related harm in rural and remote communities. Most of these, such as male sex, younger rage, poor mental health, peer or parental alcohol use, and being a survivor of sexual or physical abuse, have been widely reported for non-rural populations, underlining their ubiquitous effect across the rural-urban divide. That said, the authors discovered that some risk factors were specific to or more pronounced in rural, relative to urban, communities. These included male sex, family instability, low education level, and the timing and place of alcohol use (with harm more likely to occur earlier in the evening and after drinking in private residences as opposed to licenced establishments).

A review of the literature focusing on the links between poverty and problem drug use conducted by the Scottish Drugs Forum concluded that there is a strong association between the extent of drug problems and a range of social and economic inequalities (Shaw et al., 2007). It drew attention to a few studies highlighting a presumed association between a lack of amenities and job prospects and high levels of alcohol and drug misuse amongst young people in some rural areas (e.g. Bailey et al., 2004). An apparent association between deprivation and high levels of alcohol use has similarly been commented on in rural areas affected by industrial decline such as Ayrshire, Lanarkshire, and Clackmannanshire within Scotland (MacDiarmid, 2020).

2.5 Rural culture and public perceptions of substance use

A key theme evident in qualitative research on hazardous alcohol use or alcohol-related harm in rural contexts is the centrality of alcohol to at least some rural cultures. Loewen Friesian et al. (2022) note that participants from multiple studies across different countries reported that it can be difficult to stop or abstain from drinking due to apparent social benefits such as feelings of inclusion and community support. Some studies suggested that hazardous alcohol use can be 'expected' of rural community members and/or that abstinence may lead to social isolation (Loewen-Friesian et al, 2022). Within Scotland, Burns et al. (2002) observe that heavy drinking has historically been widely accepted in at least some Highland communities and there can be a feeling of insult or slight associated with refusing offers of alcohol.

More recently, a Scottish Health Action on Alcohol Problems (SHAAP) study involving community consultations and interviews with a range of stakeholders confirmed that alcohol use is part of daily life and social activities in rural areas, as in the rest of Scotland and the UK, but suggested that its importance is elevated in rural communities given the lack of alternative recreational activities, especially in winter (MacDiarmid, 2020). The significance of alcohol in rural Scotland, MacDiarmid

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[7] The AUDIT-C is a short (three question) version of the Alcohol Use Disorders Identification Test (AUDIT) which is a questionnaire assessing the nature and severity of alcohol misuse.

(2020) argues, is entrenched in sociocultural norms due to traditions, hospitality and economic dependence on tourism and alcohol production. She goes on to note that non-drinkers in Scotland's rural communities often feel ostracised from social gatherings and that alcohol-free community spaces are rare (MacDiarmid, 2020).

In stark contrast, service providers interviewed for the Scottish Effective Interventions Unit review highlighted what they perceived as an inclination to 'deny the existence of drugs problems' in rural and remote areas, especially those which are more affluent (EIU, 2004). On this issue, Cragg (2003) notes that some rural residents may not believe that there is a drug problem in their community, or they may be reluctant to acknowledge the extent of the problem, perhaps through fear of damage to the area's reputation or the perception that drugs are an 'inner city problem'.

The existing literature highlights difficulties associated with maintaining anonymity and confidentiality in 'tight-knit' rural communities as a challenge for people involved in substance use. There are differences of opinion regarding whether and if so to what extent this might disincentivise service use. Shaw et al. (2007) note that this issue tends not to deter drug users in Scotland's remote and rural communities from accessing services, and Cragg (2003) that these communities can actually provide enhanced support opportunities to drug users. MacDiarmid's (2020) study however found that stigma can be heightened in small communities where privacy can be difficult to maintain, and this can reduce some drinkers' inclination to access support services.

2.6 Availability and accessibility of support services in rural areas

The limited availability and variable quality of support services in rural areas within Scotland was a recurring theme in the 'Hard Edges' research which documented the experiences of people affected by severe and multiple disadvantage – that is, the co-occurrence of homelessness, substance use and/or involvement with the criminal justice system – and the challenges faced by agencies supporting them (Bramley et al., 2019).

MacDiarmid (2020) identifies a number of unique challenges facing people who need alcohol-related support and service providers in rural areas, and these are echoed in research on rural homelessness (Cloke et al., 2002; Tunaker et al., 2023) and rural substance use (EIU, 2004).   Key amongst these are typically expensive, lengthy, and/or infrequent public transport links. Further to this, healthcare and other service providers sometimes report challenges in accessing networking and professional development opportunities and difficulty recruiting and retaining staff.

The tendency for funding models to be related to population size without taking account the additional costs of providing services in a rural context is identified as an additional challenge by MacDiarmid (2020). On this subject, FEANTSA (2013) note that sparsely populated areas are less likely to offer the economies of scale that make services viable, with the outcome that many people experiencing or at risk of homelessness remain 'hidden' or are obliged to access services in urban centres (see also Bramley et al., 2019).

Heightened feelings of shame and stigma, which can be particularly acute in locations where 'everyone knows everyone else's business', are recurring themes in the literature on rural homelessness and substance use. These are often (but not always) identified as a barrier to individuals' access to, and indeed sometimes also the provision of, support services in rural contexts (see also above) (Cloke et al., 2002; FEANTSA, 2013; MacDiarmid, 2020; Tunaker et al., 2023).

2.7 Delivery of rural housing-led (including Housing First) services

A policy statement produced by FEANTSA (2013) notes that the absence or limited availability of homelessness or other specialist homelessness services, including accommodation services, means that housing-led approaches – with their emphasis on access to permanent housing solutions as soon as possible, targeted prevention for those at risk of homelessness, and provision of needs-based person-centred support – may be particularly relevant in rural contexts. Indeed, it argues that "housing-led approaches can and should be applied in rural areas to provide long-term, effective solutions to homelessness" (FEANTSA, 2013, p.14).

Housing First is widely regarded a key reference in the context of housing-led approaches (FEANTSA, 2013), given its effectiveness in resolving homelessness for those affected by severe and multiple disadvantage or co-called 'complex needs' (Mackie et al., 2017). There has been very little targeted research on the implementation of Housing First or other housing-led interventions in rural contexts, but the following is a summary of what may be gleaned from the evidence that is available.

After reviewing the scale and nature of rural homelessness and feasibility of Housing First as an intervention across 22 areas in Canada, Waegermakers Schiff and Turner (2014) concluded that there was substantial appetite for Housing First, but that a number of challenges to delivery were identified. These included: lack of funding to support implementation, lack of local clinical expertise, insufficient scatter-site housing stock, and inability to reach efficiencies of scale due to low client numbers. A number of innovative Housing First projects had however been developed at the point the research was concluded (mid-2010s), some of which had involved a regional implementation approach to leverage available resources across communities (Waegermakers Schiff and Turner, 2014).

Around the same time, Stefancic et al. (2013) documented the success of a rural Housing First scheme in Vermont within the United States. This housed 170 individuals and achieved outcomes similar to urban Housing First projects, most notably an 85% housing retention rate recorded nearly three years after project inception. Two key adaptations were attributed, at least in part, to the project's success in rural areas. The first was innovative configuration of staff teams so as to deliver a hybrid version of Assertive Community Treatment and Intensive Case Management approaches (the two models generally used in North America and many parts of Western Europe) and use of geographically-based caseloads so as to minimise travel time. The second was use of technological enhancements and support for tenants (e.g. provision of personal computers, internet access, and associated training) which enabled 'video visits' and further reduced the impact of transportation challenges.

Stefancic et al. (2013) note that the Vermont project staff who had experience of working in both urban and rural Housing First reported fairly similar experiences with housing across settings, with the exception that large landlord or property management companies were less common in rural areas, requiring a more personal dynamic when forging those partnerships. Furthermore, given what was described as a 'small town' dynamic, these staff members noted that a landlord's (former) negative experience with a tenant was somewhat more likely to delay re-housing in rural Housing First projects vis-à-vis their urban equivalents (Stefancic et al., 2013).

In Scotland, whilst only a very small proportion of the (total n=579) individuals housed via the Housing First Pathfinder programme between April 2019 and March 2022 were accommodated in rural areas (predominantly within rural Aberdeenshire), the evaluation report (Johnsen et al., 2022) highlighted a number of challenges unique to Housing First delivery in such contexts:
- poor or non-existent public transport;

- disproportionate volume of time absorbed by staff travel in support delivery;
- limited housing turnover and availability, especially in villages;
- susceptibility of some rural tenants to exploitation by 'county lines'[8] drugs gangs; and
- widespread (but not universal) appetite for lower than usual (1:7) caseloads for Housing First teams in rural areas.

Across Europe more generally, the European Federation of National Associations Working with the Homeless (FEANTSA, 2013) identify a number of challenges to the implementation of Housing First and other housing-led approaches in rural areas. These include:
- lack of access to mainstream employment, health, housing, social and other services;
- long distances and limited transport services making the provision of floating support time-consuming and expensive;
- lack of affordable housing due to urban-rural migration, growing second-home ownership, low levels of construction and the selling off of social housing stock;
- poor quality housing in areas where demand is low due to depopulation for example;
- lower incomes and limited job prospects making it difficult for people to cover housing costs in some areas; and
- potentially high price of 'failure' given a small pool of options if landlords are unwilling to house people who have struggled to maintain accommodation in the past.

The following approaches and examples of good practice are highlighted by FEANTSA (2013) as potentially helpful in overcoming such challenges in the European context:
- provision of floating support, ideally involving a flexible joined-up and case management approach where other services are involved in an individual's care plan;
- implementation of Housing First;
- increasing supply of affordable housing via investment in social housing stock;
- exploring potential for use of privately rented housing stock (e.g. via landlord incentivisation);
- activation of vacant housing in areas affected by depopulation;
- liaison with bodies such as churches or faith communities to convert under-utilised buildings into social housing;
- mediation between homeless people and the wider community to combat stigma and promote social inclusion; and
- innovative schemes to overcome transport barriers and improve access to services and employment etc. (e.g. the UK's Wheels2Work scheme).

More recently, after reviewing the effectiveness of attempts to tackle rural homelessness across the United States, Weal (2020) concluded that the provision of 'best practice' programmes such as Housing First has had a very positive impact in rural communities where service provision had previously been extremely limited. He emphasised that their adoption had been facilitated by active and assertive leadership from federal government in instigating efforts to tackle rural homelessness, along with high levels of buy-in at the local level.

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[8] The term 'county line' refers to organised criminal networks involved in moving illegal drugs around the UK using dedicated mobile phone lines or other form of 'deal line'. Driven at least in part by the relative saturation of heroin and crack markets in England's major cities, the county lines drugs supply model has become increasingly prominent in the UK's smaller satellite urban centres and rural areas in recent years, often far from their native urban hubs (Spicer et al. 2020). They tend to exploit children and vulnerable adults and have a reputation for using coercion, intimidation, violence (including sexual violence), and weapons.

2.8 Conclusion

Whilst the influence of rurality has been a focus of surprisingly little research in the homelessness and substance use fields, the (limited) existing evidence nevertheless provides a useful contextual backdrop for this evaluation.

Existing evidence indicates that whilst rural homelessness tends to be less visible in rural areas than urban centres, rates of problematic alcohol use (particularly in the most hazardous forms) tend to be higher, and the prevalence of drug misuse lower. Problematic drinking tends to be more socially acceptable than drug misuse in rural contexts, but service provision for both issues is comparably poorer than in urban centres.

Existing evidence suggests that the provision of housing-led assertive outreach services, including Housing First, remains limited in rural areas. It nevertheless indicates that whilst delivery of these types of intervention in rural areas presents unique challenges, such difficulties are not insurmountable and, importantly, these services have potential to be just as effective in rural areas as their urban counterparts.

3. Alignment with Housing First Principles

This chapter considers the extent to which the Dochas service reflects the (relevant) principles of Housing First given that the model's philosophy and approach have been very influential in shaping the design of the service in recent years. It focuses on six of Housing First's seven core principles. The principle of 'people have a right to a home' is not addressed given its lesser relevance, for whilst the Dochas service provides advocacy and practical support to help clients access stable accommodation, the responsibility for this and control over housing tenure and tenancy type lies with other stakeholders (i.e. Western Isles Council and Hebridean Housing Partnership). Dochas' degree of accordance with each of the remaining six principles is considered below, with each being assessed as either high, medium or low as per Homeless Link's Housing First fidelity classification (see Chapter 1).

3.1 Flexible support is provided for as long as needed – high/medium

The support offed by the Dochas service is extremely flexible as regards its <u>remit</u>. The support offered is not confined to the domains of housing and recovery but may address any aspect of a service user's life, be that in relation to their (mental or physical) health, financial wellbeing, sense of purpose, social relationships, and living skills to name but a few examples. As one interviewee explained, "nothing is off the table" in terms of the emotional and practical support that can be provided directly, or that Dochas staff will sign-post in relation to.

Further to this, the support offered is <u>non-time-limited</u>, that is, does not have a predetermined termination point. The length of time that service users may continue to receive support is not discussed in any direct way with service users and their understanding is that it will continue for as long as they need and want it. The ability to operate in this way is reflective of the funding body's appreciation of the non-linear nature of the recovery process and genuine potential for relapse. In this vein, the Dochas service is seen as fulfilling an important preventative function, ensuring that support is available in periods of crisis, for example, thereby reducing the risk of tenancy failure and/or substance use relapse.

> *There's really no requirement or need for us to close files or write people off the books or anything like that ... The staff would make a judgement call about whether their support was needed or required or wanted on an ongoing basis, and if they concluded that this person doesn't want to see me any more, that would be the only reason that they would stop trying to make contact... (Staff)*

The service aims to 'remain connected' with service users who no longer wish to receive support or have disengaged for prolonged periods of time. Service users are only 'taken off the books' if/when they request that that happen. For most, the 'door remains open' such that they can reactivate support if/when the need arises.

> *There are quite a number of examples of people who've said, 'Yes, I'm not using the service any more, but it's nice to have it there as a safety net,' sort of thing, in which case we're quite comfortable ... to not make any formal arrangements or appointments with somebody, but they know they can lift the phone if they need to. (Staff)*

The service offers some, albeit not unlimited, flexibility as regards <u>intensity</u> of support. The intensity of support provided does vary, in that staff contact some service users daily, but others weekly or less often. Support can be tapered off if/as service users' needs for it diminish, and whilst there is an

intention that it increase if needed, the capacity for this to happen at short notice (during a crisis for example), is restricted by staff members' part-time roles and (FTE) caseloads which are higher than is typical for Housing First projects in Scotland and other parts of the UK (Johnsen et al., 2022). For this reason, this principle is scored as high/medium rather than high.

3.2 Housing and support are separated – high

This principle is less relevant than that described above given that the Dochas service is not responsible for sourcing housing. It is however worth noting that eligibility for support from Dochas is unaffected by any change in service users' housing status. If an individual were to abandon or be evicted from their rental tenancy, for example, Dochas staff would continue providing support whilst other appropriate housing was obtained. In a similar vein, Dochas service staff aim to remain in contact with service users if they enter institutional care settings and will continue to support them following discharge from hospital or release from prison, for example.

3.3 Individuals have choice and control – high/medium

Dochas' service users have a substantial amount of choice and control over the planning and mode of delivery of support received. Whilst engagement with treatment and other services is strongly encouraged (see below), eligibility for the service is not conditional on this. Decisions regarding the timing of Dochas support sessions are led by service users, albeit within the confines of staff members' part-time schedules (see Chapter 5). Similarly, service users may determine where they'd prefer face-to-face sessions are held, be that in their own home, the communal areas of their hostel, a café, or on a walk in a public park, to name but a few examples.

The Recovery Star is used as a tool to help service users identify areas of their lives that they want to make changes in (e.g. physical health, mental health, substance use, relationships, how they spend their time etc.), but is not used in a prescriptive way.

The centrality of user choice and control to Dochas' service delivery was identified as a defining feature of the service by more than one external stakeholder interviewee. By way of illustration, one commented that:

> *The big one was for me was, they're making a tenant feel empowered that they're taking back the control and they're making these decisions, albeit they've got the support. They're getting guided to make the right decisions, as opposed to, 'If you do X, that could lead to consequences.' I think that's a really positive thing. (Stakeholder)*

3.4 An active engagement approach is used – high

Dochas staff proactively seek to engage with individuals using assertive outreach techniques at the point of referral and during any periods of disengagement.   They will 'cold-call' individuals to offer support at the request of referring agencies where this is deemed appropriate and will frequently contact existing service users if they have disengaged to reinforce the message that 'the door is always open'.

> *Some engage and re-engage or disengage for a while if they think they're doing okay … People who drop off the radar, I will text maybe every couple of weeks just to say, 'Still here if you need me,' sort of thing. Because it's hard for people to feel they come back if*

they've missed an appointment. They think, 'Oh well, I've blown it, didn't bother turning up.' So I always try and leave that door open. (Staff)

This assertive engagement approach was highlighted as a distinctive feature and key to the effectiveness of the service by external stakeholder and service user interviewees alike (see also Chapter 4).

They're very flexible, proactive, and active rather than passive. If somebody comes to them, they'll see it through and you feel that the clients get the impression, quite rightly so, that they're being listened to and that from their perspective, their felt needs and views are being taken on board and actioned as far as they can. (Stakeholder)

I think the main impact for us with Dochas is that they don't give up on clients, whereas other services we've worked with it's the three strikes and you're out approach … We've always found Dochas much more obliging. They will pursue clients, as it were, pursue an assertive outreach approach. They don't give up on them. That's a huge bonus to us. (Stakeholder)

They come out for me if they haven't seen me or heard from me. So I'm ashamed to say it but it's always them that makes initial contact with me rather than me [with them]. When I'm feeling shit and I think, 'Oh, I really want to have a drink', I would maybe not get in touch with them whereas that's the point when I should be… Their support has been unbelievable. (Service user)

3.5 The service is based on people's strengths, goals and aspirations – high

A number of service user interviewees emphasised that staff treated them with unconditional positive regard and consistently encouraged them to identify and celebrate their own strengths. The Recovery Star is used as a tool to help service users set goals.

Service user interviewees frequently commented that the person-centredness of the service and its strong focus on their own aspirations was a unique feature setting the Dochas service apart from others that they had utilised in the past.

It's mainly focussed on what I see myself doing and how I want my life to be. It's more geared towards my final outcome, I suppose. There's no other way I can put it, I don't think … because everything [name of support worker] does for me, it's - I know this is going to sound really selfish and I don't mean it to - but it all seems to be about me … [They're] a huge safety net for me. Just knowing [they're] there makes a huge difference. (Service user)

It's totally different [to other services]. It's on a completely different level. In saying that, it's on a personal level as well. It seems to be geared around me whereas every other service I've used seems to be run-of-the-mill, a uniform stance towards everyone, where I find this one more personal, more geared towards me. (Service user)

3.6 A harm reduction approach is taken – high

A commitment to harm reduction is central to the day-to-day work of Dochas staff and this was also recognised by external stakeholder interviewees. Service user interviewees recalled being encouraged to identify and mitigate risks associated with their use of alcohol and/or drugs whilst

emphasising that they did not feel pressured to attain abstinence. Staff were trained in and regularly utilised motivational interviewing techniques.

> *Harm reduction's a huge thing. So, you know, that will always come into the conversation … I don't want to - you know, jeopardise … the trust you build up. It takes a while to build up that trust … Where there's situations, I can, and I will talk to them about how much they're drinking, 'Maybe you could do this,' or, 'Maybe you could do that,' but it's not a conversation you have every time you meet them, because there's other stuff going on. Yes, that's always in your back of your mind … harm reduction. (Staff)*

3.7 Conclusion

The Dochas service exhibits a high degree of adherence to the relevant Housing First principles, that is, those governing support delivery (rather than housing provision). Strong commitment to non-time-limited and person-centred support, extending beyond that relating to housing and/or recovery, is clearly evident. Service users are able to exercise substantial choice and control over the remit and location of support received. Active engagement, harm minimisation, and a strengths-based philosophy shape day-to-day support delivery in tangible ways.

Limits to the capacity of the small team of part-time posts does nevertheless limit the degree of flexibility that can be employed as regards the intensity of support. Specifically, individual caseloads (which are higher on an FTE basis than is the case for most Housing First projects in Scotland) and the part-time nature of support workers' roles restrict the extent to which staff can flex up support at short notice without compromising the regular support of other service users or exceeding their contracted working hours.

4. Difference Made to Service Users' Lives

Drawing upon the full range of interviews (involving service users, staff, and external stakeholders), this chapter reflects on experiences and observations regarding the main differences that the Dochas service has made to the lives of the people it supports. This is followed by a series of reflections regarding key features of the service that are deemed to have contributed to these effects.

4.1 Experiences and impacts

All service user interviewees reported that the Dochas service made a positive difference to their lives, that they valued the support provided, and that they would recommend it to other people with similar life experiences. The following comment is illustrative:

> *The support's been unbelievable. Unbelievable. I don't know what I'd have done without [name of support worker]. [They're] always there. To take me to appointments … Listen when I need to talk. [They] help with all sorts of things, whatever I need, you know? (Service user)*

Stakeholder interviewees' appraisals of the service were also very positive overall. By way of example, one statutory service provider reflected that:

> *They're an asset. We certainly would not want to lose them. They work really well with our client group and provide us with invaluable support. (Stakeholder)*

Interviewees' accounts highlighted a number of positive outcomes for service users which were attributed, at least in part, to the support provided by the Dochas service. The combination and weighting of these varied at the individual level: for some service users the biggest effect has been prevention of repeat homelessness; for others the promotion of recovery from substance use or mental ill health; for yet others the mitigation of social isolation. These and other impacts referred to by interviewees are discussed in more detail below.

4.1.1 Tenancy sustainment

A number of service user interviewees, including some who had been homeless on repeated occasions or for relatively long periods in the past, confirmed that the support of Dochas staff had been critical in helping them sustain their tenancy and avoid repeat homelessness. They explained that it ensured that they were at lower risk of losing their tenancy during periods of crisis, such as during a relapse for example. Dochas' positive effects in terms of prevention of (repeat) homelessness was also commented on by a number of stakeholder interviewees.

> *The individuals who I've worked with, who have been involved with the organisation, they have maintained their accommodation. Very well, actually, and had the support with benefits, with any problems with their landlords... (Stakeholder)*

> *I would say it's helped people sustain tenancies, definitely. Some don't have much else in the way of support. They might get some from the social landlord, but there's not a lot in the way of anything else, from social work or whatever. It's difficult to say what else would have been there to prevent the issues otherwise. (Stakeholder)*

That said, a few service user interviewees reported that Dochas' support made little if any difference to their ability to sustain a tenancy because they were not (or were no longer) at risk of homelessness. For these individuals, the service's greatest impact(s) lay in recovery promotion and/or in combatting social isolation, as discussed below.

4.1.2 Physical and mental health

All of the service user interviewees had received practical and emotional support as regards addressing healthcare needs. Some were in very poor health given longstanding (and typically substance use related) conditions. These individuals particularly valued having someone to help them navigate complex service systems and ensure they attended relevant appointments, often by providing transport and accompanying them in person. A number of stakeholder interviewees were of the view that these types of assistance had led to a reduction in service users' use of unplanned emergency healthcare and improved appointment attendance rates.

The advocacy provided by Dochas staff was deemed critical in facilitating service users' access to relevant healthcare services, and in reducing the risk of individuals being excluded from healthcare services.

> *It's a heck of a difficult [thing] trying to get a GP [appointment] now. It really is, an actual appointment, it's so tough, and even worse up here with psychiatrists and CPNs because they're short on the ground. So I do think that's a wee bit of a fast-tracking to get the service that the person needs, and actually be heard … Whereas some of the clients, naturally enough, if they're depressed or they're anxious, they're not going to be able to fully express themselves in that kind of situation as well, so it's always good to have the backup of the support workers. (Stakeholder)*

> *I don't have patience, and I have my anger … We had a real problem before with the [health professional] because I was getting angry. I can't get the words out, because the words were going further and faster in my head. Then the anger comes out, so [name of support worker] was with me in that situation, so [they were] able to speak for me and say exactly what I should be trying to say myself, but I don't have the patience and I just can't get the words out properly without becoming angry or saying it angrily. (Service user)*

A number of service user interviewees reported that having regular contact from their support worker, combined with the assurance that support would continue for as long as they needed it, had had a positive impact on their mental health.

> *Having someone come to visit … a new face, it's good to talk to people. Not just be stuck in, staring at four walls, so mental health, yes, definitely, it's made a difference … It's just someone coming round and someone, just company. It's a mental health thing. I'm not saying I'm depressed, but I reckon if I didn't have these support networks, that could be a factor, depression. But I do have them, so I'm not depressed. (Service user)*

> *The fact that [name of support worker] is on the end of the phone … has had a good effect on my mental health. Oh, definitely. Oh, absolutely. (Service user)*

> *It's given me more of a positive outlook … whereas before I might have just moved into the house and thought, 'Ah, well, forget it, I'm not going to bother doing anything'. They seem to have fired up something inside me that makes me want to be proud of where I*

am, even maybe one day be proud of who I am … My mental health tends to fluctuate
quite severely and quite rapidly but again, I know I can speak to [name of support
worker] regarding my mental health and that is a great help in itself. (Service user)

4.1.3 Substance use

A few service user interviewees noted that the Dochas service had had little if any tangible impact on the amount or frequency that they drank or consumed drugs, nor the severity of their dependency. Others however noted that it had prompted them to reflect more explicitly on the impact that their alcohol consumption or drug use had on their health.

It's made me evaluate just how much I am drinking and why I am drinking so much
because - you know, when I do say to [name of support worker], 'Look, I drank so much
over so many weeks' … I know I do drink an awful lot when I am drinking. So I do tend to
think about how much I'm drinking now, whereas before it didn't really bother me.
(Service user)

For yet others, regular support sessions presented a form of accountability which had motivated them to reduce their consumption, even if only episodically. One, for example, reflected:

I wouldn't say it's stopped me from drinking, but I'd feel as though I'd really let [name of
support worker] down if I did start drinking. I suppose in that respect it does prevent me
from [binge-drinking] … Like I say, [they'd] said last week, 'I'll see you next week' … and
then say I'd go on the booze after [they] shut the door, or yesterday or the day before,
I'd be feeling guilty as sin sitting here, and trying to bluff that I'm sober, and thinking, 'I
think [they] know I've been drinking'. I'd feel really horrid inside, that I'd let [them] down
like that, because [they've] been supportive and not judgemental. It has been a huge
help. (Service user)

A small number attributed their reduction in drinking to a move away from congregate hostel accommodation, which had been facilitated by the Dochas service in concert with the council's housing team.

I wouldn't say I was drinking as bad [now]. I think probably because I've got my own
home and stuff now … With me being an alcoholic, it was hard to adjust to that …
homeless unit because it … was all alcohol and drugs, really. I was just always kicking
about there, so it was hard to get out of that circle ... [Name of support worker] pushed
my case forward. (Service user)

4.1.4 Income and debt management

Whilst a few service user interviewees were relatively self-reliant when it came to managing their finances at the point of interview, support with welfare benefit applications, budgeting, and/or the payment of utility and other bills was deemed critical and highly valued by the others. Staff and some stakeholder interviewees emphasised this outcome area was pivotal to the service's effectiveness as regards homelessness prevention by ensuring that clients did not get into unmanageable levels of debt.

[They're] very, very supportive, and [they've] made me aware of benefits I'm entitled to
that I didn't know I was entitled to … I didn't know about it because I've worked all my
life. (Service user)

A lot of work has been done … in income maximisation and debt-related issues and finance-related issues. So, ensuring that tenancies and other services are not lost for want of an application to welfare benefits, or along those lines … It's easier for people to deal with the landlord … a utilities provider … with those aspects of life with the support that's being offered. (Staff)

Support with overseeing bill payments and debt management was especially valued by a few interviewees who noted that they would otherwise feel overwhelmed by the paperwork or on-line administration associated with such things.

[They help with] paperwork stuff, sorting stuff out … Bills and things … I just can't do it. I just looked at it, and it's just - I don't know - I just thought, 'You know what? I just can't do it'. I can't take it in, can't concentrate, just can't cope with it … [The support has] been everything for me there. (Service user)

[Name of support worker] has a look through my letters for me, aye, says, 'Well, this is for courts, this is for council tax, you know, this. This is for that'. And it's not that I'm stupid that way. I'm not daft, you know what I mean, but at the end of the day, I'm starting to worry, you know, because I can feel a side of me that has just gave up … Because at one point, for a while, any letters that were coming through the door, they were stacked that high [gesticulating]. I just cut myself off completely from the world. (Service user)

Support in this area had also been beneficial for the minority of service users who had made the transition (back) into paid work since being recruited to the Dochas service, given the implications for benefit eligibility and debt repayment. (Re)-entry into paid work was noted to have offered a number of valuable benefits as regards self-worth but was not risk free as regards recovery – particularly given the drinking cultures associated with some of the industries common in the Western Isles – thereby highlighting the value of ongoing support from Dochas.

Based on or reflecting on the numbers of people we support, I think the proportion of people that have been able to re-access employment has been a success. I think it has tended to be people returning to the sort of employment that they had been doing before … It has tended to be trades, building, fishing, offshore, these types of things … People have attached a lot of self-worth to being employed again. (Staff)

4.1.5 Social isolation and support networks

All service user interviews highlighted the beneficial effects of the Dochas service in terms of combatting social isolation. These were especially marked for those who had actively cut themselves off from members of former social networks which they felt jeopardised their recovery.

Just having someone to talk to regularly helps. I don't really see anyone else, apart from my family, and I don't want to burden them. (Service user)

Staff facilitate attendance at community-based activities such as The Shed (a drop-in for people with substance use issues), The Well (a recovery support drop-in for women), and other recovery communities where service users are open to this. Not all service user interviewees were willing to engage with such activities, however, due to personal preferences regarding recovery service options, transport difficulties, or concerns regarding potential stigma (see Chapter 5).

A number of service user interviewees had retained very positive relationships with family, some of whom lived locally on the island. Dochas staff had assisted others to rebuild relationships with estranged family when they were open to doing so.

> [One service user] didn't see anybody during lockdown apart from their [family member] … maybe once a week or a fortnight, or even less sometimes, and there was me. That was it, there was not anybody else, and they had closed themselves off from a lot of family and friends because of their addiction. Very socially isolated individual who … put things in place to protect themselves, and that involved cutting off their ties with most people. They're now in touch with most of their family, and on the phone, and some of their family have started coming to see them. (Staff)

On a related issue, Dochas staff provides support for service users' families where they grant consent. Interviewee accounts indicate that this was greatly valued, where appropriate. One interviewee for example explained that they were very reassured by the fact that they could get in touch with the Dochas team if they were unable to contact their loved one or the service user concerned experienced a marked deterioration in health.

> They lifted the burden off our shoulders … They've been a great help … I can't thank them enough. (Stakeholder)

4.2 Service features contributing to positive outcomes

Interviewees' reflections regarding the Dochas service highlighted features which had, in their view, contributed at least in part to the positive experiences and outcomes described above. Each is now discussed.

4.2.1 Non-judgemental, trustworthy, and committed approach of staff

Service users frequently commented on the non-judgemental approach of staff and level of commitment that they exhibit to their work. This was often described in the vein of 'bending over backwards to help' or 'going beyond the call of duty', by way of example.

> [They don't] slag my lifestyle, or say how stupid I was doing this, that, or the next thing. You know, [they] understand what alcohol's done to me. That's the kind of support I am comfortable with. [They're] not judgemental. [They're] not calling me an idiot, which I know I am. I don't need to be told that! … [They'll] ask have I been drinking, and if I have I'll tell [them]. If I haven't, I'll tell [them]. [They] don't judge me. (Service user)

> [They're] so kind-hearted, so warm-hearted. You know, [they'll] give that and that bit more, you know … [They'll] bend over backwards, you know, [name of support worker] would bend over backwards, and take me into the chemist and different things. Talk to me whenever I need to talk. (Service user)

These attributes gave service users confidence that they could be honest about where they are on their recovery journey, and some noted that they were therefore more likely to disclose any 'blips' (e.g. relapses), without fear of rendering themselves ineligible for support. They were therefore more inclined to discuss issues with Dochas staff that they would be reluctant to disclose to other professionals.

[They're] like a good listener, you know? I can be open and honest with [them]. I don't hold back with [them], and [they don't] hold back with me, but in a pleasant way. (Service user)

Within - I think it was actually after the second or third meeting with [name of support worker], I felt quite relaxed to be quite open with [them] … I didn't expect that, to be quite honest. I didn't expect that level of commitment, that level of willingness to see me get on … The rest of the staff are just as nice. They are so, so nice. (Service user)

It's a different ballgame as in [they] believe in me. A lot of people are too quick to jump on the things I've done, you know, blah blah blah. There is a good person inside me, you know. They [support worker] can see that … [They've] gave me that push, you know, '[Own name], you're worth more than this,' you know? 'We all care about you.' (Service user)

It's been totally invaluable, [their] support. At times I have actually thrown it back in [their] face and I feel awful for doing that but that's the nature of the drink, isn't it? … When I've been drinking, I won't reply to [their] phone calls, I won't reply to [their] texts, I won't answer the door … [They're] always the same to me. It's always the same [name of support worker] I get, regardless, and that makes it so much easier to be honest and open with [them], if that makes sense. (Service user)

On a related point, a few service users emphasised the trust they had in their support worker's commitment to confidentiality. Preservation of confidentiality was deemed especially critical given the small population on the island and reputation of 'everyone knowing everyone and everyone else's business' (see also Chapter 5).

[The best thing about Dochas is] the openness and honesty. I know I can be open and honest with [them], and I know it doesn't go any further … That's a big thing. Certainly for me anyway. I don't want people going around shouting their heads off about what I do or didn't do, or what I said or didn't say. (Service user)

The level of staff expertise in engaging with their clientele and commitment was also commented on by external stakeholder interviewees.

The staff relate well with their client group, so that's a positive thing. They have good relationships with them … I think the staff commitment definitely facilitates the service that they provide. (Stakeholder)

4.2.2 Trauma-informed approach

Dochas support workers have received extensive training in trauma-informed approaches. The current team hold higher level qualifications than is usual for staff in a support worker role within the UK's homelessness and allied health and social care sectors. Stakeholder interviewees noted that this expertise, combined with the service's licence to deliver support flexibly (see Chapter 3), enabled staff to have substantial empathy with clients and respond appropriately to their needs.

One stakeholder interviewee observed that centrality of a trauma-informed and person-centred approach meant that service users were often more willing to engage with Dochas staff as a first point of contact than frontline staff in their own (statutory sector) service.

Speaking honestly of the clients who I have had with the project, if they have an issue that's causing them concern, they're more likely to go to their Dochas worker than they are any of the other individuals as their first point of contact, so I think that says it all, really. (Stakeholder)

For this reason, Dochas staff sometimes act as an invaluable 'bridge', connecting service users into other services when they may otherwise be wary of engaging.

They've just been a real supportive, positive agency for us to lean on if we need that bit of support, too, but it's all about trying to build a good rapport with our [client]. They're there to assist them, bring them to a meeting if we need to see them, or be in the house if we want to visit. (Stakeholder)

4.2.3 Flexibility and responsiveness

The relatively small caseloads and flexibility to adjust service users' support plans based on their requirements at any particular point in time was frequently identified by interviewees as key to the success of the service.

We have here the freedom to adjust things, constantly almost, based on what people need. We don't have to go asking anybody else to do that, which is great. So, that is something which I think is a big advantage. (Staff)

The benefits of this characteristic in terms of enabling a high degree of responsiveness to changes in needs were commented on not just by service user interviewees (see above), but also external stakeholders who observed that it helped them connect with and more effectively support shared clients.

I've only ever had a positive experience. What I really like about the staff with Dochas is I can pick up the phone, I've got their mobile numbers and I get to speak to them. It's not necessarily leaving messages in offices or sending emails … I know that I could phone [name of staff member] tomorrow morning and say, 'I'm really concerned about a [client]. Will you help me?' and the turnaround is quick. There's not, they're not having you jump through hoops and, 'Oh, we need it in writing, we need…' (Stakeholder)

4.2.4 Stickability of support

As is also true of Housing First and similar services, the 'stickiness' of support, in the sense that it is not discontinued during periods of non-engagement for example, was deemed key to service effectiveness. The value of this attribute was highlighted by virtually all service user and external stakeholder interviewees alike.

It's that continual engagement, that assertive side of things where they don't give up on people. That to me is the key strength, the stickability … [Service users] know they have that constant support, where other agencies might pull out. They have that worker who sticks with them. I think that really helps, that even when they relapse they know that they're still there sticking with them. (Stakeholder)

[They] don't judge me. [They've] spent so much time with me, and seen me when I was drunk, and seen me when I was sober, and there was no change. I've not been very nice with [them] at times as well. But [they're] still there for me. (Service user)

I lapsed out of it [support]. That was just myself, going on the drink, and then the shame. It would snowball and I'd think, I don't want to get in touch with anyone … I've let myself down, I've let them down, kind of thing. You know? … But after [describes a crisis] I picked up the phone. They took me back. I didn't even have to go into the office. I didn't have to fill out forms. I didn't have to do any paperwork ... If they'd said, 'Yes, but you need to come in and we need to do forms,' you know, I'd have thought, 'aye, okay' and not maybe turned up. (Service user)

On a related point, the absence of behavioural conditions – particularly as regards commitment to treatment – and staff members' unconditional positive regard were highlighted as factors fostering greater levels of engagement with support.

[Name of support worker has said] 'We'll get you there [own name], we'll get you there.' … You have [their] support unconditionally. So that gives you a boost. That gives you that, kind of, boost … They're terrific people. They really are. For what they do, you know, with my mental health at times, I don't want to get up in the morning. I don't want to face the world, you know. There's a lot of things that go on in my head … The support is unbelievable. (Service user)

4.2.5 Longevity of support

Echoing experiences commonly reported by Housing First users within and beyond Scotland (Johnsen et al., 2022), the absence of a pre-determined end-date for support was extremely reassuring for service users.

I just hope it [Dochas support] continues as long as I need it. At the moment, I don't see anything in my life changing dramatically. I'm glad to be … getting on an even keel with the drink and things like that, but I'm just not right … [and] when things fall apart … which they always do, I turn to drink and say 'Just fuck it', do you know what I mean? (Service user)

4.2.6 Emphasis on advocacy

The emphasis placed on advocacy, and skills of support workers in this area, was also identified as a defining feature of the service which was greatly valued by service users. Support in this area, particularly as regards healthcare access, was deemed critical in helping service users navigate complex systems and reducing the risk of them being excluded (see also above).

[They] take me to appointments. Sometimes there are brick walls there and [they] help me get through them.… There's not much trust about for me, do you know what I mean? So sometimes it's nice for [name of support worker] to say, 'No, this is the truth,' and somebody for people to believe in, instead of constantly trying to fight to get your point across because people just don't want to know you, so it really has made a big difference. (Service user)

So [name of support worker] comes along with me a lot to things, you know. Because I've been treated pretty badly up here by people … professionals … called a junkie … and they wonder why you lose your temper, which you shouldn't but… Having [name of support worker] there helps a lot. (Service user)

4.3 Conclusion

The Dochas service has been very positively received by service user and stakeholder interviewees. The nature of outcomes identified varies substantially at the individual level but tends to include some combination of: a reduction in risk of repeat homelessness, greater engagement with (non-emergency) healthcare services, improved mental health, better management of finances, and reduction in social isolation. Impacts on substance use were variable, with some service users reporting little or no change, but others noting that the accountability provided by Dochas had contributed to the stabilisation or a reduction in substance use.

A number of service characteristics were identified by interviewees as having contributed to these positive outcomes. Key amongst these were staff members' commitment, non-judgementalism, and trustworthiness; so too their expertise in operationalising a trauma-informed and person-centred approach. The flexibility, stickability, and longevity of support were also widely deemed critical to Dochas' success in achieving positive outcomes for service users. Further to this, the emphasis placed on advocacy, especially as regards facilitating access to health-related services, was highlighted as a key enabler. This was particularly valued given the challenges encountered when brokering access to some other services, as noted in the following chapter.

5. Delivery Challenges and Opportunities

This chapter reflects on the key challenges and opportunities encountered in service delivery, including but not limited to those which are unique to the geographic context in which Dochas operates. It draws upon interviewees with staff, service users and external stakeholders.

5.1 Service design and joint working

This section reflects on Dochas' position within the local service network and relationships with other support providers, before providing an overview of issues associated with staffing arrangements.

5.1.1 Relationship with other services

The Dochas service has long-standing and very positive working relationships with a number of service providers on the island, and particular individuals associated with these, especially within the housing and criminal justice sectors.   The nature of inter-agency relationships was described very positively by stakeholder interviewees and many examples of effective joint working recollected, even in cases where an external partner operated with a very different culture regarding behaviour change expectations (e.g. actively promoted increasing levels of 'independence' from support).

> *The staff have changed over the years, but the level of support and the work that they do has been consistent throughout, and I feel that they are a huge asset. I would be very, very sorry if we didn't have them there, because as I said, they do work closely with us and we really benefit from their existence. (Stakeholder)*

> *If there's an issue or a problem, then very often they'll attend with the Housing First officer and discuss the issues with them, and work with them to try and resolve whatever the issues are … We had an incident recently with one of them just after he moved. There were neighbour issues, neighbour complaints. Dochas was straight in with [the Housing First] worker … That was very helpful, to have them involved in that. (Stakeholder)*

This strength of relationship was not replicated with regard to services in the health sector, however.   A high level of turnover of staff within health services on Lewis in the past few years, including mental health and substance use posts in particular, coupled with a lack of opportunities for Dochas staff to interact with (new) external agency staff in person since the onset of the COVID-19 pandemic, meant that the same working relationships had not been forged with new health colleagues. Challenges eliciting the support required for clients from mental health services was a particular frustration for staff and other stakeholders, as is true for many Housing First and similar services across the UK (Bramley et al., 2019; Johnsen et al., 2022), even whilst all interviewees recognised how over-stretched these services are.

> *Mental health services, at the moment are massively overstretched … They're really struggling with a shortage of staff, so there's major gaps in mental health at the moment. Social work, again, adult services, hugely overstretched, and sometimes we have to wait quite a while to get social work support for our clients. It does happen in the end, but it can be quite sporadic, the support … Everything's understaffed! It's challenging times all around. (Stakeholder)*

Further to this, they emphasised that there is a tendency for some (statutory) services to attempt to 'step back' when Dochas becomes involved in an individual's care, thereby highlighting the need for ongoing advocacy on the part of Dochas staff. This is especially true in relation to service users whose levels of engagement with support can be limited or intermittent.

> *I think they're [other agencies are] happy to let Dochas get on with it while they disengage. If the client isn't working with them, they'll disengage and leave Dochas to get on with it. I wouldn't say it's encouraged others to be more engaged or proactive, because they have huge workloads. If somebody's not working with them, then it's an easy option to just close the case. (Stakeholder)*

Against this backdrop, a number of stakeholder interviewees called for efforts to increase the visibility of the Dochas service to ensure that other health and social care services, including GP practices, understand what it offers and are aware that they may refer into it.

> *[My recommendation] would be to put themselves out there more, because they're a really good organisation. They have got a lot of strengths that we would look for, for support, and yes, I know they're there but … I don't know if that's the same for other agencies. (Stakeholder)*

> *I think it would probably be useful to remind everybody about who they are, and what they do on a regular basis … I suppose emphasising themselves, what they offer, would be good around the NHS, around Action for Children, children and families social work, community care social work ... and perhaps some of the other voluntary organisations would be good … I think they would probably take quite a lot of referrals over time, through that process. (Stakeholder)*

On a slightly different issue, Dochas does share some clients with the council's Housing First service, in that Dochas support is brought in for (at least some) Housing First clients who have active substance use issues. It is not always entirely clear to what extent and in what ways the two services complement or potentially duplicate one another given that Housing First support should (also) be holistic and delivered in a flexible, person-centred, and trauma-informed way. This is an issue that should be monitored going forward.   On a related point, there is an appetite for the reinstatement of joint meetings between Housing First and Dochas staff which used to occur but had been discontinued during the pandemic.

5.1.2 Staffing arrangements

As noted in Chapter 3, the service aims to deliver support in a flexible way and the efforts invested by staff members in doing so (by 'bending over backwards' etc. – see Chapter 4) are widely recognised by service users and external stakeholders alike. Their capacity to exercise this flexibility is nevertheless constrained by their part-time roles which can make scheduling support sessions with some clients challenging, especially for those individuals involved in work or employability initiatives.

> *[Name of supporter] is part-time, and that's one thing that does get me a wee bit, you know, because I'm working and I was doing [name of criminal justice service requirement] a lot … So there's times I have missed … I might not see [them] for three weeks … That's not really a complaint or anything, it's just life … But that's one thing that frustrates me. (Service user)*

It can also be difficult for staff to avoid feeling compelled to deliver support outwith their usual days or exceed their part-time contracted hours, especially if/when service users experience a crisis and given that Dochas can, at times, feel like 'the last service standing' in the absence of alternative sources of support (see below). The challenge involved in providing genuinely flexible and assertive support whilst also maintaining the work/life balance of highly committed staff appears to be elevated for staff employed in part-time roles, which all Dochas support workers are.

5.2 Geographic context

Key characteristics of the context presenting challenges and opportunities for Dochas delivery include distance and transport issues, availability of other services, social networks, and religion. The effects of each are discussed in turn below.

5.2.1 Distance and transport

Limits to staff capacity dictate that the Dochas service is at present largely limited to supporting service users who are resident in and around Stornoway (see Chapter 1). A few current clients live in villages further afield on Lewis, and home visits in these locations absorb a substantial proportion of staff time. Public transport services on the island are very infrequent, which limits options for service users to travel into Stornoway independently to receive support, should this be their preference.

> If you've to go and do a visit [outside Stornoway] at 11 o'clock in the morning, by the time you can go and do that and come back, it could be two o'clock, and you've really only given that support to one person … If you are maybe going to collect somebody from … one of the villages to bring them into their hospital appointment or you're going to take them to the Jobcentre or into housing, it's really time-consuming. (Staff)

Stakeholder interviewees asserted that there was in all likelihood a need for the kind of support that Dochas offers on Harris and perhaps at least some other Outer Hebridean islands also, albeit that the level of demand beyond Lewis had not been quantified in any formal way.

> Given the island and the remoteness and the geography of where we are, it's just again about the reach for the different villages … I know … that they are starting to look at going out where they can to Harris, but then the problem with that … you've got limited staff and limited time and then going to Harris, depending where the person is, you could be talking an hour-and-a-half to get to the area, and then the time you spend there, and back. So you're basically going out a whole day, and likewise, with other areas and other villages, that would be the same situation. (Stakeholder)

Efforts have been made to expand beyond Stornoway, and into Harris in particular, but this has proven difficult for the reasons noted above, and given that with the exception of a modest number of satellite GP practices (see below) almost all other services (e.g. hospital, council offices) are located in Stornoway. At one point Dochas did set up a local 'clinic' in a community centre on Harris to expand the service's reach, but it was concluded that this was too public for the kind of work Dochas aims to deliver and did not align sufficiently with its underlying principles (see Chapter 3).

5.2.2 Service availability

As is true for many rural areas within and beyond the UK (see Chapter 2), whilst Dochas staff are arguably more likely to be aware of the range of services available to clients than their counterparts

in major urban centres, the lack of specialist services on the island presents a significant challenge. This has been exacerbated by staff shortages and the number of vacant posts in health services recently (see above).

Recent changes which mean that referrals to detoxification services can now only be made by GPs, rather than directly by services such as Dochas, was deemed to present an additional barrier. The extra time taken for detox referrals to be processed means that the risk of 'windows of opportunity' for intervention being missed is increased.

Further to the lack of specialist health and social care facilities and limited provision of more generic services beyond Stornoway, there are very few facilities to promote community integration in the more remote villages. This, it was noted, can make the task of combatting social isolation particularly difficult for service users outside Stornoway who do not have a valid driving licence and access to a car.

> *Some of the outlying communities and villages are, by nature, fairly isolated … There is not a lot available there, beyond satellite GP clinics … The majority of people would expect to travel most places by car. If you don't have access to a car, it can be difficult to get around. Buses do exist and people make use of them, absolutely, but the service is not great … Infrastructure can be a source in itself of isolation. (Staff)*

5.2.3 Social networks

Echoing what is reported in literature (see Chapter 2), the small population size and what many interviewees described as the greater familiarity within, or 'close-knit' nature of, social networks in the Outer Hebrides influence service delivery and service user outcomes in tangible ways. It was noted that Dochas service users were highly likely to have been known to other members of the local community before they developed substance use problems. The fact that these relationships pre-dated their substance use was said to mitigate the risk of social exclusion and/or isolation for at least some individuals.

> *Communities and families are still very close-knit here, wider and extended families to a greater extent than they would be in other parts of the country. People tend to have longer-lasting relationships and people that they can rely on, that clients in a similar situation on the mainland wouldn't have, so that limits or sort of mitigates against isolation … I think it's less of an issue here than it is in some mainland services. (Staff)*

> *They [service users] have more people around … that they have always known, so people that they grew up with, than people might have in the city. Most people would have a lot of relationships with people who knew them before they were dealing with the kind of issues that we're supporting them with … Most people, especially people who are from here - and not everybody is - would have relationships that go back years with people who know them before they got involved in that side of life. (Stakeholder)*

The maintenance of supportive relationships was reported to be more likely for individuals drinking in problematic ways than those using drugs, however, given the greater social acceptability of alcohol misuse in Scotland (see also Chapter 2).

> *There's still a difference in the social stigma that is applied to people who have issues with drugs versus people who have issues with alcohol … Being addicted to alcohol is relatively socially acceptable compared to being addicted to drugs, so there are often*

fairly well-maintained family relationships for people who are struggling with alcohol addiction and recovery. I would not expect to see such close ties being maintained for people who are dealing with drugs-related issues. (Staff)

The tendency for 'everyone to know everyone and everyone else's business' elevates concerns about stigma for some service users and can make them reluctant to access other services for fear of being recognised and judged.

I sometimes think [of other services], 'I don't want to go there. I know so-and-so who goes there, and I know so-and-so who runs that. It's a bit public that place'. People will see me going in and coming out, and they'll know. That kind of restricts, holds me back a wee bit, I would say. (Service user)

Concerns about confidentiality are heightened in the eyes of some service users for the very same reason, given the chance of knowing staff members or other individuals using a service. Some service user interviewees recalled being reluctant to engage with recovery group meetings or other services given anxiety that the staff or other people using them may disclose that they attended or share what they said with mutual acquaintances. This highlights the substantial value of trust that service users have in Dochas support workers (see Chapter 4).

Obviously, up here it's such a small place. Most people know everyone, or know someone who knows that person … You can tell other people who are in the [recovery community] group. You know, if you see them you'd say, 'Oh, I didn't see such-and-such, he wasn't at the meeting last week, or last night,' or whatever. You shouldn't go around saying this, that, and the next thing about people to other people … But some do … I stopped going. I gave up on it. With [name of Dochas support worker] it's fine. I know it's private and it's confidential, you know? (Service user)

Several interviewees emphasised that the risk of vulnerable individuals being excluded from services is heightened locally given the risk that past misdemeanours (e.g. rent arrears, causing neighbourhood disturbance, non-engagement with support etc.) may well be known to gatekeepers and the pool of alternative options either extremely limited or non-existent. This issue highlights the critical importance of the advocacy provided Dochas staff.

One of the downsides of small community living is that people know each other's backgrounds and know what certain people have done in the past, and therefore can be nervous about meeting them ... It's not something I've seen elsewhere, because people don't see a name and know the background immediately … It has required quite a lot of effort … to just build those bridges again, and facilitate those kinds of meetings. (Staff)

People know each other, so there's a lot of stigma, you know ... It's hard for them to escape their pasts, because of the stigma aspect of things … I've had one client who was called a junkie by a nurse … Stigma is a big thing up here, whether it's for mental health or addiction or anything. (Staff)

The same is true for access to housing, which can be especially challenging for people with complex support needs in the area given the very small pool of potential (private and social) landlords.

Our private rented sector is very small, very limited. Because it's a small community landlords tend to know who their prospective tenant is, and won't touch a lot of them with a bargepole, so that can be quite challenging … When it comes to social housing …

we only have one RSL who we can work with, so that can be challenging as well because they know the clients, and the clients have sometimes been their former tenants. That can cause issues, because they can be very nervous about taking somebody on… (Stakeholder)

A related issue highlighted by a stakeholder interviewee is that it can be very difficult to 'switch' off' from work when the potential for encountering service users or their extended family when off duty is high.

I think one challenge is that it's a very small community, so … You know your client, and you'll know someone in your client's family. You're going to be bumping into them regularly, including when you're not at work, so it sometimes feels like you're never off duty. That's an issue. (Stakeholder)

5.2.4 Influence of religion

The Western Isles have unique religious histories, and the prevalence and nature of the Christian faith(s) practiced on the islands are distinct from mainland Scotland and other parts of the UK. Whilst no service users raised this as an issue, a number of other interviewees suggested that this contextual characteristic may potentially elevate perceived or actual levels of stigma regarding addiction.

A lot of people go to church, so I think there's a mix there that probably makes stigma exaggerated … in the view of some people anyway. If there's a religious tradition there's probably a bit more of 'I shouldn't be in this situation' on top of normal condemnation, and maybe some of that's in a person's own eyes. It maybe adds to the pressure if you're struggling or if you've lapsed to then have a sense that quite a strict religious community may be thinking even less of you. (Staff)

That said, others noted that personal faith and/or membership of faith communities might equally provide an additional source of support to foster recovery, thereby highlighting the complex role that religion plays within the Western Isles when it comes to substance use.

I think the church plays a very important part, particularly in people's alcohol journeys, so I think there are contacts and peer support that's available within the church that probably isn't in other places. So if I think about people coming out of addictive behaviours, one of the reasons they would is … that they would find a religious solution or a faith solution, and so that's quite strong here … But I also get a sense that it can also disenfranchise other people, so if you're not within that peer network or support network, you're not included. (Stakeholder)

5.3 Conclusion

The Dochas service is positively regarded by key stakeholders in the housing and criminal justice sectors locally and benefits from constructive collaborative working relationships with a number of associated services. Its relationship with the health sector is weaker, however, due in part to recent turnover of staff in health services and reduced opportunities for in-person relationship building as a consequence of the pandemic. Facilitating client access to mental health services has proven to be especially challenging, as is true for many other services supporting a similar client group across Scotland and elsewhere in the UK. Dochas' emphasis on advocacy is regarded as a particular strength for this reason given its pivotal role in helping service users overcome these barriers.

There is a clear scope and appetite for awareness raising activities regarding what the Dochas service does and whom it supports going forward, albeit that this may increase referrals and the service is currently operating at capacity. Whilst a formal demand mapping exercise has not been conducted, there is a widespread belief that levels of need (and likely demand) exceed the current scale of provision for the target group on Lewis and Harris (and potentially further afield). The Dochas service has a reputation for delivering support flexibly, but the scope for support workers to be responsive to service users' needs is restricted by the part-time nature of their roles, and this should be borne in mind should the service be scaled up or replicated elsewhere.

The geographic context in which Dochas operates shapes delivery and service user experiences in notable ways. The time absorbed by travel to support clients living outside Stornoway, limited public transport options on the island, and limited availability of specialist health and social care services present significant challenges. The small population and reportedly 'close-knit' social networks on the island mitigates social isolation for some service users whilst simultaneously increasing risks of exclusion from other services because of either: a) reputations based on past misdemeanours; b) heightened concerns about confidentiality; and/or c) elevated perceptions of stigma. The Western Isles' unique religious context adds an additional layer of complexity: for some enhancing levels of support (via faith communities and/or faith-based treatment options), whilst for others exacerbating concerns about stigma associated with substance use.

6. Conclusion

This independent evaluation indicates that the Dochas service makes a very positive difference to the lives of the individuals it supports. It acts as an important safety net which reduces burden on other (statutory) services and is valued by service users and external stakeholders alike. It aligns with the relevant principles of Housing First (i.e. those governing support delivery rather than housing provision) and has showcased the benefits of assertive, flexible, and non-time-limited support for the target population.

The emphasis on advocacy is considered a key strength and is especially important given the island's small population and service network which, together, heighten the risk that clients may be known to and excluded by external service providers on grounds of past misdemeanours. Other notable strengths include Dochas' staff members' non-judgemental approach and the 'stickiness' of support offered. The main identifiable limitations or weaknesses relate to the service's geographical reach, and limits to the flexibility that staff can exercise given their part-time roles. Both are artefacts of capacity limitations.

Factors which have facilitated service delivery include the high level of qualifications, expertise and commitment of staff, together with the positive relationships established with key stakeholders in the housing and criminal justice sectors. Factors which have inhibited service delivery include the part-time nature of support worker roles, time absorbed by travel to support clients resident outside Stornoway, inability to refer clients directly into detox services, and recent reduction in capacity and responsiveness of mental health services.

The unique context in which Dochas operates presents a number of challenges and opportunities. The distances involved in delivering support beyond Stornoway raise substantial resourcing implications. The island's rural and 'religious' character simultaneously enhances social support and treatment opportunities for some individuals with a history of misusing substances whilst creating additional barriers to support for others (via active exclusion by a small pool of housing and support providers and/or self-exclusion given elevated concerns regarding confidentiality or stigma).

Crossreach may want to consider the following recommendations when reflecting on the delivery of the Dochas service or other services targeting a similar client group going forward:
- Develop a publicity campaign to promote the service, informing new (and reminding long-standing) staff in relevant stakeholder agencies (including GP practices) of Dochas' remit, aims and referral processes.
- In parallel with the above, aim to proactively build relationships with relevant staff in relevant health care roles. It may be appropriate and potentially beneficial for the Alcohol and Drug Partnership to play a role in facilitating this endeavour.
- Reflect on the relationship between Dochas and the council's Housing First project so as to avoid duplication, whilst also reinstating joint meetings with the Housing Department regarding shared clients.
- Consider employing staff in full-time roles if the service should be scaled up or replicated elsewhere in the future so as to increase support workers' capacity to respond flexibly to changes in client needs.

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