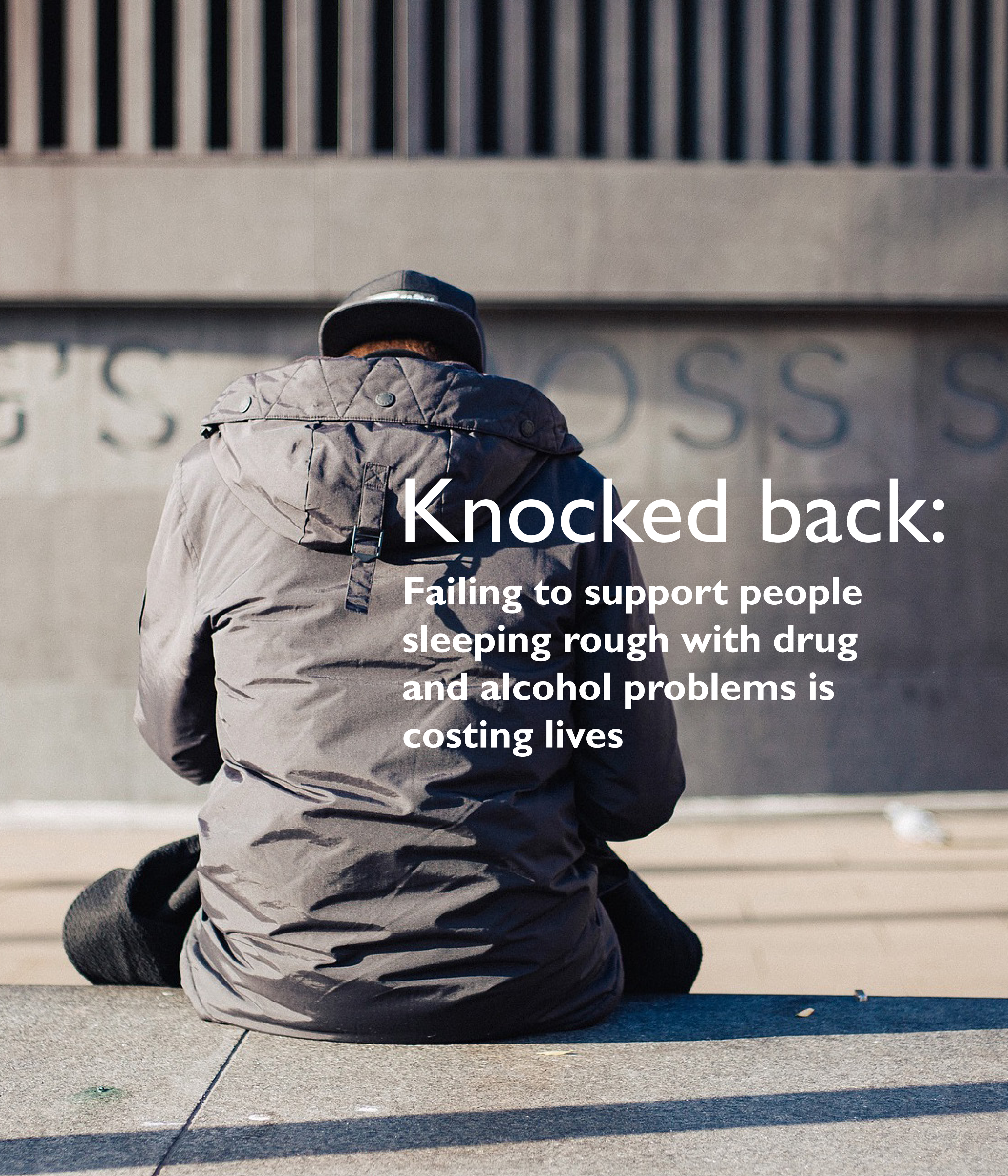

Knocked back:

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

St Mungo's
Ending homelessness
Rebuilding lives

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"The cycle of constantly scoring and drug use, and missing appointments... this is something that needs to be addressed. 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… I must have gone to maybe 20-25 appointments in the last two months.... 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

"I have seen firsthand the issues explored in this research. I'm a service manager working with people sleeping rough in Bournemouth, Poole and Christchurch. But I also know 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 my current role. I've been sober nearly 11 years. I drive home to my wife, my stepchildren and my dog – and I've never been happier.

This is such a vital issue, yet often stigmatised and misunderstood. Having worked and lived with both homelessness and drugs and alcohol, 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, like mine.

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

But when it fails, people lose everything and some pass away.

I recently ran into someone who was homeless at the same time as I was and he said, "I'm incredibly proud of you." He's still on the streets, 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 St Mungo's Bournemouth, Christchurch and Poole Street Outreach Service

The public health crisis today

Executive summary

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 accomodation, 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.

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

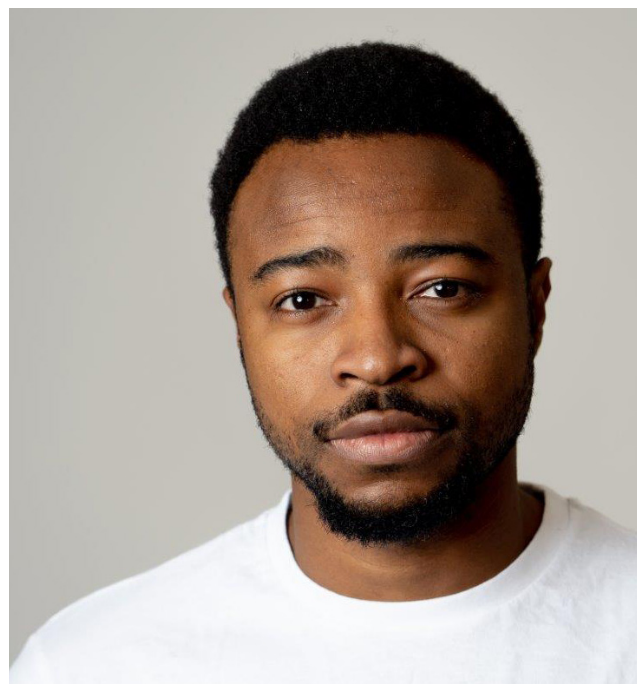
About the research

On a single night in 2018, more than 4,600 people slept rough in England, an increase of 165% since 2010.[3] Not only are more people living on the streets, record numbers of people are dying on the streets and in emergency accomodation too.[4] In 2018, for the first time, the majority of these deaths are now caused by drug and alcohol problems.[5]

St Mungo's has carried out this new research to further explore the issues behind the increase. This includes the relationship between rough sleeping and drug and alcohol problems, and how the drug and alcohol treatment system works with people sleeping rough.

This research builds the evidence base in an under-investigated area. It focuses on people's interactions with the drug and alcohol treatment system and reveals how people who have already faced traumatic experiences and set-backs throughout their lives – such as abuse, domestic violence and family breakdown – are let down again through a lack of appropriate housing and cuts to vital drug and alcohol treatment services. When people sleep rough, they often end up being knocked back from life-saving treatment, housing and support just when they need it most.

The lack of treatment and support is largely the result of government cuts to public health funding, which means spending on drug and alcohol treatment services has shrunk by a quarter, with future funding at serious risk.



This is part of a bigger picture of cuts to other services and support which are needed to prevent homelessness, including housing benefit, supported housing, mental health and criminal justice services. The result is more people living with, and dying of, preventable drug and alcohol problems on the streets.

The aim of this report is simple. No more deaths should be required to force the change we need to see. The costs of failure are too high.

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3 MHCLG (2019), *Rough sleeping statistics autumn 2018, England*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/781567/Rough_Sleeping_Statistics_2018_release.pdf

4 726 people died while sleeping rough or in emergency acocmodation in 2018 according to the ONS, the highest since their time series began, 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

5 40% of all estimated deaths in 2018 were related to drug poisoning, and alcohol-specific causes accounted for 12%; 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

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Research methods

This research was based on a mixed methods approach including:

- A survey of drug and alcohol service managers in the local authority areas with the highest levels of rough sleeping. From this we received 24 unique responses from different areas,[6] supplemented with phone interviews with service managers and drug and alcohol commissioners.
- 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 use and service provision, and to observe whether findings from London resonated elsewhere.
- In these three areas, we interviewed 20 people with experience of homelessness and drug and alcohol problems, and 22 people working within homelessness or drug and alcohol services. Quotes from interviews are included throughout the report but have been anonymised (with the exception of the personal stories of Andrew and Maz).
- We analysed and compared data from the National Drug Treatment Monitoring System (NDTMS), Combined Homelessness and Information Network (CHAIN), and the Ministry of Housing, Communities and Local Government (MHCLG) data on rough sleeping in England, to identify trends in need and access to treatment.

[6] Five of these services were commissioned at either upper tier level or across multiple lower tier local authority areas

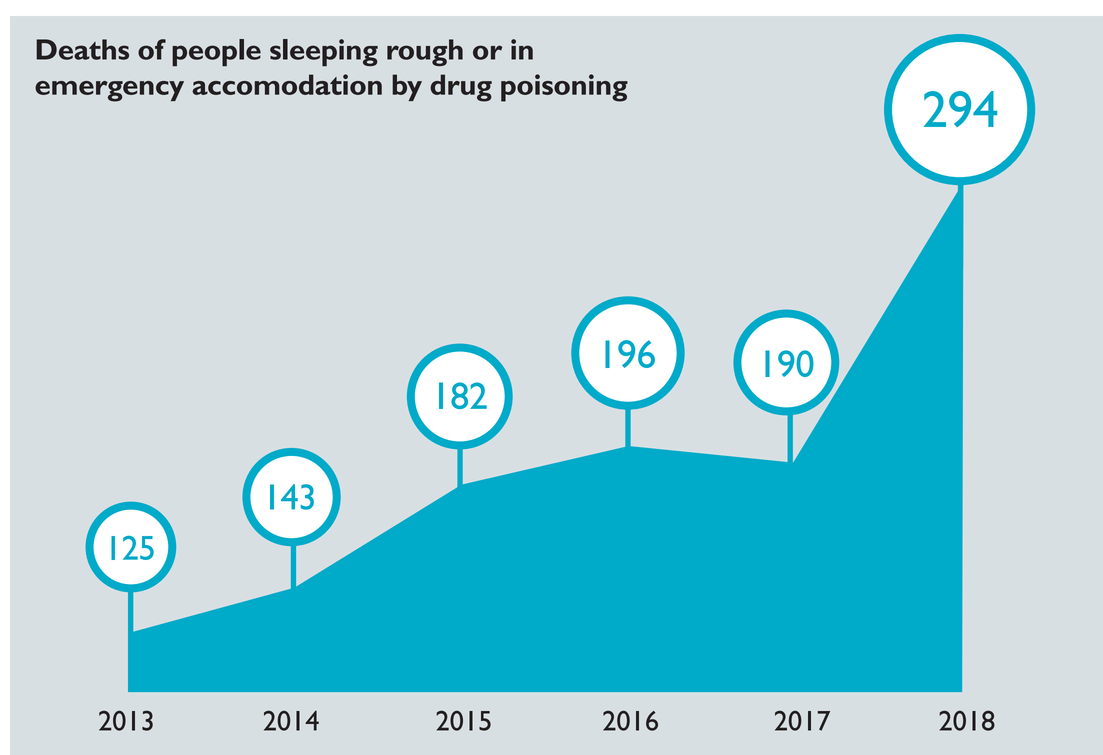
Cause or consequence?

The links between rough sleeping and drug and alcohol problems

➘ The number of people living and dying on the streets now constitutes a public health crisis

In 2018, 726 people died while sleeping rough or in emergency accommodation. The majority of these deaths were related to drugs or alcohol.[7]

The number of deaths caused by drug poisoning increased 135% between 2013 and 2018, with a 55% rise in just one year between 2017 and 2018.



This is just the tip of the iceberg. St Mungo's internal data shows that there are many more non-fatal overdoses than drug related deaths.[8] If we apply this data to the national figures, it suggests there could have been almost 3,000 overdoses among people sleeping rough or in emergency accommodation in 2018, of which almost 1,200 could have been intentional.[9] Further research is needed, but this points to the scale of the public health crisis on our streets.

> *"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."* **Joe**

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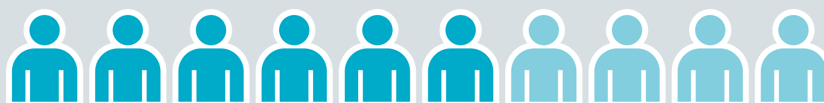
7 Office for National Statistics (2019), *Deaths of homeless people in England and Wales 2018* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018

8 Internal data from St Mungo's services shows that less than 10% of suspected overdoses result in fatality, and almost 40% are 'intentional' overdoses.

9 'Intentional' can include self-harm or suicide attempt. These figures are calculated by using the ratio of overdoses : fatalities and the proportion of intentional overdoses in St Mungo's internal data and applying it to the 294 homeless deaths caused by 'drug poisoning' in the ONS data.

There are growing numbers of people sleeping rough with drug and alcohol problems

The rising number of deaths is driven by the fact that more people are sleeping rough and that drug and alcohol problems are becoming more common among those sleeping rough.[10]



6 in 10

people sleeping rough in London now has a drug or alcohol problem, compared to 5 in 10 only four years ago.

In 2018-19 there were 3,314 people sleeping rough in London with a recorded drug or alcohol problems. This represents a total rise of 22% since 2014-15 and a shocking 65% rise among women.[11]

Deaths from drug poisoning among people who were experiencing homelessness were overwhelmingly caused by opiates (e.g. heroin, morphine or fentanyl), often combined with alcohol and sometimes other substances.[12] This reflects studies which show opiates and alcohol to be the two most problematic substances used by people sleeping rough, as well as crack cocaine. There is a well established and internationally recognised set of clinical practices to support and treat dependency on these drugs.[13]

"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." **Anthony**

Novel Psychoactive Substances (NPS) such as 'spice' or 'mamba' have gained significant public awareness in recent years. We heard in interviews how, while these drugs do present particular changes in specific areas, their national prevalence is often not as great as media reporting would suggest, particularly when compared to opiates, crack and alcohol.[14]

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[10] 62% of people sleeping rough assessed by street outreach teams 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, CHAIN (2019)

[11] 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%, the total rise among both men and women was 22%. CHAIN (2019).

[12] 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

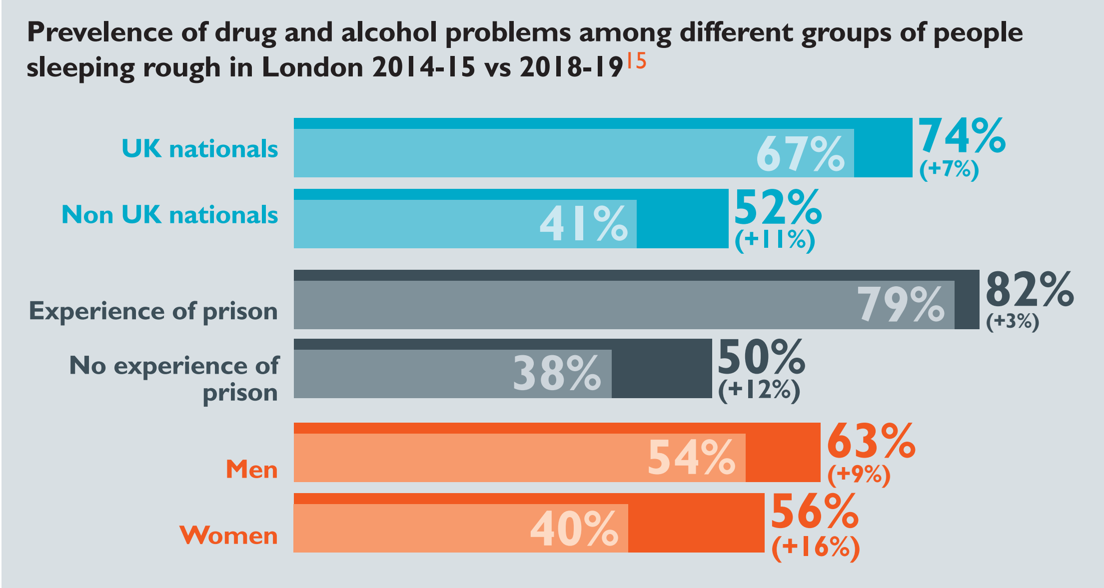
[13] Department of Health and Social Care (2017), Drug misuse and dependence: UK guidelines on clinical management, https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

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

The problem is growing fastest among groups that were less likely to be affected in the past

Not all people sleeping rough experience drug and alcohol problems equally. Certain groups are more likely to have drug and alcohol problems, including people with experience of prison, people with mental health problems, men and UK nationals. But figures show that drug and alcohol prevalence has become more widespread in recent years.

Prevelence of drug and alcohol problems among different groups of people sleeping rough in London 2014-15 vs 2018-19[15]



Groups who were less likely to have drug or alcohol problems in the past, such as women or non UK nationals, have seen rises in prevalence at a faster rate than their male and UK national counterparts. This suggests we should avoid the traditional stereotypes which often cloud this issue, and develop person-centred solutions for a wide range of different groups.

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

Rough sleeping pushes people into more dangerous situations and towards riskier behaviours

> *"[My drug and alcohol use] when I lost my flat 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 from 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."* **Sally**

The roots of people's drug and alcohol problems frequently predate rough sleeping but 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.

In our interviews we heard how rough sleeping can compound previous traumatic experiences, worsen mental health and expose people to greater levels of abuse and violence.[16] These dangerous situations push people to riskier behaviours – such as using harder kinds of drugs or multiple substances at once. This reflects the significant evidence that trauma begets trauma, and damages the way people manage their perceptions and relationships.[17]

Seeing people's experiences in terms of vulnerability, abuse and neglect helps centre the conversation on the interventions most likely to improve and save lives. Rather than deploying enforcement and coercion as a default, people who are rough sleeping and have drug and alcohol problems should be recognised as having care and support needs.[18] This means that adult safeguarding responsibilities should apply more often than they do at present.

Drug and alcohol problems often develop before someone arrives on the streets

We explored the reasons when and why people sleeping rough might engage in high risk drug and alcohol use. We found:

- Most people had problems with drugs and alcohol prior to their first night sleeping rough, often used to self-medicate the effects of trauma and exclusion.
- People who arrive on the streets with drug and alcohol problems are more likely to stay stuck sleeping rough.[19]
- Drugs and alcohol provide an escape from the realities and traumatic experiences faced by people sleeping rough, while also creating serious physical and psychological dependence which compounds these problems.
- The longer someone sleeps rough, the more likely they are to develop drug and alcohol problems, or for existing problems to worsen.[20]

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[16] A study of homeless people in Nottingham showed how Adverse Childhood Experiences 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; 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

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

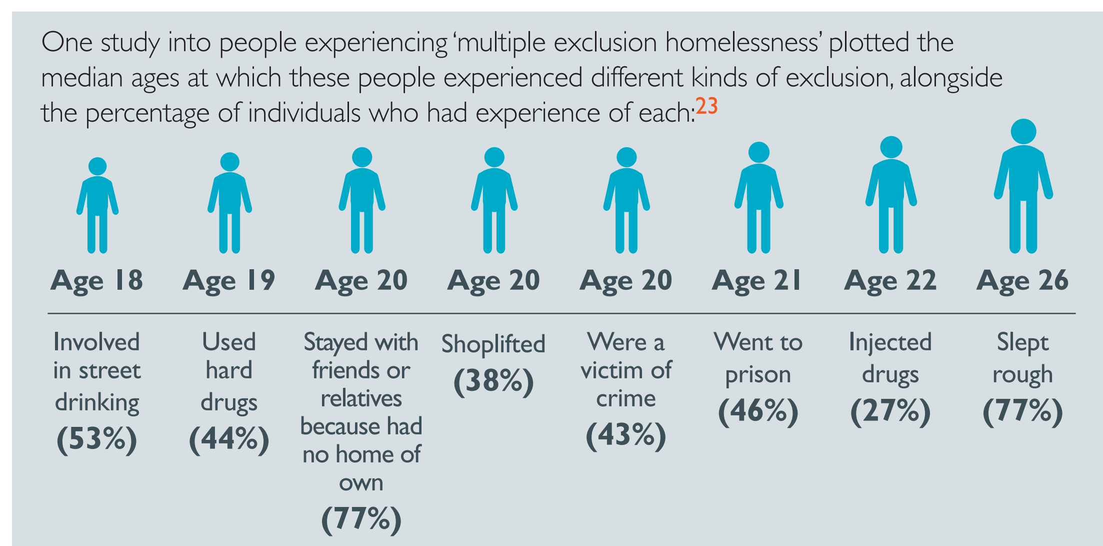
[18] For a summary of the kinds of the serious vulnerabilities and safeguarding issues surrounding people who are homeless with drug and alcohol problems, see S.J Martineau et al (2019), *Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews*, The Policy Institute, King's College London https://doi.org/10.18742/pub01-006

[19] 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. Among those who did not go on to sleep rough over a longer period, only 46% had drug or alcohol needs when they were first seen, CHAIN (2019)

[20] CHAIN (2019).

In London in 2018-19, 54% of people new to rough sleeping had a recorded drug and/or alcohol problem.[21] This compares to 71% of people who had been sleeping rough over two consecutive years. While this shows how problems get worse the longer people spend on the streets, it also builds on evidence which suggests that drug and alcohol problems frequently precede rough sleeping.[22]

One study into people experiencing 'multiple exclusion homelessness' plotted the median ages at which these people experienced different kinds of exclusion, alongside the percentage of individuals who had experience of each:[23]



Rough sleeping and drug and alcohol problems can have common causes. Research suggests that, for many people, these problems are closely related to complex trauma, arising from 'adverse childhood experiences' (ACE's). ACEs can include childhood abuse, neglect, parental substance use, mental ill health, death or separation. These events are closely associated with poverty and deprivation. Evidence suggests people experiencing homelessness have high levels of ACEs.[24]

Trauma and ACEs are also closely associated with poor mental health and we know that **seven in 10 people sleeping rough in London with a recorded mental health problem also have a recorded drug and/or alcohol problem.**[25]

Trauma has been shown to have substantial impacts on mental ill health and an individual's ability to build and maintain social relationships.[26] Drugs and alcohol can be a way of dealing with these traumatic experiences, but they can also push people into places that risk retraumatising them.

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21 Ibid.
22 Suzanne Fitzptrack 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
23 Ibid. See also, Lankelly Chase (2015), *Hard Edges* https://lankellychase.org.uk/resources/publications/hard-edges
24 Larkin et al (2018) examined a range of ACEs among a sample of 224 people experiencing homelessness. 87% reported at least one 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
25 CHAIN (2019)
26 Bessel van der Kolk (2015), *The body keeps the score: mind, brain and body in the transformation of trauma*

Maz's story

My mum had really bad mental health and, when she got sectioned, me and my sister were adopted and later separated. After that, with the people who adopted me, it was really dark.

I don't know when I became an addict. I started picking up substances when I was 13, just alcohol at first, even though I didn't like it. But eventually, I enjoyed having a drink inside me. It gave me a personality and the experience of it was good.

I started going with this lad, and he was on heroin. I always used to say, *"You'll never, ever catch me on heroin. It's disgusting, the lowest of the low."* But in the end I did. Just blowbacks to begin with, but I remember the first time I injected it. 50ml – straightaway overdosed.

We decided to pack up and run to London. As a kid I always wanted to run away to London. Then there we were, on the streets of London – Kings Cross, Euston, London Bridge – homeless.

The outreach team used to come up to us all the time and offer us help. We were so bang in addiction, we didn't care, so I'd be arrogant and abusive to them. But I started to notice that they genuinely cared – because they just didn't give up.

So I got reconnected with my drug worker and the treatment centre. Now I'm over two years clean.

I'm just thankful to be alive, and sober, with a home and friends. I'd say to anyone else – get help. I have, and it's changing my life.

As Maz's story shows, we should challenge simplistic explanations of rough sleeping and drug and alcohol problems, as well as moral judgements which blame rough sleeping on 'lifestyle choices' and label people as 'non-engaging'. These explanations do not capture how rough sleeping and drug and alcohol problems are symptoms, as well as causes, of trauma and suffering, often experienced over many years.

Unfortunately, the help that Maz received is increasingly hard to access for people sleeping rough, as the next chapter shows.

Great expectations?

The experience of accessing treatment and support

12,000 people sleeping rough or at risk of doing so are going without life-saving drug and alcohol treatment

"We've had funding cuts here, lots. … 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." **Drug and alcohol service manager**

Each year, thousands of people experiencing homelessness seek help from drug and alcohol treatment services. These are the primary agencies responsible for supporting people with drug and alcohol problems, and have a vital role in reducing harm and building recovery, as well as being highly cost effective.[27] However, these services are not currently able to support everyone who needs them, creating significant costs to other services.[28]

Central government cuts to local authority budgets, including cuts to the public health grant,[29] have seriously impacted on drug and alcohol services. Local authorities in England have reduced funding for drug and alcohol 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.[30] There is a risk that this picture could get even worse, with widespread concern about government plans to remove the public health ring-fenced grant, expecting public health services to be funded through increased Business Rates Retention.[31] This has also coincided with cuts to other services on which people sleeping rough disproportionately rely, such as homelessness, mental health and criminal justice services. In 2017-18 local authorities spent £1bn a year less on vital homelessness services compared to 2008-9.[32] The government's Rough Sleeping Strategy 2018 provided welcome additional funding for homelessness services, but falls short of replacing this wider funding which has been lost.

As our research revealed, this has created a catch-22 where more people haven't been able to access the support they need and are sleeping rough, which in turn is making it harder for services to work with them.

27 Public Health England reference studies which show that every £1 invested in drug treatment results in a £2.50 benefit to society, see 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

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

29 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

30 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

31 Figures from the drug and alcohol sector have argued this has created 'universal uncertainty' with 'a disproportionately negative impact where the need for drug and alcohol services is greatest', see 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

32 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

Our analysis of data from the National Drug Treatment Monitoring System (NDTMS) found:[33]

- In 2018-19, 9,861 people who presented to drug and alcohol treatment services were recorded as having 'no fixed abode' (NFA) – defined as rough sleeping or sleeping on a different sofa each night. This is the highest number of presentations since this data started being collected a decade ago.
- However, our analysis has identified a significant number of people in need going without treatment.
- While the number of people sleeping rough who need drug and alcohol treatment has risen sharply, the number of people presenting to treatment with NFA has risen at a much slower rate.[34]
- We estimate that 12,000 fewer people rough sleeping or at risk of doing so accessed vital treatment and support in 2018-19 than if treatment access had remained at 2010-11 levels.[35] This is likely to be a significant underestimate, given that access was far from comprehensive in 2010-11.
- The problem of unmet need is particularly acute in the 50 areas with the highest levels of rough sleeping. In these areas rough sleeping has risen 286% while there has been no rise at all in the number of people registered with NFA starting treatment.

12,000

people going without treatment in 2018-19.

"They've closed down a lot of detox units… 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." **Andrea**

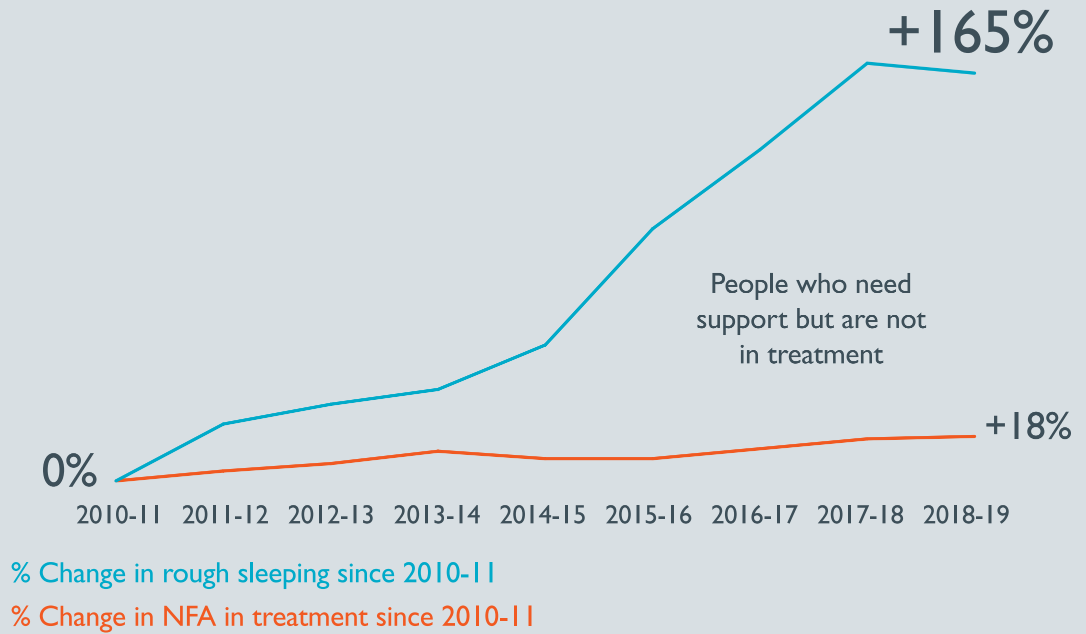
33 NDTMS data (2019), https://www.ndtms.net

34 We estimated the scale of unmet need by comparing the relative rise in no fixed abode treatment numbers with the overall rise in levels of rough sleeping. We can take the rise in rough sleeping to be representative of rising levels of need, given data from CHAIN suggests that the average person sleeping rough today is more likely to have a drug and alcohol problem than five years ago. Across England no fixed abode in treatment has risen 19% since 2009-10, while the numbers sleeping rough has risen 165% since 2010.

35 This figure is based on increasing the number of people registered no fixed abode in treatment in 2010-11 by the relative increase in need in the intervening decade.

This level of unmet need is worrying because we know that people with untreated drug and alcohol problems are more likely to stay on the streets for longer. We also know that people not engaging with treatment services are more likely to be the ones who experience serious harm, including death as a result of their drug and alcohol use.[36]

The gap between need and treatment access (trends in rough sleeping and people starting drug and alcohol treatment in England while NFA)



% Change in rough sleeping since 2010-11

% Change in NFA in treatment since 2010-11

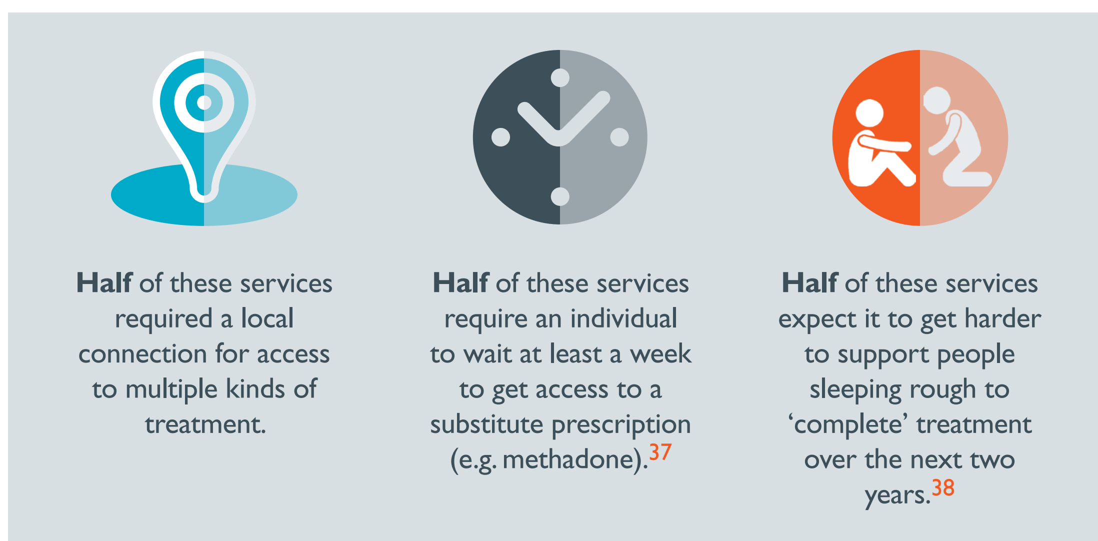
People sleeping rough are often dropping out of treatment and falling between the gaps in services

"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… I must have gone to maybe 20-25 appointments in the last two months.... 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." **Greg**

Not only are thousands likely going without drug and alcohol treatment, our interviews showed how for too many people sleeping rough, the treatment system doesn't provide the timely, flexible and accessible model of care they urgently need.

[36] Data shows 40% of the people who had drug related deaths had not been in contact with drug and alcohol services in the last decade, see 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%20%20Martin%20White%20EMCDDA.pdf

Examples of high expectations and exclusions were evident in our survey of drug and alcohol treatment services which found:



Half of these services required a local connection for access to multiple kinds of treatment.

Half of these services require an individual to wait at least a week to get access to a substitute prescription (e.g. methadone).[37]

Half of these services expect it to get harder to support people sleeping rough to 'complete' treatment over the next two years.[38]

With a reduction in drug and alcohol 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 be expected to attend appointments with other services too, such as for their mental health or to claim benefits. In our interviews we heard how this presents significant challenges for people sleeping rough, such as the practical difficulties of accessing transport and timekeeping, which are often compounded when drug and alcohol problems are added to the mix. Pushed between "pillar and post", with unreasonable expectations and frequent exclusions, the pressure can be too much for some, who simply drop out of treatment.[39]

In our interviews we found how approaches to commissioning lead to fragmented service delivery and inflexible approaches to care. Silo working between mental health, homelessness and drug and alcohol commissioning and service delivery was seen as having a particularly damaging impact on people's lives.

How success is measured was also seen as a key factor in the quality of service delivery. There is significant evidence that the most common outcome indicator of 'treatment completion', often interpreted as being free from drug or alcohol dependence, does not work as well for 'complex cases.'[40] This is often an unreasonable expectation for somebody who may have multiple needs and compound trauma – not to mention the practical difficulties of achieving abstinence while sleeping on the streets.

In our survey of drug and alcohol services, we found that the areas which reported that it was getting easier to support people sleeping rough did things differently. For example, several used a wider range of outcome measures to judge a service's success – such as the numbers in treatment (focused on vulnerable groups), and 'distance travelled' measures on a range of self-reported outcomes. Others used effective co-location between different services, had longer contracts, and used co-production to design their services with the local community and people with lived experience.

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[37] This is within the three week target set by PHE, but we heard people sleeping rough particularly valued short wait times, as one man told us: *"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."*

[38] St Mungo's drug and alcohol service manager survey (2019)

[39] Cockersell (2016), *Social exclusion, compound trauma and recovery*, p211

[40] Lankelly Chase (2015), *Hard Edges* https://lankellychase.org.uk/resources/publications/hard-edges

Particular groups experience stark disadvantages in accessing treatment

The challenges with starting and staying in drug and alcohol treatment are not experienced equally. One of the starkest barriers to drug and alcohol treatment applies to non UK nationals. Some of the treatments available from drug and alcohol services are no longer freely available to this group. For those who have 'no recourse to public funds', full payment for a course of non-urgent treatment is required up front.[41]

Women also face a range of particular barriers to presenting and staying in treatment. In our interviews, we heard how drug and alcohol problems were often related to an abusive partner who facilitated addiction or exploited it for personal advantage. This meant current abusive partners may prevent women from accessing treatment to maintain an element of control, while the fear of encountering former abusers can lead women to avoid certain facilities. With drug and alcohol services being increasingly based on single sites, we heard that this tendency is more common in some areas.[42]

> *"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."* **Outreach worker**

Drug and alcohol services alone cannot address the severity and complexity of people's needs

Despite the valuable role that drug and alcohol services have to play in supporting people sleeping rough with drug and alcohol problems, there is only so much that can be done in isolation.

The overlaps with mental ill health are particularly relevant here – we heard in our research how common it was for people with co-occuring mental ill health and drug and alcohol problems to go without the right support. In the case where someone's 'primary presenting need' is 'substance misuse', this will often prevent an individual from accessing mainstream mental health treatment. This is particularly challenging when drug and alcohol use acts as self-medication for mental health problems.

The issue of identifying a 'primary presenting need' is obvious when you have an individual with a complex combination of homelessness, mental health and drug and alcohol problems. This mix can result in frequent misdiagnosis and repeated failures to respond effectively to people's needs. In our interviews we heard that too often services were unable to address the lack of housing and complex trauma frequently at the root of people's problems.

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41 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. There are some exemptions, for example mental health services to treat conditions caused by sexual violence. See DHSC (2018), *Overseas NHS visitors: implementing the charging regulations* https://www.gov.uk/government/publications/overseas-nhs-visitors-implementing-the-charging-regulations

42 Agenda and AVA found that a lack of women-specific services reinforces this problem. 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 misuse midwives. Supported by *Mapping the Maze* (2017), a report by Agenda, the alliance for women and girls at risk and AVA (Against Violence and Abuse) https://weareagenda.org/wp-content/uploads/2017/10/Mapping-the-Maze-final-report-for-publication.pdf

From our interviews, we heard that the answer is to step up efforts to drive out poor practice – 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, collaborative commissioning to develop integrated housing and treatment pathways, and changing practice to address people's underlying problems in a more flexible and personalised way.[43]

> *"I really needed psychological support, and I was months away from getting off drugs… there has to be a mental health support team that can deal with people still using, I think that would be huge."* **Sam**

[43] Organisations like Making Every Adult Matter (MEAM) and Fullfilling Lives have demonstrated the value of this kind of systems change in practice, see: http://meam.org.uk/the-meam-approach

Providing the right housing with support is at the centre of reducing harm and rebuilding lives

"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."
Outreach worker

It is significantly harder for drug and alcohol services to work with people without a home than with a home.

In our interviews we heard how a lack of housing is leading local authorities to rely on inappropriate accommodation where support is not available. This includes 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.[44] We also heard how a lack of 'move-on' options is leading to people being stuck in supported housing, reducing the availability of these services to help people at immediate risk.

The 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 ensure suitable accommodation tailored to the individual's needs as part of their recovery journey, rather than seeing any housing as good housing.

This means in some cases providing housing as part of drug and alcohol treatment and recovery pathways (e.g. following detox, supported housing), in others providing housing prior to engagement in a drug and alcohol pathway (e.g. Housing First, floating support). Services should be housing-led, while ensuring the right support and treatment is integrated to meet people's needs.

As recent research on Tenancy Sustainment Team clients shows, accommodation alone is not a silver bullet, and there remains a high risk of drug and alcohol related mortality even after someone has stopped rough sleeping. This is why combining the right housing with the right support and treatment is essential to stop people dying and rebuild lives.[45]

We should see rough sleeping itself as a public health crisis, and ending rough sleeping as a way of tackling high risk drug and alcohol use. This requires both a renewed cross-government approach to tackling rough sleeping, as well as a plan to prevent and reduce drug and alcohol dependency and associated harm. Neither should be tackled in isolation.

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

[45] 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 average age at death amongst TST clients (52 years) is only slightly higher than the average age at death amongst homeless people (45 years), see Michelle Cornes et al (2020), *Tenancy Sustainment Team health research: morbidity and mortality amongst people with experience of rough sleeping.*

What needs to change?

Recommendations

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.

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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.[46] 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.

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[46] 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.

Examples of approaches already being used to tackle the public health crisis:

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 sleeping 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 focused 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.

The service manager told us: *"You have to change the culture and mindset of workers to thinking about risk…It is important that we create a new way of working with people that meets 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.[47]

[47] 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

Learning the lessons – reviewing all deaths in Haringey

In February 2019 Haringey Council introduced a new process for reviewing the deaths of people who died while homeless in the borough. The decision followed a sharp increase in deaths in 2018, when nine people died while homeless, of whom six died as a result of drugs or alcohol.

The new process was built on existing models including the Learning Disabilities Mortality Reviews (LeDeR) and Safeguarding Adult Reviews. Intended to complement not supersede statutory review processes, the borough nonetheless ensured that every death went for a review of some description – with referrals made for Safeguarding Adult Reviews where necessary. The programme has a set of clear aims:

- To prevent the premature deaths of homeless people.
- To improve multi-disciplinary partnership practice which is central to reducing the inequality affecting homeless people
- To recognise the particular vulnerabilities affecting homeless people as they relate to safety and safeguarding
- To create a human portrait of some of the most invisible residents, that resists framing people solely by their needs and risks

It is too soon to fully identify impacts, but the number of deaths in the borough reduced by six in 2019, with hopes numbers will continue to fall.

Many other local authorities have established, or are beginning to establish, their own process for reviewing homeless deaths, but more must be done to ensure learning from these reviews transfers into policy change at local and national level if deaths on the streets are to be ended for good.

Finding better ways of judging outcomes – 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.[48]

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 developing more user-centred outcome measures, a SURE app has been created to make these measures more widely accessible.

Professor Jo Neale from King's told us: "the SURE app was developed because people in recovery asked for it, not because clinicians or service providers thought it would be good for them. As a co-produced tool, it is consistent with the wider drive to encourage self-efficacy and person-centred care."

48 https://www.kcl.ac.uk/ioppn/depts/addictions/scales-measures-and-instruments/sure-substance-use-recovery-evaluator

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Authorship

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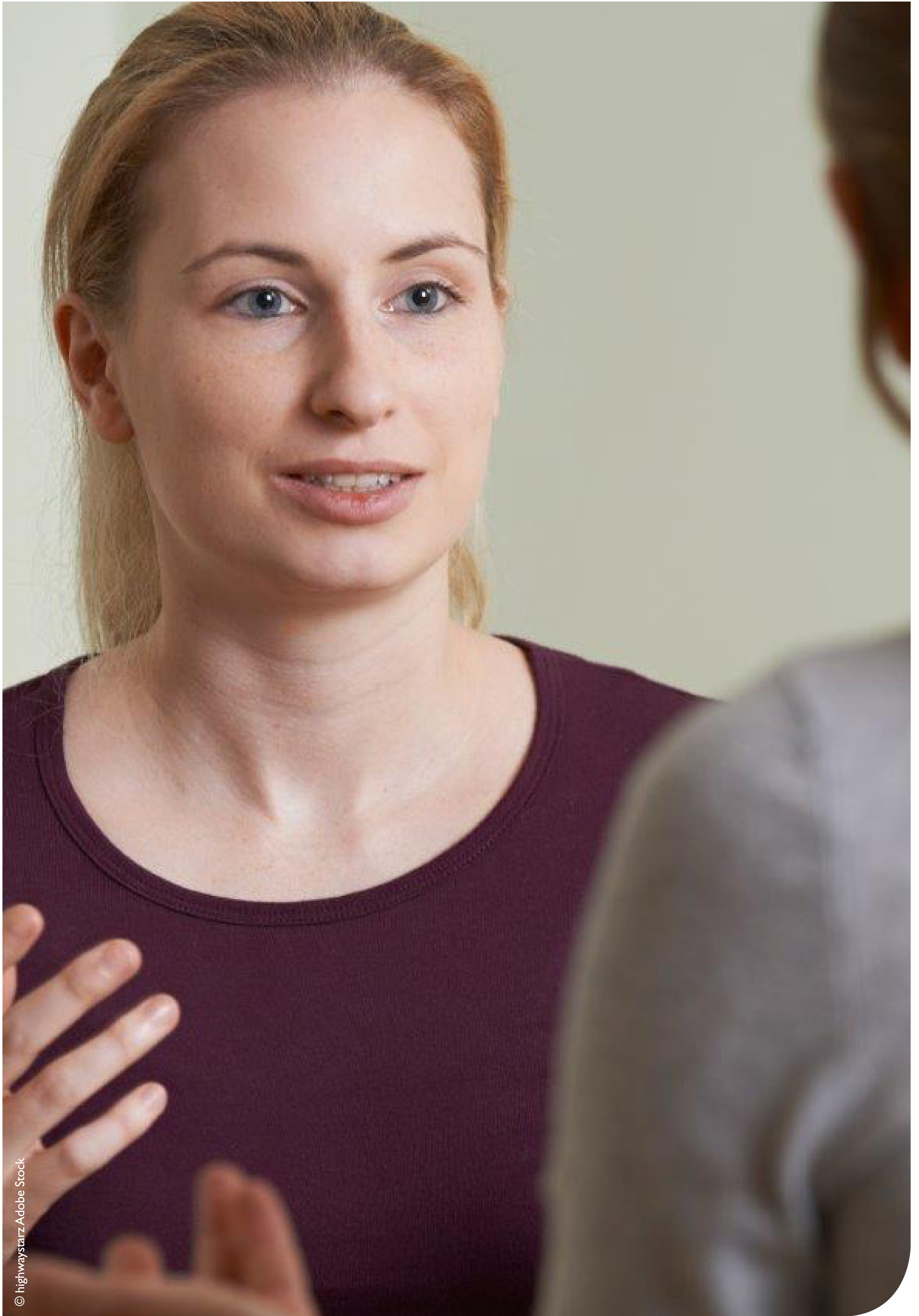

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