

Knocked back:

Failing to support people
sleeping rough with drug
and alcohol problems is
costing lives

[Full research report](#)

St Mungo's
Ending homelessness
Rebuilding lives



“The cycle of constantly scoring and drug use, and missing appointments, this is something that needs to be addressed...because at the moment, there are so many users waiting for such a limited service, that if you don’t attend one appointment, you get knocked back to the beginning. You are made to jump through hoops to prove you’re ready for this, and it’s like a revolving door... I must have gone to maybe 20-25 appointments in the last two months, and I’ve only achieved script and support once out of those 25 appointments, and I still haven’t achieved housing. I’ve got nothing to show for six times at the council, four times at the Jobcentre, nine times [at the drug and alcohol service], I’ve got nothing to show for any of it, because I can’t stick to appointments...

My God, I don’t have an alarm clock, I don’t have a diary, I don’t have a phone, I don’t have any way to even know what day it is some days...”

Greg, currently sleeping rough

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I. Foreword

I have seen first-hand the issues explored in this research.

I'm a service manager working with people sleeping rough in Bournemouth, Christchurch and Poole. At work I see the close relationship between rough sleeping and drug and alcohol problems, the impact of cuts on getting people the right support, and the lives that are lost along the way.

But I also know it because I have lived it. I spent five years homeless, living for months on a makeshift bed in the woods, going down to the garage at the end of the road to get my alcohol. I was arrested, sectioned, ordered to get treatment many times – but nothing seemed to work.

Eventually I spent 13 months in a local authority rehab and began to rebuild my life, volunteering with people who were homeless. I went on to work in drug and alcohol services, before taking on the role as service manager of the Bournemouth outreach team.

I know I'm far from alone in my experience. I manage a 17-person strong local outreach team, and around half of them have experienced homelessness. This gives me and my team the resolve and the insight we need to do our jobs effectively. Last year, we worked with 554 people and helped nearly 300 people come off the streets. Services save lives.



This is such a vital issue, yet often stigmatised and misunderstood.

But we're coming up against it, and too many people are going without the treatment, support and housing that they need. That's why I was so pleased to be involved in this research project. I helped St Mungo's researchers speak to people sleeping rough and people working in services.

This is such a vital issue, yet often stigmatised and misunderstood. I have worked in homelessness services and drug and alcohol services, and I have experienced both homelessness and drug and alcohol problems. I know how closely related those experiences are, and how difficult it can be to navigate a stretched and under resourced system. When it works people's lives are transformed, but when it fails, people lose everything and some pass away – as the shocking figures on drug and alcohol related deaths among people sleeping rough shows.

I've been sober nearly 11 years. I drive home to my wife, my stepchildren and my dog – and I've never been happier. I want to help others to be able to rebuild their life like I did. I recently ran into a person who was homeless at the same time as I was and he said, "I'm incredibly proud of you." He's still begging, but said I'd given him hope.

But hope will only get you so far – the services and support need to be there. That is what I hope anyone takes from reading this report.

Andrew Teale

Previously slept rough, now Service Manager for the Bournemouth, Christchurch and Poole Street Outreach Service

2. Acknowledgements

This research would not have been possible without input from a wide range of people sharing their professional and personal experiences, from a diverse mix of different sectors and backgrounds.

We commissioned Expert Citizens C.I.C to undertake a portion of the qualitative research in Stoke-on-Trent. We would like to thank them for their work, and the value that their peer researchers – who have experience of many of the issues raised in this project – added to this project.

We would also like to thank individuals from the wider drug and alcohol, homelessness and public health sectors who fed into the research at various points, including Director of Collective Voice Oliver Standing, former practitioner and academic Ira Unell, and individuals from Turning Point, Addaction, Cranstoun, Making Every Adult Matter (MEAM), Homeless Link, and the Association of Directors of Public Health. Thank you also to each of the drug and alcohol service managers who responded to our survey.

We would like to thank a wide number of St Mungo's staff for their input and expertise, and help with facilitating the research. Those in client-facing services who we worked with closely include Andrew Teale, Tiffany Day, Ed Addison, Lindsay Rushforth and Jill Thursby. We would also like to thank Andy Mills, Rita Martins, Stephanie Ratcliffe, Andrew Casey and Gemma Goacher for their specialist expertise in this area. Thanks to Kristian Hasler, David Wilson and Lucy Holmes for support with fieldwork and research.

Finally, we would like to thank St Mungo's clients – including Outside In – for their input throughout, as well as those who shared their personal stories.

Authorship

The lead author for the report was Rory Weal, Senior Policy and Public Affairs Officer at St Mungo's.

3. Executive summary – the public health crisis today

With record numbers of people living with, and dying of, preventable drug and alcohol problems on the streets of England, we should see the issue as a public health crisis.

The research found:

A growing problem, leading to more deaths on the streets

- Drug and alcohol related causes are the biggest killer of people sleeping rough or in emergency accommodation, accounting for 380 out of 726 deaths in 2018. Deaths caused by drug poisoning have increased dramatically – 55% in just one year (2017 - 2018).¹
- There is a growing number of people sleeping rough with drug and alcohol problems facing a wide range of serious health impacts. Six in 10 people sleeping rough in London in 2018-19 had a recorded drug or alcohol problem, an extra person in every ten compared to only four years previously.
- The problem is growing fastest among groups that were less likely to be affected in the past, with drug and alcohol needs among women rising at a particularly shocking rate (65% rise in women sleeping rough in London with drug and alcohol problems since 2014-15).
- In most cases, drug and alcohol problems develop before someone first sleeps rough, the product of traumatic experiences in people's lives. This makes it harder for people to move off the streets.
- Rough sleeping compounds previous trauma, and pushes people into more dangerous situations and towards riskier behaviours.

“You’re so vulnerable because you’ve lost all your power. Being on the streets, being homeless and being on some form of substance, whether it be alcohol or drugs... You’re just very vulnerable, you know. You’re not safe. It’s horrible.”
Nicole

¹ Office for National Statistics (2019), *Deaths of homeless people in England and Wales 2018*
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018>

Thousands going without life-saving treatment and support

- An estimated 12,000 people sleeping rough or at risk of doing so went without vital drug and alcohol treatment in England last year.
- Many who can access treatment are pushed between ‘pillar and post’, with high expectations and frequent exclusions. Many drop out or fall between the gaps.
- Particular groups experience stark disadvantages in accessing treatment, particularly people with ‘no recourse to public funds’.
- Drug and alcohol treatment services have a vital role in providing treatment for people sleeping rough, but spending on them has been cut by a quarter on average since 2015-16.²
- Half of drug and alcohol services in the areas with the highest levels of rough sleeping say it will get harder to support people sleeping rough over the next two years.
- These problems are compounded by cuts to other services, such as mental health, criminal justice and homelessness services. A lack of appropriate and affordable housing makes reducing harm and building recovery extremely difficult to achieve.

With the right support lives can be saved and turned around

- The Department of Health and Social Care should ensure that funding for drug and alcohol treatment is protected and increased, while also establishing a ‘rough sleeping and substance use personalised fund’ to meet immediate needs regardless of local connection or immigration status.
- National and local leaders should ensure services work better with the most vulnerable groups, by encouraging new trauma-informed approaches, shared ‘distance travelled’ outcome measures, and the provision of a greater number of specialist multi-disciplinary services providing integrated support.
- The government should make a clear commitment to end deaths on the streets over the next five years, backed up by an independent national programme to review trends, make recommendations and hold agencies to account.
- These efforts must be part of an updated cross-government strategy to meet the commitment to end rough sleeping by 2024. The strategy should recognise rough sleeping as a public health crisis, and set out a plan for providing the right integrated pathways of housing, treatment and support.

The link to the full research report can be found [here](#).

² Camurus UK (2019), *Towards sustainable drug treatment*, see also IPPR (2019), Hitting the poorest worst? How public health cuts have been experienced in England's most deprived communities <https://www.ippr.org/blog/public-health-cuts>

4. Introduction

Last year, it was revealed that the number of people dying while homeless was at a record high, driven overwhelmingly by drug and alcohol related deaths. In this report we explore fully the relationship between rough sleeping and drug and alcohol use, prevalence, and its impacts. We look at the services available and identify what needs to change.

St Mungo's has previously produced pieces of research and campaigns to highlight the dire health outcomes faced by people sleeping rough. Our reports *Homeless Health Matters* (2014),³ *Stop the Scandal* (2016)⁴ and *Dying on the Streets* (2018)⁵ have all highlighted the dangers of rough sleeping. This has supported the work of other charities and campaigning groups to highlight the close links between rough sleeping and serious health and support needs.

We have seen progress in some of these areas. In 2018 the Government published a cross-government Rough Sleeping Strategy, with clear commitments from the health system.⁶ In consequence, the NHS Long Term Plan saw commitments to tackling the health inequalities faced by people sleeping rough, with greater requirements on health services to deliver for this group, as well as new funding for specialist mental health services.⁷ All of this is positive and welcome reform, the product of campaigning and advocacy from a wide range of voices.

But in the wider context these are short-term changes affecting individual parts of the system. Much more needs to be done to ensure a wider range of support is available in the right place at the right time. People sleeping rough often experience so-called 'multiple disadvantage', interacting with a range of

mental health, drug and alcohol, criminal justice, social security and housing services. They have disproportionately experienced adverse childhood experiences and compound trauma which impacts their capacity to engage with mainstream services.

Any recent progress comes in the context of years of spending cuts across the board, affecting a wider range of these services and systems upon which people sleeping rough disproportionately rely. Spending cuts to drug and alcohol services, prisons and probation, welfare benefits, and housing related support have reduced capacity across the board. The added ingredient of localism for some of these services has created huge regional variation in what is available – some areas have developed innovative practices which have somewhat mitigated the impact of spending cuts, but many have retreated into silos, addressing single needs in a less flexible manner than they once could.

This has created a catch 22 where more people have fallen through the safety net and are sleeping rough, which in turn is making it harder for services to now work with an even more vulnerable – and more expensive – group of people than ever before.

This research shines a light on one part of the puzzle where these problems are particularly pronounced – services which support people with drug and alcohol problems. Out of all the needs that people sleeping rough face, substance use is perhaps the most stigmatised and sensationalised – meaning that service provision has been reduced without public fanfare. This has had a devastating impact, including a significant rise in the number of people dying on the streets.

³ St Mungo's (2014) *Homeless Health Matters* <https://www.mungos.org/app/uploads/2017/07/Homeless-Health-Matters-The-Case-for-Change.pdf>

⁴ St Mungo's (2016) *Stop the Scandal* <https://www.mungos.org/publication/stop-scandal-investigation-mental-health-rough-sleeping/>

⁵ St Mungo's (2018) *Dying on the streets* <https://www.mungos.org/app/uploads/2018/06/Dying-on-the-Streets-Report.pdf>

⁶ MHCLG (2018) *The rough sleeping strategy* <https://www.gov.uk/government/publications/the-rough-sleeping-strategy>

⁷ NHS (2019) *The NHS Long Term Plan* <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>

This research hopes to build the evidence base in an under-investigated area, to prompt wider conversations about improving the system upon which the most vulnerable rely.

The aim of this report is simple – no more deaths should be required to force the change we need.

4.1 Methodology

For this research, we sought the experiences of people who have slept rough with drug and alcohol problems, as well as those working in drug and alcohol and homelessness services. To do this, we used mixed methods at different scales and in different regions of England.

Rough sleeping vs homelessness

Our research focused on people with experience of 'rough sleeping' as distinct from homelessness more broadly. Rough sleeping is the most dangerous form of homelessness and evidence suggests people sleeping rough are more likely to experience drug and alcohol problems and the most serious associated harms as a result – including death.

Investigating how services work for the most excluded has benefits far beyond this group. We have embraced the spirit of the Government's Design Manual which says, 'when you design with groups who tend to be excluded in mind, you often end up helping everyone.'⁸

We used the definition from the Ministry of Housing Communities and Local Government, which includes:

- People sleeping, about to bed down or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments)
- People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes').⁹

This excludes other forms of homelessness, including people in hostels or shelters, people 'sofa surfing' with friends or family, or people in local authority temporary accommodation. Many people move between rough sleeping, hostels, and sofa surfing. As a result, when we talk about people 'with experience of rough sleeping', this will often overlap with many people experiencing wider forms of homelessness, but this is not the primary area of focus.

When we spoke to people working in drug and alcohol treatment services, we used their definition of 'urgent housing problem / no fixed abode', which covers a slightly wider group of people:

- Lives on streets / rough sleeper
- Uses night shelter (night-by-night basis) / emergency hostels
- Sofa surfing / sleeps on different friend's floor each night¹⁰

These groups are still among the most 'acute' forms of homelessness, and this definition does not include staying with friends and family, B&Bs, hostels or temporary accommodation. However, by covering short term sofa surfing this widens the client group and this inconsistency should be recognised.

⁸ Gov Design Community (2018) *Making your service more inclusive* <https://www.gov.uk/service-manual/design/making-your-service-more-inclusive>

⁹ <https://www.gov.uk/guidance/homelessness-data-notes-and-definitions>

¹⁰ NDTMS (2019) *Adult drug and alcohol treatment business definitions* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/785198/NDTMS_adult_drug_and_alcohol_treatment_business_definitions_CDS-O.pdf

Talking about drug and alcohol problems

Throughout the report we talk about 'drug and alcohol problems', as opposed to substance use or misuse, or 'addictions'. This is because in our consultations it was language which resonated most clearly with people with lived experience, and did not carry clinical or legal overtones, and was open enough to cover a wider variety of people who had not been in treatment.

However, in practice we are often talking about the same issues – that is drug and alcohol problems, addictions and dependency.

Framing the issue around 'addictions' would have exposed us to a wider range of addictive behaviours. Tobacco and gambling are two issues we have not been able to explore in this research, largely due to limitations on reporting and our decision to focus on drug and alcohol treatment services which do not cater to these needs. These are growing areas of enquiry, and further research is clearly needed.

Research methods

We carried out a survey of drug and alcohol service managers in the 50 areas with the highest levels of rough sleeping, as defined by the MHCLG rough sleeping count in 2018. From this we received 24 unique responses from different areas.¹¹ This was supplemented with six phone interviews with service managers, and a further two with drug and alcohol commissioners.

We decided to pursue a 'deep dive' qualitative approach in three local authority areas – Lambeth (London), Bournemouth (South West), and Stoke-on-Trent (West Midlands). This was necessary given the high regional variation in patterns of both drug and alcohol use and service provision. These areas were selected on the basis that they have significantly

different characteristics, on demographics, deprivation and drug and alcohol use prevalence. In addition, each of these areas had different providers of drug and alcohol treatment services, and ensured adequate regional variation. The exact choices were also determined on pragmatic grounds, including access to services and existing relationships.

In Lambeth and Bournemouth, St Mungo's carried out semi-structured interviews and focus groups with clients and staff of homelessness services. In Stoke-on-Trent, St Mungo's commissioned Expert Citizens C.I.C to carry out peer research. In total we interviewed:

- **20 clients with lived experience of homelessness** and drug and alcohol problems¹²
- **22 people working in homelessness services** (e.g. street outreach, hostels, and Housing First).

Quotes from these interviews are included throughout the report but have been anonymised. In addition to this qualitative research we carried out an analysis of existing national data sets including:

- The National Drug Treatment Monitoring System (NDTMS) - data collection system for drug treatment providers in England
- The Combined Homelessness and Information Network (CHAIN) – database which records information on people sleeping rough in London.

These datasets were supplemented by internal evidence gathering, such as the St Mungo's overdose review which analysed overdose incidents in St Mungo's services in 2018.

This has given us a full local picture in three areas, a well-developed quantitative picture in the capital, and a snapshot at the national level.

¹¹ Five of these services were commissioned across more than one local authority area

¹² Individuals interviewed reflected a broad range of experiences and needs, including a range of substances, co-morbidities, and different histories of service access

Deep dive profiles¹³

Stoke-on-Trent (West Midlands)

Deprivation ranking: 13th
 Rough sleeping count 2018 (versus 2010):
 34 (2)
 NFA in treatment 2018-19 (versus 2009-
 10): 90 (65)

Bournemouth, Christchurch and Poole (South West)

Deprivation ranking: 104th
 Rough sleeping count 2018 (versus 2010):
 29 (12)
 NFA in treatment 2018-19 (versus 2009-
 10): 65 (100)

Lambeth (London)

Deprivation ranking: 62nd
 Rough sleeping count 2018 (versus 2010):
 50 (13)
 NFA in treatment 2018-19 (versus 2009-
 10): 110 (85)

These three areas have distinct demographic and socio-economic profiles, in different regions of the country. Their drug and alcohol services are structured in different ways, with a mix of national, local and NHS providers. Their varying levels of economic performance means that moving from the public health grant towards business rates retention will have different impacts. However they each share high levels of need and rising levels of rough sleeping. In two of the three areas, drug and alcohol services reported that it has got and will continue to get harder to work with people sleeping rough, while the third said it had become easier.

Given the need for honesty in interviewing, we will not identify individuals based on their region. We have also supplemented these deep dives with further conversations from other parts of the country, so not all quotes will apply to these regions – though most will.

¹³ Deprivation ranking taken from the Indices of Multiple Deprivation, rank of average score, out of 151 upper-tier local authorities, MHCLG (2019) <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>; rough sleeping count taken from the MHCLG Rough Sleeping in England (2019) <https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2018>; numbers of NFA in treatment taken from NDTMS <https://www.ndtms.net/>

5

Cause or consequence:
what is the relationship
between rough sleeping and
drug and alcohol problems?

Drug and alcohol problems are very common among people sleeping rough

International evidence has consistently demonstrated that drug and alcohol problems are very common among people experiencing homelessness.¹⁴ Most recently the 2019 report by the Advisory Council on the Misuse of Drugs was clear: 'there is evidence that suggests a strong reciprocal association between being homeless and having an increased risk of problematic drug use.'¹⁵

The close links between homelessness and problematic drug and alcohol use is even stronger when it comes to people sleeping rough. In one recent study in the United Kingdom, drug and alcohol problems were significantly higher among people sleeping rough than the wider definition of 'single homeless' people.¹⁶

| | Drug use in past month | Current or recovery alcohol problems |
|-----------------|------------------------|--------------------------------------|
| Rough sleeping | 52% | 42% |
| Single homeless | 36% | 25% |

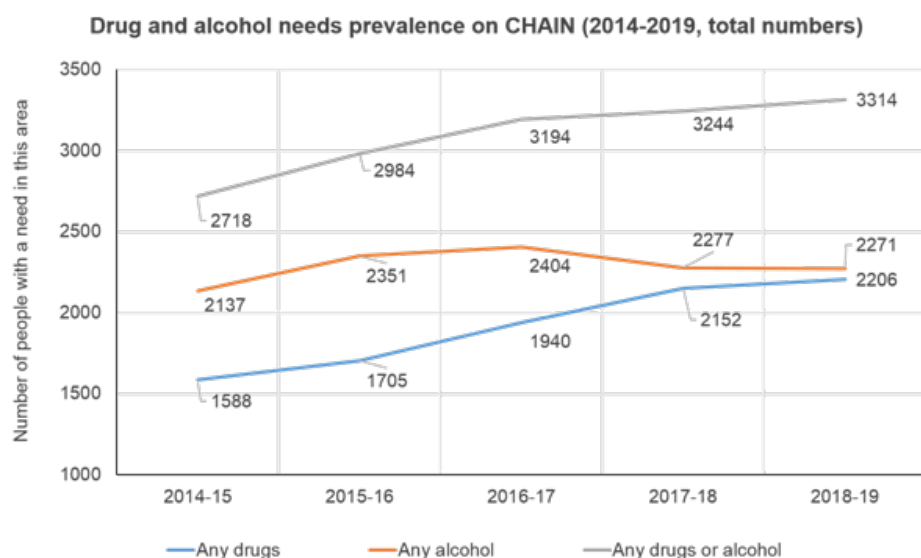


5.1 What are the recent trends in levels of rough sleeping and drug and alcohol problems?

CHAIN data shows that the number of people sleeping rough in London with a recorded drug or alcohol problem has increased significantly in recent years. In 2018-19 there were 3,314 people sleeping rough in London with a recorded drug and/or alcohol problem. This is a rise of 22% since 2014-15.¹⁷

Rising drug use is particularly serious

There has been a particularly significant rise in the number of people sleeping rough in London with a recorded drug problem, up from 1,588 in 2014-15 to 2,206 in 2018-19, a rise of 39%.

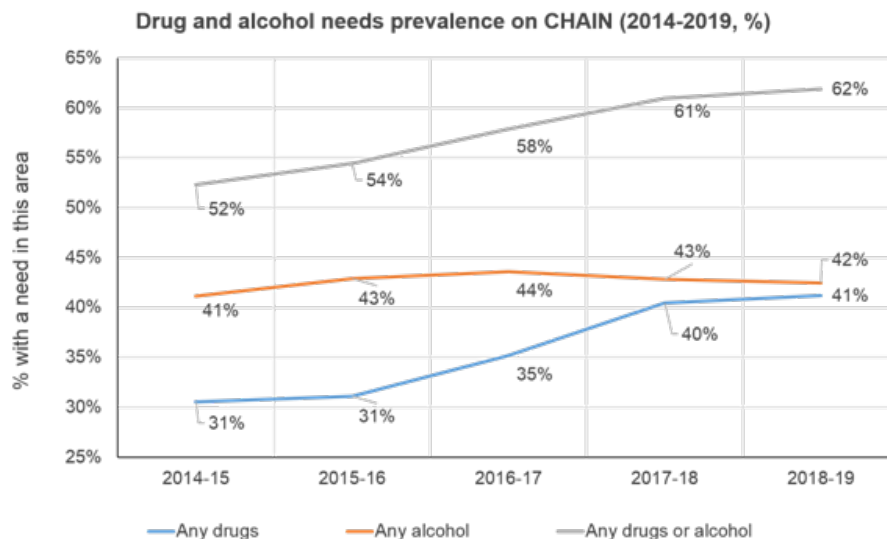


¹⁴ See Aldridge R et al. (2018) "Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis", *The Lancet*, 391(10117):241-50; Carole Christofk et al (2017) "Prevalence and predictors of substance use disorders among homeless women seeking primary care"

¹⁵ ACMD (2019) *Drug-related harms in homeless populations and how they can be reduced* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf

¹⁶ Tim Elwell-Sutton et al (2017) "Factors associated with access to care and healthcare utilization in the homeless population of England", *Journal of Public Health*, Volume 39, Issue 1, <https://doi.org/10.1093/pubmed/fdw008>

¹⁷ CHAIN (2019)



These rises are also higher than the overall increase in the number of people sleeping rough, which has risen by 17% in the same period of time. This means that not only are more people sleeping rough with drug and alcohol problems, but that the average person sleeping rough is more likely to have drug and alcohol problems than five years ago.

CHAIN data shows 62% of people sleeping rough in London had a recorded drug or alcohol need in 2018-19, up from 52% in 2014-15. This increase is almost entirely driven by the rise in drug needs from 31% in 2014-15 to 41% in 2018-19. In contrast, prevalence of illicit drug use in the general population remains at similar levels to a decade ago.¹⁸

There was already significant evidence to show that drug and alcohol problems are very common among people sleeping rough – this latest data shows that they are rising at a dangerous rate.

5.2 Are particular groups more likely to have drug and alcohol problems?

Drug and alcohol problems are not experienced equally among people sleeping rough

CHAIN data shows that not all groups experience drug and alcohol problems equally. Certain groups, and people with certain experiences of disadvantage, are much more likely to have recorded drug and alcohol problems while sleeping rough.

For example, data from CHAIN shows that the following groups are more likely to have recorded drug and alcohol problems: UK nationals more than non UK nationals, people with experience of prison compared to people without, and men more than women. This is a broadly similar group of people to what researchers have termed people experiencing 'multiple exclusion homelessness', of which drug and alcohol problems represent one exclusion.¹⁹ This has been seen as a continuous feature in countries across the developed world, and is replicated in the data from London.

¹⁸ Overall prevalence of drug use reported in general population surveys in England and Wales is similar to a decade ago, with almost 1 out of 10 adults aged 16-59 years reporting illicit drug use in the last year. See European Monitoring Centre for Drugs and Drug Addiction (2019), *United Kingdom country drug report* http://www.emcdda.europa.eu/countries/drug-reports/2019/united-kingdom/drug-use_en

¹⁹ Suzanne Fitzpatrick et al (2012), "Pathways into Multiple Exclusion Homelessness in Seven UK Cities", *Urban Studies* https://pureapps2.hw.ac.uk/ws/portalfiles/portal/7456915/US_Pathways.pdf

These particular groups – UK nationals, prison leavers and men – are all more likely to have drug and alcohol problems than five years ago. For people with experience of prison, four out of every five have a drug and alcohol problem – the strongest link of any sub-group.

Rise in drug and alcohol problems is being driven by groups often regarded as having ‘lower needs’

However, the story of change in the last five years does not lie in drug and alcohol problems among this high needs cohort. Drug and alcohol problems have risen much more significantly among other groups. These categories (particularly experience of prison and nationality) are still strong indicators of likelihood of drug and alcohol use, but are less strong indicators than they once were. Published and academic literature suggests that migrants sleeping rough tend to have less complex needs,²⁰ which while true, is becoming less pronounced. The same goes for women and people with no experience of prison.

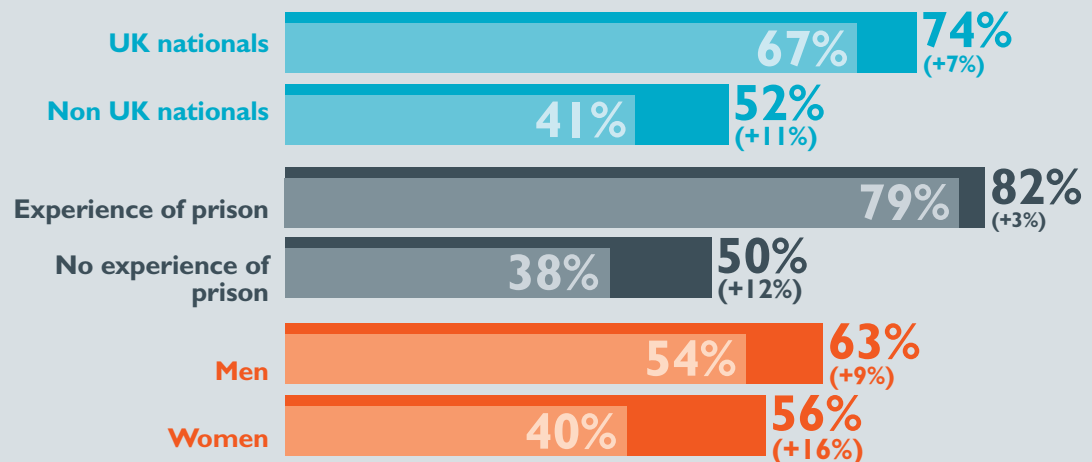
Drug and alcohol problems are rising at a much faster rate for women than men

There has been a shocking rise in the number of women sleeping rough with drug and alcohol problems, rising at a much faster rate than men. 486 women were recorded sleeping rough with a drug and/or alcohol problem in 2018-19, up 65% since 2014-15. In contrast, 2,826 men were recorded sleeping rough with a drug and/or alcohol problem in 2018-19, a rise of 16%.²¹

This is partly a product of a faster rise in the overall number of women sleeping rough, but it also reflects a significant increase in the likelihood of drug and alcohol use among women. In 2014-15 40% of all women sleeping rough had a recorded drug or alcohol problem, rising to 56% in 2018-19. For men the increase has been slower, from 54% to 63% over the same time period. This means the ‘gender gap’ when it comes to rough sleeping and drug and alcohol prevalence is narrower than ever before.

It also means that the average woman sleeping rough in 2018-19 was more likely to have a drug and alcohol problem than the average man who slept rough in 2014-15.

Prevalence of drug and alcohol problems among different groups of people sleeping rough in London 2014-15 vs 2018-19²²

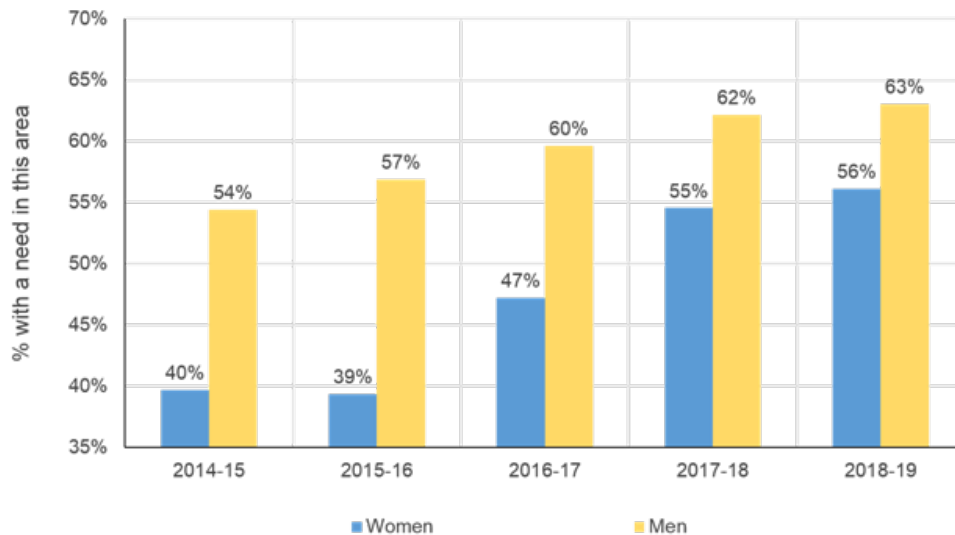


²⁰ Suzanne Fitzpatrick et al (2012), "Pathways into Multiple Exclusion Homelessness in Seven UK Cities", *Urban Studies* https://pureapps2.hw.ac.uk/ws/portalfiles/portal/7456915/US_Pathways.pdf

²¹ CHAIN (2019)

²² CHAIN (2019), proportion of people sleeping rough assessed by outreach teams with recorded drug and/or alcohol problems

Drug and alcohol needs prevalence on CHAIN (2014-2019, by gender)



Rising rough sleeping is putting more people at risk of drug and alcohol problems

There is a lot of evidence on why the total number of people sleeping rough has increased, which goes some way to explaining the total rise in numbers of people sleeping rough with drug and alcohol problems. The National Audit Office produced a report in 2017 which identified government policy changes as a key driver in rising homelessness.²³ This was echoed in the annual 'Homelessness Monitor' published by Crisis and the Joseph Rowntree Foundation, which demonstrates the cumulative impacts of welfare reform, absence of social housing, and unaffordability and insecurity in the private rented sector as major drivers of rough sleeping as well as wider forms of homelessness.²⁴

The overall rise in the number of people sleeping rough, combined with the increased prevalence of drug and alcohol problems among people sleeping rough, help to explain the dramatic rise in drug related deaths.

Wider availability of drugs and cuts to support services were suggested explanations for rising prevalence

Rising rough sleeping does not explain why the average person sleeping rough is more likely to have a drug and alcohol problem than five years ago, and why this has become particularly pronounced for certain groups – including women and people without experience of prison. This is particularly notable given overall drug prevalence in the general population has not risen in recent years.²⁵

The explanation does not appear to come from price, with street-level price data from law enforcement agencies suggesting that most recorded drug prices have remained stable in recent years.²⁶

We heard lots of anecdotal evidence about increasing accessibility of drugs, particularly when it comes to Novel Psychoactive Substances (NPS), with one man saying "I can find anything on the street now."

Street outreach manager: *"Even ten years ago, when I had experience of it, you had to go out and search for them [drugs]. You had to find somebody, you had to plan it, you had to plan getting everything, you had to have contacts. You don't now. Anybody can go on a computer and order drugs."*

²³ National Audit Office (2017), *Homelessness* <https://www.nao.org.uk/wp-content/uploads/2017/09/Homelessness.pdf>

²⁴ Crisis (2019), *Homelessness Monitor* https://www.crisis.org.uk/media/240419/the_homelessness_monitor_england_2019.pdf

²⁵ Overall drug prevalence in the general population is lower now than ten years ago, with cannabis being the main driver of that reduction; however, there has been little change in recent years. Crack cocaine is the exception here, having shown general increases in the past decade – a drug disproportionately used by people experiencing homelessness, see Public Health England (2017) *United Kingdom Drug Situation* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713101/Focal_Point_Annual_Report.pdf

²⁶ *Ibid.*

On the other hand, since the Novel Psychoactive Substances Act (2016), the reduction in supply of NPS has shown little signs of reducing overall prevalence of drug use, simply pushing people onto different substances. In particular, more research is needed to understand why groups assumed to have 'lower needs' – such as non UK nationals or people with less contact with the criminal justice system – have seen drug and alcohol problems rise at a more dramatic rate.

In the absence of a firm explanation, it makes sense to highlight the experiences of people using drugs and alcohol, the reasons why people rough sleeping develop problems, and how services work with this group. This will highlight themes and areas for further inquiry.

5.3 When and why do people develop drug and alcohol problems?

The prevalence of drug and alcohol problems only tells us so much. Understanding when and why people first develop drug and alcohol problems, and how this is impacted by the experience of rough sleeping, is arguably more important. This is because different interpretations of the root causes of drug and alcohol problems will heavily influence the kinds of policies which are developed in response.

In 2017, a Public Health England evidence review concluded 'homelessness can prompt people to start using drugs, or worsen an existing problem'.²⁷ The evidence shows there are certainly many individuals who turn to drug and alcohol use for the first time after sleeping rough. But drug and alcohol use frequently predates experiences of rough sleeping for many individuals, with rough sleeping as a compounding factor.

This should lead us to challenge simplistic explanations of rough sleeping and drug and alcohol problems, as well as moral judgements which blame rough sleeping on 'lifestyle choices'. These explanations do not capture how rough sleeping and drug and alcohol problems are symptoms and causes of trauma and social exclusion, which is often experienced over many years. This can have significant impacts on people's ability to seek out and accept care and support, which in turn compounds their problems.²⁸

People who sleep rough for longer are more likely to have drug and alcohol problems

The prevalence of drug and alcohol problems varies according to whether people are new to the street or not. Looking at the three categories on CHAIN, we can see the prevalence of drug and alcohol problems recorded by street outreach teams.²⁹

- People new to rough sleeping – 54%
- People who have been rough sleeping for some time – 71%
- People returning to rough sleeping – 64%

Looking at the data this suggests two things:

- People who arrive on the streets with drug and alcohol problems are more likely to stay stuck sleeping rough
- Drug and alcohol problems develop and worsen the more time spent on the streets

Both of these explanations ring true from our interviews, where we found that the traumatic experiences of rough sleeping pushed people to higher risk drug and alcohol use, but the roots of their problems were frequently found prior to their first night sleeping rough. The explanation suggests that for most people, their drug and alcohol problems existed *prior* to their first night sleeping rough, and this trend is becoming even more pronounced.

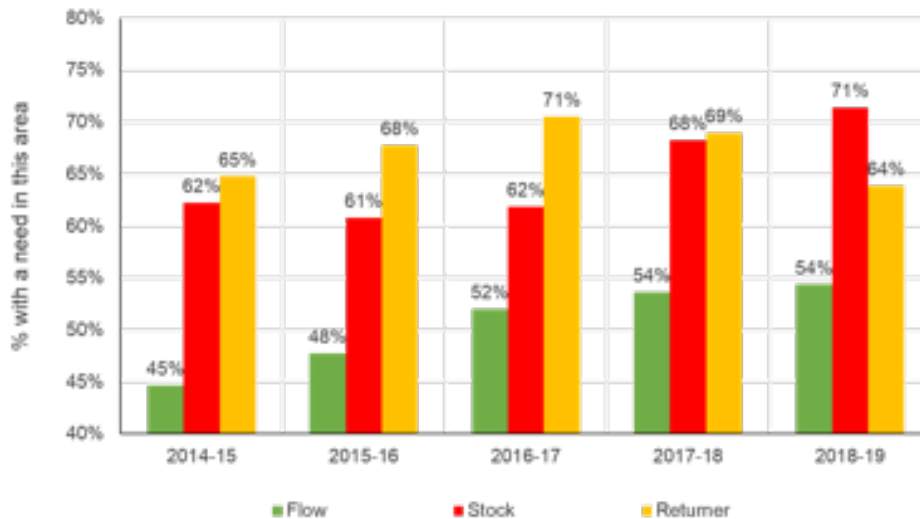
²⁷ Public Health England (2017), *An evidence review of the outcomes that can be expected of drug misuse treatment in England* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf

²⁸ Bessel van der Kolk (2015), *The body keeps the score: mind, brain and body in the transformation of trauma*

²⁹ These figures are based on individuals recorded as flow, stock or returner on CHAIN, meaning:

- Flow: people new to the street seen by outreach teams for the first time
- Stock: people seen sleeping rough in two consecutive years
- Returner: People previously seen sleeping rough who moved off the streets but return in a future year.

Drug and alcohol needs prevalence on CHAIN (2014-2019, by rough sleeping type)



The last five years have seen a big rise in drug and alcohol problems among people 'new' to rough sleeping

It is significant that more than half of people new to sleeping rough have a recorded drug or alcohol problem. This suggests that for most people, drug and alcohol problems predate their first experience of rough sleeping.

This fact is becoming even more pronounced. The biggest rise in drug and alcohol use has been among people who are new to the streets, rising from 45% in 2014-15 to 54% in 2018-19.

This is particularly concerning because we know that people new to rough sleeping with drug and alcohol problems are less likely to move off the streets than those without drug and alcohol problems.

CHAIN data shows that between 2011 and 2017, 54% of people new to rough sleeping who went on to sleep rough over a longer period of time had drug or alcohol needs at the time they were first seen on the streets, and 46% did not. Whereas a smaller proportion – 46% – of those who did not go on to sleep rough over a longer period of time had drug or alcohol needs when they were first seen, and 54% did not.³⁰

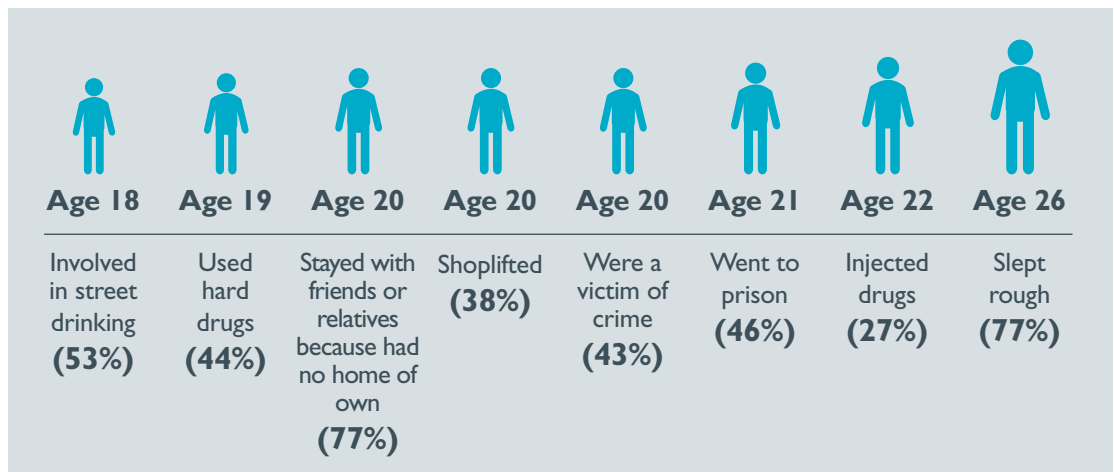
This reflects what we heard in interviews – that many people currently sleeping rough with drug and alcohol problems had struggled with addictions prior to their homelessness but this had been compounded and deepened by the experience of rough sleeping, making it harder for people to move off the streets.

It also reflects rising drug and alcohol problems among the groups of people assumed to have 'lower' drug and alcohol support needs, such as non UK nationals, people without experience of prison and women. This requires us to think about drug and alcohol problems as something which makes people vulnerable to rough sleeping, and to turn to the long-term causes of both experiences – which will often be found in an individual's early life experience.

This supports the view that people's reasons for drug and alcohol use often predate rough sleeping

Our analysis of CHAIN supports research into 'multiple exclusion homelessness', which includes people who have been homeless as well as one or more of the following domains of so-called 'deep' social exclusion: institutional care, substance use, or participation in 'street culture activities' (e.g. begging, street drinking, sex work). It found that for this group problematic drug and alcohol use frequently predated the first experience of rough sleeping.

³⁰ CHAIN (2019), the definition of 'long-term' here is 'sustained' rough sleeping recorded on CHAIN, meaning
 - Seen in at least two quarters of the year in the 12 months after first contact
 - Seen in at least one of the last two quarters of the 12 months following the first contact



Many other experiences of exclusion and disadvantage also occurred before the first night someone slept rough. One study plotted the median ages at which people experienced different kinds of behaviour or disadvantage, alongside the percentage of MEH individuals who had experience of each:³¹

This will not be the experience of every person who sleeps rough, as the percentages show. But it does demonstrate the commonality of experiences of disadvantage which frequently predate rough sleeping.

Drug and alcohol problems are often rooted in trauma, used to change how people think and feel

These experiences have common causes. Research suggests that these problems are closely related to complex trauma, arising from so-called 'adverse childhood experiences' (ACE's). ACEs can include childhood abuse, neglect, parental substance use, mental ill health or death or separation. These events are closely associated with poverty, deprivation and household dysfunction. Evidence suggests people experiencing homelessness have high levels of ACEs.³²

The seminal report *Hard Edges* (2015) by Lankelly Chase also found a huge overlap between people experiencing homelessness, histories of offending and drug and alcohol problems, with two thirds of people using homelessness services also in contact with criminal justice and drug and alcohol services.³³ This was underpinned by common experience of trauma and neglect, poverty, family breakdown and disrupted education, compounded by their experiences as adults. Trauma has been shown to have substantial impacts on cognitive functioning and an individual's ability to build and maintain social relationships, which drugs and alcohol can be used to numb or deal with.³⁴

Rough sleeping compounds trauma and existing drug and alcohol problems

While the roots of people's drug and alcohol problems frequently predate rough sleeping, the experience of sleeping rough is far from just a symptom. It has a deeply damaging independent impact on people's drug and alcohol use, worsening existing problems and creating new ones.

³¹ Suzanne Fitzpatrick et al (2012), "Pathways into Multiple Exclusion Homelessness in Seven UK Cities", *Urban Studies* https://pureapps2.hw.ac.uk/ws/portalfiles/portal/7456915/US_Pathways.pdf

³² Larkin et al (2018) examined a range of ACEs among a sample of 224 people experiencing homelessness. 87% reported at least 1 of 10 ACEs prior to age 18, whilst over half reported 4 or more ACEs https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf

³³ Lankelly Chase (2015), *Hard Edges* <https://lankellychase.org.uk/resources/publications/hard-edges>

³⁴ Bessel van der Kolk (2015), *The body keeps the score: mind, brain and body in the transformation of trauma*

A study of homeless people in Nottingham showed how ACEs related to mental health problems later in life. Researchers also found that pre-existing but 'managed' mental health issues were further exacerbated, or brought to crisis, by life events such as homelessness.³⁵

This helps us to understand why existing problems worsen drastically when people sleep rough, and echoes what we heard in interviews about rough sleeping pushing people out of situations where they could just about manage, towards high risk drug and alcohol use.

There are multiple reasons why rough sleeping has this impact, in compounding people's existing use and putting them at far greater risk of the harms associated with drug and alcohol problems.

Drugs and alcohol numbs people to the experience of rough sleeping

In the case of rough sleeping, we heard how there can be a particular value in the numbing effects of substances, particularly sedatives or depressants. This is particularly valuable when it comes to getting sleep, in often disruptive and chaotic environments.

Sid: *"When you're sleeping rough and you are actually street homeless, it's so much easier to get a few hours' kip when you're drunk... You try doing that sober, and I've done it sober, and I guarantee you... you're not going to sleep."*

We also heard of a related but distinct desire to 'blur reality', given the fundamentally unhappy experience of sleeping out on the streets. This was what was behind a higher level of drug and alcohol use to what people were used to when they were housed.

Michael: *"I used to drink, but I've always been more like a sofa drinker, and drugs, I used to mess around with them at weekends and things like that, but it never dominated my life like it does now, but that's probably because I'm unhappy. I'm unhappy, I'm drifting in the gutter, and drugs are a way of blurring reality, aren't they? That's what people do out here."*

There were multiple references to the desire to 'pass the time', which was frequently cited as a benefit of drug and alcohol use, given the pain which characterised many people's day to day lives.

People are in need of relief from physical and mental pain

We heard how problematic drug and alcohol use is a form of escape from the realities of living on the street, and a form of self-medication from the mental health problems people face.

CHAIN data shows that seven in 10 people with a recorded mental health problem in London also had a recorded drug or alcohol problem.³⁶ Rough sleeping has a negative impact on mental health, as does drug and alcohol use, which compounds people's problems and pushes them deeper into dependency and isolation. This creates a vicious cycle from which people struggle to escape.

Matthew: *"I do struggle with mental health, I get depression and anxiety really badly... I started drinking to fall asleep because of stuff that had gone on for years and years... and then it just hit boiling point. So I couldn't sleep, I was depressed, and then progressively my tolerance got higher, so my intake got higher, and then I started feeling crap the next day. I found out that if I have a beer in the morning, I feel fine, and you start day drinking, and then it gets worse and worse."*

It is not just mental health problems on the streets that drugs and alcohol give respite from, but physical health conditions too. Peer research from the charity Groundswell in 2018 found that 63% of people experiencing homelessness reported to be currently experiencing physical pain, with 53% experiencing chronic pain.³⁷ Almost a third of people experiencing chronic pain reported obtaining opioids without a prescription in order to try and manage the pain themselves.

³⁵ Kesia Reeve et al (2018), The mental health needs of Nottingham's homeless population: an exploratory research study, Sheffield Hallam University <http://shura.shu.ac.uk/21958/1/mental-health-nottinghams-homeless-population.pdf>

³⁶ CHAIN (2019)

³⁷ Groundswell (2018), *Out of Pain* <https://groundswell.org.uk/what-we-do/peer-research/out-of-pain>

Peers can have a big influence on behaviour

There are social reasons for people's drug and alcohol use too. We frequently heard how use was 'peer-mediated', with exposure to the streets and other people experiencing homelessness pulling people new to the streets into patterns of high risk drug and alcohol use. Seen in these terms, drug and alcohol problems are often a product of boredom and isolation, as much as they are self-medication for trauma and pain.

Chloe: *“Personally, I think it’s boredom. I think it’s not having anything to do...I think it’s mostly the peer pressure of people around you. When you try something for the first time, you want to stay friends, that’s how you can do it, by sharing the same drugs with them, it’s got the social thing.”*

Many people develop strong relationships while sleeping rough, with friendships or close-knit social groups forming and coalescing around drug and alcohol use. This creates significant challenges for engaging people in treatment, and often necessitates the creation of new social networks and activities as part of people's recovery.

There can be particular challenges when it comes to couples. Services are often designed for single people and lack flexibility, limiting the support on offer to this group.³⁸

Domestic abuse is a key factor – particularly for women

For women, domestic abuse is often at the centre of experiences of rough sleeping and drug and alcohol problems. We heard from women how their drug and alcohol problems developed or got worse when they became homeless because of a greater exposure to abuse.

Rebecca: *“[After losing my flat] It became worse. It became more dangerous because I had nowhere to live. I was on the street and I was going to other users’ places...and they were wanting something for me wanting a bed, so I was using more and I was using my body just to get a bed, basically, things like that. It was horrible. I thought I was going to die.”*

The lack of a home exposes individuals to a wider range of harms that in turn increase vulnerability to high risk use, a vicious cycle which leads to further exposure and greater abuse and harm. This could include abusers coercing drug use or withholding drugs or alcohol to maintain control over an individual.

Evidence suggests that women who have drug and alcohol problems are at greater risk of violence and abuse than women who do not, particularly when they are under the influence.³⁹ Victims of sexual assault are also less likely to be believed if they have consumed drugs or alcohol.⁴⁰

Substances can also help people deal with the trauma of these experiences and the constant fear of violence. We heard lots of stories of traumatic domestic abuse, with drugs and alcohol becoming ways of coping in hostile and dangerous environments.

Bernice: *“I was with this guy... he broke me wrist. He’s in prison at the moment, he’s out in November. But he’s not allowed to come near me. But he’ll find me I reckon when he gets out. Yes, I’ve just been through a lot, domestic violence. But I’m a strong person, I’ll get through it. That’s what we do, isn’t it? Every morning we get up, we don’t know what the days going to be like.”*

³⁸ Brighton Women's Centre (2018), *Couples First? Understanding the needs of rough sleeping couples* <https://www.commonwealhousing.org.uk/static/uploads/2018/12/Couples-First-Brighton-Womens-Centre.pdf>

³⁹ Cockersell (2016), *Social exclusion, compound trauma and recovery*, p144

⁴⁰ AVA (2014), *Not worth reporting: women's experiences of alcohol, drugs and sexual violence* <https://avaproject.org.uk/wp-content/uploads/2016/03/Not-worth-reporting-Full-report.pdf>

Rough sleeping compounds existing problems in new and dangerous ways

As shown, rough sleeping is often just one of multiple repeat experiences of trauma, poverty and social exclusion which push people towards drug and alcohol use. But it is a particularly damaging one.

Rough sleeping can compound previous traumatic experiences, worsen mental health and expose people to greater levels of abuse and violence. These dangerous situations push people to riskier behaviours. This reflects the significant evidence that trauma begets trauma, and damages the way people manage their perceptions and relationships.⁴¹ Drugs and alcohol can be a way of dealing with trauma while also pushing people into places that risk retraumatising them.

Quantitative data does not highlight fully the way in which rough sleeping causes drug and alcohol problems to deepen, pushes people to use multiple or higher risk substances, and exposes people to a wider range of harms than if they had been housed.

This is demonstrated in the kinds of substances people use. In our interviews we heard how on the streets people were more likely to use 'harder' drugs, frequently in more dangerous combinations, alongside heavy drinking.

5.4 What substances do people use?

Heroin, crack cocaine and alcohol are most frequently used

Available data supports the view that alcohol, heroin and crack cocaine are the most prevalent substances used by people sleeping rough in almost every part of the country – this has been the case for some time.⁴²

This contradicts some media reports which suggests that Novel Psychoactive Substances (NPS) such as spice are the dominant drug among people on the street, though clearly there are particular challenges which have emerged with these substances.⁴³

Anthony: *“If you’ve got a history of drugs, you’re likely to be using drugs more on the street, but crack and heroin seem to be the street drug, seem to be the homeless drug...it’s such an engrossing lifestyle that you forget you’re homeless, you’re too busy in the cycle.”*

It was clear from our interviews that people with a history of drug and alcohol use are more likely to have drug and alcohol problems when on the streets, but that many people will turn to new 'street drugs' that they may not have used before.

Sam: *“I started out with alcohol, cannabis when I was in my teens, but I’ve always been able to regulate it... Crack and heroin is my problem at the moment, and it’s the one that I’ve not been able to put down to go back to work, it’s taken over, especially heroin being more a physical addiction.”*

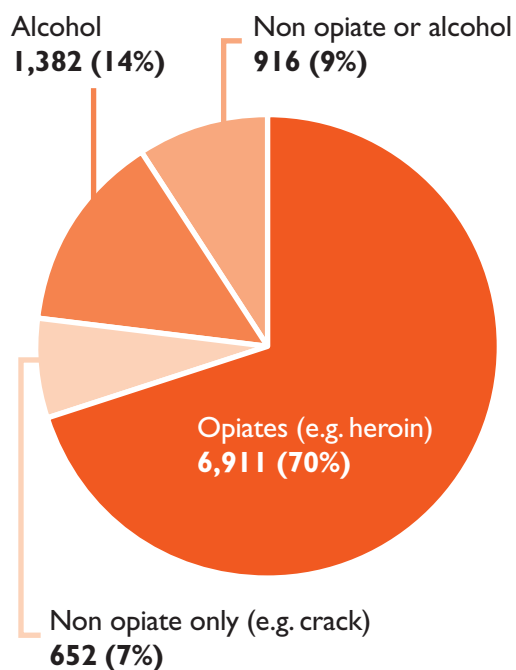
⁴¹ Bessel van der Kolk (2015), *The body keeps the score: mind, brain and body in the transformation of trauma*

⁴² St Mungo's internal data (2019), and the Guardian (2002), *Homeless in drugs epidemic*
<https://www.theguardian.com/society/2002/jul/14/homelessness.drugs>

⁴³ A variety of sources suggest opiate, crack and alcohol use is more prevalent among people experiencing homelessness with greater associated harms than NPS; this including NDTMS data on numbers presenting to treatment, St Mungo's internal data, ONS data on substance present in deaths by drug poisoning

This is reflected in treatment figures from NDTMS, which show that opiates are clearly the major substance need among people registered as homeless who present to drug and alcohol treatment. One in four people presenting with a problem with NPS had a recorded 'urgent housing problem', which is significant but still a much smaller overall number than those presenting for opiates.⁴⁴

Drug and alcohol services record people's substance problem in one of four categories. The following data shows the number of people who presented to treatment with No Fixed Abode (NFA) in 2018-19, and the substance they were recorded as needing treatment for:



These figures show the dominance of opiates, but could underestimate alcohol and crack prevalence because treatment services historically have had a less well developed 'offer' for people using these substances, particularly due to the absence of medical substitution treatments. Many people with recorded NPS problems will have simultaneous opiate problems, and be recorded under that category.

More people are using multiple substances

While heroin, crack cocaine and alcohol remain the primary high-risk substances used among people sleeping rough, there have been significant changes in recent years. More people sleeping rough are using drugs, and some limited evidence suggests this has been driven by crack cocaine in particular. This is particularly true for women, who are more likely to use drugs such as crack cocaine and heroin than alcohol.⁴⁵ On top of this, there has been a greater degree of polysubstance use, meaning multiple substances used simultaneously. As one service manager said: *"There used to be a fine line between Class As and drinkers but now it just seems like it's merged and the variety... they're taking everything."*

We did hear from multiple individuals that there are still sharp divisions between people who use drugs and people who use alcohol that remain strong. Some people whose primary problem was alcohol spoke with pride at their ability to avoid using drugs. However these identities may be becoming increasingly blurred.

Novel Psychoactive Substances present particular challenges – but risk being sensationalised

There has been significant media coverage of the growing use of Novel Psychoactive Substances (NPS). Formerly called 'legal highs' until they were criminalised in 2016, these synthetic substances were intended to mimic illicit drugs such as cocaine or cannabis. They are traded under street names such as Spice, Monkey Dust or Mamba – all examples of synthetic cannabinoid. NPS use by people who are homeless has risen in public recognition and awareness in recent years, but is highly localised and regionally variable. For example, Manchester is known to be a particular hotspot for Spice, while Stoke-on-Trent has been the epicentre for the use of 'Monkey Dust'.

⁴⁴ Public Health England (2019), *Adult substance misuse treatment statistics 2018 to 2019: report* <https://www.gov.uk/government/publications/substance-misuse-treatment-for-adults-statistics-2018-to-2019/adult-substance-misuse-treatment-statistics-2018-to-2019-report>

⁴⁵ St Mungo's (2019) *Women at St Mungo's: a three year strategy for 2019-2022* <https://www.mungos.org/app/uploads/2019/03/St-Mungos-Womens-Strategy-2019-22-web.pdf?x74044>

Homeless service worker: *“Each area has their own what I call a priority drug. So, certain areas would have focus on a certain drug like Spice, Mamba... You get a point where some months it’s like full on of a particular drug, whether it’s Dust, and then that’ll go quiet, and then it’ll be taken over by Mamba and the like.”*

Some of the main appeals of such substances was the ease of access, the wide availability, and the price. We spoke to one man sleeping rough who became homeless aged 15 and turned to using spice – he talked about how all the homeless people in his town “stopped doing gear and crack and they turned to spice. You know, it was that strong. It was cheaper and you get more of a buzz out of it.” This reflects other interviews which showed how most people who use NPS use them as a substitute for other drugs, or as a way of reducing their dependency on other drugs.

Much of the regional variation is accounted for by the supply, price and local peer-mediated cultures. However, we heard frequently that while a significant challenge – the problem of NPS can be over-represented in media reporting, versus other drugs.

Commissioner of drug and alcohol services: *“more recently, mostly because of the availability but also because of the price, we’ve had quite a surge in use of novel psychoactive substances in the city... So, although that’s not at the scale at which you might sort of imagine based on the press coverage, it’s still relatively low numbers, but we do know a lot of people were replacing heroin for say, Monkey Dust for a period of time because it was two pounds a go as opposed to ten pounds a go.”*

This was reflected in our conversations with people currently using Spice. One man sleeping rough referred to the positive impact that the 2016 legislation which made NPS illegal had had, saying: “it has been illegal for about a year or two now. So, obviously since then, it’s died down in quite a lot of places. It is harder to get which is also obviously a good thing.”

Clearly the ease of access to substances in areas has a real impact on the types of substances people use. However, with people increasingly using multiple substances and substituting one substance for another, reducing access to certain substances risks pushing people to find alternatives – which can be more dangerous. This implies it may be more important to review the commonality of issues behind people’s problems, including trauma and mental ill health, rather than focusing on specific substances.

5.5 What is the impact on people’s health and wellbeing?

Drug related deaths among people sleeping rough have risen dramatically

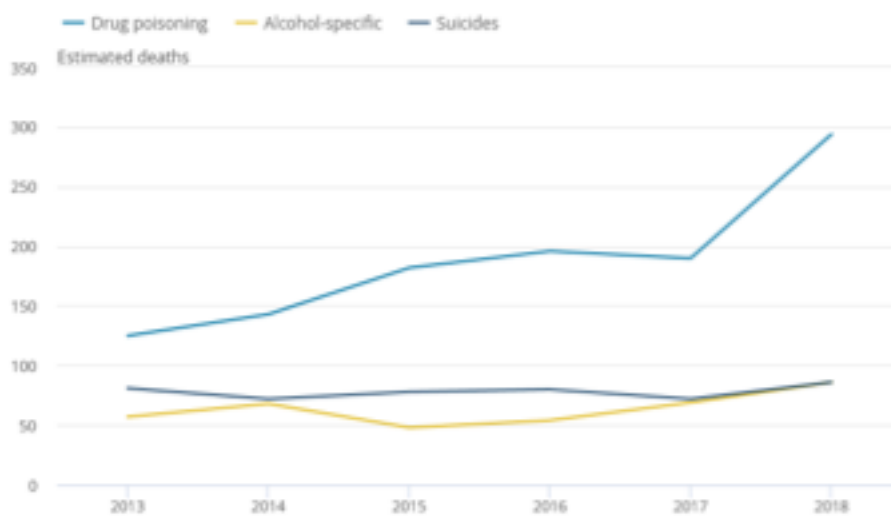
In 2019 the ONS released data which showed a record number of people dying while sleeping rough or in emergency accommodation. 726 people died in 2018, a 22% rise on the previous year and a 51% rise since records began in 2013.⁴⁶ A majority of these deaths were recorded under the categories of drug-related poisoning, suicide, and alcohol-specific deaths. 294 deaths of homeless people in 2018 were related to drug poisoning, that is 40% of all estimated deaths. Suicide and alcohol-specific causes each accounted for 12% (24% in total) of estimated deaths of homeless people in 2018.

The rising number of people dying while homeless is driven predominantly by the shocking increase in drug related deaths. The number of deaths caused by drug poisoning increased 135% between 2013 and 2018, and by 55% in just one year in 2018. There was a record increase in drug related deaths among the general population in 2018 too (16%), the highest annual increase since records began in 1993, albeit significantly smaller than the increase for people who were homeless.⁴⁷

⁴⁶ Office for National Statistics (2019), *Deaths of homeless people in England and Wales 2018* <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018>
⁴⁷ Ibid.

Figure 4: Drug-related deaths of homeless people increased by 55 % in one year

Deaths of homeless people (estimated) by selected causes of death, 2013 to 2018



Source: Office for National Statistics – Death registrations

Thousands of people sleeping rough may experience a drug overdose each year

Drug-related deaths are just the tip of the iceberg when it comes to drug harms. In 2018 St Mungo's carried out analysis of incident reports from our services, to provide more information on drug overdoses.⁴⁸ The research found that in 2018 there were 263 reported overdoses in St Mungo's services, of which 22 resulted in fatalities (8%) – the highest number on record. 100 of these were deemed 'intentional' (38%).

If we apply this data to the national figures, it suggests there could have been more than 3,600 overdoses of homeless people in 2018, of which almost 1,200 could have been intentional. Further research is needed, but this points to the scale of the public health crisis on our streets.

Higher drug and alcohol prevalence helps explain the rise in deaths and overdoses – but doesn't explain it fully

The dramatic rise in drug related deaths among people sleeping rough is partly explained by the higher number of people sleeping rough. But the 94% rise in rough sleeping in the past 5 years is still significantly lower than the 135% increase in drug related deaths.

Purity of substances may be a factor here, with heroin in 2015 being more than double the purity seen in 2011 and 2012, and crack cocaine purity rising too.⁴⁹ An increase in poly-substance use is another possible cause, something which is particularly dangerous and associated with higher levels of harm and death.

⁴⁸ St Mungo's internal overdose report (2019)

⁴⁹ Public Health England (2017) *United Kingdom Drug Situation* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713101/Focal_Point_Annual_Report.pdf

This can be seen on death certificates, where multiple substances are frequently mentioned.⁵⁰ On the death certificates, opiates were the most frequently mentioned substance (131 mentions) with heroin or morphine being the most common forms (99 mentions). Alcohol was commonly mentioned on death certificates alongside these substances (75 mentions). No deaths were specifically attributable to 'Novel Psychoactive Substances'. However coroners' conventional toxicology tests do not seem to be able to determine whether NPS such as spice are a cause of death, and internal analysis of St Mungo's overdose reports suggests there were dozens of cases where spice was in people's system when they overdosed.⁵¹

Drug and alcohol problems can also be an indirect cause of death

The impact of drug and alcohol use on early mortality is not just as a direct cause. Drugs and alcohol can have serious health impacts which result in other common causes of deaths, including diseases of the liver, ischaemic heart diseases, cancers, and influenza and pneumonia. Drug and alcohol problems can also make people less likely to engage with health services for these problems.

This also means that many of the health impacts of drug and alcohol problems which lead to early mortality do not disappear when an individual is successfully housed. Recent research on the needs of clients of Tenancy Sustainment Team (TST) services, which provide floating support to people who have experience of rough sleeping in London, shows the high risk of mortality even after someone has stopped rough sleeping.⁵²

The research found that the average age at death amongst TST clients (52 years) is slightly higher than the average age at death amongst homeless people (45 years).⁵³ While cause of deaths was not identified for around half of cases, for those where a cause was identified the most common was cancer followed by cardiovascular and gastro/liver diseases. However, drug and alcohol use was identified as a key contributing factor in many of the client deaths, creating these chronic conditions and making it harder to access support from health services.

Mental and physical pain is associated with drug and alcohol use

From our interviews we heard how pervasive physical and mental pain was, for which drug and alcohol acted as a palliative but also worsened problems in the long-term. One man said he was always "scared to go to sleep because you know when you wake up it's going to hurt."

This hurt can include mental health conditions, which can develop or worsen from drug and alcohol use. One man we spoke to said that spice had "caused me paranoid schizophrenia, drug psychosis and a few other things. It's causing issues in the long run."

Joe, highlights his experience of withdrawal from alcohol: *"You don't know what it's like unless you've lived it... You're sweating, joints are hurting to the point you can't even stand up. You know, you start hallucinating, things like that. Unless you've been through it, how do you know?... You're scared to go to sleep in case you don't wake up but then there's part of you that really wishes you aren't going to wake up because you know the pain's going to go away."*

⁵⁰ Office for National Statistics (2019), *Deaths of homeless people in England and Wales 2018* <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018>

⁵¹ St Mungo's internal overdose report (2019)

⁵² Michelle Comes et al (2020), *Tenancy Sustainment Team health research: morbidity and mortality amongst people with experience of rough sleeping*.

⁵³ These figures are not age-adjusted and the comparison should be treated with some caution.

The academic literature summarises what many people are experiencing, and it varies according to the substance and means of consumption:

- **Injecting:** There has been a rise in serious bacterial infections among people injecting drugs, with people experiencing homelessness over represented in these infected groups.⁵⁴ This includes high rates of hepatitis C, HIV as well as tuberculosis. Other injecting complications such as abscesses, ulcers and other infections are also more common. Serious infections such as endocarditis, necrotising fasciitis, septic arthritis and osteomyelitis leading to sepsis are also seen among people sleeping rough.⁵⁵
- **Smoking:** There are high levels of chronic lung damage, including chronic obstructive pulmonary disease (COPD) among people experiencing homelessness. This is associated with the high levels of smoking tobacco and/or smoking drugs such as heroin and crack cocaine.
- **Drinking:** Serious health impacts from alcohol, including high levels of alcoholic liver disease resulting in premature mortality from cirrhosis and liver cancer,⁵⁶ and commonly results in accidents, including impacts cognitive functioning and memory.

Experiences of abuse, neglect and self-neglect are common

As highlighted in the recent review of Safeguarding Adult Reviews (SARs) by Kings College London into people who died while homeless, experiences of abuse and neglect – including self-neglect – are closely associated with experiences of rough sleeping and drug and alcohol problems.⁵⁷

Nicole: *“You’re so vulnerable because you’ve lost all your power. You don’t have any power. Being on the streets, being homeless and being on some form of substance, whether it be alcohol or drugs... You’re just very vulnerable, you know. You’re not safe. It’s horrible.”*

This vulnerability is frequently compounded by other complex problems such as mental ill health, chronic physical health problems, and learning disabilities. Research by St Mungo’s in 2018 found that eight in 10 people who died while homeless in London had recorded mental health problems.⁵⁸

This suggests we should see people sleeping rough with drug and alcohol problems as often having care and support needs. In many cases these problems will be closely related to experiences of abuse and neglect, including self-neglect – a recognised legal category, but one which is poorly understood at present. Seeing people’s experiences in terms of vulnerability and neglect, over criminality and lifestyle choices, helps centre the conversation on the kinds of interventions most likely to improve people’s lives.

5.6 Treating drug and alcohol problems as a support need

As shown throughout this chapter, drug and alcohol problems frequently pre-date people’s experiences of sleeping rough – and are indeed caused by some of the same structural factors. These include poverty, deprivation, childhood trauma and social exclusion.

Other experiences of adult disadvantage will also sometimes predate rough sleeping. This includes experience of the criminal justice system as well as drug and alcohol problems themselves. The overlaps in this group are particularly strong, and suggest that more needs to be done upstream to address problems before people spend their first night sleeping rough.

⁵⁴ ACMD (2019) *Drug-related harms in homeless populations and how they can be reduced* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf

⁵⁵ Dan Lewer et al (2017), “Health-related quality of life and prevalence of six chronic diseases in homeless and housed people: a cross-sectional study in London and Birmingham, England”, *BMJ* <https://bmjopen.bmj.com/content/9/4/e025192>

⁵⁶ ACMD (2019) *Drug-related harms in homeless populations and how they can be reduced* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf

⁵⁷ S.J. Martineau et al (2019), *Safeguarding homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*, The Policy Institute, King’s College London <https://doi.org/10.18742/pub01-006>

⁵⁸ St Mungo’s (2018), *Dying on the streets* <https://www.mungos.org/app/uploads/2018/06/Dying-on-the-Streets-Report.pdf>

It also suggests that interventions which continue the cycle of exclusion will only push people further towards the margins, and increase the likelihood of rough sleeping and drug and alcohol use. As we know, the longer someone spends on the streets the more likely they are to have drug and alcohol problems.

Rough sleeping and drug and alcohol problems should not be seen as a 'lifestyle choice'. Many people experience the same currents of trauma and social exclusion, and an understanding of these experiences is essential to developing effective responses.

Focusing on supply and enforcement does not address the root causes of people's problems

More than a third of people sleeping rough have served time in prison, with many more having frequent non-custodial interactions with the criminal justice system. The overlaps with drug and alcohol use among this cohort are strong, and will often be the reason why people end up in prison.

This enforcement-led response can be known to continue when people arrive on the streets. In addition to the criminal offense of possession, there are a range of related activities which can be civil or criminal offenses, including begging and anti-social behaviour (e.g. street drinking). While it is very important to distinguish between rough sleeping and so-called 'street activities' – not all people sleeping rough are 'street active' and not all people 'street active' are rough sleeping – there is clearly a relationship to consider.⁵⁹

This means that some activities (e.g. street drinking, begging) are dealt with firstly as a law enforcement issue. Examples include the use of the Vagrancy Act as well as provisions under the Policing and Crime Act (2016) such as Public Space Protection Orders and Dispersal Orders.

This can be part of a cycle of reoffending which dominates the lives of many people sleeping rough (e.g. almost a third of people sleeping rough in London have served time in prison) without addressing their root issues.⁶⁰

Miles: *"If they're going to prison and they're just doing these little sentences, they can't wait to come back out and get their hands straight back on the [monkey] dust. So, these little sentences are doing nothing."*

When arrests are not made, the effect of dispersal or moving people on without support can sometimes push people further away from support services who can provide the interventions necessary for people to address their problems and rebuild their lives.⁶¹ Recognising that enforcement will be necessary in some cases, and can sometimes offer a 'moment of motivation' for engaging in services, it should be a last-resort when it comes to tackling issues related to rough sleeping and drug and alcohol use – and risk re-traumatising people for whom trauma is at the root of their problems.

This helps explain why a range of organisations and bodies, including the Health and Social Care Select Committee, have recently publically called for the Government to establish an expert, independent commission to develop an evidence-led approach to drugs policy and treatment, with no options 'off the table'.⁶²

This could allow for a wider range of harm minimisation interventions to be considered to tackle the rise in drug related deaths – including Drug Consumption Rooms, where illicit drugs can be taken under the supervision of trained staff with the aim of reducing the harms associated with injecting.⁶³ Already operating in several European countries, these kind of initiatives are by no means a silver bullet, but keeping them on the table ensures a wide range of tools can be deployed to deal with the public health crisis of drug related deaths.

⁵⁹ A review of evidence from across Britain by Shelter Scotland found that a considerable proportion of people who beg are homeless in some form, see Shelter Scotland (2019), *Street Begging in Edinburgh*

⁶⁰ Crisis (2019), *Scrap the Vagrancy Act* https://www.crisis.org.uk/media/240635/scrap_the_vagrancy_act_2018.pdf

⁶¹ Crisis (2017), An examination of the scale and impact of enforcement interventions on street homeless people in England and Wales Ben Sanders and Francesca Albanese https://crisis.org.uk/media/237532/an_examination_of_the_scale_and_impact_of_enforcement_2017.pdf

⁶² The Independent (December 2019), *Consider decriminalisation to tackle drug death 'crisis', say treatment providers in unprecedented plea* <https://www.independent.co.uk/news/uk/home-news/drug-policy-deaths-decriminalisation-addiction-treatment-heroin-a9215191.html>

⁶³ European Monitoring Centre for Drugs and Drug Addiction (2018), *Drug consumption rooms: an overview of provision and evidence* http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en

Piloting a diversion approach in West Berkshire

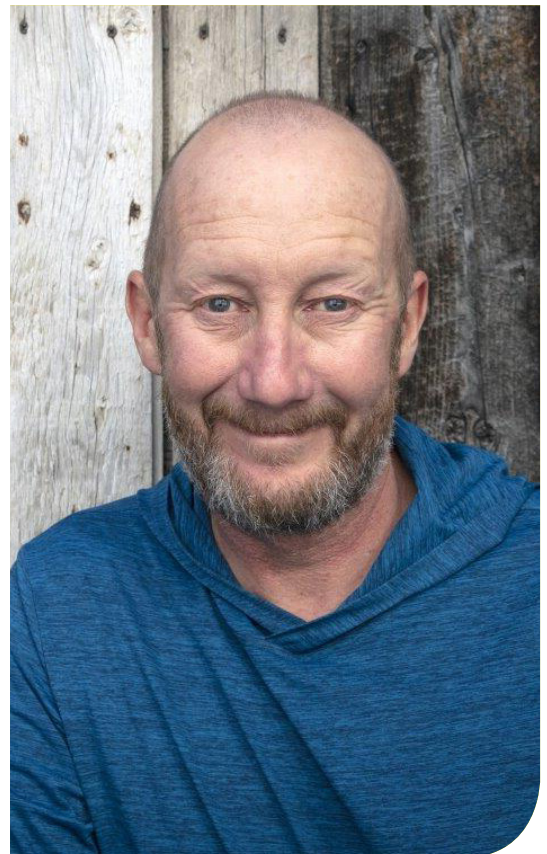
A growing number of police forces are introducing Diversion schemes for minor drug offences with clear evidence they can reduce health harms and reoffending, and increase uptake of education or treatment, without damaging life chances with a criminal record. For example, West Berkshire Local Policing Area piloted a diversion scheme with the aim of reducing deaths related to drugs, where persons found in possession of drugs for their own use are referred to a drugs service provider. Assistant Chief Constable Jason Hogg said there is “nothing soft about trying to save lives.”

The scheme offers individuals found in possession of drugs a referral to a drugs service provider instead of traditional criminal justice disposals (e.g. warning, cautions or charge). While there is no arrest, interview, admission of guilt or threat of enforcement for the initial offence, failure to engage could result in future offences being dealt with through traditional criminal justice routes. Without a diversion scheme, 46 (84%) of those who were sent for treatment would have received a sanction that would likely have left the reasons for their drug use unaddressed. There was generally favourable reviews from officers and those who underwent the diversion process and engagement with treatment providers.

People need integrated access to housing, support and treatment

While reducing the supply of certain substances can have an impact in patterns of drug use, it does not address these drivers. Instead, seeing rough sleeping and drug and alcohol problems as arising from compound trauma interacting with structural drivers is a more effective alternative to simply seeing behaviours through the lens of morality or criminality.

As shown throughout this chapter; people sleeping rough with drug and alcohol problems face a wide range of challenges and disadvantages, which have been experienced across many years. Rather than responding punitively to individual behaviours, taking a whole person approach makes much more sense. At a policy level, this means taking a whole system approach, joining up interventions to address these issues in tandem. Pioneering work from the likes of Making Every Adult Matter (MEAM) and Fulfilling Lives have demonstrated the value of systems change in practice.⁶⁴



⁶⁴ The MEAM Approach <http://meam.org.uk/the-meam-approach/>

Responding to complex needs: the Making Every Adult Matter Approach

The MEAM Approach is a non-prescriptive framework that helps local areas design and deliver better coordinated services for people experiencing multiple disadvantage. This systemic approach, developed by the Making Every Adult Matter (MEAM) coalition, is currently being used by partnerships of statutory and voluntary agencies in 27 local areas across England. MEAM Approach areas are supported to consider seven principles, which they adapt to local needs and circumstances. MEAM Approach areas:

- Develop a **partnership of statutory and voluntary agencies** to oversee the work, ensuring a shared vision and a focus on changing systems. People with lived experience are a key part of these partnerships.
- Put in place **practical ways to better coordinate services** for people facing multiple disadvantage, often through a coordinator or navigator who can be a single point of contact and follow individuals on their journey. Coordinators use a personalised yet persistent approach, building on individual's strengths and recognising the trauma that many people have faced.
- Ensure that a wide range of local services **make a shared commitment to providing flexible responses** for individuals facing multiple disadvantage. Strategic and operational groups facilitate this and usually include colleagues from relevant sectors such as health, public health, police, criminal justice, substance misuse, mental health and social care.
- Measure their success and ensure that learning is used to **create long-term systemic changes** to the way that the services in a local area work for people facing multiple disadvantage.

MEAM Approach areas that conducted an evaluation report an average 23% reduction in wider service use costs and a 44% improvement in wellbeing.

This should be closely linked to approaches designed to tackle rough sleeping, given that we know that the longer someone sleeps rough the more serious these problems become. This means a cross-government strategy to deliver the investment in welfare benefits, social house building, and investment in support services that we need – as called for in the St Mungo's *Home for Good* campaign.⁶⁵

⁶⁵ St Mungo's (2018), *Home for Good* <https://www.mungos.org/get-involved/campaign-for-change/home-for-good>

6

Great expectations: what is the experience of drug and alcohol treatment?

6.1 How drug and alcohol treatment works in England

Each year, thousands of people experiencing homelessness seek help from drug and alcohol treatment services. These are the primary agencies responsible for supporting people to manage, reduce, or abstain from drug and alcohol use, and alongside appropriate housing they have a vital role in people's recovery and chances of moving into and maintaining accommodation.

What is drug and alcohol treatment for?

There are a wide range of services which support people with issues related to drug and alcohol use, and these services often have different goals and objectives. At the heart of this is a tension between the goals of two different approaches to treatment:

- Harm reduction: prioritising the reduction of harms associated with drug and alcohol use over and above achieving abstinence
- Abstinence-based: prioritising abstinence over and above the goals of reducing harm

An older emphasis on abstinence, most clearly popularised by Alcoholics Anonymous (AA) among others, has been increasingly displaced in harm reduction approaches in recent decades. In the 2000s the National Treatment Agency (NTA) put harm reduction at the centre of its strategies, as well as developing the 'Models of Care framework' (MoC) which categorised the various components of treatment into four 'tiers'.⁶⁶

| Tier | Summary | Examples of work | Setting |
|---------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| Tier 1 | Non-substance use specific services requiring interface with drug and alcohol treatment services. | <ul style="list-style-type: none"> ➤ Drug treatment screening and assessment ➤ Referral to specialised drug treatment ➤ Drug advice and information | Settings where the main focus is not drug treatment (e.g. general healthcare, criminal justice, homeless hostels). |
| Tier 2 | Open access drug and alcohol treatment services. | <ul style="list-style-type: none"> ➤ Provision of drug related information and advice ➤ Triage assessment and referrals to structured treatment ➤ Brief psychosocial interventions ➤ Harm reductions interventions ➤ Outreach services to engage clients into treatment and to re-engage people who have dropped out | Normally delivered in specialised drug treatment services. Can be delivered by outreach. |
| Tier 3 | Structured community-based drug treatment services. | <ul style="list-style-type: none"> ➤ Comprehensive assessment, care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions ➤ A range of prescribing interventions ➤ A range of structured psychosocial interventions ➤ Liaison services for acute medical and psychiatric health services | Normally delivered in specialised drug treatment services. Can be delivered by outreach. Other settings include primary care and pharmacies. |
| Tier 4 | Residential and inpatient services for drug and alcohol misusers. | Provision of residential specialised drug treatment, which is care planned and care coordinated to ensure continuity of care and aftercare | Specialised dedicated inpatient or residential substance misuse units or wards. |

⁶⁶ National Treatment Agency for Substance Misuse (2006), *Models of care for treatment of adult drug misusers: Update 2006* http://www.emcdda.europa.eu/attachements.cfm/att_231363_EN_UK06_Models%20of%20care.pdf

However, this changed with the Government's 2010 then 2017 Drug Strategies, with 'recovery' being more strongly emphasised as opposed to harm reduction. The meaning of 'recovery' has been widely debated, in some circles being seen as a return to previous abstinence-based approaches – for example the 2010 strategy emphasising the need to help people live 'drug-free lives'.⁶⁷

This has resulted in quality metrics for drug and alcohol services in England centring on "successful completions", which is usually translated as being free from drug and alcohol dependence. However, others have sought to broaden the meaning of recovery to include a wider range of outcomes based on reducing dependence, incorporating aspects of harm reduction as part of people's 'recovery journey'. In the age of localism local areas are able to set their own outcomes measures and commissioning frameworks. This has resulted in a highly regionally varied picture.

Transferring funding for drug and alcohol services to local authorities

In 2013, the Health and Social Care Act transferred responsibility for commissioning most services under tiers 2-4 from NHS Primary Care Trusts to local authorities (and to county councils in two tier areas). The mechanism for this has been a Public Health Grant developed through a needs-based formula. Drug and alcohol services are often provided by the charity and non-profit sector, though the NHS still has a role to play in the provision of inpatient detox and community care.

The Public Health Grant funds a range of services beyond drugs and alcohol, including obesity programmes, sexual health services, and smoking cessation. There were concerns that this could lead to drug and alcohol services being deprioritised for funding, exacerbated by the fact that this funding mechanisms does not mandate the provision of drug and alcohol services, and gives no protection to these services within the ring-fence. Sadly many of these concerns have been borne out in recent years.

There have been significant reductions to funding for drug and alcohol services

There have been significant reductions in public health funding through this grant in recent years – research by the IPPR suggests that there has been a £850 million reduction between 2014-15 and 2019-20.⁶⁸ They found that absolute cuts in the poorest areas have been six times larger than in the least deprived. They also found that drug and alcohol services have been the worst hit of any public health service – a reflection of the lower priority these kinds of services have when put in competition with other public health programmes.

This is supported by other findings, which suggest that local authorities have reduced funding on drug and alcohol treatment services by an average of more than a quarter since 2015-16, with almost one in five local authorities cutting budgets by at least half since 2015-16, with the biggest cuts found in areas with the highest rates of drug-related deaths.⁶⁹ In 2017 the 'State of the Sector: Beyond the Tipping Point' report identified 'worrying signs that damage has already been done and the capacity of the sector to respond to future cuts has been eroded'.

Drug and alcohol service manager: ***“due to the uncertainty of Brexit and the ever increasing cuts to services and funding; it'll become harder for any frontline service to offer what we once did. The climate of uncertainty has a grip of fear up and down the country.”***

Drug and alcohol services deliver strong evidence-based interventions with good value for money. Research has found that every £1 invested in drug treatment results in a £2.50 benefit to society.⁷⁰ However these reductions in funding have led to what the Health and Social Care Select Committee call 'a wide gap between what is set out as evidence-based best practice, and what is being delivered on the ground'.⁷¹

⁶⁷ HM Government (2010), *Drug strategy 2010* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

⁶⁸ IPPR (2019), *Hitting the poorest worst? How public health cuts have been experienced in England's most deprived communities* <https://www.ippr.org/blog/public-health-cuts>

⁶⁹ Camurus UK (2019), *Towards sustainable drug treatment*

⁷⁰ Public Health England (2017), *Drug misuse treatment in England: evidence review of outcomes* <https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes>

⁷¹ House of Commons Health and Social Care Committee (2019), *Drugs Policy* <https://publications.parliament.uk/pa/cm201919/cmselect/cmhealth/143/143.pdf>

These problems look set to worsen with the planned removal of the public health ring-fenced grant, with the Government expecting public health services to be funded through Business Rates Retention from 2021. As argued in the State of the Sector report this has created 'universal uncertainty' with 'a disproportionately negative impact where the need for drug and alcohol services is greatest.'⁷²

Research by the King's Fund and the Resolution Foundation suggests £1bn should be invested in public health to reverse these cuts.⁷³

Cuts have been experienced across many different services

Reductions in funding have occurred across a wide range of public services upon which people sleeping rough rely – including mental health, homelessness and housing related support services. For example, research from St Mungo's has shown that £1 billion less is being spent on housing related support services (which help many people with complex needs gain and retain accommodation) than a decade ago.⁷⁴

This has a compounding impact on other services, who are put under even greater pressure to support a more complex group of people, whose range of needs are no longer being met. This means more people end up in emergency settings – as a BBC report from 2017 showed, more than 21,000 homeless people were admitted to hospital with problems relating to drink and drugs between 2014 and 2016, an increase of a quarter.⁷⁵

There is a growing recognition of the values of integration and collaboration, to provide services which adequately respond to people's holistic and multiple needs, rather than pushing people into single diagnosis, narrow-criteria services. This is particularly important for people sleeping rough who disproportionately face multiple problems including substance use, mental health and chronic physical health

problems, with common roots in adverse childhood experiences and trauma.

Lack of good housing exacerbates these problems, making it essential that solutions to people's housing problems are integrated with solutions to their needs. There have been efforts to join-up these interventions – NHS England's integration agenda has led to the creation of Sustainability and Transformation Partnerships (STPs which aim to design 'whole system' approaches). Other structures with similar aims include Health and Wellbeing Boards and Integrated Care Systems (ICSs).

But the impact of deep spending cuts, combined with a predominant approach to commissioning based on single needs services with frequent retendering across different footprints, has thwarted efforts towards integration. Localism has meant that some areas have avoided this fate. But the overall picture is one of reduced capacity and greater barriers to people getting the support and treatment they need, when compared to a decade ago.

Drug and alcohol service manager: ***"We've had funding cuts here, lots. You know, our staffing levels have dropped and our caseloads have massively increased and that impacts the amount we can do... I've worked in substance misuse for a lot of years, more than ten years, fifteen years, and the services are completely different now to what they used to be. The resources are so stripped back."***

This is the context to the many challenges facing drug and alcohol services as they work with people sleeping rough. The result is a process where people do not get the timely, high quality and integrated treatment and support they need, making them less likely to present and stay in treatment, and less likely to regain control over their drug and alcohol problems. This means more people stuck sleeping rough.

⁷² Recovery Partnership (2017), *State of the sector 2017* http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/state_of_the_sector_2017_-_beyond_the_tipping_point.pdf

⁷³ Kings Fund (2019), Health charities make urgent call for £1 billion a year to reverse cuts to public health funding, <https://www.kingsfund.org.uk/press/press-releases/reverse-cuts-public-health-funding>

⁷⁴ WPI Economics for St Mungo's and Homeless Link (2019), *Local authority spending on homelessness* <http://wpieconomics.com/site/wp-content/uploads/2019/04/Local-authority-spending-on-homelessness-FULL-FINAL.pdf>

⁷⁵ BBC News (October 2017), 'Crisis' warning over homeless addicts admitted to hospital <https://www.bbc.co.uk/news/uk-england-41260042>

6.2 The challenges when it comes to working with people sleeping rough

To understand how many people sleeping rough are interacting with drug and alcohol services we can look at data from the National Drug Treatment Monitoring System. NDTMS is the system that drug and alcohol services use to record information on people starting treatment across England.

When someone comes to a drug and alcohol services they are assessed before commencing structured treatment. Structured treatment could include getting onto a 'script' (e.g. methadone) or starting regular counselling or group work. Part of this assessment involves the recording of someone's 'housing situation' – which is grouped into one of the following categories.⁷⁶

| Housing situation | Examples |
|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| No Fixed Abode – urgent housing problem | Lives on streets/ rough sleeper Uses night shelter (night-by-night basis)/ emergency hostels Sofa surfing/ sleeps on different friend's floor each night |
| Housing problem | Staying with friends/ family as a short term guest Night winter shelter Direct Access short stay hostel Short term B&B or other hotel Placed in temporary accommodation by Local Authority Squatting |
| No housing problem | Owner occupier Tenant – private landlord/ housing association/ Local Authority/ registered landlord/ arm's length management Approved premises Supported housing/ hostel Traveller Own property Settled mainstream housing with friends/family Shared ownership scheme |

We can look at national data on the number of people starting drug and alcohol treatment by their housing situation. Looking at the data shows that the total number of people starting treatment in England has fallen slightly over the past 10 years, while the number of people registered as No Fixed Abode – urgent housing problem (henceforth called NFA) has risen to a record high. This shows a significant increase in need among thousands of people sleeping rough.

- No Fixed Abode: 9,861 (up 18% since 2009-10)
- Housing problem (e.g. in temporary accommodation, hostel): 14,704 (down 15% since 2009-10)
- No housing problem: 104,565 (down 1% since 2009-10)⁷⁷

It is unclear why there has been a reduction in people presenting with a recorded 'housing problem'. This does not reflect any reduction in the numbers of people across the country in temporary accommodation or experiencing wider forms of homelessness. It should invite some caution as to the reliability of the 'urgent housing problem' figure, as it is possible that people previously recorded as having a 'housing problem' are being recorded as having an 'urgent housing problem', which may have disproportionately risen as a result.

⁷⁶ NDTMS (2019) *Adult drug and alcohol treatment business definitions* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/785198/NDTMS_adult_drug_and_alcohol_treatment_business_definitions_CDS-O.pdf

⁷⁷ NDTMS data (2019), <https://www.ndtms.net>

Thousands of people sleeping rough going without vital treatment

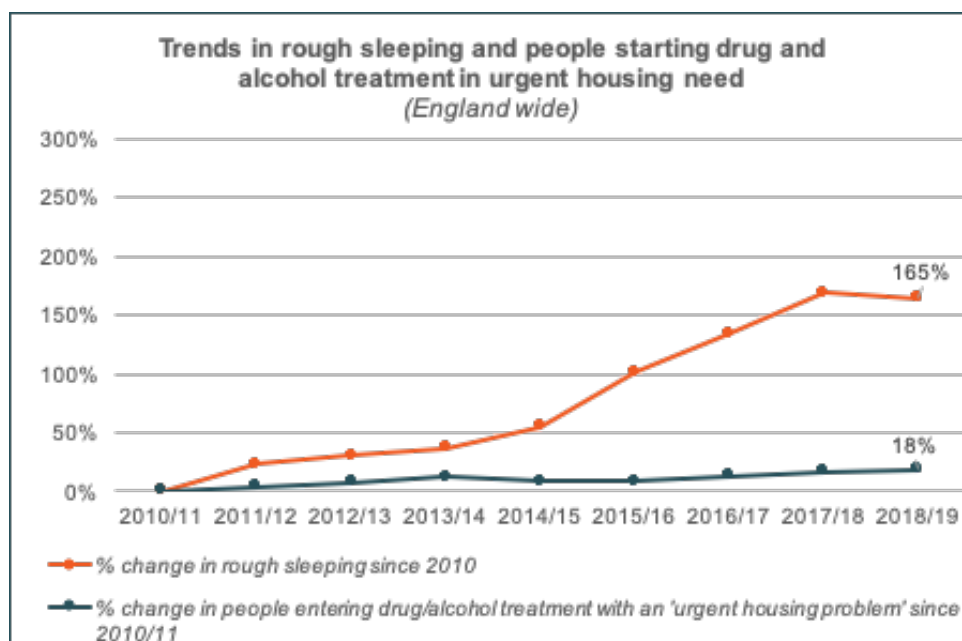
Data from NDTMS only shows the number of people who start structured treatment – it does not capture the thousands who never get this far, or only interact briefly with services for immediate harm reduction (e.g. needle exchange, BBV screening).

We can estimate the scale of unmet need by comparing the relative rise in NFA treatment numbers with the overall rise in levels of rough sleeping. We have assumed that need for drug and alcohol services among people sleeping rough has risen at least as much as the overall increase in levels of rough sleeping, given that data from London suggests that the average person sleeping rough today is more likely to have a drug and alcohol problem than five years ago.⁷⁸

However this is not a perfect comparison, because NFA and rough sleeping are different measures of homelessness (e.g. NFA includes some forms of sofa surfing). Secondly, rough sleeping counts are done by a single night snapshot whereas NFA in treatment is calculated across each financial year:

But while the raw numbers will be different, the consistent methods of collection mean that we would anticipate similar trends when it comes to percentage change over time. We have overcome challenges with collection times by comparing the single night autumn snapshot in the rough sleeping counts with the NDTMS data from the financial year the snapshot took place.

Doing this presents a striking picture. Between 2010 and 2018, rough sleeping counts soared while the number of people with no fixed abode starting treatment rose by a much more modest amount. It shows that while rough sleeping rise by 165% in this period, individuals with NFA in treatment rose by just 18%. This gap has become particularly pronounced since 2014-15.



This data looks at relative changes in need and numbers in treatment. It suggests only a small proportion of the increase in need (orange) has translated into people actually being treated (grey).

⁷⁸ CHAIN (2019), in our survey of drug and alcohol services the vast majority of areas said need had increased, and we have seen no evidence that suggests the prevalence of drug and alcohol problems has decreased outside of London.

Calculating the numbers missing from treatment

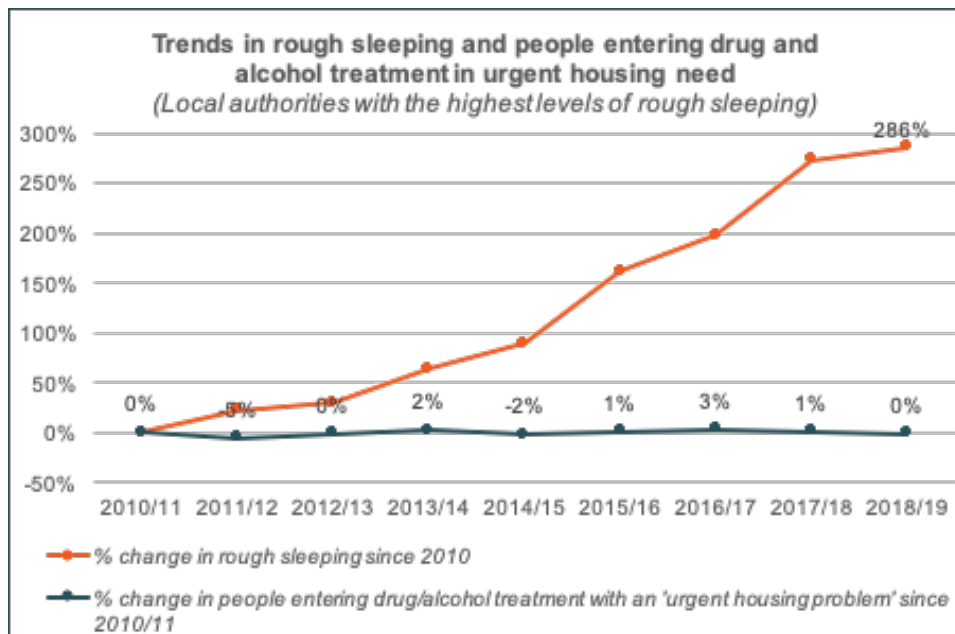
We can estimate that if the trends in rough sleeping numbers had been reflected in numbers in treatment, there would have been 22,000 people with no fixed abode starting drug and alcohol treatment in 2018-19. Instead, the actual figure for 2018-19 was just under 10,000.

This implies 12,000 fewer people experiencing the most severe forms of homelessness were accessing treatment in 2018-19, than would have done with 2010-11 levels of treatment access. While this is not a perfect estimate, it does give us an insight into the scale of unmet need among people sleeping rough with drug and alcohol problems.

Greater unmet need in the areas with highest levels of rough sleeping

Rough sleeping is concentrated in a small number of local authority areas, with many areas reporting very low numbers (including many areas reporting zero people rough sleeping). This obscures national figures and limits the value of a national picture.

We therefore decided to also look at just the areas with sizable levels of rough sleeping. To do this we looked at the 50 local authorities with the highest levels of rough sleeping (at least 24 people sleeping rough on a given night).⁷⁹



This shows in the areas where the data is stronger and more reliable, and where rough sleeping is a greater problem, the picture is starker: Drug and alcohol services have not been able to absorb almost any of the net rise in need. This suggests many people are going without the treatment they need.

⁷⁹ The top local authority trends are based on 39 local authorities from the 50 local authorities with the highest levels of rough sleeping in 2018. The missing 11 did not have comprehensive NDTMS data for the whole of this period.

Drug and alcohol services say it is getting harder to support people to stay in treatment

It is not just starting treatment which is difficult for many people sleeping rough, there is also the challenge of retaining people in treatment.

NDTMS data shows that 21% of opiate users at the start of treatment had a recorded 'acute housing problem', compared to 15% at six months.⁸⁰ This significant change suggests that individuals with an 'acute housing problem' are more likely to drop-out of treatment, or that those who stay in treatment are more likely to address their housing problems. From our qualitative interviews, the view of many people working in homelessness services is that the former was a more likely explanation.

The challenges with keeping people retained in treatment were reflected in our survey of drug and alcohol service managers in these 50 areas with the highest levels of rough sleeping.

We asked whether it had got harder or easier to support people sleeping rough to 'complete' treatment over the past five years (given that treatment completion is one of the main outcome measures for services). 23 out of 50 responded:

- 10 out of 23 (43%) services said it had become harder
- Six out of 23 (26%) said it had become easier
- Seven out of 23 (30%) said things had stayed the same.⁸¹

This picture shows little signs of easing in the current political and financial climate, including the prospect of the ring-fence around the public health grant being removed. We asked drug and alcohol service managers whether they anticipate it would get harder or easier to support people sleeping rough to 'complete' treatment over the next two years:



- 11 out of 23 services (48%) anticipate it will get harder
- Five out of 23 (22%) anticipate it will get easier
- Seven out of 23 (30%) anticipate it will stay the same.⁸²

We heard how many of these challenges apply to other groups, and it is likely that services would give similar forecasts for their capacity to work with everyone with drug and alcohol problems. Despite the best intentions of services and commissioners, the challenges are great and the impact of funding cuts has drastically limited what services can do across the board. This appears to be particularly acute for those with the highest needs, who often require the more resource-intensive interventions.

To more fully understand how these problems play out in the ground, we carried out 'deep dives' into three areas in England – Stoke-on-Trent (West Midlands), Lambeth (London) and Bournemouth (South West). This has informed our analysis of how drug and alcohol treatment services work with people sleeping rough, highlighting the value of good practice, and identifying the impact of changes to provision on people sleeping rough.

⁸⁰ NDTMS data (2019) <https://www.ndtms.net/>

⁸¹ St Mungo's drug and alcohol service manager survey (2019)

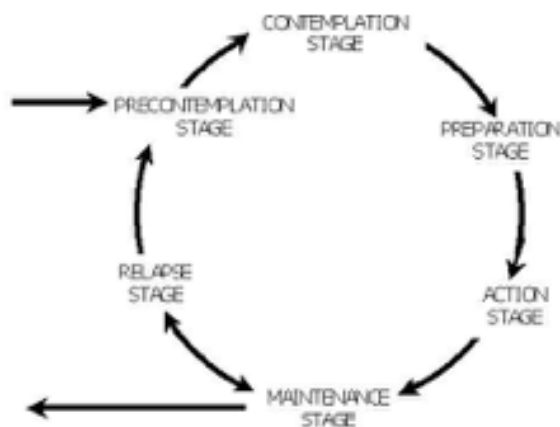
⁸² Ibid.

6.3 Reaching out – engaging people on the streets

In our interviews with people sleeping rough with drug and alcohol problems, we heard from many people who had started then dropped out of treatment, and many who had never started a programme of structured treatment.

People can sometimes struggle to present to treatment

To understand people's approaches to their own drug and alcohol problems, it makes sense to understand models of recovery. One example is the 'transtheoretical model', popularly known as 'stages of change', which describes the process by which people overcome addictions. The model forms the basis for person-centred approaches to addiction, and is widely used by people in homelessness services.



There are four main stages: pre-contemplation, contemplation, preparation, and action. Additional stages of maintenance and relapse are also sometimes included. While structured as a cycle, in practice people move between stages, go backwards and forwards, and hold multiples positions at different times.

Many people sleeping rough with drug and alcohol problems will be at the start of this cycle – 'pre-contemplative', where people do not intend to take action and do not always view their drug and alcohol use as harmful. There is evidence that experiences of multiple disadvantage and compound trauma make

people unwilling and often unable to engage in the structured ways that services expect. This can result in people being labelled as 'non-engaging' with an end to efforts to provide the support that people need.

Nicole: *"It just becomes out of control and you just live just to use. You know, all your money ends up going into using. It's like you just lose all sense of reasoning, especially when you're using, you lose sense of reasoning. You can't even reason with yourself, much less listen to any other reasoning... it just goes out the window and you just use, use, use."*

Outreach is essential to engage people

For people who do not voluntarily present to services, outreach can be vital. These workers go out onto the streets or into the places where people live or stay (e.g. day centres, emergency accommodation). Teams responsible for carrying out this outreach function will vary. In some instances, rough sleeping outreach teams may lead shifts with the support of drug and alcohol service staff. However, in other cases the drug and alcohol service may have its own team which leads this work. The crucial part of outreach work is the ability to build trusting, supportive relationships. Outreach workers are in a unique position to work with individuals to identify their needs and find solutions together:

Greg: *"I think sometimes this [outreach] is probably the best service I've ever encountered. They come to you on the street, they find you, they give you a key worker immediately. In the last four days they've given me more help than any service has over the last fifteen years."*

From our survey of drug and alcohol service providers, some four-fifths of drug and alcohol services do at least some building based inreach or outreach (either in partnership with homelessness services or independently) to engage people experiencing homelessness, with two-thirds doing this at least once a week.⁸³ In our survey of drug and alcohol treatment services, needle and syringe exchange to prevent viruses and naloxone to treat overdoses were two of the most common harm reduction interventions administered by outreach workers.

⁸³ St Mungo's drug and alcohol service manager survey (2019)

However, the work can be challenging and resource intensive. As one manager of a street outreach service said: “If they’re using drugs, they’re high. If they’re not high, they want to get high. So, it’s an absolute vicious circle. . . There’s no, sort of, good time. You’ll probably get ten minutes of good time in a 24-hour period... you have to identify the window.”

The chaotic nature of some people’s lives, combined with the nature of mental health problems and addiction, limits continual engagement, and means workers need persistence and training to do their jobs effectively. Mental health training and psychologically-informed techniques can make a significant difference here. This can mean building trust, providing support and getting people to a stage of contemplation and preparation to engage in structured treatment.

This is important because people not engaging with treatment services are often those most likely to be most seriously harmed by their drug and alcohol use – data from Public Health England shows 40% of the people who had drug related deaths had not been in contact with drug and alcohol services in the last decade.⁸⁴

Drug and alcohol service manager: *“harm reduction has got to be there first to keep them safe because people aren’t just going to stop using overnight.”*

Outreach has been reduced due to spending cuts

We heard from multiple people working in drug and alcohol services that outreach has been the first service to disappear in an era of cutbacks.

Drug and alcohol service manager: *“This population requires outreach and wrap-around support which is time consuming and resource heavy...we are struggling to meet the demands of this client group as their needs are becoming more complex and services are seeing reductions in funding in the city.”*

We heard that many drug and alcohol service outreach teams have been cut entirely. This has put extra pressure on rough sleeping teams, with whom drug and alcohol services increasingly partner. We heard in interviews how at the same time staff with specialisms have been reduced, for example mental health or alcohol specialists.

This is part of the explanation for why fewer individuals sleeping rough are starting drug and alcohol treatment than we would expect. But despite that, almost 10,000 people recorded as NFA did present to treatment in 2018-19.

6.4 Opening up – getting people scripted and supported

The majority of people presenting to drug and alcohol treatment services do so for opiate problems, particularly heroin. The standard form of immediate treatment is Opioid Substitution Therapy (OST), where an individual is put on a ‘script’ (methadone or buprenorphine) as a substitute, alongside keyworking and ‘psycho-social interventions’. It is recommended by the National Institute for Clinical Excellence (NICE) as the major form of treatment for opiate dependence.

In addition to stabilising opiate use in a controlled way and saving lives, it also helps to bring people to services, where they may receive support for other issues. This was reflected in our interviews, where many highlighted the value of scripts in stabilising opiate use and encouraging people to engage in treatment.

⁸⁴ Public Health England (2019), *The national inquiry into drug-related deaths in England* <http://www.emcdda.europa.eu/system/files/attachments/3234/7.%20Plenary%202%20Martin%20White%20EMCDDA.pdf>

Rapid access to scripting is valuable for many

Getting someone on a script is an important intervention when a so-called 'window of opportunity' is identified or when someone reaches the 'contemplative' stage of recovery. Moving people to 'reparation and 'action' is key – which is what makes it important that scripts are available in a timely and accessible way.

Peter: *“When it’s taking them six weeks to get the script, anything can happen in that six weeks. They could end up dead, you know, if they inject, or anything... If they’re delayed, it might go out their head, that confidence.”*

In our survey, we asked drug and alcohol treatment services: “for a client approaching your service for the first time, how long would it take for them to receive their first script assuming they meet the criteria for treatment and fully engage.” The results from the 24 services who responded were:

| | |
|----------------|-----------------------|
| Same day: | 5 (21%) |
| The next day | 1 (4%) |
| 3 to 6 days: | 6 (25%) |
| 7 to 14 days: | 7 (29%) |
| 14 to 21 days: | 5 (21%) ⁸⁵ |

This snapshot in areas with the highest levels of rough sleeping highlights the significant variation in waiting times for accessing a script. On the positive side, this shows that all responses were within the three week target set by Public Health England. However, from our interviews we found significant value put on same or next day scripting by people currently sleeping rough, which only six services we surveyed were able to achieve.

Ben: *“Our situation and circumstances change minute by minute, and we can’t plan more than a few hours ahead. So, if we’re not acting within 24 hours on the initial assessment, you might be in a different town by the end of the day.”*

People who struggle to keep appointments risk dropping out of treatment

With a reduction in outreach services, and fewer specialist workers able to engage people where they are, people who want help with drug and alcohol problems often have to attend drop-ins followed by structured appointments. Many people will likely be expected to attend appointments with other services, such as for their mental health or to claim benefits. Pushed between pillar and post, these expectations can be too much for some, who simply drop out of treatment.⁸⁶

Greg: *“At the moment, there are so many users waiting for such a limited service, that if you don’t attend one appointment, you get knocked back to the beginning. You are made to jump through hoops to prove you’re ready for this... I must have gone to maybe 20-25 appointments in the last two months, and I’ve only achieved script and support once out of those 25 appointments, and I still haven’t achieved housing... I’ve got nothing to show for any of it, because I can’t stick to appointments... My God, and I don’t have an alarm clock, I don’t have a diary, I don’t have a phone, I don’t have any way to even know what day it is some days.”*

The requirement to attend appointments is not arbitrary, and proper clinical process and oversight is essential for people’s safety when talking about substitute prescriptions. But a consideration of how such practices impact on presentation and drop-outs, and put people at risk as a result, should be properly considered too.

A lack of flexible approaches is making retaining people in treatment harder

More flexible approaches to scripting and support have been and are still available. In-house scripting, where drug workers are able to work with clients where they are, operates in some areas. However, these interventions are more resource and time intensive, and have therefore fallen victim to funding cuts. This has compounded the reduction in outreach services.

⁸⁵ St Mungo’s drug and alcohol service manager survey (2019), these figures apply to individuals who ‘fully engage’. This engagement may entail a drop-in, followed by assessment and follow-up appointments. If an individual misses an appointment, wait times would likely be longer. This makes these figures a ‘best case’ scenario, given many people sleeping rough struggle to make and keep appointments

⁸⁶ Cockersell (2016), *Social exclusion, compound trauma and recovery*, p21 |

Hostel worker: *“We had in-house prescribing. That was very responsive to client needs of coming into the service where people were living, and that’s gone completely...that’s been a barrier for some clients.”*

Drug and alcohol treatment service manager: *“Sustaining treatment...that’s more difficult because we don’t have the flexibility to be as reactive as we’d want. If somebody stops attending, we will try and re-engage them. We will do what we can, but ultimately, if they don’t come in then*

we’ll close them off on the system and hope that, you know, they come back at some point.”

Part of sustaining people in treatment is paradoxically to give people an exit route – not by removing support but by providing more recovery-based interventions to help people rebuild their lives. This is the value of keyworking, mutual aid and peer support, work often be done by a separate recovery team or service. From there, some individuals will have the opportunity to enter detox and rehab.

Prioritising the most vulnerable – holistic support from East Kent Forward Trust

In spite of significant funding cuts, East Kent was one of the few areas we surveyed where providers thought it would get easier to support people rough in the next two years.

Shortly after taking on the drug and alcohol service contract in 2017 Forward brought together local people and stakeholders to ‘co-design’ the support available across five districts. The new ways of working focussed on individual needs using a holistic and flexible approach.

They have agreed with their commissioners to prioritise more complex and high-risk cases – this resulted in new Key Performance Indicators (KPIs) and moving to a five year contract with a two year add-on to build practice and culture change.

The service manager acknowledges this has meant a deprioritisation of less problematic cases, but says *“you have to change the culture and mindset of workers to thinking about risk...”*

“It is work in progress, but joint working and communication has definitely improved...It is important that we create a new way of working with people that meet their needs.”

Examples of positive practice as a result include:

- Weekly joint outreach with local homelessness services, with workers seconded between services.
- Satellite services delivered in local health centres and GP services.
- Structured appointments have been replaced with open access drop-ins.

Evidence of success includes:

- Three quarters of clients reported an improvement in their psychological health as well as their quality of life.
- Clients are more likely to find accommodation during treatment, with a 10% reduction in the number of people with an acute housing problem when they exit treatment.
- In their review the CQC highlighted the effective working with stakeholders and partner agencies to design the new treatment model to meet client needs.

This example shows how a new co-production approach, prioritising the holistic needs of individuals, with changes in commissioning to back it up, can result in significant changes for the most vulnerable groups.

Forward (2019), *Involving service users and stakeholders as equal partners in the Forward East Kent Substance Misuse Service* <https://www.forwardtrust.org.uk/media/1824/pulse-5-january-2019-final-approved.pdf>

6.5 Building recovery – detox, rehab and longer-term support

Detoxification and rehabilitation are two of the major structured treatments for individuals, and. Detox occurs first in an inpatient, residential or community setting to allow an individual to physically detoxify, and can be followed by rehabilitation, with 24 hour in-house support to build recovery.

Detox and rehab are valuable interventions – but are increasingly hard to access

Residential / inpatient detox and rehab are particularly valuable for people sleeping rough, as they take people away from the dangers of rough sleeping and into an environment conducive to recovery. In rehab, people benefit from several months of intensive 24 hour support, and we heard from people how valuable this can be.

Zack: *“It was incredible...I learned everything about the drug, I learnt about myself, there are groups every day just building you up...It’s such a great environment to get off drugs, and to build your personality, and I would recommend residential care for everyone, but it’s just not available at all to anyone out here.”*

However, recent years have seen significant reductions in funding and bed spaces in detox and rehab schemes. The number of detox and rehab centres in the UK registered with the Care Quality Commission has fallen and spending by local authorities has reduced by £135 million.⁸⁷ There are now only a very small number of NHS inpatients centres remaining. This has made detox and rehab harder to access for many, with some having to wait months before getting treatment.

Andrea: *“They’ve closed down a lot of detox units... About four have been closed down...I’ve been waiting for like six months and I still ain’t on the list yet...all the cutbacks they’re making it ain’t helping.”*

Many people sleeping rough feel that expectations for engagement to access detox and rehab are set too high

Detoxification and rehabilitation are costly interventions, and a high degree of engagement and readiness is sought before it is offered to individuals. This has always been the case, but in recent years it has coincided with limited availability and in many areas appears to have become more onerous according to our interviews.

Group work is one of the most common requirements for access to longer-term treatments, such as detox and rehab. We heard from people sleeping rough as well as people working in services about the wide dislike of group work, which combined with the challenges of keeping appointments, can create significant barriers for the most vulnerable.

Sam: *“I was told when I walked in that if I wanted residential care, I’d have to do twelve weeks of groups to prove I was serious because it’s a lot of money they’re spending...There’s not a hope in hell I would make two let alone twelve or however many they wanted me to do.”*

In our interviews we heard multiple reasons for this, including a dislike of sharing highly personal information in group settings, mental health problems which lead to anxiety in such settings, and fears of interacting with people who may have been abusive in the past.

Outreach worker: *“I’ve got some clients who are so anxious that they can’t even stand in a queue in boots to get their methadone, so how are they supposed to go in and do group work, it’s impossible. They get so anxious that they’re sick in the toilets.”*

We heard that sometimes the aversion is to specific settings where group work takes place. This is particularly true for women who had experienced domestic violence, due to fears of encountering violent partners.

Outreach worker: *“Most of the substance users don’t want to attend groups. They’re trying to stop and going to the groups with people that are using or selling so they feel vulnerable, and they don’t like opening up in groups anyway. They’ve got a lot of pride... and a lot of shame.”*

⁸⁷ The Independent (July 2019) “Residential addiction services in England cut by third amid drug overdose and funding crisis figures show” <https://www.independent.co.uk/news/health/addiction-drug-alcohol-treatment-austerity-cuts-government-council-a8992696.html>

Lack of housing and support after discharge presents serious problems

The impact of a lack of detox and rehab units is compounded by the lack of housing available after discharge. Many providers will not accept people into treatment if this is not lined up, due to the dangers and risks to discharging people into environments which make relapse more likely.

In our survey of drug and alcohol services, six in 24 required a fixed address for detox (25%) and four in 24 for rehab (17%).⁸⁸ The rationale for this is fears about the safety of people returning to the streets after a detox, where individuals are most at risk from overdose. This demonstrates how rough sleeping (and lack of housing after discharge) makes getting treatment for drugs and alcohol more difficult, sometimes impossible.

Outreach worker: *“they won’t give them a detox of alcohol unless they’re housed. That’s a big problem. Somebody who wants to address their alcohol, but you’re still working with them on the street and the [worker] there went, ‘Well we can’t give them a detox because he’s lying around on the street.’”*

Even for those who complete rehab, the recovery journey can be far from over. The value of aftercare and wider forms of support in the community have a big role to play. For people with a history of rough sleeping, this includes housing related support services such as floating support, to help people who might otherwise struggle to live independently in their own home. Many of these services have specialist substance use workers, to support people with current or recovering drug and alcohol problems.

But as with access to treatment services, many of these services have been cut. Research by St Mungo’s found that funding for specialist substance use floating support services declined by 41% between 2014-15 and 2017-18.⁸⁹

Claire: *“when they do go into rehab and they’re there for three months, come back out again, start with the drugs again... because there’s not enough support there. It’s like, ‘You’ve done it, go, bye,’”* (LCF5p15)

This shows how challenges far beyond the drug and alcohol treatment system impact on the availability and effectiveness of drug and alcohol treatment. It suggests that joining up treatment with housing and wider support services is essential to give people the care and support they need to rebuild their lives.

6.6 The vulnerable groups going without treatment

While almost all people sleeping rough will encounter some form of barriers when it comes to getting support for drug and alcohol problems, these barriers are disproportionately felt by certain groups. People without a ‘local connection’ or non UK nationals are often denied full and free access to treatment, while women and minority groups face specific challenges to getting the treatment and support they need.

Migrants are particularly hard hit

One of the starkest barriers to drug and alcohol treatment applies to non UK nationals who have ‘no recourse to public funds’, a condition imposed on people due to their immigration status. For several years, regulations have been in place to charge for some NHS services for individuals deemed ‘not ordinarily resident in the UK’. However this was expanded with the National Health Service Regulations (2017), to remove secondary care provided outside of hospital, and care provided by community health services, charities and community interest groups.⁹⁰

⁸⁸ St Mungo’s drug and alcohol service manager survey (2019)

⁸⁹ St Mungo’s (2018), *Home for good: The role of floating support services in ending rough sleeping* <https://www.mungos.org/app/uploads/2018/12/Home-for-Good-floating-support-report.pdf>

⁹⁰ DHSC (2018), *Overseas NHS visitors: implementing the charging regulations* <https://www.gov.uk/government/publications/overseas-nhs-visitors-implementing-the-charging-regulations>

This means that since 2017, some of the treatments available from drug and alcohol services are not freely available to non UK nationals, with full payment for a course of non-urgent treatment often required up front before services can be provided. There are some exceptions, for example mental health services to treat conditions caused by sexual violence.

Drug and alcohol service manager: *“We have seen an increase in the number of clients who are homeless and do not have links to the Borough, in most cases Eastern European and they move from Borough to Borough, no recourse to public funds, not being able to work and having to pay for their opiate substitute prescription.”*

In 2018, CHAIN data shows that there were 1,180 non-UK nationals sleeping rough in London with drug and alcohol problems – this is a vast number of people who may be going without vital drug and alcohol treatment, and is a significant barrier to helping people address their needs and rebuild their lives.⁹¹

This is compounded by welfare reforms which have restricted access to benefits for migrants from other European Economic Area (EEA) countries. Those without work or in insecure work have no access to housing benefit, can push people to have to sleep on the street. Sleeping rough in turn increases the likelihood of drug and alcohol dependency in order to cope, making it harder to find and sustain employment. Drug and alcohol treatment is therefore required to break this vicious cycle, but current Government policy makes this more difficult to acquire.

A local connection is required to access treatment in many areas

High barriers to accessing treatment do not only apply to non UK nationals, but also to wider numbers of people who lack a 'local connection'. Local connection policies require individuals to have ties to the area, such as living, working or having family, as a pre-condition for accessing treatment. We heard how this means people sleeping rough can be pushed from pillar to post to get the support they need.

Localism combined with spending cuts can create a perverse incentive for local areas to cut services, given the relatively high mobility of many people sleeping rough. This in turn can result in some local authorities imposing local connection requirements on accessing services to prevent them being 'attractive' to people from outside the area.

In our survey of drug and alcohol treatment providers, we asked whether or not local connection requirements were in place for a wider array of interventions. We found that a majority of areas imposed local connection requirements on access to the following interventions:

- ✘ Prescribing service
- ✘ Peer support
- ✘ Psycho-social interventions
- ✘ Counselling
- ✘ NPS clinic
- ✘ Detoxification
- ✘ Residential rehab.⁹²

Given the mobility of many people sleeping rough, strict local connection policies effectively deny significant numbers from accessing treatment. We frequently heard how demoralising this is for many people who have been repeatedly excluded from services and broader society, with one saying “you just give up hope.”

We heard from people working in homelessness services in particular that these requirements do little to 'deter' people from coming or staying in their area; it simply means they are unable to access the support they need in order to leave the streets.

There are multiple homelessness service models based on assessment 'hubs' which take people in from surrounding local authority areas – the No Second Night Out model in London is one example of this. Local connection policies mean people who are brought into one of these hubs by outreach teams can be miles from where their 'local connection' is registered, sometimes limiting the ability of assessment workers to get individuals immediate support for their drug and alcohol problems.

⁹¹ CHAIN (2019)

⁹² St Mungo's drug and alcohol service manager survey (2019)

Serious consequences for people denied treatment due to lack of local connection

We heard that in some cases local connection criteria meant people desperate to overcome drug and alcohol problems were detoxing themselves on the streets, with one man who had used heroin for fourteen years telling us without a local connection in his new area this was his only option.

Mark: *“when I came here, I went and lay in the garden next to the toilets for seven days and cold-turkeyed...by the toilets because you get diarrhoea, you get cramps.”*

Despite regulations prohibiting local connection requirements being placed on individuals fleeing abuse, this was also reported by people we spoke to.

Chloe: *“My abuser found me, and the people that were meant to be looking after me and caring for me couldn’t give two hoots, they didn’t give a damn. When I came here, hoping to try and sort out, there were so many boundaries, it was unreal. So many doors closed in my face, because I hadn’t been here for six months. Within those six months, I could have been dead in a gutter...So no, I don’t think you should be stopped from giving support or whatever because you’re not from that borough. That’s wrong.”*

Women face particular barriers to accessing drug and alcohol treatment

As shown, the number of women sleeping rough with drug and alcohol problems has risen substantially in recent years – rising at a significantly higher rate than for men.

Women encounter disproportionate disadvantages when it comes to accessing drug and alcohol treatment services. This has been demonstrated in *Mapping the Maze (2017)*, a report by Agenda, the alliance for women and girls at risk and AVA (Against Violence and Abuse).⁹³ The report highlighted how women enter services later and with higher needs than men.

In our interviews, we heard how abuse and trauma can often be experienced in a gender-specific way, which created particular challenges for accessing services. Some drug and alcohol problems were related to an abusive partner who facilitated addiction or exploited it for personal advantage, and these circumstances made engaging in drug and alcohol treatment challenging.

Outreach worker: *“A lot of the time you’ll have, with the power dynamics in a lot of the couples we have, the man won’t want the woman to get treatment, because if she gets treatment, that’s less power that he’s got over her. So, a lot of the time you’ll have in the couple...the guy is getting on a script and getting treatment and the woman isn’t.”*

We heard how it is not just present partners who will impede women from accessing treatment, but that fear of encountering former abusers will lead women to avoid facilities where that individual will be present. We heard how with reductions in funding drug and alcohol services have been increasingly based on single sites, which compounds this problem.

The research by Agenda and AVA found that a lack of women-specific services reinforces these issues.⁹⁴ They found that only around half of all local authority areas in England offer support specifically for women experiencing substance use problems – and in most cases this was either a weekly women’s group within a generic service or specialist substance use midwives. Evidence in this report and others demonstrates the value of women-only spaces in facilitating safety on both an ‘emotional and physical level’. The reduction in these spaces may be making women less likely to present and sustain in treatment.

⁹³ Agenda and AVA (2017), *Mapping the maze* <https://www.mappingthemaze.org.uk/wp-content/uploads/2017/02/Mapping-the-Maze-final-report-for-publication.pdf>

⁹⁴ Ibid.

Minority groups can face additional barriers to accessing treatment

This reflects a wider challenge with limited engagement with communities who less readily 'present' to treatment. This is true for minority groups where there is historic underrepresentation in drug and alcohol services, which becomes self-reinforcing. One worker in a drug and alcohol service said "it's a community where the family deal with everything", and this prohibits engagement with drug and alcohol services. This again shows how a lack of specialist workers and outreach services, mean that underrepresented groups go without vital treatment.

Drug and alcohol service manager: *"I think we've definitely got an under-representation from other cultures. I think we've got a lot of white British people. We've got a few Polish people, but generally I don't think we're reaching the areas that we need to... When you haven't got the resources to go out there and target it, you're almost stuck with the people that come to you, and it's the people who don't come to you who need the extra support because our service isn't accessible to them."*

In our interviews we heard that language barriers can be particularly damaging, preventing effective communication and making people who do not have English as their first language less likely to present and stay in treatment.

6.7 Joining up services to address underlying needs

As shown, drug and alcohol treatment services have a vital role in helping people to address the issues underlying their drug and alcohol problems and start a meaningful recovery. But there is only so much these agencies can do in isolation. The role of other services, such as mental health, domestic violence, and services for prison leavers are all fundamental in responding to drug and alcohol problems among people sleeping rough.

Mark: *"At the end of the day, if you're using drugs, why are you using drugs? Whether you want the help at the time or not, why am I still taking drugs on and off and going through what I go through now? It's not normal behaviour. I've got issues and problems, haven't I, obviously?"*

A big catch 22 – challenges with mental health treatment

Data from CHAIN shows that 57% of all people with a recorded drug and alcohol problem have a co-occurring mental health problem.⁹⁵ There are also common overlaps with other conditions such as Acquired Brain Injury. Given this, it makes little to no sense to design services which deal with either need in isolation. However, at present this is exactly what happens in too many areas.

The relationship between drug and alcohol problems, mental health problems and complex trauma, can result in frequent misdiagnosis and repeated failures to respond effectively to people's needs.

Hostel worker: *"It doesn't matter whether its alcohol or a substance, it's whenever you've got an addiction, it's what's underneath that addiction isn't it, that's what has caused you to develop addictions really. So, it's like stripping layers and...some of it will be trauma based."*

⁹⁵ CHAIN (2019)

In many cases a 'primary presenting need' will be identified, which will determine a 'pathway' of treatment the individual will be placed on. This will often prevent an individual who has both mental health and drug and alcohol treatment from one half of the treatment they need. This is despite NICE guidance which cautions against this practice.⁹⁶ This is particularly challenging when drug and alcohol use can act as self-medication for mental health problems.

We heard that there are still parts of the mental health system which require 'readiness' before accessing mental health or psychotherapy services. At the same time many struggle to engage with drug and alcohol services because of poor mental health and relational problems.

Homeless service co-coordinator: ***“Some of the guys have clearly got mental health issues prior to even contemplating drug usage and alcohol. But, obviously, while they’ve got it, it’s just exaggerated even further and now we struggled, because they haven’t got anything to deal with their mental health, because of the addiction. In fact, the addiction now has caused a problem, because it’s preventing them from getting the mental health support, so it’s a big catch 22.”*** (SSC1p2)

We heard from multiple drug and alcohol treatment services that clients with multiple and complex needs were not being supported adequately by mental health services. As one drug and alcohol service manager said: “the presentation of service users has become more complex and the tight criteria and lack of resources of CMHT (Community Mental Health Team) has left substance misuse services holding the burden of risk.”

Prior attempts to develop specialist mental health services have faced significant cut backs. Research carried out by St Mungo's in 2016 revealed that 68% of areas where 10 or more people sleep rough on any one night do not commission any mental health services actively targeting people sleeping rough.⁹⁷ This demonstrates the challenges of services which have tried to better meet the needs of people sleeping rough – most of these have intervened in one aspect of the system or have been relatively short-term pilot programmes which have failed to ‘stick’ within the complex commissioning environment.

Sam: ***“I really needed psychological support, and I was months away from getting off drugs. So, I am still to this day undiagnosed, I’ve no idea if I have problems or not... there has to be a mental health support team that can deal with people still using.”***

The multiple morbidities and complexity of people's needs requires a flexible approach to mental health treatment and support, which addresses people's needs in a holistic and person-centred way. In October 2018, NHS England announced funding for new specialist mental health services working with people sleeping rough in seven areas with high levels of rough sleeping – this will start the process of rebuilding services and expertise lost since HMII.⁹⁸ The Government and NHS England must continue to build on this programme with additional specialist services and improved practice between different mainstream health services to better work with the most vulnerable and isolated groups.

⁹⁶ NICE (2016), Coexisting severe mental illness and substance misuse: community health and social care services <https://www.nice.org.uk/guidance/ng58>

⁹⁷ St Mungo's (2016), *Stop the scandal* https://www.mungos.org/app/uploads/2017/12/Stop_the_scandal_Nov2016.pdf?x74044

⁹⁸ NHS England (2019), *“Rough sleepers in homeless hotspots to benefit from NHS mental health outreach”* <https://www.england.nhs.uk/2019/10/rough-sleepers-in-homeless-hotspots-to-benefit-from-nhs-mental-health-outreach>

What did people sleeping rough value in drug and alcohol treatment services?

Through our interviews with people experiencing homelessness and working in homelessness services, we identified some key themes that were valued in drug and alcohol services:

- **Flexibility** – the ability to put individual needs before processes with alternative practices available, (e.g. same day scripting).
- **Person centred** – designing services around the individual, going to where they are, and providing holistic trauma-informed support and treatment (e.g. specialist outreach workers).
- **Managed expectations** – having different expectations for ‘engagement’ or ‘readiness’ for the most vulnerable (e.g. reduced requirements on engaging with group work).
- **Focus on risk** – aim resources at those most at risk of serious harm or death.
- **Specialist workforce** – Develop skills and specialisms of workforce with significant input from people with lived experience.

6.8 What treatment is for – and what needs to change

Drug and alcohol treatment can make a huge difference to the lives of people sleeping rough. But we also know that for too many, this remains a distant possibility. Rising need and cuts to services have in part created this situation.

But this need not be the case. There are examples of drug and alcohol treatment services developing innovative and effective practice in challenging circumstances. This practice needs to be shared, and services need to be supported and commissioned to develop effective interventions for the most vulnerable.

Designing services for the most vulnerable

Alongside overturning the vast sums lost to drug and alcohol treatment, there needs to be a serious conversation about who and what drug and alcohol treatment is for – and how the answer to that question impacts on the most vulnerable groups, including people sleeping rough.

There is significant evidence that the main indicator of ‘treatment completion’, often interpreted as free from drug or alcohol dependency, does not work for ‘complex’ cases or people sleeping rough.⁹⁹

Our interviews pointed to the need for a range of outcome measures, which bring together harm reduction and recovery approaches and promotes integrated service models. PHE recommend that commissioners ‘expand the use of drug treatment outcomes to better reflect the breadth of the benefits of drug misuse interventions’, including the proportion of people in need who are in treatment and housing outcomes while in treatment.¹⁰⁰

⁹⁹ Lankelly Chase (2015), *Hard Edges* <https://lankellychase.org.uk/resources/publications/hard-edges>

¹⁰⁰ Public Health England (2017), *An evidence review of the outcomes that can be expected of drug misuse treatment in England* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf

Finding better ways of judging outcomes – SURE: Substance Use Recovery Evaluator

SURE is a psychometrically valid, quick and easy-to-complete outcome measure, developed with unprecedented input from people in recovery by Kings College London, including St Mungo's clients.

In addition to specific questions around drug and alcohol use and dependence, it includes questions about hobbies, diet, sleep pattern, relationships and housing status. It is an example of a patient reported outcomes measure which better captures the success of treatment than many standard measures.

The outcome measures can be used by drug and alcohol services, as well as other services which work with people with drug and alcohol problems. It also gives commissioners a basis to judge success on a wider set of criteria which better reflects the difference services can make to the lives of the most vulnerable.

In addition to allowing more user-centred outcome measures, a SURE app has been created to allow more user-centred ways of using these measures and making them available. Professor Jo Neale from King's told us: 'the SURE app was developed because people asked for it, not because clinicians or service providers thought it would be good for them. In addition the app includes other features that people asked for. As a co-produced tool, it is consistent with the wider drive to encourage self-efficacy and person centred care.'

Drug and alcohol services can be improved – but whole-system change is needed

It is essential that the central government protects and increases funding for drug and alcohol services, alongside efforts to encourage practice which supports the most vulnerable groups to start and maintain in treatment.

But the drug and alcohol treatment system cannot be expected to tackle these issues in isolation. As shown earlier in this report, people sleeping rough with drug and alcohol problems have multiple needs and high levels of compound trauma. This means they are often in contact with a variety of agencies, and reductions in funding or changed practice in one sector impacts what is possible in another. The fundamental challenge of the availability and quality of housing continues to have a huge impact on what any service can do.

Current responses to homelessness can make these challenges greater, with separate commissioning structures and siloed working creating perverse incentives to reduce provision and push clients onto other service caseloads. This can spiral into a race-to-the-bottom, where barriers are erected and entry criteria made stricter, which is met in kind by similar responses from other services. Current practice, where people are identified as having a 'primary presenting need', and pushed into rigid single-focus pathways can compound these problems.

The answer is to step up efforts to drive out malpractice – such as individuals with co-occurring drug and alcohol problems being excluded from mental health services – as well as driving positive collaboration underpinned by adequate funding. This means building 'trauma informed' approaches to service design and wider commissioning, recognising people's multiple needs, and changing practice to address people's underlying problems in a more flexible and personalised way.

7

Right place, right time: how can housing reduce harm and build recovery?

As shown in the previous chapters, rough sleeping has a significant impact on people's drug and alcohol use, as well as on their experiences of drug and alcohol treatment. There is only so much that drug and alcohol services can do in isolation – without access to good quality housing, recovery can be very difficult. We also know that people sleeping rough are more likely to experience the most severe health harms from drug and alcohol use, including death. Providing appropriate, affordable and integrated housing can act as both prevention and cure – it minimises harm and promotes recovery.

This should come in tandem with integrating interventions from other settings, including mental health and criminal justice services – recognising how tackling rough sleeping and drug and alcohol problems is everyone's business.

7.1 The role of housing in reducing harm

Most immediately, the provision of accommodation can act as a harm reduction intervention. The harms associated with drug and alcohol use are greater when people are sleeping rough – an internal St Mungo's review of overdoses found that a client who overdosed while sleeping rough was significantly more likely to die as a result than a client who overdosed while in an accommodation service.¹⁰¹

This means the priority must be in ensuring everyone has somewhere safe to stay, through the provision of accommodation which is tolerant of drug and alcohol use, to ensure people are equipped with the right support and not using drugs and alcohol in more dangerous environments.

High tolerance supported housing can be valuable in minimising harm

Supported housing can have an important role in reducing harm. This point came through strongly in reviews into deaths of people sleeping rough. The Kings College London's thematic analysis of Safeguarding Adult Reviews (2019) found that "in the SARs where the individual had experienced Multiple Exclusion Homelessness, the importance of supported accommodation provision is often remarked upon."¹⁰²

Outreach worker: *"We're all constantly battling with them to keep them engaged positively... We can do only so much, but eventually it's the accommodation. It's too much to ask somebody to stay scripted, not use on top, engage with [the drug and alcohol service], all whilst rough sleeping. It's impossible."*

Many hostels and other supported housing services have adopted a positive harm reduction approach which enable them to work effectively with people who are actively using drugs and alcohol. Appropriate policies and procedures mean that staff can have honest conversation with residents and work with them to reduce harm (e.g. needle exchange) and to consider accessing specialist services. In our interviews, this was deemed to be an important intervention in reducing harm for people who struggle to live independently – especially those at a later stage in their life.

Nicole: *"Maybe they should have permanent sheltered accommodation for users. People that use... obviously some people really struggle with managing themselves, maybe some people need that longer than others because, obviously, some people have used for a long time and it's really hard."*

Being in accommodation can make it easier for drug and alcohol treatment services to find, retain and support an individual to stabilise their drug and alcohol use and reduce associated harms.

¹⁰¹ St Mungo's internal overdose report (2019)

¹⁰² S.J. Martineau et al (2019), *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*, The Policy Institute, King's College London <https://doi.org/10.18742/pub01-006>

Drug and alcohol treatment service manager: *“if somebody disengages from the service and they’re homeless, for us to try and re-engage them it’s so much harder because we have to phone round 25 agencies to see if anyone’s seen them, whereas if someone’s got an address, we can send a letter or go and do a home visit.”*

Housing First is a particularly effective model for people who have slept rough for a long time with high needs

Throughout our interviews, we heard positive comments about Housing First for people sleeping rough with drug and alcohol problems. This was echoed by people working in street outreach services, drug and alcohol treatment services and commissioners.

Outreach service manager: *“Housing First is a fantastic model that operates, and works on the basis of housing the client first...Housing the client first, and then dealing with the problems, issues, and everything else afterwards, and I think, historically, that’s been the other way around, and it’s not worked.”*

Housing First is both a model of service provision, as well as a principle – which gives people housing without expectations or conditions, and assigns a keyworker who is available to provide intensive support (if desired) around the client. The evidence base suggests high levels of housing retention among Housing First clients, though this comes from international studies and is currently being piloted at scale in England.¹⁰³

Drug and alcohol treatment service manager: *“It [levels of rough sleeping] did get worse, however our area was chosen by the government for a pilot scheme of Housing First and this has drastically reduced the amount of rough sleepers. Without this, I think that things would have continued to get worse.”*

7.2 The role of housing in building recovery

Housing also has a vital role beyond reducing immediate harms, and can form a part of someone’s ‘recovery capital’ – the term used to describe the internal and external resources necessary for someone to achieve and maintain recovery from drug or alcohol problems.

Drug and alcohol worker: *“I’m a massive believer that we can deal with the physical side of things in terms of medication, but then it’s sustaining that with recovery capital i.e. your housing. Your housing is your foundation, you build off that.”*

In our interviews with people working in services this was on more than one occasion explained with reference to ‘Maslow’s hierarchy of needs’ – this theory from the 1940s holds that physiological and safety needs including shelter forming the basis for people development, growth and recovery.¹⁰⁴

This is reflected in a review by Public Health England which found:

- homelessness can lessen the motivation for change and willingness to engage with treatment, including if a person is focusing on housing as the priority
- access to housing can have a positive impact on motivation to change

Chloe: *“I think if there’s more of an incentive for people to do something and improve their lifestyle, or... I think it might help in changing somebody’s outlook and being able to get up that ladder to doing better, rather than being at bottom and just taking each day as it comes. Get something to live for, something to look forward to.”*

¹⁰³ Housing First Europe Hub – research <https://housingfirsteurope.eu/research>

¹⁰⁴ Abraham Maslow (1943), “A Theory of Human Motivation”, *Psychological Review*

Lining up treatment and with appropriate housing is particularly important for individuals who desire abstinence

For people who desire abstinence, detox followed by residential rehab is the most effective NICE-approved response. There is evidence that this is particularly effective for individuals with the highest needs - NICE recommends rehab for people 'seeking abstinence who have significant comorbid physical, mental health or social problems'.¹⁰⁵

But people who have gone through rehab need appropriate housing after discharge – in the previous chapter we heard how and why detox and rehab was refused to people without appropriate accommodation after discharge. This accommodation will need to be tailored to the individual – often removed from previous social circles or triggering situations which may result in relapse. This has been echoed in a PHE evidence review which found that 'the risk of relapse is increased if no housing is available on completion of inpatient or residential treatment'.¹⁰⁶ In practice this often means abstinence-contingent housing, which can show positive outcomes for this group.¹⁰⁷

This requires more effective partnership working between drug and alcohol service providers and housing and homelessness teams, with pathways established for people to move into good housing after they leave detox or rehab. But this points to another key challenge – much of the accommodation available is not fit for purpose for people in recovery from drug and alcohol problems. To design a whole-person approach requires getting people into the right accommodation, with the right support, at the right time.

7.3 The dangers of inappropriate housing without the right support

Not all accommodation is good accommodation, especially where the right support is lacking. This explains why some people say rough sleeping is preferable to dangerous or inappropriate accommodation.

This was demonstrated by St Mungo's peer research *On my own two feet: why do some people return to sleeping rough after time off the streets?* which investigated why people return to rough sleeping after time off the streets.¹⁰⁸ Other research by Christopher Scanlon has created the concept of 'unhoused minds', as a means of explaining the ways that mental health problems and trauma can create resistance to accessing housing.¹⁰⁹ This should act as a powerful reminder why someone 'choosing' homelessness and drug and alcohol use, is not best characterised as a 'lifestyle choice', but a reflection of trauma and serious need.

Over the past decade three important factors have combined to severely restrict access to suitable accommodation for people who have experienced homelessness: the chronic and worsening shortage of social rented housing, cuts to funding for supported housing and cuts to benefits which have put the private rented sector out of reach for many.

This has had a serious impact on how the 'right' accommodation can be provided to people with drug and alcohol problems, in a way that is conducive to their recovery and minimises the harms they experience from drug and alcohol use. As a result, many people are being failed and others are simply refusing accommodation options not appropriate to their needs.

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- ¹⁰⁵ NICE (2012), "Residential rehabilitative treatment" <https://www.nice.org.uk/guidance/qs23/chapter/Quality-statement-10-Residential-rehabilitative-treatment>
- ¹⁰⁶ Public Health England (2017), *An evidence review of the outcomes that can be expected of drug misuse treatment in England*
- ¹⁰⁷ Jesse B. Milby et al (2005), "To House or Not to House: The Effects of Providing Housing to Homeless Substance Abusers in Treatment", *Journal of Public Health* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449349>
- ¹⁰⁸ St Mungo's (2018), *On my own two feet: why do some people return to sleeping rough after time off the streets?* https://www.mungos.org/app/uploads/2018/06/StM_PRR_TEXT_0718_web.pdf
- ¹⁰⁹ Christopher Scanlon et al (2015), "Housing 'unhoused minds': Inter-personality disorder in the organisation?", *Health Care and Support* https://www.researchgate.net/publication/254190135_Housing_%27unhoused_minds%27_Inter-personality_disorder_in_the_organisation

Inappropriate housing without support sets people up to fail

When it comes to providing housing, many local authorities are relying on housing options where support is not available, such as putting someone up in a bed and breakfast, a budget hotel or poor quality 'exempt' accommodation where adequate support is not commissioned by the local authority or provided'.¹¹⁰ A key problem with this kind of housing is congregate living with other people using drugs and alcohol, but without vital support. We heard about the highly negative impact this can have on individuals, particularly those with drug and alcohol problems, being set up to fail.

Outreach worker: *"You're then asking somebody who is maybe chaotic, vulnerable, to stay in a hotel where there's going to be other chaotic, vulnerable people. There's no staff, there's no support and then you expect them to succeed. Then they don't succeed because they'll be evicted or they abandon it, and then you start getting into the territory of intentionally homeless. Then the council then start going, 'Well it's their fault they're rough sleeping'. I struggle because it's not their fault because you're setting them up to fail. I think it's crazy."*

As highlighted in KCL's review of SARs in homeless deaths, providing inappropriate accommodation of this sort can put people at serious risk.¹¹¹ One of the SARs analysed by KCLs concerned Frank, a 55 year old man from Essex, who died in a hotel room provided by the local authority under its cold weather provision, as a result of 'multi-drug toxicity with a background of liver cirrhosis'. The review noted that Frank had post-traumatic stress disorder and alcohol dependence, and in the view of the SAR author would 'only have been successfully treated if he was also in appropriate, stable accommodation'.

The dangers of a one-size-fits-all approach to accommodation provision

While hostels and supported housing with a tolerant approach to drug and alcohol use is appropriate for people at immediate risk who may not be seeking abstinence, these kinds of provision will not be appropriate for people who have gone through detox or rehab and aim to be drug or alcohol free. We heard that in practice people were often ending up in this situation with accommodation not tailored to their needs.

Tom: *"When you come out of treatment, they want you to stay clean. Why on Earth do they put you in a wet house? Come on, where's the sense in that?...the first day I came out of treatment, I moved into the [hostel], and because I saw people drinking around me, I was like, 'Sod this. Nonsense.' I was straight up to the off-license. I had four beers, I just sat and drank them... So, hostels aren't any good, really."*

On the other side, we heard how an absence of abstinent-contingent or 'dry' housing limits the options available to people who have gone through detox or rehab. At the extreme end, this can create a perverse incentive for people not to address their drug and alcohol problems. This shows how a one-size fits all approach does not work, nor should one area rely on just one type of hostel provision.

Outreach worker: *"Even if they have detoxed themselves on the streets, so you've got somebody who's really pleased with themselves, they're a few weeks clean, haven't touched anything, we can't get them into accommodation then because there's so much using in the first tier that they won't put somebody because then they'll relapse. So then they're left on the street."*

The reason why people often ended up in inappropriate accommodation centred on the lack of effective multi-agency working, the lack of funding available to cover support costs in accommodation, as well as the challenges of accessing 'move-on' accommodation for people who no longer need supported housing.

¹¹⁰ Commonweal Housing Association (2019), *Exempt from responsibility?* <https://www.commonwealhousing.org.uk/static/uploads/2019/11/Exempt-from-Responsibility-Full-Report-November-2019.pdf>

¹¹¹ SJ Martineau et al (2019), *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*, The Policy Institute, King's College London <https://doi.org/10.18742/pub01-006>

7.4 Challenges accessing ‘move on’ accommodation

The lack of ‘move on’ accommodation is a major challenge – leading to people being stuck in homelessness services and supported housing which they no longer need.

Drug and alcohol service manager said: *“This means that people are stuck in stage 1 hostel accommodation for years which then makes it harder to make progress in their treatment and recovery when they are in an environment where drug and alcohol use is surrounding them daily.”*

St Mungo’s *Home for Good* campaign highlights this, including the lack of social housing, major affordability issues in the private rented sector, and lack of support services to help people maintain tenancies. All of these problems are compounded for people with drug and alcohol problems. This limits the availability of good housing and the ‘recovery capital’ which people can draw upon.

Social housing is regarded as the most appropriate tenure by many

We heard frequently about the value of social housing for this group, which is more affordable, more secure, and more likely to provide access to support workers to manage issues rather than punish and evict.

Nicole: *“I think [housing associations] have done better because they have offered places to vulnerable people, people that have been on substance abuse, alcoholism, they give them a chance because every so often...they would offer a couple of flats out to [homeless charities] who deal with homeless people, and I think that was nice, I’d never really had that before.”*

But with the general reduction in social housing these opportunities are more limited – due to a net loss in social rented housing as well as growing waiting lists. There is also evidence of more restrictive allocations policies from local authorities, meaning that some of the most vulnerable are not getting access to the kinds of accommodation which so often form the basis of their recovery.¹¹²

Private rented sector is inaccessible to many

With such a limited pool of social housing, and increasing restrictions on access, the private rented sector is the only move-on option for many. But the challenges around affordability and stability here are stark – this includes rising costs of rents and the reductions in benefits to cover this cost.

As part of the ‘Cover the Cost’ campaign, research by Crisis and the Chartered Institute of Housing shows that 97% of areas in England, just one-fifth or less of private rents are affordable within Local Housing Allowance rates to either single people, couples or small families.¹¹³ This is compounded for people with drug and alcohol problems, who will struggle to make up the difference due to their ongoing drug or alcohol problems.

Homelessness services manager: *“There’s an issue around affordability, you know, people sometimes would have to make a little bit of a payment to top-up their rent if the rent isn’t covered within the local housing allowance, so they may need to make a contribution. I think using drugs and alcohol can make it harder to do budgeting work with people.”*

Universal Credit is presenting particular challenges

Universal Credit has made issues of affordability particularly challenging for people with drug and alcohol problems. We heard from both people working in services and individuals claiming UC themselves about two major issues with UC payments – the money no longer being paid directly to the landlord, as well as the monthly payments. This has given people with drug and alcohol problems an often overwhelming responsibility with serious consequences – lots of individuals were very honest about where that money would go.

Carl: *“People on housing benefits, they’re now putting all that money into people’s account. If people have a drug addiction, they’re going to go, ‘screw my housing benefit’. They’re going to go buy drugs, then they’re not going pay their rent, then they’re going to be homeless and it’s going to be a vicious circle, without the right help, and without the right support...They need to somehow arrange with some people, that they do get it weekly split up because there are people who just can’t handle it.”*

¹¹² Crisis (2017), *Moving on: improving access to housing for single homeless people in England* https://www.crisis.org.uk/media/237833/moving_on_2017.pdf

¹¹³ Crisis (2019), *Cover the cost* https://www.crisis.org.uk/media/240378/cover_the_cost_briefing.pdf

It's not just inability to manage a budget that causes problems with these payments, but the risk of bullying, intimidation and violence. We heard from people who would be marched to cashpoints on payday by people they owed money to for drugs, or attacked by individuals who needed money to fund their own drug and alcohol problems. It is highly concerning that welfare changes have had these impacts.

Stigma from private landlords is commonplace

Alongside the unaffordability of the private rented sector, there is a serious issue around access related to stigma. There is significant evidence that private landlords are unwilling to let to people with histories of rough sleeping or those in receipt of Universal Credit, as Shelter's 'no DSS' campaign has highlighted.¹¹⁴ We heard in interviews how drug and alcohol problems add to this, and can make the chance of getting a private rented home very slim.

Carl: *"If landlords ever go, 'Have you ever had drug use' and if I say 'seven years with spice', they think, in their eyes, I'm a twenty-one-year-old kid who's on drugs, probably going to have lots of friends, like, partying, doing this. I can understand where they're coming from but there is so much discrimination nowadays. I heard there actually is a law coming out where landlords aren't allowed to discriminate people for being on DSS and being, like, homeless and things which is actually going to help a lot of people."*

7.5 Supporting the whole-person – towards an integrated, holistic and housing-led approach

The persistent challenges that exist to provide adequate housing for people sleeping rough with drug and alcohol problems demonstrates that there is no single offer which works for everyone. But what all effective interventions share is being housing-led, and recognising the role of housing in providing a platform to address people's needs, integrated with a range of support services.

The immediate focus should be on reducing harm and ending rough sleeping, in the process removing a key driver of drug and alcohol problems. But there needs to be an effort to provide suitable accommodation tailored to individuals' needs and where they are in their recovery journey, rather than seeing any housing as the right housing.

This means in some cases providing housing as part of drug and alcohol pathways (e.g. following residential rehab, supported housing), in others providing housing prior to engagement in a drug and alcohol pathway (e.g. Housing First, floating support). The right option must be tailored to the individual's needs, and inappropriate housing should be avoided wherever possible – such as B&Bs, hotels, and settings which risk retriggering people's use.

This requires tackling rough sleeping and homelessness more broadly. The right housing and support offer at the right time is often not available because of the pressures around affordability and security in the housing market, and the reductions in funding to allow support to be offered when needed. Adopting policies outlined in St Mungo's *Home for Good* campaign to:

- Increase the number of social homes available to people with a history of rough sleeping
- Improve the private rented sector to better meet the needs of people with a history of rough sleeping
- Re-invest the £1 billion a year that has been lost from single homelessness services, compared to 10 years ago.

The right housing is the foundation upon which recovery should be built. But it is not enough on its own. To provide full support for people's multiple needs, we need to move towards a more collaborative kind of service provision, to ensure people get the holistic and specialist support they need. This means integrating interventions from other settings, including mental health and criminal justice services – recognising how tackling rough sleeping and drug and alcohol problems is everyone's business.

¹¹⁴ Shelter (2019), *A vision for social housing* https://england.shelter.org.uk/__data/assets/pdf_file/0005/1642613/Shelter_UK_-_A_vision_for_social_housing_full_interactive_report.pdf

8

Recommendations for change

The Government has committed to ending rough sleeping within five years, and to better meet the health and housing needs of people sleeping rough. These aims are welcome, but achieving this will require much more than short-term pilots and funding pots. They should build on the last Rough Sleeping Strategy, but take a new approach which pushes forward collaborative systems change backed up by long-term strategic funding. This will not work without providing adequate support for drug and alcohol problems and other associated health needs.

In the short term, there should be rapid efforts to address the public health crisis and stop people dying on the streets. These recommendations outline what is needed at a national and local level to achieve this.



Our recommendations to central government:

1. Cross-government strategy

Update the Rough Sleeping Strategy 2018 with a new strategy. This new strategy should be genuinely cross-government with ministerial representation from a range of departments and arm's length bodies, underpinned by a clear recognition that rough sleeping is a public health crisis. The strategy should include objectives and measures to improve health outcomes and reduce drug and alcohol harm, and ensure the right housing and treatment is available when people need it.

2. Public health funding

Ensure that funding for drug and alcohol treatment is protected by maintaining the ring-fence on the public health grant beyond 2020-21 and increasing the grant in line with King's Fund and Health Foundation recommendation for the restoration of £1 billion public health funding lost in recent years. This is a baseline requirement to make change at a system level and prevent more people from sleeping rough with drug and alcohol problems.

3. Personalised fund

To save lives and meet the immediate needs of the most vulnerable, the government should establish a 'rough sleeping and substance use personalised fund'. This should 'follow the individual' and fund a multi-agency plan for their treatment and immediate housing related needs – while also generating learning for wider system change. Crucially, this must be available to people regardless of local connection or immigration status.

4. Commitment to ending deaths on the streets

A clear commitment from government to end deaths among people sleeping rough and in emergency accommodation over the next five years, backed up by an independent national programme to ensure every death gets reviewed, analyse trends, and make recommendations to hold government departments and arm's length bodies to account.

5. Central oversight and support

The government's planned Addiction Strategy and addiction monitoring unit should include specific considerations and progress measures for people experiencing homelessness. This should aim to encourage a wider range of 'distance travelled' and patient reported outcome measures, and ensure that local areas are adopting positive 'trauma informed' service integration and ending poor practice (e.g. no mental health exclusions). This should be aligned with how a range of departments and bodies (e.g. MHCLG, NHSE, NHSI, PHE) report progress for this population.

6. Independent commission on drugs

Listen to the calls from drug and alcohol service providers for an expert, independent commission to develop an evidence-led approach to drugs policy and treatment.¹¹⁵ Given the dramatic rise in drug related deaths, no options should be 'off the table' in this commission – for example, piloting Drug Consumption Rooms (DCRs).

7. Homelessness reduction boards

Move ahead with proposals in the government's *Tackling Homelessness Together* consultation in 2019, to establish new statutory 'homelessness reduction boards' bringing together a variety of local services and decision makers to tackle rough sleeping – including drug and alcohol services, and integrated with NHS new models of care.

¹¹⁵ The Independent (December 2019) 'Consider decriminalisation to tackle drug death 'crisis', say treatment providers in unprecedented plea <https://www.independent.co.uk/news/uk/home-news/drug-policy-deaths-decriminalisation-addiction-treatment-heroin-a9215191.html>

Our recommendations to local leaders:

This includes housing, public health, and police and crime commissioners, as well as elected members, clinical commissioning groups and other interested parties.

1. Recognising trauma

Due to the high rates of trauma among this group, all services and pathways should be trauma-informed and psychologically informed, with policies and strategies in place to support the development of appropriate service provision and suitable working practices.

2. Recognising care and support needs

Local areas should recognise that someone sleeping rough with drug and alcohol needs is highly likely to have care and support needs, with high rates of abuse, neglect and self-neglect. This means every area should have processes in place to ensure timely access to Care Act assessments for people sleeping rough and reviews into any deaths that occur, as well as building improved local understandings of self-neglect, substance use and homelessness.

3. Integrating health, care and housing

Ensure that all Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs) develop plans which include reference to rough sleeping, and prioritise the integration of housing, mental health and substance use treatment pathways. This should ensure the right treatment and housing (e.g. Housing First, supported housing) is available when people need it, and no one is denied access to detox or rehab due to a lack of housing.

4. Commissioning differently

Explore different approaches to commissioning the range of services which work with this group, including longer contracts, joint commissioning, and using a wider range of shared patient-reported outcome measures to judge treatment success. This should include measuring 'distance travelled' and levels of access among vulnerable groups – and integrate these measures across a range of services.

5. Specialist services

Commit to commissioning specialist services for people sleeping rough with drug and alcohol problems. This should include a greater number of women-only services, increased Housing First and supported housing provision, services for individuals without recourse to public funds, and multi-disciplinary teams providing integrated outreach, mental health and substance use support.

Stopping the record numbers of people living and dying on the streets requires high-level commitment and strategic action. These recommendations would go some way to improving the outlook for people sleeping rough with drug and alcohol problems. With the right action, we can stop people from dying, and ensure everyone has the support and housing they need to rebuild their lives.

Many of the images in this report are stock images.
Thank you to all the St Mungo's clients whose stories appear in this publication.
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