



Home Office

BUILDING A SAFE, JUST
AND TOLERANT SOCIETY

NHS

*National Treatment Agency
for Substance Misuse*

DH Department
of Health

drug services for homeless people

a good practice handbook

Geoffrey Randall and DrugScope



homelessness
directorate

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Published by the Office of the Deputy Prime Minister. Printed in the UK, November 2002 on material containing 75% post-consumer waste and 25% ECF pulp.

Product code 02RSU00763

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production of the handbook

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The authors would like to thank the members of the project team for their invaluable detailed comments on drafts of the guide; staff at a wide range of drug and homelessness agencies for their comments and information on good practice and Susan Brown of Research and Information Services for help with the research and drafting.

summary

This handbook aims to help Drug Action Teams (DATs) and partner agencies plan and develop more effective services for homeless drug users. By services, this document means the whole range of support services that fall within the four substance misuse treatment tiers (see pages 34-35), which include medically-based interventions, needle exchange and other harm minimisation advice, support groups, structured day care programmes offering a range of activities, family services, supported accommodation, detoxification and rehabilitation.

key points

- understanding the key issues: homelessness and drug use are closely linked (Chapter 2)
- planning a joint drug and homelessness strategy (Chapter 3)
- setting and monitoring service standards (Chapter 3)
- ensuring access to drug services, especially treatment, for homeless people (Chapter 4)
- providing a full range of mainstream drug treatment services for homeless people (Chapter 4)
- implementing integrated care planning (Chapter 4)
- planning specialist services (Chapter 5)
- partnership working with housing agencies to meet the accommodation needs of homeless drug users (Chapter 6)

What are the links between homelessness and drug use? (Chapter 2)

Between a half and three quarters of homeless single people have in the past been problematic drug users and some are difficult to engage. Many have a wide range of other support needs which reinforce each other and heighten the risk of drug use and homelessness.

How to develop strategies for homeless drug users (Chapter 3)

Homeless drug users should be treated as a distinct group when planning both drugs and homelessness strategies, which themselves should be integrated with other local strategies.

Key areas to consider when designing and implementing the strategy for homeless drug users should be the development of inter-agency work, joint services, commissioning and funding with homelessness agencies and the local authority.

How to ensure high service standards (Chapter 3)

All drug services provided for homeless people should meet the *Quality Standards in Alcohol and Drug Services (QuADS)*¹.

All staff working with homeless drug users should be working towards compliance with the Drug and Alcohol National Occupational Standards (DANOS)², as these are developed.

The National Treatment Agency for Substance Misuse is establishing a national system of performance measurement for drug agencies. Services for homeless people should adopt these when providing drug services.

Targets for drug services for homeless people should reflect the high level of needs of this group and the likelihood of relapses from treatment.

How to improve access to mainstream drug services (Chapter 4)

Some services will need to be tailored to engage homeless people, while others may need to be specifically designed.

It is critical that homeless people can access treatment rapidly.

DATs should inform homelessness agencies how they can lawfully accommodate drug users.

Specialist drug workers should train homelessness staff in using drug screening tools. Detailed assessments will continue to be conducted by drug specialists.

Although drug services will have many competing claims on their resources, they should consider giving priority to homeless people.

What services do homeless people need? (Chapter 4)

As outlined in the NTA *Models of Care*³, homeless people will need access to the full range of services.

Non-substance misuse services (Tier 1). Liaison is necessary with other health and support services. This will usually require the planning of Integrated Care Pathways. Homeless services should develop screening and referral protocols for substance misuse to ensure a seamless service.

Open access substance misuse services (Tier 2). Homeless people need speedy access routes based in services they already use, although treatment might not be provided in these premises. Harm reduction may be the most realistic first step, but it is important that adequate and rapid access to detoxification is also available. These initial services should be combined with help for people to stabilise their drug use, to move into suitable accommodation and to progress into treatment. Street-based harm reduction services should ensure they do not simply support street lifestyles. There is a need in some areas to develop new services for crack cocaine users.

Structured community based substance misuse services (Tier 3). There should be special arrangements to provide community services for people without secure housing. This could include drug services providing satellite services in day centres, or using flexible low threshold models. Community based services can also provide the support required to help people retain accommodation.

Residential substance misuse services (Tier 4a). Specialist drug treatment residential services, including those based in hostels, may be more suitable for homeless people. This should be introduced when an individual has had time to prepare. A period of stabilisation or detoxification in a specialist unit may be required first. Where residential drug treatment is provided in hostels, the treatment should meet the quality standards prescribed for mainstream drug treatment services.

What specialist services might be needed? (Chapter 5)

A range of specialist drug services for homeless people, often offered through homelessness agencies, should be considered. Some of these services can be provided by generic homelessness workers trained in drug work, others by specialist drug workers.

Street outreach services. Many will aim at harm reduction and encouraging homeless people to stabilise, take up drug treatment and to enter accommodation.

Day centres. Advice, information and screening should be offered in day centres, linked to encouraging people to enter drug treatment. Drug agencies might offer peripatetic satellite services in homelessness agencies.

Hostels and shelters. Advice, information and screening should also be offered in hostels. They are likely to engage the more chaotic drug users who might not go to an external agency. Specialist services can be provided by competent staff. In longer stay hostels, separate specialist units providing residential treatment might be considered.

Specialist comprehensive drug services for homeless people. These have achieved significant successes. The guidance identifies good practice for these projects.

Integrated care for homeless drug users. Comprehensive care management is essential for homeless clients. The first aims of care packages will often be to find accommodation and to stabilise drug use before progressing to treatment.

What is the role of accommodation in care planning for homeless drug users? (Chapter 6)

DATs should work closely with local authorities on their homelessness strategies and with the Supporting People initiative to ensure that there are plans for accommodation and support to meet the needs of homeless drug users.

Night shelters may offer a first point of contact for advice, information and harm reduction and be able to refer clients into drug treatment services.

DATs should plan jointly with *hostels and other temporary accommodation providers*, such as refuges, to provide accommodation, harm reduction and treatment for homeless drug users.

The next step for some former drug users in hostels and those moving on from residential treatment will be into *supported housing*. People with multiple needs may require long term supported housing.

Realistic longer term housing prospects for most will be in *social rented housing*.

There are advantages in housing quotas being available to drug services for suitable clients.

DATs should discuss with housing authorities the extent to which problematic drug users applying as homeless should be considered as vulnerable under the homelessness legislation.

Access to suitable housing should be planned in advance so that it is accessible for people leaving rehabilitation at the time they need it.

Many people want to be housed in areas away from their former areas of drug use so as to avoid contact with drug users.

Tenancy support helps to prevent homelessness. Drug services should work jointly with Supporting People and local homelessness strategies to ensure that adequate housing support is available.

1 introduction

Research has found that homelessness and drug use are often closely linked. Homelessness can make it difficult for drug users to access drug treatment services or to maintain a treatment programme. The Government aims to increase the participation of problem drug users in treatment programmes and to double the number in treatment by 2008. Effective services for homeless people will be an important part of reaching these targets. Drug services targeting homeless people have achieved major reductions in drug use⁴.

Why this handbook?

- 1.1 This handbook was jointly commissioned by the Office of the Deputy Prime Minister (ODPM) Homelessness Directorate and the Home Office Drug Strategy Directorate, and was produced by a multi-departmental group which included the ODPM, Home Office, NTA and Department of Health. It aims to help Drug Action Teams (DATs) and other commissioners of drug treatment and services, to plan more effective services for drug users who are homeless or at risk of becoming so. This reflects the difficulties that homeless people have in obtaining drug services and that DATs face in developing services that meet their needs.
- 1.2 The guidance is primarily for use by DATs, which have the leading role in commissioning and co-ordinating services to meet the needs of all drug users. But it should also prove helpful to other professionals planning and providing services for homeless drug users including:
 - Drug Reference Groups (DRGs)
 - Local housing authorities
 - Supporting People commissioning bodies
 - Voluntary agencies
 - Homelessness agencies
 - Drug agencies
 - Social Services
 - Primary Care Trusts
 - Probation Services
 - Government departments.
- 1.3 Previous good practice guidance has identified the need to co-ordinate action on drugs, homelessness and related problems. The NTA's *Models of Care for substance misuse treatment* recommends that the planning and design of drug treatment services should include homelessness agencies⁵. A report from the Home Office and the Department of Transport, Local Government and the Regions (DTLR) recommended that: "Housing should be seen as an integral part of successful drug treatment and rehabilitation"⁶. The London Drug Policy Forum recommended that: "DATs are well placed to promote the role housing can play in rehabilitation and treatment"⁷.

- 1.4 In the future, funding for drug services for homeless people will be channelled through DATs. The basis for planning drug services for homeless people should be through joint work between the DAT and the local authority, along with other local agencies, both statutory and voluntary, which work with homeless people. The DATs must ensure that they plan for the full range of services, including treatment, that a homeless drug user might need – ranging from vocational services, children’s services and housing, through to drop-in services, structured prescribing, residential detoxification and rehabilitation. The full range of services is provided within the four substance misuse treatment tiers (see page 34-35).
- 1.5 All housing authorities now have a statutory duty to produce homelessness strategies. A key part of these will be joint working with other agencies to plan support services for homeless people and to prevent homelessness. Local authorities are also currently mapping housing related support services both locally and between authorities through their Supporting People programmes. So DATs and other commissioners will not need to start from scratch in assessing the needs of, and planning services for, homeless drug users. Much of the necessary information and expertise should already be available from the local authority and other agencies.

The homelessness legislation

Homelessness legislation places a number of duties on local authorities which include:

- **Ensuring that advice and information about homelessness is available to everyone in their district.**
- **Ensuring that accommodation is available for people who are homeless through no fault of their own if they are in one of the priority groups, including families with children, pregnant women, young people, and people who are vulnerable because of old age, ill health or a history of institutional living.**
- **Carrying out regular reviews of homelessness needs in their areas and producing homelessness strategies to meet these needs.**

- 1.6 Within ODPM, the Homelessness Directorate will be working through local authorities to develop effective services for homeless people and to prevent homelessness. There has already been considerable work with DrugScope in helping local authorities and other agencies to develop effective drug policies for homeless people, funded by the Homelessness Directorate.
- 1.7 The Home Office Drug Strategy Directorate and the NTA continue to develop more effective commissioning of all drug services that are flexible and responsive to the needs of special client groups.

- 1.8** *Commissioning Standards: Drug and Alcohol Treatment and Care*⁸ identifies key criteria that should be considered when assessing the suitability of drug treatment services:
- Service relevance: does it match clients' needs?
 - Accessibility: are there barriers to service access?
 - Acceptability: does it meet clients' requirements? Are they satisfied with the service?
 - Equity: is there unwarranted exclusion of clients from services?
 - Efficiency: are services cost effective?
 - Effectiveness: what are the outcomes of treatment and care?
- 1.9** Mainstream drug treatment services run the risk of failing homeless people on many of these criteria, unless they tailor services to the particular needs of this client group.

What the handbook contains

- 1.10** This handbook is concerned with the needs of all homeless people, with the exception of young people aged under 18. Separate guidance will be issued on the needs of young homeless drug users. The guide complements, rather than duplicates, current published guidance on commissioning and quality standards for drug treatment services. It covers the provision of a wide range of services through outreach and accommodation, as well as clinical interventions and psychological help.
- 1.11** Homelessness is not limited to people who have been accepted by local authorities as homeless. Indeed, some of the most vulnerable and chaotic homeless drug users are likely to be sleeping rough or residents of hostels and night shelters, who may never have been in contact with the local housing authority. The handbook particularly focuses on these homeless people with the highest needs, but it is also relevant to wider groups of homeless people, who may be living in a range of temporary and insecure accommodation, such as families in B&B hotels.
- 1.12** There are homeless people in all areas and all local authorities have a duty to assess homelessness needs and to develop a strategy to tackle them. Therefore all DATs will need to consider the needs of homeless people and link into homelessness and Supporting People strategies as they are developed and implemented.

1.13 The handbook contains:

- Background information on homelessness and the drug problems of homeless people (Chapter 2).
- Guidance on developing strategies for homeless drug users (Chapter 3).
- Guidance on improving mainstream drug services for homeless people (Chapter 4).
- Guidance on developing specialist services for homeless drug users (Chapter 5).
- Information on accommodation for homeless drug users and guidance on gaining access to the most suitable options (Chapter 6).
- Sources of further information and advice on the needs of homeless people, including agencies and publications (Appendix 2 and References).

2 homelessness and drug problems: background information

This chapter outlines:

- The diverse needs of different groups of homeless people.
- The high incidence of drug use among some groups of homeless people and the ways that their needs may be hidden from mainstream services.
- The role of homelessness agencies.

2.1 Who is homeless?

Homelessness is commonly used to describe a wide range of circumstances where people have no secure home. Homelessness is defined in legislation for the purpose of determining entitlement to help from local authorities and certain groups are defined in law as being in priority need of housing.

However, in order to target drug treatment services on the most difficult to engage homeless people, it is necessary to consider a wider range of clients. Many of the most chaotic and vulnerable may not be in contact with housing authorities. Groups to consider are:

- **Rough sleepers**

Although only a small proportion of homeless people sleep rough, they represent the most extreme form of homelessness and the group with the highest concentration of multiple support needs. Concerted action by the Government's Rough Sleepers Unit (now incorporated in the Homelessness Directorate) has reduced the numbers sleeping rough on any one night by over two thirds. Those who have moved off the streets are now in accommodation, but in many cases remain in need of continuing support, including drug treatment services⁹.

- **Hostel and night shelter residents**

Night shelters normally offer basic emergency accommodation for people who have been sleeping rough, or are at risk of rough sleeping. *Hostels* vary widely from emergency direct access accommodation for rough sleepers, to shared accommodation for students or young workers who may have no support needs. Not all hostels accommodate homeless people and it is important to identify the target group of hostels before including them in drug treatment planning. Night shelters and hostels for homeless people have often in the past been used by long term homeless people as a temporary respite from homelessness and some older clients have circulated between hostels and rough sleeping for many years. As it is very difficult for people sleeping rough to access or sustain drug treatment without stable accommodation, hostels offer a major opportunity for these people to take the first steps into drug treatment services.

- **Bed and Breakfast (B&B) residents**

Some local authorities place significant numbers of homeless families in B&B hotels as temporary accommodation, often because of a shortage of permanent social housing. The Government has a commitment to help local authorities ensure that by March 2004 no homeless family with children is placed in a B&B, except in an emergency and even then for no longer than six weeks. However, many homeless people without children also place themselves in B&B for lack of any alternative and people in these circumstances may be isolated and not in touch with any support services. Others may use day centres for homeless people to access some support.

- **Homeless families**

Most recent research has focussed on the support needs of homeless people without children. There has been far less work on the possible support needs of homeless families and the assumption has tended to be that their primary, or only, need is for housing. This has perhaps happened because they are usually entitled to help with permanent housing from the local authority, whereas most homeless people without children do not have this entitlement unless they are also vulnerable and have other clear support needs such as disability or ill health. Some homeless families may have more support needs, including drug use, than previously thought.

- **People staying temporarily with friends and relatives**

These people, sometimes referred to as the “hidden homeless”, are a large and diverse group and may not have been homeless, or at risk of it, or be vulnerable. Others, however, might have a history of homelessness, insecure accommodation and drug use.

- **Squatters**

Not all squatters have been homeless or are vulnerable. However, some may have a history of both homelessness and drug use.

- 2.2 Some drug users can become trapped in homelessness because they are evicted or refused housing because of drug use or supply. So, for example, a man may be convicted of drug dealing, in breach of his tenancy agreement. He may be evicted along with his partner and children, as she too has broken the agreement for ‘allowing’ it to occur. In this situation the family may be classed as intentionally homeless and not offered accommodation. This can worsen their drug problems. Some authorities have in the past refused to accommodate people with past convictions or suspicions of drug use.

Drug use among homeless people

- 2.3** There is a large body of research, which has identified widespread problematic drug use among homeless people without children. The Advisory Council on the Misuse of Drugs (ACMD) identifies drug misuse as having a central role in homelessness¹⁰.
- 2.4** Levels of drug use among homeless people without children in five English cities have been put at between 66 and 76 per cent¹¹. A survey of rough sleepers in London found that over three quarters of service users had used a drug and at least half of the clients of all but one of the services were dependent on a drug (excluding alcohol)¹².
- 2.5** Problematic drug use can lead to the loss of a home. Research found that: "People who are unable to cope without daily doses of an expensive drug tend to concentrate on short-term goals. They may default on financial responsibilities, including the payment of rent, or completion of a Housing Benefit claim. Drug users, through their own actions, may progressively lose the trust and support of family and friends. They easily become homeless when family and marital relationships break down"¹³. A survey of clients of drug treatment services in Bristol found that a third had become homeless following arrest for drug related offences and 85 per cent had experienced housing difficulties in the past three years¹⁴.
- 2.6** Equally, homelessness may also lead to increased and problematic drug use and make it more difficult for users to stabilise, abstain or seek treatment.
- 2.7** Agencies working with rough sleepers in different areas of the country have pointed to a large increase in Class A drug use among rough sleepers over the past two to three years, in particular heroin, crack cocaine and multiple drug use. Many homeless drug users also have problems related to high levels of alcohol consumption¹⁵.
- 2.8** A high proportion of homeless drug users are chaotic users and are particularly difficult for services to engage. They are also more likely to engage in high risk injecting practices, possibly because they have to inject in semi-public areas and have nowhere to store equipment¹⁶.
- 2.9** There is a need for more research into the possible drug problems of homeless families with children and ODPM has recently commissioned research into the support needs of homeless people, including families.

The support needs of homeless drug users

2.10 Research has found that many homeless people without children have a range of other support needs. These include:

- alcohol problems
- mental health problems, including mental illness and personality disorder
- a combination of mental health, drug and alcohol problems
- experience of physical or sexual abuse
- time in local authority care
- an institutionalised background such as the Armed Forces or prison
- learning difficulties and literacy problems
- lack of qualifications
- unemployment
- contact with the criminal justice system
- marital or relationship breakdown
- previous experience of homelessness
- lack of a social support network
- failure to furnish or maintain a home
- debts, especially rent or mortgage arrears
- causing nuisance to neighbours.¹⁷

2.11 These problems inter-act to reinforce each other and to heighten the risk of both drug use and homelessness. For example, Home Office research has found that around a half of ex-prisoners were using heroin daily four months after release and less than a half had somewhere secure to live¹⁸. Both homelessness and drug use are often symptoms of other problems and may be deeply entrenched in the lifestyle of some, particularly longer term, homeless people.

- 2.12** However, like other drug users, homeless people and their needs will vary widely. Some people may be homeless for only a short time and have relatively low support needs. Users of certain drugs, such as non-opiate users may be more difficult to engage. Guidance on meeting the needs of specific groups can be found in *Models of Care and Commissioning Standards*¹⁹. Some groups may have particular needs and services should be tailored to the needs of different ages, ethnic groups and to women as well as men.
- 2.13** It has been found that women with children may be reluctant to seek help with drug problems because of concerns over the care of their children. A high proportion of homeless families are headed by women lone parents and this may mean that drug problems can remain hidden. The Home Office publication *Women drug users and drug service provision: service-level responses to engagement and retention* provides further guidance²⁰.
- 2.14** It has also been found that people from black and minority ethnic groups may under-use existing drug treatment provision. Further guidance can be found in the Home Office paper *Delivery of drug services to black and minority ethnic communities*²¹.

The work of homelessness agencies

- 2.15** Local authorities and voluntary agencies provide temporary accommodation, longer term supported housing and permanent social housing tenancies for homeless people. They also provide a wide range of other services for them. This section provides a brief outline of these other services. Further details can be found in *Homelessness strategies: a good practice handbook*²².
- 2.16** *Local Authority Homeless Persons Units*. Housing authorities have a legal duty to ensure that accommodation is available for people who have a priority need, if they are homeless through no fault of their own. People in priority need include:
- those with dependent children and pregnant women;
 - young people aged 16 or 17;
 - young people who have been in care and are aged 18-20;
 - people who are vulnerable as a result of:
 - old age,
 - mental illness or handicap,
 - physical disability,
 - having been in prison or custody,
 - having served in the Armed Forces,
 - having been in care earlier in their life,
 - becoming homeless because of violence, or the threat of violence,
 - or for other special reasons.

- 2.17** Problematic drug use, even of a severe and chaotic kind, will not necessarily be accepted by local authorities as a reason for accepting a homeless person as vulnerable. Indeed many homeless people without children do not even apply to local authorities. So, in planning services for homeless drug users, although it is important to consider those who are in contact with local authorities, it will also be necessary to look beyond this group.
- 2.18** *Outreach work in areas with people sleeping rough.* Much of this work has in recent years been funded by the government's Rough Sleepers Unit (now incorporated in the Homelessness Directorate) in the form of Contact and Assessment Teams (CATs), usually run by voluntary agencies. They aim to help rough sleepers to move off the streets, usually into a hostel as a first step, and eventually to resettle into permanent accommodation. A high proportion of rough sleepers are drug users and CATs will have contact with some who are not in touch with any other services.
- 2.19** *Soup runs and other street services.* There are many street services, which distribute free food to people sleeping rough. Some also give clothes or sleeping bags. These services often also attract people who have accommodation, but who are in search of free food or company. Most of these services are run by small voluntary groups. Some have been criticised for potentially reinforcing street living or even attracting people into it.
- 2.20** *The Big Issue* provides support to its vendors. A survey of vendors of *Big Issue in the North* found that 57 per cent said they had problems with drug use²³.
- 2.21** *Day centres.* There are around 250 day centres throughout the UK, many of whose users are homeless or at risk of homelessness. Day centres can engage homeless people who may not use hostels and other services. Traditionally, they have offered basic services such as daytime shelter, food and clothing. But they also offer the opportunity of targeting services on people at risk of homelessness and some centres have developed a comprehensive range of services. For example some provide specialist services for particular groups including people with mental health, alcohol and drug problems. Some also provide a range of general advice and support services to prevent homelessness, such as life skills and employment training, benefits advice, rent deposit schemes and tenancy support. However, some day centres providing only basic services have been criticised for possibly reinforcing street lifestyles and some may have a significant proportion of clients who are not homeless, but who may be in need of support.
- 2.22** *Housing advice services.* Local authorities have a statutory duty to ensure that advice and information about homelessness is available to everyone in their area. In practice, the quality of advice provided varies widely. In many areas there are also voluntary agencies that provide housing advice services. In addition to specialist housing advice agencies, many other agencies may be offering advice including community and day centres, other voluntary agencies, accommodation agencies, health authorities, social services, probation officers, and many others. While housing advice services will focus specifically on the housing aspects of a person's problems, the most effective also offer a referral route to other support services and provide details of these to clients.

- 2.23** *Tenancy support.* Many homeless people have had tenancies and have lost them. Agencies providing tenancy support services have demonstrated that, in many cases, tenancies can be sustained even where people have high support needs, such as mental health and alcohol and drug problems. Support is provided to tenants in ordinary tenancies, sometimes for fixed periods, or for as long as they need it. It includes pre-tenancy work and resettlement support which helps to prepare people for taking up a tenancy. It is different from supported housing, where the support is permanently linked to the tenancy. Not only can support prevent homelessness, it can also avert a range of other social problems and be extremely cost effective. Tenancy support workers do not attempt to provide all support themselves, but can link people in to other specialist agencies in their areas such as mental health services, drug and alcohol agencies, debt management schemes, befriending and mentoring schemes, probation services and Youth Offending Teams. There are also some tenancy support teams, which specialise in clients with particular needs, such as drug use.
- 2.24** Specialist tenancy support cannot be provided as a part of ordinary housing management and needs specialist staff and separate funding. From April 2003, funding of a wide range of support services to people in a variety of types of accommodation will be brought together into a single fund administered by local authorities under the Supporting People programme. This will cover not only supported housing, but also tenancy support in ordinary lettings, including private sector tenancies and even home owners.
- 2.25** The housing authority officer with responsibility for the local homelessness strategy should have information on all of the above services and should be working closely with the DAT.
- 2.26** **Many homelessness agencies are already providing a range of drug services, but often without adequate resources or expertise. There are also drug agencies that have diversified into work with this client group without support from the DAT. There is therefore an urgent need for DATs to work with these agencies to improve the effectiveness of services.**

3 developing strategies for homeless drug users

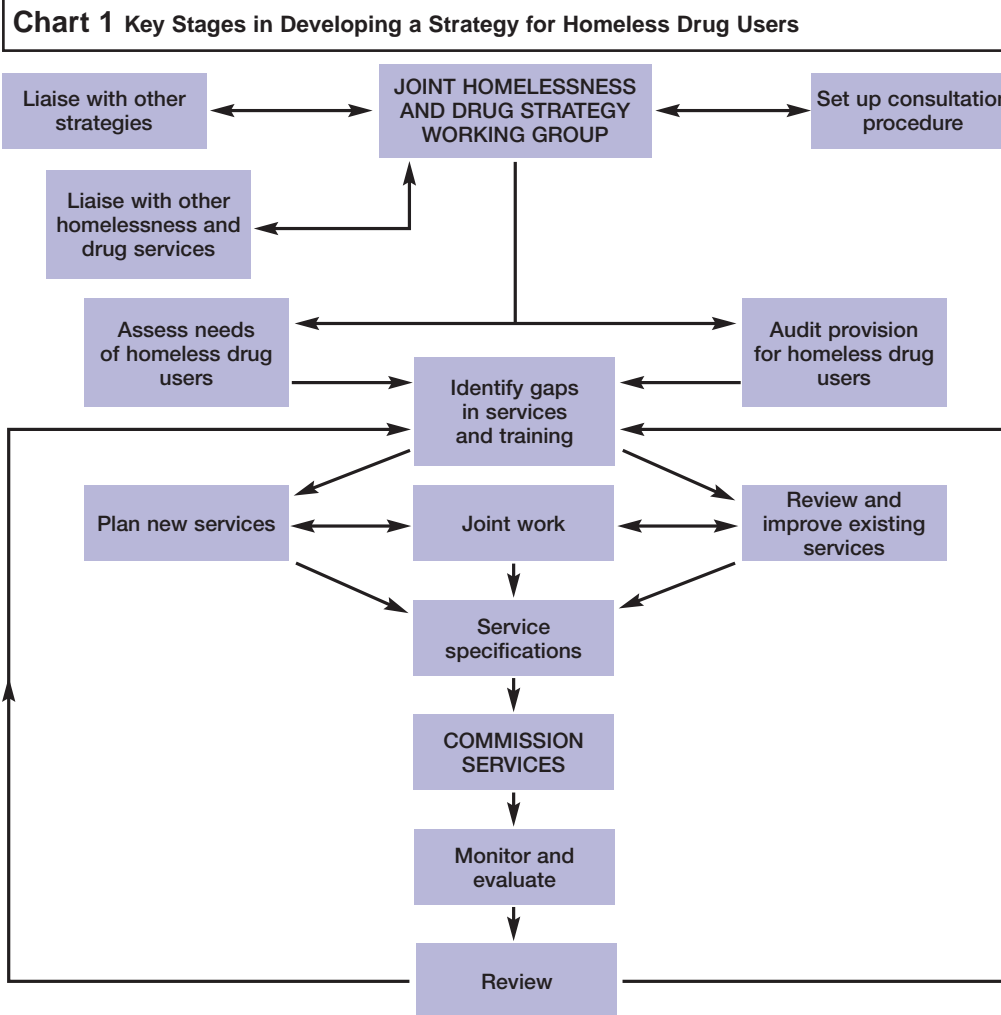
Drug services for homeless people should be developed as part of drugs, homelessness and Supporting People strategies. This chapter outlines means of drawing up a joint strategy with other agencies for homeless drug users. Chart 1 (page 21) summarises the key stages in developing the strategy.

Joint homelessness and drugs strategies

- 3.1** Services for homeless drug users should be commissioned as part of a strategy for this group. Their needs should be assessed and services planned as a distinct group within both drug and homelessness strategies, which themselves should be integrated with other local strategies, including:
- Supporting People strategies
 - Community Care plans
 - NHS Joint Investment Plans and Health Improvement and Modernisation Plans
 - Crime and Disorder Strategies
 - Local Strategic Partnerships.
- 3.2** The key link for DATs will be with the local authority's homelessness strategy. Housing authorities have a new duty under the Homelessness Act 2002 to carry out a review of homelessness in their areas and to formulate and publish a homelessness strategy based on that review. DATs will need to identify how they commission services for this client group in their treatment plans.
- 3.3** Joint work with agencies involved in the different strategies will reduce duplication and ensure that resources are efficiently deployed. It is also essential to work closely with local voluntary agencies, who are often in touch with many more homeless drug users without children than the local authority and who consequently may have more experience and knowledge of this group.
- 3.4** A small working group of representatives from the DAT, the housing authority, registered social landlords (RSLs) and other agencies working with homeless drug users, might operate as a sub-group to feed a unified strategy for homeless drug users into both drug and homelessness strategies. The working group should also consult with other homelessness and drug services and with homeless drug users. *Homelessness strategies: a good practice handbook* gives guidance on how best to consult with users of homeless services²⁴.

Assessing needs and auditing provision

- 3.5 Guidance on commissioning standards for drug services recommends that a population needs assessment is carried out, identifying target populations and the services available to each target group²⁵. The needs of homeless people should be separately identified as one of the target groups. Local authorities will also be carrying out a mapping of homelessness needs in their areas and DATs should work jointly with them and with Supporting People commissioners in mapping the needs of homeless drug users.



- 3.6** The audit of local drug services should identify the extent to which barriers to mainstream services are preventing access for homeless people and plan to fill gaps in services. Service specifications should then be drawn up, both to improve existing services and to create any necessary new services, some of which might be based in homelessness agencies, or through the diversification of drug agencies when they are able.
- 3.7** Another useful output from this review can be a directory of local services for homeless drug users, including other support services. This can be distributed to local agencies as an aid to improving referrals between them.

Improving services

- 3.8** As a part of this strategic approach, DATs should also encourage homelessness agencies to accommodate and provide services for drug users, for example by recommending to them the good practice guides produced by DrugScope²⁶. DATs should also encourage drug services to work with this client group.
- 3.9** Homelessness agencies report a shortage of skilled staff to meet the needs of clients with drug problems. A local training strategy will be needed to ensure an adequate supply of staff. The NTA and Drug Strategy Directorate are currently developing workforce planning for the drug treatment sector, which includes piloting competence based training in line with DANOS²⁷. Homelessness agencies working with drug users should ensure that their staff training in the future meets the standards set by DANOS.

Joint working

- 3.10** Key areas to consider when designing and implementing the strategy for homeless drug users should be the development of inter-agency work, joint services, commissioning and funding with homelessness agencies and the local authority. Examples of joint work include:
- Inclusion of a senior representative of the local authority housing service on the DAT, as required by the National Drug Strategy²⁸.
 - Ensuring homelessness agencies, including voluntary organisations make an input into local drug strategies and are represented on DATs and Drug Reference Groups.
 - Involving the housing authority, homelessness agencies and Supporting People in the commissioning process, including joint commissioning.
 - A joint group to bring together all funding for drug treatment services for homeless people, as recommended by the Audit Commission²⁹.
 - Developing protocols for joint work between drug treatment and homelessness services.

- Visits by drug treatment services' staff to homelessness agencies, such as hostels and day centres, to share knowledge and expertise.
- Reciprocal and joint training by drug treatment and homelessness services. Training for drug staff and other professionals in contact with homeless drug users, such as social workers and probation officers, should increase their awareness and knowledge of the problems of homeless people and the importance of housing in successful drug treatment. Training for homelessness staff should help them to identify drug problems in users of services and to make effective referrals to drug treatment services.

3.11 *Homelessness strategies: a good practice handbook* contains more detailed advice on successful joint working on homelessness³⁰.

Improving partnership work in Manchester

The opportunities and challenges of providing drug services for homeless people can be seen in the rough sleeping initiative in Manchester. This was based on partnership and joint-working arrangements. Some of the local agencies had a history of working together, but some services needed to be actively encouraged to engage in the partnership to ensure that a fully co-ordinated strategy was in place.

It is important to ensure that the individual support needs of the clients can be fully met. The staffing resources required to meet these needs were higher than had been originally envisaged by the planners of services in Manchester. This was resolved by the drawing up of clear contracts and agreements. Formal joint working protocols are necessary to avoid a lack of co-ordination if key individuals providing services move on.

Project partners who had pre-existing established working policies and procedures, have been far more effective in delivering drug treatment to rough sleepers. Continuous monitoring of services and feedback from workers allows adaptability where such procedures do not meet clients' needs. An example of this adaptation is that initially the social services department was entirely responsible for completing Community Care Assessments for access to residential drug treatment. This role has now been taken on by Counted In, the agency providing outreach work, resulting in a more detailed understanding of the needs of rough sleepers.

Clear pathways to treatment for both opiate and non-opiate users were put in place. All partners were in agreement that clients could re-engage with services following a lapse. Fundamental to delivering this type of service has been the daily liaison between agencies, a commitment to weekly case conferences, and the flexibility of workers from all agencies to react and deliver services at short notice and on the streets.

The Drug and Alcohol Specific Grant that Manchester received facilitated an easier route into accommodation for rough sleepers with drug problems. Underwriting the cost of beds in temporary accommodation for clients with no ID or current benefit claim enabled clients to stabilise their drug use. It also resulted in a greater use of outreach services, which has had a positive impact on the lives of the clients, including directing them towards harm reduction services. This form of preventative health care has a dramatic affect on the well-being of injecting drug users prior to moving on to treatment.

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Service standards, monitoring and evaluation

- 3.12** As with all drug services, setting standards and performance monitoring should be an integral part of commissioning strategies for service for homeless people. Services need to have clear aims and objectives with associated targets which are continually monitored, leading to regular evaluation and review of the services (see Chart 1).

Service standards

- 3.13** Too often in the past drug services, including treatment, for homeless people have been delivered by dedicated but unqualified and poorly trained staff in hostels and day centres. All drug services for homeless people should meet the organisational standards set out in QuADS, *Organisational standards for alcohol and drug treatment*³¹. All the minimum standards should be met and wherever possible the good practice standards should be achieved, whether services are provided by specialist drug agencies or homelessness agencies. This is likely to involve a substantial investment in training of staff and management in homelessness agencies and where necessary the recruitment of specialist staff.
- 3.14** Homelessness agencies report that they have severe difficulties in recruiting suitably competent drug workers. Any planned expansion of services will require a commensurate expansion of training resources.

- 3.15** The aim should be for all staff working with homeless drug users to be trained to the standards set by DANOS as these are developed to cover workers in these settings³². Key skills will include:
- recognising indications of substance misuse
 - carrying out screening, referral and assessment
 - referring individuals to specialists
 - enabling individuals to find out about and use drug treatment services
 - supporting individuals who are substance users
 - raising awareness about substances, their uses and effects
 - helping with the assessment of drug users' other care needs
 - contributing to the development, provision and review of care programmes.
- 3.16** DATs should work with homelessness agencies to develop a joint training strategy. This will involve liaising with homelessness agencies regarding their training needs and helping to plan training programmes.

Monitoring performance in drug services for homeless people

- 3.17** The NTA is establishing a national system of performance measurement for drug treatment services and services for homeless people should adopt these as they become available.
- 3.18** Targets for drug treatment services for homeless people should reflect the high level of needs of this group and the likelihood of relapse from treatment. Targets should avoid creating perverse incentives to focus on easier clients and to exclude those such as rough sleepers who are likely to have the most severe needs. They should also reflect the important role of harm reduction in engaging homeless drug users.
- 3.19** DAT performance in commissioning a range of services for homeless drug users will be assessed through the treatment plan and the DAT annual plan returns.
- 3.20** The following chapters give guidance on the details of commissioning specific services for homeless drug users.

4 improving the effectiveness of mainstream drug services to homeless people

This chapter outlines ways of ensuring that mainstream drug services are effective in meeting the needs of homeless people.

The key problems faced by homeless drug users are: gaining access to services; sustaining engagement with treatment; avoiding a return to the circumstances which led to their original drug problems and securing support for a range of other needs which have limited their ability to access and sustain treatment.

The chapter examines the key features which DATs should include in service specifications including access to services and the models of service which should be provided.

- 4.1** Many homeless drug users have multiple needs and are likely to need an integrated care plan. Chart 2 (page 30) summarises the main pathways that homeless drug users will need to follow for successful treatment and resettlement. There is a wide overlap between the needs of homeless drug users and others with multiple needs and chaotic use. The guidance in this chapter on commissioning services should be read in conjunction with other key publications, which are referred to in the text.

Access to drug treatment services for homeless people

- 4.2** *Models of Care*³³ states that: “Ideally all treatment services should be easily accessible to substance misusers (e.g. by virtue of location, entry criteria, assessment procedures, waiting times).” Recent research has confirmed that on all these factors many homeless people are disadvantaged in their ability to access services³⁴.

4.3 These access problems arise for a number of reasons:

- Many homeless people, particularly rough sleepers, cannot demonstrate high commitment to treatment, which statutory services often demand.
- Long waiting periods for treatment adversely affects the motivation of many drug users. This especially impacts on homeless drug users.
- Strict standards of attendance and compliance make it difficult for many chaotic homeless people to engage with or sustain treatment.
- The lack of a stable address can make it difficult to stay in contact.
- Travel problems, especially in rural areas, can make it difficult to get to services.
- Opening hours may be geared to people who are working, for example offering services in the early morning or evening, which may be inconvenient for homeless people.
- Homeless people may be seen by some services as too difficult to help or disturbing to other clients.
- For homeless families, many of whom are single parents, lack of childcare facilities can make access to treatment difficult.

4.4 GPs are an important route into drug treatment, but research has found that homeless people can experience difficulties in accessing GP services, with some doctors, nurses and receptionists reluctant to register homeless people because they believe they might be disruptive, or cause problems with other patients³⁵. The Department of Health has funded the Royal College of General Practitioners to set up a certificate in the Management of Drug Misuse in Primary Care to train more GPs to work with all drug users, including those who are homeless.

4.5 Drug treatment services have many competing claims on their resources. However, the evidence on the high levels of vulnerability of homeless people, the difficulties they have in accessing services and the success of services targeted on them, indicates that both drug and homelessness services should consider giving priority to this client group and should certainly not be excluding them through, for example, inflexible working patterns.

4.6 In commissioning drug services which are capable of engaging homeless people, DATs should ensure that services:

- Consider the scope for dealing with homeless people as priority cases both for assessment and drug treatment provision.
- Ensure effective links with street outreach work in areas where there are rough sleepers, to encourage them into treatment.
- Provide access points in places used by homeless people, such as day centres and hostels.
- Wherever possible operate an open door policy, without the need to make appointments, or to make repeated visits for assessments.
- Are located in places which can be reached by people without their own transport, including for example, peripatetic services in rural areas.
- Reduce waiting times to treatment to the minimum. The NTA has set targets for the reduction of waiting times for all drug treatment services and issued guidance on how to achieve them³⁶.
- Provide a flexible service which allows for possible repeated relapses by clients.
- Consider small scale specialist provision, such as hostels for people with multiple needs.
- Liaise with housing agencies to ensure stable accommodation is available, which may be in a hostel or temporary supported housing, pending permanent rehousing.
- Tackle the psychological needs and dependencies of users.
- Ensure other support needs are met.

4.7 Mainstream services should be reviewed to ensure that, as far as possible, barriers to access are eliminated. Achievement of this aim is likely also to increase the effectiveness of services for other groups of people with multiple problems.

4.8 Homelessness agencies and drug services providing homelessness services can play a key role in reaching drug users not in contact with other services. DrugScope has produced a good practice guide for such agencies, *Homelessness and drugs: access to drug treatment*³⁷. The guide points out that:

“Homelessness services are in an ideal position to form a bridge between this hard to reach population and drug treatment services. With appropriate training and support homelessness staff can meet the immediate drug-related need. Homelessness services may be able to provide low-threshold drug interventions and to act as a referral point to specialist drug treatment services. Homelessness services should:

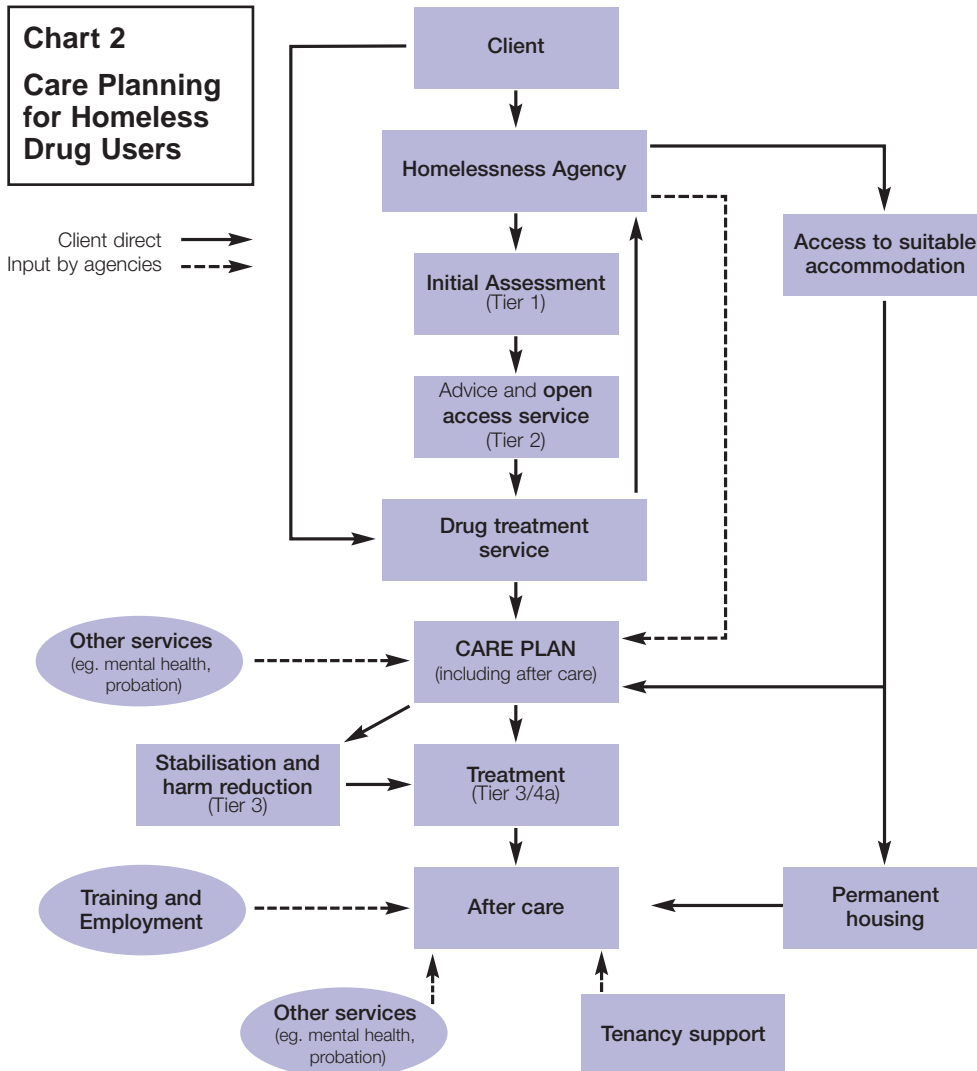
- provide drug related information and advice;
- provide harm reduction interventions;
- work jointly with drug treatment services;
- refer clients to drug treatment services when needed;
- support clients during drug treatment.”

4.9 DATs should encourage homelessness agencies to implement the recommendations in the DrugScope guide and should consider the need to commission such services from these agencies, or from suitable drug agencies.

4.10 The role of homelessness agencies as a gateway to drug treatment services may be limited by some homelessness agencies banning drug users from their projects. For example, many hostels will not accommodate known drug users. In some cases this is because agencies fear the legal consequences of allowing drug users on their premises. DATs can play a useful role in informing homelessness agencies how they can lawfully accommodate drug users and they can be referred to the DrugScope good practice guide on the subject *Homelessness and drugs: managing incidents*³⁸. The Home Office will clarify shortly the position in relation to Section 8 of the Misuse of Drugs Act. It is important for homelessness agencies to accommodate drug users within the law. Drug services should work with homeless agencies to help homeless drug users to access treatment and accommodation, rather than excluding them and increasing the likelihood of exacerbating their problems.

4.11 On the other hand, some former drug users want services, such as hostels and day centres, which exclude current drug users. It is important to provide these facilities as well, along with provision for continuing users. DATs should work with housing authorities to ensure there is a range of accommodation and support facilities for homeless people with past and existing drug problems within their homelessness strategies. This should be done in conjunction with Supporting People strategies. ODPM will be publishing a guide to accommodation and support options for people who have substance misuse needs³⁹.

4.12 Homeless drug users are usually thought of as single people and couples without children, but homelessness agencies are beginning to recognise that there may be a significant number of homeless families with drug-using parents. *Models of Care and QuADS, Organisational standards for alcohol and drug treatment*⁴⁰ provide guidance on services for drug using parents. Drug problems can themselves lead to homelessness for families. Drug services aimed at parents should ensure that any housing problems and dangers of homelessness are tackled as part the support offered to them.



Turning Point Hungerford Project: low threshold treatment programme

There is a growing recognition of the need for accessible drug services for homeless people. Mainstream drug services have started to examine more flexible and responsive ways of ensuring that homeless people can access the care they need. The Turning Point Hungerford Drug Project has developed links with mainstream services so that it can provide advice and information to a range of clients, including entrenched homeless people.

The range of interventions has been developed to:

- raise levels of motivation
- increase stability
- enable a wider take-up of substance misuse services
- effect positive change in behaviour.

The project provides a range of Tier 2 services for homeless clients to enable accessibility, successful referral into drug treatment and retention. Particular emphasis is placed on partnerships, liaison and joint working to ensure an integrated response. The Hungerford Project works closely with other treatment providers, street teams, resettlement workers, employment and training organisations and Criminal Justice Services such as Arrest Referral Schemes.

- The Hungerford has a number of formal *partnerships* that are essential to effective liaison and an integrated response for clients. These include street contact and assessment teams, hostels, tenancy support and specialist treatment providers.
- *Satellite services* are offered in a number of local homeless agencies, providing access points from which clients can be referred into treatment services.
- *Open access drop-in services* are available every week day afternoon. Clients initially attend the drop-in for harm minimisation, crisis intervention and advocacy, but it also acts as an access point into more structured treatment by also providing taster sessions, complementary therapies and statutory treatment satellites.

The project's *Low Threshold Treatment Service* has been developed to promote life skills (often a bar to successful referral and completion of treatment) and motivation to change in a currently using street-homeless client group.

Each client is fully assessed on entering the programme to determine individual need. Keyworkers are then allocated and a treatment plan devised in conjunction with the client. Services include:

- A life skills programme which incorporates a wide range of skill-based packages such as numeracy and literacy, music technology, art, anger management, Internet access and computer training.
- Daily complementary therapies.
- A wide range of targeted group work.
- Activity based sessions to encourage retention of clients.

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Initial assessment and referral

4.13 Homelessness agencies can play a key role in identifying homeless drug users and referring them to drug services. Where agencies are in contact with homeless people for long enough, they can potentially make an initial assessment and refer them to specialist services. In order for this to work successfully, the procedures will need to follow the guidance set out in *Models of Care*⁴¹ which include:

- Clear and standardised assessment processes used across all agencies.
- Clear criteria for referral and eligibility for entry to each part of the treatment system.
- A directory of support services for substance misusers, including that offered by specialist homelessness agencies.
- Clear criteria for priority treatment and emergency access, including the priority given to homeless people.
- Adequate training of staff, including those in homelessness agencies, for carrying out assessments at each level.
- Adequate sharing of information between agencies in the treatment system, with the consent of clients.
- A system of monitoring, auditing and review of the assessment system.

4.14 Many homelessness agencies do not currently carry out any formal assessment for drug related needs, or indeed for other support needs. Specialist drug services should work with homelessness agencies to develop appropriate initial drug assessments or screening which can be carried out by staff in those agencies.

Achieving better access to mainstream drug services for homeless drug users

4.15 The needs of individual homeless drug users vary as widely as other clients. They will require access to the full range of treatment services set out in the four tiers in *Models of Care* which are summarised in Table 1, page 34. However, there are a number of ways in which services may need to be tailored for the particular needs of homeless people.

4.16 Harm reduction is a term that covers activities and services that acknowledge the continued drug misuse of individuals but seek to minimise the harm that such behaviour causes⁴². Harm reduction is based on a hierarchy of goals. The following goals will all reduce the risk to the individual and to others⁴³:

- the cessation of sharing of equipment
- the move from injectable to oral drug use
- a decrease in drug misuse
- abstinence.

Often services described as providing harm reduction services tend to pursue the first two aims with clients, and refer clients to other drug treatment services once they have engaged with service provision e.g. detoxification and residential rehabilitation. In this document, where harm reduction is referred to, it is intended to refer to the first two aims in the hierarchy described above.

4.17 Detailed assessments should continue to be conducted by drug specialists, and there should be scope for them to do this in homelessness agencies, to reduce the danger of losing contact with the client. Both *Models of Care* and *QuADS: Organisational standards for alcohol and drug treatment*⁴⁴ specify the need for comprehensive assessments covering all support needs, including housing.

4.18 *Tier 1: Non-substance misuse services.* Homeless people often have multiple problems and liaison will be necessary with other health and support services to ensure their other support needs are met, if drug treatment is to be successful. This will usually require the planning of Integrated Care Pathways for homeless service users (see below paragraphs 4.29-4.35). Homeless agencies should develop screening and referral protocols for substance misuse to ensure a seamless service.

Table 1 Substance misuse treatment tiers

Tier	Tier title	Service modality	Commissioning level
1	Non-substance misuse (SM) specific services	<ul style="list-style-type: none"> ● personal medical services (primary care) ● non-SM specific social services ● children and family services ● non-SM specific assessment and care management ● housing department ● non-SM specific probation services ● vaccination/communicable diseases ● sexual health/health promotion ● accident and emergency services ● general medical/general psychiatric services ● vocational services 	local DAT*/Primary care trust (PCT)

Substance misuse treatment tiers (link).

Tier	Tier title	Service modality	Commissioning level
2	open access substance misuse services	<ul style="list-style-type: none"> ● advice and information ● drop-in services ● motivational interviewing/brief interventions ● needle exchange (pharmacy/agency/outreach) ● street outreach services ● low threshold prescribing ● liaison substance misuse services for acute medical and psychiatric disorder ● SM specific assessment and care management 	local DAT/PCT
3	structured community-based substance misuse services	<ul style="list-style-type: none"> ● care planned counselling/psychotherapy ● structure day programmes ● structured community based detoxification ● structured prescribing/methadone maintenance ● structure aftercare programmes 	local DAT/multi-DAT
4a	residential substance misuse specific services	<ul style="list-style-type: none"> ● inpatient SM units/designated psychiatric beds ● residential rehabilitation ● SM crisis centres ● residential co-morbidity services ● mother and child rehabilitation services ● young people's SM units 	multi-DAT*/regional/national
4b	highly specialist non-substance specific services	<ul style="list-style-type: none"> ● specialist liver disease units ● forensic services ● specialist personality disorder units ● specialist eating disorders units ● terminal care services ● HIV specialist units 	regional/national

*Joint Commissioning Groups or commissioning authorities (e.g. primary care trusts, local authority) commission on behalf of DATs

- 4.19** *Tier 2: Open access substance misuse services.* Homeless people will need speedy access routes based in services they already use, such as hostels and day centres, although treatment itself might not necessarily be provided in these premises. These services will need to be active in encouraging homeless people to seek treatment, including through street outreach work. Health care sessions in hostels and day centres can enable workers to discuss drug treatment and help with harm reduction. This is an important first step, because high risk injecting practices are particularly common among homeless people.
- 4.20** Open access services could be a first step for chaotic homeless people, particularly if they are sleeping rough. This should include advice on safer drug use, needle exchanges and help in accessing substitute prescribing. This helps build trust and confidence in drug services and can increase motivation for more intensive help. However, it is also important for rapid access to detoxification and rehabilitation to be available where these are the best option for the client.
- 4.21** A move into detoxification and rehabilitation without adequate preparation can sometimes lead to failure for this group. This preparation should include psychological support and counselling. An evaluation of specialist drug treatment services for rough sleepers found that introducing detoxification followed by residential rehabilitation as the only choice of drug treatment had a negative effect for some clients, such as a relapse. For some, where detoxification was offered following a period of stabilisation, it was welcomed, as they had previously been unable to access such services. Services which gave priority to the provision of accommodation, support and stability for rough sleepers were more effective and more likely to lead to successful treatment⁴⁵. However, harm reduction services, particularly needle exchanges, need to be aware of the importance of not simply supporting street lifestyles, but of encouraging the uptake of drug treatment, accommodation and other support and health services. Such services should play a role in building motivation for treatment.
- 4.22** *Tier 3: Structured community based substance misuse services.* There has been a move to community based drug treatment programmes. Community based support and prescribing services may help homeless drug users to stabilise their drug use. However, special arrangements will need to be put in place if those without secure housing can access these services. This could include satellite service provision or low threshold models offering flexible prescribing. Community based detoxification and rehabilitation may not be suitable for people without secure housing who have the most acute needs, or for those who need to withdraw from their usual environments to assist their recovery.
- 4.23** On the other hand, community based treatment might be suitable for formerly homeless people who have been successfully housed in permanent or stable accommodation away from their previous environments, or for homeless people with less chaotic or entrenched patterns of use. Community based structured after-care programmes are especially important for homeless drug users, who have completed residential treatment and have a high risk of relapse if they return to their original environment. The only social contacts for some would otherwise be with other homeless people, who may include a high proportion of drug users. Securing stable accommodation and helping them to make new social contacts is an essential part of after care support for homeless drug users.

- 4.24** *Tier 4a. Residential substance misuse services.* Residential treatment is often more suitable for homeless people and may be preferred by them⁴⁶. Homeless people have in the past encountered problems in accessing community care funding for residential treatment in part because they may not be seen as resident in the area. DATs should work jointly with social services to resolve any local funding problems for residential treatment.
- 4.25** For some clients it is important that, before they move to residential treatment, they have a period of stabilisation and counselling to understand the impact on their health, psychology and social networks. All homelessness agencies should be aware of the role of detoxification and such services for homeless people should be part of a carefully planned package of care, rather than a one-off response to taking someone into accommodation. Detoxification and rehabilitation should be planned interventions for those who want complete abstinence from drugs. It can be advantageous to place homeless people outside of their normal area so as to reduce the risk of relapse or early exit from treatment.
- 4.26** Specialist drug treatment residential services, including those based in hostels, may provide the structure and support a homeless person requires for successful treatment. Drug services in hostels should meet all the nationally agreed quality standards, (QuADS), expected of mainstream services.
- 4.27** Homelessness agencies in some areas report that crack cocaine use is increasing among homeless people, but many crack users feel that some traditional services, based on opiate dependency models, do not meet their needs. Work is developing on treatment for crack users and there is not yet an emerging consensus on what works best. Tier 3 and 4 treatment for crack users should include structured counselling and rehabilitation, both day care and residential. As part of the development of a national crack plan to support the National Drug Strategy, the NTA is developing work in this area and the lessons from this will need to be integrated into services for homeless drug users.
- 4.28** Achieving effective services is likely to involve both tailoring mainstream services and the provision of specialist services aimed at homeless people and particular groups within them. DAT commissioners will need to review their existing provision to determine to what degree they meet this requirement. Where gaps exist, they should be filled through specific contracts which may require the development of specialist provision (see Chapter 5).

Care for homeless drug users with multiple needs

- 4.29** The multiple needs of many homeless people mean that most will need integrated packages of care to meet these needs, if drug treatment is to be successful. The need for comprehensive care management has been recognised in all cases of drug treatment, but is particularly important in the case of homeless clients. This necessitates not only liaison with other agencies, but joint care planning with them. Homelessness agencies have also been advised of the necessity for joint work with drug services⁴⁷. The advice here also applies to specialist drug services for homeless people (see Chapter 5).

4.30 In addition to drug and housing support services, care services may need to cover a wide range of needs including:

- alcohol use
- mental health
- physical health
- offending behaviour
- family and relationship problems
- training and education
- employment.

4.31 This may entail joint work and joint commissioning with:

- Supporting People commissioning bodies
- primary care and other health services
- probation services
- police services
- family mediation agencies
- counselling services
- The Progress2work (p2w) initiative run by Jobcentre Plus (formerly the Employment Service), which will help people recovering from a history of drug use to find employment.

Progress2work (P2w) currently operates in about two thirds of Jobcentre Plus districts and current plans are for national coverage by April 2003. It will:

- Help clients with a history of drug use to make better use of mainstream employment services.
- Agree a local employment plan between the Jobcentre Plus and key agencies, including DATs, and the Prison and Probation Services.
- Provide a support worker who will undertake detailed personal assessments and action plans for progression through employment and training.
- Identify the need for other support such as health, accommodation and debt counselling, as well as drug treatment programmes.

Further information on Progress2work can be requested from progress2work@jobcentreplus.gov.uk

- 4.32** All the key guidance on effective drug services emphasises the need for co-ordinated care management and detailed guidance can be found in these documents⁴⁸.
- 4.33** The significant minority of homeless drug users who have severe mental health problems will require Enhanced Care Co-ordination as defined in the Department of Health *Dual diagnosis good practice guide*, which also recommends that treatment for them should be delivered within mental health services⁴⁹.
- 4.34** The first aims of care packages will often be to find secure accommodation and to stabilise drug use. Secure accommodation does not necessarily mean a permanent tenancy, but is more likely initially to be a hostel, or supported housing project, with staff who are trained and experienced in dealing with drug users, with the facility to stay for several months, or longer if necessary, and with access to professional drug treatment services.
- 4.35** There is further guidance on successful joint working on homelessness in *Homelessness strategies: a good practice handbook*⁵⁰.

5 developing specialist services for homeless drug users

In areas with high levels of homelessness, there may be a need to commission specialist drug treatment services for homeless people, *alongside* better access to mainstream services. Some of these services may be more effectively run by voluntary sector agencies, which are often more able to work in flexible and innovative ways with homeless drug users and may be more trusted by them.

- 5.1** Some specialist services can be provided by competent homelessness workers, others by specialist drug workers either employed by the homeless agency, or providing a satellite service within a homelessness agency. In the past some of these services have been provided by homelessness staff designated as drug specialists but without adequate competence. It will be important for DATs to work with homelessness agencies to ensure staff are competent according to the standards set by DANOS⁵¹. DATs will need to examine whether their existing network of agencies can provide these services and what additional provision may be required.
- 5.2** *Street outreach services.* Open access substance misuse services (Tier 2 services, see Table 1) should be available to people sleeping rough. These would be most productively provided by joint work between drug treatment services and homelessness agencies, including Contact and Assessment Teams (CATs), where these operate. Much of this work will be concerned with harm reduction which should encourage homeless people to stabilise their drug use and to enter accommodation. Street based harm reduction should include:
- needle exchange
 - advice on safer injecting
 - advice on safer use of all drugs, including overdose prevention
 - support to access drug treatment
 - support to access other health and social care services, including primary care and benefits advice.
- 5.3** Services should be carefully planned to ensure they play a part in encouraging people to move off the streets, rather than simply reinforcing street living. For example, they should encourage people wherever possible to go to a hostel or at least a day centre to receive additional services, rather than providing for all needs directly on the street. However, homeless drug users may need to develop confidence in the outreach service before they can be encouraged to more mainstream services, so this may have to be a progressive approach.

- 5.4** *Day centres.* Tier 2 open access services should also be offered in day centres for homeless people, or on a specialist basis for drug users, with the same approach as for street services. They should be linked to encouraging people to stabilise their use and, where applicable, move into hostels or other suitable accommodation. Day centres may have frequent, even daily, contact with clients and so can also have a role in helping clients to maintain progress while they are in treatment.
- 5.5** Drug agencies might offer peripatetic satellite services in a number of agencies. This might prove especially useful in rural areas with poor transport links. It is unlikely that community based treatment could be effectively operated through homelessness day centres for some homeless drug users, as clients require stable accommodation. However, day centres and particularly specialist medical centres for homeless people, might also provide Tier 3 services, including after care services, for those with stable accommodation.
- 5.6** *Hostels and shelters.* Tier 2 services should also be offered in hostels with significant numbers of homeless drug users. There are advantages in offering services on the premises, since they are likely to engage chaotic drug users who would not necessarily go to an external agency. Basic advice and information and initial assessments can be offered by competent hostel workers. Hostels are also a good base for harm reduction services for homeless people. More specialist services can be provided by drug workers either employed by the hostel or by a drug treatment service providing a satellite service in the hostel. All such drug workers, whether employed by the hostel or a drug treatment service, should be competent to work in relation to presenting drug problems and homelessness needs. It is essential that they are provided with professional support and supervision.
- 5.7** Where hostels provide for longer term stays, then separate specialist units within the hostel providing residential services might be considered (Tier 4a), including detoxification and rehabilitation. These units often operate in self contained parts of the hostel, for example a separate floor with its own entrance. Such services offer the advantage of in-house expertise in working with homeless people and the opportunity for residents staying in the hostel to move into treatment when they are ready, without having to move accommodation. Such projects should also provide access to move-on accommodation and eventually to permanent housing. These units can encourage people into treatment who might not have otherwise accepted it and can also mean that they will not become homeless should they relapse. Once again, it is essential that staff and management of such units are competent and that the service is compliant with QuADS, *Organisational Standards for Drug and Alcohol Treatment Standards*⁵². They might be operated as joint projects with drug treatment services who could provide staffing, and professional and clinical supervision, while the hostel provides accommodation and housing support, along with access to longer term stable housing.

Working with hostels: Soho Rapid Access Clinic

The Soho Rapid Access Clinic (SRAC) is based in a hostel in London's West End. The service works with drug and alcohol users, who have a current history of sleeping rough, or are vulnerably housed in temporary shelters. The service is particularly aimed at rough sleepers who have had little contact with drug treatment agencies before, because of the multiple problems which prevent access.

Referral is restricted to the local Contact and Assessment Teams (CATs), and specialist substance misuse outreach workers. Assessment is usually done at SRAC, but there is scope for on site assessment in hostels if needed. The clinic has developed close links with local services, and works in partnership with numerous agencies. It offers access to nearby primary care clinics and needle exchanges. The model of work at SRAC is centred on service user need and operates on a small and fairly intimate level, the maximum number of treatment spaces is 39. As part of the assessment it offers safer injecting advice and information as well as health promotion and information on local services.

SRAC is able to offer substitute opiate prescribing, access to detoxification facilities and assessments for rehabilitation funding. In addition it runs groups at the clinic and in local hostels which focus on combination drug use (heroin and crack injected together) and crack use.

The clinic works closely with the Substance Misuse Units at four West End hostels, where many of the service users are housed as part of their treatment package.

The clinic:

- has an awareness of the barriers to treatment faced by rough sleeping drug and alcohol users;
- offers an easily accessible assessment and treatment service;
- provides a client focused, low threshold flexible prescribing and treatment service;
- offers information and advice to substance users aimed at drug issues and harm minimisation.

A drug worker will assess a client at their first appointment to ascertain their individual needs. This worker will remain the client's keyworker for the entire treatment period, a maximum of 12 weeks, before being referred on to other longer-term services.

During their time at SRAC, the client's keyworker will work closely with the client's various workers to try to establish stable accommodation as a base for making changes to their drug use. Informed consent is given for joint working, and referrers are encouraged to continue to support service users during their treatment at SRAC.

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- 5.8 There might also be a need in some areas for small scale specialist hostels which could offer accommodation, support and treatment for homeless drug users with multiple problems, for example those with drug, alcohol and mental health problems.

Highly specialist multiple drug services for homeless people

- 5.9 The Homelessness Directorate of ODPM and the Department of Health have in the past funded a number of specialist drug services for homeless people. These included a full range of services, as described above, with a facility to spot purchase residential drug treatment, including detoxification.
- 5.10 Some specialist multi-disciplinary teams based in homelessness agencies can provide a wide range of integrated support. This includes, in addition to drug and alcohol treatment, help in accessing accommodation and other emotional and practical support to help clients achieve greater stability.
- 5.11 Independent evaluations of these projects, which were funded through the Homelessness Action Programme, found they achieved significant improvements in clients' quality of life through major reductions in drug use, in risk-taking associated with drug use and in physical and psychological health problems. Ninety per cent of clients had reduced their drug use and nearly half (48 per cent) were no longer using drugs or alcohol. Users of heroin were down from 87 per cent of clients to 46 per cent. Similar reductions were seen with other drugs, although there was an increase in the number of alcohol users. The number of injectors declined from 88 per cent to just 10 per cent. However, success rates did vary between different projects⁵³.

5.12 Key factors in successful projects were:

- inclusion of harm reduction and accommodation stability
- an offer of detoxification and rehabilitation
- agreed long term regional strategies and detailed planning
- good pre-existing partnerships between agencies and written protocols
- pre-existing access to the client group
- staff skilled in working with the client group
- a good range of specialist resources on all health matters.

5.13 Problems which reduced effectiveness were:

- introducing detoxification followed by residential rehabilitation as the only choice of drug treatment
- insufficient involvement by drug treatment providers in the planning and delivery of services
- conflict between harm reduction and abstinence approaches in different agencies
- inflexibility and negative attitudes towards the client group in some treatment agencies.

Highly specialist services for homeless drug users

Focus Housing is a large, Midlands based, RSL involved in both general needs and supported housing. Focus provides both street outreach and tenancy sustainment services to rough sleepers in Birmingham.

Very early in its work it became clear that drug misuse was a major cause and – sometimes – a symptom of rough sleeping. It also became clear that the existing model of drug treatment was not effective in tackling the scale and nature of need amongst drug-using rough sleepers. Rough sleepers, despite support from the street outreach team, struggled to engage with appointment based treatment, assessments based on group work and in-city detoxification services.

Recognition of the need and barriers led to the Rough Sleepers Unit funding the outreach team over two years to provide drug treatment services directly for rough sleepers. With the support of Birmingham Drugline, a drug worker was recruited and a service designed for rough sleeping drug users that better responded to need and expanded the treatment options available. Services ranged from co-coordinated harm reduction interventions involving treatment, accommodation and support, to the purchasing of extended detoxification and rehabilitation programmes out of the city. The services had to be based on strong client-worker relationships, with the ability to deliver opportunities rapidly at the point of need and client motivation.

Evaluation by DrugScope of the Drug & Alcohol Specific Grant received by the Birmingham CAT shows positive results. Out of 31 clients helped, there were 20 detoxifications. Six completed rehabilitation programs and a further 19 reported reduced drug use. Only five reported no significant change and seven outcomes were not known as contact had been lost. Of those that were rough sleeping at the start of the program, eight were moved into temporary accommodation, five into permanent accommodation and three remained on the streets.

Positive outcomes were achieved through active partnership work and a commitment from all partners to include, rather than exclude, homeless people. Focus Housing is part of Birmingham's Homeless & Roofless Strategy, and was able to deliver its part of the strategy through hostel, supported and general needs accommodation, street outreach and the ability to offer direct opportunities to rough sleepers entrenched on the street by their drug misuse.

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Joint work in Nottingham

Nottingham City Council has a rough sleepers strategy, which feeds into the local homelessness strategy. This has provided a framework for the organisation of services to rough sleepers with drug related needs. Joint work between partners has been an important element to the success of the initiative. It has also established common tools for assessment and referral protocols between the various agencies. This includes strong links with medical services.

Weekly meetings of agencies help in communication and planning. Clients get quick access to services because of a lack of barriers between agencies. The Rough Sleepers group formulates plans for individuals who are particularly hard to engage.

A harm reduction strategy has been adopted in Nottingham with the aim of a more settled lifestyle for the rough sleeper. This is achieved through management of drug use rather than enforced abstinence.

The first point of contact for clients is usually the CAT. Some clients are also accessed through hostels. The services include access to primary care, needle exchanges, safer injecting advice and information. Facilities are also available to access education and training on living skills.

Framework Housing provides a range of specialist hostels, including for substance misusers. The philosophy of the projects is to develop the clients' ability to sustain accommodation, to stabilise drug and alcohol use and to provide opportunities for drug or alcohol abstinence based treatment at a later date. An alternative to hostel treatment is available, with 60 units of self-contained council accommodation where Framework Housing can provide support to the individuals, via the CAT.

An NHS drug treatment and primary care clinic prioritises rough sleepers and offers prescriptions and other services. Social Services integrated support and drug treatment assessment for clients with complex needs is available, for those who may require specialist residential drug treatment.

Another important component to the success of the initiative is the status given to service user involvement. The employment of independent advocates is being considered in a review of client participation.

The project has been very successful in bringing down the numbers of rough sleepers with a high proportion rehoused and receiving specialist substance treatment. The project puts its success down to a model where rough sleeping is tackled first, providing stable accommodation allowing for the focus to then change to tackling drug use.

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6 accommodation for homeless drug users

Access to stable accommodation is essential for effective drug treatment services for homeless people. This chapter examines the assessment of housing needs and the different types of accommodation available for homeless drug users. It outlines the ways in which DATs and drug services should work with housing agencies to ensure that the provision of treatment and accommodation complement and reinforce each other.

Introduction

- 6.1 People without accommodation are unlikely to be offered treatment, and those leaving treatment without suitable accommodation and support are very likely to relapse. Treatment services for homeless people, such as detoxification and rehabilitation should be linked into wider plans for accommodation and support. This need not mean an immediate move by clients into permanent housing. Indeed hostels and supported accommodation are often more appropriate as a first step. ODPM is producing good practice guidance on accommodation with support for people with substance misuse needs⁵⁴. It is also important to ensure that adequate support is in place to prevent drug users from losing their accommodation. It is therefore essential that DATs work closely with homelessness agencies and accommodation providers to plan the provision of suitable accommodation for homeless drug users.
- 6.2 However, accommodating chaotic drug users can lead to management problems and requires that adequate expert support is in place. There will also remain the need for hostels and supported housing, which are drug free, especially for ex-drug users and for homeless people who object to sharing accommodation with current drug users.

Assessing and meeting accommodation needs

- 6.3 The most suitable type of accommodation will depend on the individual's needs and the treatment stage they have reached. Assessing the accommodation needs of drug users at each stage of treatment and ensuring they are met is central to effective programmes for homeless drug users and should be part of their integrated care plan. DATs should ensure that drug treatment services work jointly with housing agencies to include the accommodation needs of users in their care plans.

- 6.4** It is essential that a full assessment is made well in advance of any move out of each stage of accommodation. It will often be most effective to carry out a joint assessment with a homelessness or housing agency. Joint protocols should be agreed for the referral of homeless drug users to housing agencies. It is essential that referral agencies do not understate the level of drug use, or other support needs, of clients in order to obtain accommodation for them, as this is likely to lead to a failure to ensure adequate support is in place and a high risk of renewed homelessness. Equally, DATs should work with accommodation providers of all types to ensure that they are prepared to accept homeless drug users, provided care plans are in place for their support and eventual treatment.
- 6.5** The amount and type of accommodation and support available varies widely in different areas and DATs should work closely with local authorities' homelessness strategies and with Supporting People programmes to ensure that plans are in place for accommodation and support to meet the needs of local drug users. These plans should include the need to be responsive to changing circumstances in clients' lives and to any crisis points they might experience.

Supporting People brings together a number of funding sources for housing support and aims to improve the effectiveness of support services that promote independent living. It aims to integrate housing support with other local strategies, including those operated by DATs, the local Health Authority, Probation Service and Social Services. Supporting People will contribute only to the costs of ensuring that people are able to live independently and will not pay for therapeutic interventions. ODPM is publishing a guide on the operation of Supporting People for people who have substance misuse needs⁵⁵. Further information on Supporting People can be found on www.spkweb.org.uk.

Night shelters

- 6.6** Traditional night shelters offered poor standard accommodation in dormitories, where residents had to book in each night and were not allowed inside during the day. They offered only limited support for other needs. Many have been replaced by direct access hostels offering higher standards of accommodation and support. There are still some night shelters operating and they are unlikely to be suitable for detailed work with drug users, although DATs could help them to operate as a first point of contact for harm reduction services and referral to drug treatment services. Night shelters could also be encouraged to help residents to move to longer term hostels as a first step to tackling their drug problems.

Hostels

- 6.7** DATs should be in contact with all the hostels for homeless people in their areas, through participation in the local authority homelessness strategy. Hostels should be active partners in planning, and in some cases hosting, drug treatment services for homeless people. Ideally, homeless people in all areas should have access to hostels which provide both for continuing drug users and for those who wish to live in a drug free environment, particularly if they are undergoing or have completed drug treatment. In some cases, the needs of people leaving residential rehabilitation are more likely to be met by supported housing or a permanent tenancy with suitable support (see below).
- 6.8** Many hostels exclude drug users altogether, thereby making successful engagement with treatment very difficult for homeless people. DATs should plan jointly with hostels for accommodation, harm reduction and treatment for homeless drug users. Many hostels will need guidance on the legal position on accommodating drug users and on good practice in drug policies. The position in relation to Section 8 of the Misuse of Drugs Act will be clarified shortly by the Home Office. DATs can play an important role in advising hostels and referring them to the DrugScope good practice guides for homelessness agencies⁵⁶. The Homelessness Directorate will continue to work with homelessness agencies to improve their services for drug users.

Supported housing

- 6.9** The next step for some former drug users in hostels and those moving on from residential treatment will be into supported housing. Supported housing can also form a base for engagement in community treatment services. Some continuing drug users may also need supported housing.
- 6.10** For some clients, a period of intensive support will be necessary to ensure they do not relapse or lose their tenancy. They may then be able to move on to independent housing.
- 6.11** People with very high needs, for example those with a dual diagnosis of drug use and mental health problems, may need long term supported housing, although there is a shortage of such high support accommodation for this group in some areas.
- 6.12** There is a range of models of supported housing, which includes:
- Shared houses, where people have their own bedrooms, but share facilities with other residents.
 - Cluster flats, where residents have their own flats, but there may be some communal areas such as kitchens.
 - Dispersed housing with visiting support.

- 6.13** Support can range from 24 hour staff cover, to daytime cover or peripatetic visits from staff.
- 6.14** The DAT Joint Commissioning Manager should liaise with Supporting People commissioners, the local authority and supported housing providers to plan for the supported housing needs of homeless drug users, before, during and after treatment. These needs may well change over time and care plans will need to take account of possible changes. For example, some people may need only a limited time in supported housing, before moving on to an independent tenancy.

Specialist supported housing for homeless drug users in Oxford

The Oxford Drugs Recovery Project is a five bed supported housing project in the centre of the city offering detoxification and therapeutic care solely to long-term rough sleepers with a drug dependency. Set up two years ago through funding by the Rough Sleepers Unit, it is now financed by the local DAAT and Supporting People. It is a good example of local partnership, the project being managed by English Churches Housing Group (ECHG), with medical support by Luther Street Medical Centre, and with the backing of the local police and city council.

The project is abstinence-based and yet, despite the misgivings of many agencies that this could be successful, has now worked with almost all of those with a drug dependency amongst the city's long-term homeless population. Residents are able to stay for a maximum of six months and receive a medically supervised detoxification and a full timetable of group work, one-to-one counselling, and therapeutic duties. Based on the concepts of shared living and primarily cognitive-behavioural interventions, the scheme is designed to reflect the needs of rough sleepers. It is recognised that the step of moving into accommodation is in itself often a daunting hurdle, before detoxification and counselling are even embarked upon. Residents are involved in the selection of new clients and are regularly consulted in all matters of the project's development.

The project strives for an open-door policy and residents can even keep their dogs. Referrals come mainly from outreach workers and from local night shelters and hostels. A relapse loop is built into the project so that clients who do leave are able to access the project again very swiftly, dependent on them agreeing to an individually tailored contract. Resettlement sessions are held weekly and for those clients who do not remain abstinent after completing the programme, many have moved onto other forms of supported accommodation which they are now able to hold down because of their reduced level of drug use.

Of the 31 individuals who have been into the scheme, 12 have moved onto rehabilitation and ten have been resettled in to permanent housing, which are higher than average rates, despite the known difficulties of working with this client group. The project's success has been a major reason why the number of rough sleepers in Oxford has drastically declined.

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Permanent housing

The role of permanent housing in effective drug treatment

- 6.15 Most homeless drug users will have histories of unemployment and low skills. The most realistic long term housing prospects will usually be in the social rented sector, although private sector options should also be explored in the local authority's homelessness strategy. However, in some areas, particularly in the south of England, there are severe pressures on the social housing stock, with high levels of applications from homeless people and long waiting lists. Local authorities and registered social landlords (RSLs) also have major concerns over potential housing management problems, which might be caused by housing drug users and the impact on other tenants.
- 6.16 The Home Office and DTLR have issued a good practice guide for social landlords *Tackling drug use in rented housing*⁵⁷ This gives advice on the role that housing agencies should play in local drugs strategies. It also outlines how private landlords can be helped to contribute to these programmes.
- 6.17 It will not be realistic in the short term to assume that all drug users in housing need will have priority for housing. However, DATs should discuss the housing needs of homeless drug users with local authorities and RSLs, through participation in the local homelessness strategy and Supporting People programmes. Where possible, quotas of housing for recovering drug users should be negotiated.

Homelessness legislation

- 6.18** DATs should discuss with housing authorities the extent to which authorities should take account of drug problems in assessing whether a person applying as homeless should be considered as vulnerable under the homelessness legislation and therefore entitled to help with permanent accommodation. Problematic drug use is not included in the legislation as a specific reason to consider homeless applicants as vulnerable, but authorities may consider applicants for any “other special reason”. The 2002 draft *Homelessness Code of Guidance* states that “The critical test of vulnerability for applicants...is whether, when homeless, the applicant would be less able to fend for himself than an ordinary homeless person so that he would be likely to suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects”⁵⁸. Some homeless drug users could fall within this definition.
- 6.19** Each homelessness application should be considered on its merits and authorities should not, for example, exclude all drug users. Some drug users may well qualify as vulnerable on other grounds, for example because they have dependent children, or mental health problems, or because they are HIV positive, or because of a combination of needs, of which drug use is but one. Local authorities and drug treatment services should consider the ways in which problematic drug use can contribute to vulnerability in individual cases. Authorities will be concerned not to add to management problems on some housing estates and it will be important that care plans are in place for any people accepted as vulnerable who have drug problems, even if this is not the prime reason for their acceptance as vulnerable. DATs should discuss with housing authorities the importance of taking account of drug problems and the need for stable accommodation for recovering drug users, in considering the vulnerability of homeless drug users who apply to the local authority.

Quotas for people needing housing as part of treatment, or on leaving rehabilitation

- 6.20** Where clients do not qualify as vulnerable under the homelessness legislation, there may be advantages in housing quotas being available to drug treatment services for suitable clients, rather than depending on individual referrals.
- Quota schemes can specify the circumstances in which they will be used and the support that will be available to nominated clients. They can help both drug services and local authorities to manage supply and demand.
 - Quotas are a more cost effective means of referring clients since they remove the need for detailed negotiation on each case.
- 6.21** Local drugs strategies could seek to include plans for a quota of nominations to local social housing, linked to support plans for those nominated. However, quotas can restrict the number of places available and should not become a restraint on the amount of available housing.

Private renting

- 6.22** Private landlords are likely to be extremely wary of housing homeless drug users, even after successful treatment. However, some local authorities have developed schemes with private landlords for housing homeless people along with guarantees of support. Where such schemes are in place, DATs could discuss with the housing authority the scope for using them to provide for former drug users.

Coordinating lettings and treatment needs

- 6.23** It is very important that housing is available for people leaving rehabilitation at the time they need it. If it is offered too early, for example while clients are still in residential treatment, they may be tempted to leave treatment to take up the offer. If no suitable housing is available when they leave treatment, the risk of relapse is likely to be greater. Timing of nominations is easier to manage where quotas and agreed procedures are already in place. DATs should ensure that drug treatment services work jointly with housing agencies to coordinate access to accommodation with treatment timetables. For other clients, who have not been accessing residential treatment, the offer of stable accommodation is, in itself, a crucial part of treatment.

Area of rehousing

- 6.24** Many people want to be housed away from the areas of former drug use, so as to avoid contact with drug using acquaintances and dealers. It is important that this is offered both within the landlord's stock and by mutual arrangements with other landlords. It has also been found that strong social and family support can increase successful outcomes from treatment. Where clients have such support available every effort should be made to secure housing for them close to their support networks⁵⁹.

Tenancy support

- 6.25** DATs need to have a central role, with local authorities and Supporting People partnerships, in commissioning a range of housing support services for drug users, including homeless people. Tenancy support can help to prevent homelessness. This is strongly supported in the joint Home Office / DTLR guidance *Tackling drug use in rented housing*⁶⁰.
- 6.26** Tenancy Sustainment Teams have been funded by the Homelessness Directorate across the country and there are also similar services funded by local authorities and housing associations. Care plans for formerly homeless drug users should include a detailed assessment of their tenancy support needs and plans for meeting them. Without support there will be a high risk of tenancy failure, renewed homelessness and drug use. Previously community care provision has tended to focus on treatment and residential rehabilitation and overlooked longer term support needs. Research in one area found that approximately 90 per cent of tenants with a history of drug use acknowledged the need for further support after they had been rehoused. It found that housing support played a vital role in the stabilisation or recovery of drug users⁶¹.

6.27 Local authorities have been encouraged by ODPM guidance to develop tenancy support programmes as part of their homelessness strategies. *Homelessness strategies: a good practice handbook*⁶² and *Tackling drug use in rented housing* outline the range of tenancy support, which covers help with many problems including:

- Choosing a new home which is suitable and at a time when the client is ready to manage their own home.
- Ensuring the tenant understands their rights and responsibilities, particularly the payment of rent.
- Moving in and furnishing the home.
- Claiming welfare benefits.
- Money management.
- Basic help with personal and emotional problems.
- Access to specialist support for mental health and substance use problems.
- Resolving disputes with neighbours or the landlord.
- Education, employment and training.
- Helping the tenant to integrate with the local community.
- Coordinating and acting as a broker for other services.
- Emergency support if a tenant is at risk of abandoning their home.

6.28 Effective tenancy support can reduce tenancy breakdown to very low levels. Common features of successful schemes include:

- Dealing with people with multiple needs and not excluding them because, for example, they have both mental health and substance use problems.
- Providing detailed pre-tenancy support to ensure that the housing they are offered is suitable and people are aware of their rights and responsibilities.
- Focusing on practical ways of sustaining the tenancy, rather than seeking to solve all the client's problems.
- Providing multi-disciplinary services, without rigid professional boundaries between team members.

- Assertive support work in seeking to engage tenants with the service.
Simply offering the service is unlikely to be successful with many clients.
 - A flexible style of work which is often better managed by independent agencies.
It is also important to clients that support workers are seen as independent of the landlord and not part of a statutory system from which many of them feel alienated.
 - For tenants in need of long term supported housing, a planned move is arranged before the breakdown of the tenancy.
- 6.29** The most effective schemes offer help for as long as it is needed, while ensuring clients do not become dependent on the service for responsibilities they are capable of fulfilling themselves.
- 6.30** Some agencies provide tenancy sustainment through contracts with local authorities and Registered Social Landlords for tenants with mental health and substance abuse problems.
- 6.31** Specialist tenancy support cannot be provided as a part of ordinary housing management and needs specialist staff and separate funding. From April 2003, funding of a wide range of housing related support services to vulnerable people in a variety of types of accommodation will be brought together into a single fund administered by local authorities under the Supporting People programme.

Tenancy support for drug users

Brighton and Hove Tenancy sublet scheme is a partnership between Brighton and Hove City Council, Southdown Housing Association, Crime Reduction Initiative, and Hove YMCA. It aims to provide a supported housing service to vulnerable tenants assessed as in priority need by the City Council. Nominations come via the City Council's Special Needs Housing Officer. Clients can include homeless people with drug problems.

The scheme provides a full tenancy support service whose objectives are to:

- reduce tenancy breakdown and cycles of homelessness
- reduce the numbers of homeless people in Bed and Breakfast accommodation
- help to alleviate isolation
- address issues of anti social behaviour
- support moves into more independent tenancies.

The City Council leases single occupancy flats and bedsits to the Housing Association, which issues assured shorthold tenancy agreements. Southdown Housing Association takes on full housing management responsibilities. A joint assessment of needs is undertaken with an agreed independent support agency. Southdown Housing Association and the support agency agree a housing support plan with the tenant to identify the support needed to sustain the tenancy. The support plan is reviewed on a regular basis, setting targets and goals to meet the tenants' needs to develop independent living skills. The Supported Housing Officer provides the intensive housing management service, including maintenance responsibilities and coordinates the support package provided by Southdown Housing Association and the support provider.

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

Should a tenant no longer need support to maintain their tenancy then the tenancy will revert to the City Council general needs stock. Should a tenant refuse support, or their needs become too great for the service, then they will be moved on by the City Council if deemed appropriate, following discussions with Southdown Housing Association and the support provider.

Tenancies are funded by a claim for Housing Benefit including Transitional Housing Benefit to include the cost of the support.

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6.32 *Tackling drug use in rented housing*⁶³, emphasises that DATs and drug treatment services should work jointly with Supporting People and local homelessness strategies to ensure that adequate housing support is available to drug users and former drug users. This might involve:

- Joint commissioning and funding of specialist support services for tenants who are drug users.
- Developing protocols for the referral of homeless drug users to social landlords and information sharing protocols between drug services and landlords on the drug problems of clients, with client consent. Drug users may be unwilling to approach their landlords about their problems, for fear of losing their homes. Drug treatment services have a vital role to play in acting as a link between the two and in providing specialist support. These, combined with training for housing staff, should ensure that housing officers are adequately informed of the support needs of tenants who are drug users. Arrangements will need to be made for informed client consent, for example as part of the tenancy agreement.
- Training for housing staff on dealing with drug users and on their legal position when doing so.
- Developing support policies to ensure that eviction is only used as a last resort for tenants using drugs. If they are evicted, homelessness is likely to exacerbate their problems and to place extra burdens on local services, which could cost several thousand pounds.
- Developing suitable allocation policies that do not exclude drug users.
- Setting up services to help people return to their home areas. Many homeless people, including drug users, have drifted to areas such as city centres because of the availability of drugs and other services, but want to return home to escape from that environment. However, many do not have the resources to do so and need help with services such as finding accommodation and drug treatment services in their home areas, or perhaps with family mediation to help them return to their family homes⁶⁴.
- Ensuring that tenants who have to leave their home temporarily, for example for treatment or a prison sentence, can return there or to an alternative home. Guidance on keeping tenancies in such circumstances, including the continuing payment of housing benefit can be found in the joint Home Office and DTLR good practice guide, *Tackling drug use in rented housing*, and in *Housing drug users: balancing needs and risks*.
- Ensuring that drug users and former drug users leaving prison have suitable accommodation and support. The CARAT services (counselling, assessment, referral, advice and throughcare) aim to provide integrated services for drug users in prison. Secure housing will be an essential part of the aftercare programme for released prisoners.
- Jointly reviewing local tenancy support services to ensure they are fully equipped to deal with drug problems.

7 conclusion

The way forward

DATs now have the lead role in ensuring effective drug services are available for homeless people. In doing so, they should have substantial help from partners in other agencies working with this client group. Key aims for DATs will be to:

- Adapt mainstream services so that they are accessible to homeless people and provide them with effective treatment.
- Establish specialist services where these are needed.
- Play their part in ensuring that the full range of accommodation and support needs are met for homeless people as a basis for successful drug treatment.

Effective partnership work between the DAT and other agencies will be critical. It is also essential that drug services obtain the required flexibility and adaptability to meet the needs of this vulnerable group.

appendix 1 abbreviations

Abbreviations used in the handbook

ACMD	Advisory Council on the Misuse of Drugs
CATs	Contact and Assessment Teams: street outreach teams working with rough sleepers.
CARAT	Counselling, Assessment, Referral, Advice and Throughcare: integrated services for drug users in prison
DAT	Drug Action Team
DAAT	Drug and Alcohol Action Team
DANOS	Drug and Alcohol National Occupational Standards
DH	Department of Health
DRG	Drug Reference Group
DSD	Drug Strategy Directorate in the Home Office
DTLR	Department of Transport, Local Government and the Regions, former name of ODPM
NTA	National Treatment Agency for Substance Misuse
ODPM	Office of the Deputy Prime Minister
P2W	Progress2work
PCT	Primary Care Trust
QuADS	Quality in Alcohol and Drug Services: Organisational Standards for Alcohol and Drug Treatment Services
RSLs	Registered Social Landlords, for example housing associations
Social housing	Includes both local authorities and RSLs

appendix 2 useful contacts

Useful contacts

Drug Misuse Team
Department of Health
Room 580D
Skipton House
80 London Road
London
SE1 6LH
www.doh.gov.uk/drugs/index.htm

Drug Strategy Directorate
Home Office
50 Queen Anne's Gate
London
SW1H 9AT
www.drugs.gov.uk

National Treatment Agency
5th Floor, Hannibal House
Elephant and Castle
London
SE1 6TE
www.nta.nhs.uk

DrugScope
32-36 Loman Street
London
SE1 0EE
www.drugscope.org.uk

Homelessness Directorate
Office of the Deputy Prime Minister
Ashdown House
123 Victoria Street
London
SW1E 6DE
www.housing.odpm.gov.uk/information/index04.htm

Homeless Link
1st Floor
10-13 Rushworth Street
London
SE1 0RB
www.homeless.org.uk

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