Research into Homelessness and Substance Misuse

Deloitte MCS Ltd

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Acknowledgement

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1. EXECUTIVE SUMMARY

1.1 Background

The Information and Research Working Group, created under the Joint Implementation Model of the Drug and Alcohol Strategies, identified the need to conduct a province wide needs analysis of individuals who have an alcohol and/or drug problem where homelessness has become a feature. A Steering Group was appointed to oversee a research project exploring this issue, with representatives from the Department for Health, Social Services and Public Safety (DHSSPS), the Northern Ireland Housing Executive (NIHE), the Council for the Homeless and the NI Community Addiction Service (NICAS). Deloitte was appointed to undertake the research project in conjunction with the Simon Community.

The overall aim of the research is to provide a detailed account of substance misuse among homeless people that could be used to inform future prevention and treatment activities (detailed objectives are listed in Section 2.2).

The methodology for the research is set out in Section 3. In summary it involved the following activity:

- interviews with 154 homeless people recruited via 33 temporary accommodation providers across Northern Ireland;
- a survey of homelessness and substance misuse service providers;
- consultation with other stakeholders; and
- a literature review of policy context and good practice in the areas of homelessness and substance misuse.

1.2 Conclusions

Conclusions are detailed in Section 8.1 and the key points are summarised below.

1.2.1 Patterns of Substance Use

The research leads to the conclusion that substance misuse is a significant issue among homeless people in terms of both prevalence of use and dependency. Risk behaviours were associated with substance use and the incidence of mental ill-health among the population was high. The research also indicates that substance use is a factor in becoming homeless on one or more occasions and remaining homeless.

1.2.2 Review of Services

There is a requirement to address the range of services available to homeless people with problem substance use, both in terms of treatment and homelessness provision.

Homeless people strongly urged the need to improve substance misuse and homelessness services to better meet their needs in terms of the range and specialisation of services available, preventative services, information provided on services and the quality of support available from staff to deal with the joint problem of homelessness and substance misuse. A recurrent finding was that despite the prevalence of substance use, homeless people prioritised securing accommodation over addressing their drug and alcohol problem.

1.2.3 Policy and Strategy Issues

The issues of homelessness and substance misuse are not well integrated at a policy and strategy level, although there has been some evidence of effective integrated practice at operational level. A number of joint policy and working structures already exist which have a part to play in addressing this issue. However, a specific bridging mechanism is required to bring various strategies and structures together at a regional level and to identify and meet needs at a local level.

1.3 Recommendations

The primary recommendation is that the findings of this research and the issue of substance misuse and homelessness be disseminated widely and that an appropriate co-ordinated response to the problem be developed. Further detailed recommendations are set out in Section 8.2 and the key issues are summarised below.

1.3.1 Policy and Strategy

It is recommended that mechanisms be put into place to develop a regional strategy for an integrated housing, homelessness and substance use service, both from a preventative and reactive perspective. A possible model for the strategy is set out in Section 8.2.1. The suggested model involves a two-tier approach, with a Regional Strategy Group whose role is to set policy and oversee service integration, and four Area Groups whose role is to identify and meet local needs. In addition to the establishment of this model, reviews of existing strategies should also ensure that the issue of homelessness and substance use is given appropriate weight.

1.3.2 A Service Continuum

Feedback from homeless people through this research highlights a clear need to ensure that homeless people across Northern Ireland have access to a continuum of integrated services in relation to substance misuse and homelessness. This continuum should be appropriate to different groups with varying needs, and consistent with the 'good practice' identified in the literature review and the findings of this research.

1.3.3 Information and Prevention Services

Those in temporary accommodation need support to deal with substance misuse and its impact on both their health and their capacity to move into more permanent accommodation.

Information and prevention services must be designed to be more accessible to those in temporary accommodation, for example, through greater provision of outreach services, clinics in hostels and other on-site support.

Those under threat of homelessness where substance misuse is an issue also need support, and mechanisms should be put in place to ensure early intervention that prevents these individuals from becoming homeless. The role of primary health care, housing, police and other public services in providing early intervention services should be explored.

1.3.4 Training

It is recommended that steps be taken to ensure that those in accommodation services working with homeless people can access a programme of training in substance use issues. The training needs of those working in treatment services who may have contact with homeless people should also be considered and a regional programme of training or set of guidelines be delivered.

2. INTRODUCTION

2.1 Background

The Research and Information Working Group (created under the Joint Implementation Model of the Drug and Alcohol Strategies) identified the need to conduct a province wide needs analysis of individuals who have an alcohol and/or drug problem where homelessness has become a feature. A Steering Group was appointed to oversee a research project exploring this issue, with representation from the Department for Health, Social Services and Public Safety (DHSSPS), the Northern Ireland Housing Executive (NIHE), the Council for the Homeless and the NI Community Addiction Service (NICAS). Deloitte was appointed to undertake the research project in conjunction with the Simon Community. A launch event was held for the research in May 2003, attended by representatives of organisations across Northern Ireland that provide homelessness and substance misuse services.

2.2 Aim of the Study

The overall aim of the research is to provide a detailed account of substance misuse among homeless people that could be used to inform future prevention and treatment activities.

The objectives of the research were:

- to map out patterns of substance misuse among homeless people in Northern Ireland and in each of the four Health and Social Services Board (HSSB) areas;
- to analyse their involvement in risk behaviours that impact on health;
- to explore the backgrounds of homeless people and in particular to highlight risk factors that make them more vulnerable to substance misuse;
- to conduct a literature review to identify models of good practice and inform the provision of services;
- to examine homeless people's access to substance misuse information, prevention and treatment services and to consider gaps and 'blockages' that may exist within the existing system; and
- to outline a series of recommendations that will assist in bridging any gaps in current service provision and inform future developments.

2.3 Format of Report

This report sets out the results of the research project, the conclusions drawn and recommendations for future developments in services for homeless people with problem substance use. There are six further sections, detailing the following:

- **Section 3** provides details of the research methodology employed. The following are attached as appendices to the report:
  - copies of all questionnaires and interview guides;
  - details of the alcohol and drug dependency tests used;
  - a list of respondents to provider surveys;
  - a list of stakeholders consulted during the research;
- **Section 4** outlines the key policies, strategies and legislative mechanisms in place in relation to homelessness and substance misuse;
- **Section 5** provides the results of a literature review of good practice in respect of the issue under review;
- **Section 6** presents the research results in relation to the prevalence of substance use, dependency rates, risk behaviours and health impacts among the homeless people involved in the research;
- **Section 7** discusses the range of feedback from the research in relation to homelessness and substance misuse services including the views of homeless people, service providers and stakeholders; and
- **Section 8** presents the conclusions reached on the basis of the research findings and recommendations to inform development of services.

3. RESEARCH METHODOLOGY

3.1 Introduction

This section provides details of the methodology employed for this research. It outlines the steps taken to complete the research, namely the literature review, interviews with homeless people, surveys of providers and consultation with key stakeholders.

The research instruments and details of respondents surveyed and consultees are included in the appendices.

3.2 Context and Literature Review

A key objective of the research was to conduct a literature review to identify models of good practice which could be used to inform the provision of services in Northern Ireland. The review focused on models that aimed to address substance misuse and homelessness in the United Kingdom and Ireland in particular those considered to be most applicable in the Northern Ireland context. Full details of the literature review are provided in Section 5.

In addition, a range of source material was consulted to identify the policy context with regards to homelessness and substance misuse, and data was collated on the prevalence of substance use among other populations for comparative purposes.

3.3 Interviews with Homeless People

Interviews with homeless people were carried out in order to:

- understand their patterns of drug and alcohol use;
- seek their views on the information and services available to them;
- understand their needs, particularly in relation to alcohol and drug problems; and
- gain information to help plan future support to meet their needs.

3.3.1 Recruitment Methods

Deloitte in consultation with the Council for the Homeless developed a list of temporary accommodation providers that could be approached in order to recruit interviewees for the research. A sampling frame was drawn up prior to recruitment in order to ensure that a balanced sample was achieved. Factors considered were age, gender, location and family situation (i.e. whether single homeless or not).

A research team member from Deloitte directly approached each hostel and asked the hostel manager to help identify homeless people that would be willing to take part in the interviews. Hostels took various approaches to recruitment, including displaying posters about the research, asking for volunteers and directly approaching hostel residents. The sampling method was therefore self-selection.

A payment of £20 was made to each interviewee to acknowledge their participation in the research. With the exception of one hostel, payments were made directly to the interviewees. However, in the Ormeau Centre payments were

held by staff due to their concerns about resident's current chaotic substance use. In this case, staff made a commitment to each interviewee that they would jointly agree on how best to spend the money.

A total of 154 interviews were completed in 33 hostels during the period from November 2003 to April 2004.

3.3.2 Interview Structure

The interviews were conducted by trained researchers from Deloitte. Protocols were drawn up in advance for interviewers to follow and an information sheet was prepared to give to interviewees. This information sheet included commitments regarding confidentiality, information on the research and expectations of those taking part. The information sheet is attached at Appendix II.

Each hostel made a private room available for the interviews to take place, ensuring that it offered an adequate level of security for interviewers and interviewees. The majority of interviews were conducted on a one to one basis and lasted approximately one hour (in a small number of cases, two interviewees were present).

The full interview guide is attached at Appendix I. The issues discussed included the interviewees' experience of homelessness, alcohol and drug use, experience of accessing services, health, income and current needs. Background information was gathered on each of the interviewees in relation to gender, age, accommodation type, education, employment, income, training, contact with the criminal justice system, nationality, community background and ethnic origin. Appendix III provides details of this information. Section 5 and 6 discuss the interview results in detail.

3.3.3 The Research Sample – Key Characteristics

The following section provides key information about the 154 homeless people interviewed for this research.

Gender and Age

The gender balance of interviewees was fairly even with 53% being male and 47% female. Of those interviewed the majority (55%) were aged between 26 and 59 and 33% were aged between 18 and 25. Table 3.1 provides details of the gender and age range of those interviewed.

Table 3.1
Age and Gender (Number)

	16-17	18-25	26-59	60+	Total
Male	7	21	53	0	**81**
Female	8	30	31	4	**73**
Total	**15**	**51**	**84**	**4**	**154**

Household Type

Seventy-nine percent of those interviewed were living alone. Of these over 60% were male and 55% were aged between 26 and 59. Twelve percent (19 people) were living alone with children and most of these were female (10% of the sample

or 16 people). Similarly of the 8% (13 people) living with a partner and children, 10 were females. All of those living with children were aged between 18 and 59.

Table 3.2
Household Type (Number)

	Living Alone	Living alone with children	Living with partner and children	Total
Male	75	3	3	**81**
Female	47	16	10	**73**
Total	**122**	**19**	**13**	**154**

Accommodation Type

Table 3.3 outlines the types of accommodation that interviewees were using.

Table 3.3
Accommodation Type

	Number	Percentage
Direct Access Hostel	70	45
Move On Accommodation	26	17
Night Shelter	15	10
Private Rental	2	1
Other	41	27
Total	154	100

Note: 'Other' accommodation include bail hostels, probation hostels and other temporary accommodation.

The policy of each accommodation service in terms of substance use was also analysed to ensure that the sample was representative of wet (substance use allowed on the premises), damp (substance use by residents tolerated but not on the premises) and dry hostels (substance use by residents not tolerated). In some accommodation, resident's substance use was not monitored as units are self-contained and others had a mixed approach, depending on the needs of residents at any particular time. The following number of interviews were conducted in each type of accommodation:

- 50 interviews (32%) were conducted in 12 Dry hostels;
- 74 interviews (48%) were conducted in 13 Mixed/Damp hostels;
- 3 interviews (2%) were conducted in Wet hostels; and
- 27 interviews (18%) were conducted in other types of hostels (22 interviews in self-contained/unmonitored accommodation and 5 in a dry/mixed hostel).

Other Information

Additional information about the sample is detailed below:

- all interviewees had one or more sources of income and for 94% their source of income was social security benefits;

- 45% had no formal educational qualifications, but 36% had between one and five GCSEs;
- 64% had been unemployed in the last year and of these 32% had been unemployed for between one and four years;
- 44% did not currently have any legal trouble (i.e. on probation, awaiting court appearances etc.);
- 84% were from Northern Ireland;
- 57% were Catholic; and
- 99% were white.

3.3.4 Homelessness in Northern Ireland

The Northern Ireland Housing Executive (NIHE) records statistics on people presenting and those accepted as homeless in Northern Ireland. Between 2001 and 2004 homelessness rates increased for both those presenting as homeless and those found to be unintentionally homeless and in priority need by NIHE (awarded Full Duty Applicant (FDA) status). Table 3.4 outlines these figures.

Table 3.4
Homelessness Figures

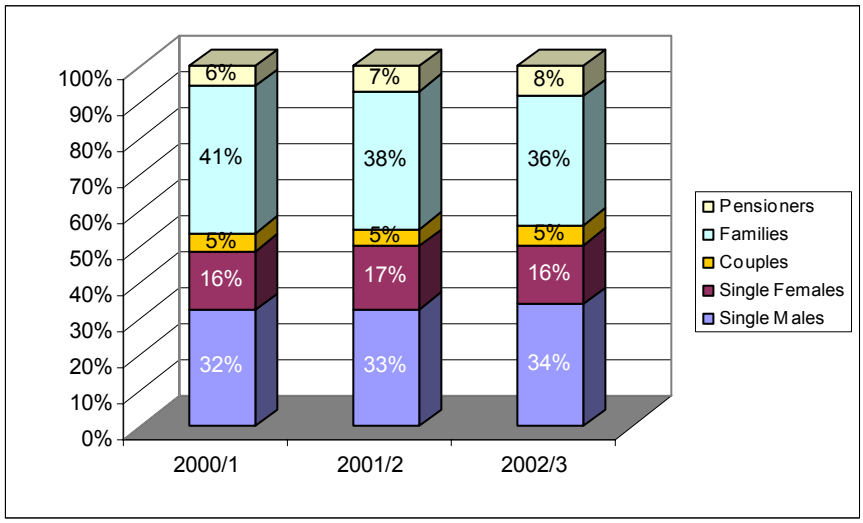
	2000/01	**2001/02**	*%*	**2002/03**	*%*	**2003/04**	*%*
Total number presenting	12,694	14,164	*+12*	16,426	*+16*	17,083	*+4*
Homeless (FDA)	6,457	7,374	*+14*	8,580	*+16*	8,594	*0*

Source: NIHE/Housing Rights Service

Of those presenting, the largest proportions each year are single people followed by families. In 2002/3 single people accounted for 50% of those presenting and families accounted for 36%[1]. In our sample, a larger proportion were single, but reasonable coverage of those living with partners and/or children were also included. Figure 3.1 provides details of the household types presenting to the NIHE between 2000/1 and 2002/3.

[1] In addition 5 % were couples, and 8 % were pensioners

Figure 3.1
Presenters by Household Type



Note: 2000/1 n=12,694; 2001/2 n=14,164; 2002/03 n=16,426
Source: NIHE/Housing Rights Service

Table 3.5 outlines the age ranges of those presenting to the NIHE in 2002/3 and provides a comparison with the age ranges of those interviewed. The figures indicate a similar age structure between the two sets of data, with homeless males more likely to be aged between 26 and 59, and homeless females between the ages of 18 and 59.

Table 3.5
Age Ranges (Percentages)

	16-17		**18-25**		**26-59**	
	NIHE (%)	**Interviews (%)**	**NIHE (%)**	**Interviews (%)**	**NIHE (%)**	**Interviews (%)**
Male	3	9	31	25	66	65
Female	11	12	44	43	46	45

Note: NIHE: male, n=5587; female, n=2692. Deloitte: male, n=81; female, n=69. Deloitte sample included 4 women aged 60+ who are not included in this analysis.
Source: NIHE/Deloitte

The geographic spread of homeless people presenting to NIHE in 2002/03 and of the research sample is outlined in Table 3.6. The information shows that, compared to the total number of individuals presenting for treatment, a higher proportion of the study sample originated from Belfast. However, each geographic area was well represented by the research.

Table 3.6
Geographic Spread (Percent)

	NIHE Presenters 2002/03 (%)	Interviews (%)
Belfast	22	47
South East	14	7
South	17	6
North East	25	13
West	21	27

Note: NIHE n=15,211, Deloitte n=154. The NIHE Presenters figures do not include those presenting from housing associations who accounted for an additional 1,218. The total number presenting as homeless in 2002/03 was therefore 16,429.

Source: NIHE/Deloitte

3.3.5 Measuring Alcohol and Drug Dependency

A key part of the interview focused on determining alcohol and drug dependency among the homeless people interviewed. For alcohol dependency the Alcohol Use Disorders Identification Test (AUDIT) was used and for drug dependency the Drug Abuse Screening Test (DAST) and Severity of Opiate Dependence Scale (SODQ) were used. Further information on these tests is provided below.

AUDIT

The AUDIT was developed by Babor et al (2001) for the World Health Organisation (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It provides a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. The AUDIT also helps to identify alcohol dependence and some specific consequences of harmful drinking.

The AUDIT was developed and evaluated over a period of two decades, and it has been found to provide an accurate measure of risk across gender, age and culture. The test consists of a series of 10 questions which measure three domains in relation to alcohol use. The questions are presented in Section C1 of the Interview Guide (see Appendix I) and the three domains are outlined in the table below.

Table 3.7
AUDIT Domains

Domains	Question Number	Item Content
Hazardous Alcohol Use	1 2 3	Frequency of drinking Typical quantity Frequency of heavy drinking
Dependence Symptoms	4 5 6	Impaired control over drinking Increased salience of drinking Morning drinking
Harmful Alcohol Use	7 8 9 10	Guilt after drinking Blackouts Alcohol-related injuries Others concerned about drinking

The AUDIT is scored as follows:

Each of the 10 questions has a set of responses to choose from, and each response has a score ranging from 0 to 4. An example of this is provided below.

How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never

(1) Monthly or less

(2) 2-4 times a month

(3) 2-3 times a week

(4) 4 or more times a week

The interviewer indicates the score corresponding to the response given. All scores are then added to provide a total.

Details of how the scores are interpreted are provided in Section 6.3.1.

DAST

The DAST is a screening instrument designed to identify individuals who have had a drug abuse problem (excluding alcohol) in the last 12 months. It was developed to provide a brief instrument for clinical screening and treatment evaluation research. The test covers the use of drugs, physical and medical complication, and emotional and personal problems arising from drug use in the preceding 12 months.

The original test contained 28 questions, but two shorter forms, the 20-item and 10-item versions have been developed. The 10-item version has been used in this project, as research has shown that it does provide highly correlated results to the original test.

The DAST is scored as follows:

- each of the 10 questions are either answered as "Yes" or "No"; and
- the total of the "Yes" scores provides the total score.

Details of how the questions and scores are interpreted are provided in Section 6.3.3.

SODQ

The SODQ is a five-section questionnaire designed to assess severity of opiate dependence, (Phillips et. al., 1987). For the purpose of this research we have adapted a series of questions from one section of the questionnaire to measure drug use in general among interviewees.

No cut-off point has been agreed for this scale, but the results provide additional information about the drug abuse and dependency of those interviewed.

3.4 Surveys of Providers

The survey of homelessness and substance misuse providers was carried out in order to:

- gather information on the patterns of substance misuse among homeless people using the providers' services;
- examine the range of substance misuse information, prevention and treatment services available through the providers; and
- explore providers' perceptions of any gaps in provision and identify any access issues.

3.4.1 Selection of Providers

Questionnaires were distributed by Deloitte to all organisations that provide homelessness and substance misuse services in Northern Ireland. These organisations were identified by research Steering Group members.

3.4.2 Response Rates

Questionnaires were distributed in October 2003 to 36 homelessness service providers and 22 substance misuse service providers. One copy of the questionnaire was issued to the lead contact in each organisation. Providers were free to respond on behalf of the organisation as a whole or to request additional copies of the questionnaire so that responses could be made by individual units.

Table 3.8 shows the number of responses received and Appendix VII provides details of the organisations returning completed questionnaires.

Table 3.8
Response Rates (Number)

Homelessness Service Providers	**Total**	**Organisations**
No Questionnaires Issued	41*	36
No Questionnaires Returned	45	19
Substance Misuse Service Providers		
No Questionnaires Issued	23*	22
No Questionnaires Returned	8	7

* additional copies of the questionnaires were requested by some organisations

Of the homelessness service providers that responded:

- 53% returned at least one questionnaire;
- returns from the NIHE and the Simon Community accounted for almost 62% of all questionnaires received; and
- 14 of the responses were from statutory organisations and 26 from voluntary organisations.

Of the substance misuse providers that responded:

- 32% returned at least one questionnaire; and
- four responses were from statutory organisations, three from voluntary, and one from a community organisation.

3.5 Consultation with Key Stakeholders

The aim of the consultation stage of the research was to discuss the issues of substance misuse and homelessness with stakeholders not involved in direct service delivery to these groups. A list of consultees was agreed with the Steering Group for the research and a discussion guide drawn up. These are attached in Appendices VIII and IX respectively.

4. REVIEW OF POLICY CONTEXT

This section sets out the policies, legislation and strategies relevant to the issues of homelessness and substance misuse. Recent changes are highlighted and comments are made on the degree to which the policy environment is co-ordinated across the two issues.

4.1 Homelessness

The contextual review below describes legislation in relation to homelessness, the patterns of homelessness in Northern Ireland, the NIHE Homelessness Strategy (2001), the role of the Promoting Social Inclusion Working Group and the changes introduced through the Supporting People programme.

4.1.1 Homelessness Legislation

As the regional housing authority for Northern Ireland, the Northern Ireland Housing Executive (NIHE) became responsible for a range of duties in relation to homeless households in line with the provision of the Housing (NI) Order 1988. This included the requirement to assess homeless applications according to the three "tests" set out in the legislation. In February 2003, the Housing (NI) Order 2003 amended the 1988 Order and introduced the requirement on the Housing Executive to determine eligibility for homelessness assistance.

Where an applicant is homeless, in priority need, and eligible for assistance, there is a requirement on the Housing Executive to provide temporary accommodation pending the completion of its enquiries. This duty also exists where the Housing Executive is making enquiries into homelessness, priority need and eligibility.

In line with the rules of its Housing Selection Scheme, the Housing Executive accepts a permanent housing duty to those applicants who are unintentionally homeless and in priority need, and eligible for assistance.

The aim of the above mentioned tests is to determine if the applicant is:

- homeless
- in priority need

} and eligible for assistance;

- unintentionally homeless.

The **official definition of homelessness** states that:

- a person is homeless if he has no accommodation available for his occupation in the United Kingdom or elsewhere; and
- a person shall be treated as having no accommodation if there is no accommodation which he, together with any other person who normally resides with him as a member of his family, or in circumstances in which it is unreasonable for that person to reside with him.

The definition also takes into account those who are:

- actually homeless – this would include anyone sleeping rough or anyone without shelter at that time;

- deemed to be homeless – this includes situations where the person has the right to occupy accommodation but it is not deemed to be reasonable to expect the person to occupy it – either because of disrepair or in cases of abuse; and
- threatened with homelessness – this includes people currently occupying their own accommodation but where it is foreseen that this situation will change within 28 days.

Having determined those cases where applicants are assessed as homeless, the NIHE identify those in priority need according to the legislation. The **priority need** groups are:

- pregnant women;
- dependant children (under 16 or under 19 if in full time education);
- vulnerable people e.g. due to old age, mental or physical disability or other special needs;
- people subject to violence;
- people under 21 at risk of financial or sexual exploitation; and
- households made homeless due to fire, flood or other disasters.

In applying the text of intentionality, the NIHE must consider if there is any information to suggest that an applicant has put themselves in such a position that homelessness is inevitable.

The 2003 Order allows the NIHE to deem applicants ineligible if they have been "guilty of unacceptable behaviour serious enough to make him unsuitable as a tenant of the Executive". The behaviour of other members of the applicant's household is also taken into account when making this assessment. Unacceptable behaviour relates to that which would entitle the NIHE to seek a possession order, including nuisance to neighbours, using premises for illegal or immoral purposes or damaging property. Guidelines have been produced by the Department for Social Development as to the implementation of the eligibility clauses of the new Order. These state that where an applicant's behaviour is due to a mental, physical or learning disability, the NIHE must first consider whether that person could maintain a tenancy if they had an appropriate package of care. If, following this assessment, an applicant is deemed ineligible under the legislation the NIHE will have no duty to find accommodation for that person.

Applicants meeting all three tests and deemed to be eligible for assistance are awarded Full Duty Applicant (FDA) status and the NIHE is required to secure temporary accommodation for that person. FDA status attracts an additional award of points on the Housing Selection Scheme used to rank applicants for permanent social housing.

However all applicants (homeless and otherwise) are assessed across a range of factors that determine their total points, so those meeting FDA status will not automatically have a higher ranking than other non-homeless applicants. Individuals may stay in temporary accommodation for some time if no suitable permanent accommodation is available. The location in which housing is available is often the main issue as regards suitability of housing.

Currently, there are 25 Housing Executive hostels which provide temporary accommodation to those meeting FDA status and a further 50 (approximately) voluntary sector managed hostels which provide additional temporary accommodation for those who are homeless but have not been awarded FDA status.

The Housing (NI) Order 2003 also sets out new arrangements for dealing with anti-social behaviour, including greater power for the NIHE to impose sanctions on tenants, including repossession. The Order has also introduced the concept of **Introductory Tenancies**, also designed to support the NIHE in dealing with nuisance behaviour. With effect from 1st April 2004, all new NIHE tenancies will be granted on a 12 month trial basis. During the introductory period, NIHE will have greater power to repossess than in a full tenancy scenario. It is likely that introductory tenancies will be implemented in Housing Association properties in the near future.

4.1.2 The Homelessness Strategy

The Housing (NI) Order 1988 sets out the statutory requirements with regards to meeting the housing needs of homeless households. However, the Order does not consider the causes of homelessness, how it might be prevented and the impact of homelessness on individuals, families and the wider society.

The NIHE's study '*Housing and Health, Towards a Shared Agenda'* highlighted the links between health and housing. It concluded that homelessness is one of the most extreme forms of social exclusion and that it can result in a significant negative impact on health.

The NIHE, along with the many other agencies seeking to tackle homelessness, was also concerned at the higher rates of homelessness in Northern Ireland compared to other parts of the UK and the rate at which these were increasing (see figure 3.1 in Section 3.3.4 for Northern Ireland figures). Around 50% of those presenting each year is awarded FDA status, with the NIHE not having a statutory duty to re-house the remaining households. The NIHE data showed that single people presenting as homeless were comparatively less likely to be awarded FDA status than families.

To address the growing concerns over homelessness, the NIHE initiated the Homelessness Strategy and Services Review in 2001. The review involved broad consultation across the statutory, voluntary and community sector organisations that have contact with homeless people. The review culminated in the publication of the Homelessness Strategy in September 2002.

An implementation plan was developed for the Homelessness Strategy, which also took account of the findings of the NI Audit Office (NIAO) investigation of the NIHE homelessness services (March, 2002) and the Social Development Committee's Inquiry into Homelessness (February, 2002). Both of these investigations made similar recommendations to the NIHE's Homelessness Strategy and Services Review.

The Strategy sets out a revised approach to tackling homelessness, which is based around three key strands i.e. primary prevention, the provision of high quality temporary accommodation with needs assessment and support requirements and the provision of "floating" support to help sustain tenancies and prevent recurrence

of homelessness. The Strategy includes recommendations to meet the needs of particular groups, namely:

- families and single parents;
- victims of domestic violence;
- young people and single homeless;
- those with physical disabilities and those with mental ill health or addictions;
- rough sleepers;
- people leaving the criminal justice system and people leaving care; and
- sex offenders.

In respect of those with mental ill health or addictions, the recommended actions are:

- to evaluate the Belfast Homeless Support Team Model (delivered by Extern) and its relationship to the proposed multi-disciplinary homeless needs assessment team to be developed by the NIHE;
- to develop more move-on accommodation as part of the supported housing programme to discourage the 'silting up' of temporary accommodation; and
- to introduce floating support to help people with addictions and/or mental ill health to sustain tenancies.

Underpinning the recommended service improvements, legislative changes, strategic developments and research activities, is the commitment to work collaboratively across the statutory and non-statutory sectors, and to involve service users and key stakeholders in service planning and projects. Homelessness Action Plans have been developed for each NIHE Area.

4.1.3 Promoting Social Inclusion Working Group on Homelessness

The Social Development Committee's Inquiry into Homelessness recommended that homelessness should be included in the New Targeting Social Need (TSN) action plans, as a Promotion Social Inclusion (PSI) target. To this end, an Interdepartmental Working Group was established at the beginning of 2003/04.

For the purposes of the PSI Working Group's Review, homelessness is defined as:

- anyone who is roofless, i.e. sleeping rough, newly arrived immigrants, victims of fire and flood;
- those who are houseless, including those in temporary accommodation;
- those in insecure accommodation, including staying with friends and squatting;
- those who are involuntarily sharing accommodation in unreasonable circumstances; and

- those threatened with homelessness, including those due to be released from prison, care or hospital with no home to go to, those faced with possession proceedings and those needing to leave accommodation due to relationship breakdown.

The objective for the group is to research the issue of homelessness and ways to address it, and to make recommendations for the development of a more strategic approach to tackling homelessness. The recommendations will go beyond 'bricks and mortar' issues, by considering the social factors that lead to and result from homelessness, considering the needs of particular groups and suggesting how access to health and social services can be improved for all those faced with or threatened with homelessness. It will build upon the recommendations of the NIHE Homelessness Strategy, the NIAO report and the Committee for Social Development's inquiry referenced above. Following public consultation on the report, it will be finalised for publication by the end of 2004/05.

4.1.4 Supporting People

The Supporting People programme was introduced in Northern Ireland on 1st April 2003. It is a national programme that aims to improve the planning, development and delivery of housing related support services to vulnerable people. The programme was introduced following a review of funding arrangements for housing and housing support across the UK. The review concluded that Housing Benefit should only cover the costs of accommodation (including rent, rates and service charges) and that housing support services should be met from another source. The Supporting People grant is now the source of funding for all housing support. The policy aims to meet the support needs of vulnerable groups including older people, those with disabilities, vulnerable young people, those with mental ill health, victims of domestic violence, those at risk of offending and those who misuse substances.

The key feature of Supporting People funding is that it is linked to the individual rather than their housing. Therefore, it moves with the user in the event that they change address or landlord. The intention is that this arrangement will give the individual more control over what type of support they receive and greater opportunity to live as independent a life as possible.

Housing Support is defined by the NIHE for the purposes of the policy as:

"any service which provides support, advice or counselling to someone with particular needs with a view to enabling that person to occupy or continue to occupy their home"

(http://www.nihe.gov.uk/supportingpeople/services.asp)

This can include support that helps individuals to maintain security in their homes (e.g. an emergency alarm system), support with developing life skills required for independent living, assistance in dealing with neighbour disputes and support in resettling from temporary to permanent accommodation.

An important distinction is drawn between the support services which are eligible for Supporting People funding and those which fall into the category of personal care and are therefore not eligible for Supporting People funding. Personal care involves physical support, for example help with washing, feeding and personal hygiene. Importantly, from the perspective of substance misuse services, personal

care also includes counselling to deal with drug or alcohol addiction or overcome mental health problems, including running group therapy sessions. Therefore, while some substance misuse services provided by homeless accommodation providers may be eligible for Supporting People, others will fall into the personal care category and will have to be funded from a different source.

4.2 Substance Misuse

The key framework documents in relation to substance misuse are the various policy and strategy documents issued by the Department for Health, Social Services and Public Safety (DHSSPS) and these are described below. In addition, the contextual review sets out details of the Misuse of Drugs Act as it relates to housing provision, and information on the aspects of the Community Safety Strategy relevant to substance misuse.

4.2.1 Department of Health, Social Services and Public Safety Strategic Objectives

The DHSSPS strategic mission is to improve people's health and social well-being. The Department's Corporate Plan 2002/3 to 2004/5 sets out its corporate values and the aims and objectives it hopes to meet. These objectives are underpinned by a range of strategies, the most relevant of which to substance misuse are set out in 4.2.2 to 4.2.3 below.

4.2.2 Investing for Health

Health improvement was identified as one of the Northern Ireland Executive's five overarching priorities under the heading "Working for a Healthier People". Consequently, it was decided to develop a cross-cutting strategic approach to health improvement – Investing for Health. The Investing for Health consultation paper was circulated in November 2000, and the final strategy was published in March 2002.

Investing for Health aims to improve the health of the population in general and in particular that of groups at greatest risk. It recognises that good health and well-being encompasses physical, mental and social well-being, and improved quality of life. The aim is to extend health policy beyond the traditional focus on ill health, by developing a broad ranging, preventative approach those results in people living longer and having an improved quality of life. The strategy seeks to give greater priority to the wider determinants, particularly social and economic inequalities, which cause poor health.

In relation to substance misuse, Investing for Health points out the costs to society of drug and alcohol use including:

- there are an average of 15 deaths per annum due to drug use and 730 deaths per annum associated with excess alcohol consumption;
- drug misuse is associated with crime, which affects both victims and the community and drug misusers have increased use of health and social services;
- costs attributable to enforcement, prevention, treatment and rehabilitation in relation to drugs are estimated at £8 million; and
- the cost to the economy of excess alcohol use is estimated at over £800 million.

Investing for Health sets the objective, "**To enable people to make healthier choices**". This encompasses a wide range of public health and health promotion issues, including support in relation to drug and alcohol use.

Investing for Health brings together a range of factors that impact on health and many of these are beyond the remit of the DHSSPS and the HPSS, for example, housing, environment, education and employment. Therefore a partnership approach is taken to implementation, including the establishment of Investing for Health Partnerships in each of the four Health and Social Services Board areas. These Partnerships comprise the key statutory, community and voluntary interests in the area together with the social partners with a role to play, including representation from the NIHE.

4.2.3 Drugs and Alcohol Regional Action Plan 2002

The joint implementation of the Drug and Alcohol strategies represents the integration of the Drug Strategy for Northern Ireland (1999) and the Strategy for Reducing Alcohol Related Harm (2000). It combines the action plans of six thematic working groups and four area-based local co-ordination teams under the model.

The 1999 **Drug Strategy for Northern Ireland** sets out four over-arching aims:

1. to protect young people from the harm resulting from illicit drug use;
2. to protect communities from drug-related, anti-social and criminal behaviour;
3. to enable people with drug problems to overcome them and lead healthy and crime-free lives; and
4. to reduce the availability of drugs in the community.

In relation to Aim 3, objectives include accessible treatment for drug users, provision of information on the effects of drug use and an approach that addresses the full range of drug users needs including health, education, employment and accommodation.

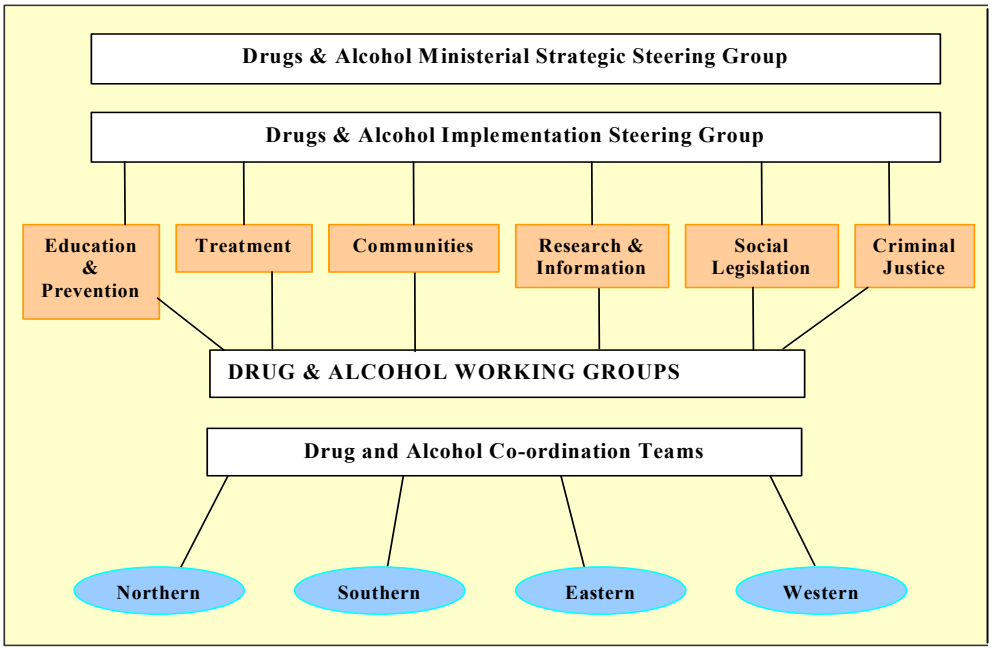
The Drug Strategy is underpinned by a number of key principles including partnership, co-ordination, information sharing, monitoring, evaluation, research, accountability and inclusivity.

The **Strategy for Reducing Alcohol Related Harm** was published in September 2000 and has the following objectives:

- to encourage the responsible use of alcohol through health promotion and education programmes, which will have particular emphasis for those groups identified as being most at risk;
- to promote and improve treatment and support services, ensuring they are effective, adequate to the real level of need in the community, and fairly available; and
- to protect individuals, families and communities from the anti-social and often criminal consequences of alcohol misuse.

The Model for the Joint Implementation of the Drug and Alcohol Strategies is shown diagrammatically in Figure 4.1. It includes ministerial and inter-departmental steering groups as well as Working Groups. These groups have a specific issue based remit and they are tasked with developing an action plan based on clear priorities within their area. The groups are Treatment, Education and Prevention, Communities, Research and Information, Social Legislation and Criminal Justice. The Treatment and Communities Working Groups have a remit that relates to substance misuse and homelessness.

Figure 4.1
Model for the Joint Implementation of the Drug and Alcohol Strategies



The Treatment Working Group is tasked with ensuring that the drug and alcohol treatment available is adequate to meet the population's needs and that services are accessible, flexible, effective, equitable and accountable. It also aims to minimise the public health impact of drug use.

The aim of the Communities Working Group is to support and promote community action to reduce the harm caused by alcohol and drug related anti-social behaviour. This includes addressing the broader needs of problem drug and alcohol users, including accommodation. It is also tasked with ensuring that effective partnerships are established to meet needs at a local level.

4.2.4 Section 8 of the Misuse of Drugs Act

The chief legislation with regards to use of illicit drugs in Northern Ireland is the Misuse of Drugs Act 1971, which controls supply and possession of controlled substances. Section 8 of the Act (amended in 2002) relates to drug incidents on premises, and has implications for agencies that provide services to people who are drug users. Section 8 means that it is an offence for an agency (for example a hostel) to allow the use or administration on their premises of a controlled drug. If staff of an agency know or could reasonably expect that someone on the premises is using illegal drugs, they will commit an offence if they do not act to stop them.

4.2.5 Review of Mental Health Policy

In October 2002 DHSSPS announced the start of a major and wide-ranging review of mental health policy and legislation in Northern Ireland.

The review involves a comprehensive evaluation of the Mental Health Order 1986, which includes provision for those with a learning disability. It also takes into account recent policy and other developments here and in the European Union, and addresses how best to provide services to people with specific mental health problems in accordance with the statutory equality obligations of the Northern Ireland Act 1998, with the Human Rights Act 1998, and to promote social inclusion. Equally the review considers how to promote positive mental health in society, analysing the relevance of key concepts such as community education, prevention and the promotion of mental health awareness. The review will undertake research to facilitate its work and will seek out exemplars of best practice which are available regionally, nationally and internationally.

4.2.6 Community Safety Strategy

Community safety means preventing, reducing or containing the social, environmental and intimidatory factors, which affect people's right to live without fear from crime and which impact upon their quality of life. The Criminal Justice Review recommended that a Community Safety Strategy be devised for NI, based on widespread consultation with criminal justice agencies, political structures, and the voluntary, private and community sectors. *'Creating a Safer Northern Ireland Through Partnership'* was published in March 2003. The aim of the strategy is to reduce crime and the fear of crime and it includes nine priority areas for action. Substance abuse is included as one of the priority areas, due to the number of seizures of illegal drugs in Northern Ireland and the impact of using substances on criminal activities, anti-social behaviour and road safety. The strategy commits to supporting the achievement of the aims and objectives of the Northern Ireland drug and alcohol strategies.

The strategy also recommended the development of new locally accountable structures to oversee crime prevention activities, chiefly, a Community Safety Partnership in each District Council area in NI. The aim of these bodies is to co-ordinate local efforts to meet community safety objectives by providing strategic, operational and project specific support.

A total of £7.5 million was made available to fund the implementation of the Community Safety Strategy, including a Challenge Competition for local community safety projects and the cost of establishing Partnerships in each district council area. Some of the successful projects funded under the competition focused on substance use and homelessness, for example, several diversionary and education programmes for young people and a day time rough sleepers outreach service.

4.3 Policy Integration

In Great Britain (GB) both the drugs strategy, *'Tackling Drugs to build a Better Britain', (1998)*, and the rough sleepers strategy, *'Coming in from the Cold, (1999)*, recognise the need to tackle the issue of substance misuse and homelessness. There are also statutory

requirements in GB to produce Health and Homelessness Strategies. Housing, health and social services are delivered according to local authority boundaries in GB.

The policy review above indicates that the situation differs in Northern Ireland. The drug and alcohol strategies do not have explicit objectives in relation to substance misuse among homeless people, although the Communities Working Group is tasked with considering the broader needs of this group, including accommodation. Various NIHE reports (e.g. the Homelessness Strategy, *'Housing and Health'*, Supporting People and NIHE Corporate Plans) highlight the impact of homelessness on health, and the Homelessness Strategy includes specific recommendations for individuals with addictions and/or mental ill health. In addition, initiatives have been introduced by various voluntary and statutory partnerships at local operational level to integrate approaches to meeting the needs of homeless people with problem substance use (see Section 7.4 for examples). However, the policy review above highlights that there has been limited integration of issues at a policy and strategy level. In particular, there is no specific strategy setting out the issues to be addressed, objectives and target outcomes in relation to homelessness and substance misuse. (The issue of policy integration is discussed further in Section 7.4.) The inconsistent geographical boundaries within which housing, health and social services are delivered also makes joint working across these sectors more difficult.

5. MODELS OF GOOD PRACTICE

5.1 Introduction

This section reviews research that focuses on models of good practice in addressing substance misuse and homelessness. The literature review focuses on research conducted within the United Kingdom and Ireland, exploring models considered to be most applicable in the Northern Ireland context. The literature reviewed included:

- primary research with homeless people that highlights their needs with regards to housing and treatment services, and recommends how best these needs can be met;
- case studies and evaluations of working practices that jointly address the issues of homelessness and substance misuse; and
- best practice guidelines developed for organisations that work with homeless people with substance use problems.

In the sub-sections below, the elements of good practice demonstrated within this body of literature are described and examples are given of projects where they have been put into practice.

The stakeholder consultation highlighted that there are a number of projects already in operation in Northern Ireland that are consistent with the good practice identified in the sub-sections below. Examples of such projects are provided in Section 7.4.

5.2 Providing a Range of Treatment and Housing Services

The Home Office and Office of the Deputy Prime Minster (ODPM) produced a strategy in 2002 for Drug Action Teams (DAT) in Great Britain to meet the drug treatment requirements of homeless people (Randall and Drugscope on behalf of Homelessness Directorate, 2002). Although the guidance is written for drug teams (i.e. without reference to alcohol) many of the recommendations are applicable to a broader substance misuse strategy for homeless people. The strategy is based on the premise that homeless people's substance misuse cannot be addressed without also addressing their housing problems:

"Housing should be seen as an integral part of successful drug treatment and rehabilitation"

(Randall & Drugscope, 2002)

The guidance sets out the range of homelessness and treatment services that should be provided to ensure that the needs of homeless people who also have a substance misuse problem are met.

It recommends that accommodation be provided to meet the needs of homeless substance users at each stage of their recovery. The following four tier model is set out:

1. night shelters and emergency accommodation – to meet immediate housing needs and provide a contact point with treatment services;

2. hostels with a continuum of substance misuse policies from wet to dry provision – this range should provide an entry point to 'the system' for those with substance misuse problems, enable access to harm reduction strategies and progression as individuals gain more control over their substance misuse problem and provide a safe environment for rehabilitation post-detox;

3. supported housing – more independent accommodation for those ready to move on from hostels, to ensure ongoing stability and prevent relapse. This provision may be short or long term depending on the client's needs, for example, individuals with a dual diagnosis may need long-term support; and

4. permanent housing with appropriate tenancy support. The guidance recommends that homeless people with substance misuse problems are assessed as vulnerable or that quotas are set so that individuals who have successfully reached this stage are less likely to relapse.

At each tier, sufficient places must be provided and movement along the continuum must be ensured to prevent 'silting up' of the system.

The guidance also includes a model for drug treatment services which intersects with the homeless services model. The four-tier treatment model comprises the following support services (we have assumed in the descriptions below that provision at each tier would be equally applicable to alcohol as to drugs):

1. Non-drug and Alcohol Specific Health and Social Services – including information and services in relation to primary care, social services provision and health promotion;

2. Open Access Drug and Alcohol Services – advice and information on substance misuse, harm minimisation (e.g. needle exchange), outreach services, assessment of needs, provision of support and motivational coaching/counselling;

3. Structured Community Based Drug and Alcohol Services – counselling, day programmes, community detox, community prescribing, aftercare support post-detox; and

4. Residential Services (a) Specific to Drug and Alcohol Use – including residential detox and rehabilitation units; (b) Non Drug and Alcohol Specific – including palliative care, specialist services in liver disease, HIV, forensic services.

In order to fully meet the range of needs of homeless people with substance misuse problems at each stage of their recovery, sufficient accommodation and treatment services must be available at each tier and must be co-ordinated to ensure progression and maintenance of gains made at previous stages.

5.3 Enabling Access to Services

Research on homeless people often finds that their knowledge of and uptake of services in relation to substance misuse is poor. For example, Crisis' research with street drinkers and beggars (conducted by Danczuk (2000) on behalf of Crisis) found that fewer than 50% of those interviewed had accessed drug services and 50% reported that they had never been approached by an outreach service. Those who had contact with services generally, whether through day centres, soup runs or arrest, reported that this contact tended to be a 'friendly chat' rather than any attempt to intervene more systematically. The research concludes that there are numerous opportunities to engage with homeless people (and street drinkers in particular) in relation to their substance misuse, health and housing needs. However these need to be used more effectively to provide information and to refer people onto appropriate services.

Key features of approaches that aim to improve access to services are that they:

- use all engagement opportunities with homeless people to intervene in respect of their substance misuse needs, e.g. contact with the police, emergency healthcare, soup runs, housing advisors etc;
- provide services on a flexible basis to enable ease of access, e.g. drop-in services and weekend/out of hours provision;
- treat homeless people as priority cases; and
- take services to the homeless people, e.g. outreach teams, satellite services and one-stop shop arrangements.

5.3.1 Cardiff Arrest Referral Scheme

Street drinkers often have contact with police, and the Crisis study recommends that arrest referral schemes be established to take advantage of this contact point. A partnership has been established in Cardiff between the local police and an initiative providing support to street drinkers. In this 'assertive outreach' model, the police act as referral agents to the initiative. If they come across a street drinker whom they deem to need substance misuse support, they will refer this individual to the support service rather than arresting them. Otherwise, the individual may be arrested or simply moved on without any support being provided.

5.3.2 **Turning Point Hungerford Project,** (Randall & Drugscope, 2002)

This project is led by the Turning Point drugs agency. It has developed links with mainstream services so that it can provide advice and information to a range of clients, including long-term homeless people. It has created formal partnerships with hostels, tenancy support and specialist treatment providers, which enables them to give an integrated response to homeless people with substance misuse problems.

The project aims to ensure homeless people can access substance treatment services and maintain treatment by providing:

- open access drop-in services which, facilitate harm minimisation, crisis intervention and advocacy;
- satellite services in homeless agencies;
- full assessment by a drug worker at entry to the project and development of a treatment plan; and
- a key worker model to encourage individuals to sustain their involvement in the project and complete their treatment plan.

The project hopes that this range of intervention will raise levels of motivation, increase stability, enable a wider take-up of substance misuse services and effect positive change in behaviour.

5.3.3 **Focus Housing,** (Randall & Drugscope, 2002)

This project was delivered by Focus Housing in the Midlands with support from the Rough Sleepers Unit (RSU). The agency was aware that rough sleepers had difficulty in engaging with mainstream treatment services which relied on appointments and group sessions. They aimed to address this issue by building strong client-worker relationships so that opportunities could be delivered rapidly at the point of need. The Rough Sleepers Unit provided funding for an outreach team to liaise with rough sleepers and encourage them to avail of treatment services. The range of services provided included harm reduction interventions, treatment, accommodation, support, detoxification and rehabilitation.

Evaluation of the project showed positive results. In total 31 people participated in the programme and there were twenty detoxifications. Six participants had completed the rehabilitation programme with a further nineteen reporting a reduced drug use. Five participants had reported no change and contact had been lost with the remaining seven participants. Of those who were sleeping rough at the beginning of the project only three remained so at the time of the evaluation. Eight people had been moved into temporary accommodation with a further five being placed in permanent accommodation.

5.3.4 **Soho Rapid Access Clinic (SRAC),** (Randall & Drugscope, 2002)

SRAC is located in London's West End. It is particularly aimed at rough sleepers and those in temporary accommodation who do not use the treatment services available to them. They aim to reduce the use of substances by offering access to detoxification facilities, as well as substitute opiate prescribing and assessments for rehabilitation funding. A drug worker is appointed to each individual and they work closely with the homeless person's various workers to try to establish stable accommodation and enable access to treatment.

The entire treatment period will last a maximum of 12 weeks after which time the homeless client will be transferred to a more long-term programme.

5.4 Providing Specialist Accommodation

Crisis carried out research with homeless people in 2002 to identify the links between homelessness and substance misuse and the services required to address the joint issue (conducted by Fountain & Halls (2002) on behalf of Crisis). There was a high level of drug use among the 389 homeless people interviewed. Although drug users were not targeted for the study, 4 in 5 (83%) had used a drug – excluding alcohol in the last month. In addition, 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 research found that (23%) of the total sample had been barred from accommodation services. Amongst those who were substance dependent 42% had been barred. Misuse of alcohol and the associated behavioural problems was the main reason for individuals having been barred. The 'dry' policies of many hostels effectively bar those with continuing addiction problems from accommodation. A negative perception of homeless people who also misuse substances is discussed in the research. For example, *'Room for Drugs – Guidelines for Direct Access Hostels'* (Flemen, 1999) highlights the need to challenge the view that there are 'undeserving' homeless people by attempting to broaden the range of accommodation developed specifically to meet their needs.

The literature review found several examples of specialist accommodation projects developed to meet the needs of homeless people with substance misuse problems. Examples of these are provided below.

5.4.1 De Paul Trust Wet Hostel, (Brooke, 2003)

This project set in Dublin provides a wet hostel for street drinkers and is operated by the De Paul Trust. The project houses 23 residents and has 17 staff with two volunteers. The project targets long-term street drinkers, most of who have been barred from other hostels. This group are unlikely to stop drinking but their drinking can be controlled and with sufficient support they may move into long-term supported accommodation. The project also deals with people who have poly-substance misuse problems, mental health issues, learning difficulties, serious physical health problems and other issues. Many of these people are living chaotic lives and while they may seek help with their substance misuse they are easily lost to the system. The working model for the project is to gain the user's trust, create rapport and make their lives a little easier. Once all of this has been established the staff tries to help them change aspects of their drinking behaviour.

Individuals must be referred to the project and there is no restriction on the duration of stay or number of times an individual can come back. The policy is not to bar anyone but to go through a process of re-referral when problems arise.

The project began in December 2002 and five months later the centre had 80% of its original residents still staying in the hostel. Any progress made with this client group will be made slowly. However, the lack of appropriate move-on accommodation in Dublin is also reported to be a problem.

As a result of the project, there have been health improvements for the residents, less use of accident and emergency services, greater use of primary healthcare services, and less contact with criminal justice system due to reduced anti-social behaviour.

5.4.2 Simon Residential Detox Facility, (Brooke, 2003)

This project is run by the Dublin Simon Community, which provides a detox facility for rough sleepers and other homeless people who find it difficult to access mainstream services. The facility is totally funded by the South Western Area Health Board (Republic of Ireland). Referrals to the facility are provided via outreach teams whose job it is to build relationships with homeless people and to help them access services. Once an individual requests to engage in a detox programme the outreach workers start the assessment process and carry out an in-depth assessment that looks at drinking patterns and treatment history, as well as questions about housing and health. Having accessed the service an individual can stay for a maximum of three weeks. The project has 24 hour nursing cover with a visiting GP service on a daily basis. The service aims to:

- offer respite from the street and to bring some stability;
- manage alcohol withdrawals (seven day detox regime);
- offer a further 14 days respite complete with a group programme;
- key working and individualised care plan;
- identify move-on options (treatment and accommodation); and
- discharge in a planned way.

The service to date has been successful and over 70% have completed the programme. However, after they leave many drink again due to the limited availability of supported move-on accommodation. A residential project to support individuals post-detox was opened in September 2003 and will accommodate people for up to three months. The approach used is the Community Reinforcement Approach (CRA), which acknowledges the powerful role that an individual's environment plays in encouraging or discouraging drinking. It originated in the United States in the 1960s and 70s as a model of treatment for people with alcohol or drug dependence.

It is based around the philosophy that in order to overcome alcohol problems, it is important to initiate changes to lifestyle and social environment so that abstinence is more rewarding than drinking. CRA has not been widely used, despite research showing positive outcomes.

5.4.3 Proposed Model for Specialist Accommodation in Dublin

Dublin Simon Community in partnership with the Merchant's Quay Project, proposed a model for providing direct access hostel accommodation in Dublin, for people who are sleeping rough and using drugs.

The organisations sought to establish accommodation which:

- would not discriminate against clients on the grounds of drug use and would provide a high level of care for residents;
- would have a target group of people (over 18) sleeping rough and using drugs;
- a psychiatric nurse and a drugs worker would be part of the outreach team;

- a needle exchange service should be provided and facilities for safe use, storage and disposal of injecting equipment;
- regular twice weekly visits would be made by a doctor and psychiatric nurse to address the health needs of residents; and
- a drugs worker and a nurse would be working on-site 24 hours a day.

The organisations are no longer taking forward this project due to other service developments in Dublin, but they would still endorse the model as best practice.

5.4.4 **Birmingham Prime Focus,** (RSU, 2001)

This centre is designed for single homeless men with complex needs. It provides single, self-contained rooms with 24 hour support and the opportunity to access substance misuse treatment services. Referrals to the centre are made by probation, primary healthcare providers, community mental health workers and Community Addiction Teams.

5.4.5 **The Oxford Drugs Recovery Project,** (Randall & Drugscope, 2002)

This project was set up through funding received from the Rough Sleepers Unit. It is now financed by the local Drug Addiction Team (DAT) and Supporting People and managed by English Churches Housing Group (ECHG).

The project is backed by the local police and city council and its aim is to provide specialist supported housing for rough sleeping drug users in Oxford with medical support being provided by a medical centre. It recognises that moving into accommodation is a very daunting step to take even before detoxification and counselling.

The project requires abstinence with the residents able to stay for a maximum of six months and receive a medically supervised detoxification. There is also a full timetable of group work, one-to-one counselling, and therapeutic duties as well as a relapse loop whereby those who relapse are quickly able to access to project.

The implementation of this project has resulted in the number of rough sleepers in Oxford drastically declining. So far, thirty-one individuals have participated on the scheme. Of these twelve have moved onto rehabilitation and ten have moved into permanent housing.

5.5 Developing Joint Strategies

The guidance produced by the Homeless Directorate (Randall & Drugscopes, 2002) recommends that DATs plan substance misuse services for homeless people jointly with the agencies providing homelessness services, but that services are funded from DAT sources. The strategies developed in each local area should be consistent with other local strategies for:

- homelessness;
- supporting people;
- community safety;
- health; and

- regeneration/development.

The strategy sets out recommendations as to the respective role of accommodation service providers and treatment service providers in terms of addressing the joint issue of homelessness and substance misuse. While primarily focusing on the housing needs of their clients, homelessness agencies should support substance misuse services by:

- providing information and advice on substance misuse and services available to their clients;
- supporting harm reduction, e.g. through provision of needle exchange service and sharps bins, or through allowing drinking on premises;
- developing close relationships with treatment agencies and making appropriate referrals; and
- supporting clients through their substance misuse treatment.

Guidelines produced by Drugscope (2001) made similar recommendations for the role of accommodation providers in supporting clients with drug misuse. It also recommended that accommodation providers should screen for drug use among their clients as a basis for making appropriate referrals and managing clients' behaviour while resident.

This input requires training for housing services staff to deal with and assess drug and alcohol problems, including the legal aspects of drug use on the premises. Research conducted by Cox and Lawless (1999), on behalf of Merchants Quay, Ireland also highlighted the need for training among homelessness workers in relation to drug and alcohol issues. Joint measures should be put in place between homelessness and treatment service providers to facilitate appropriate training and also to develop information sharing protocols, joint service planning and commissioning, and joint intervention/referral mechanisms.

Models of effective joint working between homelessness, treatment and other service providers are described below.

5.5.1 Joint Work in Nottingham, (Randall & Drugscope, 2002)

Nottingham City Council has a rough sleepers' strategy that feeds into the local homelessness strategy. This has created the framework for joint work between partners and to establish common tools for assessment and referral protocols between the various agencies, including medical services.

The aim of the harm reduction strategy is to create a more settled lifestyle for the drug misuser and to achieve this drug use by the misuser is managed rather than abstinence forced on them. Services include access to primary care, needle exchanges, safer injecting advice and information. It also provides a range of specialist hostels for all including substance misusers.

Since the inception of the strategy, the number of rough sleepers has decreased with a high proportion being rehoused and receiving specialist substance treatment. The reasoning behind the success of the project is that the issue of housing is tackled allowing the focus to then change to tackling the drug use.

5.5.2 **Improving Partnership Work in Manchester,** (Randall & Drugscope, 2002)

The aim of the project was to improve working partnerships between statutory and voluntary agencies in the Manchester area to ensure that a fully co-ordinated strategy was in place to meet the treatment and accommodation needs of clients.

Daily liaisons take place between agencies so that each agency is able to react and deliver services at short notice and on the streets. Formal joint working protocols were put in place so as to ensure that the co-ordination between the groups continued even if key members of the project moved on. Protocols were also required due to the higher than expected resource requirements placed on agencies involved in the joint strategy.

A Drug and Alcohol Specific Grant was received which uses pre-existing services with a range of agencies working together to help target key individuals. The grant allowed the cost of beds in temporary accommodation to be underwritten, which facilitated an easier route for homeless people into accommodation. This enabled substance users to stabilise their drug use and resulted in a greater use of outreach services.

From this many were directed to harm reduction services, which has had a dramatic impact on the well being of users prior to moving on to treatment.

5.5.3 **Newcastle Homeless Liaison Project,** (RSU, 2001)

The statutory and voluntary homeless agencies in the city came together to jointly address access issues and promote uptake of treatment and other health services by homeless clients. The project resulted in:

- the development of a clearing house for all beds in the city with a single contact point;
- a database of all provision available and patterns of uptake to highlight pressure points and assist in targeting funding;
- a co-ordination forum to allow joint training and policy development between agencies; and
- the development of 'one-stop hostels' providing emergency accommodation and staffed on a 24 hour basis with teams including social workers, GPs, health visitors, psychiatric nurses, housing advisors, drug workers and education advisors.

5.5.4 **Southampton Ban Review Policy,** (RSU, 2001)

In Southampton a joint protocol has been developed to ensure that individuals are not forced to sleep rough due to being banned from all housing in the area. Information is shared on individuals who have been banned and in cases where multiple bans are in place, multi-agency reviews take place to ensure that accommodation is provided.

5.5.5 **Sharing Data – Southampton's Regional Recording System,** (RSU, 2001)

The chaotic lifestyles of homeless people with substance misuse problems can make it difficult for service providers (both housing and treatment) to maintain relationships with clients, ensure that they continue to receive appropriate services

and to reduce duplication of effort. To counteract this problem, Southampton City Council developed a Regional Recording System – a database to track contact between services and homeless people.

The database holds information on referrals and uptake of services, including accommodation and treatment. The system uses coding and informed consent to ensure client confidentiality.

5.6 Attempting to Prevent Homelessness due to Substance Misuse

The Rough Sleepers Unit published a manual in 2001 setting out strategies for preventing rough sleeping (*'Preventing Tomorrow's Rough Sleepers',* RSU, 2001). Although not specific to cases where substance misuse is a feature, the strategies proposed offer potential ways in which a range of problems that may lead to homelessness may be addressed. Substance misuse could be one such problem, for example, the Home and Dry study (Fountain & Howes, 2002) found that 63% of respondents used a substance. Thirty-six percent of these reported that alcohol was the main reason for their homelessness and 50% reported that their drug use was the main reason for their homelessness.

5.6.1 Manchester Tenancy Support Service, (RSU, 2001)

The aim of the project was for the Council to be able to identify and address tenants' needs through multi-agency working and to maximise independence. This was implemented through the creation of partnerships between housing, social services and the health authority. The tenancy support team liaise with the Anti-Social Behaviour Unit and Neighbour Nuisance Department to identify individuals who appear to need support. The team's role is to liaise with those individuals to help resolve whatever issues they have and thus prevent homelessness. The outcome of the project is that the Council is now better able to identify and target people who need support to ensure that they do not end up in a housing crisis. This has reduced the reliance on crisis intervention services.

5.6.2 Westminster Support Scheme, (RSU, 2001)

A similar model is in place in the Westminster area of London, where the housing authority will refer all cases of anti-social or nuisance behaviour among its tenants to a support team, unless an existing care package is in place. The support team liaise with the tenant to explore the root cause of their behaviour and to link them to appropriate support agencies.

5.7 Follow-on Support

As described in Section 4.2, a continuum of services is required to help homeless people with substance misuse problems to progress as far as possible towards fully independent living. In order to reduce the likelihood that those who have successfully completed treatment will relapse, the sense of stability provided by temporary accommodation must be maintained through the resettlement period. Floating support aims to address this need.

The floating support model is based on the assignment of a key worker to each client, who continues to provide them with support irrespective of where they live. This provides continuity of support for those moving from hostel accommodation into support accommodation and on into independent housing.

5.7.1 **Private Sector Floating Support in Bournemouth,** (RSU, 2001)

Implementing floating support assumes that those in temporary accommodation can find permanent accommodation, either in public housing or the private sector. Hostel residents' financial situations often make the private sector an unrealistic option and there is no guarantee that public housing stock will be available to meet their needs. Bournemouth Housing Association's floating support model tries to address the lack of permanent housing options by involving the private rented sector. In this scheme, private landlords are encouraged to let their properties to tenants who need additional support. A rent deposit facility is provided and the housing association provides ongoing support for both the tenant and the landlord. If problems arise, mediation support is provided. Around 750 former hostel residents have been re-housed through the scheme.

5.7.2 **Brighton and Hove Tenancy Sublet Scheme (Home Office),** (Randall & Drugscope, 2002)

This scheme is a partnership between Brighton City Council, Southdown Housing Association, Brighton Crime Reduction Initiative and Hove YMCA. The scheme is preventative in nature, identifying vulnerable tenants who are nominated by the City Council's Special Needs Housing Officer.

Some of its objectives are to reduce tenancy breakdowns and cycles of homelessness and to reduce the numbers of homeless people in bed and breakfast accommodation. It also aims to alleviate isolation and support moves into independent tenancies by leasing flats and bed sits to the Housing Association which issues assured short hold tenancy agreements. Each tenant has a housing support plan to identify the support needed.

The scheme is reviewed every quarter with Individual tenants being reviewed every six weeks by the Homeless Resource Team, Southdown Housing Association and the support provider.

5.8 Key Elements of Good Practice

Consistent themes were present throughout the literature as regards good practice in addressing the substance misuse needs of homeless people. The key elements of good practice are:

- developing integrated, area-based strategies to address the needs of homeless people where substance misuse is an issue, and pulling together a range of funding mechanisms to deliver them;
- developing joint working protocols between agencies, and training workers in homelessness and treatment provision in the particular needs of the group concerned and how best to address them;
- providing a continuum of co-ordinated accommodation and treatment services that reflect the needs of those with substance misuse problems, from current active use through to harm minimisation, active treatment, rehabilitation and beyond;

- ensuring that services are accessible to the target group by making mainstream services more flexible, using all available opportunities to intervene, bringing services to homeless people and providing specialist residential services that meet both housing and addiction needs; and
- intervening to prevent homelessness due to substance misuse by engaging with individuals when problems first arise.