The Housing Needs and Experiences of Homeless Drug and Alcohol Users in Stoke-on-Trent

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Housing Homeless People with Complex Needs

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CRESR
Centre for Regional Economic and Social Research

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This report is based on research undertaken by the authors and the content does not necessarily reflect the views of Stoke-on-Trent City Council or of any participating agencies. We do, of course, accept full responsibility for any inaccuracies or omissions.

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About the Research

On July 3rd 2007 a fire engulfed a derelict warehouse in Stoke-on-Trent resulting in the death of two young homeless people. This tragedy prompted the City Council and partners to closely scrutinise provision for homeless people in Stoke-on-Trent and consider ways in which this could be improved. As part of the drive to reduce homelessness and rough sleeping, Stoke-on-Trent City Council commissioned research exploring the housing needs of homeless people with complex needs. This focused on client groups thought to be particularly marginalised and vulnerable to rough sleeping including people with drug and/or alcohol dependencies, female street sex workers, and people with a history of violent behaviour. This report presents the findings relating to homeless people with drug and/or alcohol dependencies.

The research was conducted between July 2007- June 2008 and involved a questionnaire survey of 112 people with a drug and/or alcohol dependency who were homeless or at risk of homelessness in Stoke-on-Trent; and in-depth interviews with 40 homeless people with a drug or alcohol dependency. These activities were supplemented with discussions and interviews with local service providers working with or accommodating homeless people with drug or alcohol dependencies (collectively referred to in this report as 'substance misusers')

A Profile of Homeless Substance Misusers

Most of the problematic alcohol users surveyed drank daily rather than in periodic 'binges' and reported drinking strong cider or lager rather than spirits. Heroin was the drug most commonly taken by the drug users surveyed. Over half of those reporting use of methadone also reported taking heroin.

Evidence from the survey and in-depth interviews suggests that **alcohol and drugs were not typically used interchangeably** (a relatively small proportion - 19 per cent - of those surveyed were dual users). Many of the dual users were people with drug dependencies who had developed problematic drinking habits while attempting to reduce drug intake.

Respondents revealed **very complex patterns of drug use.** Many were engaged in an ongoing battle with their dependency, combining substitute medication with a 'top up' of

Class A drugs and combining formal treatment programmes with independent efforts to cease drug use. Methadone and other substitute medication was sometimes obtained illicitly, a history of treatment and relapse was common, and alcohol consumption tended to escalate as drug use subsided.

The longevity of addiction was a defining feature of respondents' drug using histories: 65 per cent had been using heroin for ten years or more, and 29 per cent for 15 years or more. The vast majority were drug dependent by the time they were in their early 20s. The same was not true of the problematic drinkers interviewed, many of whom were a little older when their alcohol consumption became problematic. Despite this difference, **common 'causes' or pathways into substance dependency** were shared by drug users and problematic drinkers alike, including:

- **turning to drugs or alcohol as a means of coping with emotional distress** (divorce, bereavement, separation from or death of a child, experience of abuse).
- **'drifting' into drug or alcohol use in adolescence,** sometimes under the influence of local acquaintances, usually subject to inadequate parental care, and living in neighbourhoods where drugs and alcohol were commonplace.
- a number of the women interviewed were **introduced to, or encouraged to take drugs (typically heroin) by their partners.**

Analysis of the life experiences of the homeless substance misusers surveyed revealed that mental ill health and related issues were prevalent, a disrupted education was extremely common as were a host of experiences likely to have impacted detrimentally on their psychological and emotional well being. Specifically:

- 54 per cent reporting having had an **unsettled life** while growing up
- 53 per cent were **estranged from their family**
- 45 per cent had been **excluded or suspended from school**
- 45 per cent had experienced **domestic violence** and 40 per cent had experienced **'other' forms of abuse**
- 37 per cent reported **mental ill health**
- 30 per cent had been in the **care of the local authority**
- 24 per cent had **engaged in street sex work** (mainly female drug users)
- 22 per cent reported **self harming**

Offending behaviour and contact with the criminal justice system was relatively prevalent amongst the substance misusers participating in this study. The majority had a criminal conviction, had been on probation and had served a custodial sentence. Many of the **offences committed by the drug users participating in the study were done so in order to obtain funds for drugs** (and many of the custodial sentences served were for non-payment of fines or breaches of various Community Orders. **Problematic alcohol users were more likely to have convictions for public order offences and acts of violence/ aggression,** usually committed whilst under the influence of influence of alcohol.

Homelessness Careers

The evidence from this study suggests that **the key triggers of homelessness** amongst substance misusers are:

- leaving the family home at an early age (including chaotic living conditions with parents)
- leaving local authority care
- a traumatic experience
- a relationship breakdown
- criminal activity resulting in a custodial sentence

Many respondents made the **transition to independent living long before they reached adulthood** and some described leaving home as young as ten years old. In total, 41 per cent of survey respondents had experienced homelessness by the age of 16 and 55 per cent by the age of 18. For 25 of the 33 interview respondents whose homelessness careers could be plotted accurately, homelessness represented their first experience of independent living.

A fixed moment could sometimes be identified as marking the beginning of an individuals' homelessness career (the day they were evicted, the day they left their partner) but substance misusers' trajectories into homelessness tended to be more complex than this, with **homelessness occurring incrementally over a period of time.**

Drug or alcohol dependency was found to play a crucial role in respondents' trajectories into homelessness, and typically preceded and episode of homelessness amongst those interviewed. It then played a role in sustaining respondents' homelessness - landlords and housing providers are reluctant to accommodate problematic drug or alcohol

users because they are deemed undesirable tenants, because their support needs are too high, or because of concerns about tenancy sustainment. A criminal record acts as a further barrier. The experience of homelessness and rough sleeping, particularly in winter and when coupled with a sense of hopelessness and despair was also found in a few cases to act as a catalyst for drug and alcohol use.

The survey and interview data reveal very complex housing careers amongst substance misusers, with regular movement in and out of precarious housing situations. A high degree of mobility was evident, with respondents moving swiftly through a wide range of accommodation situations and rarely remaining in one place for long. Frequently evicted from hostels and temporary supported housing and having exhausted the goodwill of friends and family, **the substance misusers participating in this study frequently found themselves in unsafe and unsanitary housing situations such as squatting in derelict buildings or sleeping rough.**

Experiences of Sleeping Rough

Rough sleeping was extremely common amongst the homeless substance misusers participating in this study: 90 per cent of those surveyed reported having slept rough and 43 per cent reported having done so in the month prior to being surveyed. **Rough sleeping was more common amongst problematic drinkers** than drug users (98 per cent had slept rough and 60 per cent in the past month).

Respondents pointed to a **wide range of locations** in which they slept rough (including parks, skips, abandoned cars, huts) but reported **prioritising safety and invisibility**, seeking places which were out of sight. Social networks within the rough sleepers' community were an important means of finding places to sleep.

Friends and family were relied on by respondents to limit the time spent sleeping rough so those without such networks were more prone to extended periods of rough sleeping.

Respondents reported a range of challenges and problems associated with rough sleeping. Daily necessities were reportedly hard to come by, and keeping warm, dry and clean could prove extremely difficult. Having nowhere to store belongings was a common problem mentioned and personal safety was a key concern. Personal hygiene and health

were found to suffer, and managing existing health conditions could be problematic. Respondents had devised a range of strategies to cope with these challenges.

Respondents' drug or alcohol use often increased during periods of rough sleeping, and regular reference was made to the use of drugs and alcohol as a coping mechanism. Substance misuse was described as a means 'to survive', with respondents noting that it helped to pass the time and mitigate the boredom and harsh conditions associated with living on the streets. Problematic drinkers tended to refer to the warming qualities of alcohol while drug (heroin) users described the benefits of 'losing time' and numbing depression.

Experiences of violence were commonplace amongst those interviewed. Most reported feeling unsafe on the streets, never sleeping soundly for fear of attack, and many reported incidents of abuse, harassment, and violence at the hands of the public and other homeless people. Being under the influence of drugs or alcohol carries additional risks. Already exposed to high risk of violence by virtue of a lack of secure shelter, visibility, and stigma, this increases significantly when inebriated, people being less able to defend themselves.

Accessing Housing

Many of the substance misusers surveyed and interviewed had encountered difficulties accessing temporary and permanent accommodation. Drug and alcohol use and associated behaviours (criminality, unpredictability, accrual of rent arrears) render them undesirable tenants while (legitimate) concerns amongst housing providers about tenancy sustainment further reduce the housing options of this client group. Drug and alcohol users can rapidly exhaust the goodwill of friends and family on whom they might otherwise rely and high support needs limits the housing providers able to accommodate them appropriately. A lack of planning for future housing needs combined with a history of limited engagement with services and relatively chaotic lifestyles meant respondents were rarely in the process of progressing a carefully laid plan for exiting homelessness.

A number of **key barriers preventing substance misusers from accessing housing** emerged from the in-depth interviews, including:

- **limited access to information, advice, and advocacy,** with very few respondents having secured interim or permanent housing without the help of, for example, a key worker, probation officer, or support worker.

- **housing history** (particularly amongst drug users), including failed tenancies and placements, rent arrears and anti-social behaviour in the social rented sector.

- **the need to avoid substance misusers and past associates** limits temporary and permanent housing options, some of the cities supported housing being located in neighbourhoods that (recovering) substance misusers wish to avoid.

- **incompatibility between the lifestyle of some substance misusers** and the bureaucratic requirements of housing services. They move frequently, lose essential documents, letters fail to reach them or they remain unopened, they cannot always recall dates or events with precision and much of their energy is spent getting by each day. Engaging with the housing system, making phone calls and applications, remembering to attend appointments, and complying with bureaucratic and administrative requirements can prove extremely difficult.

- **inadequate housing advice on entry to prison and on release.** Respondents held few expectations about retaining housing while in prison and those already homeless at the start of their prison term generally remained homeless on release.

- **Limited supply of accommodation** which is appropriate for, and accessible to substance misusers, many of whom had high support needs and would (and did repeatedly) fail to sustain a single unsupported tenancy.

Accessing Treatment and Support

The majority (85 per cent) of the drug dependent substance misusers surveyed had received treatment or support to help them combat their drug addiction, most commonly in the form of prescribed substitute medication although many had also been treated as an in-patient and had received drugs counselling. **respondents were overwhelmingly positive about the support they were currently receiving**, with 85 per cent reporting that it was helping a lot (60 per cent) or a little (25 per cent).

The problematic drinkers surveyed were less likely to have received support with their dependency than the drug users surveyed although the majority (71 per cent) had done so. Therapeutic interventions such as counselling and group therapy were the most common forms of help provided to problematic drinkers. **Respondents generally positive about the support they were receiving**, although less so than the drug users surveyed.

Two thirds of the problematic drinkers reported that their current treatment/support was helping but a relatively high proportion had only recently engaged with alcohol support services so 29 per cent reported that it was ‘too early to tell’ whether this was of benefit.

The homeless substance misusers participating in this study presented with a wide range of support needs in addition to drug and alcohol dependency. Mental ill health, coping difficulties and such like were also commonplace (see ‘a profile of homeless substance misusers’ above). Survey respondents were asked to specify those issues for which they had never received assistance, despite wanting such help or support and the results suggest that **homeless substance misusers are experiencing difficulties accessing emotional support and help with mental health issues as well as practical assistance such as housing advice and help with budgeting.**

It was common for respondents to have 'moments of motivation'; short periods of time when they decide to cease using drugs, felt motivated to do so and sought help. All too often, however, immediate assistance did not materialise and their motivation waned.

Independent efforts to access treatment were often unsuccessful, mirroring respondents' experiences of attempting to access accommodation**.** The problematic alcohol users interviewed had rarely sought help independently, for example by making contact with alcohol treatment or counselling services or requesting assistance from key workers to do so. Most had accessed alcohol treatment when prompted to do so or when referred by another agency. They were usually very willing to accept help when offered but rarely initiated contact with support services themselves.

A lack of responsiveness to requests for assistance or long waiting lists for treatment and counselling emerged as problematic for substance misusers and there was some evidence of respondents (drug users in particular) actively seeking convictions and custodial sentences in order to access the services available through the criminal justice system.

Introduction

On July 3rd 2007 a fire engulfed a derelict warehouse in Stoke-on-Trent resulting in the death of two young homeless people. The couple had been sleeping in the premises when the fire took hold and were unable to escape in time. This tragedy prompted the City Council and other local agencies to closely scrutinise provision for homeless people in Stoke-on-Trent and consider ways in which this could be improved to reduce the number of people having to sleep rough in the City. To this end a Task and Finish Group was established, which sought to understand the causes of rough sleeping and identify priority issues to be tackled.

As part of this drive to reduce rough sleeping in Stoke-on-Trent, and to better understand and meet the needs of homeless people like those sleeping in the warehouse in July 2007, Stoke-on-Trent City Council commissioned the Centre for Regional Economic and Social Research at Sheffield Hallam University to carry out research exploring the housing needs of homeless people with complex needs. The study was focused on several distinct subsections of the homeless population - client groups thought to be particularly marginalised and vulnerable to rough sleeping. These were: female street sex workers; people with drug and/or alcohol dependencies; and people with a history of violent behaviour. The research culminated in a series of reports: one focused on each of the client groups; and an overarching report summarising key issues, linkages between drug and alcohol dependency, street sex work, violent behaviour and homelessness; and using case study material to explore respondents' 'homelessness journeys'. This focus of this report is the housing needs of homeless drug and alcohol users.

Context

The past decade has witnessed significant government investment in tackling homelessness and rough sleeping, driven by a stated commitment to homelessness prevention. The Rough Sleepers' Unit, tasked with reducing the number of rough sleepers by two thirds, was established in 1999 and by 2003 had met its targets. Legislative changes in the form of the 2002 Homelessness Act confirmed the Governments commitment to tackling homelessness by placing new obligations on local authorities to offer assistance to all homeless households and to produce homelessness strategies, as well as extending the main housing duty to additional vulnerable households. The importance of understanding the underlying causes of homelessness was acknowledged in the 2003 government report *'More than a Roof: a report*

into tackling homelessness and a target of halving the number of households in temporary accommodation by 2010 was set out in the national strategy for tackling homelessness published in 2005 (*Sustainable Communities: settled homes; changing lives).* Meanwhile the challenges and importance of meeting the housing needs of the multiply excluded have been recognised through the development of PSA 16 (the Public Service Agreement relating to socially excluded adults such as care leavers and offenders), and by the government's new rough sleeping strategy, launched in November 2008, which aims ambitiously to eradicate rough sleeping altogether by 2012. And non-governmental homelessness organisations and charities continue to highlight to needs of homeless people with complex needs. 'Making Every Adult Matter', for example, is a new coalition seeking to improve the way in which services are delivered to the most excluded, and which has developed a clear Manifesto for change.

Locally, Stoke-on-Trent city council and their partners have been responding to the challenges of understanding and tackling homelessness and rough sleeping, particularly amongst those with complex and multiple needs. There are housing and support providers working with roughs sleepers, with street sex workers, with offenders, drug user and problematic drinkers. In 2009 Stoke-on-Trent City Council was named as one of 15 'ending rough sleeping' champions in England and in 2008 was awarded Enhanced Housing Options trailblazer status. In recognition that more needs to be done new services are being, or have recently been developed including a one stop shop for women offenders, a family Intervention project, and a new outreach service for young men and women at risk of sexual exploitation. These new services are likely to have a significant impact on tackling many of the issues and problems highlighted in this report.

Definitions

The 1996 Housing Act states that a person is homeless if they have no accommodation they are entitled to occupy or that it is reasonable for them to continue to occupy and this definition was applied, although not interpreted as rigidly as is sometimes the case. People sleeping rough, in squats, hostels, staying temporarily with friends or family, and in all other forms of temporary accommodation were included. People with a history of homelessness who were living in interim, or 'medium-term' supported accommodation were also included in the research. Interim supported accommodation refers to provision intended to provide a longer-term and more stable solution than emergency homelessness accommodation but from which people are expected (and assisted) to move on, usually within a specified timescale. A small number of housed people were also included in the research on the

grounds that they had a history of homelessness and were deemed 'at imminent risk of homelessness', for example because they were under threat of eviction and had nowhere else to go.

Problematic drug and alcohol users are collectively referred to in this report as 'substance misusers'. This term is employed to denote the use of illegal drugs (excluding recreational use of cannabis) or the problematic use of:

- alcohol
- prescribed medication
- over the counter medicines
- volatile substances such as aerosols and glue

Chapter Structure

Following a description of the methods employed for this study in Chapter One, Chapter Two profiles the population of homeless people with drug and alcohol dependencies, offering insight regarding the life trajectories and history of substance misuse which culminate in homelessness and other support needs. Chapters Three, Four and Five turn attention to issues relating specifically to housing, identifying common routes into homelessness and key features of substance misusers homelessness careers (Chapter 3); exploring respondents experiences of rough sleeping (Chapter Four) and highlighting the barriers homeless substance misusers face accessing accommodation (Chapter Five). Finally, Chapter Six provides information on the extent to which homeless people with drug and alcohol dependencies are accessing the services they require to meet their support needs.

1

Methods

This study was conducted between July 2007- June 2008 with data collection focused on two principle tasks:

- a questionnaire survey of 112 people with a drug and/or alcohol dependency who were homeless or at risk of homelessness in Stoke-on-Trent
- In-depth interviews with 40 people with a drug or alcohol dependency who were homeless or at risk of homelessness in Stoke-on-Trent

In addition the study team held discussions with local service providers working with or accommodating substance misusers.

The survey of homeless substance misusers in Stoke-on-Trent

A total of 112 homeless substance misusers were surveyed using a questionnaire which collected information about their housing situations, homelessness careers, personal characteristics, and histories. This included 90 drug users and 43 problematic drinkers (21 were dual users). In total, 41 respondents were known to be substance misusers and were targeted for inclusion in study. The remaining 71 respondents were drawn from a wider survey of homeless people (which included 24 people known to have a history of violent behaviour, 22 women known to be street sex workers, and 69 respondents about whom nothing was known beyond their circumstance of homelessness). Substance misusers were selected from this sample if they indicated illicit use of drugs or medication, if they indicated use (illicit or otherwise) of substitute medication, or if they answered positively to the question 'do you have an alcohol dependency'?

The decision to include individuals on substitute medication such as methadone was made on the basis of the patterns of drug using reported by people interviewed in–depth early in the study. Their histories suggested that homeless drug users with complex needs frequently

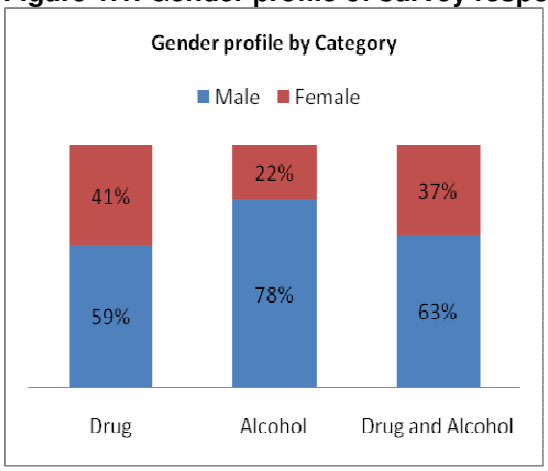
relapse (some respondents on methadone had been taking heroin a week earlier and were using again a week later), that many 'top up' their methadone with illicit drugs, and some purchase their methadone illicitly. People reporting recreational use of cannabis were not included in the survey unless they were also problematic users of other dugs or alcohol.

Respondents were accessed through housing and support services working with homeless people, drug users, problematic alcohol users, and rough sleepers. Surveys were completed in the following ways:

- face-to-face with a member of the research team
- face-to-face with a project worker
- self-completion

In total, 62 per cent of the survey sample was male, rising to 78 per cent of problematic drinkers (see figure 1.1). The majority were aged between 21 and 40 (see figure 2). Problematic drinkers had a slightly older age profile than the drug users in the sample: no drug user was over the age of 50 while this applied to 10 per cent of those with an alcohol dependency; and drug users were considerably more likely to fall within the 21-30 age group (40 per cent compared to 22 per cent of problematic drinkers)

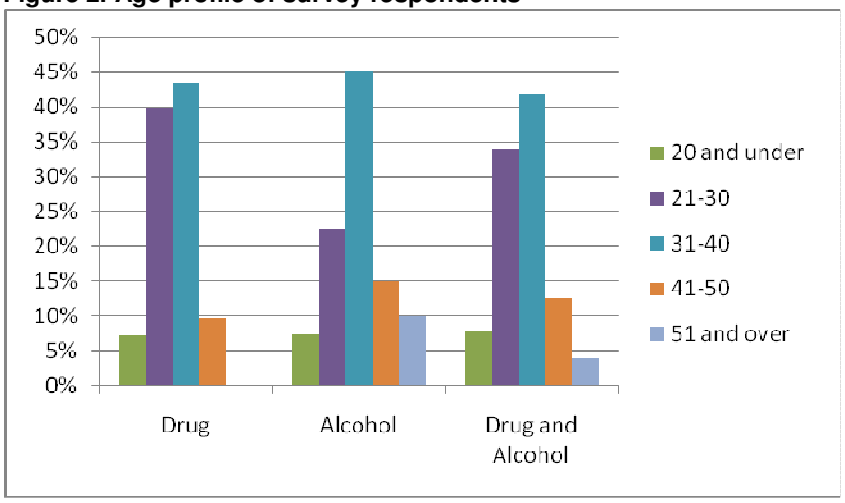
Figure 1.1. Gender profile of survey respondents



The majority of those surveyed were single (75 per cent) and heterosexual (93 per cent), although 5 per cent recorded their sexuality as bisexual. A total of 80 per cent recorded their ethnicity as 'White British'. No respondent was of a black ethnic minority group (although 2 per cent recorded their ethnicity as Mixed Heritage White and Black Caribbean) but 14 per cent were White Irish and 4 per cent were of an 'other' White ethnic origin. The problematic alcohol users surveyed were slightly more likely than the drug users to record their sexuality

as 'heterosexual' (97 per cent compared to 93 per cent of drug users) and their ethnicity as White British (93 per cent compared with 77 per cent of drug users).

Figure 2. Age profile of survey respondents



The substance misusers surveyed were living in a range of housing situations. Just over half were currently living in hostel accommodation, 10 per cent were staying temporarily with friends or family and 4 per cent were squatting. Nine respondents (8 per cent of the sample) were currently sleeping rough. A small number had social or private rented tenancies but were under threat of eviction. A higher proportion of the problematic drinkers surveyed were sleeping rough (19 per cent) than the sample of drug users (8 per cent). The housing profile of survey respondents is largely a reflection of the services through which they were accessed, rather than an indication of the accommodation most commonly relied upon by homeless substance misusers (an issue discussed in detail in Chapters Three and Four).

In-depth interviews with homeless people with a drug and/or alcohol dependency

A total of 40 in-depth interviews were conducted with homeless substance misusers. This included 14 problematic alcohol users and 33 drug users (7 respondents were dual users). Interviews were flexible and informal, lasting approximately one hour (although some were considerably longer), and took a biographical approach, exploring respondent's life histories, their homelessness careers, and contact with services. Respondents were accessed through hostels, drug and alcohol support services, criminal justice agencies and the rough sleepers' team. All interviews were transcribed verbatim.

Half the substance misusers interviewed were male and half were female. However, a higher proportion of the alcohol users interviewed were male (11 of the 14 people surveyed) than the drug users sample (approximately half were female). The majority of the substance misusers interviewed were aged between 20 and 39 (31 of the 38 respondents whose age was known) although several were teenagers or over the age of 40. The age profile of the drug and alcohol users interviewed was broadly similar. Virtually all recorded their ethnicity as White British with the exception of five respondents who were White Irish and one woman who defined herself as Mixed Heritage, White and Black Caribbean. More drug users in relationships were interviewed than problematic drinkers, all but one of whom was single. In contrast, one third of the drug users interviewed were in relationships. The majority of respondents were living in hostels at the time they were interviewed (24 of the 40 surveyed) but three were rough sleeping and a couple were living in their own tenancies but under threat of eviction.

Discussions with stakeholders in contact with homeless drug and alcohol users

In addition to the core data collection activities (survey and in depth interviews) the study team had regular discussions with local service providers such as hostel workers, drug and alcohol support workers, Probation staff and housing providers.

2

A Profile of Substance Misusers in Stoke-on-Trent

This chapter explores the profile characteristics of the substance misusers participating in this study, drawing attention to the relationship between drug and alcohol use and exploring in some detail respondents' substance misuse histories and other personal characteristics and experiences.

2.1. Substance Misuse

Of the 112 substance misusers surveyed 90 reported a drug dependency and 43 reported an alcohol dependency. Only 21 were dual users, representing 19 per cent of the substance misusers surveyed. These figures are presented visually in Figure 2.1 and show that dual usage was evident but that alcohol and drugs were not typically used interchangeably. The reported experiences of interview respondents suggest that many of the dual users were drug users who developed problematic drinking habits while making efforts to address drug dependency. In depth discussions with substance misusers revealed that problematic drinking amongst drug users was often associated with attempts to reduce drug intake, used as a substitute and to alleviate the effects of withdrawal. Richard, for example, explained that *"I've tried coming off drugs before and I do. But then again, I've started drinking heavily"*. He is currently on a methadone programme and when asked whether he 'tops up' with heroin replied:

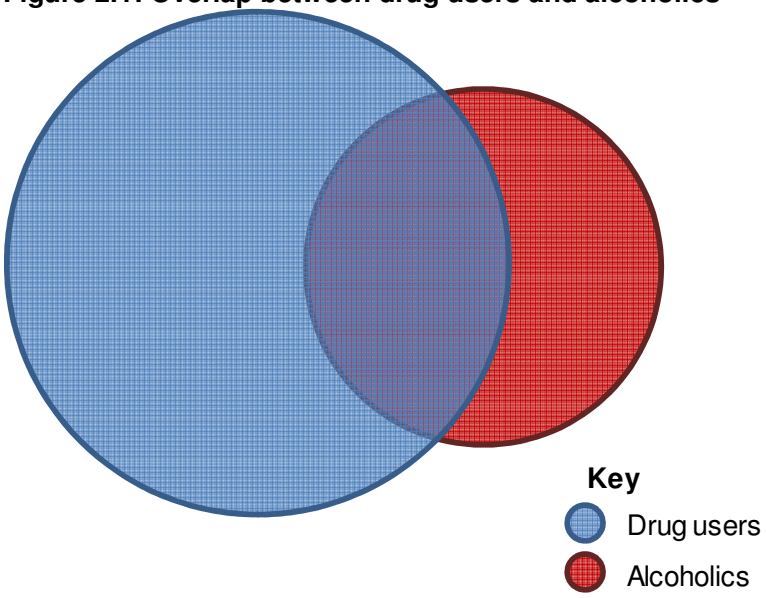
> *"no, not really, don't find I need to. I have a drink on top of it, you see, that's me…about a litre of cider a day, that's the minimum, maximum would be till I pass out"(Richard)*

In contrast, it was extremely rare for problematic drinkers to report using drugs as a means of coping with alcohol withdrawal, although a few (usually those who started drinking heavily in early adolescence) started taking drugs in addition to alcohol and have lived with fluctuating

dual addiction ever since. Amongst dual using interview respondents it was usually possible to identify a 'primary' dependency.

Most of the problematic alcohol users surveyed drank daily rather than in periodic 'binges' and reported drinking strong cider or lager rather than spirits (a reflection of financial considerations as much as preference). All reported drinking daily with the exception of one who drank every other day, one who only drank at weekends and one who had abstained for six weeks after a long period of chronic alcoholism. Alcohol consumption was relatively high, even amongst those currently trying to reduce their alcohol intake, with most survey respondents consuming a minimum of three litres of strong cider or super lager per day, representing approximately 22 units. Government guidance recommends a maximum daily intake of 2-3 units for women and 3-4 units for men and warns of the health consequences of consuming the recommended maximum intake every day. Many survey respondents consumed considerably more than 22 units per day (*"about 12 litres of cider daily", "6 or 7 litres of cider or Lambrini" "12 cans of Lynx strong 8.5%", "3-6 litres of strong cider*).

Figure 2.1: Overlap between drug users and alcoholics



Heroin was the most common drug on which respondents were dependent (53 per cent), although use of crack cocaine and illicit use of prescription drugs were also relatively common (see Table 2.1.). The relatively high illicit usage of prescription drugs reported is likely to reflect variable reporting of methadone use. Some illicit users of methadone (i.e. those who purchase methadone on the street rather than having it prescribed) may have

recorded this as use of methadone, some as illicit use of prescription drugs and some as both. All but two of the Crack users were also heroin dependent whilst those reporting Cocaine use tended not to combine this with other drugs (the number of cocaine users in the sample is, however, very small). Over half the methadone users were also taking heroin and, drawing on the patterns of drug use described by interview respondents, some of the remainder will have been purchasing their methadone illicitly. Very few respondents reported use of other drugs or substances but a couple of those participating in the survey reported taking amphetamines and a small number of interview respondents reported previous addictions to gas and glue. Just over one third (36 per cent) were regular users of cannabis in addition to Class A drugs or substitute medication.

Table 2.1. Drug use

	%
Heroin	53
Methadone	42
Prescription drugs (illicitly)	23
Crack	20
Cocaine	6
Other	5

n=90

In-depth discussions revealed very complex patterns of drug use, particularly once respondents embarked on a (formal or otherwise) programme of drug reduction or cessation. Many of the drug users interviewed were engaged in an ongoing battle with their dependency, combining substitute medication such as methadone with a 'top up' of Class A drugs, and combining formal treatment programmes with independent efforts to cease drug use. Methadone and other substitute medication such as Subutex (the trade name for Buprenorphine) was sometimes obtained through drug treatment programmes but often illicitly, a history of treatment and relapse was common, and alcohol consumption tended to escalate as drug use subsided.

The longevity of addiction was a defining feature of respondents' drug using histories: 65 per cent had been using heroin for ten years or more, and 29 per cent for 15 years or more. With a relatively young age profile (see Chapter One), many survey respondents would have been teenagers when they first took Class A drugs. This is echoed in the accounts provided by interview respondents, many of whom started taking drugs in adolescence, often prior to leaving the parental or guardian's home. The vast majority were drug dependent by the time they were in their early 20s. The same was not true of the problematic drinkers interviewed. Some did share this profile – excessive alcohol consumption in early adolescence, typically alongside drug use (as well as criminal activity, truanting or expulsion from school and

running away from home) - but many were a little older when their alcohol consumption became problematic. Despite this difference in age profile, common 'causes' or pathways into substance dependency were shared by drug users and problematic drinkers alike.

Many of the homeless people interviewed had turned to drugs or alcohol as a means of coping with emotional distress (divorce, bereavement, separation from or death of a child, experience or memories of abuse). This was true for Saskia, for example who explained that "*me youngest [child] died of cot death and then I ended up turning back to drugs, and that's where I am now" (Saskia).* Roy was much older than Saskia and turned to alcohol rather than drugs when he faced similar personal tragedy but the commonalities between them are clear:

> *"Me ex at the time, I caught her actually cheating on me, I lost my daughter at the age of 2 1/2 through Leukaemia and basically ever since that I've been suffering really bad depression and I suppose that's when my drinking started, cos I lost me mum, I found me mum on the kitchen floor one day…and 7 or 8 months later I lost me dad and a year and a half later I lost me brother through a hit and run" (Roy)*

In this context the anaesthetic qualities of heroin were much needed, with respondents talking in terms of 'numbing' and 'blocking out' emotional pain. The quotes below illustrate this point:

> *"I got into drugs because I kept thinking about him [grandfather], because obviously he was messing with me when I was younger. That's what got me on drugs...I just wanted to block it out and it was doing me head in" (Danielle)*

> *"it [heroin] depresses all your feelings, do you know what I mean? it's easier to live, it's not as cold, you know what I mean? it just numbs all that stuff. (Elaine)*

> *"What people don't realise is when you've had a taste of it [heroin]...when you're going through a really hard time and you have that taste of it and you know it can make you forget everything…, I was doing really well. I cut right down. I was doing one bag a day,... and when they took the kids I just fell to pieces, really I fell to pieces...because I lost my life without me kids, to me I'd lost everything..." (Emma)*

Substance misuse was not always a response to a specific set of circumstances or trigger event. A significant minority of respondents described drifting into drug and/or alcohol use in adolescence, sometimes under the influence of older friends or local acquaintances. These individuals were usually subject to minimal or inadequate parental care or supervision, living

in neighbourhoods where drugs and alcohol were commonplace. And a number of the women interviewed were introduced to, or encouraged to take drugs (typically heroin) by their partners. In a couple of cases women were given heroin by their partners over a period of time without their knowledge. Elaine, for example, thought the daily injection she was receiving from her partner was medication for her severe back and pelvic problems, and Emma was unaware that her cannabis joints were being laced with heroin. Neither had any idea their partners were drug users.

2.2. Personal Experiences and Circumstances

Survey respondents were asked a series of questions about their life experiences and personal circumstances. The results are presented in Table 2.2. and show that mental ill health and related issues (coping difficulties, self harming) were prevalent, a disrupted education was extremely common as were a host of experiences likely to have impacted detrimentally on respondents' psychological and emotional well being (domestic abuse, unsettled childhood, estrangement from family). Nearly one third spent some of their childhood in the care of the local authority. The experiences of drug users and problematic drinkers were not found to diverge significantly although drug users were more likely to have engaged in street sex work and to have experienced domestic violence while alcohol users were slightly more likely to report coping difficulties. Comparison between those with and those without a history of substance misuse suggests that substance misusers are more likely to face virtually all of the issues listed in Table 2.2.

Table 2.2. Personal Experiences

	All substance misusers (%) n=112	Drug Users (%) n=90	Alcohol Users (%) n=43	Non substance misusers (%) n= 44
sometimes find it difficult to cope	59	58	67	43
had an unsettled life while growing up	54	54	49	64
has little contact with family	53	52	56	48
excluded or suspended from school	45	49	41	45
has experienced domestic violence	44	49	37	36
has experienced abuse other than dom. violence	40	40	37	41
has experienced mental ill health	37	39	42	27
has been in local authority care	30	33	26	25
Has engaged in street sex work	24	27	10	10
sometimes self harms	22	20	28	27
has literacy problems	17	19	26	25
has a learning disability	17	18	23	14
has a physical disability	11	12	9	7
has been the subject of an ASBO	8	10	5	4

Drug or alcohol abuse can act as both cause and consequence of mental ill health and so the prevalence of mental health issues amongst the substance misusers surveyed is not surprising. This relationship is further complicated by the influence of emotional distress or trauma on mental health and on levels of substance use. We reported above that many of the homeless people interviewed for this study had turned to drugs or alcohol as a means of coping with emotional distress, but distressing experiences also prompted the onset of mental ill health. One man, for example, explained that he suffered a 'mental breakdown' following a fire in his home and another following his wife's late miscarriage while Hannah explained that *"I'm a paranoid schizophrenic.…that wasn't after the drugs though…it was the background I had from a child. I had a really rough childhood, I got abused in the family, things like that".* Drug or alcohol abuse can, in turn, represent a consequence of mental ill health as people 'self medicate' in the absence of appropriate mental health intervention, and can also result in it. Hannah's mental health issues, for example, are complicated by the fact that she additionally experiences mental health problems (drug induced psychosis) which result directly from her drug abuse.

Drug dependency and sex work were found to be inextricably linked, and virtually all those working in street prostitution entered sex work to fund their drug habit. Although less than one third of the drug users surveyed reported having worked in street prostitution this applied to the majority (61 per cent) of female drug users.

Over half of the substance misusers surveyed reported having little contact with their families, a situation reflected in the high proportion who also reported having had an 'unsettled life while growing up'. Many respondents' formative years were characterised by rejection, abandonment, neglect and abuse. Sexual and physical abuse were commonplace (reflected in the figures in Table 2.2 regarding experiences of domestic and other forms of abuse) and many were not adequately cared for. Many respondents felt an acute sense of abandonment and betrayal having been 'rejected' by their mother in favour of a partner, or left in the care of grandparents following parental separation. Charlotte's mother, for example, was given the option by Social Services of retaining care of her children if she separated from her partner whose previous offences against children had come to light. She chose to let Social Services take her children into care. And Harry's mother left him in the care of his elderly grandparents to move in with a new partner, taking Harry's sister with her but leaving him behind. Other respondents spent their childhood coping with parents who themselves had complex needs such as alcoholism and histories of chaotic homelessness.

But familial conflict and estrangement did not always stem from the actions of parents. A significant minority of interview respondents reported having been brought up in a stable home environment with loving and supportive parents. Some of these (exclusively problematic drinkers) did not develop substance misuse problems until later in life while others were drinking and/or misusing drugs while still living at home. In both cases, but particularly amongst those living in the parental home, their substance misuse and related activity (criminal activity, aggression, truanting) tested familial relationships to the limit. In some cases the parents of young people in stable family circumstances could apparently cope no longer with their 'out of control' teenagers and requested the intervention of Social Services. In other cases they asked their children to leave. Respondents' experience of the care system is picked up in the Chapter Three, when we examine common routes into homelessness.

Substance misuse, then, can result in conflict with and eventual estrangement from parents, their tolerance having been tested to the limit. Survey data and discussions with interview respondents (female drug users in particular) suggest separation from children is also a common consequence. Of the 34 female drug users surveyed whose family status was known 15 reported having school age children but only three lived with their children. The majority were being cared for relatives (five on a temporary basis and three on a permanent basis) and four had been adopted. In depth interview respondents also talked in some detail about this issue. The circumstances under which they separated from their children, the arrangements under which their children were currently living, the level of contact they had, and the scope to be reunited with them varied. Some babies had been taken directly into care at birth and quickly adopted, a decision likely to have been taken prior to the birth, probably by Social Services. Some women lived with their children for a while (months or sometimes years) but they were subsequently taken into care, or relatives successfully applied for custody, usually against the mother's wishes. There were also instances where women tried to manage drug and alcohol addictions and look after their children before deciding they could cope no longer or it was not in the interests of the child to remain with them. These women had often resolved not to visit on their own children the neglect they had experienced themselves. A couple placed their children in the care of the local authority but in most cases parents and other relatives were called upon. Charlotte and Hayley explained why they placed their children with someone else:

> *"I couldn't look after myself. If I can't look after myself I can't look after a baby either and I couldn't cope anyway. She weren't being neglected but it was not long from that stage...in the end I had to turn round and say to me mum 'look, you're going to have to*

take her because I can't look after her'. I didn't want her to be neglected because that wouldn't have been fair on her" (Charlotte).

"I felt too much guilt. I weren't clean [of drugs], I didn't think I could have him. Made the hardest decision I've had to make but it was the right decision for him. I put him in care" (Hayley)

Many of the women interviewed held out hope that they would be reunited with their children once they had resolved their dependencies and homelessness, and considered this a key component of a long-term life plan.

Respondents were not asked specifically about physical health needs (no questions were included in the survey about physical health) but interview respondents raised this as an issue. Years of alcohol abuse or intravenous drug use, combined with exposure to harsh conditions while sleeping rough had taken its toll on many:

"I have problems with me gullet, cos I were born with it but I've burnt it with all like cider shit." (Larry)

"It's [drug use] given me bad health issues now. I've got lacerated legs, scarred DVTs, bad circulation. I'm 34 and me body's fucked" (Larry)

"I hit the bottle again and ended up in Haywood hospital with psoriasis and arthritis in me feet, I was in bed for nearly a week, I couldn't walk" (Alex)

2.3. Contact with the Criminal Justice System

The results from this study suggest that offending behaviour and contact with the criminal justice system is relatively prevalent amongst substance misusers. Table 2.3.shows that the majority of survey respondents (drug users more so than problematic drinkers) had a criminal conviction, had been on probation and had served a custodial sentence. Alcohol users reported relatively frequent nights spent 'in the cells' following excessive drinking, with no recollection of the nights events. Roy recounted the events of one such night:

"I got absolutely and completely drunk…spun out and woke up in a prison cell on Saturday morning with a [cut] just above my eye…I've no idea [what happened] all I

remember is waking up in a prison cell early hours of Saturday morning, couldn't open this eye. I did remember drinking an awful lot of Vodka, must have gone through three litres…Just out on the street basically, just drank three litres of Vodka" (Roy)

Table 2.2.Contact with the criminal justice system

	All substance misusers (%) n=112	Drug Users (%) n=90	Alc. Users (%) n=43
been on probation	70	76	67
been in prison/YOI	62	67	51
has a criminal record	85	88	80

Many of the offences committed by the drug users participating in the study were done so in order to obtain funds for drugs (burglary, shoplifting, fraud, soliciting) and many of the custodial sentences served were for non-payment of fines or breaches of various Community Orders. Of the 88 per cent of drug users who had a criminal record, 82 per cent had been convicted for shoplifting. Problematic alcohol users were more likely to have convictions for public order offences and acts of violence/aggression, usually committed whilst under the influence of influence of alcohol. Nearly 40 per cent of the problematic drinkers surveyed had a conviction for violence while this applied to 30 per cent of drug users.

2.4. Conclusion

Exploring the profile characteristics and life exp3eriences of the homelessness substance misusers participating in this study suggests that this client group tend to have long standing dependencies which frequently result in contact with the criminal justice system. The chapter had also shows that homelessness substance misusers also present with multiple support needs in addition to their drug and alcohol use and homelessness.

3

Homelessness Careers and Experiences

This chapter explores the homelessness careers of people with drug and alcohol dependencies, identifying common routes into homelessness and the situations on which they rely whilst homeless. It also explores the relationship between drug and alcohol use and homelessness and the extent to which substance misuse is a cause or a consequence of homelessness.

3.1. Routes into Homelessness

Identifying the causes of homelessness amongst substance misusers is complicated by difficulties disaggregating the relative effects of substance misuse from a myriad of other issues which tend to combine to produce a homelessness outcome. Exploring interview respondents' first experiences of homelessness does, however, suggest several common 'triggers', including:

- leaving the family home at an early age (including chaotic living conditions with parents)
- leaving Local Authority care
- a traumatic experience
- a relationship breakdown
- criminal activity resulting in a custodial sentence

However, several of these 'triggers' (crime, relationship breakdown, leaving home, running away from care or home) and the homelessness which results are intrinsically linked to substance misuse, acting as an ever present underlying influence. Custodial sentences are served because of offences committed to fund drug dependencies or while under the influence of alcohol; relationships fail and young people are asked to leave home because of unacceptable behaviour associated with substance misuse; or the lifestyle associated with excessive drug and alcohol consumption is incongruent with rules and curfews imposed in parental or care homes and people run or drift away.

Most commonly, the substance misusers interviewed first experienced homelessness when they left home (parental or children's home), usually at a young age and in difficult circumstances. This transition to independence was rarely straightforward, occurring in the face of seemingly irreconcilable problems. Often young people left home of their own accord, despite having nowhere to go, to escape physical, emotional and neglectful abuse or other intolerable family circumstances. Larry, for example, attributed his homelessness and his drug addiction to an abusive home-life:

> *"It's from 16, I've had the issues from 16. Then I was hectic, I had … a lot of discomfort from my home life, I suffered abuse, mental abuse, so I carried around a lot of hatred and that I suppose aimed at authority, me parents' authority on me when you're a kid like, the authority figure, I wouldn't do as I was told and what not so it was like a backlash, started taking drugs, found I coped better taking drugs so that was what I did". (Larry)*

We saw in the previous Chapter that one third of the substance misusers surveyed had been in the care of the Local Authority (experience of the care system was slightly but not significantly more common amongst drug users than alcoholics. One third of drug users reported having been in the care of the local authority whilst this applied to 26 per cent of survey respondents with an alcohol dependency). This experience was commonly a troubled one, involving regular movements between care homes and foster placements but including extended periods in children's homes. Many found children's homes difficult environments in which to live and responded with prolific absconding, during which times respondents tended to encounter rough sleeping for the first time. Hayley, for example, was taken into Care at the age of 13, following a difficult childhood and early adolescence in which she was sexually abused by her stepfather and neglected by her mother. She described her experience of, and exit from care in the following terms:

> *"[the care home] was horrible, one of the worst places I've ever been in. Kids my age addicted on heroin and crack cocaine…I hated it, I couldn't wait to be 16, to look after myself [so when I turned] 16 I went to stay with a friend from school for two weeks, then I went to stay with me mates sister's older friend who'd got a flat…(Hayley)*

Hayley spent the next ten years moving between hostels, squats, rough sleeping, staying with friends, in refuges, interim supported housing, and served two prison sentences. Along the way she developed a heroin addiction and started working as a street prostitute. Hayley's story demonstrates the way in which transitions from care to independent living can

place young people in vulnerable situations and at risk of homelessness. The absence of intensive (or any) follow-on support and/or arranged move-on provision is noticeable in Hayley's case. In effect, there was no planned exit from care or pathway from care to independent living,. This was true for many of those interviewed. No interview respondent moved from care into their own tenancy or into interim supported housing and most went to stay temporarily with friends or slept rough. This was true of James who became homelessness at the age of 16 immediately after leaving care, mainly due to a lack of organised move-on provision or support, and slept rough for 7 months.

James *From the age of 2 to 16 I was under the local authority care and then just after me 16th birthday I was… [unclear] on part of the children's unit so I was put out with no accommodation.*

Interviewer *You were put out of the children's home with no accommodation at all lined-up?*

James: *Nothing at all. … My care worker should have been involved but they didn't get them involved until I was 17 which was about 6, 7 months later.*

Interviewer *So from the time you left care you were sleeping rough?*

James *Yeah, I don't really have much contact with me family so I didn't ask them.*

In these circumstances, young people leaving care rarely had close family on whom they could rely and the risk of rough sleeping was extremely high. It is not clear how these young people were able to leave care, in an unplanned way and (apparently) have no further meaningful contact with social services but this does seem to have been the case. The young people in question may have made every effort to avoid such contact. For whatever reason, the apparent absence of contact with social services was striking.

Many respondents made the transition to independent living long before they reached adulthood and some described leaving home as young as ten or 11 years old. Charlotte, for example, explained that by the age of 11 she had effectively left home and *"I'd just hang around with me mates. I'd go and stay at friends houses, I'd do anything I could not to go home…."* Charlene, similarly, left the children's home in which she lived when she was aged 15. She explained that:

"I haven't been at home since I was about 8. I went into residential [care] till I was about 15 and then I just started doing my own thing" (Charlene)

The early homelessness career of someone so young is very predictable: with very few options, not yet able to secure their own tenancy or access hostels, they can only stay with friends, in squats or sleep rough.

Traumatic personal events and experiences often acted as the catalyst for homelessness (typically mediated by drug or alcohol abuse, or deteriorating mental health). The distress surrounding the death of a family member, relationship breakdown, redundancy, dismissal and other personal misfortune was a common theme in the accounts of those interviewed. In many cases, homelessness resulted from the depression and chaos such events caused, and the analgesic use of drugs and alcohol that followed. Steve's homelessness, for example, was triggered by the death of his baby daughter which resulted in a nervous breakdown, hospitalisation and drug addiction. Abandoning the property he shared with his partner (*"I went [home] that night and…my head went at that second, I couldn't go in that house and I never went back"*) he has spent the last seven years in hostels, sleeping rough, in prison and in hospital.

Separation from a partner tended to act as a catalyst for homelessness for people later in life, and after a period of settled housing. Again, drug and alcohol abuse was usually part of the picture. Rochelle, for example, led relatively stable life until the age of 32 when she separated from her partner and Alex also became homeless and started drinking following his divorce:

> *"my life didn't get bad until I'd say five years ago when everything started going wrong…I was settled and then he [partner] did the dirty on me and we broke up and I just fell apart then, hence starting on drugs, drink, because he was my backbone, I thought I'd be with him for life, I thought, I'd beared his children, do you know what I mean? (Rochelle)*

> *Basically got two suitcases of clothes off the ex wife and then stayed on a mate's sofa for a couple of nights until the YMCA could, had to go for interview at the YMCA and then I had a room there. … I started to hit the bottle and I had a serious drink problem, I was drinking up to nine litres of cider a day…. when I left the ex wife was missing me two kids and I just hit the bottle big time. (Alex)*

Homelessness amongst problematic alcohol users was more closely tied to a breakdown in personal relationships than amongst drug users, partly explaining why alcohol users were more likely than other respondents to have first experienced homelessness later in life (see

below). This reflects that alcohol users were more likely than drug users to be in relationships with non-users, who could no longer tolerate their alcoholism. Drug users, in contrast, tended to have relationships with other people dependent on drugs and so became homeless for different reasons, and together.

We saw in the previous chapter that offending behaviour and custodial sentences were common amongst the substance misusers surveyed (62 per cent had been in prison or a young offenders institution – slightly higher for drug users, 67 per cent of whom had served a custodial sentence). The housing consequences of being in prison were usually detrimental. Analysis of the homelessness careers of interview respondents revealed that many substance misusers were already homeless when they begin their sentence but for those who were not, prison represented a direct route into homelessness.

Interviewer *So immediately when you came out of prison where did you spend your first night?*

James *In a car park in Newcastle because they should have sorted some accommodation out when I was in prison but they never did.)*

Struggling to maintain accommodation while in prison (Housing Benefit is only paid for 13 weeks; rent arrears accrue and they are evicted; private landlords won't hold a tenancy open; people assume they have to give up their tenancy; or acquaintances take over their home in their absence and they are evicted) and in no position to organise accommodation for their release respondents were reliant on the assistance provided within the prison. In-depth interview respondents pointed to a distinct lack of housing advice within many prisons, making rough sleeping the most likely outcome for those who had lost their homes while in custody.

A fixed moment could sometimes be identified as marking the beginning of an individuals' homelessness career (the day they were evicted, the day they left their partner) but substance misusers' trajectories into homelessness tended to be more complex than this, with homelessness occurring incrementally over a period of time. Young people gradually left home or care, spending more time with friends and sleeping rough until they failed to return altogether. Others 'drifted' away from their accommodation, or their tenancy was taken over by other people, or they were evicted in absentia while in prison or away. Martin's route into homelessness highlights the incremental nature of homelessness. He has an alcohol dependency and has experienced unsettled living arrangements for most of his life:

Interviewer	*you first became homeless when you were about 14?*
Martin	*I've been homeless, I'd say before that, I never lived with me mum or dad, I grew up with me nan and granddad. … say from two upwards and I stopped with me nan until she died when I was 16 but all me teenage years I sort of like stopped with friends all the way through really, I never had a sort of relationship with me mum. Me step dad used to beat me up when I was younger so when I were older I hit him back so I wasn't allowed to go back there to be honest. (Martin)*

The transition from 'housed' to 'homeless', then, can be gradual, and multi-factorial, with individuals moving through some combination of drug and/or alcohol abuse, depression and other mental ill health, and offending and somewhere along the line losing the settled accommodation in which they live. Respondents themselves were often unable to clarify the precise circumstances under which they became homeless, describing instead a chaotic time, where things 'fell apart', 'went pear shaped' or when they were 'all over the place'. Saskia sums this up in her response to the question about how she finally lost her home and became homeless: *"I can't even remember, I lost me house or summat, I don't know, it's all a bit of a daze" (Saskia).*

3.2. Drugs and Alcohol: Cause or Consequence of Homelessness?

It is very difficult to disaggregate the relative influence of homelessness, substance misuse, and personal difficulties (relationship problems, bereavement, unemployment and so on) and determine the nature of the relationship between them. Drug and alcohol abuse did typically precede homelessness amongst those interviewed but reciprocity between substance misuse and homelessness was very evident: the experience of homelessness and rough sleeping, particularly in winter and when coupled with a sense of hopelessness and despair acted as a catalyst for drug and alcohol use. It was more common for an experience of homelessness or rough sleeping to prompt a relapse amongst recovering addicts, or an increase in usage amongst those already dabbling in drugs or drinking in moderation, but in a small minority of cases the experience of rough sleeping represented the start of a drug or

alcohol problem. Charlie, who has a long term alcohol dependency, is a case in point. He explains:

> *"I had a bit of a bad time when I was young, like [sleeping] on the streets, and begging for money to get drink to get warm, because then I was using the drink just to keep warm, might sound daft but I was using it to keep warm and I just started from there. (Charlie)*

In cases where substance misuse preceded homelessness the routes respondents took from developing a drug or alcohol dependency to losing their home were usually somewhat circuitous. Some started drinking heavily or abusing drugs and were asked to leave home by parents (more common amongst drug users) or partners (more common amongst alcoholics) at the end of their tether. Others prioritised the purchase of drugs or alcohol over the payment of rent, accrued rent arrears and abandoned their home or were evicted. Others lost their tenancies while serving prison sentences for offences committed to obtain funds for drugs. Sometimes, respondents' accommodation became a magnet for other alcoholics or drug users and dealers and they were evicted for anti-social behaviour or abandoned the property. Following the breakdown of her long-term relationship , this was how Rochelle eventually lost her tenancy. She explained that *"well, I was living chaotic. I just didn't care about nothing and I was letting cronies in drinking and everything"* Some respondents, like Alex described the way in which the pursuit of drugs or alcohol dominated their lives, to the exclusion of any interest in resolving their impending housing crisis:

Alex	*No I just didn't think about going bed and breakfast or something because alcohol was more important to me at the time, all I wanted was my fix.*
Interviewer	*So it never occurred to you to go to the council and ask for some housing or go anywhere?*
Alex	*No I wasn't bothered, all I wanted was this drink inside me.*

Drug or alcohol dependency, then, can play a crucial (causal) role in people's trajectories into homelessness but homelessness is then sustained by drug or alcohol dependency, it proving very difficult for users to resolve their housing crisis once homeless. Landlords and housing providers are reluctant to accommodate problematic drug or alcohol users because they are deemed undesirable tenants, because their support needs are too high, or because of concerns about tenancy sustainment. A criminal record acts as a further barrier and (as discussed in Chapter Two) is common amongst both alcohol and drug users. Both prioritise

the purchase of drugs and alcohol over payment of court fines and risk a custodial sentence, further deterring housing providers from offering accommodation.

3.3. Homelessness Situations and Experiences

The survey and interview data revealed very complex housing careers amongst substance misusers, with regular movement in and out of precarious housing and homelessness situations. A high degree of housing (and to a lesser extent geographical) mobility was evident, with respondents moving swiftly through a wide range of accommodation situations and rarely remaining in one place for long. Frequently evicted from hostels and temporary supported housing (usually for misuse of drugs or alcohol or related anti-social behaviour) and having exhausted the goodwill of friends and family, the substance misusers participating in this study frequently found themselves in unsafe and unsanitary housing situations such as squatting in derelict buildings or sleeping rough. One respondent, for example, described living in a squat with 16 others, the majority of whom were injecting, with no toilet or running water. Nor was safety guaranteed in the temporary accommodation provided by friends. This was particularly true of the problematic drinkers interviewed, several of whom reported that the friends on whom they relied for short term accommodation were also drinkers and prone to violence when under the influence. Larry for example explained that he chose to move on from his friend's house *"because he got violent when he's had a drink…he were alcoholic so we got on smashing but he were violent"*

Although difficult to ascertain the magnitude of inward and outward flows, there was also evidence that the homelessness careers of substance misusers regularly pass in and out of the local authority area. Several respondents had previously lived elsewhere (Crewe, Manchester, Newcastle-under-Lyme, Devon, and London were all mentioned) and some moved back and forth between Stoke-on-Trent and other locations, sometimes under the misguided apprehension that a change of place might prompt a change of lifestyle.

The mobile and often chaotic nature of respondents' homelessness careers was reflected in levels of repeat homelessness and in the range (and insecurity) of temporary accommodation they moved through. The vast majority (84 per cent) of survey respondents had experienced more than one episode of homeless, one third had been homeless more than five times and 20 per cent more than ten times. There were no stark differences between drug users and alcoholics with regard to levels of repeat homeless although alcoholics were marginally less likely than drug users to have experienced multiple episodes

of homelessness. Discussions with interview respondents regarding their homelessness careers suggested that homeless substance misusers move frequently (and rapidly) between formal homelessness provision such as hostel accommodation and the more insecure, informal environments of rough sleeping, squatting and sofa surfing.

Information gleaned from the survey supports this picture. Survey respondents were asked to specify all the accommodation situations in which they had ever lived and the results are presented in Table 3.1. This shows that the vast majority had accessed hostel accommodation (82 per cent) but this was also true of rough sleeping and staying with friends and nearly half had squatted. Substance misusers' experiences of sleeping rough are discussed in the following chapter. This apparent rapid movement between accommodation partly reflects relatively frequent, but usually temporary eviction/exclusion from hostels, typically for misuse of drugs or alcohol, or associated behaviour (anti social or aggressive behaviour, non-payment of service charge). As Richard, a dual drug and alcohol user explained:

> *"One day you could be in there and the next day you can't because you've done summat wrong or you haven't paid your service charge or you've breached [your tenancy] or summat like that" (Richard)*

Table 3.1 The accommodation situations in which respondents have lived

	All (n=108)	Drug users (n=86)	Alcohol users (n=43)
Homeless Accommodation Situation			
Rough sleeping	90	88	98
Homeless hostel	82	80	86
Temporarily with friends	59	59	60
Squatting	47	49	46
Temporarily with family	43	44	37
B&B	38	40	37
Temporarily with a partner	30	27	35
Night shelter	19	17	23
Bail / probation hostel	18	16	23
Settled accommodation situation			
Private rented tenancy	48	45	49
Social rented tenancy	38	37	37
Owner occupied	6	3	7

Table 3.1. shows that survey respondents were more likely to have slept rough, stayed in a hostel and stayed with friends than they were to have lived in a private rented tenancy, and

also more or as likely to have squatted, stayed with family and in a B&B than lived in social rented accommodation. This will partly reflect the young age at which the substance misusers surveyed experienced homeless - a defining feature of their homelessness careers. We saw in Section 3.1 that unplanned and unsupported transitions to independence, intolerable conditions in the parental home and prolific absconding from children's homes characterised the lives of many those interviewed. The consequence was adolescent homelessness. Most of those interviewed, then, had experienced homelessness before they had experienced settled independent living and some have never been in a settled housing situation. Full details were obtained from 33 interview respondents regarding their early housing careers. Homelessness constituted the first experience of independent living for 25 of these. Only eight respondents moved from their parental/care/foster home into their own tenancy or other settled housing situation prior to becoming homeless for the first time.

The survey findings concur with this: 41 per cent of substance misusers reported having experienced homeless by the age of 16, and 55 per cent by the age of 18. Only 8 per cent were over the age of 35 when they first became homeless. The alcoholics in the sample were more likely to first experience homelessness later in life than the drug users: several were in their 50s when they first became homeless and, in total, 18 per cent were over the age of 35 while this applied to only two drug users (representing just over 2 per cent of survey respondents). Never the less, a significant proportion of alcoholics (36 per cent) were homeless by the time they were 16 and nearly half (46 per cent) had experienced homelessness by the age of 18 (44 per cent of drug users reported having experienced homelessness by the age of 16 and 58 per cent by the age of 18)

3.4. Conclusion

The homelessness careers of the substance misusers interviewed for this study were characterised by insecurity, repeat and prolific homelessness, and a reliance on some of the most informal and unsafe temporary housing situations. Experience of homelessness was more common than experience of settled living conditions and many were still adolescent when they first experiences homelessness. Rough sleeping was prevalent – an issue we turn to and explore in more detail in the following chapter.

Rough Sleeping

4

The evidence from this study suggests that homeless substance misusers rarely avoid sleeping rough during episodes of homelessness: 90 per cent of survey respondents reported having slept rough and 43 per cent had done so in the month prior to completing the survey. The experiences of in-depth interview respondents suggest it is also common for substance misusers (drug users in particular) to sleep rough for extended periods of time (months and sometimes years) and to return to rough sleeping frequently during their homelessness careers. The pattern of rough sleeping exhibited by substance misusers is a complex one, but the data indicate some behavioural trends:

- occasional nights or short periods sleeping rough in between temporary or permanent accommodation, while 'sitting out' a temporary ban from a hostel, or having lost consciousness following excessive substance misuse.

- extended periods of rough sleeping associated with lifestyle and the prioritisation of drugs or alcohol (i.e. few efforts are made to secure accommodation)

- extended periods of rough sleeping reflecting exclusion from or difficulties accessing housing (including an absence of emergency provision in particular areas combined with reluctance to move away from the neighbourhood in which respondents grew up and/or local support networks of housed family and friends) .

Squatting was also common (47 per cent of survey respondents had done so) and typically represented a form of rough sleeping. Interview respondents described squatting in partially derelict buildings, sometimes awaiting demolition, with no windows, heating, lighting or running water. The conditions in which substance misusers squatted were occasionally better than this but such reports were rare. Some reported squatting alone or with a partner but it was common for respondents (drug users in particular) to squat in relatively large groups, with other users.

Regularly barred or evicted from hostels (for example for using drugs on the premises, for returning drunk, or for aggressive behaviour whilst under the influence of alcohol), having exhausted the good will of friends and family, and prioritising their addiction rather than their housing crisis, rough sleeping and squatting could represent the only options for this client group. Interestingly, rough sleeping was slightly more common amongst problematic drinkers than drug users: 98 per cent reported having slept rough (compared with 88 per cent of drug users) and 60 per cent had slept rough in the month preceding the survey (compared to 42 per cent of drug users). Drawing on the experiences of interview respondents this is likely to reflect that problematic alcohol users are prone to occasional nights spent sleeping rough after drinking heavily, having been refused access to their hostel accommodation or having chosen not to return knowing they would be refused entry at the door. Alcohol users were also more prone than drug users to becoming so inebriated as to lose consciousness outside, sleeping rough inadvertently despite having access to temporary accommodation (for example while staying with friends).

4.1. Rough Sleeping Locations

The substance misusers participating in the study specified a range of locations in which they had slept rough. These are listed below. Respondents reported prioritising safety and invisibility when rough sleeping, specifically seeking places which were out of sight. Remaining out of sight was a safety strategy but also minimised the risk of being 'moved on'. Problematic alcohol users were less motivated to find out-of-the-way places to drink and sleep than drug users, mainly reflecting the illicit nature of drug use. This pattern may change, however, with the increasing criminalisation of public consumption of alcohol reflected in new initiatives such as drinking banning orders (DBOs). Favoured locations were found to shift over time, usually in response to increased control of those spaces. Several respondents, for example, reported that the bus station had once provided opportunities for sleeping rough but is no longer viable as homeless people are now moved on very quickly.

Places where rough sleepers in Stoke-on-Trent reported having slept rough	
• on the street • warehouses • car parks (open access and locked) • public landings of blocks of flats • huts on public land/parks • garages • public parks • under a railway bridge • abandoned cars	• train station • bus station • in skips • outside toilet • sheds (including belonging to friends) • the steps of buildings • tents in parks/wasteland • benches

Social networks within the rough sleepers' community were an important means of finding places to sleep rough or squat. Maintaining contacts within homelessness circles increased the chance of finding an 'out of sight' place to shelter. This was particularly true of squatters, who were adept at circulating information about new sites for squatting as and when the need arose. In one instance 'Albert' had lived with a group of 8-10 squatters over a two year period. Their squat was raided by the police and the group went their separate ways. However they kept in touch with one another on a daily basis and found a new squat together within a few weeks.

Friends and family were relied upon heavily by respondents to limit the time spent sleeping rough so those without such networks were more prone to extended periods of rough sleeping. Limited knowledge of the area and isolation from other, more knowledgeable homeless people also reduced respondents' options. Richard (an alcoholic and drug user), for example, slept on the streets for three weeks after leaving a bail hostel. Being new to the town, he had no friends and family on whom to rely for temporary accommodation, knew little about hostel availability, and had no network of homeless friends to advise him regarding emergency accommodation or safer places to sleep rough. He explained:

> *"… I'm not from the area so I didn't know anything. … Just got my head down and slept wherever I could … Just wandering about … you just get to know each other through, at first it was quite frightening, so you learn to look after yourself. (Richard)*

4.2. Daily Life and 'Getting by'

Respondents reported a range of challenges and problems associated with rough sleeping. Daily necessities were reportedly hard to come by, and keeping warm, dry and clean could prove extremely difficult. Having nowhere to store belongings was a common problem mentioned and personal safety was a key concern. Respondents reported a number of strategies to cope with these challenges, including:

- washing in public toilets
- using the showers at the local swimming baths
- shop-lifting new clothes to replace dirty ones
- scavenging food from bakeries, supermarkets - past its sell-by date, but still edible.
- stealing food

- spending time in libraries and other 'indoor' public places
- carrying belongings everywhere to combat the risk of them being stolen
- using the support provided by local churches for food, sleeping bags and clothes
- use of day-centres (the Women's Project provide hot food for example)

Larry is a problematic drug and alcohol user. Currently in hostel accommodation, he has a history of rough sleeping and is experienced in 'getting by' on the streets. He described strategies for obtaining decent free food:

> *"If I was kicked out [of this hostel] I'd find me-self somewhere to sleep, somewhere secure to sleep, find out what's nearby, where I can get food from, i.e. bakery, they chuck away good food at night, good clean food, that sort of food, find a newspaper, try Marks and Spencer's, go to the hostel, it's all right for a few days that stuff, round here it's chucked in the bins, all that stuff they leave you could help people with who are on the streets and got nothing." (Larry)*

In the absence of day centres for the homeless (these are scarce in Stoke-on-Trent) indoor public spaces provided a resting place, respite from the cold, and leisure opportunities. Steve described a typical day:

> *"… we'd go and sit in the library and read books and play on the computers or go in the bookies and sit on the comfy chairs and watch the telly, just go in the bookies and just sit watching the football or whatever or we was in the library all the time reading books and playing on the computers." (Steve)*

Some respondents were also able to avail of the support of family and friends to help alleviate the difficulties of being homeless. The support of family and friends mediated the homeless experience and 'enabled' some respondents to cope with their homelessness situation better than they might otherwise have done. For example some rough sleepers regularly used friends' houses to wash, have a short nap and have something to eat before returning to the street. One couple (both long-term drug users and regular rough sleepers) ate a hot meal each day at the house of one of their parents. Respondents also reported several instances where they slept in the immediate vicinity of friends and families' houses (with and without their permission), in the garden shed, for example.

"… well I could go to me mate's house and wash, change and eat and everything, I just couldn't sleep there, couldn't stop there." (Richard)

"Now and again I'd knock on me brother's just have a quick wash, change me clothes." (Alex)

"Every time I've had to sleep rough I've always made sure I could nip in me mum's for an hour and have a shower or I can leave some washing there and make sure I've got clean clothes" (Martin)

Ironically, rough sleepers who managed to keep on top of personal hygiene occasionally encountered problems accessing homelessness services. Martin, quoted above, explained that the extent of his need had been questioned because of his clean appearance.:

"…any time I've gone somewhere and I've said 'look I'm homeless' and they've said 'you're clean, your clothes are washed and that' and I've said 'just because I'm homeless and I've had a shave doesn't mean that I'm not on the streets' … It's happened at the council, it's happened here [hostel], it's happened at the [other hostel] 'you're wearing a white tracksuit, it's completely white, how have you been sleeping rough?' 'cos I've just been me mum's and got changed and walked six miles to have a shower' but I suppose some people just can't be arsed, it's up to you and yourself isn't it really. (Martin)

Many rough sleepers' however, do not have such resources to draw upon. We saw in Chapter Two that 53 per cent of those surveyed reported having little contact with their family. The reality for many who slept rough, then, was that they didn't get by. Personal hygiene and healthy suffered, and substance abuse exacerbated or relapses occurred. Characteristically, Saskia found it difficult to articulate how she got by on the streets. She was asked how she managed for food while rough sleeping:

Saskia: *"[I] Just do, steal something or scrounge something, I don't know, I just do, just get by.*
Interviewer *I suppose we're interested in how you get by?*
Saskia *I don't know.*

Darren similarly described rarely eating or washing:

Interviewer *What about all the rest of it like food, washing yourself, keeping warm.*

Darren *To be honest you don't do half of that. only time you're probably eating food is if someone buys you something, a pie or if you've had a pay day you'll get bits and bobs of food but when I was on the streets I wouldn't bother looking after myself or nothing to be honest, let myself go.*

Managing existing health conditions could also prove problematic. Health workers were reportedly reluctant to administer prescription drugs to rough sleepers, and the chaotic nature of people's lives while rough sleeping often made effective treatment difficult. James is a drug user with a mental health condition who had lived on the streets for several months at a time. He found it very difficult to obtain the correct medication and the chaotic nature of his circumstances makes effective treatment very difficult:

"Well me head was everywhere with me having mental health issues before I didn't have no medication, had no money at the time and no way of contacting anyone so I was in a bit of a mess at the time." (James)

Some of the strategies employed by rough sleepers to manage daily life and meet their basic needs were inventive and resourceful (washing in public toilets, making use of warm public buildings, ascertaining where and when food is discarded by local businesses) but others were severely detrimental, often involving increased use of drugs and alcohol. Substance users, like Richard (a dual user) quoted below, made regular references to the use of drugs and alcohol as a coping mechanism that made rough sleeping bearable and mitigate the harsh reality of homelessness:

"cos I was on the streets, really either you drink or you have drugs to take yourself out of it so you can get your head down at night, just escaping it basically" (Richard)

Substance misuse was frequently described as a means 'to survive' by respondents, who noted that it helped to pass the time and mitigated the boredom and harsh conditions associated with living on the streets or in squats. Problematic drinkers tended to refer to the 'warming' qualities of alcohol while drug (heroin) users more commonly described the benefits of 'losing time' and numbing depression. Tony, for example is an alcoholic who recently slept rough for a year. When asked whether he was drinking while on the streets he replied *"well yeah, to keep warm"*. Alex similarly spent all day drinking, sometimes with other street drinkers, and reported that being unconscious made the nights much easier:

the drink just blocked everything…drank all the way through the day and then just went to this garage that was empty and passed out" (Alex)

And Tom's account illustrates well the way in which drug use is used as a coping strategy, to numb the boredom and depression of rough sleeping:

"That's how I got back into using heroin again so it just melted one day into the next to the next. instead of counting days I was counting weeks… I knew it'd take all the feelings away and everything else.and time'd just become insignificant … you'd open your eyes and you'd be slipping off the day because you'd had your heroin and you didn't want to wake up and when I did it was only for a few hours and I'd go and have a cup a soup down me friend's house and that'd be me tea or whatever and then soon as it was getting dark again me eyes'd shut and that'd be another day done". (Tom)

Steve was firmly of the view that the conditions in which he lived during a period of rough sleeping and squatting were only made possible by taking drugs:

"… we wouldn't have been able to stay there for a day without a lot of drugs, you wouldn't sleep in that warehouse all night without being very drugged up, you couldn't, you can't do it, impossible. You've got a big massive warehouse, no windows, no doors …" (Steve)

Being under the influence of drink and/or drugs was found to carry significant risks for the rough sleepers interviewed. Already exposed to high risk of violence by virtue of the combination of lack of secure shelter, visibility, and stigma, this can increase significantly when inebriated, people being less able to defend themselves under these circumstances. Experiences of violence were relatively commonplace amongst those interviewed. Most reported feeling unsafe on the streets, never sleeping soundly for fear of attack, and many reported incidents of abuse, harassment, intimidation and violence at the hands of the general public. Larry recounted his experiences:

"… you don't feel safe, you're never feeling safe, you're always on edge, you sleep with one ear open so any slightest noise you're there…[it's]… they're out on the piss on a Friday night, see someone they think is either a druggy or a fucking tramp and give you hell over it, they think it's your responsibility for being on the streets, that you're a target 'let's give him some jip, make his life a misery' know what I mean? I've been in a couple of squats a few weeks ago when I got kicked out the hostel because I didn't pay

me rent and I was there one Friday night [and someone] threw the window with bricks and I was covered in glass and he were like 'fucking this fucking that' chucking bricks 'get out of there now before we burn you out'. … I was out of there and going to find somewhere else so that was me dry shelter gone then, wouldn't dare go back there, give me a kicking. So it's not easy on the streets." (Larry)

Other respondents, like Tom, had experienced violence from people in similar situations to themselves.

"after about two weeks of being in there [abandoned hut] actually got beat up by somebody with an axe. … I knew the person, he was a so called friend but he'd had a drink and I think he's been taking steroids and I don't know whether he'd got a bit of road rage or what but he sort of hit me a couple of times and then pulled an axe out and beat me up with an axe. I didn't press any charges but for two weeks after that I was still on the street but obviously I'd got stitched in me lip and me gum where me teeth had been knocked out and it took them two weeks after I'd been beat up before I got the place at the hostel through the rough sleepers." (Tom)

Particular problems were reported when problematic drinkers and drug abusers shared space, as Tony's experiences illustrate. Drug users and (non drug using) problematic drinkers tended to segregate but occasionally they shared squats or rough sleeping locations. Tony described his experiences of being repeatedly robbed by other homelessness people while sleeping in a derelict building:

"We had quilts, we'd got them from charity shops, but they'd be on smack, crack, whatever they're on, I'd be an alcohol so they'd be ripping me off if they could. Coz they'll do anything for a bag won't they? So I got my clothes nicked, me money, I went through a lot of shit there"

4.3. Conclusion

Rough sleeping was extremely common amongst the substance misusers participating in this study and respondents reported a host of difficulties and challenges associated with rough sleeping including deteriorating physical and mental health, incresing drug and alcohol consumption and regular experiences of violence. The prevalence of rough sleeping in part reflects the difficulties substance misusers face accessing accommodation and it is to this that we turn in the following chapter.

5

Accessing Housing

The findings presented in the previous two chapters regarding the housing experiences of the substance misusers participating in this study - insecure and highly mobile homelessness careers; frequent and extended episodes of rough sleeping; hidden and repeat homelessness - reflect the difficulties they encountered accessing and sustaining temporary and permanent accommodation. Drug and alcohol use and associated behaviours (criminality, unpredictability, accrual of rent arrears, chaotic lifestyle) render substance misusers undesirable tenants while (legitimate) concerns amongst housing providers about tenancy sustainment further reduce the housing options of this client group. In the survey, 25 per cent of substance misusers reported having been excluded from a housing service because they were a problematic drug or alcohol user (no differences between drug and alcohol users emerged in this respect), and in-depth interviews suggested that considerably more may face exclusion or significant barriers for reasons related to their substance misuse and associated needs. Martin's account illustrates that the housing options for substance misusers can be extremely limited and that many are consequently at constant risk of rough sleeping.

Martin	*Not been any beds [at the hostels], council couldn't do nothing so… that was it really, just had to wait.*
Interviewer	*and in the meantime you have to sleep rough or in squats?*
Martin	*Yeah I've stopped in a car with no windows and everything.*

Martin's assessment that hostels represented his only opportunity for accommodation (a perception confirmed by the actions of the housing advisor at the Local Authority who gave him a list of hostels) may not have been wide of the mark. Drug and alcohol users can rapidly exhaust the patience and goodwill of friends and family on whom they might otherwise rely for temporary accommodation, burning these supportive bridges more quickly than homeless people without dependencies. High support needs and the anti-social behaviour commonly associated with drug or alcohol dependency limits the number housing providers willing or able to accommodate them appropriately and it was rare for the substance misusers

interviewed for this study to have a range of housing applications in progress which could be pursued or reactivated in an effort to avoid rough sleeping. A lack of planning for future housing needs (common in our sample) combined with a history of limited engagement with services and relatively chaotic lifestyles meant respondents were rarely in the process of progressing a carefully laid long-term plan for exiting homelessness. The availability or otherwise of a hostel place, then, could represent the difference between being accommodated and sleeping rough – true for Martin and for many of those interviewed. This being the case, the risk of rough sleeping increases significantly for single women over the age of 25, there being far fewer hostel spaces in the City for this population group.

Once a hostel place became available Martin was able to escape rough sleeping but respondents frequently mentioned being unable to access hostels, or being excluded from them for other reasons, including:

- age and gender criteria
- lack of additional support services to provide for an individuals needs (mental health needs for example)
- exclusion for violent or threatening behaviour
- exclusion for breaking rules (usually drinking or drug-use within the hostel)
- temporary exclusion when 'under the influence'.
- prior rent/service charge arrears

The hostels in the City do not operate policies excluding known drug or alcohol users and there was no evidence to suggest that informal exclusions were practiced. Rules are applied regarding use of drugs or alcohol on the premises, levels of sobriety required while on site, and conditions of residency were sometimes imposed such as attending drug or alcohol counselling. If spaces are available, if applicants meet the general criteria of the hostel, and if they comply with the rules and tenancy agreement then the hostels in the City are accessible to substance misusers.

General needs housing providers (of interim and permanent accommodation) were, however, reportedly very reluctant to accommodate problematic drug or alcohol users (although none of those interviewed reported operating exclusion *policies* to this effect) and there is no specialist provision targeted at drug or alcohol users. Some of the limited provision of interim supported housing for other client groups with multiple needs (such as offenders) is accessible to some substance misusers although very few of those participating in this study accessed this provision until such time as they were addressing their drug or alcohol

problems. A short survey of general needs and specialist housing providers in the City suggested that drug and alcohol users are rarely actively excluded but very few were able to provide data regarding the numbers accommodated.

Analysis of in-depth interviews revealed a series of further key barriers preventing substance misusers from accessing temporary accommodation (thereby escaping rough sleeping) and interim or permanent accommodation (thereby escaping homelessness).These are discussed below.

5.1. Barriers to Accessing Accommodation

A number of key barriers preventing substance misusers from accessing accommodation emerged from the in-depth interviews. Discussed in more detail below, these include:

- limited access to information, advice, and advocacy:
- housing history
- the need to avoid other substance misusers and past associates, which limits temporary and permanent housing options
- the imcompatability between the lifestyle of substance misusers and the bureaucratic requirements of housing services
- oneffective or inadequate housing advice on entry to prison and on release
- limited supply of accommodation which is appropriate for, and accessible to substance misusers.

Limited access to information, advice, and advocacy. The assistance of others emerged as key to facilitating access to housing amongst the substance misusers interviewed. Very few had secured interim or permanent accommodation without the help of, for example, a key worker, support worker or probation officer. Limited knowledge and information regarding housing options and availability, combined (sometimes) with lack of motivation left most facing extreme difficulties negotiating their way into and through housing and support system. Lack of knowledge regarding who to speak to, or where to go on becoming homeless frequently resulted in younger respondents' first experience of rough sleeping. Respondents lacked the 'know how' and confidence to approach agencies able to help them and had little knowledge regarding their entitlement, rights, and the provision available to

them. Jennifer and Elaine (both drug users) described not knowing how to 'go about' getting help, having no idea what assistance was available or how to access it. Jennifer stayed with family and Elaine slept rough:

Jennifer:	*I've had a private tenancy but I had to move out because I had a violent partner*
Interviewer:	*Did you get any help?*
Jennifer:	*No*
Interviewer:	*Did look for any help?*
Jennifer:	*I've never known how to go about it, I've never....no*
Interviewer:	*So where did you go?*
Jennifer	*To me family's, that's why I was staying back and forth*

"I don't know what to do. It's alright for people to say 'oh there's help there if you want it' but you've got to get to it. How do you get to it?" (Elaine)

Others held misguided views regarding eligibility for housing, erroneously believing that certain groups (drug users, offenders, people in prison) were automatically excluded from social housing. It was only when furnished with accurate information (again, usually by a hostel key worker or similar and sometimes many years after becoming homeless) that respondents finally applied for accommodation. This was true of Elsa, a drug user, who explained that she had never applied to the council because *"I know I wouldn't get on the council, the council aren't going to give a place to someone on drugs are they?* The result for many was extended periods of homelessness and rough sleeping with no service contact. In the survey, 53 per cent of substance users said they had wanted help, support or advice with finding a home, but had not received that help. Drug users were particularly likely to report unmet needs in relation to finding a home (58 per cent compared with 45 per cent of alcohol users).

Although it was very rare for the substance misusers interviewed to have made independent applications to interim or permanent housing providers, some had contacted hostels directly and had approached the local authority. An (independent) approach to the local authority most commonly resulted in provision of a list of hostels and contact details for the rough sleepers' team. Respondents' knowledge about hostel provision tended to have accrued in a rather haphazard manor as Roy and Harry's responses to the question 'how did you find out about the hostel' indicate:

"Just basically when I was walking round the streets when I was homeless, basically went in the charity shops asked them if they knew of any hostels or anything like that, I was put in touch with the YMCA" (Roy, alcohol user)

Interviewer *How did you know about the [Hostel]?*

Harry *Cos when we used to be young we used to play football up there, go up, me and me mate, just play on the pitches and that at night, we knew there were like young kids in there living and that.*

The haphazard manor in which these respondents found their way into hostels is of some concern: it was often only once in a hostel that respondents began the process of engaging with other support services and taking steps to resolve their housing problems, indicating clearly the important role that temporary supported housing provision potentially plays in the resolution of individuals' homelessness. Key worker support was found to be vital in this regard and respondents generally valued their key workers' advice and expertise. The key workers' ability to view the respondent's situation 'in the round' (taking into account their life history; substance misuse; emotional and physical health; support needs), combined with their housing expertise gave respondents the confidence that they could assist them with finding suitable accommodation. The individuals interviewed who had applied for supported or social housing (including actively bidding on the Choice Based Lettings Systems) were those currently living in a hostel who had been assisted to do so by their key worker and who had also been referred for drug or alcohol treatment. Very few of those not living in hostels were actively pursuing housing opportunities. This being the case, clear routes into temporary provision become all important.

The rough sleepers' team in Stoke-on-Trent does provide a route into hostel accommodation and is working well in this regard. Independent approaches aside, the rough sleepers' team was the main route through which the substance misusers interviewed accessed hostel provision, often after an extended period of rough sleeping and limited engagement with any services. It is very likely that without their assistance many would not have escaped the streets. Sarah is a drug user who was sleeping rough. Her story provides a typical example of the way in which the Rough Sleepers Team were able to secure a hostel place for Sarah when her own efforts had failed:

"Yeah it was freezing, it was absolutely cold, and I happened to be on a course for the job centre, and on the wall they've got the numbers of [hostels] and places like that and I thought 'oh well I'll ring there' I rang [hostel A] and they said I'd have to go for an interview and it would be like 30 days and I said 'obviously I need something now' and they said they wouldn't be able to do nothing at the moment anyway cos they had no bed spaces and I rang the Rough Sleepers team, they come and see me the next day and that afternoon they rang me back and said... 'I've got your and your partner in the new hostel on [X] Street'." (Sarah)

In Steve's case it was his lack of knowledge which kept in on the streets but, like Sarah, it was his contact with the rough sleepers team that enabled him to exit rough sleeping:

… we was on the streets and we seen the Rough Sleepers team and they just sort of said 'we'll fill a form out for you and refer you to wherever' but we'd already been on the streets seven months like waiting to get in a hostel, because we didn't know about them straight away, till like six months before we even knew about them and then we got in touch with them [the rough sleepers' team], it took like a month to get a hostel after that (Steve)

The key benefits of the team were found to be:

- frequent, assertive outreach visits, and effectiveness in keeping in touch - particularly important to drug and alcohol users who tended not to be proactive in accessing housing and support services
- ability to provide access to accommodation quickly
- ability to secure hostel accommodation for people who had struggled to do so on their own
- positive personal relationships with the team's workers, establishing trust, and promoting consistency.
- assertively supporting people to engage with other relevant support services such as drug and alcohol treatment (making referrals but also reminding and driving people to appointments)

However, questions remain about hostel access (and the subsequent routing into interim, supported or permanent accommodation and support services) for those not in contact with this team. Sarah story above illustrates well the way in which a referral from the rough sleepers' team acted as a 'fast track' into particular hostels but that without this referral bed

spaces are limited. Indeed several respondents reported that direct access places are now more restricted as a result of the priority given to those referred by the rough sleepers team. Those not sleeping rough or squatting (people staying with friends for example), or sleeping in locations unknown to the rough sleepers team do not benefit from the support they provide. And housing advice and assistance is hard to come by elsewhere, there being no homelessness drop-in centre in the City where an advisor would be readily accessible to homeless people. Some respondents had received limited assistance from specialist support services (drug and alcohol services, health providers, employment advisors) but housing generally falls outside their remit and their capacity to assist is usually limited.

Housing history. The housing history of the substance misusers interviewed – which often included failed tenancies and placements, rent arrears, and anti-social behaviour in the social housing sector – was acting as a barrier to accessing housing (particularly permanent housing). This was particularly true of drug users, but not exclusively so. Respondents and services providers working with this client group reported the view that failed tenancies and evictions were held against substance misusers by general needs housing providers, reducing their chances of securing accommodation. It was also reported that the full circumstances surrounding previous tenancy failure were rarely considered, nor the extent to which these circumstances had changed in the meantime.

Outstanding rent arrears were proving particularly problematic but were also very common amongst respondent, many of whom at times prioritised the purchase of drugs and alcohol over rent payments. This was exacerbated for those funding their dependency through criminal activity such as forms of theft or prostitution (applicable mainly to drug users) who faced the additional financial burden of fines and victim charges. These too often took precedence over housing costs because failure to pay can result in a custodial sentence. Alternatively, limited 'know how' or motivation to deal with the bureaucratic process of applying for Housing Benefit, advising of change of circumstances (such as an additional household member), dealing with processing errors, or serving a custodial sentence longer than 13 weeks (the period of time Housing Benefit remains payable) could result in the accrual of significant arrears. Respondents would either be evicted or would abandon properties without formally terminating the tenancy, thereby accruing further arrears. Thus rent arrears tended to trigger eviction but there were often multiple underlying causes of tenancy failure. Geoff was evicted for rent arrears but attributed the loss of his council house to his drug-addiction which in turn made it impossible for him sort out 'problems' with benefit payments:

Geoff *Through drug [taking] I'd think 'sod it' all [I'm] on benefits and stuff, I lost my flat, it was my fault, it's benefits agencies, they messed us up a lot like, I went to court and got something like about eight months backdated rent and they paid all that and just started again.*

Interviewer *So they weren't paying the housing benefit?*

Geoff *No. … I'd applied for it but … I should have phoned up meself really but…*

*I*nterviewer *So were you taking drugs throughout this period?*

Geoff *eah a lot yeah.*

interviewer *So you were evicted for rent arrears?*

Geoff *Yeah*

Whatever the 'underlying cause' of the rent arrears, once in this predicament it often proved difficult for respondents to negotiate a way back into the social housing sector. Sarah (who had successfully maintained a methadone programme for some time now and was living in a hostel when she was interviewed) is a case in point. When we interviewed her she had applied to the local authority with the help of her key worker but reportedly had been told she could not be allocated a tenancy until she had substantially reduced her £1,500 debt.

Interviewer *Do you think you'd be able to pay off those rent arrears?*

Sarah *Er not straight away, they give me a card where I pay like so much a fortnight on it and I said at the moment the only bit what I pay is like £4 a fortnight.*

Interviewer *It shows willing though.*

Sarah *That's what I said to him, I said 'I haven't missed so far but I will start paying…' and I did ask somebody whether, they had a meeting at the civic centre in Stoke and I went down there and I said 'does this help with me putting myself back on the housing?' and she said 'well to be truthful' I told her how much my rent arrears was… 1700 … she said 'to be truthful you'd have to get that right down before we'd even consider' and I said 'to me now, that £4 I'm giving you I could be spending that on something else, bus fare for going somewhere else, seeing what other properties I could get whereas I'm giving it to you thinking I'm paying off, put me back on cos they do me again' and they were like 'no you have to go all the way down' I was a bit shocked really cos I thought you start paying them off they start… cos you're showing willing that you are paying and they start… it wasn't like that at all.*

Rent arrears had also prevented a couple of respondents accessing temporary accommodation[1]. Accrued during a prior hostel residency, having spent all their money on drugs or alcohol, Graham and Ryan's were refused places at a hostel until they had cleared their debt. They explained how their arrears built up:

> *Yeah I've stayed there [Hostel], I got kicked out of there. [For] rent arrears, I owe them 180 quid. … Like basically like I was there in the morning like, I was just spending it all on drink and drugs so …. (Graham)*

> *I didn't really pay [the hostel rent] cos I spent the money to be honest with you. [And from there] I was on the street. (Ryan)*

In some cases, then, relatively small sums of money (one week's arrears in one case) were preventing substance misusers from exiting rough sleeping.

The local authority policy in relation to applicants with rent arrears has changed in recent years and local authority officers reported that applicants like Sarah with outstanding arrears were no longer excluded or required to make a substantial contribution to the arrears before being considered for a tenancy. There is, therefore, a degree of conflict between the reported experiences of some interview respondents and the reported policies and practices of local authority staff. This may reflect inaccurate reporting of timescale by interview respondents or it may indicate that some front-line staff are not acting in accordance with local authority policy

The need to avoid other substance misusers and past associates limits temporary and permanent housing options: A crucial component of rehabilitation and tenancy sustainment for drug and alcohol users is breaking the associations from people and places from their substance misusing history. Some of the city's supported housing is located in neighbourhoods that (recovering) substance misusers wish to avoid and the allocation policies of many housing providers were reportedly insensitive to this requirement. Darren's story highlights the issue:

[1] In most cases the rent payable in hostels was covered by Housing Benefit. The charge respondents are expected to pay themselves is a service charge but this was usually refered to as 'rent' by respondents.

Interviewer *And when you were sleeping rough, what was the main barrier to you getting a place then, cos presumably you did want to get your own place?*

Darren *Getting the money together for your rent deposit. The council weren't. I think the council... they're saying places I don't want to go to, I don't want to go back to round where [I was using drugs] and that. … Cos I think it'll start me back on drugs again. … Yeah I know that many people round there, I'd just want to go back on the drugs, it would be too much..Yeah, if I was strong enough in me head, if I was a bit more stronger in me head then I could probably live down [location] and say no to drugs but at the moment I feel I'm not in that, I'm not feeling that way at the minute. … Yeah that's what I mean about these areas, people see me like and they're on drugs and it'll be 'let's come to your place, have a crank or do some drugs'*

A local authority officer reported that they do act responsibly in allocations, attempting to accommodate people (drug users and offenders in particular) away from known associates (whether this has been requested or not) but acknowledged that the consequence can be longer waiting times. The experiences of interview respondents also suggests that this is not always possible and that the locations open to them tend to be those they wish to avoid.

The presence of substance misusers in hostels (despite strict regulations banning the use of illicit drugs or alcohol on the premises, which were rigorously enforced by hostel staff) was also a problem for respondents on drug and alcohol rehabilitation programmes and influenced their choice of accommodation. Some respondents reported avoiding hostels, or particular hostels, for this reason, staying with friends, family, and sleeping rough instead. Hostels thought to enforce a strict policy of refusing entry to residents apparently 'under the influence' of drugs or alcohol were viewed more positively and considered a viable option while those operating a more relaxed 'open door' policy were not. The converse, of course, was true for those drinking or using drugs excessively.

The fact that many respondents were from the city or surrounding environs, so were well known and had history in the area, also had a bearing on their willingness to take up available temporary housing. In contrast to London and other large cities where the abundance of temporary accommodation offers choice and anonymity, being a homeless substance misusers in a city with more limited provision presents a challenge if there are

people one wishes to avoid (former drug and alcohol -using acquaintances in some cases; someone to whom a drug debt was owed in another). Maintaining anonymity or avoiding others can severely restrict housing options. Robert, for example, has a long history of drug misuse and after several failed attempts to cease heroin use he secured a place at a residential rehabilitation and resettlement centre. Robert was there for three weeks and was making good progress but, much to his distress, a former drug using acquaintance then moved in. He discharged himself from the unit three days later and immediately returned to rough sleeping and heroin use.

The lifestyle of substance misusers is rarely compatible with the bureaucratic requirements of housing services. The lives of the homeless substance misusers interviewed are often chaotic. They moved frequently, lost essential documents, letters failed to reach them or they remained unopened, they could not always recall dates or events with precision and much of their energy was spent getting by each day. Engaging with the housing system, making phone calls and applications, remembering to attend appointments, and complying with bureaucratic and administrative requirements (providing documentation, proof of identification and such like) could prove extremely difficult. Failure to do so, however, generally meant no access to housing. Larry and Jane highlight some of these issues.

> *"I've always put me name down for council like but being homeless you can't, you're not specifically anywhere so you don't get your letters or you can't follow it through. I've been in and out of hostels where you try and get help in there but before you know you're back in jail… Obviously if I had me own accommodation it'd be even better but I've got to supply the council with proof of me address and identification, I've got no identification, I've lost everything with moving out all them years, I've got nothing to say who I am, no letters from water board or electric, I never have any, where would I get anything like that?" (Larry)*

> *"I have been the council but I'm struggling at the moment with ID, to get ID together so I can give them the council. … your national insurance number, like a card, and then you need certain other ID which I haven't got." (Jane)*

Sarah missed out on permanent accommodation for failing to attend interviews. She was living in temporary accommodation (a flat), on a methadone programme and had a newborn baby. The consequence for Sarah was a period of rough sleeping and separation from her son:

And at the time I was pregnant, got the [temporary] flat, everything was ok, and me being stupid missed two appointments, homeless appointments where them appointments would have got me a secure place. … so I can't blame anyone else for that apart from me, that was my own stupid fault for missing them meetings. After missing them meetings they wouldn't really give me another one, they let me stay there for three months, they come round and said 'obviously you're going to have to move' and then made homeless again, me son went to live with [a relative]. (Sarah)

For different reasons the requirement placed on people with criminal convictions to produce a record of their offences was also deterring respondents from pursuing housing applications. It is apparently common practice in Stoke-on-Trent for social housing landlords to ask applicants indicating they have a criminal record to provide documentation detailing their convictions. This was found to have a significant impact on respondents' access to housing for a number of reasons. Firstly, this requirement was deterring people with convictions from pursuing their application, assuming that once their record was known they would be excluded, or not wishing to a have any further contact with the police. Secondly, there was a degree of confusion (or lack of clarity) about what information or documentation the landlord was demanding. Several respondents reported having been asked for a 'reference from the police'. Under the impression that they were being required to obtain a statement from the police confirming their suitability for housing respondents tended to drop their application. Thirdly, Stakeholders reported that obtaining a record of one's criminal convictions was far from straight forward because of data protection concerns but that without it respondents would not be considered. One offered the view that *"The lack of proof of pre-cons is a significant obstacle to being accepted on the housing register"* This chimed with the experiences of interview respondents several of whom reported being told they could not submit their application until they could produce an official record of their previous convictions. Finally, it carries a cost, reported variously as £10 and £15, which most respondents could ill afford. This is articulated clearly by Larry:

"How am I going to find this extra money to go and get a piece of paper from the police telling me… know me bloody records for the council, find this extra money, forget I've got a drug issue, I'm on the streets, how am I supposed to get the extra money to do it? Stupid really. (Larry)

Ineffective or inadequate housing advice on entry to prison and on release is preventing people with substance misuse issues avoiding or escaping homelessness.

We saw in Chapter Two that the majority (62 per cent) of the homeless substance misusers surveyed had served a custodial sentence (67 per cent of drug users and 51 per cent of problematic drinkers) and noted in Chapter Three that, without adequate housing assistance, substance misusers are consequently exposed to increased risks of sustained homelessness. We saw in Chapter Three that respondents with settled accommodation (not many) when they were incarcerated rarely sustained their tenancies for the duration of their sentence. The exception were a small minority (exclusively problematic drinkers) with partners who maintained the family home in the respondents absence. Generally speaking respondents held no expectation of retaining housing while in prison, even when serving relatively short sentences, illustrated by Elsa's comment that *"you go into prison and then you automatically lose your property anyway".* Those already homeless at the start of their prison term remained homeless on release. Either way, most commonly respondents were released from prison to a situation of homelessness (and rough sleeping in many instances) having received little or no advice and assistance about sustaining or securing housing. Over and again respondents, like Elsa quoted below, recounted how little help they had received with securing any accommodation on release:

Interviewer	*Did anyone ever give you any housing advice or…?*
Elsa	*No nothing, they told me to go to places like [X supported housing project]*
Interviewer	*They just give you a sheet of paper with contacts?*
Elsa	*Mmm, contact numbers and all that on……all different places to get in touch with them...they never phoned up places to try get me in anywhere or anything like that.*
Interviewer	*So every single time you came out of prison you were homeless?*
Elsa	*Mmm…. I'd come out and wouldn't have a roof over my head and obviously have to go round trying to sort things out for meself.*

Respondents also reported that this was despite frequent requests for assistance and, in some prisons, the apparent availability of a housing advisor. Both Jane and Sarah made active requests for help. Sarah's eventual housing outcome illustrates the potentially detrimental consequence of limited housing assistance:

"I did try me best in there [prison] this time to get in touch with the housing people but I kept putting apps [applications] in after apps to see 'em and not once did they came to me door and ask to interview me or nothing." (Jane)

"Yeah, asked for help in there [prison] with accommodation, didn't really get much, they were more concerned on like me drugs, they wanted to make sure when I got out that I'd got a prescription, plus I was drinking alcohol and I was getting dependent on that so I did a detox…they were more supporting me on that than getting somewhere so me friends said 'yeah you can come back to here when you come out' so I told them that and I said 'but obviously it's temporary so I do need somewhere' and as it happens when you're living with friends anything can go wrong, we had an argument, back on the street again and then that's when we ended up…in a tent on the field." (Sarah)

Maintaining a drug, alcohol and offending free existence under these circumstances proved more challenging than when adequately housed. Many respondents reported returning to drug or alcohol use, offending behaviour and sex working in the weeks following release from prison.

Limited supply of accommodation which is appropriate for, and accessible to substance misusers. Substance misusers have relatively high and complex support needs, particularly those still regularly abusing drugs or alcohol, or those who have only recently taken steps to combat their dependency. The reality, then, is that many of those interviewed would not cope (and previously have not coped) in a single unsupported tenancy, and they acknowledged this fact. No evidence emerged in this study of active substance misusers sustaining unsupported tenancies for any length of time unless in a relationship with a non-user who managed the household (true for some alcoholics). Indeed many failed repeatedly to maintain their place in hostels staffed 24 hours a day. But the supported housing sector in Stoke-on-Trent is relatively small and the limited floating support available tends not to be intensive enough. There is no supported housing targeted specifically at substance misusers (although the residential rehabilitation unit does have resettlement provision) and so they are reliant on a small sector of supported housing for offenders and people with complex needs.

It is not, then, immediately obvious where a substance misuser with high support needs would apply for (appropriate) accommodation. This is particularly true for current problematic users but the sobriety of those abstaining from drugs or alcohol or on treatment programmes can remain precarious for some time. When we interviewed him in a hostel, Tony, a (recently) recovering alcohol was due to view a local authority studio flat. Very keen to secure his own place he was also concerned about being lonely (common amongst alcoholics more so than drug users) and expressed much anxiety about the potential impact on his recovery.

"I'll miss the company as well [of the hostel]. That's what I'm frightened of, going out for company ,thinking 'I'll just go for a pint', I can't have one can I? (Tony)

Tony valued the social interaction in the hostel, explaining that he need not leave the building if he wanted company but could instead go to the communal area or games room. Living alone in a flat, he was concerned that he would be more likely to seek company in a pub if he felt lonely. He asked: '*so where would I go [if I felt lonely]? Could be the pub couldn't it? And then what happens? You gets the taste again'.* Tony is not from the area and has few established social networks. To avoid drinking again he said he might resort to returning to the hostel - *"If it think about drink I'll probably come here and have a chat to someone or have a game of pool. It'll be worth the bus ride won't it?"*

Several gaps in service provision, found to be hampering respondents' efforts to escape rough sleeping, also emerged. These include:

- readily accessible, direct access, emergency housing. The hostels in the city do provide direct access accommodation but, as discussed elsewhere in this report, waiting lists and temporary exclusions invariably left many respondents unable to secure on-the-spot accommodation when needed. Increased availability of emergency accommodation would almost certainly reduce the numbers of respondents sleeping rough.

- homeless couples found it particularly difficult to meet their short-term housing needs because of the lack of temporary accommodation for couples. The danger here is that the desire to be together can override other priorities and at least one couple interviewed chose to sleep rough rather than be separated in hostel accommodation.

- women-only temporary housing. Bed spaces for homeless women are fewer than for men yet, according to the findings from this study, rough sleeping is not significantly less prevalent amongst women. In addition, mixed environments can be off putting for homeless women, many of whom have experienced violence and abuse at the hands of men and would prefer not to share space with men they do not know.

5.2. Conclusion

We have seen in this chatper that the housing options for homeless substance misusers are limited. There is little specialist provision targetted at this client group, general needs housing providers can be reluctant to accommodation them and they face a host of barriers to accessing appropriate temporary and permanent accommodation.

6

Access to Treatment and Support

In the preceding chapters we have seen that homeless people with drug and alcohol dependencies in Stoke-on-Trent have a range of housing and support needs. The profile of the population presented in Chapter Two suggests they are a vulnerable population with multiple and complex needs including mental health issues, disrupted childhoods and education, and offending histories. Their drug and alcohol abuse plays a key role in causing and sustaining homelessness: restricting access to accommodation and making tenancy sustainment difficult. Addressing drug and alcohol dependency as well as meeting other support needs is crucial if substance misusers are to escape homelessness. In this chapter, then, we examine the extent to which homeless substance misusers are accessing the treatment and support they need in order to escape homeless and sustain independent living.

6.1. Access to Drug Treatment and Counselling

The majority (85 per cent) of the drug dependent substance misusers surveyed had received treatment or support to help them combat their drug addiction. Most (70 per cent) were currently in receipt of support and the same proportion had done so previously. Over half (54 per cent) had benefited more than once from intervention, perhaps indicating relatively high levels of relapse and non completion of treatment amongst this population group, a scenario supported by the experiences of in-depth interview respondents.

Those respondents who reported having received assistance to address their drug dependency were asked to specify the type of support or treatment they had received. Table 6.1 shows that specialist prescribing of substitute medication such as methadone was the most common form of treatment accessed by survey respondents (48 per cent had benefited from specialist prescribing) although many had also been treated as an in-patient and had

received drugs counselling. It was less common for respondents to have entered a residential rehabilitation programme. Most of those reporting having received some 'other' form of assistance were referring to the support provided by key workers and support workers, for example in hostels or other supported housing.

Table 6.1. Treatment and support received to address drug dependency

Assistance received	% of those who have accessed assistance
specialist prescribing	48
in-patient treatment	43
drugs counselling	42
residential rehabilitation	22
Day programmes	14
Group therapy	16
other structured treatment	17
other treatment or support	19

n=67

Respondents were overwhelmingly positive about the support they were currently receiving with 85 per cent reporting that is was helping a lot or a little (60 per cent reported the intervention to be helping 'a lot' and 25 per cent 'a little'. Only 4 per cent reported it had not helped at all. They were also positive about past treatment despite this (presumably) not having been entirely effective, with a similar proportion reporting it had helped overall (but only 35 per cent reported intervention had 'helped a lot' in the past and 53 per cent 'a little')

The positive views of respondents towards their treatment is of interest if we consider the circumstances of in-depth interview respondents, many of whom were on methadone programmes or in contact with drug support services but talked at length about the extreme difficulties they encountered ceasing drug use. Many were 'topping up' their medication, or had only slightly reduced their intake. They talked about regular relapses and the likely prospect of relapse, and only a small minority were managing to abstain from street drugs for a sustained period of time. Never the less, the results from the survey suggest that even this gradual and precarious combating of addiction may not be achievable without the help and support of drug treatment services.

In an effort to gauge demand for different forms of support respondents were asked to specify the kind of assistance they would like to receive in the future. Their responses broadly matched the profile of the assistance they had already availed of, a reflection perhaps of the positive experiences respondents had of previous treatment. The exception

was with regard to specialist prescribing. Considerably fewer respondents reported wanting specialist prescribing in the future than had accessed this intervention. This is unlikely to reflect dissatisfaction given the generally positive reports of its impact by survey and interview respondents alike. If we consider the accounts provided by interview respondents regarding efforts to combat their dependencies, two possible explanations emerge. Firstly, although most interview respondents had taken substitute medication and reported benefits in doing so, most were also still using drugs (having relapsed or in addition to their medication) or were not confident that they could desist from doing so. In other words, they felt a need for more intensive or structured treatment (in addition to or instead of substitute medication) in order to effectively address their dependency. Secondly, substitute medication, as a form of intervention, helped respondents combat the physical effects of withdrawal but provided no personal, emotional or psychological support.

There were also a small minority of interview respondents who were firmly against the use of methadone to combat heroin dependency, reporting that they found methadone highly addictive, more painful to withdraw from and more difficult to cease using. These respondents had previously been on methadone programmes but said they would not do so again. .

6.2. Access to Treatment and Support for Alcohol Dependency

The problematic drinkers surveyed were less likely to have received support with their dependency than the drug users surveyed although the majority (71 per cent) had done so. Only half (52 per cent) were currently in receipt of treatment or support. Table 6.2 shows that therapeutic interventions were the most common forms of help provided to problematic drinkers, with 38 per cent reporting having received counselling and 24 per cent group therapy. Alcohol users were less likely than drug users to have accessed residential or 24 hour treatment (residential detox/rehabilitation, in-patient treatment).

Table 6.2. Treatment and support received to address alcohol dependency

Assistance received	%
counselling	38
Group therapy	24
Day programmes	19
in-patient treatment	12
residential rehabilitation	12
other structured treatment	12
specialist prescribing	2
other treatment or support	21

n=42

Respondents with alcohol dependencies were generally positive about the support they were receiving, although less so than the drug users surveyed. Two thirds of the problematic drinkers reported that their current treatment/support was helping (one third said it was helping a lot and one third a little). A relatively high proportion had only recently engaged with alcohol support services so 29 per cent reported that it was 'too early to tell' whether this was of benefit. Oddly, 80 per cent reported that the support and treatment they had received previously had been of benefit (35 per cent reported this to have helped a lot and 45 per cent a little), despite still battling with their dependency.

Table 6.3. Treatment and support wanted in the future

Assistance wanted	%
counselling	45
residential rehabilitation	30
specialist prescribing	20
in-patient treatment	15
Group therapy	10
other structured treatment	10
Day programmes	5
other treatment or support	30

n=42

There was some evidence that problematic drinkers may not be accessing the support they feel would be most beneficial. This was particularly true with regard to residential treatment (30 per cent said they would like to enter a residential rehabilitation programme while only 12 per cent had previously done so) and specialist prescribing (20 per cent reported wanting prescribed medication while only one person reported having benefited from this intervention previously). It is also of interest that day programmes had been accessed by 19 per cent of respondents but only 5 per cent expressed an interest in attending such a programme in the future.

The relatively high proportion of respondents who said they would like some 'other' form of treatment or support may reflect the reported benefits to alcohol users of non- specialist services and interventions. A number of the alcohol users interviewed reported that 'keeping busy' was the most effective way of combating their dependency. Access to sport and leisure activities, training courses, education and employment was therefore much wanted in this regard. In contrast to the sample of drug users, many respondents with an alcohol dependency had a history of employment and reported frustration at not working. The financial difficulties associated with working while living in a hostel (the costs were prohibitive

for those not in receipt of benefits) emerged as a particular point of contention. Specialist alcohol support services were highly valued, but a few respondents reported that 'talking about' their dependency only heightened their desire to drink, whilst sport and employment could distract them from it. This was true for Martin:

> *"I've tried 'em [counselling and group therapy] and it just doesn't seem to do anything at all, it's just sitting there saying what I said last week, same as what I said the week before and I feel as if I go in there all right and I come out wanting a drink more than I went in there". (Martin)*

6.3. Meeting Support Needs: Difficulties Accessing Services

We saw in Chapter Two that homeless substance misusers present with a wide range of support needs in addition to problems with drug and alcohol abuse. A history of sex working and offending, mental health issues, coping difficulties, estrangement from family, care histories and literacy difficulties were commonplace. There is no doubt that the support needs of this client groups are high and multiple. Evidence from the survey suggests that substance misusers are experiencing difficulties accessing the help they require. Survey respondents were asked to specify those issues for which they had never received assistance, despite wanting such help or support, and the results are presented in Table 6.2.

The figures suggest that drug users are more likely to face difficulties accessing the help they require than problematic drinkers, although they may also reflect the greater propensity amongst drug users to *need or want* help with particular issues (i.e. their support needs may be higher).

Table 6.2. Unmet Needs: Wanting help but not receiving help with:

Help wanted but not received	All substance misusers (%) n=110	Alc users (%) n=42	Drug users (%) n=79
Finding a home	53	44	57
Drug use	30	19	37
Budgeting	25	16	30
Someone to talk to	23	23	25
Claiming Benefits	23	21	25
Mental health	22	19	24
Seeking employment	20	19	22
Counselling	19	12	22
Alcohol use	15	29	14
Domestic violence	13	10	14

We would expect the figures in Table 6.2 to be relatively low: respondents who had never experienced mental ill health, for example, will never have wanted assistance with this issue and so would not record a positive response to the question. The figures rise somewhat if we look only at those respondents to whom such assistance would be most relevant. For example:

- 44 per cent of substance misusers with mental health issues reported having wanted but not received help with this issue (39 per cent of problematic alcohol users and 47 per cent of drug users)

- 27 per cent of respondents who had experienced domestic violence reported having wanted but not received help wit this issue (25 per cent of alcoholics and 26 per cent of drug users)

- 25 per cent of the problematic drinkers who also used drugs reported having wanted but not received help to address their drug dependency

- 32 per cent of the drug users who also reported a dependency on alcohol said they had wanted but not received help to address this issue

The proportion of problematic drinkers reporting difficulties accessing assistance to address their alcohol dependency (29 per cent) mirrors the proportion reporting having accessed help at some point (71 per cent, discussed above). That more than one third of drug users reported difficulties accessing help to address their dependency is, however, somewhat at odds with the fact that 85 per cent also reported having received assistance (see 6.1. above). An explanation for this apparent disparity emerges from discussions with in-depth interview respondents who expressed frustration that help was rarely available *at the point at which* they required it, with delays and waiting lists commonplace.

It was common for drug users (and to some extent alcohol users but less so) to have 'moments of motivation'; short periods of time when they decide to cease using drugs, and feet very motivated to do so. These 'moments' represented times when the drug users interviews sought help. All too often, however, immediate assistance did not materialise and their motivation waned. A lack of responsiveness to requests for assistance or long waiting lists for treatment and counselling emerged as problematic for substance misusers. Danielle explained that she had to wait three months for a Methadone prescription:

"I asked 'em for it, if they could put us on [methadone], me and me fella went in there and he actually filled in the forms that day but it took three months for me to get scripted...my fella were the same as well...you could lose your motivation to do it for a start" (Danielle)

Jane never did access the drug treatment she asked for. She started taking heroin to cope with the loss of her young son to cot death and was soon working as a prostitute to fund her growing drug dependency. At risk of losing custody of her two young children, Jane was desperate to address her drug problem and stop working as a prostitute. She approached a relevant organisation for assistance but without success. She explains what happened:

Jane**:**	*It was so hard because I wasn't getting any help off, like, the drug places and that so it was hard for me to come off [heroin]*
Interviewer:	*Did you try to get help for drugs? For your drug habit?*
Jane:	*A lot of times….I got in [to the service], I can't remember who it was but he did a questionnaire with me, did that, sat down, spoke, and I never got a reply after that.*
Interviewer:	*Did you go back?*
Jane:	*Yeah, I went back about three times after that, begging them for help.*
Interviewer:	*and they didn't?*
Jane:	*No, nothing at all….they didn't respond.*

Jane's parents were awarded custody of her two daughters and a chaotic period of homelessness, rough sleeping, and continuing drug dependency followed. Jane did eventually access a drug treatment programme during one of the many prison sentences she served for shoplifting but continues to struggle with her dependencies, using heroin occasionally, drinking daily, and working as a prostitute.

Jane's experience highlights a problem relatively common amongst the drug users interviewed; namely that independent efforts to access treatment were often unsuccessful. This mirrors the experiences reported in the previous chapter regarding access to temporary

and settled housing, with respondents encountering far greater difficulties when approaching housing providers independently than when referred by other agencies.

Interestingly, and in contrast to drug users, the problematic alcohol users interviewed had rarely sought help independently, for example by making contact with alcohol treatment or counselling services or requesting assistance from key workers to do so. Most interview respondents had accessed alcohol treatment when prompted to do so or when referred by another agency (rough sleepers' team, hostel worker, probation officer) and in some cases it was made a condition of hostel residency. They were usually very willing to accept help when offered but rarely initiated contact with support services themselves.

Delayed access to urgently needed support was not restricted to drug treatment but evident in relation to other services also. This is reflected in Roy and Alex's accounts of their attempts to access help for mental health issues. Both are problematic alcohol users. Roy lost his young daughter to Leukaemia two and a half years ago and several other close family members died soon after. He has suffered depressed since the death of his daughter and has survived one suicide attempt. The following (abridged) discussion with Roy demonstrates that the assistance offered to substance misusers does not always accord with their own support priorities (Roy's health provider is concerned about his cholesterol while Roy would like treatment for depression). And Alex and Roy both had to wait patiently before they could access much needed mental health intervention:

Interviewer	*Are you going to get any help with your depression?*
Roy	*I'm just waiting for an appointment now with a bereavement counsellor. That could take anything up to 6-8 weeks before I get seen*
Interviewer	*Are you on any medication for your depression?*
Roy	*no, still waiting to see a doctor as well*
Interviewer	*How come you haven't got an appointment [with a GP]?*
Roy	*I've been to see the practice nurse there but she's worried about things like my blood pressure, me cholesterol and other things*
Interviewer	*So is she dealing with those things first?*
Roy	*Yeah, and then hopefully I'll get an appointment see a doctor up there, get me medication, get me depression under control*

"I've got to wait 12 – 14 weeks [for an appointment with a mental health support service]…I went for a brief meeting last Wednesday with 'em and they wanted to know

about my state of mind etc so I was giving them information and they said 'we think you could really make use of the service that we provide but there's a 12-14 week waiting list'" (Alex)

In the absence of easy (or speedy) access to treatment for drug and alcohol dependency there is evidence that some homeless substance misusers (drug users in particular) actively seek convictions and custodial sentences to access the services available through the criminal justice system. The availability of methadone programmes within prisons and through the courts (for example via Drug Treatment and Testing orders) was well known amongst the homeless population and several interview respondents talked about actively exposing themselves to the criminal justice system with the express purpose of accessing drug treatment. One woman, for example explained that she solicited when she knew the police were watching her because *"it was the only way to do it, I knew if I got caught by the police I'd get scripted up"*. Others talked about wanting to go to prison, asking for custodial sentences when convicted, or committing crime in the hope of receiving a custodial sentence because they felt this was the only way they would receive support with their drug dependency.

"And then I ended up getting arrested from shoplifting and I begged 'em to send me to jail for get off heroin and that." (Jane)

However, entering custody could also act as a trigger point for the resumption of or increase in drug use as well as exposure to the risk of homelessness or continued homelessness.

6.4. Conclusion

The substance misusers participating in this study presented with a range of support needs and, although many had accessed effective treatment for addressing drug and alcohol problems, many also encountered difficulties accessing the help they required, at the point at which they needed it.

Recommendations

The evidence presented in this report has provided detailed insight into the housing needs and experiences of substance misusers in Stoke-on-Trent who are homeless or at risk of homelessness. It has highlighted the detrimental housing circumstances in which many substance misusers live and revealed some of the barriers they face accessing housing and support services. These findings point to some important issues worthy of consideration by service providers, commissioners, and policy makers. This research was commissioned with the express aim of identifying ways in which the housing and related needs of substance misusers could be better met. This section presents a series of recommendations for ways in which this could be achieved[2].

Drawing on the evidence gathered and presented in this report, it is possible to identify a series of broad principles which should guide service development. In particular there is a need to:

1. develop models of service delivery capable of providing clear **pathways** through services to independent living, and of **tracking** individuals at risk

2. develop **flexible** supported housing provision, offering a range of accommodation and levels of support within a single service

3. Provide **direct and fast access** housing, support and advice services

4. develop **specialist housing services** which are explicitly targeted at, and understand the needs of drug or alcohol users

5. develop **outreach and in-reach** services in recognition that homeless drug or alcohol users will not always make independent efforts to seek help, or know how to go about doing so

[2] A full set of recommendations for better meeting the needs of homeless people with complex needs can be found in the allied report, '*The Homelessness Journeys of Homeless People with Complex Needs in Stoke-on-Trent'*. Here, only those recommendations of particular relevance to homeless substance misusers are presented.

6. twin the development of specialist services with efforts to **improve access to, and conditions within mainstream housing**
7. acknowledge that **homelessness and related issues such as substance misuse and criminal activity are faced before people reach adulthood** and that services must adapt to address this fact

8. develop a programme of **preventative initiatives,** including building organisational capacity to respond rapidly to emerging indicators of 'risk'

9. acknowledge that **meeting the welfare and support needs of people with complex needs is as important as meeting housing need.**

Specific ways in which services can be developed within these broad principles are presented in the 13 recommendations which follow.

Recommendation 1. The work of the Priority Needs Group should be built on and extended and efforts should be made to ensure that substance misusers are benefiting from it. This could take the form of a multi-agency panel, comprising representation from different services who come together at set intervals to discuss individuals known to be particularly vulnerable and homeless or at risk of homelessness. Current issues pertaining to these individuals could be discussed, emerging needs and problems identified, and appropriate responses actioned. Particular attention could be paid to clients experiencing transition (from care, from custody, from rehab, into independent living, on methadone programmes). Ideally the panel would be co-ordinated by someone whose explicit role it is to do so; would be established as a formal initiative rather than an informal gathering of interested parties; and would be fully multi-agency to span the broad spectrum of needs which substance misusers present with. The benefits of such an intervention include: providing a means through which people can be tracked through housing and other life changes; enabling early intervention to prevent homelessness or rough sleeping; and providing a means through which tailored packages of support can be delivered.

Recommendation 2. 'Fast track' systems into drug and alcohol treatment should be developed, so that substance misusers can access treatment when they are motivated to address their dependency**.**

Recommendation 3. Consideration should be given to ways in which **provision of 'emergency', or direct access temporary accommodation can be increased.** This could be achieved by increasing the number of direct access hostel bed spaces available, or by providing emergency accommodation such as night shelter provision.

Recommendation 4. Consideration should be given to developing **in-reach advice and advocacy services** (housing, benefit, debt, family, health, mental health) in places where substance misusers spend time. This might include the hostels, drug and alcohol support services (Druglink, Adsis) and the Women's Project. Alternatively funding for a part time advice worker post in a relevant support service would achieve similar results.

Recommendation 5. A full **'Direct Access Service'** is likely to be well used in Stoke-on-Trent (incorporating several of the service developments recommended above). This could take the form of a drop-in day centre. Advice and support services (benefits, debt, housing advice as well as health services) could offer 'sessions' there, and consideration could be given to attaching emergency housing provision to such a service.

Recommendation 6. Supported housing provision which offers flexibility and different levels of support should be developed. The level and intensity of the support required by substance misusers shifts over time and they can move rapidly from a position of relative stability to one of chaos and vice versa. Moving between housing providers can also represent a time of 'risk'. The ideal model of supported housing provision (some of which exists already in Stoke-on-Trent) would be one which combined the following features:

- a single provider offering a range of accommodation and levels of support, for example 24 hour staffed (hostel type) accommodation; more independent 'studio flats' attached or near to the core hostel; single (and/or small group) tenancies with intensive floating support; and single tenancies with limited floating support.
- allowing respondents to move around within the service and being able to respond rapidly to changing circumstances - i.e. moving residents from the 'cluster' or single tenancy back to the core.
- a facility for residents to re-contact or remain in contact with the service after they have moved on, acting as a safety net in the event of a change of circumstances and risk of tenancy breakdown in the future.

Consideration would need to be given to the differing needs and lifestyles of drug and alcohol users, and the fact that the two populations do not always co-exist well. The desire of many substance misusers and recovering substance misusers to distance themselves from other users would also require consideration.

Recommendation 7. Update training should be provided to all Local Authority housing staff so they are fully cognisant of the policies and legislation to ensure compliance. Alternatively, a review or audit of Local Authority front-line housing practices could be carried out to ensure all staff are complying with the homelessness legalisation and local policies.

Recommendation 8. Meaningful housing advice and support should be available to people leaving prison. No-one should be released from prison without being offered extensive assistance with their housing and the outcome should be followed up on release. Assistance should also be available on entry to prison so that where possible homelessness can be prevented. A housing link worker or similar post would be beneficial – liaising between prison officials, prisoners, housing and support agencies, and drug and alcohol treatment services to ensure smoother transitions from prison to independent living. A floating support service targeted at people making this transition would also be beneficial.

Recommendation 9. It is essential that existing outreach services such as the Rough Sleepers' team and the Women's Project outreach service continue to receive funding. Assertive outreach is crucial for engaging with drug and alcohol users, particularly those sleeping rough.

Recommendation 10. Steps should be taken to develop services for homeless minors and adolescents such as emergency housing provision and drug and alcohol treatment**.** Such provision currently falls within the remit of 'adult services' but is needed by many young substance misusers.

Recommendation 11. There is a need for greater **support for the carers of young people with drug and alcohol problems,** or those at risk of developing a dependency. A service offering practical and emotional support (and which stand separately to family mediation) to parents and other carers would be beneficial and could help tackle youth homelessness.

Recommendation 12. There is a need to better understand and meet the needs of those with dual diagnosis. No-one should be denied treatment for substance misuse because of mental health issues or vice versa, and the significant relationship between the

two issues needs acknowledging and building into service planning and delivery. Options might include: training for mental health workers to educate them about substance misuse issues and vice versa; funding a dual diagnosis worker to support staff in mental health and substance misuse services; establishing a dual diagnosis working group; and joint planning, strategic development, and commissioning.

Recommendation 13. Efforts should be made to **educate and raise awareness amongst all relevant service providers (including schools) of common trigger points,** risk factors, and indicators of impending homelessness and/or substance misuse. Training, or written information sheets are two ways in which this could be achieved. A programme of activity **educating young people** about homelessness and related issues would also be beneficial. Peer education initiatives are worth exploring in this regard (some peer mentoring already exists in Stoke-on-Trent)