Scottish Government
Riaghaltas na h-Alba

Recovery Housing in Scotland: Mapping and capacity survey of providers 2022/23

HEALTH AND SOCIAL CARE

social research

Key Findings

A mapping and capacity survey was sent to recovery housing facilities following a scoping exercise. Data was collected between the 19th of July and the 15th of August 2023. The survey received 12 responses from facilities based in Scotland.

The responding providers are based in four different ADP areas (Edinburgh City, Glasgow City, Highlands and West Dunbartonshire). A range of workforce sizes and job roles were described by respondents. Of those who responded, all reported that there is some level of lived experience involvement within the running of their service.

Most providers are third sector organisations and are registered with the Care Inspectorate and reported having several funding streams to support their service, commonly though housing benefit. All providers expect residents to make a financial contribution towards their living costs ranging from £7 - £30 per week.

Providers reported a combined total maximum capacity of 235 places at 84% full capacity at the time of the survey. Providers reported offering a variety of types of accommodation.

Referrals are made by a range of organisations, most often residential rehabilitation providers and drug and alcohol services. Residents most commonly come from the provider's local ADP or NHS health board area. Providers use a range of means to publicise their service.

Most providers accept both men and women and accept a range of ages to their facility. The focus of most providers is on supporting people with both problem alcohol and problem drug use and reported being able to support a variety of needs, including people who had experienced homelessness, people who had formerly been in prison, and people with specific mental health concerns**.** Notably, fewer respondents reported being able to support specific demographic groups such as women who are pregnant or with dependent children, and men with dependent children**.**

Providers reported having specific entry criteria for residents and that service staff are involved in the admission process. **The majority of the providers did not have a waiting list at the time of the survey.**

Recovery housing models adopted in Scotland are not directly comparable to what is described in the international literature. In Scotland, recovery housing tends to be provided in the form of single occupancy flats. Specific models for recovery from substance use are followed and a range of treatment options are available to residents and providers describe a variety of governance arrangements. Residents stayed an average of between 12 and 18 months.

Most providers require their residents to abstain from using alcohol and/or drugs. Of those that required abstinence, most actively monitored this. Residents are not commonly evicted in the event of a relapse.

Providers reported a range of ways used to monitor resident outcomes. Most providers offer some form of continued contact to residents once they leave, however a formal after plan was only described by some. Residents most commonly move on to housing association and council accommodation and rarely go to residential rehabilitation during or after their stay.

Suggestions to service improvement included funding and resources, improvements to service design, better linkages across the sector and other services, and improved pathways to and from this service. The importance of meaningful co-production was also highlighted.

The responses highlight the similarity across providers however the term 'recovery housing' may not be widely recognised by providers of this type of service in Scotland. Providers generally agree on key characteristics take make up these services and that these are in line with how recovery housing is described in the literature. These responses can be used as the starting point for developing a broad definition of recovery housing that is applicable to a Scottish context.

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1. Introduction

There is a high level of problem drug and alcohol use in Scotland, which causes preventable harm to people and their families. Scotland has a higher drug death rate than any other European country – this is 2.7 times the rate of the UK as a whole[1] and disproportionately affects people living in more deprived areas. The most recent evidence suggests that as of 2019/20, around 45,700-48,600 people aged 15-64 were opioid dependent in Scotland[2].The most recent Scottish Health Survey found that over one in five people aged 16 and over (22%) self-reported drinking alcohol at harmful levels (in excess of 14 units per week) in 2022[3]. However, the true size and scale or problem alcohol and drug use are challenging to determine.

In January 2021, Nicola Sturgeon, in her role as First Minister, made a statement to Parliament that set out a National Mission to reduce drug deaths through improvements to treatment, recovery and other support services. One of the five priorities was increasing capacity and improving access to residential rehabilitation.

The Residential Rehabilitation Development Working Group (RRDWG), chaired by Dr David McCartney, was established in April 2021 as a successor to the Residential Rehabilitation Working Group (RRWG). Its role is to advise Scottish Ministers and the wider drug and alcohol sector on implementing the recommendations made by the RRWG in December 2020. These recommendations were published in a suite of reports that provided insight into the pathways into, through and out of residential rehabilitation in Scotland. A specific "need to ensure robust exit planning and continuity of care for those leaving residential rehabilitation" was outlined as a recommendation for future work. The RRWG also highlighted the need to better understand the "local community-based resources […] and other recovery initiatives" that operate alongside residential rehabilitation (recommendation 6b) and the diversity of residential treatment interventions across Scotland (recommendation 7a).

Recovery housing has been put forward as a potential avenue for meeting early recovery needs that can be incorporated into the continuity of care for people in recovery. Although a definition of recovery housing is yet to be agreed, it is generally accepted that **recovery housing is a shared-living, substance-free living environment, centred on peer support to promote sustained recovery and independent living**. Recovery housing therefore acts as a bridge between residential treatment and independent living. Recovery housing is one continuity of care service that can run alongside or independently from residential rehabilitation. A recent review of the literature on recovery housing shows that although there is considerable evidence for recovery housing and information on models of care, this is mostly from research conducted in a U.S. context. It remains unclear how relevant and directly applicable this is to a Scottish context. The review also highlights that little is known about the current provision and capacity of recovery housing in Scotland, and that more work needs to be done to better understand the Scotland-specific landscape.

[1] NRS Drug-related deaths in Scotland in 2022
[2] PHS Estimated prevalence of opioid dependence in Scotland 2014/15 to 2019/20
[3] The Scottish Health Survey 2022

The research presented in this report intends to address this, by means of a survey of recovery housing providers in Scotland. The principle aim of this research is to better understand the provision and capacity of recovery housing facilities for drug and alcohol use in Scotland. Specifically, the objectives of this report are to identify the key characteristics of the services that operate and identify as recovery houses in Scotland, and to better understand access and current capacity of these services. This will inform future policy and planning around recovery housing and aftercare in general for people with problem substance use in Scotland.

The report first outlines the methodological approach taken in the survey before discussing the findings of the study, conclusions and next steps.

2. Methodology

A mapping and capacity survey was sent by email to a list of pre-identified potential recovery housing facilities. This list was developed from a prior scoping exercise, where respondents were asked to provide the name, location and, where possible, contact details for recovery housing facilities or providers they were aware of, and to forward on the request for information to anyone who may have relevant information. Scoping work took place in June 2023. The following organisations and groups were consulted as part of this exercise:

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

Subsequent desk research identified whether the facilities put forward still existed and if they indeed offered a recovery house-like service in its broadest sense: namely that they offered housing for people recovering from problem substance use and were not a residential rehabilitation facility. The final list was shared with Alcohol and Drug Partnership (ADP) leads as a further means to quality assure the longlist.

The final list consisted of 43 potential recovery housing-type facilities to whom the mapping and capacity survey was distributed by email[4]. Additionally, the housing departments at each of Scotland's councils were contacted by email to determine if they offered any recovery housing type accommodation. Recognising that people residing in Scotland may travel for a recovery housing service, the survey was distributed to 17 recovery housing type services in England. These England-based facilities were identified as part of the scoping exercise and underwent desk-research as described above. The survey was designed to only capture information from facilities elsewhere in the UK that had current or past residents who had previously either resided or attended a residential treatment service in Scotland (see Appendix A).

A desired outcome of this research was to inform the development of an operational definition of recovery housing. Therefore, an inclusive and generally low threshold approach to participation was adopted in the research design phase, whereby the survey was open to any service that self-identified as offering a recovery house-type service. Despite efforts to capture all services, some will inevitably not have been captured by this research.

[4] It should be noted that due to the wide net approach taken by the research team, this list likely captured some services unlikely to be considered a recovery house. This figure should therefore be used as an indicator of the response rate only.

The survey was composed of 60 questions on topics such as the characteristics of the facility (e.g. workforce, number of beds/places); identification, referral, and admittance of residents; resident life; and resident outcomes. The survey (see in Appendix A) also employed routing to minimise burden of completion. The survey included both multiple choice and open text questions, with the majority being open text questions due to the exploratory nature of this work. To maximise the utility and appropriateness of the survey questions, a draft version of the questionnaire was distributed to the RRDWG; relevant stakeholders from Public Health Scotland, Health Improvement Scotland, and Scotland Excel; and relevant Scottish Government policy colleagues for comments.

Data was collected between the 19th of July and the 15th of August 2023. Follow-up emails and calls were made to providers in the initial long list to ensure they had the opportunity to be included in this research where they did not initially respond to the email invitation.

3. Findings

The survey received 19 responses. Five providers identified through the scoping exercise responded to specifically say they did not consider themselves to be a recovery house[5]. A further 23 of the 43 potential recovery houses did not respond. As such, the research presented may not have captured the totality of recovery housing services available to people in Scotland.

Three invalid responses were removed and a duplicate response consolidated, resulting in a total of 14 responses for analysis (see Appendix B). One of these facilities[6] was identified in a previous mapping survey of residential rehabilitation facilities in Scotland published in 2020. However, that report highlighted that the distinction between residential rehabilitation services and specialised supported accommodation services was, at times, ill-defined. Specifically, four of the residential rehab services offered "specialised supported accommodation services", which may be a form of recovery housing (see Appendix B). The decision was made to include this service in this report based on the content of their response to the survey of recovery housing facilities and how this aligned with the recent review of the literature.

Two of the 14 responses were from facilities based in England. One of these responses was incomplete and due to issues around base numbers and risks around identification, these findings could not be reported on. However, the partial information provided in these responses indicate that these providers are broadly in line with those in Scotland in terms of the service they provide. Although they would in principle accept applications from people in Scotland, these were reported to only make up a small percentage of their past or current residents.

The remaining 12 responses were from facilities based in Scotland and are included in the analysis presented in this report.

3.1 Profile of providers

3.1.1 Location

The providers are based in four different ADP areas (Edinburgh City, Glasgow City, Highlands and West Dunbartonshire), and describe having a range of single, double or multiple occupancy flats or houses spread across these areas.

3.1.2 Workforce

A range of workforce sizes and job roles were described by respondents. All but one employ staff in a paid capacity, although the composition of this workforce in terms of

[5] The invitation to the survey used the following broad definition of recovery housing to identify appropriate responses: 'Recovery housing may also be referred to as supportive accommodation; sober living houses; move on housing; dry houses; halfway houses; transitional living; or oxford houses. They generally consist of alcohol- and drug-free living environments that provide peer support for those wanting to initiate and sustain recovery. Although recovery housing is often described as aftercare following formal residential rehabilitation to support people to transition back into independent living, we understand that this is not the only pathway that may exist in Scotland.'
[6] Safe as Houses Project.

job roles varied considerably across providers. All of these providers employ support workers; most listed administrative staff including finance officers; some also mentioned house managers (including deputy managers, operations managers and project coordinators) and project worker/service leader/team leaders; a couple mentioned addiction workers or recovery coaches and clinical roles, (e.g. clinical nurse manager). In addition, the majority of the providers reported having unpaid staff or volunteers in roles that included peer mentors, students on placement, support staff and house warden.

Of those who responded (n=11), all reported that there is some level of lived experience involvement within the running of their service. About half explicitly stated that both their paid and unpaid workforce have lived experience of problem substance use, with one provider specifying that over half of their staff had previously been residents. Less commonly, providers reported having resident-level involvement in the running of the service. For example, with residents involved in staff interviews and participating in expert panels to shape the development of the service.

3.1.3 Funding and accreditation

All but one (n=11) of the providers are third sector organisations, and one is statutory funded.

Most providers who provided information on their funding (n=9) reported having several streams to support their service. The most commonly mentioned source of funding was housing benefits. Other sources included the local council or ADP, private trusts and grant funders or private donors, the NHS and the Church of Scotland. Only one provider who responded to this question described themselves as self-funded.

All providers expect residents to make a financial contribution towards their living costs (e.g. groceries, bills, rent), although they described different arrangements and amounts. Responses were fairly evenly divided between two approaches. In the first, residents are responsible for covering the totality of their living costs, although a few mentioned that some of this (e.g. rent) is covered by housing benefits that residents receive. One of the providers specified that residents are offered support to manage their budget. In the second, residents are required to contribute a weekly or monthly payment towards their living expenses. Where specified, these payments ranged from around £7 to £30 a week.

Of those who provided a response, the majority of providers (n=9) are registered with the Care Inspectorate. Three providers stated that their staff are also registered with the Scottish Social Services Council. Other registrations/accreditations include the NHS[7] (n=1).

3.2 Capacity

Providers reported a combined total maximum capacity of 235 places at 84% full capacity at the time of the survey, with 197 of these 235 places being filled. The size

[7] The provider was followed-up to gain clarity on this; however, no response was received.

and structure of the recovery housing providers and their facilities varied considerably. The largest provider had capacity for 79 residents, making up a third of the total places across Scotland. However, most providers had capacity for much smaller numbers of residents; over half of the providers (n=6) had capacity for between 5 and 11 residents and the rest (n=5) for between 16 and 35 residents.

Providers reported offering a variety of types of accommodation. Around half of the providers (n=6) offer only shared-living housing, from two-bed to 16-bed flats or houses. Three providers offer only single-occupancy flats. Three providers offer a combination of both single-occupancy and shared living accommodation.

3.3 Referral pathways

Referrals are made by a range of organisations but most often come from residential rehabilitation providers (n=9) and drug and alcohol services (n=8). Referrals from ADPs (n=5), local authorities (n=5) and prisons (n=5) were also fairly common. Residents tend not to self-refer, with half of the providers (n=6) reporting that this is never the case.

Residents most commonly come from the provider's local ADP or NHS health board area (n=11). Over a third of the providers (n=5) had only received residents from these areas, while the others reported sometimes accepting residents from the rest of Scotland or, more rarely, the rest of the UK.

Providers use a range of means to publicise their service. All reported using online platforms (e.g. websites or social media) and other routes included paper-based promotion materials such as leaflets and posters (n=8) or promoting at in-person events (n=4). Only two providers specified that promotion was not relevant to their service, as their referrals were from a single established pathway.

3.4 Admission criteria and process

3.4.1 Resident demographics

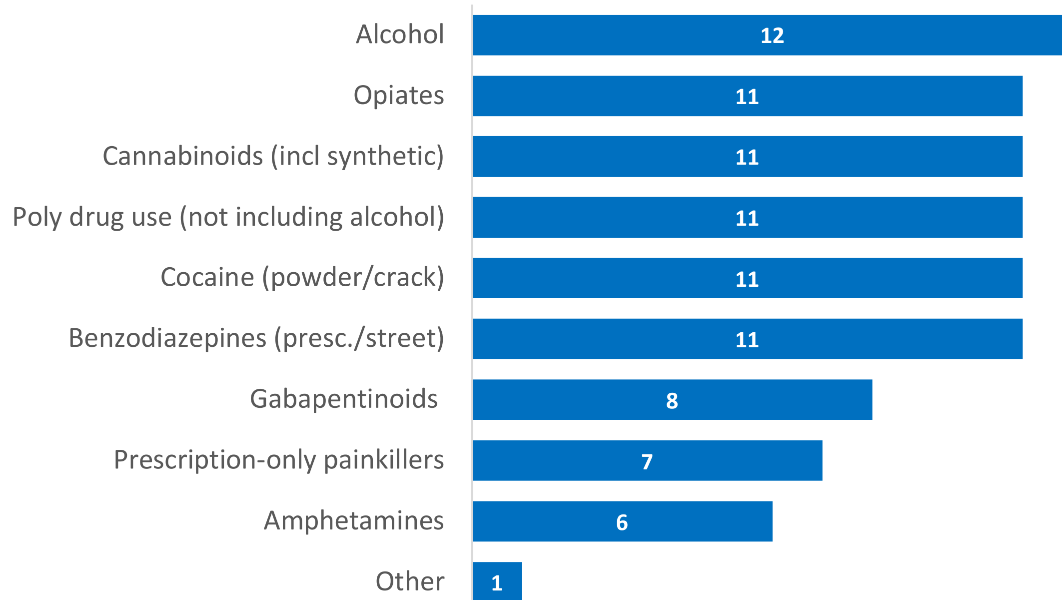
Most providers accept both men and women (n=8), while three are limited to men only and one to women only. All providers cater for adults and most accept a wide range of ages to their facility. All cater for adults aged between 26 and 64, most (n=9) also accept people from the age of 18, and five providers cater for older adults (aged 65+). None cater directly for children (under 18 years old), although, as discussed below, some can accommodate residents with dependent children.

The focus of most providers (n=8) is on supporting people with both problem alcohol and problem drug use. While the remaining providers responded that their primary focus was on homelessness (or in one case, mental health), they also reported that their residents are often in recovery from a range of substance use profiles.

Respondents reported a range of substances previously used by their residents, the most common of which were alcohol, opiates, cannabinoids, cocaine, or benzodiazepines (See Figure 1). Being in recovery from polydrug use (not including

alcohol) was also reported to be common (n=11), with one provider unsure of its prevalence. Other substances reported were etizolam and "legal highs"[8].

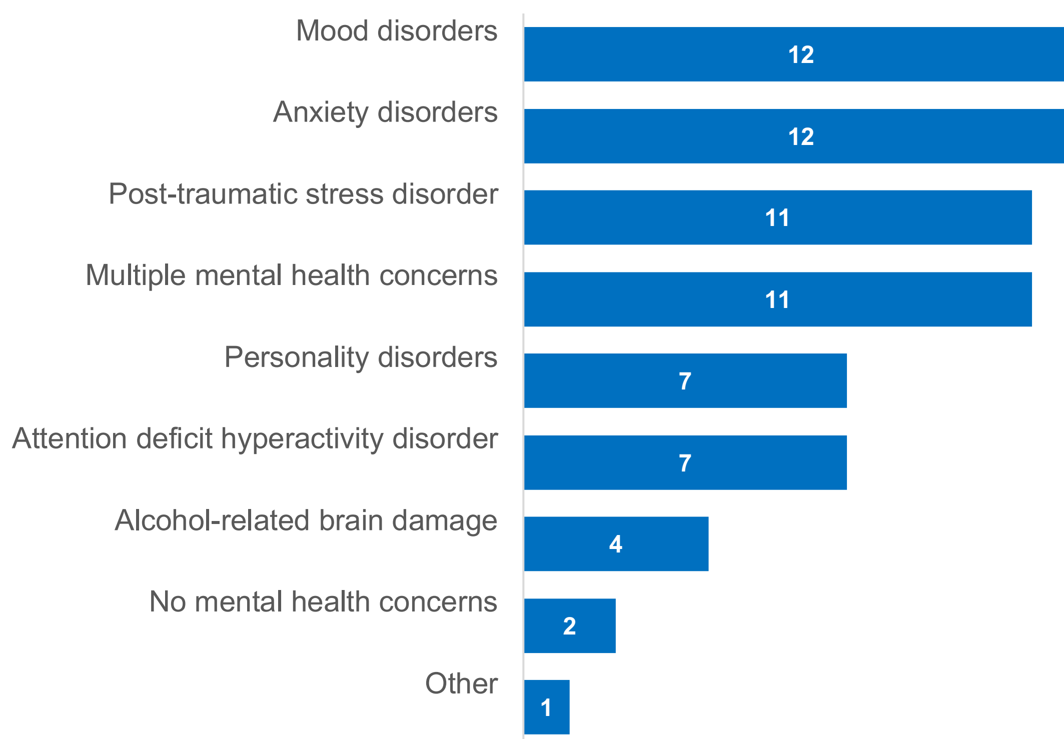
Figure 1: Number of respondents reporting that residents 'often' or 'very often' have a history of substance use, by type of substance (base n=12).



Respondents reported being able to support a variety of needs. All reported accommodating people who had experienced homelessness and most support people who had formerly been in prison (n=10). Most also support people with specific mental health concerns (n=10) and reported a range of mental health concerns among their residents (See Figure 2). Most respondents (n=9) reported that it is rarely or never the case that residents present without one. It is common for people to have multiple mental health concerns (n=11), with respondents all reporting that anxiety and mood disorders are most often observed. One respondent also reported that psychosis is common in their residents.

[8] These are also known as novel psychoactive substances.

Figure 2: Number of respondents reporting that residents 'often' or 'very often' have a history of mental health condition, by type of condition (base n=12).



Other groups that providers were able to cater for included people from the LGBTI community (n=8), people from different religious backgrounds (n=8), people with a physical disability (n=7) or a learning disability (n=6), and people from the Traveller community (n=6). Notably, fewer respondents reported being able to support specific demographic groups such as women who are pregnant (n=3) or with dependent children (n=2), and men with dependent children (n=2).

Specific measures taken to accommodate different demographics included adopting a person-centred approach to meet needs; providing women with separate accommodation from men; engaging interpreters; arranging specific needs assessments and referrals; and accompanying people to appointments.

3.4.2 Individual-level entry requirements

All providers reported having specific entry criteria for residents, with the majority citing the need for evidence of motivation toward recovery (n=9). Other common entry requirements are:

- Completion of a residential rehabilitation programme (n=6)
- Period of abstinence prior to admission (n=6)
- No/limited use of non-prescribed medication (n=5)
- Homelessness status or risk of homelessness[9] (n=5)
- No history of specific offences (e.g. arson, violence crime) (n=4)

[9] This was not one of the response options to this multiple choice question and is instead derived from the qualitative responses to the "other" option and may therefore be an undercount.

- Stable on Opioid Substitution Therapy (OST) (n=3)
- Stable on prescribed medication (excluding OST) (n=3)
- Evidence of a plan in place for future accommodation (n=2)
- Has support network of family and friends (n=2)
- Extended period (years) of problem substance use (n=1)
- 'Other' criteria mentioned included already being engaged in their recovery programme, eligibility for housing benefits, and the current profile of other residents at the time of entry.

3.4.3 Process for assessing applications

Most of the providers reported that paid service staff (e.g. support workers, house managers, pre-admission officers, housing officers) are involved in assessing and responding to applications. Some providers also noted that the local authority is involved in assessing applications. None of the respondents described current residents being involved in screening and responding to applications.

Over half of the providers (n=6) reported that they had declined between one and two applications in the last month, while over a third of services (n=4) had not declined any. The most common reason for declining applications cited was entry requirements not being met. Other reasons mentioned were that the service could not accommodate the accessibility needs of the applicant and a lack of capacity at the time of application.

3.4.4 Waiting list and waiting times

The majority of the providers (n=8) did not have a waiting list at the time of the survey, and most described operating on a first come-first served basis or based on an assessment of priority needs. The four providers who reported having a waiting list cited waiting times that could vary considerably from weeks to months. Two of these providers reported that people often dropped off the waiting list during this period for reasons such as experiencing a relapse or finding accommodation at another service.

3.5 Service offered and approach to recovery housing

Despite being commonly used in the literature, 'recovery housing' was not a term that most respondents felt best described their service. While five respondents felt this was one of several terms that could describe their service (others included 'dry house' and 'sober living house'), most (n=7) agreed that their service could be described as 'supported accommodation'. This is in line with a review of the literature that found that a lack of clarity in the terminology used to describe and differentiate between the various models that fall under the umbrella term of 'recovery housing'.

However, when asked to describe their service, respondents often referred to key aspects of recovery housing as it is outlined in the literature: an abstinence-based and supportive environment in which people were provided somewhere to live while receiving varying types of 'professional', 'personalised' or 'holistic' support to transition into healthy independent living.

Additionally, when asked to what extent they agreed with several statements about recovery housing drawn from a review of the international literature on recovery

housing, there was a strong consensus of agreement with all the statements[10]. This suggests that while there may be different levels of awareness of the term “recovery housing” and variations in how the providers operate, they share a common ethos that resonates with how recovery housing is described in the literature.[11]

Recovery housing models adopted in Scotland are not directly comparable to what is described in the international literature. The survey included several questions aimed at assessing whether recovery housing providers in Scotland mapped onto the levels of recovery housing identified in a review of the international (but primarily US-based) literature. Analysis of the responses to these questions indicated that, while there are some similarities with aspects of the recovery housing model described in the review, this cannot be said to clearly map onto how recovery housing operates in a Scottish context.

In Scotland, providers can broadly be described based on whether accommodation is shared with other people in recovery or not. About two thirds (62%, 146 out of 235 places) of the available recovery housing capacity in Scotland is provided in the form of single occupancy flats**.** The majority of these places are offered by three providers. While the majority of providers (n=9) offered some form of shared accommodation, this was most commonly for small numbers of people (2 or 3 residents per flat). Only three providers catered for larger numbers (between 5 and 16 people) and they tended to provide more structured support within the house to their residents than the other providers. However, further research is required to better understand how these two categories of recovery housing providers may differ in the service they deliver, and in the outcomes they achieve for their residents.

3.5.1 Treatment and support offered

The majority of respondents (n=10) reported following a specific model for recovery from substance use. These included a faith-based model of recovery (n=3), one based on the principles of the 12-Step model (n=3) or therapeutic community model (n=4).

A range of treatment is made available to residents, either by the provider or through facilitated access to relevant services, with only two providers reporting that they do not offer or actively facilitate specific treatment. Treatments listed included counselling/ group therapy and recovery groups (both on and off site) as well as access to recovery support groups (e.g. alcoholics anonymous, narcotics anonymous), faith-based programmes, recovery cafes, local hubs and abstinent day programmes. One provider mentioned a 14-week residential rehabilitation treatment programme, which is available to the residents before joining the recovery house. Three providers provided detail on their group programmes. Two facilities discussed

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[10] Statement 1: ‘Recovery housing generally refers to alcohol- and drug-free living environments that provide peer support for those wanting to initiate and sustain recovery from alcohol and other drug disorders’ (n=10)
Statement 2: ‘Recovery housing helps individuals in recovery to transition into independent living and sustain recovery’ (n=11)
Statement 3: ‘Recovery houses are safe, healthy, family-like environments that support individuals in recovery from addiction’ (n=11)
Statement 4: ‘While recovery housing facilities vary widely in structure, all are centred on providing connections to other peer in recovery and services that promote long-term recovery’ (n=12)
[11] One provider did not fully complete this section, and only responded to the final statement.

a 15-week group recovery programmes that is delivered in-house. This programme covers recovery; emotions and feelings; and developing skills. Another provider described '*intensive*' group work that tackles diverse topics relevant to recovery, including offending, health and wellbeing, relationships, finance, housing, and meaningful activities.

Recovery housing providers also offer or support access to range of specific activities (e.g. house meetings, one-to-one support, life skills training, mutual aid, peer/mutual support groups and exercise classes) and harm-reduction interventions (e.g. provision of naloxone, blood-borne virus screening and overdose prevention support), either within the accommodation or by facilitating access to relevant services.

Most providers (n=9) have no requirements for their residents to work, study, train, or volunteer. The reliance on residents' housing benefits may be a barrier to pursuing work while living in recovery housing, with a few providers highlighting that due to the benefit's requirements only allows for part-time employment. Only two providers require residents to pursue either work or some form of learning, either by participating in the facility or engaging in a certain number of hours of meaningful activities. However, most providers encourage and support what residents want to achieve by facilitating access to external education, training/apprenticeships and employability support services, although some provided this support in-house.

3.5.2 Duration of stay

Most providers reported that residents stayed an average of between 12 and 18 months. Three providers reported an average stay of around 2-years, with one specifying this is because residents have to wait for social housing to become available. Most also did not operate with an upper limit on duration of stay. Where a limit on duration was set, this ranged between one and three years.

3.5.3 Governance and house rules

Providers reported a range of governance arrangements, ranging from staff entirely running the service (either with or without resident involvement) to providing support to residents. None described a service entirely run by residents.

Most providers (n=10) require their residents to abstain from using alcohol and/or drugs. One of the two providers that did not reported a focus on tackling homelessness and disagreed with the statement that recovery housing generally refers to substance-free living environments. The other provider strongly agreed with this statement[12].

Of those that required abstinence, all but one (n=9) said that they actively monitored this through conducting drug/alcohol tests either randomly or if substance use was suspected.

Residents are not commonly evicted in the event of a relapse. Instead, most providers (n=11) described dealing with these instances on a case-by-case basis to determine what support could be provided to the resident to enable them to remain

[12] The provider was followed-up to gain clarity on this; however, no response was received.

and maintain abstinence. Some described notice periods during which support was provided but should the resident be unable to maintain abstinence, would lead to eviction.

In addition to abstinence, providers described a range of core rules and expectations that their residents are expected to adhere to. Most commonly, this included restrictions on overnight guests, keeping the accommodation clean and tidy and adhering to a curfew. Less commonly reported rules and expectations included: adhering to the tenancy agreement, zero tolerance to violence, respecting other residents, attending support, staying for at least 5 nights, undertaking drug/alcohol tests on request, no children on-site, and no visitors under the influence of substances. Failure to adhere to the rules was cited as possible grounds for eviction, alongside others such as violence, engaging in criminal activity, and non-payment.

The majority of providers (n=7) allow current residents to set or amend house rules by following different types of processes including an open-door policy for ideas and amendments to rules, house meetings, house rules reviews meetings with residents, or a suggestion box.

3.6 Resident outcomes and next steps

Providers reported a range of ways used to monitor resident outcomes. Tools mentioned included Outcome Star and a separate outcome web matrix to monitor progress in different areas of recovery. Other approaches included exit evaluations, support/care plan reviews, risk assessments, gathering feedback from family and residents, and working with other agencies.

Over a third of providers (n=5) have no formal aftercare plans, however most providers offer some form of continued contact to residents once they leave. The type of support and formality of the arrangements vary across providers and ranges from adopting an open-door policy where ex-residents are welcome to get back in touch if they feel the need for light-touch support (e.g. sign-posting, help with forms), to more structured formal arrangements that included weekly or monthly meetings with a support worker, or following-up at the six-monthly or yearly mark following departure.

Residents most commonly move on to housing association accommodation and council accommodation following a stay in recovery housing. Less common types of accommodation included private tenancies or ownership, returning home, the provider's own move-on/scatter flats and moving in with family. Most providers reported that residents rarely if ever choose to move to another form of recovery housing during or after their stay.

Residents rarely go to residential rehabilitation during or after their stay in recovery housing. Most providers noted that this is because residents often come to them following completion of a residential rehabilitation programme. One provider noted that residential rehabilitation could be an option in the case of a relapse during the stay in recovery housing.

3.7 Improvements to recovery housing services

Respondents made a number of suggestions for improvement:

- More and better funded recovery housing facilities. One of these responses highlighted the importance of being able to access recovery housing following completion of a residential rehabilitation programme to support people to transition back into the community. They argued that without safe and stable housing at this early stage of recovery, people are being “set […] up to fail” as the alternative is often to return to homes and environments where they had historically been using substances.
- Recovery houses that incorporate different stages of housing (with varying degrees of structure and support) to support the transition to independent living are needed. This was argued to be a more inclusive model of recovery housing and provides more options to individuals at all levels of recovery. Increased funding for other aspects of recovery housing, including: to increase recovery house staffing; more care funding for clients to be referred; and investment in meaningful activities to give residents purpose and direction, as boredom and isolation are leading drivers of relapse.
- Increased linkages between recovery housing providers and other recovery services, including: better therapeutic employment links; having a wide range of community peer and professional support; better access to professional counselling and mental health support; and more informed aftercare provisions once residential rehabilitation is completed that can link to recovery housing.
- One provider raised the importance of meaningful co-production in developing recovery housing. They asked for increased engagement of individuals who have lived in and worked in recovery housing in recovery housing matters.

4. Conclusion

The survey found a total of 12 providers offering some form of recovery housing in Scotland, with a combined total maximum capacity of 235 places at 84% full capacity at the time of the survey. Providers varied in their size and structure but broadly fall into two categories based on whether the accommodation they provide is shared with other people in recovery or not. About two thirds (62%, 146 out of 235 places) of the available recovery housing capacity in Scotland is provided in the form of single occupancy flats, with the majority of these places being offered by three providers. While the majority of providers (n=9) offered some form of shared accommodation, this was most commonly for small numbers of people (2 or 3 residents per flat). Only three providers catered for larger numbers (between 5 and 16 people) and they tended to provide more structured support within the house to their residents than the other providers.

The responses highlight the similarity across providers in how they are funded, governed, the demographic of their residents, and day-to-day life in the houses. Facilities differed in their delivery of recovery services and activities, the house structure (shared or single occupancy), and the level of workforce within the house. However, further research is required to better understand how the two categories of recovery housing providers in Scotland may differ in the service they deliver, and in the outcomes they achieve for their residents.

The results of this survey suggest that the term ‘recovery housing’ may not be widely recognised by providers of this type of service in Scotland. The responses to the survey indicate that providers identified more with ‘supported accommodation’ or ‘move-on housing’ than ‘recovery housing’ and suggests there may be a need to use one of these terms in future research and policy making to ensure they are understood.

However, it is clear that providers generally agree on key characteristics that make up these services and that these are in line with how recovery housing is described in the literature. These responses can be used as the starting point for developing a broad definition of recovery housing that is applicable to a Scottish context, such as:

> “Recovery housing aims to offer people a safe, supportive and abstinence-based living environment, while receiving support (including peer support) to transition into independent living and sustain their recovery from substance use.”

This proposed definition would benefit from engagement with various stakeholder groups, including people with lived and living experience.

4.1 Considerations for future research

1. The results of this survey provide a basic understanding of the provision of recovery housing for people in recovery from substance use in Scotland. However, further research with providers is required to better understand the level of need and demand for recovery housing; service-user profiles; pathways into, through and out of services; and differences between models (single-

occupancy or shared accommodation) to better understand how the service is delivered and to identify potential gaps in provision.

2. Peer support is the key aspect of recovery housing definitions in the U.S. context. However, the role of peer support in a Scottish context is not fully clear from the data collected as part of this survey. This is due to the inherent overlap with peer support in many aspects of the services' governance and delivery. Further research is required to explore this in more depth, and may benefit from adopting a qualitative interview methodology.

3. It would be beneficial to go beyond the insights of providers and conduct specific research on the lived and living experiences of current service users, people seeking to access recovery housing support, and those referring them. This would enable a better understanding of the needs and barriers experienced by the population of people who would benefit from this service.

Appendix A – Recovery Housing in Scotland: Capacity Survey

The Residential Rehabilitation Development Working Group (RRDWG), chaired by Dr David McCartney, was established in April 2021 as a successor to the Residential Rehab Working Group (RRWG). Its role is to provide independent advice to the Minister for Drug and Alcohol Policy and advise the Scottish Government on good practice, funding or other areas within devolved competence in relation to residential rehabilitation for problem substance use. The RRDWG has highlighted the need to better understand how other services that operate alongside residential rehabilitation provide support to people who use drugs or alcohol.

Specifically, this survey has been developed by the Scottish Government to help us better understand the provision of recovery housing support for people using drugs and/or alcohol. This survey seeks to gather information about recovery housing facilities in Scotland, in order to develop a fuller understanding of the existing provision and capacity of this service in Scotland.

You may have been invited to take part in this survey if you are based somewhere else in the UK. Although we are interested in mapping the provision and capacity of recovery housing facilities in Scotland, this includes exploring whether Scottish residents travel elsewhere for recovery housing services. We would appreciate any information you can provide.

The survey will be live until Friday, the 11th of August and should take about 30 minutes to complete. Not all questions may be relevant to you, but we would be grateful if you could complete the survey to the best of your ability as gathering this level of detail is essential to getting as full a picture of existing provision as possible.

If your recovery housing service is split over several sites/buildings and these buildings differ in how they are managed (including governance and entry requirements), operate, the profile of residents (e.g. sex or age) and/or with the recovery model they follow, please provide a separate response per recovery housing facility. If they do not differ, please only respond to the survey once but specify the different geographic areas of these buildings and how places for individuals are broken down across these.

While the recovery housing facilities will be listed in the report, data will be aggregated (including business sensitive data), and steps will be taken to ensure that individual providers are not identifiable from their answers. Data will be managed in line with data protection protocols. In filling out this survey, please do not describe any identifiable information about your residents. Participation in this research is voluntary and you have the right to stop or withdraw your consent at any point during or after completing the survey. If you have any concerns about how your data will be processed, please contact DataProtectionOfficer@gov.scot.

We hope to provide a summary report of the findings in summer 2023.

If you have any questions about this survey or would like more information, please do not hesitate to get in touch by email at substanceuseanalyticalteam@gov.scot.

Do you consent to being a participant in this research and for your data to be used as outlined above?
[single option]

- Yes
- No [End of Survey]

1. About You (Key Contact)

Q1a) Name [open text]
Q1b) Job title [open text]
Q1c) Email address [open text]
Q1d) Name of your organisation [open text]
Q1e) Organisation type [single option; response options: Statutory, Third Sector, Private, Other]
Q1f) Postcode of your recovery housing facility (If you have multiple buildings/sites and they differ in how they operate, please submit a separate response for each. If they operate the same way, then please list the different post codes here) [open text]

2. The Facility

Q2) Where are you based?
[single option]

- Scotland [go to Q7]
- England [go to Q3]
- Northern Ireland [go to Q3]
- Wales [go to Q3]
- Other (please specify) [go to Q3]

Q3) Did you have residents who were living in Scotland prior to starting at your facility during the financial year 2022/23?
[single option]

- Yes [go to Q4]
- No [go to Q5]

Q4) What proportion (e.g. a third, half, all) of your residents were previously living in Scotland during the financial year 2022/23?
[open text]
[go to Q8]

Q5) Please provide more details.
[open text]
[go to Q6]

Q6) Do you have any other relevant information to share on Scottish residents accessing recovery housing in your area?
[open text]

[Survey ends]

Q7) How often did your residents come from the following areas prior to starting at your facility (in the financial year 2022/23)?
[single option; response options: Very Often, Often, Rarely, Never, I don't know]

- Your local Alcohol and Drug Partnership area/NHS Health Board area: [text box]
- Rest of Scotland: [text box]
- Rest of UK: [text box]
- International: [text box]

Q8) Which of the following terms, if any, does your facility identify with? (select all that apply)
[multiple choice]

- Dry house
- Halfway House
- Move on house/flats/housing
- Oxford House
- Recovery House
- Sober living house
- Supported accommodation
- Other (please specify)

Q9a) To what extent do you agree with the following statements describing recovery housing?
[single option; response options: strongly agree, agree, disagree, strongly disagree]

- 'Recovery housing generally refers to alcohol- and drug-free living environments that provide peer support for those wanting to initiate and sustain recovery from alcohol and other drug (AOD) disorders.'
- 'Recovery Housing helps individuals in recovery to transition into independent living and sustained recovery.'
- 'Recovery houses are safe, healthy, family-like environment that support individuals in recovery from addiction.
- 'While recovery housing facilities vary widely in structure, all are centred on providing connections to other peers in recovery and to services that promote long-term recovery.'

Q9b) How would you best describe your facility?
[open text]

Q10) How many buildings (e.g. flats/houses) make up your recovery housing service?
[open text]

Q11) How many beds/places per building do you offer?
[open text]

Q12) How many residents do you currently have? If your facility is not based in Scotland, how many residents coming from Scotland do you currently have (total number at time of survey completion)?
[open text]

Q13) What is the main focus of your recovery facility?
[single option]

- Sole focus on problem drug use
- Sole focus on problem alcohol use
- Focus on both problem alcohol and drug use
- Other (please describe)

Q14) How often did residents have the following substances in their history of use (in the financial year 2022/23)?
[single option; response options: Very Often, Often, Rarely, Never, I don't know]

- Alcohol
- Poly drug use (not including alcohol)
- Amphetamines
- Benzodiazepines (prescription/street)
- Cannabinoids (inc. synthetic)
- Cocaine (powder/crack)
- Gabapentinoids
- Opiates
- Prescription-only painkillers
- Other (please specify)

Q15) How often did people attending your facility have the following mental health concerns (in the financial year 2022/23)?
[single option; response options: Very Often, Often, Rarely, Never, I don't know]

- No mental health concerns
- Multiple mental health concerns
- Attention deficit hyperactivity disorder (ADHD)
- Alcohol-related brain damage
- Anxiety disorders, including general anxiety, obsessive compulsive disorder (OCD)
- Mood disorders, including bipolar disorder and depression
- Personality disorders
- Post-traumatic stress disorder
- Other (please specify)

Q16) What sex does your facility admit?
[multiple choice]

- Only males
- Only females
- Both males and females
- Other (please specify)

Q17a) Which, if any, of the following groups does your facility cater for? (select all that apply)
[multiple choice]

- Men with dependent children
- Women with dependent children
- Pregnant women
- People experiencing homelessness
- People who were formerly in prison
- People with mental health concerns (e.g. depression, anxiety, etc.)
- People with a physical disability
- People with a learning disability
- People from the Traveller community
- People from the LGBTI community
- People with different religions
- People with no religion
- Other (please specify)
- None of the above

Q17b) If applicable, please provide details of any specific measures taken to cater for these groups.
[open text]

Q18a) Which of the following age groups does your facility cater for? (select all that apply)
[multiple choice]

- Children (Under 18)
- Young People (18-25)
- Adults (26-64)
- Older adults (65 and over)

Q18b) Which age group is the most common demographic of your residents?
[open text]

Q19) Please describe the paid staff workforce in your facility and their role (e.g. doctors, nurses, administrative staff, support staff, house manager).
[open text]

Q20) Please describe the volunteer staff workforce in your facility and their role (e.g. doctors, nurses, administrative staff, support staff, house manager).
[open text]

Q21) Please describe whether people with lived experience are involved in the running of the facility and what role they play. Please specify whether this is in a volunteer or paid capacity.
[open text]

3. Identification, Referral, and Admittance of Residents

Q22a) What criteria must typically be met for individuals to be deemed to suitable for admission at your recovery housing facility? Please select all that apply and provide details where appropriate.
[multiple choice]

- Completion of a residential rehabilitation programme
- Evidence of motivation towards recovery
- Extended period (years) of problem substance use
- No history of specific offences (e.g. arson, violence crime)
- No unspent/outstanding arrest warrants/criminal charges.
- No diagnosed mental health concerns
- Stable on Opioid Substitution Therapy (OST)
- Stable on prescribed medication (excluding OST)
- No/limited use of non-prescribed medication
- Evidence of a plan in place for future accommodation
- Has support network of family and friends
- Period of abstinence prior to admission
- No specific entry requirements
- Other (Please specify)

Q22b) Please provide details.
[open text]

Q23) What is the process for assessing and responding to applications to your facility? Please describe who is involved in the decision-making process.
[open text]

Q24a) In the last month how many applications have you declined? If you are not based in Scotland, how many applications coming from Scotland have you declined?
[open text]

Q24b) Please specify why this was (e.g. capacity constraints, individuals did not meet entry criteria, other reasons).
[open text]

Q25) What do you think are the main barriers for individuals seeking recovery housing?
[open text]

Q26) How often do individuals come to you from the following pathways?
[single option; response options: Very Often, Often, Rarely, Never, I don't know]

- Alcohol and Drug Partnerships
- Armed forces
- Drug and alcohol agencies or services
- Hospital
- Housing First
- Housing Organisations

- Local Authorities
- Mental health services
- Police
- Primary care
- Prisons
- Probation Service
- Residential rehabilitation
- Self-referrals
- Youth services
- Other (please specify)

Q27) Please list the names of organisations who referred individuals to your facility during the financial year 2022/23. For each, please provide if know their location, whether you have established links with them and the number of referrals you have received from them.
[open text]

Q28) How do people self-referring typically access/find your facility?
[open text]

Q29) How do you make yourself known to potential referrers and the wider public?
[multiple choice]
- Facebook
- Twitter
- Other social media
- Website
- Paper-based (e.g. leaflets and posters)
- In-person events
- Other (please specify)
- Not applicable (please specify)

Q30) Is there currently a waiting list for your facility?
[single option]
- Yes
- No

Q30a) How does the waiting list operate? Please provide details, for example assessing priority or first-come.
[open text]

Q30b) What is the average waiting time (days/ weeks/ months)?
[open text]

Q30c) How often do people drop out while on the waiting list?
[single option]
- Very often
- Often
- Rarely
- Never

- No waiting list

Q30d) If applicable, please outline the most frequent reasons for people dropping out whilst on the waiting list.
[open text]

Q31) Please describe your funding model and where the funding comes from (e.g. self-funded, funded by the Alcohol and Drug Partnership, residential rehab providers, charities etc.)
[open text]

4. Resident Life

Q32) On average, how long do residents stay in your facility?
[open text]

Q33) What is the maximum length of time residents stay in your facility? State if there is no limit on duration.
[open text]

Q34) Please describe how residents move toward independent living (e.g. Moving to less structured housing etc.).
[open text]

Q35) Which, if any, of the following harm reduction interventions do you offer (on-site, off-site) or facilitate access to? (select all that apply)
[multiple choice; response options: on-site, off-site, facilitate access to, do not offer]

- Blood-borne viruses screening
- Naloxone
- Overdose prevention
- Other (please specify)

Q36) What, if any, treatment programmes or services do you offer or facilitate access to? Please specify where these take place, who this is provided by and for which residents. Please also state if no treatment programmes take place.
[open text]

Q37a) Which, if any, of the following activities/services do you offer (on-site, off-site) or facilitate access to? (select all that apply)
[multiple choice; response options: on-site, off-site, facilitate access to, neither]

- Education
- Employability support
- Exercise classes
- House meetings
- Life skills training
- Mutual aid
- One-to-one support
- Peer/mutual support groups
- Training/apprenticeships

- Other (please specify)

Q37b) Please provide further detail on these activities and their frequency.
[open text]

Q38) Does your facility follow a specific model (e.g. 12 Step Model/based on Therapeutic
Community principles/faith-based approaches)? Please provide details.
[open text]

Q39) Please provide details of any accreditations you have and of any regulatory framework you operate within (e.g. NHS, Care Inspectorate, etc.).
[open text]

Q40) Please describe the living/bedroom arrangements at your facility/facilities (e.g. shared or private bedrooms, house or stand-alone private flats, etc.).
[open text]

Q41) Please describe the governance of your facility (e.g. ran by residents, ran by staff, ran in combination)
[open text]

Q42) Please describe the role of peer support in your facility.
[open text]

Q43) How are resident meals organised in your facility? Please provide details (e.g. are food/meals provided? Or are residents responsible for buying food and cooking meals?)
[open text]

Q44) Are residents in your facility required to undertake full-time work / studying / training / or volunteering? Alternatively, is full-time work discouraged? Please provide details.
[open text]

Q45) Do you expect your residents to contribute to living costs (e.g. groceries, bills, internet, rent, etc)?

Q46) What core rules and expectations, if any, are outlined to residents (e.g. curfews, overnight guests, household chores)?
[open text]

Q47a) Are current residents able to set or amend house rules?
[single option]

- Yes
- No

Q47b) Please provide details on your answer.
[open text]

Q48a) Do you require your residents to abstain from drug and/or alcohol use?
[single option]

- Yes [go to Q48b]
- No [go to Q49]

Q48b) If you require abstinence from drugs or alcohol, do you monitor this (e.g., drug test)?
[single option]

- Yes [go to Q48c]
- No [go to Q49]

Q48c) Please provide detail on frequency and procedure for monitoring abstinence.
[open text]

Q49) What policy do you have in place in the event that one of your residents uses substances or relapses in treatment?
[open text]

Q50) Can residents be evicted? If yes, please provide detail on the grounds for eviction (e.g. breaking house rules) and the process involved (e.g. involving a house vote).
[open text]

5. Resident Outcomes

Q51) How does your facility measure different types of recovery outcomes? (Please give details of any specific tools you may use)
[open text]

Q52) Is there an aftercare plan for people leaving your facility?
[single option]

- Yes
- No

Q53) Please describe whether and for how long you follow-up with individuals after they have left your facility (including details of the aftercare plan where appropriate).
[open text]

Q54) Please describe the range of accommodation residents typically move to immediately after their stay in your facility.
[open text]

Q55) How often do your residents go to residential rehabilitation after or during their planned stay?
[open text]

Q56) How often do residents chose to move to another form of recovery housing during or after their stay with you?
[open text]

6. Final comments

Q57) Do you have any recommendations for improving recovery housing?
[open text]

Q58) Are there any other comments you would like to make which you feel are relevant?
[open text]

Q59) We are trying to obtain as comprehensive a list as possible of recovery housing across Scotland. Are you aware of any other recovery housing facilities in Scotland or elsewhere in the UK that accept Scottish residents? If so, please forward the link to this survey to them. Alternatively you can provide us with their name and, if known, their address, website or contact details.
[open text]

Q60) Can we contact you about future research?
[single choice]

- Yes
- No

[Thanks and End of Survey]

Appendix B – Summary of recovery houses in Scotland

NHS Health Board	ADP/ Local authority area	Recovery House	Provider type	Entry Requirements	Beds/ places	Buildings
Highland	Highland	CrossReach Cale House	Third sector	• Age 18+ • Evidence of motivation towards recovery • No/limited use of non-prescribed medication. • Period of abstinence prior to admission.	20	Shared flats and one-bed flats
Greater Glasgow & Clyde	West Dunbartonshire	Alternatives' Safe As Houses Project *[move-on flats stage of project]*	Third Sector	• Age between 18-64 Completion of a residential rehabilitation programme (specifically the Safe as Houses residential programme) • Stable on Opioid Substitution Therapy (OST) • Stable on prescribed medication (excluding OST) • No/limited use of non-prescribed medication. • Evidence of a plan in place for future accommodation	8	4 two-bed flats
Greater Glasgow & Clyde	Glasgow City	Scottish Christian Alliance	Third Sector	• Only accept male residents, 21+ • Homeless status • Completion of a residential rehabilitation programme	23	23 one-bed flats

				• Evidence of motivation towards recovery • No history of specific offences (e.g. arson, violence crime) • Stable on Opioid Substitution Therapy (OST) • Stable on prescribed medication (excluding OST) • No/limited use of non-prescribed medication. • Has support network of family and friends. • Period of abstinence prior to admission.		
Greater Glasgow & Clyde	Glasgow City	Street Connect	Third Sector	• Age between 18-64 • Completion of a residential rehabilitation programme • Evidence of motivation towards recovery	5	2 two-bed flats, 1 one-bed flat
Greater Glasgow & Clyde	Glasgow City	Phoenix Futures, Supported Housing	Third Sector	• Age between 18-64 • Completion of a residential rehabilitation programme • Evidence of motivation towards recovery • Extended period (years) of problem substance use • No history of specific offences (e.g. arson, violence crime);No/limited use of non-prescribed medication	16	6 two-bed flats and 4 one-bed flats

				• Evidence of a plan in place for future accommodation • Has support network of family and friends. • Period of abstinence prior to admission.		
Greater Glasgow & Clyde	Glasgow City	CrossReach Whiteinch Move-on	Third Sector	• Age 18+ • Completion of a residential rehabilitation programme • Evidence of motivation towards recovery • Stable on Opioid Substitution Therapy (OST) • Stable on prescribed medication (excluding OST)	11	3 two-bed flats, 4 one-bed flats
Lothian	Edinburgh City	Lothian and Edinburgh Abstinence Programme (LEAP) Recovery House	Statutory	• Only accept male residents, 18+ from Lothians and Edinburgh. • Completion of a residential rehabilitation programme • Evidence of motivation towards recovery • Period of abstinence prior to admission • No/limited use of non-prescribed medication	5	Five-bed house
Lothian	Edinburgh City	CrossReach Rankeillor Initiative	Third Sector	• Age 18+ • Evidence of motivation towards recovery. • Period of abstinence prior to admission.	9	3 two-bed flats

				• Local connection to Edinburgh and homeless.		
Lothian	Edinburgh City	Bethany Christian Trust (BCT) - Bethany Homes Edinburgh	Third Sector	• Age between 18-64 • Currently homeless or at risk of being homeless. • Only accept residents from rehab units within the local authority.	79	79 one-bed flats
Lothian	Edinburgh City	BCT - Bethany Christian Centre	Third Sector	• Only accept male residents, 26+ • Evidence of motivation towards recovery • No history of specific offences (e.g. arson, violence crime) – specified history of arson or sexual offences. • Period of abstinence prior to admission – specified 3-5 days.	16	16-bed house
Lothian	Edinburgh City	BCT - Anne Hope House	Third Sector	• Only accept female residents, age between 18-64. • Evidence of motivation towards recovery. • No history of specific offences (e.g. arson, violence crime) • Must be registered homeless. • Must be entitled to full housing benefit.	8	8-bed house
Lothian	Edinburgh City	BCT - Edinburgh Move-on Support	Third Sector	• Age between 26-64. • They will have been homeless and have started to work	35	35 one-bed flats

				towards having their own tenancy		
						241

An additional recovery housing provider was contacted as part of this research but not included in the reporting as their facility was under construction at the time of the survey. Steps to Hope operate in Edinburgh and estimated that their facility (Hope House in West Lothian) would open in early 2024 and would be able to host a maximum of 10 residents.

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