



Home and dry?

*Homelessness and
substance use in London*

Jane Fountain
Samantha Howes

Edited by Oswin Baker





Home and dry?

*Homelessness and
substance use in London*

Jane Fountain
Samantha Howes
National Addiction Centre

Edited by Oswin Baker
Vision 21

The National Addiction Centre

Nationally and internationally renowned, the National Addiction Centre (NAC) is a field leader in substance use research and service evaluation. The NAC is based at the campus of the Institute of Psychiatry and Maudsley Hospital, a major provider of specialist healthcare for those with drug and alcohol problems.

Vision 21

Vision 21 is a social research company specialising in community consultation. They work in the fields of housing, regeneration, social exclusion and democracy. Vision 21 projects have won or been short-listed for the IPPR/Guardian Public Involvement Awards for the past two years, and they are also winners of the 2001 Duke of Westminster Award for innovation in business.

Crisis is the national charity for homeless people. Its aim is to relieve poverty and distress arising from this group's social, economic and emotional vulnerability. It provides lasting solutions to homelessness.

The organisation works year-round to help vulnerable people through the crisis of homelessness, rebuild their lives, reintegrate into society and live independently. It provides access to support for mental health and addiction problems as well as accommodation and training and employment opportunities.

It develops services and runs them directly or in partnership with groups and agencies across the UK. It also regularly commissions and publishes research to raise awareness about the causes and nature of homelessness, to find innovative and integrated solutions to it and share good practice.

Crisis Hidden Homeless Campaign

There are 400,000 hidden homeless people in England living in emergency hostels, B&Bs, squats or on friends' floors. On 3 December 2001 Crisis launched its Hidden Homelessness campaign to highlight their plight. A series of publications have been commissioned to map out the experiences of hidden homeless people. For more information please go to www.crisis.org.uk/hidden.

Crisis

Warwick House 25/27 Buckingham Palace Road London SW1W 0PP
Telephone: 0870 011 3335 Fax: 0870 011 3336
E-mail: enquiries@crisis.org.uk Website: www.crisis.org.uk

Crisis UK trading as Crisis
Charity No 1082947 Company No 4024938

©Crisis, 2002 ISBN 1 899257 50 0

Photo: ©Crisis

For a full list of publications and an order form please visit the Crisis website at www.crisis.org.uk/publications or call the main number above.

Typeset by Gargoyle Graphics
Printed by Stephen Austin, Hertford.



CONTENTS

	Page
Foreword	
Introduction	1
Chapter 1: The survey – homelessness	2
Chapter 2: The survey – drugs	6
Chapter 3: The survey – drugs and homelessness	9
Chapter 4: Homeless service uptake	12
Chapter 5: Drug service uptake	14
Chapter 6: Service provision and policy-making – issues and views	16
Chapter 7: Service provision and policy-making – the current context	20
Chapter 8: The way forward	22
Bibliography	28
Acknowledgements	27
Publications order form	32

FOREWORD

This year sees the final phase of the Rough Sleepers Units work and the inauguration of a new National Homelessness Directorate. It is crucial that we take a moment to reflect on what has been achieved in recent years and to think about what is yet to be done.

The last three years have seen some exciting and innovative developments in the world of homelessness, and with an unprecedented level of support from government; we have achieved a genuine and significant reduction in the number of people living on the streets.

But homelessness remains with us. Though numbers have declined, rough sleeping is still a problem and those who have moved on, are all too often still homeless, but living as part of a burgeoning hostel population hidden from view.

What is clearer, now more than ever, is that homelessness is about more than housing. What is heartening is that this message is now recognised beyond the homelessness sector, by government and increasingly the general public.

The importance of Jane Fountain and Samantha Howes' research lies in the fact that it explores one of the most complex and controversial aspects of the homelessness problem. In its unflinching examination of the relationship between substance misuse and homelessness, *Home and Dry?* reveals the extent and nature of the problem that we face and draws the necessary conclusions.

What emerges is a picture of multiple needs. For those who are most vulnerable there is no single intervention that will suffice to resolve their difficulties. Substance misuse is part of the web of exclusion that traps so many homeless people and the answer can only lie in tackling all of these problems.

With the support and backing of government, those of us who care deeply about homeless people have taken the initial tentative steps towards finding solutions to homelessness. We have reached first base and now we must prepare for the second stage, *Home and Dry?* is part of that preparation.



Shaks Ghosh *Chief Executive, Crisis*

INTRODUCTION:

Homelessness and substance use – a complex issue

Homelessness and substance use represent two of today's most pressing social concerns. Both are strongly associated with social exclusion and often coalesce with a wide range of other social and individual problems into an impenetrable tangle.

Periods of homelessness place a person in a vulnerable position for the development of patterns of problematic substance use. This may be related to the peer-mediated nature of drug and alcohol initiation, or because homelessness acts as a stressor to which substance use is seen as a palliative. Whatever the case, these factors are also likely to impact on a homeless drug user's ability to access and benefit from service provision: the revolving door which spins people from insecure housing to the street and back again, can turn that much quicker when drugs are involved.

All this has, of course, been recognised and some notable practical work carried out – but there is still a serious gap in the knowledge base to guide the development of service delivery. Despite the enormity of the issues concerned – as a literature search of Britain's most comprehensive drugs library shows – only a handful of studies have been conducted in the UK looking at homelessness and drugs.

If interventions and policy-making are not informed by a better understanding of the relationship between homelessness and substance use, they are likely to be at best ineffective – and at worst counter-productive.

The research

This research project was initiated to provide that evidence base. A key aspect of the study has been to ensure that an improved understanding of the relationship between homelessness and substance use will have practical relevance for improving and developing service provision. The conclusions therefore focus on how services can be developed to better meet the needs of homeless people who are also drug or alcohol users.

There were three parts to the study. Interviews with 389 homeless people were conducted in London – one of the largest surveys in Britain looking at homelessness and drugs. The only criterion for inclusion in the study was sleeping rough for at least six nights in the last six months.

In-depth, themed interviews with service providers were also conducted. These interviews were designed to provide insight into what practitioners see as the key issues when providing services to homeless drug users. Some of these people therefore came from the drug sector and others from the homelessness field.

Finally, in the autumn of 2001, we re-visited London-based service providers in a series of meetings to find out whether and how their experiences had changed in the intervening year. We used this information to shape the final direction of the report.

An immense amount of work has already been done by government and the sector; but closer collaboration between the homelessness and drugs sector is still needed.

Chapter 1

THE SURVEY – HOMELESSNESS

For the purposes of this report homeless people are defined as those people living on the margins of society slipping between rough sleeping and temporary accommodation.

Of the 389 people who were interviewed, just over four in five (81 per cent) were men. It was also a young sample – only five per cent were over 50 years old, with the vast majority (73 per cent) being 35 or under. A third were 25 or under and 12 per cent were under 21.

Most also described themselves as ‘white’ (83 per cent). Only 29 people described themselves as ‘black’, ‘black Caribbean’ or ‘black African’.

Table 1: Age of sample

Under 18	3%
19–21	9%
22–25	21%
26–30	21%
31–35	19%
36–40	10%
41–45	7%
46–50	6%
51+	4%

The sample was monitored throughout the study in order to ensure that it reflected the whole population of those sleeping rough according to age, gender, race and the inner London borough where respondents last slept rough. The age, gender and race of respondents was compared with the statistics in the annual Outreach Directory (HSA, 1999), which covers central London only.

The inner London borough where the sample last slept rough was compared with statistics provided by the Rough Sleepers Unit (2000) for the numbers of people sleeping rough in London in June/July 2000. The results showed that the sample is broadly representative of all those sleeping rough in inner London boroughs. Once again, it should be stressed that a history of sleeping rough was only the ‘gateway’ into this study. As the research found, rough sleeping is only one among many forms of homelessness which our sample had faced.

Past and current homelessness

Overall, the respondents first became homeless at a young age. Over half (54 per cent) had first become homeless when they were 18 or under and nearly two in five when they were 16 or under. Only one in seven (15 per cent) had first become homeless when they were over 30.

Almost half the sample had been continually homeless since that first time. And almost half of *this* group – nearly a quarter of the whole sample – had been continually homeless for more than five years.

Over half (52 per cent) were 18 or under when they first slept rough, and a third were 16 or under. Nearly half (48 per cent) had slept rough for more than six months in the last year, and one in six (17 per cent) had slept rough the night prior to interview.

Table 2: Time spent sleeping rough

Time slept rough in last year	%	Time slept rough in last month	%
1 week – 1 month	8%	none	42%
1–3 months	17%	1–5 nights	10%
4–6 months	27%	6–10 nights	12%
7–9 months	21%	11–20 nights	14%
9–12 months	27%	21–30 nights	22%

It should be noted that a third of the interviews took place between January and March 2000, when temporary cold weather shelters were open. Therefore, the night before the interview, more than one in four of the whole sample (28 per cent) were sleeping in these shelters. It is possible that many of these people would otherwise have been sleeping rough.

In spring 2000, rolling shelters replaced cold weather shelters. These shelters were open all year round for four months in different locations in inner London. One in five of the whole sample had slept in a rolling shelter the night before the interview.

Over half (54 per cent) had first become homeless when they were 18 or under and nearly two in five when they were 16 or under.



Reasons for becoming and remaining homeless

The relationship between substance use and homelessness is a stark and early one. Two-thirds of the sample cited drug or alcohol use as a reason for first becoming homeless – a similar proportion as those who cited relationship problems with a parent – and just under half (47 per cent) reported this as the major reason.

Mental health problems, leaving care or leaving prison were each cited by one in five as a factor, while just over two in five (43 per cent) said that money problems played a role.

Two-thirds of the sample cited drug or alcohol use as a reason for first becoming homeless

Table 3: Perceived reasons for first becoming homeless

Reason	% of people interviewed
Drug and/or alcohol use	63%
Alcohol use	36%
Drug use	50%
Relationship problems with parents	62%
Relationship problems with partner	30%
Money problems	43%
Came out of care	18%
Came out of prison	20%
Problems with police	33%
Mental health problems	19%
Other reasons*	15%

* Leaving the army, coming out of hospital, fleeing violence in their home, death of partner/parent, wanting to get away from the area where they were living, losing their job, problems with their children, losing their accommodation, fleeing from drug dealers and being a refugee.

Since first becoming homeless, nearly half the sample (48 per cent) had been continuously homeless. These respondents were asked to give reasons for this and the two most commonly cited (by 29 per cent each) were drug use and financial problems.

As for the rest of the sample, drug use was by far the most common reason for episodic homelessness, with just over two in five (42 per cent) viewing it as a reason why they still experienced homelessness.

Main income sources

The longer people had been homeless, the more likely it was that begging was their main income source. For example, over a third (35 per cent) of those who had been homeless for more than ten years reported begging as their main source of income, while only one in five of those who had been homeless for two years or less did so.

Buying drugs and alcohol was the main expenditure for the majority of the sample – over half of the whole sample (53 per cent) said their biggest expenditure was drugs and nearly a quarter (23 per cent) that it was alcohol.

Conversely, state benefits were more likely to be the main income source if someone had not been homeless that long – nearly half (47 per cent) of those who had been homeless for two years or less gave this as their main income source, whereas only a third (35 per cent) of those who has been homeless for ten years or more did so. The highest proportion to cite theft as a main income source came amongst those who had been homeless for six to ten years – and even then, it was less than one in five (18 per cent).

People were also asked what they spent their money on, and 71 per cent reported spending money on drugs and 57 per cent on alcohol. Buying drugs and alcohol was the main expenditure for the majority of the sample – over half of the whole sample (53 per cent) said their biggest expenditure was drugs and nearly a quarter (23 per cent) that it was alcohol.

For those who had been homeless for more than ten years, physical health problems became the priority, followed by the usual suspects – drug and money problems.

Needs and wants

The most commonly-reported need – by almost all respondents – was help to find permanent accommodation (91 per cent). The second most reported need was help in sorting out their money problems (46 per cent).

Putting the wish for permanent accommodation to one side, those who had been homeless for two years or under were most likely to want help with money problems, followed by help with drug and alcohol problems. Money problems dropped out of the equation for those who had been homeless for between three and five years, but re-emerged for those who were homeless for between six and ten years. For those who had been homeless for more than ten years, physical health problems became the priority, followed by the usual suspects – drug and money problems.



Chapter 2

THE SURVEY – DRUGS

The sample had a high level of drug use. Although drug users were not targeted for this study, four in five (83 per cent) had used a drug – excluding alcohol – in the last month. Only four per cent (just 17 people) had not used any drug or alcohol in the last month.

In the last month, around two-thirds had used cannabis and alcohol, while almost half had used heroin and/or crack. Around a third had used benzodiazepines and the same proportion had used opiates other than heroin. The use of stimulants other than crack was lower, although a quarter of the sample had used cocaine powder, amphetamine and/or ecstasy.

Table 4: The samples drug and alcohol use

	% of people who had used drugs or alcohol in last month	% of people who had used drugs or alcohol in last year	% of people who had used drugs or alcohol at some point in their life
No drugs or alcohol	4%	2%	1%
Any substance (incl alcohol)	96%	98%	99%
Any drug (excl alcohol)	83%	88%	94%
Alcohol only	13%	10%	5%
Heroin	47%	55%	67%
Other opiates [1]	30%	41%	58%
Crack	47%	56%	66%
Other stimulants [2]	25%	46%	74%
Benzodiazepines [3]	32%	47%	65%
Hallucinogens [4]	6%	12%	51%
Cannabis	65%	73%	86%
Solvents	3%	6%	27%
Alcohol	68%	78%	93%

[1] methadone, morphine, DF118 (dihydrocodeine tartrate), Temgesic (buprenorphine), Diconal (dipipanone hydrochloride), Palfium (dextromoramide).

[2] cocaine powder, amphetamine, ecstasy.

[3] diazepam (eg Valium), temazepam, Rohypnol (flunitrazepam), Mogodon (nitrazepam), Librium (chlordiazepoxide), Ativan (lorazepam).

[4] LSD, PCP, magic mushrooms, ketamine.

When the 372 respondents who had used a substance during the last month were asked which they preferred, almost one in three (32 per cent) said heroin. Next favoured was alcohol (26 per cent) followed by cannabis (21 per cent).

The main reason given for the preference was that respondents liked the effect of the substance (given by 69 per cent), although one in six said it was their favourite because they were addicted to it.

In terms of how often particular drugs were used, over two in three heroin users took it on a near daily basis (70 per cent) as did around half the crack or alcohol users (46 and 53 per cent respectively). Overall, three in four users of any drug (excluding alcohol) took it nearly every day.

Given this level of use, it is hardly surprising that polydrug use was common. On average, respondents had each used three or four drugs in the last month. Nearly two in five (38 per cent) had used both heroin and crack in the last month.

In general, the use of crack seemed synonymous with heroin use, as four in five of those using crack in the last month had also used heroin. The use of benzodiazepines in combination with heroin and crack was also common. Just over half of those using heroin and crack in the last month had also used benzodiazepines (54 per cent).

Overall, three in four users of any drug (excluding alcohol) took it nearly every day.

Injecting

In the month prior to interview, two in five of the whole sample had injected a drug – almost half of all those who had used a drug in this period. Just over a third of the total sample had injected heroin and a fifth had injected crack.

Table 5: Injecting in last month, by drug type

	Used in last month (number of users)	Injected in last month (% of number of users)
Heroin	184	78%
Other opiates	117	21%
Crack	182	38%
Other stimulants	97	39%
Benzodiazepines	125	6%
Hallucinogens	23	13%*
Any drug	324	48%

* ketamine in all cases

Note: See notes from Table 4 regarding descriptions and definitions of drugs

There were no significant differences between injectors and non-injectors in terms of gender: 41 per cent of females and 40 per cent of males had injected in the last month. However, female injectors were significantly younger than male injectors. The mean age of female injectors was 26.7 years and male injectors were, on average, 30.5 years old.

Few injectors were sharing injecting equipment. In the last month, only 15 per cent of injectors had passed on a syringe to someone else after using it themselves, while 14 per cent had used a syringe after someone else had used it (most of whom had also passed on a syringe).

Current dependence

Respondents were asked to name the main substance (including alcohol) that they had used in the last month. They were then asked a series of questions to measure their dependence on that drug, using a checklist of symptoms derived from and compatible with both DSM-IV and ICD-10 (American

Psychiatric Association, 1994; World Health Organisation, 1992). This method is widely recognised as valid and reliable. It consists of a series of ten questions, such as “In the last month, did you have a strong or persistent desire to use this substance?”. If a respondent answers “yes” to three or more of the ten questions, they score as dependent.

Table 6: Dependence by substance type

	Used in last month (number of users)	Stated as main substance used in last month (% of number of users)	Scored as dependent on main substance (% of number of users)
Heroin	184	76.0%	76.0%
Other opiates	117	13.0%	12.0%
Crack	182	21.0%	19.0%
Other stimulants	97	7.0%	7.0%
Benzodiazepines	125	0.8%	0.8%
Hallucinogens	23	0.0%	0.0%
Cannabis	253	18.0%	8.0%
Solvents	13	8.0%	8.0%
Alcohol	264	46.0%	37.0%
Any substance	372	not applicable	84.0%
Any drug (excl alcohol or solvents)	324	not applicable	66.0%

Over four in five current substance misusers (84 per cent) scored as dependent on their main substance – that is, 312 out of the 372 people who had used any substance in the last month. Two in three current drug users also scored as dependent on their main drug.

Just over a third of the total sample scored as heroin dependent and a quarter as alcohol dependent – and all those who cited heroin as their main substance scored as dependent. Four in five of those whose main substance was alcohol were dependent on it, while 34 of the 38 people whose main substance was crack scored as dependent.

Given the above, it follows that those who were dependent on drugs were more likely to want help with physical and mental health problems than their non-dependent peers.



Chapter 3

THE SURVEY – DRUGS AND HOMELESSNESS

It is now time to look at the relationship between homelessness and drugs. It is a strong relationship, and it is a relationship which binds many homeless people to a life of uncertainty and instability.

Three stark facts should be borne in mind throughout this chapter. Firstly, that homelessness is clearly a trigger for increased drug use. Four in five of our sample said they had started using at least one new drug since they became homeless.

Secondly, there is a clear association between increased dependence on drugs and the time someone spends homeless – just under half of those homeless for under two years scored as dependent on their main drug. But nearly two in three of those homeless for between three and five years did so.

Perhaps most worrying, though, is the finding that only one in five felt that their drug use had decreased over the last year. And when we set this self-reported drug use alongside people's living conditions, we found a strong correlation between an increase in drug use and a worsening housing situation. Not only can drug use trigger homelessness, then, but it can prolong and deepen it.

Fewer than two in five (39 per cent) of those who had been homeless for two years or less had used heroin in the last month, whereas nearly one in two (49 per cent) of those who had been homeless for ten years or more had used the drug in the last month.

Time and drugs

As would be expected, it seems that substance use, injecting and dependence increase over time. For instance, fewer than two in five (39 per cent) of those who had been homeless for two years or less had used heroin in the last month, whereas nearly one in two (49 per cent) of those who had been homeless for ten years or more had used the drug in the last month.

Alcohol use was most common among those who had been homeless for over ten years – more than three in four (76 per cent) of them had used it in the last month, while only three in five (60 per cent) of those who had been homeless for two years or less had done so.

The relationship between time and increased drug use does not always hold firm, however. There was very little change in the proportion of people who had used crack in the last month depending on the time they had been homeless, hovering just below the one in two mark. This may, however, be a historical blip – the drug has not been around in Britain long enough for many people to develop long-standing dependencies of over ten years.

That said, the use of all other substances did increase over time, with a sharp increase after two years – 57 per cent of those who had been homeless for two years or less had used a substance other than heroin, alcohol or crack, while 88 per cent – nearly nine in ten – of those who had been homeless for three to five years had done so.

As for daily use of heroin or crack, it rises from under a third (30 per cent) of those homeless for under two years to over two in five (41 per cent) of those homeless for six to ten years before falling again to just over a third (36 per cent) of those who were homeless for more than ten years.

Injecting also increased with the time respondents had been homeless. In the last month, just over a quarter (27 per cent) of those who had been homeless for two years or less had injected a drug. But almost half (46 per cent) of those who had been homeless for more than six years had done so.

When it came to dependence, as already stated, just under half (49 per cent) of those who had been homeless for two years or less scored as dependent on their main drug. This was not the peak, however – nearly two in three (63 per cent) of those homeless for between three and five years were addicts.

Substance use of other homeless people

Respondents were asked how many other homeless people they hung around with on a typical day, and about the substance use of these peers. Most spent their time with groups of other homeless people who used the same amount of, or more, drugs and alcohol than the respondent did.

On a typical day, four in five spent time with other homeless people, and around half said that these people had similar levels of drug use to their own. A third spent time with people who used more drugs than they did, while only seven per cent spent time with people who used fewer drugs than they did themselves.

It is significant, that respondents who had not used drugs or alcohol in the last month were half as likely as drug and alcohol users to spend time with other homeless people.

Substance use since becoming homeless

Drug use is traditionally seen as one of the major routes into homelessness, and this was borne out by our survey. Four in five people (83 per cent) had used cannabis and almost half had used heroin prior to becoming homeless. Just over two in five had used cocaine, ecstasy or amphetamines and just over a quarter had used crack.

However, when asked whether they felt their drug use had contributed to their first episode of homelessness, only half believed that it had. More importantly, four in five also said that they had started using at least one new drug while homeless. Drug use may well be a trigger for homelessness then, but homelessness is clearly a stronger trigger for drug use.

Table 7: Substance use since becoming homeless

	% of those who have used the drug who first used it after becoming homeless
Heroin	54%
Other opiates	73%
Crack	72%
Other stimulants	58%
Benzodiazepines	70%
Hallucinogens	37%
Cannabis	17%
Solvents	22%
Alcohol	12%

Drug use may well be a trigger for homelessness, but homelessness is clearly a stronger trigger for drug use.

We asked people how often they had used each substance during their last period of rough sleeping. Equal proportions (41 per cent) replied that they had always or almost always used heroin and alcohol during this period, and one in three (32 per cent) that they had always used cannabis. Just over one in four (27 per cent) said they had always used crack.

Perceived changes in substance use and housing

People were also asked if their drug use had increased, decreased or stayed the same in the last year. Over a third (36 per cent) thought their drug use had increased; around one in five (22 per cent) believed it had decreased; and just over two in five (42 per cent) thought there had been no change. We correlated these perceived changes with perceived changes in their housing situation and found that an increase in drug use was strongly related to a worsening accommodation situation. As with drug use, an increase in alcohol use was also correlated with a worsening housing situation.

Given this, it is hardly surprisingly to find that those who predicted an increase in drug or alcohol use over the next year were also likely to think they would be sleeping rough.



Chapter 4

HOMELESS SERVICE UPTAKE

Perhaps as a result of this general worsening housing situation, our sample made great use of homelessness services. We divided these services into cold weather shelters, rolling shelters, night shelters, day centres, services offered by an outreach team, hostel accommodation and food runs.

Only six people had not used any of these services in the year before the interview, although a similarly low number – just ten people – had used all of them. The most commonly used were those which provided temporary and emergency accommodation (88 per cent), day centres (86 per cent) and food runs (80 per cent). On average, respondents had used four different services for homeless people in the year before the interview. The average length of time clients of each service had been homeless was more than seven years in all cases.

Table 8: Use of services for homeless people

	Used in last month	Used in last year	Ever used
Cold weather shelter	29%	61%	74%
Rolling shelter*	22%	*	*
Night shelter	6%	27%	53%
Day centre	61%	86%	93%
Outreach team	40%	64%	75%
Hostel	35%	56%	86%
Food run	52%	80%	87%

* Rolling shelters were not introduced until several months after interviews began.

Respondents were very knowledgeable about where services for homeless people were and how to access them. However, for all service types except hostels, there were significant differences in knowledge according to the length of time respondents had been homeless. In general, those who had been homeless for two years or less were less likely to know of services compared to those who had been homeless for more than two years. For example, 57 per cent of those homeless for two years or less knew of an outreach service, whereas 82 per cent of those homeless for longer did; and almost twice the proportion of those homeless for more than two years knew of a night shelter than those homeless for two years or less.

However, while people tended to know about and use homelessness services, a substantial number had also been barred from them. In the previous year, nearly two in five (39 per cent) had been excluded from one or more service for homeless people. A third of these were excluded for physical violence towards other clients and a fifth because of drug use.

People who were dependent on drugs or alcohol were almost twice as likely as non-dependent users to be banned.

The relationship between exclusions and substance misuse does not end there. People who were dependent on drugs or alcohol were almost twice as likely as non-dependent users to be banned (42 per cent of those with dependencies were excluded from services compared to 23 per cent of non-dependent users). Equally important, is the finding that, the one substance which contributed significantly to someone being banned was alcohol – over half of those who were dependent on alcohol had been excluded, compared to only a third of those who were not dependent on alcohol (52 per cent versus 34 per cent).

The implication is clear – whether as a direct result of substance misuse or of the violence that it often brings in its wake, drugs and alcohol are major barriers to people being able to access services. And – perhaps contrary to many expectations – alcohol is the most problematic substance of all when it comes to service exclusions.

Over half of those who were dependent on alcohol had been excluded, compared to only a third of those who were not dependent on alcohol.



As for proactively deciding not to use a service again, over a third (36 per cent) said they would not use a night shelter, 19 per cent a hostel, 17 per cent a cold weather shelter, 13 per cent an outreach team, seven per cent a food run and five per cent a day centre. The main reasons given for not using any particular service were that there was too much substance use, violence and chaos and that respondents did not know where to find them.

Those who would not use a homeless service were asked how it could be improved to encourage them use it. Overall, the most common response was that there was nothing the service could do, given by between one in two and one in four of all those who would not use a particular service. Other suggestions for improvements were more publicity, better security and the separation of substance users and those with mental health problems from other service users.

These findings reinforce other research studies carried out this year by Vision 21 that of all the services available to homeless people, emergency accommodation is the one with which they are least satisfied. People go to day centres and seek out food runs because they know what's on offer and they know that they can walk away. In hostels and night shelters, on the other hand, violence and drug use are invariably just around the corner.

Chapter 5

DRUG SERVICE UPTAKE

As with homelessness services, so too with drug services – over nine in ten of all those currently dependent on any drug had used a drug service in the last year.

This high level of service uptake should be welcomed. However, there is one important caveat. This service use was almost exclusively confined to needle exchanges rather than drug treatment programmes. When the use of services in the last month is examined, needle exchanges were visited by nearly nine in ten (88 per cent) of those who had used any service. The next most used service was the drop-in centre – used by fewer than two in five drug service users.

Crucially, clinical services (such as detox, methadone treatment or day programmes) accounted for only a quarter of dependent drug users' visits to drug services in the last month. There is a simple but unavoidable truth here – if homeless drug users are not receiving treatment, their levels of drug use are not being tackled effectively.

Table 9: Current use of drug services among those dependent on the main drug they had used in the last month

Drug Service	% of dependent drug users who had used a service in last month*
Any drug service	71.0%
Needle exchange	62.0%
Drop-in advice and information	27.0%
Treatment with methadone	20.0%
Residential drug detoxification unit	3.0%
Day programme for drug users	2.0%
Narcotics Anonymous or other self-help group	0.5%

*Calculated only for those who scored as dependent on heroin or were using it daily or near daily (n=155).

This relationship between treatment need and treatment access is something that we wanted to analyse further. Specifically, we wanted to find out about drug users who needed help but were not accessing drug services. Need was measured in two ways:

'Subjective need': a positive response to the questionnaire item asking if they wanted help now with drug problems. 170 respondents (44 per cent of the whole sample) fell into this category.

'Objective need': those who had scored as dependent on a drug; and/or were using heroin or crack near daily; and/or were injecting a drug. 221 respondents (57 per cent of the whole sample) fell into this category. It should be noted that as indicators of objective need were measured on current behaviour, it is not known whether or not this behaviour occurred throughout the previous year. Nonetheless, the findings do provide a useful indication of the level of service use by homeless dependent drug users.

Clearly, some of these people were the same, but the facts speak for themselves.

Clinical services (such as detox, methadone treatment or day programmes) accounted for only a quarter of dependent drug users' visits to drug services in the last month.

Over two in five of those who wanted help had not used a general support service in the last year, and over three in five had not accessed a clinical service.

One in five of those who were assessed as ‘having a major drug problem’ had not used any drug service in the last year. Only one in seven (15 per cent) of those whose needs were measured subjectively had not.

As for the use of general support services (such as drop-in or day programmes), just over half of those with ‘objective needs’ (53 per cent) had made use of these over the last year. Nearly three in five (58 per cent) of those with ‘subjective needs’ had also done so.

Similarly, only one in three of those with ‘objective needs’ had used a clinical drug service in the last year. This compares to nearly two in four (39 per cent) of those who recognised that they had a problem.

Granted, the differences are not stark, but it is fair to say that those whose needs were measured subjectively were more likely to have accessed a drug service than those whose needs were measured objectively. This suggests that some drug users do not recognise that they are in need of help – may not be ready to receive it.

On the other hand, it is equally clear that over two in five of those who wanted help had not used a general support service in the last year, and that over three in five had not accessed a clinical service. One way or another, a significant number of people who know that they need help are not receiving it.

Uptake of alcohol services

Before we turn to those thorny issues, we will briefly examine access to alcohol services. Unlike the drug users, of the 97 people currently dependent on alcohol, only one in three (36 per cent) had used an alcohol service in the last year – and only one in seven (14 per cent) in the last month.

The most commonly used services were drop-in centres, residential detoxification units and self-help groups. As with the drug users, few had used day programmes. But unlike dependent drug users, those dependent on alcohol were likely to use only one type of alcohol service – over half had used only one service type in the last year (54 per cent).

Of those who had used an alcohol service in the last year, almost a quarter had been excluded from at least one. And as with exclusions from drug services, the major reason was their own substance use.

In terms of subjective and objective need, a similar pattern that was seen for drug service uptake emerges: those whose needs were measured subjectively were more likely to have accessed any alcohol service than those whose needs were measured objectively. In the last year, 36 per cent of those with an objective need for an alcohol service had used one whereas 44 per cent of those with a subjective need had done so. But also as with drug services, the flipside is that over half of those who wanted help for their problem were not receiving it.



Chapter 6

SERVICE PROVISION AND POLICY-MAKING – ISSUES AND VIEWS

We now turn from the people who need the services to the people who provide them.

The strategy

The context of this research – and the period in which it was undertaken – was the rapidly evolving political and policy-making interest in homelessness. In general, service providers also thought that the work of the Rough Sleepers Unit was a move in the right direction (“We need something like the RSU to tackle the drugs issue, it’s not just a health issue, it’s not a crime issue, it’s everything isn’t really?”).

Service providers were asked who they thought would be left on the streets if two-thirds were successfully removed, as was the government’s aim. This aim was subsequently achieved in December 2001. Some thought it would be those with the most problems. However, a few service providers were worried that the new strategy catered only for those with the most chaotic lifestyles. Those who were less chaotic, but still had service needs, would miss out: “The ones who are vocal are seen to get the services which they are asking for. The ones who aren’t vocal are the ones who have got a dual diagnosis or multiple needs, who are sitting quiet, who are rocking on pavements, who aren’t getting hardly anything.”

That resources should be strictly targeted to those most in need was appreciated by most people. However, identification of these clients could be problematic. As one manager put it, “People are literally having to make themselves noticed as street homeless. I know if I was a rough sleeper, I’d be in some dark alleyway somewhere, where no-one would find me.”

Service providers and drugs

All the homelessness agencies we spoke to had a policy on illicit drug use, possession and dealing, and most had taken legal advice on formulating this. The impetus for clarifying this issue was often stated as being the Wintercomfort case (when two homelessness workers were imprisoned after drug dealing had occurred on the premises that they managed in Cambridge during 1999). Several respondents pointed out that even before the Wintercomfort case, homeless drug users had been regarded as a difficult client group to work with, and that the incident had acted as a further disincentive to work with this complex group of people.

However, while service providers were clear about their policies regarding drug dealing, the dilemma of the legal aspect of the possession and use of illicit drugs on the premises of a service which caters for drug users – or at least accepts them as clients – remained. While some agencies had a finalised version of a comprehensive policy (“a ten-page document... a very extensive bible”) which they were successfully implementing, others were still in the process of formulating one and some were experiencing difficulties in translating the legal advice into practice.

Several respondents reported that their drug policies had been formulated not only with the legal implications in mind, but also the effect of drug users on other clients and on staff: “I think quite often the attitude [from non-drug-using clients] here is ‘We don’t want to be near smackheads or illegal users.’”



Multiple needs

Service providers almost universally raised the thorny issue of prioritising certain needs above others when dealing with their clients. According to one frontline worker, “They may have a priority that they want to do X, Y and Z and my priority might be different to theirs... Housing won’t be at the top of their priority, but it may be a priority for me, in seeing that as part of changing some part of their environment.”

They also had to face the question of prioritising certain clients above others, “There are heavy-end users, injecting drug users, and those who just dabble a bit. The heavy-end users are the ones who are the hardest to place because they have got multiple needs. How do you prioritise?”

It was also pointed out that if a homeless drug user wants to address their drug use, they are often reluctant to accept a place in a hostel for drug users – commonly seen as chaotic environments – and so choose to hide their use. Such a strategy is almost always going to end in eviction. One service provider, putting himself in the shoes of a user, said: “I am street homeless, I want to address my drug use, so when I am meeting the Contact and Assessment Teams¹ and they say ‘Do you use?’ I am going to say ‘No’ because I don’t want to be surrounded by drug users... I get shipped off to somewhere which has a no drug use policy, and then I break the rules because I am really a user. Then I am back on the streets.”

Finally, when asked about differences in service provision for homeless drinkers and homeless drug users, a number of service providers thought that there were fewer services for the latter, particularly in terms of hostel accommodation. Several people cited the difference in the legal status of drugs and alcohol as the main reason for this.

Waiting times

Waiting times were discussed at length by most interviewees. Some service providers found it difficult to work with clients who were waiting for a service: “It is supposed to be a nice little flowing transitional period, but it can’t happen like that because there is a six to eight-week waiting list... I am finding it so hard to work with the clients I am working with, who are chaotic injectors. They are so pissed off with everything. Now they aren’t trusting me... They are saying ‘What is the point of you coming here to talk to me?’”

¹ Contact and Assessment Teams work with street homeless people to place them into accommodation.



The effect of waiting on a client's motivation to address both their homelessness and their drug use was frequently noted. As one manager put it, "What we've got is a client group who are notoriously unmotivated and the distance from sleeping on the street into residential rehabilitation – they don't make that jump. So our job is to help them be prepared to either go to rehousing, to go to some type of detox... because what it does is to get people to have a positive experience of services."

Others, however, appreciated the rationale behind the waiting time – "If you are saying to that person there is a three-month waiting list, you can spend that three months preparing somebody properly, so that he or she knows what to expect, knows what is going to happen to them physically, mentally – and looking at what they are going to do afterwards."

This seemed to echo a recognition that however long someone waits, they still need 'bite-sized' long-term help to keep going.

Good and better practice

We also asked service providers about their agency's particular successes, as well as any suggestions for improving services for clients who were resistant to change.

A number of interviewees cited their agency's strength as being able to cater for 'failures': "What we are saying is 'You will be in our system and we will do all we possibly can to make sure that you succeed'... What we have to try and do, if people can't make the system, is to work out why, and try and alter that system as much as we possibly can to suit them."

In general, suggestions for improvements could be split into the following five main areas.

Increase the number and accessibility of drug treatment services

The importance of being able to offer a homeless drug user an immediate and tangible service was stressed by everyone. As one provider put it, they needed to, "Bring the service to where the punters are rather than expecting them to jump through all these hoops... If there is an acknowledgment that these people are that unmotivated, how do you get them into services quickly?"

The lack of detox places and waiting times to access them was also a common complaint – "You need to have bed spaces in detoxes available within a few days, in order to get the person assessed and for you to be satisfied that it is the right place for them and that they are not just mucking you about or hiding from their dealer."

Increase the accessibility of hostel places for drug users

Most service providers admitted that flexibility could be improved ("There are some that are so inflexible you can't get any information about any vacancies that day without speaking to a certain person"), while one person made a plea for individual, lockable rooms in hostels. This would make it "easier for them to accommodate drug users and ensure harm reduction measures (such as the provision of sharps bins) could be implemented.

Increase cooperation between agencies

More inter-agency cooperation was stressed by several respondents, such as this manager: "Our clients are multi-service users. I think there is something about more coordination within the sector, on a client level and also on a strategy level. Some of that has already started... We need to work better around substance misuse and mental health, so we are not tripping over each other."

Clarify workers' tasks

One service manager was concerned about clarifying tasks in order that services reached those most in need: "Half of my workers are trained youth and community workers, who work on the streets – basically give advice and education and referral to someone else to do the in-depth work. The other half of them are 'counsellors' who like people coming here and they can sit in a room and talk about problems... And what none of them really wants to do is what I class as task-centred casework."

More preventative work

Another interviewee suggested more initiatives directed at tackling the issues which led to people becoming or remaining homeless – "There are a few services that have got a family mediation service, which is very, very good, but they are still only dealing with a handful of people... we could build on that, but there are not a lot of good models around... Perhaps we have not been very imaginative... At the moment people are getting lost in London – it's a nightmare."

Chapter 7

SERVICE PROVISION AND POLICY-MAKING – THE CURRENT CONTEXT

The main body of this research project was carried out over a two year period between 1999 and 2000. As already stated, this took place against the backdrop of the initial rollout stage of the RSU's strategy. Much has changed since then.

In particular – the government's target was eventually met in December of 2001 with the number of people sleeping on the streets of England falling by 71% to 532. This has largely been due to the successful operation of the 22 Contact and Assessment Teams (CATs) which were established across the country from early 2000 onwards

More specifically, significant financial and human resources have been directed towards tackling drug use among the capital's rough sleeping and homeless populations. The RSU and the UK Anti-Drugs Coordination Unit made over £1 million available in London, which has gone towards the provision of over 50 specialist substance misuse workers, as well as new units in three hostels, more places in specialist treatment services and part-funding of Soho's Rapid Access to Treatment Centre. In its first six months of operation, this last service saw over 50 rough sleepers received into its treatment programme.

Moreover, the Department of Health has allocated a further £1 million extra in each of the years 2000/01 and 2001/02 to Westminster Council's Social Services Department to help rough sleepers with substance misuse and mental health problems.

Obviously, these extra resources may have impacted substantially on the problems facing London's homeless drug users.

With this in mind, Crisis called together experts from across government, the voluntary homelessness and drug sectors and the statutory health sector to re-examine the research findings. This is what they thought.

Still relevant?

Nearly all of those consulted in November of 2001 felt that the picture painted by the survey still held true. If anything, crack use may have increased over the past year, but apart from that, our sample's levels of drug use, experiences of homelessness and associations between the two were still felt to apply.

What may well have changed, of course, is people's ability to access drug services. A view was expressed that there were now enough service gateways in London (including the highly praised piloting of Personal Medical Services), and that those who were not using them had effectively made a decision not to access treatment. This may be because they are frustrated with institutions or don't believe that the services will be able to help them.

Recent years have seen an increasing dependence upon specialist drug workers and there was a feeling within the housing field that it was now almost impossible to find new specialist drug and alcohol workers to work in the housing sector.

Cross-sectoral working?

Some things, however, may not have changed. Whether the people we consulted were from the voluntary, private or public sectors, there was a general feeling that while great steps had been taken in the last few years towards a better integration of service delivery, there was still a lot more which needed to be done.

With the majority of funding in the homelessness sector channelled through housing providers, drug services often feel that they do not have access to the finances necessary to provide the services that are needed. The problem is further compounded with Drug Action Teams (DATs)² and Health Authority drug and alcohol commissioning structures working in multi-disciplinary partnerships without input from housing providers.

A strong view was expressed that partnership operated much more successfully outside London. This seems to be as much due to practical reasons (there are fewer agencies and stakeholders outside London and so community development has to be more integrated) as to the peculiar situation of the capital (where it was felt that services tend to be more fragmented anyway).

One suggestion as to how this could be remedied was to break down the firewalls that exist between different disciplines and view the problems of homeless drug use through the prism of social care. On this basis, Drug Reference Groups and Special Needs Housing Fora could become the vehicles for bringing continuity of care to London that is visible in places like Birmingham.

There was also a feeling that services were driven by a system of funding that did not effectively recognise the multiple needs. To use the words of one housing provider, “Can we please recognise ‘multiple needs’ as a client group. If you’re batted from one pot of money to another, that’s not going to help.”

Specialist or generalist?

This takes us onto one of the liveliest debates currently facing the various sectors – whether services should be specialist or generic.

There was strong agreement among service providers that a historical focus on generalist provision ill-equipped them for people with multiple needs (“We do not have the level of skills that I would have hoped for at this time”).

Partly as a result of this recent years have seen an increasing dependence upon specialist drug workers and there was a feeling within the housing field that it was now almost impossible to find new specialist drug and alcohol workers to work in the housing sector. Many actually specialised themselves out of their jobs and switching to the drug field and to the DATs in particular.

As one manager put it, “In some ways, we’ve created a monster by trying to be more focused”. The generally held view was that by trumpeting the role of the specialist, the impression had been given that only specialists can help homeless drug users. In fact, as some service providers noted, the distinction was really one between generic, (“Who should be able to cope with complex needs anyway”) and clinical workers.

If there was a commitment from agencies to maintain a staff/client ratio which allowed complex and multiple needs to be addressed, then there was no reason why generic housing workers (and organisations) could not regain the confidence to stream clients towards the relevant clinical interventions – and vice versa. Such a needs-led approach – rather than a service-led one – was felt to be the Holy Grail for this particular client group.

But ultimately such an approach was only thought to be viable if the funding structures came to recognise multiple needs.

² Drug Action Teams are the bodies with local responsibility for the provision of Drug Treatment Services.

Chapter 8

THE WAY FORWARD

The one word that comes through loud and clear in this research is ‘complexity’. Although this final chapter details a number of recommendations under neatly defined headings, the multiple problems and service needs of homeless substance users are interrelated and cumulative. No recommendation should be taken out of this context.

Hopefully, this report has also shown that much has already been done to address this most complex of social problems. However, the fact remains that the homelessness and drug sectors have inhabited parallel universes for too long. Many of the issues that they face and deal with on a day-to-day basis have the same roots and the same consequences. It is therefore time for these separate fields to find ways if not of merging their responses to what are ultimately the same problems, then at least of finding the common language of social care.

Even if this can be done, the battle is hardly over. Complexity and the long-term care which it carries with it will open up a whole new area of good practice, at the end of which – with a bit of luck and a lot of funding – could well lie an understanding of how we can tackle homelessness *and* drug use together.



Prevention of homelessness and of drug use

This study has shown that homelessness tends to manifest itself at a young age. Unless effective primary prevention initiatives are implemented, this situation will continue, with new people replacing those who have been helped off the streets and into permanent accommodation.

- RECOMMENDATION** ✓ **Primary prevention initiatives to forestall homelessness and arrival in London should be increased throughout the UK. These initiatives should concentrate on drug users.**
- RECOMMENDATION** ✓ **Drug prevention, harm reduction and low-threshold drug services should be readily accessible for homeless people, especially for those who are newly homeless and those sleeping rough.**

Barriers to the uptake of services for homeless people

Those who had been homeless for under two years were less likely to know about homelessness services than those who had been homeless for longer.

- RECOMMENDATION** ✓ **Services for homeless people should be publicised among those who are newly homeless and this initiative should also be incorporated into primary prevention strategies.**

After lack of information, the main barriers to using services were that there was too much substance use, violence and chaos. This is obviously a particular problem for those trying to address their own drug use. Thus, while many services for homeless people are supposedly substance-free, it appears that they are not perceived as such by some of those in need of them.

That said, the most common response when respondents were asked for suggestions for improvements that would encourage them to use each service was ‘nothing.’ These respondents are likely to be those who are the most entrenched in a lifestyle that involves sleeping rough and therefore the most difficult for services to cater for.

- RECOMMENDATION** ✓ **Create a greater understanding of the services on offer to dispel negative preconceptions and inform on the opportunities that are available.**

Although the use of homelessness services was high, nearly two in five of the sample had been excluded from one or more of them in the past year. These people were more likely to be dependent on their drug of choice.

- RECOMMENDATION** ✓ **With physical violence identified by homeless people as a main barrier to service use and a major cause of exclusions by service providers, it is crucial that environments should be created, particularly in hostels, where physical violence can be minimised.**

The combination of the lack of accommodation for homeless drug users and the threat of exclusion was seen by service providers as being responsible for much of the covert drug use within accommodation services.

- RECOMMENDATION** ✓ **While illicit drug use cannot be condoned, more agencies – especially hostels – should offer services to support those who continue to use drugs, until they are motivated to want to seek help. Government support for this strategy, including the legal implications, is essential.**

Uptake of drug services

Knowledge of drug services and how to access them was, overall, somewhat lower than it was of homeless services, although dependent heroin users were more knowledgeable about drug services than other groups of drug users.

RECOMMENDATION ✓ **Given the vulnerability of homeless people to drug use, drug services and how to access them should be well publicised by the providers of other services for homeless people.**

The uptake of drug services other than needle exchanges was low, and a number of service providers suggested that some of those accessing clinical treatments were doing so because it was a requirement of their housing rather than because they wanted to become drug-free. If these perceptions are correct, the long-term effectiveness of this strategy must be addressed, particularly in the case of those not motivated to long-term change.

RECOMMENDATION ✓ **Other ways to address the drug use of homeless people should be investigated and disseminated as good practice models. Clinical interventions should not be regarded as the immediate goal for all homeless drug users.**

RECOMMENDATION ✓ **More services should be provided for homeless people who continue to use drugs, in order that their drug use does not remain hidden and so that interventions – including harm reduction initiatives – can be implemented.**

RECOMMENDATION ✓ **While immediate clinical interventions for homeless drug users may not always be the most appropriate response to their needs, the availability and accessibility of all drug services should be increased.**

RECOMMENDATION ✓ **In spite of the widespread use of needle exchanges, there should not be a reduction in the provision of needle exchange facilities, so that the number of those sharing injecting equipment remains low.**

The unmet needs of homeless drug users

The drug service needs of respondents were measured objectively and subjectively. Around one in three homeless drug users in need of help were not accessing drug services (with the exception of needle exchanges).

The major reason that those in need of drug services did not access them was that they did not feel the need for them. This points to a lack of motivation to change, particularly as few respondents had suggestions for improvements to drug services in order to encourage their uptake. This finding is underlined by the service providers – both during the original research and in the recent follow-up – who reported clients' lack of motivation to change as a major obstacle to drug service uptake.

RECOMMENDATION ✓ **Many homeless drug users will require long-term contact with services, in order to build their motivation to accept drug treatment. Policy-makers and practitioners need to explicitly recognise this and ensure that the resources are made available to continue this long-term work with clients.**

Agencies' reluctance to work with drug users

All the service providers reported that their agency had a policy on illicit drug use, possession and dealing, but some were experiencing difficulties in translating legal advice into practice.

RECOMMENDATION ✓ **It is recognised that much work has been done to enable agencies working with drug users to formulate effective drug policies. Attention should now be turned to the implementation of those policies, and help provided to those agencies which still find it difficult to apply their policy.**

There was a belief among service providers that homeless drug users are more difficult to work with than homeless alcohol users, not least because of the Wintercomfort case. Apart from the legal situation, other aspects of drug use which make it difficult for agencies to work with drug users are their behaviour when under the influence of drugs, a lack of confidence, a fear of drugs and drug users, insufficient knowledge and the opposition of local residents.

RECOMMENDATION ✓ **Given the difficulties already faced by homeless substance misusers it is essential that services do not further exclude them. Substance misuse services must take into account the particular problems faced by homeless drug users, such as chaotic lifestyles.**

Uptake of alcohol services

The uptake of alcohol services by those dependent on alcohol was extremely low. In the month before the interview, only one in seven of those who scored as dependent on alcohol had used an alcohol service.

RECOMMENDATION ✓ **The low uptake of alcohol services by homeless people is a cause for concern, and government should undertake investigations into the reasons for this.**

RECOMMENDATION ✓ **The proportions of resources allocated to services for homeless people dependent on drugs and for those dependent on alcohol should be examined by government, to ensure they accurately reflect service needs.**

The move from temporary to permanent accommodation

Over three in five of the sample had been homeless for more than six years, almost half had slept rough for more than six months in the year before the interview and almost all respondents said they wanted help to find permanent accommodation. This would tend to suggest that even when people have been able to access temporary or emergency accommodation, a move to permanent housing did not follow – or if it did, it had failed.

RECOMMENDATION ✓ **Follow-up studies of those who have accessed temporary or emergency accommodation need to be conducted in order to explore the reasons why move-on sometimes fails some people.**

Hidden clients

The small proportion of women and members of minority ethnic groups in both our sample and the street counts carried out by many local authorities does not, however, mean that members of these groups do not become homeless. In all likelihood, there are substantial numbers either sleeping rough in inaccessible places or vulnerably housed. Whatever the case, they are unable to access the services available only to those sleeping rough. This situation places them in a dangerous position for the development of future problems, including rough sleeping and substance use.

RECOMMENDATION ✓ **Further research is required on the prevalence of homelessness among women and members of minority ethnic groups and their associated service needs. These needs should then be addressed in order to prevent the development of future problems and demands on services.**

Conclusion

The combination of homelessness and drug or alcohol use represents what is perhaps one of the most challenging issues in social policy today.

Many of these people also sit at the confluence of crime, mental and physical health problems – in other words, they live a life camped outside the revolving doors of home and street, stability and chaos.

The recommendations in this report are not intended to discourage service providers and policy-makers. However, it has been clearly shown that despite the great strides made in recent years, services still need to increase their efforts to tackle simultaneously homelessness and substance use.

Much remains to be done. It is likely that the long-term needs of many homeless drug users, and, importantly, those who are at risk of becoming homeless, will remain unmet unless the issues raised in this report are addressed. One of the principles of the RSU's strategy is "Never give up on the vulnerable". The people we spoke to for this study clearly fall into that category. It is time now to stop the revolving door which spins them from insecure housing to the street and back again.



ACKNOWLEDGMENTS

Many individuals contributed to this study, although the views expressed in this report are those of the authors. The authors gratefully thank:

Crisis, for funding this study, and especially Oswin Baker who managed the project and as development coordinator for Vision 21, edited the hard copy of this report. Many thanks also to Carole Bates, Mary Carter, Emma Low and Kate Tomlinson for all their support and encouragement.

Colleagues at the National Addiction Centre – Paul Griffiths and John Marsden for their contributions to the project design and analysis of the data, Colin Taylor for his statistical expertise and John Strang for his advice and support.

Colleen Hamilton and colleagues, Jeremy Swain, ‘Westy’ and members of the Rough Sleepers Unit, for initiating Jane Fountain into the world of homelessness and related service provision.

All the members of St Mungo’s Substance Use Team who conducted the interviews with homeless people. Thanks are specially due to Suzanne Smith who also supervised this part of the project.

Jean Carpenter for transcribing the tape recordings of interviews with service providers.

Those service providers and policy-makers who attended the seminars and focus groups in the autumn of 2001 to help guide the direction of the final report.

Finally, this study would not have been possible without the participation of homeless people and the staff and clients, who must remain anonymous, at the following services:

Ashley House Rolling Shelter	London Connection
Birkenhead Street hostel	Look Ahead hostel
Bondway Nightshelter	Marsham St Cold Weather Shelter
Bridge Housing Association	Neville House Rolling Shelter
Canbria House Rolling Shelter	New to London Project
Central CAT	North Lambeth Day Centre
Centrepont Soho	The Passage
Crispin Street Cold Weather Shelter	Release
Albert Embankment Cold Weather Shelter	Riverpoint
Dean Street hostel	Talgarth Rd Cold Weather Shelter
Dellow Day Centre	Tavistock Hse Cold Weather Shelter
Equinox	Southampton Row hostel
Hungerford Drug Project	Southwark Street Cold Weather Shelter
Kay Street Cold Weather Shelter	St Giles Trust
King George’s hostel	Thames Reach

REFERENCES

American Psychiatric Association (1994): *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Washington DC: APA.

CRASH (The Construction and Property Industry Charity for Single Homeless) (2000), *Survey of Users of Winter Shelters in London, Brighton, Bristol and Cambridge*, December 1999 – March 2000, under the Department of the Environment, Transport and the Regions Rough Sleepers Unit. London: CRASH.

DETR (Department of the Environment, Transport and the Regions (1999) *Coming in from the Cold: The Government's Strategy on Rough Sleeping*, London, DETR.

HSA (Housing Services Agency) (1999) *The Outreach Directory: Annual Statistics 1998-1999*, London: HSA.

Fountain, J, et al (2000) *Diversion of Prescribed Drugs by Drug Users in Treatment: Analysis of the UK Market and New Data from London*, *Addiction* 95(3):393-406.

Lambert, E.Y. (ed) (1990), *The Collection and Interpretation of Data from Hidden Populations*, National Institute on Drug Abuse (NIDA) Research Monograph 98, Rockville MD: NIDA.

Social Exclusion Unit (1998) *Rough Sleeping: Report by the Social Exclusion Unit*, London: Cabinet Office.

RSU (Rough Sleepers Unit) (2000) 1999 estimate of the number of people sleeping rough in England. Statistics provided by Rough Sleepers Unit to the authors.

Tackling Drugs to Build a Better Britain (1998) *The Government's ten-year Strategy for Tackling Drug Misuse*, London: The Stationery Office.

World Health Organisation (1992): *International Statistical Classification of Diseases and Related Health Problems* (10th edition), Geneva: WHO.

CRISIS PUBLICATIONS

Publications in the Hidden Homelessness series

Hidden but not Forgotten

Oswin Baker

ISBN 1 899257 49 7 2001 £7.50

This ground-breaking report examines the life of over 50 hostel residents. By mapping their experiences not only within the hostel system but also before they became homeless, we have been able to build up what is perhaps the most detailed picture of hostel life today.

The report will be required reading for anyone who wants to help shape the response to homelessness in the next decade.

Publications in the New Solutions to Homelessness series

Crisis' New Solutions research programme is dedicated to identifying the major problems facing homeless people and suggesting innovative responses, designed to enable practical, long-term responses to homelessness.

Trouble at Home: Family conflict, young people and homelessness

Geoffrey Randall and Susan Brown

ISBN 1 899257 48 9 2001 58pp £7.50

Family conflict is the main immediate cause of homelessness amongst at least two thirds of homeless young people. *Trouble at Home* looks at the causes of such family conflict and the scope for intervening to prevent young people from becoming homeless. Based on case studies with 12 organisations and structured interviews with 150 young people this powerful and timely report calls for a programme of long-term prevention and crisis intervention.

Trouble at Home identifies new opportunities for the development of crisis intervention services, highlighting the role that can be played by the latest government initiatives. The report goes on to look at the benefits of mediation services in preventing youth homelessness and calls for the implementation of a nation-wide network of family mediation services.

Healthy Hostels: A Guide to Promoting Health and Well-being Among Homeless People

Teresa Hinton, Naomi Evans and Keith Jacobs

ISBN 1 899257 47 0 2000 40pp £7.50

How can housing, resettlement and health workers promote the health and well-being of homeless people? What are the most effective ways of working and what resources do they need? This is the first guide to comprehensively explore health promotion work with homeless people and begin to answer these questions. It represents a unique attempt to bring together the experience and knowledge gained through current work, with ideas for developing future work with this population. It contains a wealth of material and information and practical examples of health promotion activities. It also outlines the principles of good practice and offers valuable insights into how housing providers can gear up and become more effective in this area.

The guide will provide readers with a number of new insights into the diverse range of initiatives and activities that have come to be known as health promotion and provide a greater understanding of the scope for action.

Lest We Forget – Ex-servicemen and homelessness

Scott Ballintyne and Sinead Hanks

ISBN 1 899257 46 2 2000 36pp £7.50

Up to one in five hostel residents and nearly one in three rough sleepers have been in the Armed Forces. This bald statistic shocks now just as it did five years ago.

So, what has happened since then? What have the Armed Forces done to stop ex-squaddies put their training to sleep rough into practice? Have the dozens of ex-Service organisations been able to weave an effective safety net? And does the homelessness sector even recognise someone's background in the Forces as a relevant factor?

Lest We Forget plugs this information gap and points the way ahead to close down, once and for all, one of the most well-recognised routes into homelessness.

Walk on By... Begging, Street Drinking and the Giving Age

Simon Danczuk

ISBN 1 899257 46 2 2000 34pp £7.50

Few issues spark controversy more than begging and street drinking. Should you give? Should you walk past? Should you feel guilty? Or scared? Or angry? When all is said and done, should people really think that they have the right to beg?

Drawing on interviews with hundreds of beggars and drinkers, and on dozens of case studies from all over Britain, *Walk on By* shows how new and imaginative thinking can be translated into lasting solutions both for the community and for the people literally helped off the pavements.

Homelessness and Loneliness – The Want of Conviviality

Gerard Lemos

ISBN 1 899257 43 8 2000 19pp £4.50

Homelessness is about many things – but it is isolation, loneliness and despair which perhaps leave the most damaging legacy. This report seeks to explore this overlooked area and proposes new ways to rebuild people's social networks through mentoring, befriending and family mediation. Ultimately it looks towards the establishment of 'the convivial life' as the key to any successful reintegration into society.

A Future Foretold – New Approaches to Meeting the Long-term Needs of Single Homeless People

Gerard Lemos with Gill Goodby

ISBN 1 899257 35 7 1999 48pp £7.50

This highly influential report states that homelessness is the symptom of a multitude of life problems rather than people not having anywhere to live. The author argues that, although homelessness is not a new phenomenon, its causes, characteristics and consequences change frequently and that work done by the Government, and voluntary agencies needs to reflect this changing landscape.

The authors argue that multiple causes can make homelessness a future foretold for some people. It makes recommendations to address the barriers currently facing single people in housing need.

Leaving Homelessness Behind – New Solutions for a New Age

Oswin Baker

ISBN 1 899257 41 1 1999 20pp £3.50

This booklet sets out Crisis' key pledges and proposals which could make homelessness a thing of the past. Through empowerment and the forging of links both between people and within support systems, Crisis believes that the next century can see us learning from the mistakes of the past.

Prevention is Better than Cure

Geoffrey Randall and Susan Brown

ISBN 1 899257 33 0 1999 54pp £6.50

Recently described by the Joseph Rowntree Foundation as “the key study on the prevention of homelessness”, this report is based on structured interviews with 120 homeless people. The authors explain the causes of homelessness and recommend a programme of measures aimed at reducing the risk of vulnerable people ending up on the streets. Examples include young people, those leaving the armed forces or prison and anyone experiencing mental health problems.



NEW SOLUTIONS PUBLICATIONS ORDER FORM

Please cut out or photocopy, complete and return (with your payment) to Crisis, Warwick House, 25/27 Buckingham Palace Road, London SW1W 0PP. Thank you.

	Crisis code	Quantity	Price	Total
Hidden Homeless series				
Hidden but not Forgotten	HBF/01/P/082	_____	£7.50	_____
New Solutions publications				
Trouble at Home	TAH/01/P/082	_____	£7.50	_____
Healthy Hostel	HHH/01/P/082	_____	£7.50	_____
Lest We Forget	LWF/00/P/082	_____	£7.50	_____
Walk on By	WOB/00/P/082	_____	£7.50	_____
Homelessness and Loneliness	HL/00/P/082	_____	£4.50	_____
A Future Foretold	FFT/99/P/082	_____	£7.50	_____
Leaving Homelessness Behind	LHB/99/P/082	_____	£3.50	_____
Prevention is Better than Cure	PBC/99/P/082	_____	£6.50	_____
			Sub-total	_____
Bookshop discount*				_____
Post & packing**				_____
I would like to make a donation to help Crisis' work				_____
			Total	_____

* Please take off 35% discount (25% on single copy order)

** Please add £3.00 post & packing for UK and £5.00 for overseas

Please debit my Mastercard/Visa/Amex/Switch/CAF Charity Card (*delete as appropriate*)

Card number / / /

Expiry date (mm/yy) / / Issue no. (*Switch only*)

Signature Date

OR

I enclose a cheque/postal order/charity voucher made payable to Crisis UK

OR

Phone the credit/debit card hotline on 0870 011 3335 with your order.

Title First name Surname

Organisation

Position

Address

..... Postcode

Telephone (*please specify: home/business/mobile*)

E-mail

I would like to receive a complete Crisis publications leaflet; you may alternatively call 0870 011 3335 to request one or visit the Crisis website at www.crisis.org.uk/publications

I would like to be included on Crisis' mailing list to be invited to its conferences (annual Innovations Fair etc)

I do not want to receive information about other Crisis publications.



HOME AND DRY?

Homelessness and substance use in London

Homelessness and substance misuse are two of today's most pressing social concerns. Both are clearly linked to social exclusion and are often closely associated with one another.

Yet despite this and the notable practical work that has been carried out there is still a serious gap in the knowledge base to guide service delivery and policy development.

Home and Dry? is an attempt to fill these gaps.

Home and Dry? explores the nature and causes of substance misuse and looks at some of the ways that we might begin to tackle these problems. Based on interviews with 389 homeless people and dozens of service providers it is a powerful and comprehensive piece of research, unflinching in its investigations, it has few qualms in drawing the necessary conclusions.

ISBN | 899257 50 0

£7.50



Crisis

Warwick House 25/27 Buckingham Palace Road London SW1W 0PP

Tel: 0870 011 3335 Fax: 0870 011 3336

E-mail: enquiries@crisis.org.uk Website: www.crisis.org.uk

Crisis UK trading as Crisis Charity No 1082947 Company No 4024938