Review of the Low Threshold, Harm Reduction Service based in the Northwest

EVALUATION REPORT

Dr. Karen Orr and Dr. Leeanne O'Hara
Optimum Research & Innovation NI
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DEPAUL
Homelessness has no place

FIRST HOUSING
Aid & Support Services

solace

Contents

1.0 Introduction and Requirements of the Brief

Depaul and the consortium commissioned Optimum Research and Innovation Northern Ireland (ORINI) to act as an external research partner to evaluate their 'Low Threshold Harm Reduction Service' based in the Northwest. The objectives of the evaluation were:

a. To evaluate the impact of the service over the past 10 years, analysing data collected across the monitoring periods, and exploring how this fits within the context of public health strategies across that time.

b. To engage with staff, service users and stakeholders from the wider sector in the evaluation process.

c. To identify key learning points and recommendations, where there is potential for adaptation and/or growth.

d. To identify key successes and service user case studies, which may support ongoing communications activity.

e. To consider the learning in the context of the ongoing needs of service users in the Northwest over the coming 3-5 years.

f. To establish any data needs going forward.

Aligning with these key objectives, the research team (Dr Orr and Dr O'Hara) recommended a two-fold evaluation to include a quantitative and qualitative component. As such, the following research questions (RQs) were proposed:

RQ 1: How has the service been delivered over the past 10 years?

- How have service users experienced the service?
- From the perspectives of service users and delivery partners, what have been the key learning points, challenges and successes?
- From the perspectives of service users and delivery partners, what are the key recommendations? Particularly, for adaptation, scaling and growth?

RQ 2: What impact has the service had on service users over the past 10 years?

- From the perspectives of service users, what impact has the service had on their lives?
- From the perspective of other stakeholders, what impact has the service had on service users and the broader sector?
- From the perspective of all stakeholders, how does the service and reported impact align with key public health strategies.

RQ 3: How can the learning from this evaluation inform future service delivery?

- Considering the evidence, what recommendations could be made for addressing the needs of service users in the North-West over the next 3-5 years?
- What recommendations would be made for future and ongoing monitoring and evaluation?

2.0 Methodology

An advisory group was established at project inception which consisted of members from Depaul and the consortium (Solace and First Housing). The main roles of the advisory group were to co-produce the evaluation methodology and for members to act in a gatekeeper capacity to research participants. The advisory group also reviewed the first draft of the report. Two stages of evaluation were designed to address the research questions to include (1) Policy review and analysis of existing data; (2) Stakeholder engagement.

2.1 Stage 1: Policy Review and Analysis of Existing Data

Working alongside the advisory group the research team began by collating relevant anonymised data from the 10 year time frame in question. Data collected by Depaul and the consortium was interpreted and explored within the context of the public health strategies across that 10 year period.

2.2 Stage 2: Stakeholder Engagement

Key stakeholders were invited to participate in an interview or focus group. Participant groups are described below.

Service users: A strong proportion of the stakeholder sample was made up of service users, ensuring this voice is strongly represented in the findings. Current service users across all three partner organisations (Depaul, Solace, First Housing) were invited to take part in face-to-face interviews. If face-to-face was not possible, participants were offered to share their perspectives online (using a bespoke Google Form) or via a telephone interview. A trauma informed approach to data collection with service users was implemented, respecting the utmost sensitivities of the topics at hand. Face-to-face interviews were held in the Depaul site (Foyle Haven) and in Solace premises (Arc Healthy Living Centre). A total of 34 service users took part in the evaluation. Of these 34, 11 interviews (32%) were completed face-to-face, 19 (56%) were completed online (using google forms) and 4 (12%) over the telephone. Across the three sites, 65% (n=22) of service users who took part were from Depaul, 21% (n= 7) from First Housing and 14% (n=5) from Solace. In terms of gender, 62% (n=21) of the sample were male and 38% (n=13) female. The age ranged from 18-54. Interviews addressed issues such as, service users' initiation with the service and length of contact; perceptions and

experiences of the service; perceptions of support services; targeting their perceived outcomes, benefits, challenges with a focus on physical/mental health and wellbeing; and expectations and future recommendations for improvement. There were variations in the length and depth of interviews with service users across the three sites.

Delivery partners: Focus groups (n=3) were undertaken with the delivery partners (staff from Depaul, Solace and First Housing). A total of 13 staff members took part in the research. In addition, an interview took place online with the senior services manager for Depaul whose role is the operational management and development of services in the North. Interviews with all delivery partners focused on a range of delivery-level issues (service delivery/ resources/ funding/ challenges encountered) as well as their perceptions of outcomes and future recommendations.

Additional stakeholders: Finally, focus groups and one-to-one interviews were conducted with external stakeholders. These included individuals from Trust based health care provision, voluntary and statutory services, and the Public Health Agency NI. Interviews explored the relationship between stakeholders and the services as well as perceptions of service delivery, any perceived gaps in service delivery and recommendations for the next 3-5 years for the Northwest.

2.3 Ethics and Working with Vulnerable Groups

This work adhered to strict ethical protocols (for example, those set out by the British Psychological Society) for consent, data collection and storage and GDPR. With regards to safeguarding, the research team liaised with Depaul regarding appropriate and meaningful safeguarding procedures.

3.0 Policy, Deliverables and Output

3.1 Overview of relevant policy

The 'New Strategic Direction (NSD) for Alcohol and Drugs (2011-2016): A Framework for Reducing Alcohol and Drug Related Harm in Northern Ireland' was published in 2011 (DHSSPS, 2011). The strategy highlighted the current position of alcohol and drug use in Northern Ireland and emerging issues of concern. In addition, five supporting pillars were defined in the development of the framework which provide conceptual and practical stand points for the NSD. These include (1) Prevention and Early Intervention; (2) Harm Reduction; (3) Treatment and Support; (4) Law and Criminal Justice; (5) Monitoring and Evaluation. Further, key priorities were outlined to include, (a) Developing a regional commissioning framework for treatment; (b) Targeting those at risk and vulnerable; (c) Alcohol and drug related crime including anti-social behaviour and tackling underage drinking; (d) Reduced availability of illicit drugs; (e) Addressing community issues; (f) Promoting good practice in respect of alcohol and drug related education and prevention; (g) Harm reduction approaches; and (h) Workforce development (DHSSPS, 2011).

In September 2021, the 'Preventing Harm, Empowering Recovery: A Strategic Framework to Tackle the Harm from Substance Use (2021-31)' was published and presented proposals for tackling the harms caused by substance use over the next decade. The vision was set out that '*people in Northern Ireland are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs, have access to high quality treatment and support services, and will be empowered to maintain recovery*.' In essence, the framework set out five specific outcomes to include, (1) Through prevention and reduced availability of substances, fewer people are at risk of harm from the use of alcohol and other drugs across the life course; (2) Reduction in the harms caused by substance use; (3) People have access to high quality treatment and support services; (4) People are empowered and supported on their recovery journey and; (5) Effective implementation and governance, workforce development and evaluation and research supports the reduction of substance use related harm. (DoH, 2021).

3.2 Public Health Agency NI Commissioning Brief

The Public Health Agency produced a service specification for tender for the provision of support, care, facilitation and harm reduction services for people who are mis-using substances (Low Threshold Services). The contract period was to run 2013-2018 with options for extension. Key service objectives were outlined along with sixteen anticipated outcomes (see table 2 for further information). The objectives of the service were:

- To provide a person-centred service to those who misuse drugs and alcohol at harmful levels (and who are not able or willing to consider abstinence or engage in structured treatment), to reduce harm caused by their dependence on substances;
- To facilitate access to other relevant support services (Housing, Health, Employment etc.);
- To adapt service provision (e.g. balance between drop in versus outreach service delivery and range of services required from the menu of services in line with the needs of the service user population);
- To ensure that relevant pathways are established for service users;
- To ensure appropriate liaison and engagement with the families of service users;
- To ensure service users are involved in the design and delivery of the service in accordance with the PHA Service User Engagement Framework;
- Where specific requirements for supported accommodation are identified in a locality, provide dedicated support or facilitate access to existing accommodation;
- To advertise and promote the services through relevant media.

Funded by PHA in 2013, Depaul and the consortium commenced the provision of support, care and harm reduction services for those misusing substances in the Western Trust through a low threshold service. Delivered through the consortium partnership, the service notably provides '*health related interventions, advice and support to those who misuse alcohol and drugs at harmful levels and/or in harmful ways but who are unable to commit to formal treatment.*' (Depaul, 2014). The work was designed to meet the needs of substance users in the West while also addressing key policy objectives outlined by the Department of Health, Social Services and Public Safety with the vision of being adaptive to both on the ground and policy developments over the course of the funding.

3.2 Alignment of Depaul deliverables and output

Over the course of service delivery, Depaul and the consortium submitted quarterly and yearly monitoring reports relating to PHA service specification outcomes. These specification outcomes were seen to map onto strategic policy priorities and therefore a more robust exercise mapping Depaul deliverables and outputs was undertaken by the research team.

The main purpose of this mapping exercise was to address one of the key research objectives: *'To evaluate the impact of the service over the past 10 years, analysing data collected across the monitoring periods, and exploring how this fits within the context of public health strategies across that time.'* Content detailed in section 3.1 was mapped across both relevant policy for the 10 year time period and service specification outcomes as presented in the PHA tender document. Table 1 depicts and details common themes identified across all documentation.

Table 1: Policy and service specification map

Mapping of common themes	New Strategic Direction for Alcohol and Drugs, Phase 2 (2011-2016)	Preventing Harm, Empowering Recovery (2021-2031)	PHA Service Specification (2015-2020)
	The Five Pillars (1-5)	Outcomes (A-D)	Outcomes (1-16)
1.	1. Prevention and early intervention	A. Through prevention and reduced availability of substances, fewer people are at risk of harm from the use of alcohol and other drugs across the life course	Reduction in the number of crisis interventions requiring emergency medical help from ambulance services or emergency department (11). Reduction in the number of crisis interventions by the PSNI (13) More people and families receiving low threshold services (15)
2	2. Harm reduction	B. Reduction in the harms caused by substance use	Increase in the uptake of blood borne virus testing and treatment/ hepatitis B vaccination (1) Reduction in alcohol related harm (2) Reduction in drug related harm (3) Reduction in risky injection practices (4) Reduction in risky sexual practices (5)
3	3. Treatment and support	C. People have access to high quality treatment and support services	Improvement in mental health (6) Improvement in physical health (7) Improvement in housing stability (10) Greater access to low threshold services (14)
4	4. Law and criminal justice		Reduction in criminal involvement (12)

5.		D. People are empowered and supported on their recovery journey	Increased ability to manage daily activities (8) Improved relationship with family members (9)
6.	5. Monitoring, evaluation and research	E. Effective implementation and governance, workforce development, and evaluation and research supports the reduction of substance use related harm.	Regional standardisation of the service model for low threshold services (16.).

*Note also broader PH policy framework (Department of Health, Social Services and Public Safety. (2014) *Making life better. A whole system strategic framework for public health 2013-2023.* Belfast: DHSSPS. Available at: https://www.health-ni.gov.uk/articles/making-life-better-strategic-framework-public-health [Accessed 31/05/2023])

Information requested and provided to PHA in terms of service monitoring was lengthy and detailed across the 10 year period. Information was presented for the consortium integrating outputs and case studies from across the three services. In an attempt to demonstrate the service meeting objectives of the PHA service specification and policy objectives from across this period, examples from submitted monitoring reports are presented by mapped theme (see table 1) below in Table 2.

Table 2: Depaul deliverables (examples) across common themes

Mapping of Common Themes	Examples of Depaul Deliverables
1	➢ More people and families receiving low threshold services. Exceeded the yearly minimum of 235 service users per year (e.g. 2019: n=579; 2023: n=346; 2024: n=413). ➢ Reduction in the number of crisis interventions (through first response e.g. naloxone administration, relieving pressure on ambulance services and A&E).
2	➢ Reduction of harms caused by substance use: Advice on blood testing (e.g. 2018: n=68; 2024: n=61) Reduction in risky injecting including advice/equipment/practices (2018: n=23; 2024: n=67, *Our needle and syringe service has really taken off this quarter and we had over 25 visits to this service for clean needles and harm reduction advice.)* Reduction in alcohol related harm through person centred harm reduction approaches (2018: n=77; 2024: n= 232) Reduction in drug and alcohol related harm through person centred harm reduction approaches (2018: n=68; 2024: n=197)
3	➢ Improvement in mental/physical health through the delivery of a range of physical and emotional health intervention (e.g. course on depression, mental health assessments through GP, accompanying SU to GP with physical ailments – falls, injuries etc.) ➢ Housing stability improved for a number of individuals through direct homelessness interventions (e.g. communication with or on SU behalf to NIHE; working to secure temporary accommodation; 2019: n=114 referred to specialist accommodation/appropriate housing/hostels).
4	➢ Reduction in criminal involvement Working closely with PSNI and community policing including supporting knowledge around consumption (e.g. 2024: *Foyle Haven staff were able to retrieve 3 of these tablets and they are now in the process of being tested*

	by the police to identify their contents; 2024: support offered on offending behaviour)
5	➢ Improved ability to manage daily activities ➢ Improved relationships Meeting basis needs of service users (e.g. food, warmth, clothing) as first response to helping with daily activities. Harm reduction interventions and strategies to reduce the use/control times of use to assist in management of daily activities (e.g. 2024: delivery of managing money, managing tenancy, drug misuse support, self-care support, meaningful use of time). Interventions that are family focused to help improve relationships.
6	➢ Standardisation of the LTM for service delivery Regular engagement with service users on design and delivery of LTM and service provision. (e.g. 2024: *Our annual service user survey also captures feedback from as many service users as possible. We also have a suggestion box which is visible to all in our common room. Evaluations are also gleaned through daily key working sessions and through holding a quarterly service user forum*.)

It is important to highlight that snippets from monitoring reports presented above (Table 2) are for demonstrative of the service meeting objectives across both PHA service delivery specifications and policy directions across the 10 years and is by no means exhaustive of what was delivered and achieved by the service over this time period. Full final year reports have been attached for further reference in appendix 1. The primary research component of this evaluation will also add detail and depth to service outputs and outcomes relevant to the mapped themes above. This will be discussed further in sections 5, 6 and 8.

4.0 Service User Representation: Survey Findings

Respondents

In total, 19 service users responded to the online survey, the majority of which were male. There was a varied age range, with a majority aged between 36 and 45 years. Most of the respondents were engaged with Depaul see Figures 1, 2 and 3.

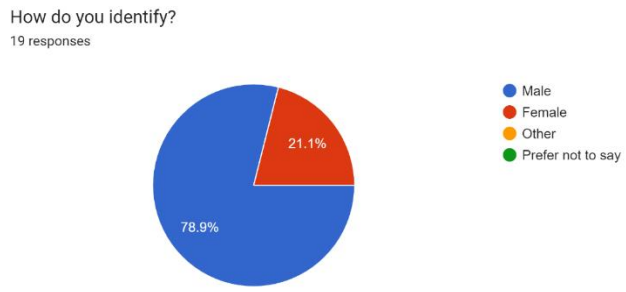

Figure 1: Gender

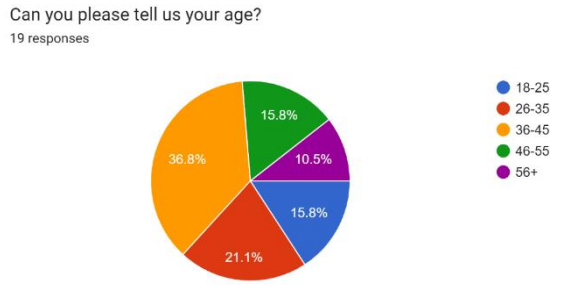

Figure 2: Age

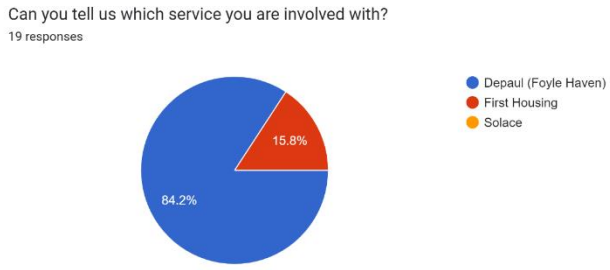

Figure 3: Service used

A large majority of the service users who responded to this survey (79%, n=15) stated that they did feel they have noticed improvements in their physical health since being involved in the service (see Figure 4). When asked to detail the improvements noticed to their physical health, three key themes emerged, ranging from lifesaving intervention service users had received, to practical supports facilitating recovery, and the receipt of fundamental physiological needs (see Table 3 for an overview of the physical benefits reported, note, these excerpts are verbatim).

Table 3: Physical health benefits reported

Lifesaving intervention
Naloxone
SU states he feels he would be dead if he did not have the Foyle Haven. He has got his bloods taken a sexual health check in the fhdc
Facilitating recovery (refraining/ facilitating service engagement)
Detox arranged through Depaul. Tony states that attending the FHDC regularly reduces his use of substances and the thought of taking substances therefore having a positive impact on his physical health, as Tony has now stopped drinking alcohol and has been sober for several months now. Support attending appointments for physical health SU states we have also supported her to make medical appointments regarding her physical health.
Fundamental needs met (personal hygiene and food)
SU states that we have supported her in maintaining personal hygiene which contributes to her physical health. getting a meal making sure I'm eating Having somewhere to go and have something nutritious to eat Daily meals provided me with nourishment that I required as I had multiple fractures to my right leg following a RTC. I have gained much needed weight and my social anxiety has improved. The meals that are provided by the FHDC are very nutritious. I feel that my physical health has improved as I get to eat nutritional food at the FHDC. My meals are usually microwaved.

Because I have access to a hot meal and nutritional food at the FHDC. If it wasn't for the FHDC I wouldn't be able to eat properly.

A slightly larger proportion of the sample (84%, n=16) reported having noticed improvements to their mental health since being involved in the service (See Figure 5). When asked to provide more detail on the mental health benefits they had noticed, the majority referred to the social interaction it provided them and, as such, reductions in isolation and social anxiety. Additionally, one service user commented on the sense of safety they experienced whilst at the service, others referred to the positive influence of the staff, as well as the positive influence of difference services and activities they had experienced as a result of their engagement with the service (see Table 4 for an overview of the mental health benefits reported).

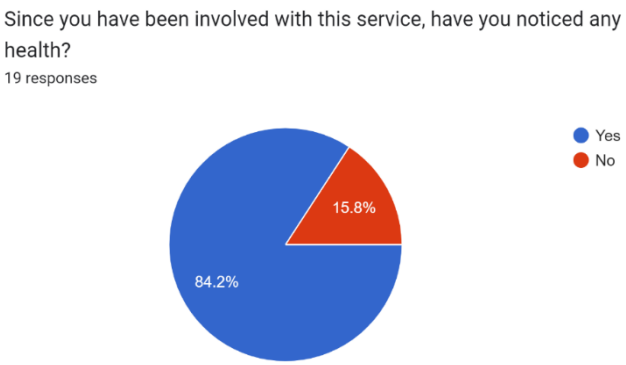

Figure 5: % reporting mental health benefits noticed

Table 4: Mental health benefits reported

Social benefits/ friendship/ less isolation
When staff chat to me helps to come and meet other people less lonely SU states that attending FHDC regularly is a great means of social interaction for him which reduces feeling of isolation Socialising in the haven It is a form of social interaction and harm reduction Service said that it improves his mental health and is a source of social interaction. It also reduces isolation. My social anxiety has improved with attending the centre I am now street homeless, so having access to the FHDC greatly improves my mental health.
Safe
He feels safe whilst he is in the centre
Avail of different services
The service user was temporarily moved to a B&B outside the City and noted that NOT being able to attend the FHDC affected his E/M health as he felt isolated. I also attended a 10 week mental health course which was run by the FHDC and greatly benefited from this. Yes, I completed a 10 week mental health recovery course in the FHDC and this helped me immensely. SU states he enjoys coming into fhdc as he feels this helps his mood and the day trips have helped his mental health big time. He states his day goes in better when he attends the fhdc
Staff
[staff name] in First Housing is always there to answer any questions I have and it helps my mental health because it takes stress of me having someone there to help me with questions I wouldn't know. staff are helpful and listen everyday

The survey also addressed the ways in which the service has facilitated their access to other help and support (see Figure 6). The most commonly reported help received (reported by

71%) was help with housing issues, followed by support in accessing GPs (65%) and other health services e.g., hospital appointments (59%). When asked to further explain their responses (see Table 5) many participants referred to the practical help they received regarding their housing needs, as well as accessing medical appointments in order to respond to need (e.g., accessing emergency dental or GP appointments), as well as the support they received to proactively look after their health via attending for physical health screening and reviews.

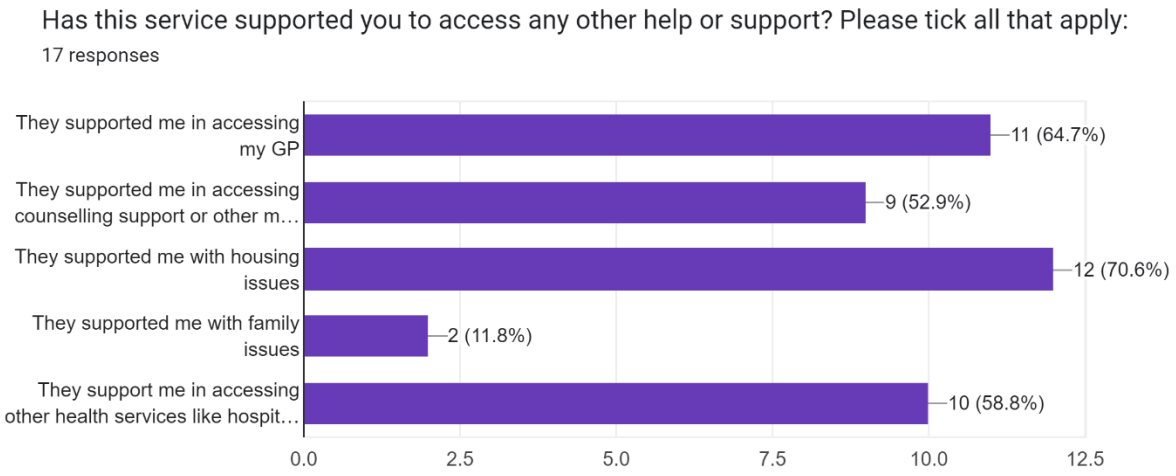

Figure 6: Service facilitating access to other supports

Table 5: Types of support received for accessing other help

Medical appointments – Reactive need
Supported him with attending GP and encouraged him to attend a&e when he was sick
helped me link with gp and an emergency dentist through Brian and link with ATU
I've been supported to make medical appointments and attend them as well as link in with mental health services and programmes at FHDC
SU states that FHDC staff has supported him in making medical appointments
When I wasn't well Tina told me to make an appointment with my Doc and Woodlea house when my mother died.
SU states fhdc has helped him with all of the above. staff supported him with getting appointment at the atu.

Medical appointments – Proactive health screening
The FH Health Peer Advocate has helped me access my GP for a physical health review.
I have had health screening by the Public Health Nurse.
I received physical health screening from the homeless Public Health Nurse.
Housing
Supports me to link with my key worker from housing rights
Supported him with managing his tenancy.
She also came with me to sign for my new house as I didn't have anyone else to come with me.
They have helped with my housing applications.
FHDC have supported me in making appointments and supported me in moving into a permanent accommodation.
Other
Service User is linked in with our Floating Support Team and her support needs are also met there.
My mental health team has done the work

Finally, in terms of substance use harm reduction, many of the participants (n=11, 65%) reported that the service had helped them reduce the harm caused by substances. Additionally, 53% (n=9) reported that the service has reduced their use (see Figure7). Further information regarding their substance usage reduction or harm reduction is presented in Table 6, demonstrating the tangible examples of service users' self-reported harm and usage reduction, as well as insights into the facilitatory support received from service staff.

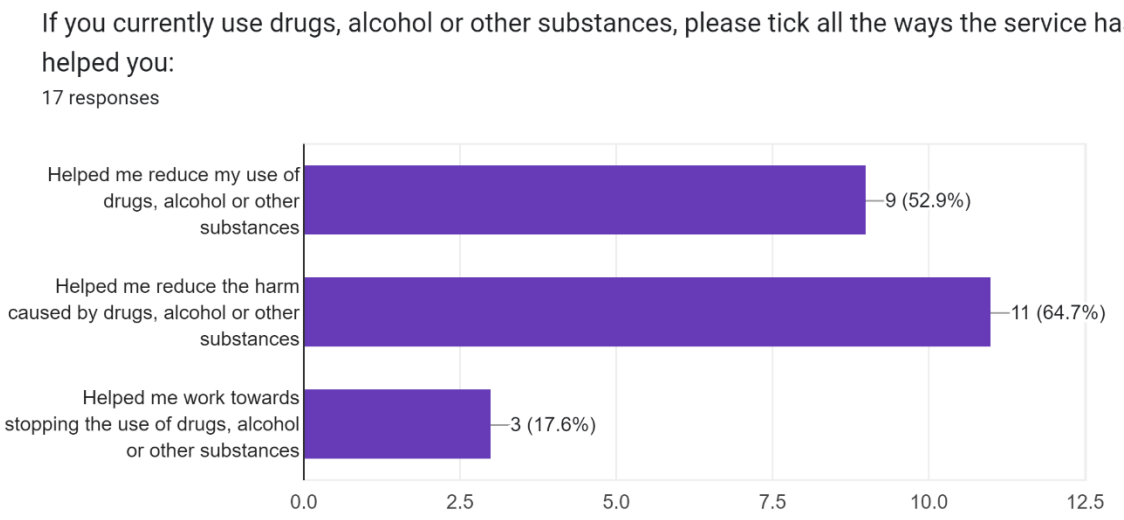

Figure 7: Service helped with substance use

Table 6: Substance Use

Reducing substance use
I have reduced my alcohol consumption a little bit
Attending FHDc helps reduce my drug use
I have reduced my intake of drugs since attending the centre.
Being able to attend the FHDC has been a good way of harm reduction for me.
SU has been sober for several months now, he stated that knowing he can attend FHDC as a means of harm reduction and distraction, as well as for a listening ear and support has really helped him in stopping his use of alcohol and other substances.
Being able to attend the FHDC helped me reduce my drug and alcohol intake and was a great means of harm reduction.
It definitely is a good source of harm reduction
I am now off heroin and cocaine. It helps to have someone supporting you. [staff name] is amazing xx
SU states their drug and alcohol use has reduced since attending FHDC regularly.

SU states when he is in fhdc he does not drink as much. he is provided with a hot meal daily.
Staff support and lifesaving intervention
Staff provided emotional support and a listening ear whilst SU was completing his detox staff can help when I'm HUTI staff have administered naloxone to SU

5.0 Service User Representation: Qualitative Findings

This section will present the data collected from service users across the three services involved. Note, that the duration and depth of the participant interviews varied widely across participants. Further depth and insights tended to be provided by those who reported greater progress in their harm reduction journey. As such, some individuals and some services may appear more frequently than others. This is not a reflection, in any way, of service provision, rather a true reflection of the data collected.

Firstly, the positivity, compliments, and appreciation the service users had for all services must be recognised (a snapshot of this general appreciation is presented in Figure 8). As this section progresses, insights into participants' circumstances, how they have used the service and how the service has benefitted them will be explored.

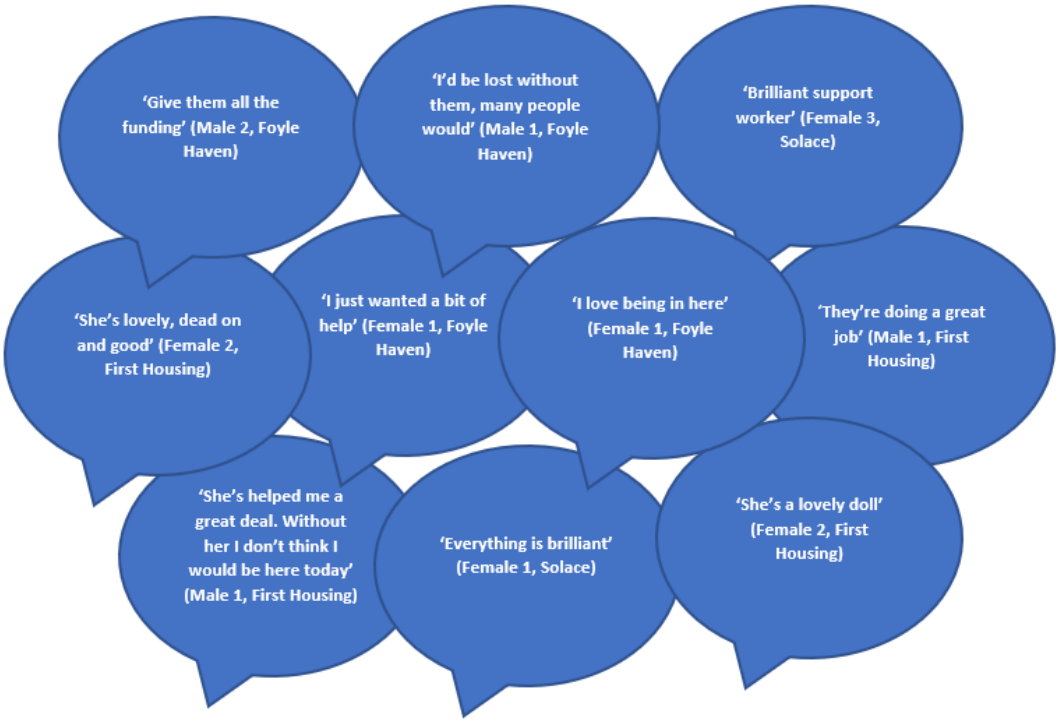

Figure 8: Participants' general appreciation

5.1 Participants' substance misuse and challenges

Some of the participants interviewed presented information and insights into their background and their substance misuse. One service user described their early onset of drugs

as a teenager and the motivation for change sparked by eyesight loss, as a result of drunkenness.

> *'Always dabbled with drugs from I was a teenager and never realised the effect and never really thought of the effect it would have on my life…I was drinking at least 12 tins every evening and July 2019 I [injury] ending my self-employed …business and then I really started drinking. I suppose it was my own therapy, I would have always been fond of it but I had to get drink every evening. The following spring was Covid, lockdown, barbeques everybody was drinking. And it's not until I had a bad car accident in October 2021. I knocked drink on the head myself but then I would have been using powder or cocaine as a substitute as a crutch. I wouldn't have been a heavy drug user. I could have got an eighth and it done me a week. (Male 1, Solace)*

The resulting impact on this participant's life was also presented, as a life lived in chaos and without fulfilment.

> *'I wouldn't have got out of bed. I went through ruts of not getting out of bed until 6/7 in the evening. That's not healthy. And then when you are out and about get a second wind, maybe meet somebody and then you're not in until 7/8 in the morning. It's not the way to live your life. (Male 1, Solace)*
>
> *'I wasn't keeping appointments. I didn't give a damn. As long as I had a tenner for a pack of beer I didn't care. And then a wee bit of the toot as well. And it's not the way to live. I was back living with my mother at the time. Rows at home and the whole thing… you can go into a dark hole very quickly… I still have problems sleeping at night but I'm usually up and out at 9 in the morning.' (Male 1, Solace)*

Other participants discussed the mental health vulnerabilities they have experienced, which may have played a role in their substance misuse.

> *'Drinking self-harming, suicidal thoughts in and out of hospital. Every counselling session I could do. I didn't want to be helped. I just wanted to die.' (Female 1, Solace)*
>
> *'I have a drink problem. More of a binge drinker. When I go on it I go on it. I have mental health issues.' (Female 3, Solace)*
>
> *'When my son went into his teenage years he got involved with legal highs and it's been a 10 year rollercoaster since that…I now use the service from a parent point of view. For my son….I have two other children as well so I'm very focused on harm reduction…but [staff name] tells me I have to look after myself….(son) fell into the*

wrong crowd at the wrong time. He was dyslexic, vulnerable. He would have told me that he felt he fitted in with them and that was the first time that he fitted in…he smoked a lot of cannabis very young. When the brain is still forming and the legal highs and all that. He feels broken.' (Female 4, Solace)

Additional adverse life experiences were also expressed by other participants, such as, accidents, stress, and bereavement, which, from the participants' perspectives were triggers/ contributing factors to participants' substance misuse.

'I was in a serious accident a few years ago and I've had violent relationships. She helps me with all that. A brilliant support worker.' (Female 3, Solace)

'So I am with them 5 years. When my dad died in 2018 I was off drink for 9 months and then come February 2019 I started drinking again, so from that date until I met [Support Worker] which was 4 years ago.' (Female 1, Solace)

5.2 Service engagement

The ways in which service users used the service differed depending on the service. For example, those engaged with First Housing and Solace referred to interactions that were either face-to-face or over the phone (in their own home), at a frequency that best suited their needs.

'I would rather have a phone call than visits.' (Female 1, Solace)

'[Support Worker] came out to me a few times and he keeps in touch with me every week. At least once a week on the phone now. There are people that will need him more than me but he has given me a willpower inside and I do want him to keep in touch with me.'' (Male 1, First Housing)

'She's lovely, dead on and good. She is actually good to me. She comes out and visits me.' (Female, First Housing 2)

'Once a week, then it was…once a fortnight…I'm out of them now at the minute…I had to go back to Woodley house…I can ring if want to…she says no problem, ring me' (Male, First Housing, B)

'There have been situations when he has come out (to the house). One time he had to get medical intervention for me and he did that. We would also do phone calls, or come in here or go for a walk.' (Female 4, Solace)

'She keeps on ringing me and she comes out to me and all.' (Female, First Housing 2)

For one participant the type of service engagement differs, whereby her son (substance user) is no longer engaged, but she remains engaged for support.

> *'It was me and my son, he has come to the house and met my son but he has stepped away from that at the minute. Not engaging. But the door is always open and he knows that and is well aware of the service and I've always encouraged him. It is a minefield out there trying to access services. I couldn't do it without the support to navigate…I'm using the service a lot at the minute but if things settle down … (Female 4, Solace)*

Foyle Haven, due to its centre-based delivery model, offered a more immersive experience. Many of the service users reported spending a large proportion of their week at Foyle Haven.

> *'Five days a week minimum' attendance (Male 1, Foyle Haven)*
>
> *'I'll hit the five days, sometimes six or seven' (Male 1, Foyle Haven)*
>
> *'I moved from [location name] 23 years ago and I was in a hostel….got me in touch with this place, I had knew nothing about it…I came in craic 90…I've been coming back since' (Female 2, Foyle Haven)*
>
> *'Five days a week' (Female 2, Foyle Haven)*
>
> *'Every day' attendance (Male 2, Foyle Haven)*
>
> *'Every day is different, some days I don't come at all…sometimes I come two or three times a day' (Male 2, Foyle Haven)*
>
> *'Near enough every day' (Male 3, Foyle Haven)*

Those attending Foyle Haven tended to appreciate the 'home from home' dynamic with a regular routine involving them 'simply' (though the power in this is recognised) being socially active in a communal environment, enjoying a game of pool, cup of tea and a hot meal.

> *'Sit and have chats with people…play pool…get something to eat…it's good' (Female, Foyle Haven)*
>
> *'Socialise…game of pool and chat, I'd be here for hours' (Male 1, Foyle Haven)*
>
> *'Play pool…talk to people' (Male 2, Foyle Haven)*
>
> *'We would just come in and have a game of pool or two, cup of coffee, something to eat, have a shower' (Male 3, Foyle Haven)*

In addition to these regular activities, Foyle Haven service users (as well as one participant from First Housing) also complimented the 'extra' activities they participated in.

'I go to all wee courses and all here….arts and craft courses…a wee bit of counselling and all'

'I've done pottery…cooking, it's just the basics, it's getting you into interact with other people…learning new things you've never done before' (Female 2, Foyle Haven)

'They try to do day trips…we went to an adventure place two or three weeks ago….enjoyed this, good to do more. (Male 2, Foyle Haven)

'aye she got me into a couple of ones (support services)….(names one)…meditation…grand…she was trying to get me into ship…well health group….aye I go now and then…' (Male, First Housing B)

'They offer you things to do…like go out for the day…go to the beach…they put on pool competitions…for lunch there the other week they had Domino's pizza…its lovely' (Male 3, Foyle Haven)

'The stuff we do at 'ship' is making stuff with my hands…aye I do (enjoy it)' (Male, First Housing, B)

Whilst those engaged in this research (from Foyle Haven specifically) appeared respectful and appreciative of Foyle Haven for the 'regular' and 'extra' activities they could avail of and for the general support provided, there was a perception that others use and abuse the service.

'It annoys me when junkies come in….they just come in and slabber to the staff…use and abuse the place' (Male 3, Foyle Haven)

'Ones that come in there and they don't care…it annoys me' (Male 3, Foyle Haven)

'I would pass myself….what I've found with all them ones they're jut out to get what they can get….use and abusers' (Male 3, Foyle Haven)

Others '…use and abusing...shouting and slabbering…not in a place here to help you…show respect' (Male 3, Foyle Haven)

Those engaged in this research were keen to demonstrate, in contrast to the above, their respect for the service and the facility.

'But I don't spend all day…I don't want to put that look across…using the service…'I'm always polite and they're polite to me' (Male 3, Foyle Haven)

'I would never disrespect this place in my life' (Female 2, Foyle Haven)

'If I ever have weed I would never smoke it out the back…I'll not sneak around' (Male 3, Foyle Haven)

Finally, one participant who had been using the Foyle Haven services for many years recognised over the years the changes in how the service is used and the changes in those using it. Changes noted included a perceived increase in drug usage (and subsequent new challenges for delivery staff), displaced service users from elsewhere, and a reduction of support and community amongst service users.

> *'It's changed you know…years ago whenever we used to drink on the streets there would have been no bickering…if anyone needed a pound, if anyone had a pound they would have given it…it's all changed because drug users…in here has changed a lot over the last 10 years because the staff is hands on to deal with people who come in…overdoses, people fall asleep…naproxen would be used quite a lot…I wouldn't know I don't associate with that' (Female 2, Foyle Haven)*
>
> *'It's changed a lot, because we're getting people from…Belfast, Antrim…coming here and they're sort of way using the place' (Female 2, Foyle Haven)*

5.3 How the service has helped

All of the service users (across all three services) interviewed described a range of different ways in which support workers have helped them, from practical assistance, to liaising with external agencies and social and emotional support.

> *'I think it (the service) is the best thing I ever got. To tell you the truth.' (Male 1, First Housing)*

5.3.1 Practical help: Food, transport, liaison

There were a range of reported ways in which service staff provide practical support to service users to ensure their fundamental needs are met. For example, by ensuring they have eaten or have enough money for food and essentials.

> *'She helped me with food and getting this place. And I got a new friend.' (Female, First Housing 2)*
>
> *'I come in in the morning, they say hello, ask me how I'm doing 'are you hungry'…make sure I'm fed…they're happy to help' (Male 3, Foyle Haven)*
>
> *She helped me times I didn't have food and all. My money was messed up. I couldn't afford it like. (Female 3, Solace)*

'Somewhere you can come to get something to eat, shower, wash my clothes…it's a God send' (Male 3, Foyle Haven)

Additionally, some service users also referred to service staff helping them with transport needs, e.g., to get home or to and from appointments.

'I was trying to get a house and [staff name] helped. She's more like a counsellor. She comes out once a fortnight and phones me the odd week as well. That's how I got to know her.' (Male 1, First Housing)

'Phone calls and visits with her. I have an awful lot of hospital appointments. She brings me to my hospital visits and all.' (Female 3, Solace)

'Aye she does (help)…she always asks if want me to take you to the shops or anything' (Male 2, First Housing)

'Given lifts home.' (Female 2, Solace)

'If you're stuck to get home, they'll get you home' (Female 2, Foyle Haven)

'People drinking in the street…they'll make sure they're taken to a safe place' (Female 2, Foyle Haven)

'She asks me if need to go to the shop or anything, she'd take me.' (Male, First Housing, B)

Some of the service users also described the practical help they receive from the support staff in terms of liaising with different services and helping them with the administrative processes involved.

'I talk to her about drugs and alcohol. Eh....Anything I need I would ask her. She helps me. Fill in forms and all.' (Male 1, First Housing)

'If I ask for help…they ring my doctor…I wouldn't do it myself…I can't talk on the phone…paranoia and anxiety' (Female 1, Foyle Haven)

'I needed housing and she helped me get this place.' (Female, First Housing 2)

'Any paperwork I need help with including my doctors, housing application' (Male 1, Foyle Haven)

'They're very hands on with everything…housing…whatever you need…doctor appointments…everything' (Female 2, Foyle Haven)

'*Get me involved with housing solutions there…they're on my side too…all thanks to these girls in here' (Male 3, Foyle Haven)*

'[Staff name] made a lot of phone calls for me.' (Female 2, Solace)

She helped me so much with the housing executive. She's been a great help that way.' (Female 3, Solace)

5.3.2 Providing a culture of (and relationship based on) care for emotional support and wellbeing

The service users interviewed were extremely complimentary of the staff with whom they were engaged.

'She's a great girl. Talks to you. She's a great person and only for her I would have no one at all.' (Male 1, First Housing)

My worker is absolutely brilliant. I would find it hard to connect with people but she has been absolutely brilliant. She's a credit like. She has helped me talk and takes me for shopping and stuff. (Female 3, Solace)

'I'd be lost without them…many people would' (Male 1, Foyle Haven)

'She's a lovely doll.' (Female, First Housing 2)

Service users provided examples of the emotional support they have received from the service staff, whether during a time of crisis, or just a point of support in everyday life.

'And then before I met [staff name] in April, I was took into hospital because I was suicidal and I think then it was the crisis team that wanted to send me to see about my alcohol. I just went along with it and said that's ok but I didn't think it would work. And then when [staff name] landed… he had a lot of work ahead of him I tell you' (Female 1, Solace)

'My addiction...I've a good boy and a bad boy…I have to be a good boy now…I'm stage two of liver failure…[staff name] is brilliant…see my counsellor on Friday' (Male 2, First Housing)

'I had a wee thing with my brother…care worker came in…I go to talk to her…she helped me feel better…I've had those sort of workers before in my life but…she helped me like' (Male 3, Foyle Haven)

Having a chat, giving me a lot of support. (Female 3, Solace)

[When asked what is the best thing about the service] 'Waiting for her to come and see me and having a good yap (Male 2, First Housing)

The data suggests that the service staff have cultivated a respectful, trusting and supportive relationship with the service users, facilitating meaningful and (apparently) successful spaces

for emotional and social support. This positive and trauma-informed dynamic appears to be facilitated by four foundational underpinnings, 1. Relatability, equality and lack of judgement; 2. Trustworthiness and transparency; 3. Genuine care and professional closeness; and 4. Forever support.

1. Relatability, equality and lack of judgement

There were numerous examples in the data whereby the participants discussed the 'down-to-earth' approach of the service worker, whereby a sense of common ground and relatability was established, without hierarchy or judgement.

> *'It's nice now…when [staff name] was there…waiting for her to come…auld yap…talking about the auld days and auld sayings…all that there' (Male 2, First Housing)*
>
> *'They don't judge anybody…everybody's equal' (Female 2, Foyle Haven)*
>
> *'They're not judgemental whatsoever' (Male 3, Foyle Haven)*
>
> *'It's the more down to earth (approach). There two younger ones on the mental health team and I would not feel comfortable talking to them at all. I'm comfortable talking to [staff name]. (Male 1, Solace)*
>
> *'Feel accepted, no judgement' (Female 1, Foyle Haven)*

2. Trustworthiness and transparency

The service users appreciated the confidentiality and trustworthiness they received from the service delivery staff, as well as the transparency and honesty they shared.

> *'The confidentiality is brilliant' (Female 2, Foyle Haven)*
>
> *'Some people you can't trust, I found that trust in [staff name].' (Female 2, Solace)*
>
> *'I don't want to let him down [staff name]. If I took extra drink on a Saturday night I would tell it to him. There is no point telling him a lie. When I was in counselling before and you took extra drink you would get a lecture from them. Talking to you like a child. [staff name] will say, 'it's done, we just get going again'. (Female 1, Solace)*

3. Genuine care and professional closeness/understanding

The service users believed and trusted that their service providers genuinely cared for them and their physical and mental wellbeing. There was evident professional closeness and understanding between staff and service users, whereby service users gave examples of staff recognised their cues (when they were not ok) and where staff went over and above duty for them.

'I would never go up to them and say I'm feeling down….they seen me and seen I was a bit down…they're actually worried, they actually care' (Male 3, Foyle Haven)

'I knew the first day he came through the door it was going to be hard work. Not really me. He asked a load of questions. I wanted to tell him what he wanted to hear and I did do that for a while until he picked up … you're not telling me the truth. He phoned me one day and asked if I was alright and I said aye. I was a disaster and he picked up on it on the phone. And I need that. I don't need to go to appointments and say I'm alright when I'm not alright. It's not normal. (Female 1, Solace)

'I've been in hospital a few times…my head goes…they have come out to see me in hospital…anything I needed they would have went out of their way to get it…floating support…they come out.' (Female 2, Foyle Haven)

It is this genuine care that appears to set the Depaul and Consortium staff above other service providers that the service users have engaged in the past. On occasion, service users directly compared the services they have received, with the Depaul and Consortium staff consistently described as superior.

'…I'd been using [different service mentioned]…totally different…girls here want to help you' (Male 3, Foyle Haven)

'He has given me something that even mental health (couldn't). It's the way he talks to me. He's more on your level. More personal.' (Male 1, Solace)

'Listen I've attended mental health and all and they are good but the support that you get here is different. It is support.' (Male 1, Solace)

'He will phone me out of the blue. You have to torture for an appointment (with other services). It's the fact that someone is thinking about you. Wanting to see a doctor you feel like a nuisance.' (Male 1, Solace)

'So many people have helped me but never got me to stay off the drink.' (Female 1, Solace)

'You know when you talk to other counsellors you nearly know that they don't care like. Whether you stop drinking or not. [Staff name]'s is a different approach all together. Like I remember that morning the fella rang me and said it's a girl coming out to see you and then he rang back and said she can't come it's going to be a man coming out to see you. I said don't send no man out to see me, I don't want to see him. I told him when he came through the door, 'I don't want to see you like'. He said,

'let's just try and see how we get on'. He has a real good approach about things. A caring approach.' (Female 1, Solace)

5.3.3 Forever support

The data demonstrates that there was no perceived 'deadline' for the support service users were receiving rather there were numerous examples where the service users highlighted the ongoing nature of their support and their sense that, if ever they need it, the support they have received from these services will be available to them. Much like a friendship.

'I'll always keep in touch with [staff name]. Whether I need him or not I will always keep in touch with him until the day I die.' (Male 1, Solace)

'I thought that would have been us finished. When I had cut down. But he said even though you have cut down you still have bad days. And [staff name] was the only one who ever got through to my head.' (Female 1, Solace)

'When I met [staff name] I thought there would be a deadline. A date to stop because most of them do that and if you don't go to some appointments they don't want to see you. But I try and never miss an appointment with [staff name]. And I said to him is this going to be long term or what? He said I'm here until you need me. Whereas I was getting scared after a year thinking I was going to get discharged and back to normal again.' (Female 1, Solace)

5.3.4 Harm reduction

With regards to the harm reduction help, some of the service users provided brief insights into the harm reduction help they have received.

'Them staff has told me….and they said 'you've our support 100%' [to get back off drink] (Female 2, Foyle Haven)

'Help with alcohol use.' (Female 2, Solace)

'Assistance to go to Ramona house to do a detox. Referral through the doctor.' (Female 2, Solace)

'They would try and get you either in touch with somebody…try and wean you off it' [if wanted to stop] (Female 2, Foyle Haven)

For one of the participants, the low threshold harm reduction services provided a welcome social support system, one which can encourage their harm reduction,

'I was off the drink there…I am a drinker…in here helped me a 'ell of a lot…people who come in 'come on you're doing great' – getting the feedback from the users in here…unfortunately I'm back on it, but I'll get off it again' (Female 2, Foyle Haven)

Another service user provided a more nuanced insight into what the harm reduction assistance has looked like for her, by way of:

1. Supporting her to gradually reduce her drinking to set days and times in order to meet a specified goal.

   'I had [Support Worker] come twice a week, we chatted. Still my drinking wasn't cut down. But gradually he got my drinking down. He's let me miss a day. So I was down to 6 days drinking. Then I got down to 5 days, then 4 days and at the moment I'm down to two days. But if I drink on Saturday I'm not drinking all day Saturday. We have it down as a set time and a set amount of drink that I can drink.' (Female 1, Solace)

   'I was on the waiting list for [treatment centre name] for [traumatic experience] and they wouldn't take me because I was drinking. I was on the waiting list for years for it and I said to [staff name] 'that appointment could come up any day'. And he said that is the target we need to work on. So the drink was cut down for a whole year and then I started with their services and I'm with them as well as [staff name]. So that means I have the two services together.' (Female 1, Solace)

2. Encouraging her to reach out whenever she feels in crisis

   'Still now there are times I feel like I am still in crisis. But I haven't went to suicidal thoughts since I met [staff name]. Because he said if I have a bad day just lift the phone and talk to him. Or if there is a day that I am craving alcohol I ring [Staff name]. Cause I know I can't go back. The way I was before I can't afford to go back there.' (Female 1, Solace)

3. Building capacity and resilience in acknowledging and responding to triggers

   'A couple of months ago I self-harmed. I'd took drink and saw the person who had abused me. [staff name] and I talked about it and he said you should have lifted the phone and talked to me but I was scared to lift the phone and tell him I had done this. But now we have both chatted about it I have realised I have met that person a few time since and I can't afford for this to keep happening. I always learn, from making mistakes. (Female 1, Solace)

'One day I had a disaster week and [staff name] picked up on it on the Friday. And I said to him I feel like I'm in crisis and I need to go into hospital and he said you're in crisis but you are not going into hospital. So, we chatted through it and I had his phone appointments all weekend and he got me out of it. (Female 1, Solace)

4. Facilitating transparency regarding 'slip ups' and carving out progressive pathways forward.

   'Like if you make a mistake today and have a drink, that's ok you have it done. Let's talk about it. Tomorrow we can't afford to be doing that again. Brilliant, absolutely brilliant.' (Female 1, Solace)

5.3.5 Wider familial help (in light of poor statutory provision)

One service user, who was attending the service due to her son's addictions, had been relying on the support of Solace to help navigate the challenges and to help bolster her own wellbeing for the sake of her full family. This service user exemplifies the need for wider familial help and support in navigating substance misuse (and the additional social and mental health complexities often associated), for the benefit of the substance user, but also for addressing the wider ripple effect that substance misuse has on families. For this service user, the support available to her was essential for providing an independent sounding board.

'It's just like a sounding board outside of families because if I have learnt anything on this journey it's if you go back you think one thing and …I'm separated from my son's father. He had a family and I had a family and everybody had all of these opinions all of the time. For me it's having someone to sound out and be completely independent of both parties. Someone who is emotionally detached as well was good to have as well.' (Female 4, Solace)

This participant spoke of the value in the support she had received from Solace, this was in stark contrast to her expressed disappointments and frustrations in the statutory service provision which she felt had failed her son. For example, by leaving mental health challenges untreated.

'He needed mental health support but they won't deal with that until you deal with the addiction. They separate them.' (Female 4, Solace)

And by leaving him for days in A&E with unmanaged detox.

'[Name] was in A&E for four days on a trolley before he got (detox/rehab)…. It's more the statutory side. Its constant barriers everywhere you go. You just feel that your doors are closing in your face everywhere you go. It is the statutory end of it. Even to go to A&E and sit with someone for four days who is suicidal…. There needs to be a separate mental health accident and emergency from the physical one because it is completely different. For example, because [Name] was there and he couldn't leave until he got a bed so he started to go into detox. I was saying this is really dangerous. This is why we couldn't do this at home. What are you going to do? And they didn't really know. They didn't really know what to give him. Then they gave him a medicine that's used when you withdraw from alcohol. And they gave him diazepam and anti-sickness and by the time he got to Asher he started to fit. The consultant in [treatment centre name] said he was lucky he didn't have a massive heart attack. Had he another day in A&E… He actually put him back on pregabalin and stepped down the dose. Managed detox. (Female 4, Solace)

This service user recognised the challenges faced by Depaul and the Consortium who are providing the best service possible, in spite of statutory challenges and failures.

'These organisations are trying to navigate this (statutory services) for people with very little resource'. (Female 4, Solace)

'Disconnect between Trusts… services.' (Female 4, Solace)

'[Name] can only offer what he has available.' (Female 4, Solace)

5.4 Outcomes

Finally, in terms of self-reported outcomes, the service users acknowledged a range of positive outcomes which they have attributed to the help received from these services. All of the participants, when asked, reported that the services had improved their physical and mental health.

'Helped mental health' (Female 1, Foyle Haven)

[Helped with wellbeing?]: 'oh aye, it really has' (Male 3, Foyle Haven)

'My head was so messed up and now I feel so content.' (Female 1, Solace)

Some participants recognised the reduction in their substance misuse.

'The help and support he has given me has given me the willpower to stay away.' (Male 1, Solace)

Service has helped me in lots of ways. I wouldn't be as far on, I wouldn't have had someone to turn to. (Female 2, Solace)

'I wouldn't be as bad now (on alcohol) … it's not as much I would drink.'. (Female 3, Solace)

Additionally, some participants pointed to the powerful lifesaving and life changing impact of having engaged in these services.

'She's helped me a great deal. Without her I don't think I would be here today.' (Male 1, First Housing)

'Well I want to live. When I met [staff name] I didn't want to live. Ten years ago I wanted to die. I didn't want to be here. [staff name] has made me think now even when I take a drink, I might cry the odd time but I'm not as bad as I used to be. When I used to drink I used to do so much crying. And then hurt myself because I couldn't get it out of my head. Now I'm content. [staff name] has made me feel that way. Only [staff name] is here I wouldn't be here like… He saved my life. Mentally I'm stable and I've made a friendship.' (Female 1, Solace)

'I have been very low at points and this service has saved me at key junctures.' (Female 4, Solace)

Similarly, one participant acknowledged the amount of time she had previously spent in A&E, whereas now this is no longer necessary.

'My partner can't believe it like…every weekend I was nearly in hospital. If it wasn't that I was in A&E for something else. It was just a disaster for him. Now that [staff name] is here he can't get over the change…You would nearly think I had a ward of my own I was in hospital so many times.' (Female 1, Solace)

Some participants also acknowledged improvements that centre around the ability to create more manageable and less chaotic lives, hereby, they are now eating well, engaging in hobbies, maintaining appointments and keeping on top of medication.

'I think I'm looking a bit better than I did. I'm taking care of myself a bit better. Eating better. I don't eat in cafes anymore I cook.' (Male 1, Solace)

'Better day routine.' (Male 1, Solace)

'But I say I have my appointments every week no matter what happens I have to go to them all. And they don't even believe it. I was a complete disaster. I have 3 routine

appointments and I go to the 3 a week. Before that I wasn't interested.' (Female 1, Solace)

'When I was drinking I wasn't taking my antidepressants or anything. I would have got them from the chemist and let them lie there. So I'm on all my routine medication now since I met [staff name]. Drinking has gone down to where I am content. I can't see me ever stopping as it's too scary but if he is content where I am and I'm content then that's grand. (Female 1, Solace)

'I still keep a few horses and stuff and I'm lucky that I have that interest.' (Male 1, Solace)

Additionally, social outcomes were also noted whereby new friendships have been formed, old relationships have been enhanced, negative relationships ceased, and social confidence improved.

'Relationships are better now with my family. My mother and father. People close to me.' (Male 1, Solace)

'I've made many friends in this place' (Male 1, Foyle Haven)

'I wasn't aware of people trying to drag me back into substance use. And the games that people would use. People I avoid now, I stay away from them.' (Male 1, Solace)

'I never thought I'd be like this. I never thought I would even be able to sit and talk to you two.' (Female 1, Solace)

'Even taking my tablets and all now I feel brilliant' (Female 1, Solace)

Additionally, one participant discussed holiday plans, whilst another also discussed future ambitions.

'Things get better for me I could come back here and volunteer' (Male 1, Foyle Haven)

'I go on holidays now. I'm going away in May. Everything is brilliant. I can make those targets now.' (Female 1, Solace)

5.5 Concluding remarks

On the whole, the service users demonstrated immense appreciation for the services they have received. In particular, their relationship with their support worker and the help they have received via them is of particular note. The service user data suggests the invaluable

services provided by Depaul and the Consortium, particularly in light of a dearth of other services within the area and in the face of increasing pressures.

6.0 Staff and Stakeholder Engagement: Qualitative Findings

6.1 Depaul Service Delivery

6.1.1 Mission and delivery model

Depaul Foyle Haven's mission is described as,

> *'Our mission is…..reaching the most marginalised in our society that were experiencing homelessness but who had health related issues associated with that.' (DP staff 1)*

Data from the staff focus group suggests that this mission is realised via a holistic, person-centred and wrap-around support provision which spans both the physiological and psychological wellbeing of their service users. All of which is delivered by a centre-based delivery model where Foyle Haven acts as a central communal hub and where every service user has a bespoke support plan.

> *'This is the hub, it acts as a central focal point and we have all sorts of services who bring clients here or collect them from here. It's that meeting place.' (Depaul FG)*
>
> *'Every service user has an individualised support plan so it is person centred practice as well. Our remit really is anything for that individual at that time, however small.' (Depaul FG)*

6.1.2 Services attending to physiological wellbeing

In terms of the services and support offered to service users, Depaul staff highlighted a wide ranging remit, attending to both the physiological and socio-emotional needs of their clients. In terms of the physiological needs, Foyle Haven offers a safe place for service users to attend to their own personal hygiene and to receive a hot and nutritious meal,

> *'(our service) covers so many things from people just coming into the centre and receiving nutrition, showers, emotional support, getting involved in activities, staff helping with housing.' (Depaul FG)*

Additionally, via a 'health hub', a range of health services are brought to the service users, facilitating screening, treatment, and capacity building for safer and healthier practices.

> *'We would see a deterioration in people's physical health as a result of their substance use and mental health. So, we have been able to develop a health hub in Foyle Haven and that means we bring health related individuals to the service so we are bringing the services to them. That's things like podiatry, eye tests, counselling services, holistic*

services, massage, chest heart and stroke. We would do cooking and nutritional programmes and educational programmes around substance use, harm, safer injecting and we now have the needle exchange programme out of the day centre as well. We also brought in screening for blood borne viruses, Hep B in particular. When the homeless health nurse was introduced into the West, we would have led on that occurring and she would have been based out of Foyle Haven to a great extent at the beginning and worked out of the medical room.' (DP Staff 1)

Secondly, Foyle Haven provides much needed peer advocate support, often acting as an intermediary between service users and the complexities of statutory services.

'Part of my role [peer support worker] is to advocate for service users. Our service users may not have the confidence to ask for help. Part of my role is to get them access to services, to GP appointments, take them there, advocate on their behalf as a lot of them don't understand or take in the information that is being said to them by health professionals. When I am there I am able to digest that information and pass that on for whoever I am advocating for. Also taking them to appointments where there may be financial barriers as a barrier to attendance I am able to take them to appointments, sit in with them and explain to them after if there is anything they didn't understand. We are also instrumental in trying to set up a dental service for homeless people and it is the first time that a local dental lead within the Trust has been approached to try and get outreach and get service users with severe dental issues seen. So that is work in progress. One of the proposals is to get outreach to give advice on good dental hygiene and possible referral onto dental services.' (Depaul FG)

Importantly, Foyle Haven provides lifesaving first response services in the administration of Naloxone, as well as facilitating safe needle exchange services and evidence-informed safer substance use.

'Also we shouldn't forget in terms of harm reduction the administration of naloxone and the staff here are experts and all have done it many many times. And that equates to saving lives really. And the police come here… the last time was two weeks ago, they came to the door and came to us because someone was unconscious in the city. We train people in the city as well. The needle exchange as well.' (Depaul FG)

'We are part of the DAMIS system and feed into the database. We do get reports sometimes about certain substances here or other parts of the country or the UK that

have a danger or risk from testing them so if we get those reports we pass them on to service users straight away.' (Depaul FG)

6.1.3 Services attending to psychological wellbeing

Beyond the physiological, Foyle Haven is also attending to the psychological needs of their service users, for example via in-house counselling provision.

'We have an in-house counsellor. And a volunteer who is also a counsellor.' (Depaul FG)

Additionally, psychological wellbeing is also enhanced via a range of social and emotional supports, for example via both in-house and external activities.

'*We have internal and external activities that we would encourage them to engage in and to try and remain sober for, trips out to the beach.' (Depaul FG)*

'…Nutrition workshops, art therapy, pottery, hairdressers, movie night, celebration of big events, colouring (therapeutic).' (Depaul FG)

'The day trips, staff take them physically away from the centre and some of them haven't been outside the city in years so this is a huge thing for them. One of the biggest things we hear is that recreational activities give them hope. That's the things they love.' (Depaul FG)

The staff acknowledged the benefits of the PHA funding for funding such recreational activities, as well as additional health-related programmes facilitated by external experts. There was a recognition that Foyle Haven's positive reputation encourages external facilitators to engage with their service also.

'Without the extra monies those activities would be restricted and would be few and far between.' (Depaul FG)

'We do some stuff ourselves but the PHA has given us additional monies and that makes a big difference to our project. So, we bring in facilitators and experts in their field particularly in health. We would not be able to do that if we did not have the additional monies. The programmes are distractions and diversionary tactics to get them away from using or whatever and get involved in here. We would have an extensive list of facilitators who would work with marginalised groups.' (Depaul FG)

'We are quite notorious the Haven. A lot of people are very happy to come in and be associated with us which is a good thing.' (Depaul FG)

6.1.4 Safe environment and underpinning policies

The safe and inclusive environment cultivated in the Haven was discussed by the staff. Described as a 'hub', the Foyle Haven model was described in contrast to other types of services (e.g., floating support services), whereby deeper connections between staff and service users were highlighted in what was described as a 'home from home' environment.

> *'There is a welcoming and validating environment. It breaks isolation. It is also a safe environment. The street might be their natural environment but it is not a safe place.'' (Depaul FG)*
>
> *'It's also that non violating environment, a safe place for people who are marginalised and isolated or who might cut themselves away from the community. This is a safe supervised space with all the support they get here too. Social interaction, positive experiences creating happy memories. They could be here every single day so it is about building that strong therapeutic working relationship which then gives us deeper access to inner thoughts and stuff that is maybe the source of the problem that we can help them address through structured programmes, referrals, counsellors so all those aspects. We also have eyes on people. A phone call or visit will only take in so much but spending this amount of time with people lets you delve deeper. It's a home from home. We have a communal area, a games room, a garden… it is laid out like a home. Gives a sense of belonging. People are here by choice.' (Depaul FG)*

Underpinning the safe environment cultivated and the services provided, as noted above, are core policies and practices which facilitate the ethos described and the services highlighted.

> *'In terms of our harm reduction, we have a damp policy which means they can be under the influence when they access the service but the idea is that they do not use on the premises. Encouraging them to measure their drinking, to think about their drinking and during the three visits it actually restricts the amount of time they spend outside drinking. All of those measures helps them reduce, address or at least be aware of the amount they are drinking, the number of times they are drinking, all of those things. (Depaul FG)*
>
> *'They are allowed in and out three times a day. That is to minimise the risk cause a lot of them when they go out they use. Drinking or using.' (Depaul FG)*
>
> *'People come in and out, they chat to staff, vibrant buzzing atmosphere. ' (Depaul FG)*

6.2 Solace Service Delivery

6.2.1 Mission and delivery model

Solace operates within the overarching mission of Arc, which strives to *'help others to help themselves'*, whereby as a service they focus on building resilience and capacity within service users in order to facilitate them in improving their own life circumstances and outcomes.

> *'Helping others to help themselves…. not creating a dependency on us…with our help and assistance to improve their circumstances… link them up with support from other services…. not as isolated, as lonely, as stigmatised, as vulnerable as they were when they first come in.…try and advocate and skill people to understand how they make life better for themselves.' (Solace, FG)*

Solace services are provided via a floating support model (considering the geographic spread and rural nature of the service and its users) as well as being supplemented by 'centre-type provision' where possible.

> *'We try to run a centre as far as we can…we have a centre on a Monday morning there in the Salvation Army at present where people can come in socially, a couple of hours of respite, get a snack and a cup of tea…socially mix…'(Solace, FG).*

6.2.2 Service users with Solace

The service users engaged in Solace tend to be referred from *'housing mainly recently or the hospital'* (Solace FG), but can also be referred from a wide variety of neighbouring services.

> *'We have a referral form…all the neighbouring services have it like the GP's, social workers… sometimes there was a couple of people who self-referred through that but mainly have referrals in from social work, alcohol counsellors, the hospital, the mental health team (Solace FG).*
>
> *'We take referrals from absolutely anywhere when it's within our jurisdiction. Within the southern half of the Western Trust…self-referrals, social workers, community addictions team, alcohol liaison nurse, housing executive, family member, PSNI, all kinds of agencies …we triage the person…they are literally coming from all and any sources… only caveat…that the person themselves must consent in writing to the intervention' (Solace, FG)*

6.2.3 Services attending to physiological need

A range of different services are described by the Solace staff, all of which are determined by the specific individual needs of the service user, for whom more intensive support might be required, whilst others require less.

> *'Approaching them to provide befriending, advocacy and support service…you identify need, you meet the person, introduce yourself and form a relationship…carry out an assessment to identify need and then you would put in place what services might be appropriate as far as resources can allow…' (Solace FG)*
>
> *'Some might not need very much…just a bit of support for a few days' They maybe have the academic or career background…they have the information themselves…have one like that at the minute…she's got herself back on track, she's saying 'I'm ok now' (Solace FG)*

With regards to the types of support offered, the staff referred to a wide range of service provision, spanning every aspect of the service user's life, from housing, to health (physical and psychological), and finances.

> *'Gaps in medical things…referrals to counselling…transport to get to doctors…neglected themselves…dentistry…missed medical appointments…trying to get that back on board. We're usually very successful with that. Housing as well sometimes, you can negotiate a wee bit with the Housing Executive. We would have a good relationship with the Housing Executive, first housing, all the local services really, SVP, accessing furniture, second hand furniture shops…get them down to citizens advice…benefits have stopped…in poverty and hardship…sometimes they can be victims of so called friends who are using their money so you're trying to…get other people involved…' (Solace FG)*

6.2.4 Services attending to psychological wellbeing

Whilst not necessarily undertaking therapeutic work, one support worker referred to his own counselling background and the opportunity he has to exercise this skill in his role, filling a much-needed gap in service provision for the service users.

> *'The management…will allow me that space….there's no one coming behind me…it's better me using my skills when I'm in there' (Solace FG)*

Additionally, the service's role in empowering service users (rather than 'policing' their substance issue), building self-esteem and equipping them psychologically to better improve their own physiological wellbeing was also recognised.

> *'We advocate on their behalf...in the background we're always talking about why are we here, what has brought us to here…what's brought us to here is the substance, how do we manage that and how do we reduce that? (Solace FG)*
>
> *'We're trying to empower them, not create a dependency…we build up their self-esteem…we step back and step back…and hand them the power' (Solace FG).*

6.3 First Housing Service Delivery

6.3.1 Mission and Delivery model

Staff acknowledged a wide and varied service provision in order to facilitate '*early intervention and prevention'.*

> *'We achieve this through simple, yet impactful measures such as identifying those at risk of harm due to alcohol consumption, providing information on reducing consumption, and connecting individuals to specialist services, when necessary.' (Follow up communications from First Housing Director of Operations)*

First Housing service was described as a remote service, rather than the centre-type provisions at Depaul and Solace (to a lesser extent).

> *'As a low-threshold service, our approach differs slightly. While it may resemble Solace's model, it's less like DePaul's. Unlike these organisations, which have centres, we are entirely community-based. I cover rural areas, in Strabane and Limavady and surrounding environs engaging with clients directly in their environments. My role is part-time, spanning 26 hours a week, which limits my capacity in providing these services.' (First Housing FG)*

In practice, staff explained this involved a mixture of face-to-face visits, supplemented by telephone support, the frequency of which very much is dependent upon the service user and their needs.

> '*For me, it typically involves a face-to-face visit every fortnight, supplemented by weekly phone support. The phone is always available, and sometimes, the need can be quite urgent—I've had instances where I spoke to a client five times in one day. It really depends on their situation and whether they are experiencing a crisis. Face-to-face*

conversations are more structured, allowing for a deeper connection.' (First Housing FG)

6.3.2 Service users engaged

The staff member highlighted a range of different referral mechanisms and a variety of different types of service users engaged in their service.

'Referrals come from various sources. I deliver additional hours within the First Housing floating support team, so referrals might also come through them, particularly if addictions are flagged as the issue. Occasionally, there are specific referrals for harm reduction, which may come from mental health services. Just this morning, I received a referral from a social worker at a GP practice.' (First Housing FG)

'We also receive self-referrals and referrals from families, the addiction service, the Housing Executive, and social workers.' (First Housing FG)

In terms of the types of service users currently engaged, a large majority suffer from alcohol misuse, with fewer using drugs (prescribed or otherwise).

'I'm currently supporting 11 clients who all have alcohol-related issues. I have one client who uses crack cocaine and is an ex-heroin user now on a substitute prescribing program. Another client on the same program for heroin had been using cocaine but has since reduced that. In our area, alcohol misuse is predominant, though other substances are also present. I know that in [location name], drug use can be much more intense.' (First Housing FG)

6.3.3 Limits to service delivery

As a part-time floating support worker who spends a great deal of time travelling throughout the remote areas to reach service users, there was a recognised finite amount of time and resource to fully addressed the volume of recognised need in the community.

'I manage 13 clients in just 26 hours a week, with two more waiting to be opened. There's a significant amount of driving involved as well. If there's an influx of people needing the service, it can become overwhelming.' (First Housing FG)

'Managing the needs of those who are isolated and in need of support can often be challenging. With limited capacity I am hampered by how much support I can provide.' (First Housing FG)

The staff interviewed provided insights into enhanced delivery models, involving additional floating support workers and additional support provisions, however, they recognised that within the current funding structures, such enhancements are not feasible.

> *"We always thought our service would be more effective with two workers. This would reduce travel time, allowing more direct engagement with clients and better connection-building." (First Housing FG)*
>
> *'If additional funding were available, I have huge plans to be more creative. I would implement programs like a six-week cooking course where I'd provide ingredients and instruction on meal preparation. Recently, I distributed hygiene packs to clients, and for those without mobile phones, we secured funding to provide them. This has been really good for tackling social isolation. I have numerous ideas for service enhancements if the resources were available.' (First Housing FG)*
>
> *'There are ample opportunities within the PHA collaboration and some community groups to set up and facilitate new initiatives, should funding become available.' (First Housing FG)*

6.3.4 Services attending to physiological wellbeing

In terms of the service provision remit, due to the service user client base (primarily suffering from alcohol misuse, rather than drugs), focus is on harm reduction and minimising risk, rather than cessation promotion.

> *'Our low-threshold service includes offering safer injecting advice, links to needle exchanges, and overdose prevention initiatives like take-home naloxone. While I don't encounter many heroin users, our focus is primarily on alcohol use. This often involves tapering down consumption, keeping diaries, and ensuring basic needs are met—such as maintaining sustaining accommodation, electricity and eating daily.' (First Housing FG)*

In terms of what this looks like operationally, a wide remit of varied support services was described, for example, supporting physical health and wellbeing via supporting and educating.

> 'My direct support often centres around ensuring basic needs are met, such as maintaining a balanced diet, staying hydrated, and encouraging light exercise, even if it's just walking around the living room or to the shop. When a formal reduction plan

is in place, we work on tapering down and keeping a diary. I use various tools, such as the alcohol or cannabis use booklets, to educate and raise awareness. My role also includes informing clients about the dangers of polydrug use and updating them on any DAMIS alerts related to specific substances.' (First Housing, follow up communication from Director of Operations)

'In [location name], I regularly visited the needle exchange program. In smaller towns, clients are often hesitant to approach local chemists due to the lack of anonymity. To address this, I sometimes collected injecting kits on behalf of clients, maintaining their privacy.' (First Housing FG)

6.3.5 Services attending to practical, social and emotional wellbeing

Supplementing the services aimed at addressing physiological wellbeing are a range of support and advocacy services aimed at facilitating healthy living and connecting to services and supports, such as housing.

'We assist with benefits and housing issues and address mental health concerns by signposting clients to appropriate community groups.' (First Housing FG)

On a practical note, this looks like making appointments for service users, bringing them to said appointments, liaising with family members

'Many clients have hospital appointments, and I do my best to attend with them, especially those without family support who might struggle to process information on their own.' (First Housing FG)

'Advocating for our clients is a key part of my role, whether it's with community groups or primary care, or the Benefits Office. I assist in making appointments and ensure clients attend, all while encouraging them to develop their independence.' (First Housing, follow up communication from Director of Operations)

'That would be another thing. Working with families as well. They appreciate me going in and we would work together.' (First Housing FG)

Additionally, and in response to economic challenges, staff also facilitate financial assistance to ensure service users are in receipt of the correct benefits and that they are able to receive adequate food and travel assistance etc.

'When a client is in financial crisis, I assist by applying for and delivering food parcels. I also help with budgeting, working with clients to develop a plan together. During

Christmas, I arranged and delivered hampers that included everything needed for a full Christmas dinner.' (First Housing, follow up communication from Director of Operations)

"Due to the cost-of-living crisis, I've established links with local supermarkets to offer a small weekly shop for £5, which has been a significant help. The one in Strabane is particularly supportive." (First Housing FG)'

'I help clients apply for benefits and grants, such as discretionary support, local transport, and travel passes, and connect them to community groups and statutory services, including the Community Addiction Service, NIHE, and Primary Care." (First Housing, follow up communication from Director of Operations)

7.0 Overarching themes emerging

7.1 Collaborations with external agencies

A range of different agencies engaged in this research, providing insights into their own roles and remits and how they intersect with the services of Depaul and the consortium. Stakeholder 1, a lone working nurse in the Western Trust provided a wide and varied remit of health care provision, covering outreach, sexual health clinics and antenatal service provision.

'Support people living in temporary accommodation, no fixed abode…sofa surfing. Daily street outreach…provide some type of healthcare to prevent hospital attendances…all about protection, prevention…'Link in with antenatal services…link in with Royal, for anyone with blood borne virus' (Stakeholder 1; WT Nurse)

'Foyle Haven we go see clients there…we have run sexual health clinics from Depaul as well…I go there most days…just chatting with the clients, see what their needs are…we work together…we communicate what's the best way to do it.' (Stakeholder 1; WT Nurse)

Stakeholder 1 also referred to the value of Foyle Haven for those service users who were trying to refrain from substance usage and her liaising with First Housing for outreach support.

'Some clients are trying to keep themselves safe they don't want to be using drugs and alcohol, they want to be in a space where that isn't about' (Stakeholder 1; WT Nurse)

'Night support…First Housing…I would work closely with this group, they support me… if I'm out doing outreach and someone is unable to walk independently…or at risk of

falls…we would work together to get the person to a safe place so that's reducing harm to the person and harm to others…(Stakeholder 1; WT Nurse)

Stakeholder 2, a representative from city centre management initiative (CCMI) using CCTV, highlighted their role as the 'eyes and ears' in the city, liaising with other bodies, including Depaul and the consortium (Foyle Haven and First Housing primarily) as a communications hub.

'Housing…we would see them on CCTV. There have been occasions when we have rang Foyle Haven as well…primary focus for us would be the night time rough sleeping….we would engage with First Housing on that' (Stakeholder 2; CCMI)

Stakeholder 2 highlighted the collaborative nature of the work across all agencies, who endeavour to work together to improve the outcomes of this vulnerable population.

'We try to work together as a group' (Stakeholder 2; CCMI)

'Police, Housing Executive, day wardens ….case conference…'what are we going to do'? (Stakeholder 2; CCMI)

Stakeholder 3, an A&E consultant, described the challenges he faces in terms of developing consistent care plans for repeat A&E presenters.

'My main role here…I've tried for years to try and push some of my work in the community but it is just impossible so I try to get a consistent care plan for when they present and it is usually people who present on numerous occasions over a short period of time. They tend to have a very specified risk by the time they reach the department so if they are violent or known to take drugs etc etc … we can get a clear consistent plan early in their journey.' (Stakeholder 3; A&E Cons)

Stakeholder 4, a harm reduction nurse, described her role in detox management and the importance of community-based services that alleviate A&E or hospital pressures.

'My main job is detox management or management or alcohol or drug related conditions. Withdrawal, seizures sometimes overdose and carrying that through the hospital. For example if you came in and broke your leg after an alcohol related fall you also need an alcohol detox while you are here so I would manage the detox in the background of the medical care that you need. That extra layer of input.' (Stakeholder 4; HR Nurse)

'And from an A&E perspective expediting discharge, community supports and services if you can be treated outside of the hospital then we will do that. We have a home

detox nurse service, home detox options. To save our beds basically while giving people the appropriate care but just in a different setting.' (Stakeholder 4; HR Nurse)

Stakeholder 4 also highlighted Depaul and the consortium's role in providing a 'safety net' service, whereby they pick up certain needs that are otherwise being missed.

'A lot of my patient group anyway and probably the service users that we mutually share are not aligned well with services because of their substance use whereas Foyle Haven don't do that. They will keep working…keep working…keep working. They don't put them out because of what they are doing or the choices they are making. So it is one of those few safety nets that we have in the locality.' (Stakeholder 4; HR Nurse)

'Also the floating support, a lot of my guys who come in here who have floating support that's the only support they have and they have very complex physical and mental health needs. Many present with alcohol related brain injury and we don't have any services for alcohol related brain injury in Northern Ireland, at Trust level, and I think Depaul pick up a lot of that patient group. Especially the 50 plus men with memory problems related to alcohol and need that extra bit of support. I would refer to floating support as well.' (Stakeholder 4; HR Nurse)

'…So I try not to send them out with nothing. I try to influence and get them a taxi to the Foyle Haven. What happens after that is their choice. They can go there get something to eat they will look out for you, give you a change of clothes, toiletries. I would give them a call and have never had any problems.' (Stakeholder 4; HR Nurse)

Stakeholder 5, an addiction support project and training officer (AS) recognised the fit between Foyle Haven and other services was also recognised,

'My programme is aimed at people with complex addictions. Opioids, injecting and that. So, the clients that would have been coming into the Haven would be the clients that we would be targeting. So, it suited the needs of the Haven and ourselves in terms of providing services for that kind of client. And then the clients in the Haven maybe didn't have the confidence or know about the service that we are providing. It suited both organisations and clients, that the service was available to them in the Haven. We were able to bring counselling services, alternative therapies and group work. It suited all parties involved.' (Stakeholder 5; AS)

Stakeholder 6, interim head of service for primary care and professional services (HOS), highlighted both the challenges and opportunities for statutory and non-statutory services to

collaborate around the care of complex clients in terms of their progression through different pathways of care.

> *'We work very closely with those complex clients who are really difficult to get through to the GP. I also chair the WDACT and Depaul is part of that forum as well. We also have that exchange group meeting and Depaul would be part of that and they would bring feedback from the tier 2 services so that tier 3 and 4 services are then aware of the trends on the ground. And that really helps us to engage with our patients as well. I think when they come in to statutory services they tend to be a bit guarded and don't give us all the information. After working in a tier 2 service myself it is very different because the service users tend to treat the staff in the Haven like family. They would be much more open with them so see in terms of trends and themes and new drugs on the market and everything they would have access to and new drugs that would come in to the city you would be much more likely to find out about that through your tier 2 services. That helps us inform, educate, harm reduction for our service users. Equally it works the other way. When our service users are complete with the tier 4 or tier 3 and it is safe to step them down to tier 2 we would work very closely with Depaul to make sure that there is a follow-up advocate as well.' (Stakeholder 6; HOS)*

Stakeholder 6 also flagged the complexity of the services Depaul and the consortium provides, as well as the value (and discretion) of the health related services on offer, particularly for physical issues that are often neglected amongst service users.

> *'There is the homelessness nurse that we also provide from the Trust that also comes in and can do Hep C blood testing, health testing for these individuals. The Western Trust podiatrist would go in because foot health is something homelessness and addiction, they don't pay attention to it. You have people that are diabetic and high risk, all those services in the Haven is done so discretely. There is no sign above that door saying its Depaul services and there is power in that. People can go in there and nobody knows where they are going to.' (Stakeholder 6; HOS)*

Finally, Stakeholder 7 a Health Improvement Officer for the Public Health Agency (HIO) highlighted the challenges faced by Depaul and the consortium and commended their approach in the challenging environment that they work within.

'It is multi layered and they are looking after the needs of very complex individuals so I've always found that the staff in the Foyle Haven and the LTS, have always been really good people. Really caring and supportive and sometimes I wonder how they deal with the difficult situations that they are dealing with. They do a really good job for the kind of difficulties that they face.' (Stakeholder 7, HIO).

7.2 Strengths and outcomes of the Depaul and consortium service delivery

In general, the Depaul and Consortium services appear to be well regarded by the external community. Their work appears to be valued by external stakeholders and the challenging circumstances within which they deliver such work is also recognised.

'My view is that it is a very well [run service]… they are working in a chaotic environment and it's very difficult and they have different people coming in and out so from the point of view it's not a simple service where you do one task and that is it.' (Stakeholder 7; HIO)

'I think they are amazing services. Any opportunity I get I refer, especially to clients struggling with homelessness and addiction issues. It's great. In terms of what they do when they work with them and benefits for clients.' (Stakeholder 5; AS)

'The amount of work and quality of work that comes out of this office is unrivalled' (Solace FG)

'Without them I don't know how this place would operate' (Stakeholder 2; CCMI)

'Because of the demands of the services, Foyle Haven is under pressure and they do phenomenal great work.' (Stakeholder 2; CCMI)

Across both the internal Depaul and Consortium staff, as well as the external stakeholders, a wide variety of strengths of the service were acknowledged, as well as resulting positive outcomes. Each of these are presented in turn below.

7.2.1 Addressing gaps in statutory service provision

Firstly, the role of Depaul and the consortium in capturing a range of service users, and particularly those who would otherwise not meet the criteria for statutory services, was a recognised key strength of the service provision.

'You've to be over 65 to be eligible for the elderly team….you've to be quite fragile to get help there…physical disability to qualify…hard to get them across the line for social

work…there's no social worker for alcohol as such….don't meet the criteria – bridging that gap' (Solace FG)

It was recognised that for many service users, their connection with Depaul and the consortium was the only support they were availing of, where statutory services had missed or failed them.

'Often…. we are the only people in the game and that includes family…we are dealing with lots and lots of people that if we weren't communicating with them they would be dealing with nobody…absolutely nobody…the nature of addiction, they've burnt a lot of bridges and they don't come under the radar until they are physically unwell and end up in A&E or in hospital…addiction is the great reliever, it relieves you of everything…family members are gone, they've burned their bridges with the GP, not turned up to addiction appointments…society as a whole…they're seen as a little bit eccentric or a loner…nobody goes near them….that is the beauty of this service' (Solace FG)

7.2.2 Meeting the needs of service users and building foundations for improvements

As Stakeholder 6 recognised, Depaul and the Consortium's services are facilitating improved life outcomes by providing stable foundations, by attending to the basics of human need. For example, Stakeholder 2 recognised the value of First Housing's role in getting people off the streets and into accommodation.

'Getting people off the streets…First Housing are superb at that…finding them accommodation and the right services…First Housing are superb at that…' (Stakeholder 2; CCMI)

Furthermore, Stakeholder 6, usefully framed in the context of Maslow's Hierarchy of Needs, highlights the importance of stability in such foundational outcomes (food, heat, shower) in order for service users to address subsequent challenges in their lives.

'If you think of your Maslow's hierarchy of needs your family is in there and they are such a stabiliser for you and if there was a family support worker working on that stabiliser the food, the housing, they are all practical elements that those staff work on. If I had to embody Foyle Haven I would say that is it a stabiliser for your Maslow's hierarchy, that is what they work on. They try to work on those stabilisers to try and get you back into the community and confident in yourself.' (Stakeholder 6; HOS)

'The fact that they have a cook in there and even just getting people to eat on a daily basis is harm reduction in itself. Creating that communal environment where people can come with the same issues, there is no judgement they can have a meal, they can have a cup of tea and then they can speak to someone they can really trust about what is going on or what is escalating in their life or what has got better in terms of stability.' (Stakeholder 6; HOS)

'For someone who has maybe rough slept or they maybe have been sofa surfing for a few days, to come in and have a warm shower. To be able to come out into the laundry room and get something that smells fresh there are so many donations so it is good clothes they are getting as well. Then to come downstairs and get a bit of food.' (Stakeholder 6: HOS)

The value in providing the basics of physiological and social need was also recognised by Stakeholders 2, where the services of Foyle Haven were equipping service users with the capacity to engage in society again.

'The services that Foyle Haven provide…they get fresh clothes, fresh showers, they get fed and looked after…' (Stakeholder 2; CCMI)

'[the service that] Foyle Haven provide is underestimated…how isolated some people are …not your normal indigenous vulnerable people…provides a friendship for people…comradery…it's amazing how that can build self-esteem…a bit of recovery…they're sharing, they're in with experts, they're getting their food, medication, they're clean and their amongst their friends…that creates a great platform for people who have been on the street….taken off the street with first housing and then to Foyle Haven…giving people an opportunity to be part of society again' (Stakeholder 2; CCMI)

7.3 Relationships

7.3.1 Relationships with each other within the consortium

Strong working relationships involving both those stakeholders external to the consortium, as well as those internal to the consortium was recognised. The regular meetings of consortium members and the facilitation of these relationships of developing seamless operations was recognised.

'Regular meetings with the consortium.' (First Housing FG)

'Our partnerships, notably with the Consortium comprising De Paul, First Housing Aid & Support Services, and Solace (Arc Healthy Living Centre), have enabled us to develop seamless referrals to addiction services. Furthermore, we have cultivated alliances with diverse agencies to address the multifaceted needs of our clients, spanning healthcare, housing, benefits, and leisure.' (Follow up communications from First Housing Director of Operations)

7.3.2 Relationship with service users

The relationships that each of the services have with the service users emerged as a core strength of the services. Staff from across each of the three services recognised and celebrated the hard earned trusting relationships they have developed with service users.

'It has taken blood sweat and tears to develop the trusting relationships that have been developed through this programme and that's from the service users point of view, it's from a reputational point of view. Building that trust and being able to engage with people at the level we have and becoming household names.' (DP Staff 1)

'It is very much about…relationships…we're viewed as a trusted partner…were a long long time in the game…we're 22 years running Solace…' (Solace FG).

'Gaining access to these vulnerable individuals requires patience and persistence. We invest time in building trust and understanding the full extent of alcohol's impact on their lives and the broader community. Through our Harm Reduction Service, supported by PHA, we have witnessed first-hand how timely interventions can save lives.' (Follow up communications from First Housing Director of Operations)

These trusting relationships appear to have subsequently facilitated (or indeed the trust has been encouraged by) the approachability of staff and the comfort service users feel in engaging with the staff.

'We give people the ability to realise it is ok to ask for help before it goes wrong and because of the relationship we have with them, they have no bother doing that' (Solace FG)

'I [peer support worker] have a lot of experience through addiction and mental health so a lot of the service users find it easy to chat to me and feel comfortable talking about things that they maybe wouldn't chat to other staff about.' (Depaul FG)

Additionally, the on-going support that is available was also highlighted, whereby service staff reported their ongoing availability for service users, extending for as long as a service user might require.

> *'I always leave the door open with service users. It's a tier 2 service, if I can get someone who is actively willing to address their use then I refer them up to the tier 3 service and that is the alcohol treatment team. And they do the more formal work then.' (First Housing FG)*
>
> *'We make ourselves available. I always leave my phone open to anyone I've worked with…It means a lot to them people to know there is somebody on the phone and that door is never closed…prevention is better than cure…if I sit with that man for an hour and it stops him from opening the bottle' (Solace FG)*

The non-judgmental approach afforded by staff was also strongly recognised in the focus group with Solace staff, who recognised that for their service users, they *'are the family that people don't have' (Solace FG)*.

> *'I'll use one example of a guy who had lost a job through alcohol, was drinking, was ending up in the SWAH with chest infections…cycle of ill health…this guy now...has got his licence back, back out working…and leading a completely new life and he will tell you…we have just give him a life line…interventions were, going in there helping him with his mental health…making him believe in himself…we didn't judge him…we don't judge anybody…you see the person…I don't go into judge…I go in to try and find that person that's there…we do it in a very special way, these people have been around other organisations…they've been dropped…we build up that relationship' (Solace FG)*

The 'family' type dynamic and the benefits this holds for successfully delivering such services was recognised by staff who underpinned the value of rapport and trust for engaging in *'meaningful work'.*

> *'It feels to the service users like a family environment so I have to say the way that they come in and use the environment they are very comfortable in the area, they are very open with staff members. You really get to the crux of the issues and trust and that cohort of clients have never had that within their lifetime. That is the beauty of the Haven, they get to build a really good rapport … that's where you engage with real meaningful work. With a low threshold service you do meet the service user where they are at. Part of recovery is relapse and it is absolutely accepted that when they*

relapse you still celebrate that they maybe got a few weeks sober at that point and time. And we may get another two weeks, three week, maybe only one next time but we will go again.' (Depaul FG)

7.3.3 Relationships with external agencies

The positive relationships that each of the services has cultivated with external agencies is another key strength that has emerged from these qualitative data. For example, the positive relationship (and information sharing) established between the consortium and the commissioning body (Public Health Agency) was recognised.

'The first thing I will say is that the working relationship with the PHA has been nothing but positive. Really positive and has grown from strength to strength from we got this contract' (DP Staff 1)

'PHA [staff member name] said it would be really helpful if you could ask your service users what they take, when they take it just so that I have a map. Service users have a good relationship with staff so they described maybe I take this when I've so much money, I'll take cocaine, I'll take tablets, I'll take x amount of vodka etc. And we were able to document all that and [staff member name] was absolutely blown away. She wants to take that to her bosses to say this is what is happening daily. It was all done in a chart and it was really valuable. She know if she needs information on drugs, consumption, whatever just to ask here and the service users will tell us that.' (Depaul FG)

This established relationship between the consortium and the commissioning body was recognised by Stakeholder 7, who noted the value of being close to the service, facilitated by the positive relationships cultivated.

'It's that relationship that we have built over the years…..For me it's being able to call in and see how they are working. I've been there at Christmas parties, Halloween, different times of the year, I've spent a whole day in the Haven talking to people and just being there. Last year when I went into the service I wrote up my notes and [staff name] followed it up and did an audit of people coming into the service on one day for me and she had 28 people coming in. She asked them what are you drinking today? What are you having today? And I was able to take that information, calculate the number of units of alcohol consumed or what people are using and then literally

was able to use that as evidence to get additional funding for them.' (Stakeholder 7; HIO)

With regards to the relationships between Depaul and the Consortium and external statutory agencies was highlighted. Throughout the data there is evidence of the wide and varied agencies with whom the services work, as well as evidence of the trust established.

'We also do a lot of liaising with external voluntary and statutory bodies. Like psychiatric nurses, social workers, GPs. It's very varied. No two days in terms of what you are working with is the same. Everyone's needs are different and the staff are very knowledgeable.' (Depaul FG)

'Also, on the part of our statutory partners who have also become trusting in the services that we provide, we have established those relationships albeit to some level operationally. The stability of that in an unstable environment is critical going forward….we have established ourselves to the wider sector, communities and partners across the voluntary and statutory sectors.' (DP Staff 1)

Depaul staff commented on the positive relationships they hold with a range of statutory services, whilst also recognising that whilst there was no legislative requirement for these bodies to work in partnership, nonetheless, the relationships built facilitated these inter-agency operations.

'We have a very good relationship with acute services and emergency services. Suicide ideation we would work very closely with the PSNI and also Foyle rescue service as well'. (DP Staff 1)

'I would say at an operational level, relationships are good but they are built on relationships as opposed to legislative requirement to work in partnership or they are not legislated to do so, work with the voluntary/community sector the way they need to be. So, on the ground it's very positive. We have been able to achieve the direct referrals from the data sharing agreements and that has been a major achievement out of this project and that has been driven by ourselves.' (DP Staff 1)

The Solace staff described their service as the hub of a wheel of services, which only turns effectively with their central service provision.

'The wheel - We sit in the middle of that wheel but that wheel doesn't turn without all the spokes…the GP, the social workers, the addiction counsellors, citizens advice' (Solace FG)

Similarly, the benefits of these inter-agency relationships were also recognised by Stakeholder 6, particularly in terms of Depaul and the consortium's relationships with statutory services which the services draw upon in order to advocate for service users, particularly in circumstances where service users are unable to advocate for themselves.

> *'The relationships that the Haven have with other partners like the Housing Executive, night support like the Western Trust, they have really good relationships with those individuals so in terms of finding access to services those people are able to advocate for those individuals who cannot advocate for themselves because of their current addiction issues. It's such a valuable service and I am so invested in it.' (Stakeholder 6; HOS)*

7.4 Staff

The commitment, passion, quality and professionalism of the Depaul and consortium staff was recognised as another key strength of these services. Many of the external stakeholders shared their admiration of the staff involved and the exemplary work they undertake in the most challenging of circumstances.

> *'They do a really good job for the kind of difficulties that they face. Especially during the pandemic. They were able to keep that site in Derry open the majority of the time with support so in general terms I find it a really fun helpful and kind service for the people that they are dealing with and the way that it has changed over the years, traditionally would have been on street drinkers but now they are dealing with a lot of younger people with drug addictions and they are adapting really well to that. And the changes in the type of people. More younger people, more girls and the difficulties. Sometimes I wonder how they can do the things that they do.' (Stakeholder 7; HIO)*

The quality and professional development of the staff was raised as a key factor contributing to the success of the staff on the ground.

> *'Central to our success is the training provided to our staff, empowering them with the knowledge and skills necessary to navigate barriers and combat stigma effectively. This investment not only enhances service delivery but also fosters a culture of continuous improvement.' (Follow up communications from First Housing Director of Operations)*

The staff interviewed highlighted a wide variety of training that they themselves had undertaken.

> *'First housing is great with their training, there are always opportunities. I've done my level 5 in addiction. And I've done the dual diagnosis up at Queen's as a postgrad cert. I also sit on the drug and alcohol forum for Foyle. Great work with all community groups as well.' (First Housing FG)*
>
> *'Training that I have completed whilst in this role…: OCN Level 3 Certificate in Tackling Substance Misuse; Post Grad Cert Dual Diagnosis; Understanding missus of Prescription and OTC drugs; First Aid; Naloxone Administration; Supporting Trauma-Informed Assessments: The MACE Toolkit and Handbook; Novel Psychoactive Substances Training; Motivational Interviewing; Addiction and Gambling; Substance Use, Mental Health and Wellbeing During Covid-19; Health Literacy Training; OCN Level 3 Housing Advice Training; Needle Exchange / Safer Injecting Training.' (First Housing, follow up communication)*

Specific training in needle exchange and Naloxone administration were raised (by internal staff and external stakeholders) as core examples of the specificity of the training staff receive and the lifesaving impact this training and subsequent service provision provides.

> *'The guys are also specifically trained. There is a needle exchange in there as well which is done so discreetly. Because you are able to have those conversations. A lot of individuals, particularly those who have maybe fallen into addiction and they are at the start of their journey, which is quite scary, would hide needle use and maybe use groin injecting instead of their arm. Those staff are at least able to show them how to safely inject, give them a clean needle, give them the education behind that and there is something so powerful in that. You can start to look at other alternatives as opposed to injecting to bring that harm reduction journey.' (Stakeholder 6; HOS)*
>
> *'Being able to administer Naloxone also requires people to be first aid trained to a level where they can also deliver CPR and they so that on a regular basis*.' (DP Staff 1)

The challenges of delivering such services (Naloxone administration) was recognised, in terms of the impact on the wellbeing of staff, and the pressures such valuable and important training put on each of the three delivery partners, in terms of the resource and cost required and the subsequent impact of such training on the services (i.e., by taking staff 'off the floor').

'You are also considering the health and wellbeing of staff as well. That in itself for staff is traumatic after resuscitation and injecting Naloxone in the hope they are going to come out of the overdose situation. It's also put a bit of a stress on being able to train staff and as an organisation we have been able to cope with that reasonably well because of our cross boarder nature and all of that. That has definitely put pressure on our two partner organisations from a capacity point of view as well because you have to be available to attend training. That wasn't factored in to the extent that it maybe needed to be, how resource intense that would be and costly that is as well. If you take staff off the floor in order to have them properly trained then the service has to back fill that, the service still has to be delivered. That is something that definitely needs to be further considered.' (DP Staff 1)

Additionally, the care and trauma informed manner in which staff undertake their roles was also flagged as a key strength of service provision, so too was the approachable nature of staff and their ability to meet service users where they are at without expectation or conditions.

'We are a trauma informed trained organisation and staff. That didn't solely come through this programme but it certainly is a significant part of it because of the trauma that individuals are experiencing.' (DP Staff 1)

'Everyone of us here, it is a vocation for helping people…in rural areas where there is no one else to do it…we were in contact to people all the time throughout Covid…we were the only ones doing it' (Solace FG)

'Service users always engage with Depaul, with Foyle Haven. You really need a service to take them in where they are at, whatever they need with no expectations on them to make big changes if it is not appropriate or possible. They offer that. The staff themselves are so approachable. It's like the guys are just in their own house having lunch, having a chat and being looked after. In a way that is non-confrontational. In the Trust if you miss an appointment you are out!' (Stakeholder 4; HR Nurse)

7.5 Holistic and participatory service user centred approach

The user-centred and holistic approach afforded by the Depaul and consortium services was also identified as a core strength of service delivery. Service users are met with respect and treated with dignity.

'The work is so meaningful and it genuinely meets the service user where they are at and it's so important. That relapse is ok and that's how they get to recovery.' (Stakeholder 6; HOS)

***'**We don't look at the individual through the lens of their addiction, we look at them as an individual first and foremost and then it's around the complexity of need thereafter.' (DP Staff 1)*

'This project has helped make connections in a more holistic way wrapping the services around the person.' (Follow up communications from First Housing Director of Operations)

Aligned with the service user centred approach is the non-judgemental and non-discriminatory approach that these services adopt. The universal availability of the services, without exclusion or barriers differs in nature to some of the statutory services and ensures these services provide the aforementioned safety net service provision.

'And we meet people where they are at and that's critically important without judgement. I think that is the other side of it. It's for the whole community and the issues that our client users face doesn't discriminate against age, colour, race, class it's everybody and everybody is welcome. I think the fact that we all in the consortium keep access to our services, there are no barriers for people to be able to access our services and I think that is also really important because they don't have to meet any particular criteria that would exclude them if they have an addiction, a mental health issue, facing homelessness, one or all of those they are able to access the services and that becomes a portal from where they can access many other services.' (DP Staff 1)

Additionally, the data also revealed the participatory and partnership approach that has been adopted, whereby autonomy and respect is afforded to the service users with regards to their participation in decision making. Examples were provided of the services gathering service users' feedback and perspectives on the services, affording them ownership and power over how these services are delivered, as well as empowering them to share their views via engagement in broader government level strategies.

'Every single activity we do evaluations with service users. People are engaging and we have service user feedback. That's how we run our courses. We ask what do you want us to do? What would be beneficial to you? Generally they are the ones who

suggest the activities. We have a consultation group. They are very appreciative.' (Depaul FG)

'We have service user meetings, service user questionnaires, we have an audit process and our clients feed into all of that and that is about service need, service design and service delivery. We also support service users to engage in wide and varied research projects that are ongoing. We have supported our service users to engage in the Northern Ireland Housing Executive Homelessness Strategy Review and the review of accommodation services. And just about any strategy across health and housing sectors. And our service users are also supported to give their voice.' (DP Staff 1)

'We do everything in partnership with our service users. We have developed the homeless health peer advocate programme as well and that's where it is an individual with lived experience. With some seed funding that we sought elsewhere to work with individuals to access health related services. They are coming to it from the point of view of supporting an individual, they understand where that individual is at because they are personal lived experience and they accompany them to medical appointments. They encourage them to attend their appointments. They remind them of their appointments, they advocate for them on their behalf at appointments. We are now seeking long term funding for that. That advocate has met with seniors in A&E, in the hospital setting across various different health disciplines including dentistry. Our intention is to grow that. And dentistry has never been approached and he approached someone very senior in dentistry who are now saying why has no one ever approached us about this for homelessness. And we absolutely will consider it now.' (DP Staff 1)

Finally, within this holistic and user-centred approach, there is also evidence of an appreciation for the wider family and community network within which the service user lives. As the below staff member highlights, the services ensure that their clients are able to avail of the full network of supports encircling them.

'Also, family support has also been really important...Also their full network of support. It has always been around strengthening community and networks and support for individuals while supporting families as well to cope and deal with the challenges that they are facing when they see a loved one go down that route and maybe not enter into recovery or abstinence.' (DP Staff1)

'And you can say send me your mummy, send me your daddy or brother or sister and at least they can keep you safe if you have overdosed and you can't do this yourself. And it was bringing the family into it as well. You know yourself a lot of families disconnect because they are just so hard to live with from a family perspective too. And for them to know there are staff there who don't judge their loved one but actually they can provide them with a tool that can help the individual as well. I also had family members just coming in for a chat as well because the door is open to them too. There is no wrong door at Foyle Haven and I think there is a real beauty in that.' (Stakeholder 6; HOS)

7.6 Community embedded and ripple effect

Related to the positive relationships and holistic and user-centred approaches adopted, there was a recognition of the power held within the community connectedness evident amongst the services and the ripple effect of their positive work.

'The Haven is the backbone of that community.' (Stakeholder 6; HOS)

'The real power in that place is the peer support. If one person has gone up and had a needle exchange conversation you'll find that day you might get three or four people saying 'I do that actually, was it grand where they ok? Ok I'll go up too'. And you'll find just because they have come down and said that was really good, now I feel a bit safer, they will come up and get it. It was the same with Naloxone training too. I really seen how that grew with service users as well. When you are able to say this actually keeps you safe.' (Stakeholder 6; HOS)

7.7 Perceived lifesaving and life improving positive outcomes

The service staff interviewed recognised the importance of their role in addressing the full 'spectrum' of challenges facing service users with the ultimate goal of reducing the long-term impacts of substance misuse.

'Our work has unveiled a spectrum of challenges, from neglect and malnutrition to severe mental health crises. However, we firmly believe in the power of early intervention and prevention. By identifying at-risk individuals, providing education on reducing consumption, and facilitating connections with specialised services, we aim

to mitigate the long-term consequences of alcohol misuse.' (Follow up communications from First Housing Director of Operations)

Improvements across a variety of outcomes were broadly recognised, that is, improvements in *'mental health, physical health, overall wellbeing. Being isolated and having no one else.'*. Within and outside of the services, there was a strong recognition of the 'vital' role their services play in terms of saving lives.

'We are week on week on week saving lives…without a shadow of a doubt' (Solace FG).

'It's the amount of opportunities that they avail of to save lives…anybody's of who overdose, provision of Naloxone, prevention of blood borne virus…needle exchange...that's phenomenal.' (Stakeholder 1; WT Nurse)

The positive outcomes of their harm reduction services were also recognised by Stakeholder 6 who appreciated the successes to be found in reducing intake and the impact this, and the provision of fundamental physiological needs such as a home and food, has on broader life outcomes.

'To you or me might not seem like a success like reducing the amount of alcohol they are reducing the amount of drugs… I remember hearing of someone who went from smoking 5 bags of grass a week down to 2….that impacts and that can change people and the fact that they are supporting people, giving them a home, cooking and things like that, those things make a big difference to the service users. Clean clothes and making them feel better. And all the add on things that they do make a big impact for the service users. The case studies demonstrate how in their own personal way it has been useful and helpful to the service user.' (Stakeholder 7; HIO)

Another one of the key recognised positive outcomes of the services was the reduction of alcohol intake which results in the clients being able to manage their lives better, with less chaos and healthier choices. Whereby despite the continuation of drinking, lifestyles and outcomes are perceived as being undoubtedly improved.

'Relapse is built into this cycle, but from drinking every day, drinking large quantities every day for 40 year, he now in a cycle where he will drink for 2 or 3 days, with the information we have, he knows to stop…he needs to eat, he needs to do this, or if he's in real bother he needs to do this…his life is much…less chaotic, much more manageable, he's a lot healthier, although he continues to drink. He doesn't cause the

social difficulties for himself and others that he did 12/13 years ago…that's a big win and he hasn't stopped drinking. His life is immeasurably different (Solace FG)

'Prolonging their life, home improvement. Maybe their home situation wasn't great or living situation wasn't great. They may not have been on all the benefits they are entitled to. So maximise and improve them and their income.' (First Housing FG)

However, unfortunately, there was also some recognition from one staff member that for some clients, whilst alcohol intake may have reduced, the long-term impacts of usage have left irreparable health damage.

'I'm finding that my longer-term clients, you are there with them that long you wouldn't be closing them down. One of them called me the angel from the north the other week. Because I'd be the only one going in. His circumstances will never change. We may have reduced his alcohol use from two bottles of wine a day to maybe a bottle, but now over time their health is really deteriorating.' (First Housing FG)

Similarly, in one sad example, whilst the outcome of this case was the passing of a service user, with the intervention of service staff, the service user was spared of dying alone.

'I had a patient last week come in who was so unwell, he passed away a few days later. It was the floating support worker that came in and found him and knew he wasn't well. Took him to the car and got him to A&E. Thank god. He would have died, and he did but he would have died at home. He was compos mentis and was able to say the support worker was great. No one else would have looked in on him. You miss how challenging that would be for their service to deal with that all the time. But that is what they are dealing with.' (Stakeholder 4; HR Nurse)

7.8 Savings for health service

A key strength of the Depaul and Consortium service provision was the widely accepted perception that their intervention and service provision was alleviating burden (practically and financially) on the Health Service. For example, the services acknowledged that for the comparatively low budget and resources that they are afforded, they are subsequently 'saving' the health services.

'For £80,000 a year what we're saving the NHS, the return on investment is enormous…we are keeping people out of hospital…many people have said 'I'd be dead if it wasn't for you guys'' (Solace FG)

It was suggested that the intervention of these services diverted a range of NHS interactions, including ambulance and A&E services.

'Public will call an ambulance, the clients don't want an ambulance…the ambulance comes and they don't want to go… …without having that support, ambulances will be called constantly' (Stakeholder 2; CCMI)

'They definitely reduce hundreds of calls for ambulances and A&E attendance which people don't see cause it's not happened' (Stakeholder 1; WT Nurse)

'This person was attending A&E every night…we attend to their personal hygiene here…we got access to Depaul Foyle Haven shower, we were able to address all the personal hygiene needs…then they get into temporary accommodation…stopped them going to A&E…they have not been to the hospital since, whereas they were costing thousand and thousand of pounds a month' (Stakeholder 2; CCMI)

'*Sometimes they get agitated and probably call ambulances and the person just needs to sleep it off…so you're reducing ambulance and A&E attendance' (Stakeholder 1)*

External stakeholders were adamant that without the Depaul and the Consortium services, local hospitals and statutory services would be under more severe pressure.

'For all those in the community providing a service to people who are homeless...if we didn't have it I don't think Altnagelvin would be standing….For me alone last year I had 769 referrals to navigate….even having 2 o3 of them not calling an ambulance or sitting A&E…it's a huge saving' (Stakeholder 1)

'The actual services that Foyle Haven and First Housing provide and (Stakeholder 1 named) in the work she does as well…it would cripple Altnagelvin… if they weren't being triaged by people who probably aren't really, were never meant to triage on the street…but the natural instinct …seeing somebody lying on the street would be to call an ambulance, it's a natural instinct for anybody. But it's not an ambulance that's required quite a lot of the time….' (Stakeholder 2)

'Without Foyle Haven and without First Housing and the work they do on the ground, I just think the health service in this city dealing with people who are vulnerable on top of people who may have emergency needs, it would be crippled…their interaction and

their availability is immense…the people who I'm talking about that we take away from the riverfront, they practically all go to ED and ED is not the place for them but there's no other place to bring them….they usually go with the police…have to wait with them because there's usually, not always there's usually substance on board …. and they won't be assessed until that wears off. If we had more funded…Foyle haven and crisis intervention service was open more often…then we'd be able to deal with this in a better fashion….and save the exchequer money' (Stakeholder 2)

Finally, there was a recognition that supporting and investing in this vulnerable population will have knock on effects across society, alleviating pressures within families, health and justice.

'From a purely economic sense, if I had another 10 Support workers…they would save the criminal justice system a fortune…the health service a fortune…knock on effect on those families' (Solace FG)

7.9 Challenges

7.9.1 Demand on the service – Manageability and sustainability

Quantifying and managing the demand on the services emerged as a key challenge faced by Depaul and the Consortium. In terms of the number of clients 'on the books', Solace recognised the challenge with quantifying this, due to the transient nature of the client base and the aforementioned long term 'open door policy'.

> *'That's really hard to quantify…between the three (Support workers) they each have a list which comprises of about 35 people, so that's about 100 people who are actively engaged. Some of them on the phone, some on visits…We will also have a considerable cohort of people who are ad hoc. They will turn up at the centre.' (Solace FG).*

When asked about the manageability and sustainability of the service, the 'thin' spread of the ageing staff (who are 60 plus years old) was highlighted.

> *'Is it manageable, yes, does it cause me worry in terms of how thin were spread and potential vulnerability…absolutely…In terms of sustainability…that would worry me, inters of continuity' (Solace FG).*

The pressure facing services working in this area was also recognised by Stakeholder 2, who highlighted the potential for improved joined up service provision in order to alleviate some of the pressure experienced.

> *'This is such a wide and complex area…so many different agencies working in and around this area…a lot of silo working…pressure on department and charities, they can only do what they can do…if the agencies worked better together then we could provide a more rounded service' (Stakeholder 2)*

7.9.2 Changing landscape and complex challenges

The changing landscape within harm reduction services was recognised as an ongoing concern.

> *'The landscape has changed' (Solace FG).*

Changes were recognised in terms of the demographic shifts witnessed amongst service users, as well as the nature of their substance misuse, progressing from alcohol towards greater usage of drugs, particularly, cocaine.

> *'So much has changed…the substances have changed…the clients have changed, used to be all men…now is women…demographics have changed' (Stakeholder 2)*

'In Jan, we reported more drug related referrals than alcohol for the first time in 22 years…the environment has changed, the nature of contacts, the nature of the relationships is definitely changing, it's a lot more aggressive…a lot more physical' (Solace FG).

The complexity of the issues faced was also recognised, for example, issues related to debt and the vast overlap between homelessness and addiction.

'People very immersed in debt…in drugs…and all that brings…it brings a lot of risk…its becoming harder to manage' (Solace FG).

'Outside of the organised vagrant… I would say practically 100% would have addiction issues' (Stakeholder 2)

Additionally, the complexity and intersection between addiction and mental health challenges (and the myriad of social challenges that these issues attract) appears to be a major challenge facing services currently.

'Yes it has changed. Mental health issues are much more prevalent now. Poor mental health diagnosed and undiagnosed now can be attributed to poly substance use and drug use but it can also be attributed to the significant rise in the people that are homeless and the impact and trauma that causes. And the causes of homelessness in the first instance. The financial pressures, external environment placed on people. Relationship breakdowns, lack of housing supply, so we are seeing a rise in homelessness and the homeless population. And the factors that contribute to that have changed and that creates a much more traumatic circumstance for an individual and therefore their mental health takes a hit. So that is difficult.' (DP Staff 1)

'There's such a variation in our work…cases are more complex now…before you would have just got addiction, now you're getting mental health in with the addiction….we've got to deal with the issues of mental health before we can get to the addiction' (Solace FG)

Additionally, specific challenges around the prevalence of alcohol related brain damage (ARBD) was also highlighted, and so too was the lack of provision for addressing such health concerns.

'Even going back to the alcohol related brain damage, there is very little provision in Northern Ireland. ARBD is massive in our locality. They don't fit into the normal services, like addiction services, brain injury services, old age. They tend to be quite

young people who have a brain injury because of their alcohol use. And they are continuing to drink alcohol which is compounding the issue…. And there is a lot of hidden alcohol related brain damage in Northern Ireland. I feel Depaul take that on and it's so unfair for them.' (Stakeholder 4)

Furthermore, the specific nuances and challenges encountered during the Covid-19 pandemic were also recognised, however, so too was the adaptability of the services who adapted to meet the needs of service users during those challenging times.

'The pandemic was also very difficult but we were able to adapt the service and through this approach and the experience that we have gained as an organisation, and the partnerships that we have across the sector both in the statutory and voluntary sector enabled us to literally overnight change how we delivered the service. So that is testament to the experience, the knowledge, the skill and the flexibility of the organisations to be able to adapt to crisis situations …Many of our service users were living in B&Bs, everybody was off the streets and they were in various types of accommodation. We were then able to bring vaccination clinics to Foyle Haven and support individuals to isolate in a safe way, bringing them food parcels doing all of those thing.' (DP Staff 1)

The ever changing landscape and the increasing social, emotional and physical and mental health challenges arising as a result of substance misuse is summarised in the below comment from a member of Depaul staff.

'I would say that the service is delivering a lot more than it ever set out to deliver and the client group that it was set up to support and serve. In the beginning our client groups were alcohol only dependency and that has shifted over the passage of time and we are now dealing with a lot more poly substance use. A significant impact on mental health. We are also dealing with a lot younger population than at the beginning. We see more females coming into the service as well. Unfortunately, how information was captured, maybe in the earlier days, may not reflect that shift but that is the reality of what we are dealing with. I would say 90%, if not more of the service users would have been alcohol dependent and very little drug use and maybe would have been prescription medication abuse rather than street drugs, heroin, cocaine or what is being used now. Certainly safer injecting would not have been a consideration. Naloxone was not something that was on anybody's radar at that point

so we weren't dealing with people on a daily basis that were in an overdose situation that were on drugs, from opiates particularly. Therefore it has required us to constantly ensure that our staff are trained to the level they need to be in order to meet those emerging trends and the challenges and that they are able to provide the right support and intervention at the right time.' (DP Staff 1)

7.9.3 Funding

The lack of adequate and core funding to equip the services to successfully meet the demand and need of their service users is a recognised challenge. It was suggested that other jurisdictions have superior resources compared to the Depaul and Consortium localities.

'A priority going forward is proper core funding. We have to reapply for this project. It is not a given. It's always a worry. The procurement may not go our way.' (Depaul FG)

'Probably resource and I think Belfast has a lot more than we have. Like even in Belfast they have staff in pink t-shirts that are mental health nurses that you would know that is someone I can talk to if I am struggling. Even when you are waiting for medical care or formal mental health care. We have nothing like that here.' (Stakeholder 4)

The funding challenges experienced raised substantial concerns regarding service delivery, whereby the funding received does not adequately cover the expenses incurred.

'Every year were propped up by the reserves in this organisation to keep alive' (Solace FG).

Such financial pressures appears to have resulted in staffing reductions and limits to service delivery,

'It was great that we were always invited to activities courses and training that the Haven would offer. Given that I am located in a rural area, it was very difficult to get Service users motivated who are continuing to drink. I have to be flexible and recognise that although you can make plans, however, they need to change due to service users' circumstances. Some of my clients have mobility issues exacerbated by years of alcohol abuse and find it very difficult to attend external activities. I also have to consider lone working concerns being just one person in the service. This is the reason why I believe taking the service to the person really works.' (First Housing FG)

There is a recognition that demand and social complexities within which these services operate within has increased and yet, as per the perspectives shared, funding has not adequately reflected these growing concerns and challenges.

> *'The thing that worries me as a [staff role]….as safe space and low threshold programme for people who are very easily forgotten about, the funding hasn't gone up and yet there's more and more asked…issues are more complicated' (Solace FG)*

There was recognition of some additional and welcome supports from PHA, however, whilst additional funds are well received and used, they are not sufficient to lead to substantial change.

> *'I know the service is oversubscribed. I always keep an eye out for the Foyle Haven if they need anything and if there is any extra money. You know it is going to be spent well. And used in a way to help people. Been times when we have given small amounts for haircuts… this is helping people. It's just a great service it really is. They work really hard.' (Stakeholder 7; HIO)*
>
> *'PHA would offer a bit of money if we are struggling but that is not really to bring on more staff which is unfortunate.' (First Housing FG)*

Funding challenges were recognised beyond the service delivery of Depaul and the Consortium, recognised as a broader systems-level challenge by the external stakeholders interviewed.

> *'I have went out to GPs and all previously pre COVID and post COVID and they won't do anything without funding so my hands are sort of tied. So any of the changes needed in the community are non-existent.' (Stakeholder 3; A&E Cons)*
>
> *'Trying to get my work into the community is impossible without funding. GPs are over run, social services are overrun so my role is to make sure they are safe here and give them a care plan when they attend.' (Stakeholder 3; A&E Cons)*
>
> *'Our waiting times have exploded.' (Stakeholder 3; A&E Cons)*

7.9.4 Access to housing and statutory health services

There were also recognised gaps and challenges in terms of accommodation provision.

> *'Gaps that we are seeing is in terms of accommodation. One guy in here has been homeless for 5 months and he has nowhere. He has a violent background but in fairness he has come in here and he has been fine and we have made hundreds of*

phone calls but coming up against a wall. She now has housing rights because they don't like him and don't want to deal with him so he has been left for 5 months. He's living in a derelict house. He's here at 10 o'clock every morning for warmth, heat, conversation, nutrition. It is really bad…that's a basic human right giving someone accommodation. That's one of our big gaps.' (Depaul FG)

Furthermore, challenges encountered in accessing statutory health services was raised by a range of service staff and stakeholders. For example, accessing GPs, successfully acquiring and ensuring service users present to appointments, waiting times and accessing community addiction supports were all raised as ongoing concerns.

'Getting GPs and getting prescriptions is a massive thing.' (Depaul FG)

'It is trying to get appointments and getting people to appointments because most of our service users their lives are chaotic to say the least. Trying to make an appointment for them. Just after COVID all the rules changed. We can ring some practices on the day and get an appointment. Others you have to ring today for Thursday and come Thursday some service users won't turn up. Part of my role engaging with them making these appointments, I keep giving reminders. Try and get them to appointments.' (Depaul FG)

'…even helping find dentists which in the current climate is difficult.' (First Housing, follow up communication from Director of Operations)

'Also the waiting lists for community addiction. At the time they are quite willing to attend and then by the time the appointment comes up ….' (Depaul FG)

Additionally, dental pain appears to be a rising concern, so too is the availability of NHS dentists. Service providers and external stakeholders report resorting to sending service users to Belfast to the Royal Hospital, having not been successful in gaining access to local services.

'Dental pain is a big thing for our clients…. if you're homeless you can't get access to a dentist…we go to the Royal (Hospital)..the dental school…I am working with PHA on this…there is a project coming in the future to provide a dental service in this area….early stages of that' (Stakeholder 1; WT Nurse)

'The other big thing is dentists. Not one dentist in Derry is taking on any NHS patients at the minute. Not even for emergencies. You can't even get put on an NHS waiting list. On behalf of some service users I've had to refer them to the Belfast Royal School of Dentistry. That is not ideal. Service users have to pay to get up there in the first

place, taxi fare and it all comes at a cost. So we are trying to get them engaged with the community dental service here in Derry. We have a number of places they work out of.' (Depaul FG)

7.9.5 Place-based challenges: Rural and vast geography

Stakeholder 5 suggested that there were additional challenges facing service users in the Western Trust compared to other Trusts, suggesting those service users based in the Western Trust were strongly disadvantaged.

'The parody with other Trusts areas and the homeless health provision is so much more superior than what we have here.' (Stakeholder 5; AS)

'I think if you live in this Trust area you are more likely to die from your addiction issue than anywhere else…any other Trust.' (Stakeholder 5; AS)

This point was supported by staff at Solace and the First Housing staff who highlighted the gaps of service delivery available in the Fermanagh, Strabane and Limavady areas specifically.

'There is literally dearth of services in Fermanagh for dealing with people with addictions….we're the only one dealing with adult addiction…we're the only ones actually on the ground….solace is the only one going out to the cold face of people with addiction issues…There is nothing here… (Solace FG)

'As stated, the service works in rural locations and getting the help they need for addiction and mental health tends to be very much in short supply. Our support has allowed us to tackle some of these barriers.' (Follow up communications from First Housing Director of Operations)

This concern was further corroborated by the First Housing staff who recognised the comparatively poor support amongst 'wee towns' compared to those larger jurisdictions.

'I think with the intensity that the service is under, there are services there but they are exhausted. Also because we work in the rural areas there is less support. The wee towns feel like they don't get enough. The big towns is where the support is, Derry, Omagh and that.' (First Housing FG)

The rural, remote and geographically widespread nature of the service users (engaged with Solace and First Housing specifically) was a key recognised concern. Transport issues and the travel time incurred both appear to pose barriers to service delivery, limiting service delivery partner's capacity to effectively meet the growing demand.

'The biggest crux for me is that they are spread out so geographically and it is me myself. Getting out and about to them can be difficult. We would use the office in Strabane as a base for those who are more rural. If they don't have transport I would set up transport with Easylink. They would help bus them in at a cheap cost for their appointments with myself.' (First Housing FG)

'Initially I was Enniskillen area but it stretched out…more wide spread into the county and outlining areas' (Solace FG)

'If we get a referral for somebody in Rosslay, that's a 70/80mile round trip from here…getting there and nobody there or the person says 'I never heard of you, what do you want.' (Solace FG)

'This service has been in existence for a great many years working in the rural location of Strabane and Limavady. We deliver 26 hours of support to people who are isolated. Based on the capacity of our service and our current referrals our capacity falls short of meeting the growing demand. The geographical distance between these locations poses a challenge, resulting in precious time lost in transit.' (Follow up communications from First Housing Director of Operations)

7.9.6 Stigma

Societal stigma surrounding those suffering from substance misuse emerged as another challenge for both the service users and those delivering vital services, who can at times struggle to reach those 'hidden' clients who suffer from the stigma and shame associated with substance misuse.

'Our reflections are that those who face issues of alcohol feel stigma and shame. To a great extent they remain hidden and are not easy to reach. The Pandemic made things even worse. When other services withdrew our service continued to offer support tackling isolation and loneliness helping individuals to deal with the physical, mental, and social harm alcohol creates. '(Follow up communications from First Housing Director of Operations)

The qualitative data points to issues associate with personal hygiene and the resulting impact this has on accessing accommodation or services. The subsequent life changing possibilities of accessing Foyle Haven's showering facilities are also highlighted as a 'simple' yet effective foundational assistance.

'I meet clients on the street and they mightn't have eaten in three days or their mental health isn't good or their personal hygiene isn't good…. then people won't take them in cause of their personal hygiene…Foyle Haven does have the shower facilities…its important people have access to this…they don't have that (shower)...to have that is huge…having access.it can turn somebody's life around' (Stakeholder 2; CCMI)

'Those particular clients that come through the Haven sometimes have no fixed abode so sometimes their physical health and their presentation wouldn't be very good. So sending them to a GP surgery, even if we did get them there it was very had to get them to wait for the appointment because of others reactions to them in the waiting room. ' (Stakeholder 6; HOS)

The role of the Depaul and Consortium's services in tackling and dismantling this stigma is also important to recognise service. For example, the service's persistent attempts to access those 'hidden' clients and the stigma free environments that the services cultivate and encourage for their service users appears to go some way to mitigating the stigma experienced by the service users from broader society.

'Our Harm Reduction Service with support from PHA has confronted head on the stigma and idea that alcohol is down to those who are vulnerable or irresponsible. We have witnessed how stigma causes people to withdraw and remain hidden. Throughout our response we have continually pushed through the stigma to get to the person. The project has allowed meaningful conversations about alcohol its dangers to health and offered strategies for reducing the damage.' (Follow up communications from First Housing Director of Operations)

'When you go into the Foyle Haven there is absolutely no stigma in having mental health problem, there's no stigma with having addictions,...everyone is welcomed…and accepted for who they are without judgement…that a great stepping stone for people to start recovery and engage in services…I've seen people go in …at their lowest...they've been given hope…they start believing, they start engaging and then they recover…there's numerous examples…turn people's lives around' (Stakeholder 1; WT Nurse)

7.9.7 Displacement issues

The displacement of service users (from Belfast and to London/Derry specifically) also appears to pose a variety of challenges to service users and service delivery. The prevalence of displacement appears high, a result (as per the perceptions expressed in these interviews) of individuals being forced to leave Belfast.

> *'In January and February 63% of our service users were from Belfast. It's province wide though.' (Depaul FG)*
>
> *'The reason why they come is because they have been asked to leave Belfast. A lot of paramilitary threat around social behaviour so they have been told to leave.' (Depaul FG)*

It appears that many of these service users are arriving without the necessary prescription medication, documentation, or support plans, thus adding to the pressure and burden of the Depaul and Consortium services. Additionally, the transient nature of this population was also a cause for frustration, whereby staff invested the necessary time to embed supports for those displaced service users, only for them to 'disappear' thereafter.

> *'Some people have been trans-placed or landed here from other parts of the North. No ID, no local services, no chemist to get a prescription, no substitute prescribing, none of that so we are starting from scratch with a lot of cases.' (Depaul FG)*
>
> *'In January and February a lot of people were landing. The staff have to do registration, needs assessment, support plan… that all takes a significant amount of time and then they come in they get a bed, clothes, food… and then they disappear. And that is frustrating because of the time that staff have taken.' (Depaul FG)*

The external stakeholders also recognised this trend and highlighted their dependence on Depaul services to manage this transient population.

> *'We have a lot of sites here and some of the clients have been put out of Belfast due to paramilitaries…they are up here seeking refuge…they come up here they are without their GPs, without their mental health support, they have no prescribed medicines…people always think they are drug seeking…I find the minority are drug seeking…the majority are seeking their prescribed medication for things like bipolar, epilepsy…there's just huge barriers to accessing GP up here…clients don't have photo ID, they're looking maybe five or six pieces of documentation…it's impossible to get…we have to jump through hoops…. Even to get somebody registered, even to get*

their epilepsy medication…you're having people having seizures in B&Bs r on the street which could have been resolved if you had…a doctor who would prescribe them their epilob' (medication). (Stakeholder 1; WT Nurse)

'If I have a patient that is homeless or maybe just new to the area, we are getting a lot from Belfast at the minute, those people are coming here with no GP, no home nowhere to go and having Depaul I would usually arrange a taxi straight over to Depaul to help them. Get something to eat, get clothes on their backs whatever it is. I usually give Depaul a call and say I'm sending over. Can you keep an eye on them. My link with Depaul would usually be signposting patients.' (Stakeholder 4; HR Nurse)

The challenges this presents in terms of upsetting the existing community of indigenous service users is also a potential concern and cause of conflict.

'Our clients would be….they all know each other and they're a community and they're a family, they all look after each other and then when a group comes up from Belfast…they're an unknown territory…they're trying to navigate their way through our territory…sometimes would end in violence…and so then you have that conflict on the streets' (Stakeholder 1; WT Nurse)

So too is the pressure this additional cohort of service users' places on existing and already stretched service providers.

'Layer on top of an already stretched community providing help for those most vulnerable…Everybody needs your help all we've ever said to the HE is let us take our fair share, forget about the pole saying we'll provide more accommodation because you're giving us money' (Stakeholder 2; CCMI)

There was a sense that those displaced service users were using/abusing the services available to them and that emergency accommodation providers were profiting from this 'industry'. The resulting conflict and stress this has caused has been addressed below.

'The displacement issue (ones coming from outside the city)…they've got in touch with people back home, they've got them to come as well because this is a good place for them….there's a whole network of industry going on… Covid probably initiated this, we've had people who have presented as vulnerable and …put in emergency accommodation. There's emergency accommodation providers can make more and more money with the more accommodation they provide…we have had a small cohort of people who have bought more property and made it readily available to the housing

executive for emergency accommodation…largely in around city centre areas (names streets/roads)…very condensed area…high vulnerability…Foyle Haven placed right in the middle of this…away from their home setting…inclined to be more cavalier…more boisterous…do things differently than in their own patch…they have no direct access to the services…they're sent down in a taxi with their knapsack…the council set up a task force to deal with this…this is becoming a real industry for people…quite a bit of money per night per unit….have to try and put services in place for them…it also piles an awful lot of pressure on Foyle Haven and First Housing who already have a massive client base' (Stakeholder 2; CCMI)

' They're switching the tap off on this…they are going to be more selective…they realise the impact that's had…not only on Foyle Haven and First Housing…these non-standard accommodation being set up right in the middle of commercial areas where independent retailers are trying to do their business and all of a sudden they're having major conflict on the streets from people not from the area…policing figures would tell you…their calls to these areas are immense…residents living on Abercorn Road living in fear' (Stakeholder 2; CCMI)

7.9.8 Measuring success

Finally, the difficulty in measuring their success or outcomes was also highlighted, due to the harm reduction (rather than cessation) nature of their service and the person-centred nature of their approach, where each individual's circumstances are varied and so successes for some differ to those of others and may not, on the surface, appear substantial.

'It's a lifeline for some people. It is hard to measure cause sometimes something you feel is small they see as huge.' (First Housing FG)

'So even though their attendances are increasing, that is more to do with the impact the service is having, more people are accessing it and more people trust them. They have that trust environment there.' (Stakeholder 6; HOS)

7.10 How to improve service provision

7.10.1 Joined up, collaborative and person-centred inter-agency working

Improved inter-agency, person-centred, joined up and collaborative working was recommended by many as a means of enhancing service delivery. Stakeholder 2

recommended a model akin to the *'Complex Lives'* model implemented in Belfast, i.e., a person-centred approach that brings together a range of agencies (in Belfast this includes Depaul, Police Service of Northern Ireland, Housing Executive, Extern, and The Welcome Centre) in order to tackle the complexities associated with homelessness and to help those experiencing homelessness to gain access to housing, healthcare, addiction and mental health supports.

Whilst in the localities represented by Depaul and the consortium, collaboration and inter-agency working is taking place to a degree, this could be strengthened by legislative underpinning, rather than depending upon the strength of professional relationships, which are, as per the evidence collected, vulnerable and have been dented by staff turnover and the Covid-19 pandemic.

> *'We haven't been able to change the legislation as we would have liked that being services should be co-funded with a holistic approach to people who present at our services.' (DP Staff 1)*
>
> *'In the past if they had given naloxone or something and an ambulance was called they would give me a heads up but we don't know each other as well as we did maybe a few years ago because COVID happened and you sort of lost a bit of that to-ing and fro-ing.' (Stakeholder 4; HR Nurse)*
>
> *'It's also reaching out to each other again. I think COVID took a lot of that co-working away and that collaboration where we were really open to these things. Now we are back in the … we are on our own here… no one helps A&E and I think as well the change in staff. Our staff changes every 3-4 months doctor wise and nurse wise probably a new induction every 4 months. When you constantly have a change in staff they don't have the information. The whole thing to me is a lottery. Who you see, what support you get, who tells you this that or the other.' (Stakeholder 4; HR Nurse)*

Enhanced integration and flexible pathways to better meet the needs of each individual has been proposed as essential.

> *'Streamlined Pathways, improved integration between addiction and mental health services to ensure a cohesive approach to care. Personalised Support, flexible pathways that cater to individual needs, guided by a principle of "no wrong door.'*

One key feature of this joined up working is embedded data sharing, the provision of which is lacking between some of the agencies. For example, improved information sharing was highlighted as beneficial between the services and A&E.

> *'I'm going to be honest there isn't a great link between us. I had a meeting with FH in February time. They were essentially looking for ideas cause they would have people who present to us and then go to them and they have no information. And we have no way of giving information. So they wanted to see if they could attend with them in order to facilitate a complete consultation if that makes sense. Sometimes they come back and tell them one story and it's a different thing that happened in the hospital. So they didn't really know what they were working with.' (Stakeholder 3; A&E Cons)*

There is evidence where information/ data sharing agreements appear to be working well, for example between Depaul and the consortium and the PHA and the Trust, whereby Depaul are capable of progressing service users from tier 2 to 3 whilst bypassing the GP. Further agreements across the system have potential to alleviate pressures and facilitate more seamless operations.

> *'Couple of weeks ago we had some overdoses in here and the staff were able to retrieve a couple of tablets. The PHA were trying to get hold of tablets to test them because there was a bad batch in the North. We were able to get those tested and that was a big big thing. It's like a two way thing. We will share information with them.' (Depaul FG)*

> *'So we have a data sharing agreement which I wrote prior to me coming to the Trust. We had proposed at that moment and time that the tier 2 patients that, given the cohort of patients we were finding it very difficult to get them a GP appointment and even more difficult to get them to a clinical environment. But they very much wanted to engage with addiction support tier 3 and they would have met the criteria. So we approached the Trust at that time and there is a data sharing agreement in place with Depaul and they are the lead agency in that consortium. They can refer individuals directly through from tier 2 to tier 3 bypassing the GP. And that is not leaving the GP out. Everything is appropriately triaged by clinicians when it gets to the other side. Currently we are doing an evaluation of that at the minute.' (Stakeholder 6; HOS)*

'That data sharing agreement and roll out across the region – it really knocked down barriers in the low threshold world.' (Stakeholder 6; HOS)

'It is a data sharing agreement for us to share data with the Health and Social Care Trust and the PHA funded consortium which we are tier 2 in that low threshold services in the Western Trust. It means that we can directly refer service users into the Trust so it means their personal data can be sent across in the hope they will be able to access those services and get treatment. Beforehand they would have to go to a GP and the GP would have to make that referral. One of the things with the health service as it is and the pandemic and how GPs now work, having access to your GP is very difficult and for our population of people as well. You have to take the opportunity there and then and sometimes you wouldn't get the appointment for weeks and weeks and sometimes they wouldn't show up. Then once they would see the GP, the GP would make the referral, that could take weeks and months again. So it could be a year down the line before someone is actually seen in treatment services. What this allows us to do is directly refer into those services… We hope to influence this to occur across all the Trust areas.' (DP Staff 1)

Another key feature of the joined-up service user centred approach is high level planning, funding, scoping and strategising, whereby there is better connection between statutory and non-statutory services.

'We need to look at things together and understand each other's roles and trying to see right well who is in the middle of it or the service user what do they need? From an all singing all dancing coordination service which we just don't have. Between funding and planning I think they have a problem.' (Stakeholder 4; HR Nurse)

'I have a fabulous relationship with the community addictions team….same with SWAH…Enniskillen….we do that arm, we do that arm….things work well because of personalities…we probably should all be under one umbrella…(statutory umbrella?)….I don't know about that' (Solace FG).

'We could do so much more if we sat down together and scoped out…what does the environment look like, what are the vulnerabilities?' (Stakeholder 2; CCMI)

Related to an improved joined up approach is the potential for peer advocates connecting the dots between services and facilitating wrap around service provision.

'We also talked about more connection between the acute department with consent from the patient, we are going to tell Depaul or the peer advocate that you were here yesterday in a way to have a check in that day or to prevent re-presentation here which would be a great thing. Some present every day for days on end for no reason. Just social issues unfortunately and we are limited to what we can offer so we did talk about expanding some link there between our services and if we are able to offer that wrap around service….They may have to wait in A&E all night to get a taxi somewhere which is fine but not ideal. At least if you had a follow up the next day, the peer advocate will check in with you...see how things are, GP whatever it is. Needs to be more joined up working.' (Stakeholder 4; HR Nurse)

'See [peer support worker name] role, peer advocate, I know we really want to develop that and improve outcomes for health. That's a big priority.' (Depaul FG)

7.10.2 Service/system level delivery gaps

In terms of Depaul and the consortium's actual service delivery, there are ongoing targets and challenges that remain a priority for service delivery improvement.

'Needle exchange that is taking off. Homelessness prevention, reducing rough sleeping all of those targets are always there. What we are seeing is more and more mental health issues so more mental health nurses, we see so much in terms of suicidal ideation. On a certain day not necessarily in crisis, so having someone on hand with a mental health background would be something beneficial to us going forward.' (Depaul FG)

Additionally, there were some identified gaps and recommended improvements for the consortium's service delivery, for example, with regards to Depaul Foyle Haven, suggested improvements included improved accessibility and registration processes.

'A gap for me would be registration (Foyle Haven)…they can't access the services until they get registered…that might be a day or two days later…it would benefit the person better if they could access the service when we bring them to the door' (Stakeholder 2; CCMI)

'More people with mobility problems' (Stakeholder 2; CCMI)

Identified gaps in the wider system were highlighted more frequently (compared to particular service level gaps). The data revealed existing vulnerabilities in terms of service users being

able to access the service, depending on service opening hours/ availability and service users meeting specific criteria for accessing statutory healthcare services.

> *'There is a gap in the system whereby it's a lottery depending on what time to present to A&E or them. There will be a time where there will be no service for you. I'm only here 8-4 and they are 12 hours a day or whatever it may be and we talked about the stop gap. If someone comes to A&E after hours what happens to that person?' (Stakeholder 4; HR Nurse)*
>
> *'We did a paper on premature ageing done during the lifetime of this project and the sector spoke to the need for that because those who experience homelessness and complexity of issues associated with that age much more prematurely which means they are not categorised correctly in the health related services that they should be able to access. So you have a 30 year old who doesn't meet the criteria for services maybe for a 50 year old because of their age. But because of their experience of homelessness and addiction they are at the age of 50. We hope presenting information that is evidence based should have changed the pathways for this cohort. This hasn't happened to the level that we would hope.' (DP Staff 1)*

Further wider systems level suggested improvements offered included improvements across dual diagnosis, family support and emergency accommodation.

> *'Dual-diagnosis for the future as well. We need to move to that dual diagnosis and community detox as well. We need safer environments where people can safely use, get support and we need that community detox and we need dual diagnosis for sure.' (DP Staff 1)*
>
> *'I would strongly advocate for family support as well. It isn't commissioned or covered in that and I think it is really key for those low threshold workers to get involved with the family or at least try. If that can help the service users journey as well.' (Stakeholder 6; HOS)*
>
> *'Equipping professionals with the necessary tools to address dual diagnoses effectively and prioritise prevention, as advocated by Dr. Helen McAvoy ("We'll never treat ourselves out of the situation we are in…we have to start with prevention").'*
>
> *'We need emergency accommodation. Homelessness is increasing and having a specialised service to provide that in the community is important.' (Stakeholder 5; AS)*

7.10.3 Enhanced (joint) funding and resource

The funding challenges have been well documented, and so too is the need for further resource. There was a sense of a lack of appreciation for the cost savings these services incur for the wider health system. A cost-benefit type analysis was recommended as a means to assess the savings that these services have on the health service, in terms of reducing ambulance call outs and A&E attendance, for example.

> *'I would like commissioners to take a look at the impact these services have on ED attendances. They are minimising those. They are keeping people stabilised that they are not coming through the emergency department and spending nights on wards. That's a huge saving.' (Stakeholder 6; HOS)*

The current short-term funding model appears to inhibit best practice by allowing for 'firefighting' practice only, rather than providing space and scope for future proofing, innovation, scaling and replicability.

> *'We need committed long term funding.' (DP Staff 1)*
>
> *'You're fighting year on year just to keep the service going…staff are on protective notice…don't know if they are coming or going…and they know the clientele' (Stakeholder 2; CCMI)*
>
> *'We need to analyse the problem as we see it on the street…instead of dealing with it hand to mouth' (Stakeholder 2; CCMI)*
>
> *'Resources for addiction, the more the better. Services and funding.' (Stakeholder 5; AS)*
>
> *'Increased Funding: To bolster our staff resources and extend our reach within the community.'*
>
> *'The service provided by Foyle Haven could and should be replicated in the other towns and cities and in a more permanent basis. Foyle Haven is unique on its own and then the outreach is there for Enniskillen and outsourcing. It would be lovely to see another dedicated centre.' (Stakeholder 7; HIO)*

Adequately resourcing (and looking after) the staffing infrastructure was also a recognised and necessary improvement. Enhanced salaries and terms and conditions were highlighted as important for service stability, in order to retain the existing qualified, trained and vocationally driven workforce who have an established trusting relationship with service users.

'Look at low threshold commissioning of services generally. Because what I did find is that the staff have a heart of gold. An open heart and they are hard workers. But you can't keep them because the wages. Trust wages were invoking those staff members out. You lose the staff, the knowledge and you lose the relationship with those clients. So that is so key in stabilising a service. The risk that these individuals are dealing with on a daily basis. A model like Foyle Haven you do not know who is coming to that door. They are having to do a risk assessment on the spot and some really innovative work. Trying to get a bit of background so that they can support this individual correctly. The pay does not reflect that at all. And it is not just the wage they are losing of that staff it is so much more than that. And they have to start that again with someone else. And that is ok we all do that in terms of staff retention but it can be like a merry-go-round at stages. You could keep these people forever if the wages were right cause they loved the work.' (Stakeholder 6; HOS)

'The community and voluntary sector are haemorrhaging people' (Solace FG).

'They also need to look at their terms and conditions too. I think its two weeks sick pay.' (Stakeholder 6; HOS)

'Staff wellbeing needs to be invested in. I suppose working in the Haven I have been on shift when there has been 3 CPR sessions going on and god knows how many Naloxone injections and then you still have your clientele coming in that are street homeless and you need to maintain the service.' (Stakeholder 6; HOS)

Related to the joint up and person-centred approach aforementioned, there is also the recommendation for a collaborative funding model, where there is appreciation for cross-departmental obligations, including housing, health and justice. The cross-departmental commitment extends beyond funding only, towards a collective impact approach, facilitating information sharing, resource sharing, and expertise harnessing across sectors, with the service-user at the centre.

'There is an overreliance on housing being the core funder of the voluntary and community sector when in actual fact it is evident that this is not only a housing issue, it's a health issue, it's a justice issue and it's also educational. But I would say the three key players should be housing, health and justice. We are not getting the commitment and cross-departmental legislation to compel the departments to fund and resource. It's not always money, it's the sharing of the resources in that making it

accessible for changing the pathways, changing the access and working more closely with the sectors and enabling that to happen. So in the next 3-5 years there has to be a rethink and a refocus across all government departments for this sector and how it is commissioned and funded going forward. And that has not been enough. That has been one of the challenges for the programme. And I have to honestly say PHA have been amazing in responding to the requests and the growing needs that have occurred in the lifetime of the project. And being able to provide uplifts in funding and finding pockets of money that has enabled particular initiatives to be delivered. But the difficulty of that is because it is not re-occurring funding and core funding going forward, you're running an initiative for a period of time because you don't have the core funding for going forward.' (DP Staff 1)

8.0 Discussion and Recommendations

8.1 Returning to the research questions

At the outset, three overarching research questions were proposed (see Table 7). Throughout this section of the report, the key findings will be discussed, which align with the overarching questions around delivery, impact, recommendations and learning. A snapshot of the evidence-based responses to the posed research questions is offered in Table 7, with further detail presented throughout the discussion of findings. Additionally, the stakeholder engagement data is also presented in alignment to the policy context in Table 8.

8.2 Service delivery

Firstly, the implementation and delivery of the Depaul and consortium services will be addressed. The data highlights different delivery models present within the three services. Depaul Foyle Haven offers a daily 'centre-based' approach, a 'home-from-home' type environment for service users. Whereas, First Housing and Solace, due largely to their rural nature and the geographic spread of their client base, offer outreach services, whereby support workers visit service users in their own home (Solace, it should be noted, organises some 'centre-based' activities also).

Table 7: Addressing the research questions

Research question posed	Research question answered
RQ 1: How has the service been delivered over the past 10 years? How have service users experienced the service? From the perspectives of service users and delivery partners, what have been the key learning points, challenges and successes? From the perspectives of service users and delivery partners, what are the key recommendations? Particularly, for adaptation, scaling and growth?	The service has been delivered differently across each delivery partner, using a holistic and person-centred approach to best meet the needs of service users and the locality. The services are held in high regard by all the stakeholders, service users speak very highly of the services (a key strength is the support worker/ service user relationship) for helping them with their harm reduction which has facilitated self-reported lifesaving and life changing outcomes. Key successes/ strengths of the service includes: meeting service users' 'hierarchy of needs'; filling in statutory gaps; relationships; the workforce; providing a holistic and person-centred service; and the reported subsequent saving for the health service. Key challenges include systemic issues, such as funding models, high demand and ever changing complexities and challenges.

RQ 2: What impact has the service had on service users over the past 10 years? From the perspectives of service users, what impact has the service had on their lives? From the perspective of other stakeholders, what impact has the service had on service users and the broader sector? From the perspective of all stakeholders, how does the service and reported impact align with key public health strategies	Service users (and the staff and stakeholders) highlighted the lifesaving and life changing impact the service has had on them, they highlighted physical health improvements as well as mental health improvements (also corroborated by the small scale survey). The extent of outcomes was very much dependent on the individual, for some, this may be seeking help again after returning to substance misuse, for others this could be living a more fulfilled and less chaotic life. All the data collected suggests the services are directly targeting numerous public health strategies (e.g., NSD 2011-2016; Preventing Harm, Empowering Recovery (2021-2031 – see Table 1), as well as meeting the objectives as set out by the PHA service specification (see Table 1).
RQ 3: How can the learning from this evaluation inform future service delivery? Considering the evidence, what recommendations could be made for addressing the needs of service users in the North-West over the next 3-5 years? What recommendations would be made for future and ongoing monitoring and evaluation?	There is great learning in the data collected via this evaluation, providing a sound evidence base for service planning and systems-level influence. Three key recommendations are provided, centred around 3 core themes: Implementation, Learning and Expert by Experience input (see section 8.5.3).

Table 8: Alignment with policies

Mapping of common themes	New Strategic Direction for Alcohol and Drugs, Phase 2 (2011-2016)	Preventing Harm, Empowering Recovery (2021-2031)	PHA Service Specification (2015-2020)	Deliverables: Monitoring reports	Deliverables: Stakeholder engagement
	The Five Pillars (1-5)	Outcomes (A-D)	Outcomes (1-16)	More people and families receiving low threshold services. Exceeded the yearly minimum of 235 service users per year (e.g. 2019: n=579; 2023: n=346; 2024: n=413). Reduction in the number of crisis interventions (through first response e.g. naloxone administration, relieving pressure on ambulance services and A&E).	

1.	Prevention and early intervention	Through prevention and reduced availability of substances, fewer people are at risk of harm from the use of alcohol and other drugs across the life course	Reduction in the number of crisis interventions requiring emergency medical help from ambulance services or emergency department (11). Reduction in the number of crisis interventions by the PSNI (13) More people and families receiving low threshold services (15)	Reduction of harms caused by substance use: Advice on blood testing (e.g. 2018: n=68; 2024: n=61) Reduction in risky injecting including advice/equipment/practices (2018: n=23; 2024: n=67, *Our needle and syringe service has really taken off this quarter and we had over 25 visits to this service for clean needles and harm reduction advice.)* Reduction in alcohol related harm through person centred harm reduction approaches (2018: n=77; 2024: n= 232) Reduction in drug and alcohol related harm through person centred harm reduction approaches (2018: n=68; 2024: n=197)	The stakeholder engagement data corroborates these findings, demonstrating: Perceived savings on other statutory services, including A&E and ambulance services. Self-reported reduction in harm, as per service user accounts. Perceived lifesaving and life changing impacts achieved via a mixed delivery model across the three services, all of whom adopt a person-centred and holistic approach.
2	Harm reduction	Reduction in the harms caused by substance use	Increase in the uptake of blood borne virus testing and treatment/	Improvement in mental/physical health through the delivery of a range of physical and	84% of survey respondents (note, small sample size) reported improvements in mental health, 79% reported improvements in physical health. The

			hepatitis B vaccination (1) Reduction in alcohol related harm (2) Reduction in drug related harm (3) Reduction in risky injection practices (4) Reduction in risky sexual practices (5)	emotional health intervention (e.g. course on depression, mental health assessments through GP, accompanying SU to GP with physical ailments – falls, injuries etc.) Housing stability improved for a number of individuals through direct homelessness interventions (e.g. communication with or on SU behalf to NIHE; working to secure temporary accommodation; 2019: n=114 referred to specialist accommodation/appropriate housing/hostels).	qualitative stakeholder engagements corroborated this finding. Qualitative findings point to the service's fulfilling a range of human need, with physiological need, such as housing, food, clothes etc. providing solid foundations for further improved outcomes. The service user data also demonstrates examples of much improved stability amongst service users' lives (more manageable and less chaotic). Respect and engagement with the harm reduction service (and noted engagement with a range of other related health services) also points to the harm reduction outcomes, which many of the service users reported.
3	Treatment and support	People have access to high quality	Improvement in mental health (6)	Reduction in criminal involvement	Across all participants engaged, it appears the services are of top quality.

		treatment and support services	Improvement in physical health (7) Improvement in housing stability (10) Greater access to low threshold services (14)	Working closely with PSNI and community policing including supporting knowledge around consumption (e.g. 2024: *Foyle Haven staff were able to retrieve 3 of these tablets and they are now in the process of being tested by the police to identify their contents;* 2024: support offered on offending behaviour)	The workforce is presented as caring, professional, well skilled/trained, and have cultivated safe, conducive and comfortable spaces for service users to engage in. It is upon these solid foundations, improvements across health, housing, and accessing additional services are built.
4	Law and criminal justice		Reduction in criminal involvement (12)	Improved ability to manage daily activities Improved relationships Meeting basic needs of service users (e.g. food, warmth, clothing) as first response to helping with daily activities. Harm reduction interventions and strategies to reduce the use/control times of use to assist in management of daily activities (e.g. 2024: delivery of managing	Issues of criminality and antisocial behaviour were not a strong theme emerging from the qualitative data. Nonetheless, the well-established association between substance use and criminal behaviour (see, for example, Lowenstein, 2001; Pierce et al., 2017; Turnball, 2019), suggests harm reduction will subsequently reduce criminal involvement.

				money, managing tenancy, drug misuse support, self-care support, meaningful use of time). Interventions that are family focused to help improve relationships.	
5.		People are empowered and supported on their recovery journey	Increased ability to manage daily activities (8) Improved relationship with family members (9)	Standardisation of the LTM for service delivery Regular engagement with service users on design and delivery of LTM and service provision. (e.g. 2024: *Our annual service user survey also captures feedback from as many service users as possible. We also have a suggestion box which is visible to all in our common room. Evaluations are also gleaned through daily key working sessions and through holding a quarterly service user forum*.)	The qualitative data suggests that service users are treated with autonomy and respect, they are involved in decision making, and they are well supported in their recovery journey.
6.	Monitoring, evaluation and research	Effective implementation and governance, workforce development, and	Regional standardisation of the service model for low threshold services (16.).		The data collected has revealed little by way of implementation or governance frameworks. Ongoing monitoring to PHA takes place regularly.

		evaluation and research supports the reduction of substance use related harm.			

8.3 Strengths of the service

The service staff and stakeholder findings present a range of strengths of the services involved, which are often complemented by the service user's own testimonies as presented in their interview findings. The findings across all participant data suggest the following key strengths.

8.3.1 Meeting the 'hierarchy of needs' of service users: Lifesaving and life changing outcomes

This is a core and fundamental strength of the services. Across all participants engaged, there was evidence of these service's meeting the needs of their service users across a range of levels. The different ways in which the services were meeting these needs was framed usefully by Stakeholder 6 within Maslow's Hierarchy of Needs (Maslow, 1954). Building upon this model, the findings from these data align neatly with this conceptual framework, whereby the staff, stakeholders and service users have provided examples of how different tiers of this hierarchy of needs were being met (see Figure 9):

Physiological needs: Firstly, there was evidence of service staff meeting the most fundamental need of preserving life, that is, by acting in a first response capacity and saving lives (by administering Naloxone), as well as testimony from service users who acknowledged how service staff had saved their lives with their intervention and support. Thereafter, there were multiple examples whereby the services were meeting the most basic and fundamental of human need, that is, by providing shelter or assisting with housing, by providing a hot meal or ensuring service users have enough money for food, and by providing shower facilities and clean clothes. The data suggests that meeting these needs, on occasion, facilitate the realisation of other needs, for example, by providing personal hygiene opportunities, clients were then able (or less embarrassed) to access additional services, whereby social stigma (particularly around cleanliness) would have been previously prohibitive.

Safety: Whilst the data points to many examples of the services providing physical safety, e.g., by taking people off the streets, ensuring clients get home safe, providing safe shelter etc., these data also point to the extension of the 'safety' tier to include also 'relational safety'. Many of the service users discussed the safety and comfort they felt with their support

worker, which then facilitated a more conducive 'therapeutic' relationship and dynamic, which in turn, opens up further opportunity for harm reduction and improved life outcomes.

Love and belonging: On one level, there are many examples whereby the services themselves, including the staff involved and the other service users involved, have provided a sense of community, belonging and even family for the service users. Furthermore, the data also points to the rebuilding of pre-existing familial relationships and healthier choices regarding friendships and trust.

Esteem and self-actualisation: The foundational blocks of these higher-level needs are evident in the data. There is evidence of lives once lived in chaos (not making appointments, sleeping all day, not taking any care in oneself), which are now lived and managed effectively, with purpose, enhanced esteem and self-respect. For example, where service users (particularly those further along their journey from Solace) mentioned their taking more pride in themselves, their appearance, and looking forward to the future.

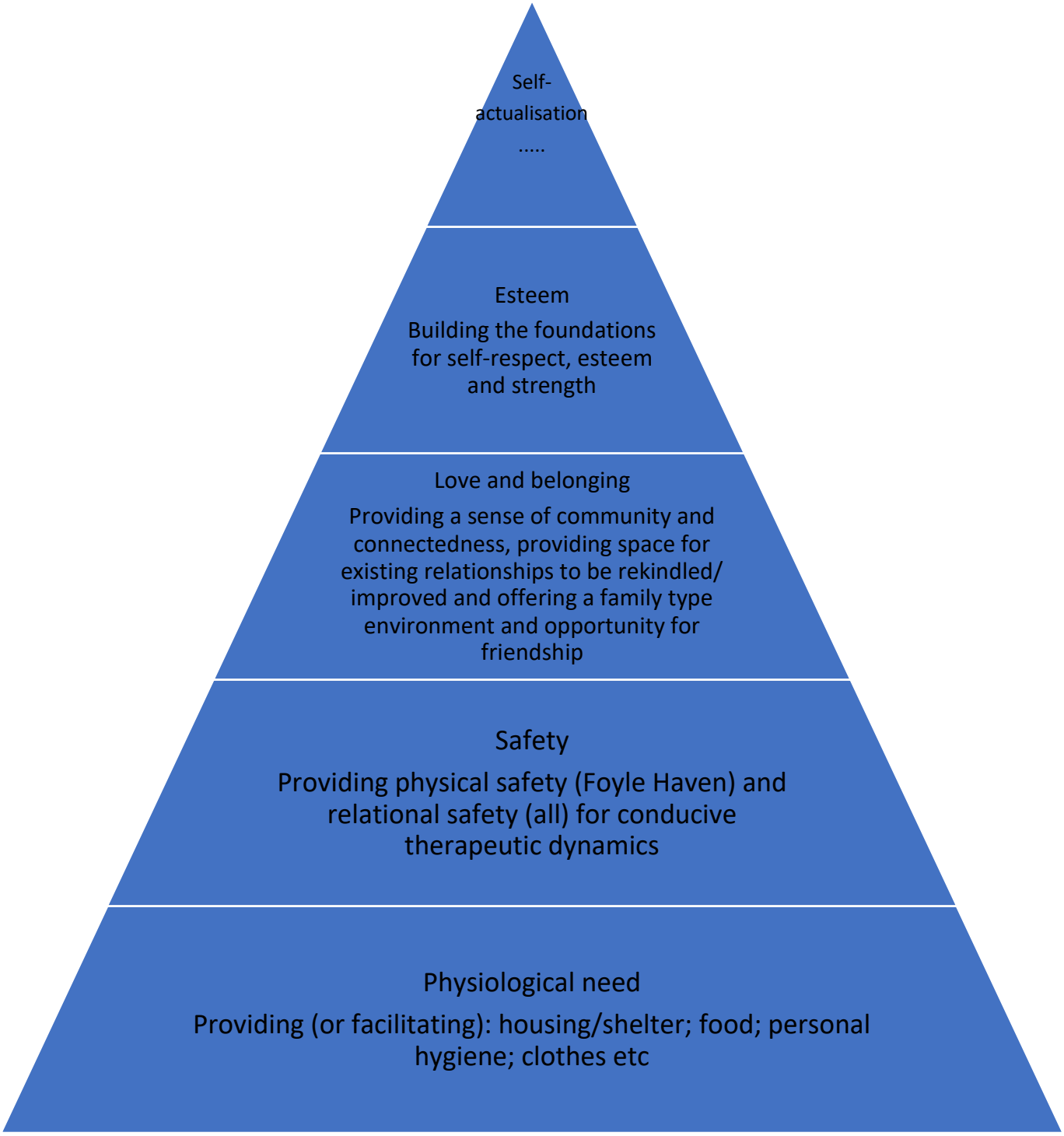

Figure9: Depaul and consortium meeting client's 'hierarchy' of needs, based on Maslow's Hierarchy of Needs (1954)

8.3.2 Filling in the statutory gaps

All participant groups (staff, stakeholder and service users) acknowledged the valuable role these services play in addressing statutory provision gaps. The staff and stakeholders referred to the 'safety net' the services offer in tackling issues or clients who, for a range of reasons, don't meet the criteria for statutory services. Similarly, the service users acknowledged the role that these services played when they had felt let down by statutory service provision in the past, or where the statutory support did not offer the same level of care and compassion afforded by the Depaul and consortium staff.

8.3.3 Relationships

Another key strength of the programme are the relationships cultivated between each of the three services themselves, between the services and external stakeholders and between the services and the service users (which feeds into the safety and love and belonging needs mentioned above).

Consortium relationships: In terms of the inter-relationships between the consortium, this was mentioned lightly in the data, however, there was no strong evidence of the services as a collective. Rather the data depicted three distinct services working independently, with crossover and support[1].

Relationships with stakeholders: Strong relationships were evident between the consortium staff and a range of external stakeholders working within the homelessness, addiction and health arenas. These relationships appear to have facilitated strong collaborations for the betterment of patient/ client treatment and outcomes, e.g., data informing/sharing agreements. However, these relationships and collaborations appear to be more informal (and so at risk in terms of sustainability), rather than formalised in legislature or policies.

Relationships with stakeholders: The standout relationship dynamic throughout the data were the relationships between the service users and the support workers/ service staff. The data suggests that the service staff have cultivated a respectful, trusting and supportive relationship with the service users, facilitating meaningful and (apparently) successful spaces for emotional and social support. The data suggests that these relationships have flourished as a result of four underpinning pillars (highlighted in Figure 10).

[1] Note, this is not to say further collaboration between the consortium partners does not take place, rather this was not a strongly emerging theme from these data

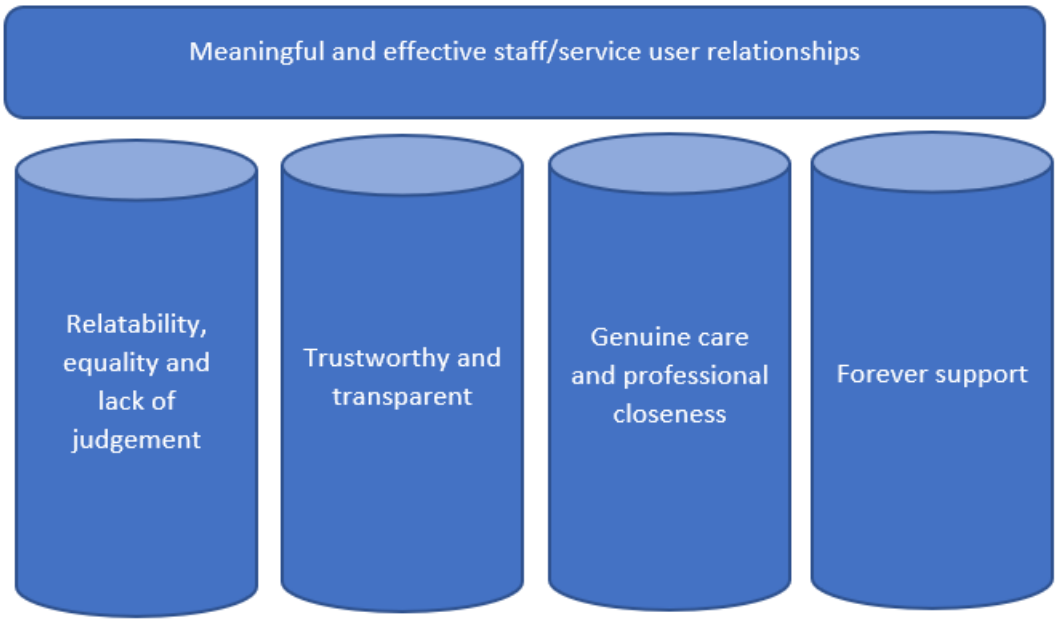

Figure 20: Pillars to meaningful and effective staff/service user relationships

8.3.4 The workforce

A standout strength of each of the services are the people. Central to the positive relationships described above is the quality, professionalism, care, and commitment of the services' workforce. The vocational commitment of the staff was evident across all participant groups, so too was the professionalism, qualifications, commitment to continuous professional development (necessary in an ever-changing societal context) and pride they each take in their work and the organisations and communities they represent.

8.3.5 Holistic and person-centred approach

The data highlights the strength in the service's adopting a person-centred and holistic approach to harm reduction, whereby they meet the service user where they are at, work with the existing supports (familial, wider community) and advocate on their behalf for the betterment of lives. Building on Bronfenbrenner's ecological systems theory (which is focussed on child development and the complex and relational systems within which they live and develop), a model of patient/ service user engagement emerges from the data, whereby the service user is at the centre with varying systems operating around and with them. The data points to three core systems: 1) Microsystem -their immediate social supports, including family, friends, and the services they are engaged with, which often fills the roles of the latter

(often destroyed by the impacts of substance misuse); 2 Exosystem - the statutory sector, i.e., housing, health service, benefits; and 3) Macrosystem - the wider socio-political and cultural context, which determines how services are funded, how they work together and the culture and ethos of society (i.e., encompassing issues of social stigma and social isolation etc) (see figure 11).

Figure 11: Service user ecological systems model, based on Bronfenbrenner's ecological systems theory (1977)

8.3.6 Savings for health service

Finally, a key strength of the services involved is the perceived savings they are making for the National Health Service. Acknowledged by a range of external stakeholders and staff, the intervention of these services is invaluable for the health services, i.e., by reducing ambulance call outs and A&E presentations. The perceptions-based data suggest that the return on investment for the health service is considerable. These services operate on stretched budgets, with increasing demand, short-term funding and constant instability, yet without them, the system would be crippled (as suggested by the stakeholders engaged).

8.4 Systems-level challenges

The data suggests that the strengths and successes these services have seen have been in spite of wider systemic and societal challenges, which appear to be exacerbating problems, rather than facilitating or supporting service delivery. The findings have revealed a host of different challenges, few of which represent gaps in the actual service delivery, whilst the majority represent broader systems-level issues, such as those represented in the exo and macro systems depicted in Figure 11.

8.4.1 Service demand, increasing complexity and sustainability

The increasing demand and nuanced complexity of the addictions/ homelessness landscape is undoubtedly evolving and increasing the pressures on services. The nuances and challenges of: the localities involved, particularly the rural communities (dearth of services, wide spread client base etc.,); the displacement of Belfast-based clients to an already overstretched service; the introduction of more drug-related addictions; the changing demographic; and added mental health complexities; all of which are compounded by a host of socio-political, environmental and economic challenges (e.g.., cost of living crisis, Covid etc.,) which appear to have stretched these services to the limit.

These findings point to concerns regarding both the manageability and the sustainability of these services. Services which, due to the ever-evolving complexities of need, the sometimes transient nature of service users who can 'dip in and out' and their admirable ongoing and 'forever support' (which has been a key differentiating factor attributed to the success of the 'therapeutic' dynamic between support workers and clients), are unable to definitively measure the number of service users they engage with. The services which are reportedly under-resourced and under-funded, are reliant on the commitment and (to an extent) goodwill of their staff who, by the service users' account, go above and beyond duty. The staff in some services are approaching retirement, there is risk of burnout amongst all, as reported the terms and conditions are lacking – all of which points to issues of sustainability and business continuity. This is of great concern not only to the services themselves, but to the wider statutory health systems who, by stakeholders' accounts, could not withstand the increasing pressure that would come their way, should these services not exist.

8.4.2 Funding, collaborative investment and collective impact

The lack of funding, under resourcing, and cost-to-benefit ratio (in terms of savings on the health service) have already been touched upon. Of additional note, is the current funding

model, whereby funding is provided by one statutory body only (Public Health Agency). As recognised by Depaul staff (1), the issues attended to via these services, extend far beyond health, and towards justice, housing, economy, and beyond. By adopting the person-centre model depicted in Figure 11, the range of influences and outcomes associated with a person's life are recognised. The data points to the potential for a more collaborative funding model, and a more collective approach to tackling these issues, involving a range of non/statutory partners, akin to the 'Complex Lives' initiative in Belfast.

8.4.3 Demonstrating impact

Challenges were raised in terms of definitively demonstrating impact. The measurement challenges emerging from the data include:

- Difficulty in demonstrating harm reduction, particularly within a person-centred approach. For example, for one service user success might look like getting out of bed, drinking one less unit of alcohol. Whereas, for others, it might be returning to drinking only day a week, improved relationships, and returning to work/hobbies.
- Difficulty measuring what didn't happen, i.e. those who did not attend A&E, or those for whom an ambulance wasn't called, due to the service's early intervention.
- Difficulty in collating an overarching monitoring and evaluation framework. Whilst there are vast amounts of data recorded and reported to PHA from each of the delivery partners, these appear to be framed according to PHA's templates and structures, rather than being driven by the service delivery and outcomes. Additionally, there are variances in terms of what is reported and how. Whilst some level of flexibility is required due to the differing services, further standardisation between delivery partners and over time points would facilitate improved impact measurement.

8.5 Recommendations

Considering the vast amount of data collected and information consolidated, the recommendations provided centre around three overarching objectives: 1) Implementation - covering all aspects of implementation (service level and systems level interacting; funding); 2) Ongoing learning (monitoring and evaluation); and 3) lived experiences underpinnings to all, provided by a sustained and resourced 'experts by experience' advisory group.

8.5.1 Enhanced Implementation: Collaborative, participatory and person-centred approach

For current enhanced service delivery, as well as for sustainability, growth and scalability, the research team recommends a collective overview and review of service delivery. The co-development of a logic model and theory of change is recommended, whereby implementation, delivery, activities and outcomes (individual across each partner as well as collective across all) are formalised, providing a sound underpinning and framing for service delivery moving forward. One approach of note for consideration is the 'Collective Impact' approach (see here: https://www.tamarackcommunity.ca/collective-impact-toolkit).

As per the Complex Lives initiative, involving all relevant stakeholders within a place, including: service staff, external stakeholders from across the sector, commissioning bodies (thus formalising the current strong but informal working relationships), and those with lived experience (i.e., via the aforementioned advisory group, if established). The goal of which would be to enhance service delivery as well as the pursuit of systems-level change for a collaborative funding model and more formalised networks, relationships and collaboration.

The collective impact model is based on five key principles which could act as a guiding framework for any such work:

- Shared measurement systems across the three services with key indicators of success
- Common agenda
- Mutually reinforcing activities
- Continuous improvement
- Back bone support

As noted, a sustainable cross-departmental funding model would also assist in securing longer term delivery to enable forward planning and optimum resourcing of the service.

8.5.2 Enhanced Learning Frameworks

The development of a bespoke and co-constructing 'Learning Framework' is recommended, grounded in the core activity, objectives and outcomes of the services, whilst also aligned to policy and commissioning body priorities. It is recommended that this framework will be shared amongst all delivery partners, providing consistency and capacity for assessing collective impacts (whilst also facilitating some service-delivery bespoke measures). Considering the person-centred nature of the work and the variability in outcomes, it is

suggested that via each service user's personal plan (i.e., those actively and regularly engaged), an individualised target system is developed and reviewed (collected, collated and analysed for reporting) regularly, in order to show progress against individualised targets, rather than broader organisational or policy objectives. This would afford a more accurate reflection of outcomes as well as offer an empowering motivator for service users.

8.5.3 Experts by Experience Groups

Finally, in recognising and building upon the services' existing participatory approaches and the value placed on the service users' perspectives, it is recommended that this is 'formalised' via 'experts by experience' or 'lived experience' advisory groups across each of the services/ the collective. Whilst it will not be feasible/ best practice to involve certain service users (depending upon their current circumstances), it is suggested that those service users willing to participate would be supported to do so. The remit of this group would be co-constructed, but it is intended that this group would ensure the lived experience 'voice' is heard and acted upon within both the service delivery as well as any efforts for systems-level change. The anticipated outcomes of such a group would be twofold: 1) to enhance service delivery/ broader systems and practices, via rich lived experience insights, and 2) to empower and encourage the service users involved. It is recommended that the formalisation of such a group is prioritised ensuring service user perspectives are centred in the consideration and implementation of all recommendations and actions moving forward.

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