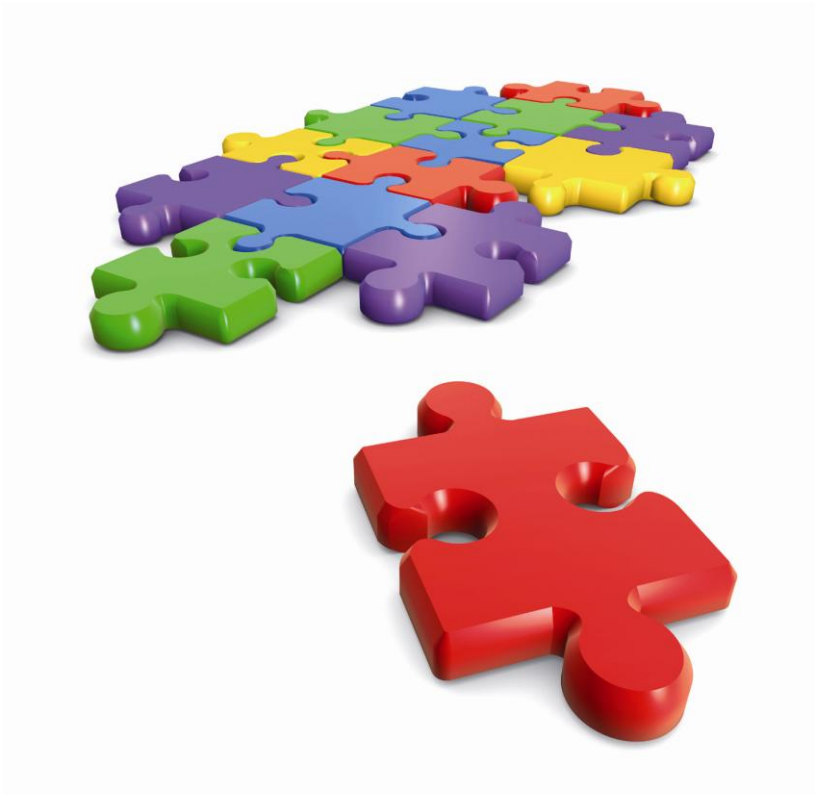
2010

A REVIEW OF THE SUBSTANCE MISUSE NEEDS OF HOMELESS PEOPLE IN EDINBURGH AND HOW WELL THESE NEEDS ARE MET BY EXISTING SERVICES



EVIDENCE INTO PRACTICE

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Executive Summary

Background and Aims

This document presents the findings of the review of the drug and alcohol needs of homeless people conducted across Edinburgh City and reports on the future requirements for services in the area.

The purpose of this study was to review the provision of accommodation available to people with substance misuse problems in Edinburgh with specific focus on the range of options available, current nature and extent of joint working between substance misuse services and housing providers and potential for enhancing the therapeutic value of these within existing resources.

Figure 8 Consultancy Services Ltd. was commissioned by Edinburgh City Council in July 2010 to carry out the study, and field work took place between August and November 2010.

The aims of this project were:

1. To estimate the prevalence of substance misuse problems amongst homeless people (including people rough sleeping, those in forms of temporary accommodation, and those taking up settled accommodation) in Edinburgh;
2. To identify the substance-misuse related needs of homeless people; and
3. To examine to what extent existing substance misuse services work effectively with homeless people and the homelessness/housing services that support them and suggest recommendations to how this can be improved.

Methods

The study was conducted in six stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods including questionnaires, online surveys, one-to-one interviews and focus groups. Sample populations included service users, housing and homelessness service managers and staff and a range of wider stakeholders from health, social care and criminal justice settings.

Recommendations

The recommendations set out below are drawn from the evidence of prevalence, current practice and views of stakeholders with regard to the provision of substance misuse services for people in unstable accommodation in Edinburgh compared to the research and guidance referred to throughout this report. These are presented for the consideration of the EADP and their partner organisations.

1. There needs to be better linkages between services for people with alcohol and drug problems and homelessness services. This could be achieved by:
   - The ADP and Services for Communities should make reference to services for people who are homeless and have substance misuse problems in their respective commissioning strategies
   - Joint training for managers and frontline staff
   - Agreements over joint working arrangements between substance misuse services and homelessness services (e.g. conducting joint assessments, identifying link workers and developing information sharing protocols where required).
   - Piloting the provision of peripatetic substance misuse services in hostels and other settings for homeless people

   (Section 4.2 & 6.4)
2. Alcohol and drug services need to better understand the provision of housing services and how to support clients access these services; as do homelessness services in terms of considering the needs of drug and alcohol users who are making steps towards recovery and ensuring the provision of accommodation which seeks to support these aspirations. Joint training should be considered as well as setting out clear training requirements in Service Level Agreements and Contracts. This needs to include housing support services that are provided to people who live in Bed and Breakfast and other temporary accommodation.

   (Section 2.4)
3. There are a number of protective/risk factors to both homelessness and alcohol and drug misuse including employment status, mental health, family relations. Alcohol and drug services and homeless services need to ensure that these issues are addressed as a part of care plans for their client groups. Consideration should also be given to carrying out an audit to accurately identify the extent to which this is embedded to routine care and identify aspects of good practice.

   (Section 3.3 & 5.2)
4. Commissioners of substance misuse services and homelessness services need to communicate decisions about strategy, investment and current performance clearly to service providers to avoid misperceptions about service provision.

   (Section 6.4)
5. Where these are not clearly in place and followed multi-agency protocols should be developed regarding the safe dispensing and storage of methadone for people in temporary accommodation. This is necessary to ensure a legal

framework to protect those working in the homelessness sector as well as ensuring best practice in line with published clinical guidance.

(Section 5.3)

Section 1: Background and Methods

In March 2010 Figure 8 Consultancy produced a report on needs assessment for drug and alcohol services in Edinburgh City. The report was submitted to the Edinburgh Alcohol and Drugs Partnership on 10th May 2010. During the consultations with service providers, service users and wider stakeholders there appeared to be a growing recognition of the role of housing and homelessness in the recovery journeys of people who were attempting to make lasting positive changes in their lives.

This issue was discussed between the research team and EADP prior to the submission of the needs assessment report and it was decided that consideration would be given to conducting a more focussed piece of work.

This report explores this relationship in more detail and suggests ways in which current resources could be employed more effectively to support homeless people with substance misuse problems.

1.1 Rationale

The Road to Recovery[1] describes a 'clear link' between deprivation and drug misuse. It identifies housing to be part of a joined-up approach to promoting recovery.

There is some evidence to indicate that post-treatment housing can have a significant effect on the potential for lapse and relapse. Progress towards a drug or alcohol free life can be impaired if substance misusers exit treatment and return to '*an environment that promotes crime and drug use*'[2]. A study of group homes in America found that the type of accommodation provided could impact on criminal justice and substance abuse outcomes. Specifically, residents living in larger group homes have greater opportunities for social contact with recovering addicts and were found to have improved criminal justice and substance abuse outcomes compared with their counterparts living in smaller homes.[3] This has been well understood within some treatment programmes in Scotland which facilitate new tenancies and a break from the old life for many substance users exiting treatment.

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[1] Scottish Government (2008) *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, Edinburgh: Scottish Government, http://www.scotland.gov.uk/Publications/2008/05/22161610/0 [accessed 12th May 2010]

[2] Polcin, D, Galloway, GP, Taylor, K and Benowitz-Fredericks (2004) 'Why We Need to Study Sober Living Houses', *Counselor* Vol. 5, pp. 36-45

[3] Jason, LA, Groh, DR, Durocher, M, Alvarez, J, Aase, DM and Ferrari, JR (2008) 'Counteracting "Not In My Backyard": The Positive Effects of Greater Occupancy within Mutual-Help Recovery Homes', *Journal of Community Psychology*, Vol. 36, No. 7(Sep), pp. 947-958

Research into relapse among homeless populations found that there was not a significant difference between the length of time which it took for homeless and non-homeless people to resume their drug use. However, where homeless people were offered a booster to normal treatment their rate of return to substance misuse was lower. These boosters consisted of stabilisation programmes which were 'voluntary, short-term, transitional facilities offering temporary treatment support and residence for 2 to 6 weeks while longer term residential placement options are considered.'[4]

The two-year evaluation of the Lothians and Edinburgh Abstinence Programme (LEAP) highlighted the extent to which patients attending LEAP benefitted from the support provided by the Randolph Crescent hostel as part of the therapeutic milieu.

This report provides a review of the provision of accommodation available to homeless people with substance misuse problems in Edinburgh with specific focus on the range of options available, current nature and extent of joint working between substance misuse services and housing providers and potential for enhancing the therapeutic value of these within existing resources.

1.2 Aims

1. To estimate the prevalence of substance misuse problems amongst homeless people (including people rough sleeping, those in forms of temporary accommodation, and those taking up settled accommodation) in Edinburgh;
2. To identify the substance-misuse related needs of homeless people;
3. To examine to what extent existing substance misuse services work effectively with homeless people and the homelessness/housing services that support them and suggest recommendations to how this can be improved.

1.3 Project Design

This piece of work was conducted in 5 distinct stages. Table 1.1 below summarises the different elements of each phase.

Table 1.1: Summary of Study Methods

[4] Kertesz, SG, Horton, NJ, Friedmann, PD, Saitz, R and Samet, JH (2003) 'Slowing the Revolving Door: Stabilization Programs Reduce Homeless Persons' Substance Use after Detoxification', *Journal of Substance Abuse Treatment*, Vol. 24, No. 3(Apr), pp. 197-207

Stage 1	Method	
Review of existing datasets	Desk-based review of prevalence of substance misuse amongst homeless populations	
Stage 2	**Method**	**Sample**
Quantitative Survey	Online Survey	Managers of all drug and alcohol services and Housing/homelessness services in Edinburgh
Stage 3	**Method**	**Sample**
Quantitative Interviews	Online Survey	All specialist service staff
	Paper-based Survey	Service users
Stage 4	**Method**	**Sample**
Qualitative Survey	Semi-structured interviews	• Stakeholders • Providers
	Focus Groups	• Service users (housing and homelessness services)
Stage 5	**Method**	
Analysis & Reporting	Quantitative and qualitative analysis of data and production of final report.	

1.3.1 Stage 1: Review of existing datasets

The objective of this stage is to seek to establish an overview of prevalence rates of substance misuse within homeless groups in Scotland, UK and abroad. This also includes data provided by City of Edinburgh Council, ISD Scotland and local partners.

The research team sought to review current prevalence research, policy and good practice guidance in the provision of drug and alcohol services to homeless people. This would be achieved by reviewing and analysing nationally available data as well as undertaking a review of international literature.

By doing this, we aim to provide a background and context against which to place the rest of our findings.

1.3.2 Stage 2: Quantitative survey of existing local services

The second stage of the project sought to gain a detailed picture of the way in which services in Edinburgh collect and record information on the demographic

profile of homeless people with substance misuse problems, how they categorise and record their needs and how unmet need is monitored, both individually and collectively. An online survey was created using the Survey Monkey software tool and distributed to the managers of all local services. Data fields, categories and questions about data collection and monitoring processes were agreed with Edinburgh ADP prior to distribution.

1.3.3 Stage 3: Quantitative Survey of views on current service provision

In order to collect views on the range, capacity and quality of current service provision across the city a second brief quantitative survey was created.

An online version of this survey was distributed for completion by all staff and volunteers working in the services identified in Appendix AI.1 It asked them to identify relative strengths and gaps in service provision from their perspective as well as allowing an opportunity to provide comments and suggestions.

In addition, a paper-based version of the survey was targeted at homeless people accessed via housing and homelessness services, inviting them to rate statements regarding their experience of the range and quality of drug and alcohol services, as well as allowing an opportunity to provide comments and suggestions. Pre-paid envelopes were provided to allow people to post their completed forms. As an incentive to participate, people completing the survey were given the opportunity to be entered into a prize draw for a £50 shopping voucher. At the end of the collection period, the boxes were collected by the research team.

1.3.4 Stage 4: Qualitative Interviews

In order to gain a more in-depth insight into the current needs and issues facing homeless drug and alcohol users in Edinburgh, as well as to identify gaps in provision, a series of 19 semi-structured interviews were carried out with key stakeholders. Where possible, interviews were conducted face-to-face, though where practical constraints do not permit this, telephone interviews were undertaken instead.

Interviews were conducted with representatives of the following groups:

- CEC - Access to Homelessness and Support
- CEC - Commissioning Team
- FourSquare
- Bethany Christian Trust
- Crossreach
- Edinburgh Cyrenians
- Move On
- Edinburgh Access Practice
- Streetwork

- Hillcrest/Gowrie
- Orchard and Shipman
- EHAP – CHAI
- The Access Point
- Turning Point Scotland (Midpoint)
- Castle Cliff Hostel
- Dunedin Harbour Service
- Cranston Street Hostel
- Stopover
- Number Twenty
- Shakti Women's Aid

A detailed list of these stakeholder interviews is given in Appendix AI.2.

In addition, a focus group was arranged to further explore the issues raised in the questionnaire responses from service users. Service users were recruited through housing and homelessness services in the first instance. The focus group consisted of 8 participants. These individuals were thanked for their time and assistance with a £10 shopping voucher.

1.3.5 Stage 5: Analysis and reporting

Data from the online and postal questionnaires was entered into statistical software package SPSS v17 for analysis. Interview data was audio recorded and notes taken during and after the interviews. The notes and transcripts from the interviews were entered into QSR NVivo v8 (a qualitative data analysis software package) where they were categorised and coded. NVivo does not carry out the analysis but it does facilitate the key phases and processes associated with carrying out qualitative analysis whilst allowing the researcher to revisit tests and revise where appropriate earlier assumptions.

1.4 Definitions and Concepts

1.4.1 Homelessness

'The definition of homelessness… is that developed by the Homelessness Task Force. This includes people defined in current legislation as homeless persons and persons threatened with homelessness, people sleeping rough and other insecurely or inappropriately accommodated households.'

1.4.2 Substance Misuse

'The definition of substance misuse [was] provided by the Scottish Drugs Forum to determine the range of issues it would examine. This definition was the use of, and/or dependency on, psychoactive drugs that causes demonstrable harm,

either for the individual or society, in terms of negative health, social or economic effects and would usually apply to such use of illegal drugs, prescription drugs or alcohol.[5]

1.4.3 Alcohol Use Disorders

Alcohol use disorders have been classified for the purpose of this study in terms of the World Health Organisation's International Classification of Mental Disorders (10th Revision; 1992). Within this system, Alcohol Use Disorders (AUDs) are classified into three categories: Hazardous Alcohol Use, Harmful Alcohol Use, and Alcohol Dependence. These can be viewed as increasing levels of risk and harm associated with alcohol consumption. Drinkers not meeting the criteria for an AUD have been described variously as 'sensible drinkers' or 'low risk' drinkers.

1.4.4 Specialist Treatment

Specialist treatment is defined in this report as publicly funded treatment interventions for alcohol problems delivered by statutory, non-statutory and independent providers in Scotland. For the purposes of this report, the alcohol dependent group is considered as the group needing specialist treatment.

1.5 Limitations and Assumptions

There are a number of factors which should be taken into account when reading this report. These are:

- The views of stakeholders interviewed are given in good faith and are representative of their organisation;
- The views of service users are drawn from those currently engaged with housing and homeless services. This 'self-selecting' group are likely to be positively disposed towards these services, their staff and the interventions that they provide; and
- The review of prevalence literature reports on a myriad of studies with differing client groups, contexts and outcome measures. The comments made regarding normative rates can therefore only be regarded as indicative.

[5] Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review*. Edinburgh: Scottish Government. Available at: http://www.scotland.gov.uk/Resource/Doc/233172/0063910.pdf [accessed 30th November 2010]

Section 2: Prevalence of Substance Misuse and Homelessness

2.1 Methods

The basic search terms were '*substance misuse*', '*housing'* and '*homelessness'*. A review of the evidence was conducted in each of these areas narrowing the search by English language, last 10 years and published in English language journals.

There were four key steps involved in the literature review phase:

- Preliminary search
- Re-defining of search terms
- Review by citation
- Review by abstract

The preliminary search strategy for the literature review envisaged a three level search as detailed in Table 2.1.

Table 2.1: Systematic literature search strategy

Substance Domain	Link Domain	Theme
Drug Drug misuse Drug abuse Drug dependence Substance misuse Substance* Drug* Heroin Crack cocaine Cocaine Amphetamines Methadone	Housing Homeless*	Prevalence Treatment Intervention

The research team undertook searches of Ovid MEDLINE, All EBM reviews, EMBASE and PsycINFO,[6] with limitations of English only articles written after 2000. Initial searches combined all the terms under the SUBSTANCE domain combined with one or more of the LINK DOMAIN items.

The terms 'drug', 'drugs', 'substance' and 'substances' in the SUBSTANCE domain were removed as the search results were not specific to drug misuse and included papers on therapeutic pharmaceutical drugs. The remaining terms were combined with the LINK DOMAIN terms to further focus the search. This resulted in a more relevant set of references, i.e. relevant to drug misuse and housing, so it was decided to exclude 'drug', 'drugs', 'substance' and 'substances' from all future searches.

In order to further reduce this to a set of core articles the citations to all identified articles were sourced. The citations were reviewed by the research team, based on their relevance to the domains of housing and homeless. Further inclusion/exclusion parameters were applied. Thus, articles which assessed only acute effects of interventions were primarily epidemiological or which had no measures that related to prevalence were excluded.

The abstracts of all remaining articles were reviewed in order to ensure relevance to the subject area. A small number of papers were removed at this stage, predominately because their relevance was tenuous. This was then followed by a review of full articles. This was the final elimination process. This excluded papers which were not appropriate but where the abstract had not provided enough relevant information to make this decision. Using this further filtering process a final set of research articles was established. These articles provide the evidentiary base for the literature review.

2.2 Prevalence from research

Many studies, though very few in Scotland, have attempted to estimate the prevalence of substance misuse amongst the homeless and, conversely homelessness amongst substance misusers.

2.2.1 Drug Use amongst homeless populations

In 2000 Kershaw et al[7] interviewed over 200 homeless people in Glasgow, ¼ showed some form of drug dependence, with 18% dependent on heroin.

Fountain and Howes interviewed 389 homeless people in London. 83% had used drugs in the last month. 84% of those who had used any substance in the last

[6] Using Knowledge Network (formerly known as the NHS E-Library). Available at: http://www.knowledge.scot.nhs.uk/home.aspx [accessed 29th November 2010]

[7] Kershaw A., Singleton N., and Meltzer H, published as ONS (2000) 84, *Substance misuse and mental disorder among homeless people in Glasgow.* Office for National Statistics: London

month were dependent on their main substance. Over a third of the total participants scored as dependent on heroin.[8] Gill et al reported that 37% of those in their study (who were sleeping rough or were hostel dwellers) were using opiates.[9]

Homeless Link's[10] 2009 annual survey of homeless services showed that 42% of clients in an average homelessness project have drug problems. In their 2010 survey 92% of services reported that at least some of their clients were affected by drug problems and 16% of services reported that over three quarters of their clients were affected by drug problems.[11]

A number of studies in England have looked specifically at these issues in relation to young people. A Home Office study in 2003 on Youth Homelessness and Substance Misuse[12] reported that, from a sample of 160 homeless under 25s, 95% had used drugs and 75% continued to do so. 17% were identified as problem drug users. In 2010 Liverpool John Moores University's study found that 83.3% of the 55 participants indicated they had tried an illicit drug (most commonly cannabis, then cocaine and ecstasy),[13] a higher prevalence of drug use than in the general population.[14]

O'Gorman[15] reviewed research in Ireland up to 2002. The author reported on studies by Feeney (2000) where a quarter of the sample had a drug problem and Smith (2001) where 45% of sample (who were all women) were classed as dependent on drugs (all on opiates).

In Northern Ireland Deloitte MCS conducted interviews with 154 homeless people. The results from those interviews were compared with a survey of the general population that had been carried out one year previously. The homeless sample had higher levels of lifetime, recent and current drug use and lifetime alcohol use.[16] All 61 participants who had used drugs in the last 12 months and completed the questions received a score which indicated a drug abuse problem.[17]

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[8] Fountain J., and Howes S. (2002) *Home and dry? Homelessness and substance use in London.* Crisis: London, pp. 6-8

[9] Pleace, op. cit., p. 12

[10] Homeless Link (2009) *Policy Briefing: Drugs and Alcohol.* Homeless Link: London

[11] Schertler E (2010) *Survey of Needs and Provision 2010.* Homeless Link: London, Table 19, p. 36

[12] Wincup E., Buckland G., and Bayliss R. (2003) *Youth Homelessness and substance use: report to the drugs and alcohol research unit.* Home Office: London

[13] Liverpool John Moores University (2010) *Patterns of Substance Use & Support Needs of Residents in Young People's Hostels & Foyer Accomodation in Liverpool*. Liverpool John Moores University: Liverpool, p. 31

[14] When compared to British Crime Survey, 2009, p. 67

[15] O'Gorman A (2002) *Overview of research on Drug Misuse among the Homeless in Ireland,* Paper presented at conference on 'Homelessness and Problem Drug Use', 18th July 2002, Merchant's Quay, Ireland, pp. 4 and 8

[16] Deloitte MCS Ltd (2004) *Research into Homelessness and Substance Misuse* Department of Health, Social Services and Public Safety: Belfast, p. 44

[17] ibid., p. 52

In 2005 the Irish National Advisory Committee on drugs commissioned a study into drug use among homeless people in which 355 homeless people participated. That study found that 36% were problematic drug users.[18]

Grinman et al's[19] 2010 study in Toronto of 1191 homeless people found current drug problems present in 40% of participants. Prevalence of drug use was reported as being very high compared to that of the general population.

The table below sets out the findings from the main studies described. These studies do not lend themselves to a meta-analysis as they have used different measures and also differed in methodology and context. However, for the purposes of comparing the Edinburgh population with more universal measures it would be reasonable to expect that, from the figures presented here, a prevalence rate of approximately 40% drug dependence within homeless populations would be within normal parameters.

Table 2.2: Summary of prevalence of drug use amongst homeless populations

Author	Year	Sample Size	Rate	Measure
Kershaw	2000	200	25%	Drug dependence
Fountain	2002	389	84%	Drug dependence
Homeless Link	2009		42%	Drug problem
Wincup	2003	160	17%	Problem drug use
Lawless	2005	355	36%	Problem drug use
Grinman	2010	1191	40%	Problem drug use

2.2.2 Homelessness amongst drug users

Kemp et al analysed the data collected as part of the DORIS study in Scotland. The study involved conducting two interviews with 878 drug users around 8 months apart. Participants all had a primary dependence on an illicit drug. 24% were homeless at 1st interview, 12% became homeless between 1st and 2nd interview, while 14% found a home in that period, therefore overall 36% were homeless at some point during the study.[20] This movement suggests that

[18] Lawless M., and Corr C (2005) *Drug Use Among the Homeless Population in Ireland.* National Advisory Committee on Drugs: Dublin, p. 17

[19] Grinman M., Chiu S., Redelmeier DA., Levinson W., Kiss A., Tolomiczenko G., Cowan L., and Hwang SW (2010) Drug Problems among homeless individuals in Toronto, Canada: prevalence, drugs of choice, and relation to health status. *BMC Public Health,* Vol. 10, p. 94

[20] Kemp PA., Neale J. and Robertson M., (2006) Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health and Social Care in the Community.* 14(4): 319-328, p. 322

homelessness amongst problem drug users is a dynamic, rather than a static, state. The prevalence of homelessness amongst the general population in Scotland is much lower than amongst problem drug users, 5% compared to 36%.[21]

In 2008/09 National Treatment Agency in England reported on figures for new drug treatment journeys. For those who answered the question on accommodation status (89%) 10% reported an urgent housing problem (no fixed abode) and 16% reported a housing problem (which covers staying with friends or in a hostel etc). The figures also show that newly presenting problem drug users were much more likely than new clients who were non-problem drug users to have no fixed abode (11% compared to 4%) or any other housing problem (18% compared to 13%).[22]

Homeless Link quotes research stating that one in ten drug users starting treatment has no address and up to a third have a housing need of some kind.[23]

In Ireland Corr[24] found, when evaluated a drug outreach programme, that 75% of those in contact with the programme were homeless at some point. Another study in Ireland carried out with regular needle exchange users, 93% had experienced homelessness at some point and 63% reported being homeless at the time of the interview.[25]

[21] ibid., p. 326

[22] Department of Health & National Treatment Agency (2010), *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2008 to 31 March 2009* (Revised February 17 2010) at 4.7 - The NTA did not give a definition for non-problem drug user within the report

[23] Homeless Link, op. cit.

[24] Corr C (2002) *Reaching the 'Hard to Reach'.* Paper presented at Conference on 'Problem Drug Use and Homelessness: Two Faces of Social Exclusion', Dublin Castle, 18th July 2002, p. 6

[25] Cox G. and Lawless M. (1999) *Wherever I lay my hat.. A study of out of home drug users.* Dublin: Merchant's Quay Project, para. 4.4

Table 2.3: Summary of prevalence of homelessness amongst drug using populations

Author	Year	Sample Size	Rate	Measure
Kemp	2006	878	24%	Homeless at first interview
			12%	Homeless at second interview (8 months)
NTA	2010	74,877	10%	Urgent housing problem
			16%	A housing problem (e.g. staying with friends or residing at a short-term hostel)
Homeless Link	2009		10%	No address
Corr	2002	262	75%	Homeless at some point during a calendar year
Cox and Lawless	1999	190	93%	Homeless (defined as hostel, B&B, squat, with friends and relatives and/or sleeping rough) at some point
			63%	Homeless at time of interview

The studies by Kemp, NTA and Homeless Link measured homelessness at a point in time whereas the Corr study and that of Cox and Lawless measured homelessness at some *'Point in Time'* in the year. From these studies, again given the wide variations in context, methods and sample size, it would be reasonable to assume that around 15% of drug users in Edinburgh may be homeless at any one time.

2.2.3 Alcohol misuse amongst homeless populations

In Kershaw et al 54% of the sample of homeless people in Glasgow reported hazardous drinking.[26]

The Department of Health in England's alcohol strategy in 2007 estimated that half of homeless people are dependent on alcohol.[27]

[26] Kershaw et al., op. cit.

In Fountain and Howes' London study 68% of homeless people had used alcohol and over a quarter of the total participants scored as dependent on alcohol.[28] 36% of the participants in the study conducted by Gill et al were alcohol dependent.[29] Homeless Link's[30] 2009 survey indicated that 39% of clients in an average homelessness project have alcohol support needs and in their 2010 survey 92% of services reported that at least some of their clients were affected by alcohol problems. 12% of services reported that over three quarters of their clients were affected by alcohol problems.[31]

In the study conducted at Liverpool John Moores University[32] in 2010, 70.9% of the 55 young people who participated indicated they drank alcohol.

Irish studies include Feeney (2000) in which half of the sample was alcohol dependent.[33] The Deloitte MCS report found that of 106 interviewees who said they drank alcohol, 70 were classed as hazardous or harmful drinkers with possible alcohol dependency.[34] They noted that levels were high when compared with the general population (70% showed indication of possible alcohol problems compared to 7%).[35] The Irish NACD study found that 51% of participants were problematic drinkers.[36]

[27] Department of Health (2007) *Safe. Sensible. Social. The next steps in the alcohol strategy*. Dept of Health: London. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085386

[28] Fountain and Howes, op. cit., p. 8

[29] Pleace, op. cit., p. 12

[30] Homeless Link, op. cit.

[31] Schertler, op. cit., Table 19, p. 36

[32] Liverpool John Moores University, op. cit., p. 4

[33] O'Gorman, op. cit., pp. 4-5

[34] Deloitte MCS Ltd., op. cit., p. 50

[35] ibid, p. 51

[36] Lawless and Corr, op. cit.

Table 2.4: Summary of prevalence of drug use amongst homeless populations

Author	Year	Sample Size	Rate	Measure
Kershaw	2000	200	54%	Hazardous drinking
Dept of Health UK	2007		50%	Alcohol dependence
Fountain	2002	389	25%	Alcohol dependence
Gill	2008		36%	Alcohol dependence
Homeless Link	2009		39%	Alcohol support needs
Liverpool John Moore Univesity	2010	55	71%	Drank alcohol
Feeney	2000	171	50%	Alcohol dependence
Deloitte MCS	2004	106	70%	Showed alcohol problems
NACD (Ireland)	2005	355	51%	Problematic drinkers

Measurements of alcohol dependence in the above studies vary between 25-50% in studies conducted in UK and Ireland. Studies measuring hazardous drinking and alcohol problems demonstrated higher rates of between 54-71%. For the purposes of comparison with rates of alcohol dependence amongst homeless people in Edinburgh, the Gill study provides a reasonable mid-range estimate (36%).

2.2.4 Homelessness amongst alcohol misusers

Figures are also collected in England by the NTA for new alcohol treatment journeys. In 2008/09 of those who answered the question on accommodation status (82%) 4% reported an urgent housing problem and 11% reported a housing problem.[37]

2.2.5 Age

The NACD study showed that homeless problematic drug users were significantly more likely to be younger.[38] Approximately half of the 18-34 age group in one Irish study were dependent drug users, compared to 24% of the overall

[37] Department of Health & National Treatment Agency (2010) *Statistics from the National Alcohol Treatment Monitoring System (NATMS) 1st April 2008 – 31st March 2009* at para. 4.4

[38] Lawless and Corr, op. cit.

sample.[39] In the Kershaw Glasgow study drug use was most widespread in the 25-34 year old group, 70% of them showed some drug dependence compared to none of the participants aged 55 or over. Conversely, alcohol use was particularly widespread in those aged 55 and over, 63% of them reported hazardous drinking compared to just over 40% of the 25-34 age group.[40] While not strictly showing that the homeless people in question are older Fountain & Howes found that alcohol use was more common in those homeless for more than 10 years.[41] However, in a study conducted by Condon the sample was predominantly older and male but still a high prevalence of illicit drug use was found.[42]

In relation to housing the NTA alcohol treatment figures show that newly presenting clients aged under 30 (20%) were more than twice as likely as those over 50 (9%) to have a housing problem, with 16% of clients aged between 30 and 50 reporting a problem.[43]

2.2.6 Gender

Some of the research studies suggest that male homeless people are more likely to have a dependency problem. In Scotland men are more likely to show a hazardous pattern of drinking than women – 60 per cent compared with 16 per cent of women.[44] Also in Ireland evidence is of a higher rate of problematic alcohol use in males than females (76% to 63%).[45] In the Northern Irish report of the 70 participants showing hazardous or harmful drinking with possible dependency, 69% were male, 31% were female.[46] Males also showed a higher level of drug abuse problems than females.[47]

In terms of housing of the 2,378 people presenting to alcohol treatment in England with an urgent housing problem, 81% (1,929) were men. Men were much more likely to have a housing problem, either urgent or not, than women (18% compared to 11%).[48]

[39] O'Gorman, op. cit., p. 5

[40] Kershaw et al., op. cit.

[41] Fountain and Howes, op. cit., p. 9

[42] O'Gorman, op. cit., p. 7

[43] Department of Health & National Treatment Agency, op. cit.

[44] Kershaw et al., op. cit.

[45] Lawless and Corr, op. cit.

[46] Deloitte MCS Ltd., op. cit., p. 47

[47] ibid., p. 52

[48] Department of Health & National Treatment Agency, op. cit.

2.2.7 Single homeless

The literature also suggests that the focus of drug use within the homeless population is in the single or lone homeless sub-populations, i.e. those not living with a family.[49] In a 2008 study in England, 11% of adults in homeless families self-reported a history of substance misuse compared to 37% of lone young homeless people. Homeless Link quote an estimate of 80% prevalence of problematic substance use in single people living in hostels[50] significantly higher than other prevalence rates found amongst homeless population. In comparison to a study by Grinman the percentage who had current drug problems was 53% amongst those who were single homeless men compared to 12% for those who were accompanied by dependent children.

2.2.8 Increased risky behaviours

Another feature found amongst homeless drug users was high levels of risky behaviour. Fountain & Howes found that polydrug use was common amongst their sample[51] and four out of five participants said they had started a new drug since becoming homeless.[52] Homeless drug users also exhibit increased levels of life-threatening behaviour, such as suicide attempts.[53]

Seventy-seven percent of those who were current users in the Irish NACD sample reported changes in their drug use patterns, such as change in route of administration or increased frequency/quantity, since becoming homeless[54] and 69% reported that their injecting behaviours had changed as a result of homelessness.[55] 53% of the current injectors reported sharing injecting equipment in previous 4 weeks.[56] By comparison 10% of new clients at drug services in Scotland in 2008-09 had shared needles/syringes within the past month.[57] The Northern Irish sample showed fairly low levels of injection (11%),[58]

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[49] Pawson H., Netto G., Jones C., Wager F., Fancy C., and Lomax D. (2007) *Evaluating Homelessness Prevention.* Department of Communities and Local Government: London, Annex 3 and Pleace, op. cit., para 2.39

[50] Homeless Link, op. cit.

[51] Fountain and Howes, op. cit., p. 7

[52] ibid., p. 9

[53] Kemp et al., op. cit., p. 320

[54] Lawless and Corr, op. cit.

[55] ibid., page 18

[56] ibid.

[57] NHS National Services Scotland (2010) *Drug Misuse Statistics Scotland 2009*, Table B1.27

[58] Lawless and Corr, op. cit., which the authors attributed to low prevalence of lifetime heroin use amongst their sample (9.7%)

but over 35% responded that they had been involved in suicidal behaviour, unsafe sex and criminal behaviour due to their substance abuse.[59]

However, findings from the recent youth homelessness and substance misuse study suggest that participants were disinterested in heroin and crack and none reported injecting.[60]

2.2.9 Risk Factors

There is a wealth of evidence linking the occurrence of drug use and homelessness. Substance misuse is recognised as a risk factor for homelessness occurring[61] and for its prolongment.[62] Homelessness can also be a key factor in substance misuse either by triggering it, exacerbating an existing problem[63] or making it more difficult for the user to stabilise and seek treatment.[64] Chronic homelessness and poor housing have been associated with greater alcohol use and with injecting drug use.[65]

However, the relationship is far more complex than simply each being a trigger for the other. Many homeless people do not misuse drugs.[66] The two behaviours share similar risk factors, such as disrupted families, physical and sexual abuse, low school grades and bad attendance, crime and health problems.[67] Homeless substance misusers are frequently also characterised by mental health problems.[68] It is often a combination of these factors being present that can result in the nature and level of homelessness and substance misuse problems that the person encounters.[69]

[59] Deloitte MCS Ltd., op. cit., p. 57

[60] Liverpool John Moores University, op. cit., p. 69

[61] In Wincup et al., op. cit., 21% gave it as a factor; Fountain and Howes, op. cit., ½ said drug use contributed to their first episode of homelessness and the authors found a strong correlation between increased DU and a worsening housing situation, also a correlation with increase in alcohol use and a worsening housing situation

[62] Grinman et al., op. cit.; Fountain and Howes, op. cit., p. 9

[63] Neale J., and Kennedy C., (2002) Good practice towards homeless drug users: research evidence from Scotland. *Health and Social Care in the Community,* Vol. 10, No. 3, pp. 196-205

[64] Drugscope (2002) D*rug services for homeless people*. Office of the Deputy Prime Minister: London, p. 15

[65] Stein JA., Dixon EL., and Nymanthi AM. (2008) Effects of Pyschosocial and Situational Variables on Substance Abuse Among Homeless Adults, Vol. 22, No. 3, pp. 410-416

[66] Pleace, op. cit., para. 2.18

[67] Kemp et al., op. cit., p. 320

[68] Pleace, op. cit., para. 2.14

[69] Drugscope, op. cit., para. 2.11

2.3 Prevalence in Edinburgh

This section seeks to establish the number of people living in unstable accommodation in Edinburgh City who are dependent on alcohol and/or drugs. This mapping of the population will help to contextualise the findings from the evidence collected and provide a guideline for future service planning and delivery.

In order to do this, there are three questions to be considered:

- How many people are living in unstable accommodation in Edinburgh?
- How many people are dependent on alcohol and/or drugs in Edinburgh?
- What are the overlaps between these two populations?

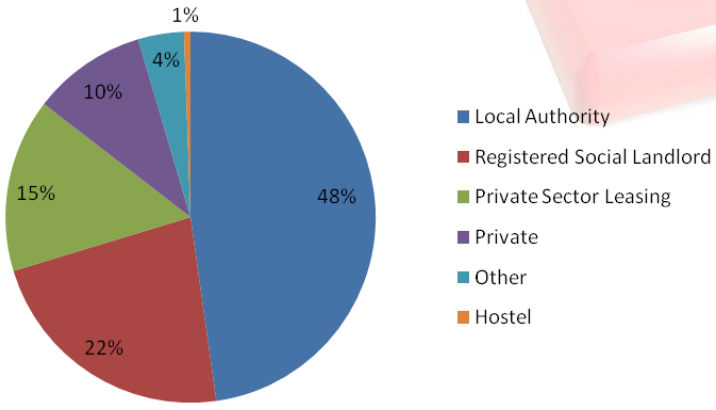
The information sources from which the following data are drawn were Edinburgh City Council Homeless Information System (HIS), Edinburgh Common Client Outcomes monitoring system (ECCO) and the online questionnaires completed by the managers of housing and homelessness services.

2.3.1 How many people are living in unstable accommodation in Edinburgh?

Data from the HIS confirms that there are almost 5000 homeless presentations to Edinburgh City Council each year.[70] Of these, 97% are assessed as homeless, 78% assessed as priority need. Last year 2501 people were accommodated in temporary accommodation, 1579 (63.1%) of these were accommodated in B&B's first. Two thirds of those who were homeless were male (65%).

Of the 3794 Priority Need Cases, 2617 (70.5%) of the cases were closed as the individual had been housed. Figure 2.1 displays the distribution of tenancy housed by type.

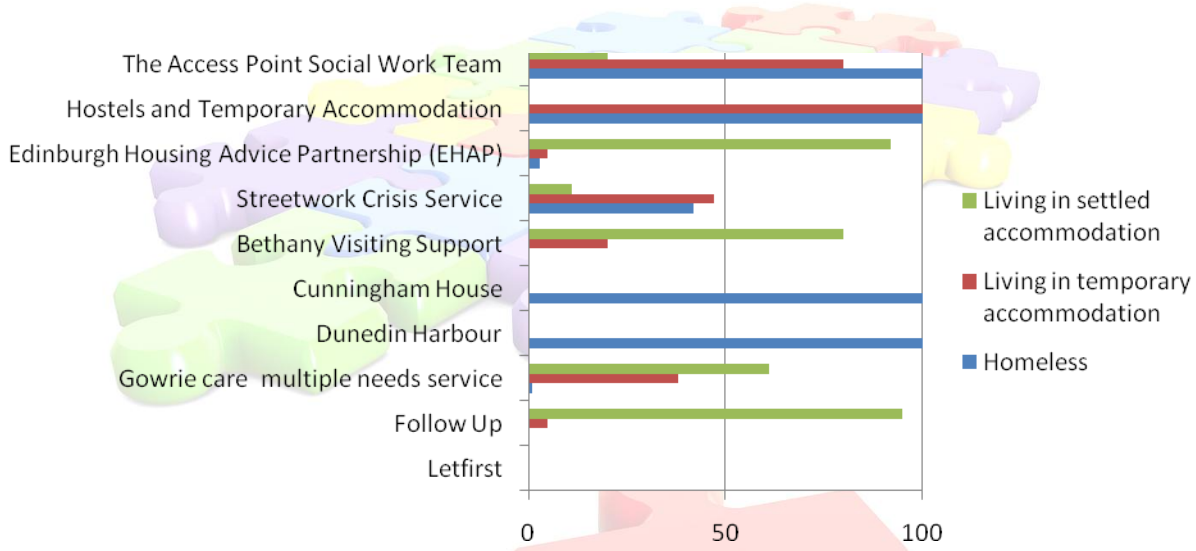
Figure 2.1 Tenancy Housed by Type



[70] 4881 (2008/09) and 4779 (2009/10)

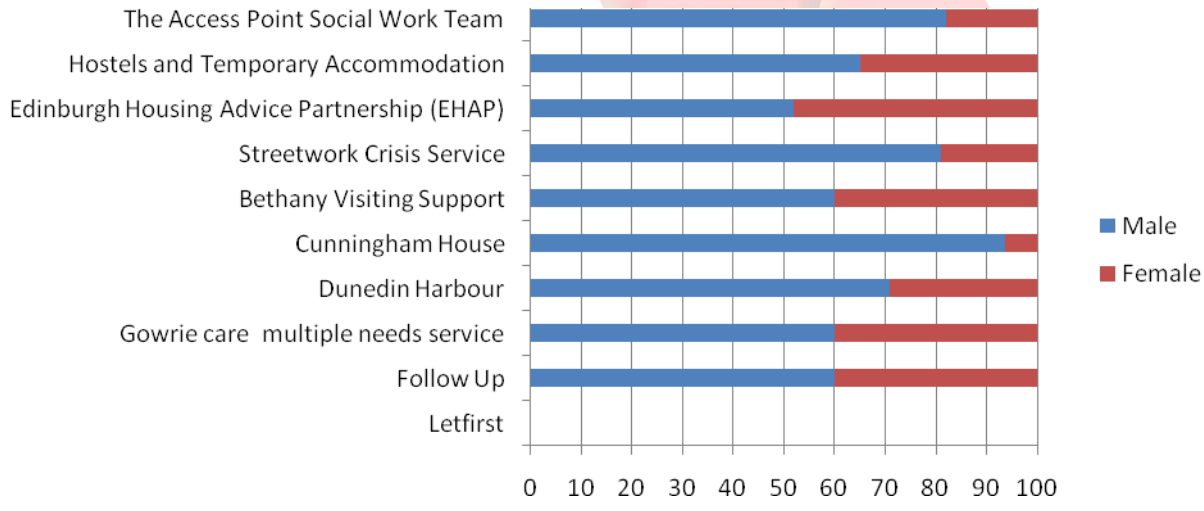
The survey of housing and homelessness service providers revealed that there is a balanced provision of support with some services aimed exclusively at people who are homeless (Cunningham House, Dunedin Harbour), with other providing service to people in temporary or unstable accommodation and others primarily focussed on providing support to people who have secured settled accommodation (Edinburgh Housing Advice, Bethany Visiting Support and Follow Up).

Figure 2.2: Percentage of clients who are homeless, in temporary or settled accommodation



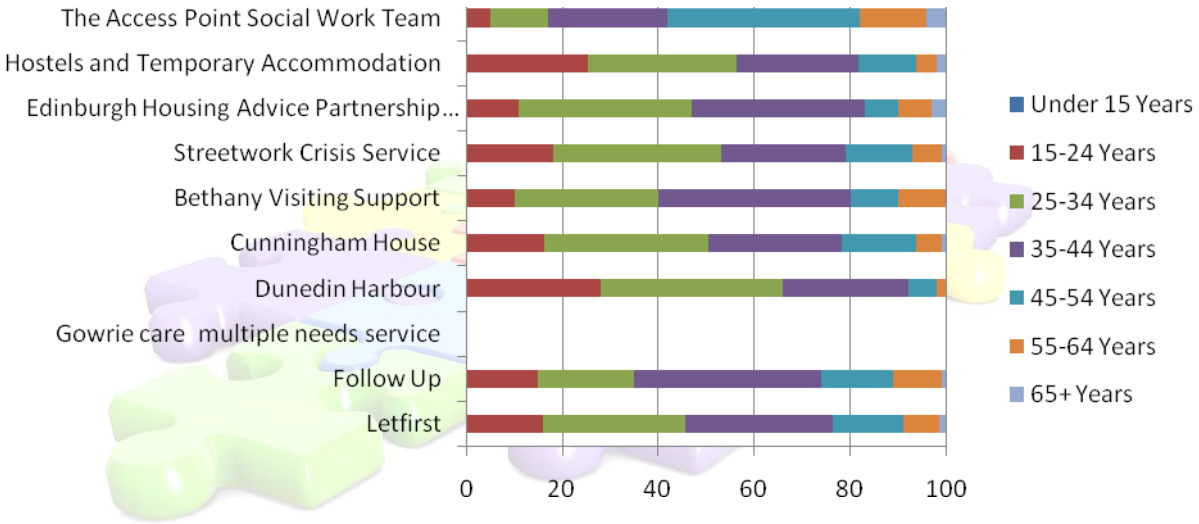
The mean gender distribution across all services that responded was 69% male, ranging between 52% (EHAP) and 93% (Cunningham House).

Figure 2.3: Gender distribution (%) by service



No service stated that they provide support for people under the age of 15. Almost half (46%) of service users were under the age of 35 years and almost a quarter (23%) over 45 years. Individual age profiles of each service are set out below.

Figure 2.4: Age profiles (%) of service users by service



2.3.2 How many people are dependent on alcohol and/or drugs in Edinburgh?

There are approximately 477,660 people living in Edinburgh City.[71] The prevalence of problem drug use amongst people aged 15-64 years is estimated to be 1.6% (1.50-1.75, 95% CI)[72]. In the Edinburgh Alcohol and Drugs Needs Assessment this was calculated as 5202 people of whom 1644 (34.4%) were accessing treatment. This primarily relates to opiate and benzodiazepine use and does not include stimulant users.

Similarly, the prevalence of alcohol dependence in Edinburgh is estimated to be 5% (4.6-5.4, 95% CI)[73] of the population aged 16 years and above. This equates to 20280 alcohol dependent people in Edinburgh of whom 1267 (6.2%) are accessing treatment.[74]

[71] General Register Office for Scotland. (2010) *Mid-2009 Population Estimates for Scotland*, p. 20

[72] Hay G., Gannon M., Casey, J. and McKeganey N. (2009) *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland*: Scottish Government

[73] Drummond C, Deluca P, Oyefeso A, Rome A, Scrafton S, Rice P. (2009) *Scottish Alcohol Needs Assessment*. Institute of Psychiatry, King"s College London: London

[74] Needs Assessment of drug and alcohol problems in Edinburgh city (Figure 8 Consultancy, 2010)

2.3.3 What are the overlaps between these two populations?

The rate of homeless presentations to Edinburgh City Council with drug or alcohol support needs has been constant over the last two years at 12.6%. That is, in 2009/10 there were 604 homeless presentations with drug or alcohol support needs.

Aggregated data from the ECCO system confirms that of the 7824 clients worked with last year, 2458 (31.4%) were homeless. One thousand and eighty nine (44.3%) of these were identified as having a substance misuse problem; 623 (25.3%) had an alcohol problem and 703 (28.6%) had a drug problem. Overall, 425 (39%) reported reductions in their alcohol or drug use. Of the 86 people referred for detoxification or rehabilitation 48 (56%) were able to access these services.

In 2008/09, 1,419 "new" individuals (256 per 100,000 population) were reported to the Scottish Drugs Misuse Database (SDMD) from Edinburgh.[75] Of those who answered the question (1290) 19% reported themselves as being homeless (this includes temporary/unstable accommodation, hostels and roofless).[76] This was up from 17% who reported themselves as being homeless in 2007/08.[77] The SDMD is likely to underestimate homelessness among PDU as it doesn't include those whose homelessness may be concealed, e.g. because they live with friends.[78]

The survey of housing and homelessness service providers estimated that 66% of service users had either drug problems (28%) or alcohol problems (38%). Of these it was thought that about a quarter (23%) had problems with both drugs and alcohol. The individual estimates of each service are set out in Figure X below.

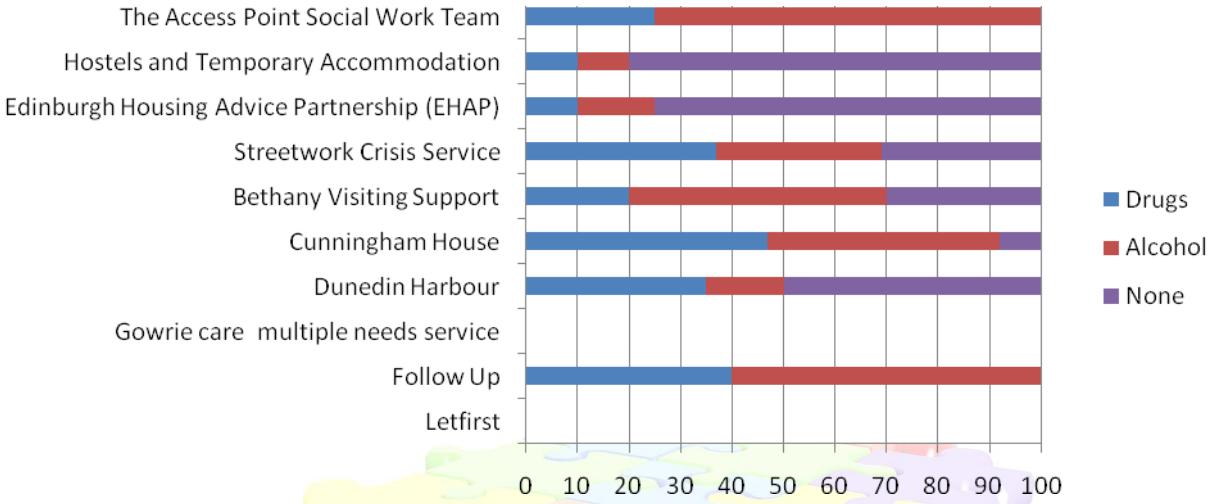
Figure 2.5: Estimates of proportions (%) of clients with drug or alcohol problems by service

[75] NHS National Services Scotland, Table B1.1

[76] ibid., Table B1.41

[77] NHS Scotland National Services National Statistics (2009) *Drug Misuse Statistics Scotland 2008*, Table A1.1 and A1.41

[78] Kemp et al., op. cit.



2.4 Key findings

- Data from housing and homeless providers and ECCO suggest that about 28% of homeless people in Edinburgh have a drug problem. This is lower than the 40% rate identified through a number of studies but similar to the 25% rate found in the Glasgow study conducted by Kershaw.
- Data from housing and homeless providers and ECCO suggest that between 25% and 38% of homeless people in Edinburgh have an alcohol problem. This is in line with the 36% rate identified in the Gill study and within the 25-51% range of alcohol dependence and problematic drinkers identified through a number of UK studies.
- 19% of 'new individuals' in Edinburgh reported to the Scottish Drug Misuse Database described themselves as being homeless. This indicator is in line with the 'Point in Time' indicators of around 15%.
- Limited data exists nationally and locally about the percentage of alcohol dependent people who have problems with housing and homelessness. In 2008/09 the NTA reported that 11% of 'new individuals' had housing problems.
- The age and gender distributions amongst homeless populations in Edinburgh are similar to those identified in the literature and these are fairly reflected in the profiles of housing and homeless service provision across the city.

Section 3: Policy and Practice

3.1 Policy in Scotland

This section identifies and explores the main policy publications in relation to substance misuse and homelessness in Scotland and UK.

3.1.1 Homelessness

The main policy intersection between drug misuse and homelessness policy is through the statutory responsibility on local authorities to prevent and alleviate homelessness, on which local authorities are required to have a strategy.[79] Since 1997 the UK Government has been increasingly encouraging local authorities to take a more pro-active approach to tackling homelessness.[80] This policy pre-dates devolution so is the origin of the current Scottish approach. The key messages of the most recent guidance on preventing homelessness jointly produced by the Scottish Government and the Convention of Scottish Local Authorities (COSLA)[81] recognise that prevention does not happen in isolation and that a holistic approach to meet the needs of each person is required[82] and that it should focus on sustainable housing outcomes based on person-centred assessment and planning measures.[83] The guidance recognises substance misuse as an indicator of homelessness risk.[84]

In 2005 the Scottish Executive published Health and Homelessness Standards for Scottish NHS Health Boards.[85] They require NHS Health Boards at strategic level to improve NHS health services for the homeless,[86] some of which impacts on substance misuse. They are required to work with relevant agencies to prevent and alleviate homelessness and improve the health of homeless people[87] which includes drug and alcohol services. The standards also demand that access to health care is equitable in that being drug or alcohol free must not be a pre-requisite to accessing health services.[88]

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[79] Scottish Government and Convention of Scottish Local Authorities (2009) *Statutory Guidance for local authorities on preventing Homelessness*, found at: http://www.scotland.gov.uk/Publications/2009/06/08140713/0 (last accessed 6/8/10)

[80] Pawson et al., op. cit., p. 7

[81] Scottish Government and Convention of Scottish Local Authorities, op. cit.

[82] ibid., p. 4

[83] ibid., p. 5

[84] ibid., p. 13

[85] Scottish Executive (2005) *Health and Homelessness Standards* Scottish Executive: Edinburgh

[86] ibid., p. 5

[87] ibid., Standard 2, pa. 20

[88] ibid., Standard 4.3, p. 22

3.1.2 Drugs

In its 2008 drugs strategy Road to Recovery[89] the Scottish Government identifies tackling and preventing homelessness as a key area that has a bearing on whether people become problem drug users.[90] The strategy states that recovery is most effective when the service user's needs and aspirations are placed at the centre of their care and treatment[91] and for homeless people stable housing is a big part of those needs. The strategy sets out a number of principles for the delivery of treatment services. It states that treatment services must integrate effectively within a wider range of generic services to fully address the person's needs, not just treat their addiction.[92]

Essential Care[93] a report produced in the lead up to Road to Recovery set out factors to take into account when providing services to homeless substance misusers. These are:

- listen, treat them with respect, offer care not just treatment;
- diversity within homeless population;
- integration of homeless within mainstream; and,
- services to act as gateway which provides access to and information on other services.

The Scottish Government, on recommendation from the Homelessness & Substance Misuse Advisory Group, commissioned an international literature review on effective services for substance misuse and homelessness in Scotland which was published in 2008.[94]

3.1.3 UK Policy

The current policy situation of the UK is uncertain due to the change of government in May 2010. The content of policies in both the Home Office (drugs) and Department of Communities (housing) are currently under review. A drugs strategy consultation was issued by the UK government on 20th August 2010, with the drugs strategy proper to be published by end of the year. No specific details have yet emerged as to how it will operate but one of the strategy's stated aims is a more holistic approach with drugs issues being assessed and

[89] Scottish Government, op. cit.

[90] ibid., p. 14, para. 49

[91] ibid., p. 23, para. 81

[92] ibid., p. 24, para. 85

[93] Scottish Advisory Committee on Drugs Misuse Integrated Care Working Group (2008) *Essential Care: a report on the approach required to maximise opportunity for recovery from problem substance use in Scotland*

[94] Pleace, op. cit.

tackled alongside other issues such as alcohol abuse, child protection, mental health, employment and housing.[95]

Up to now the UK policy has been fairly similar to that outlined for Scotland above, except the UK government has provided more detail on the interaction between homelessness and drug misuse.

In 2002 the Office of the Deputy Prime Minister published a good practice guide for providing drug services to homeless people.[96] It set out local authorities' statutory duty to prevent homelessness, for which they must have a strategy.[97] The guidance sets out as the starting point the creation of joint strategies for dealing with homeless drug users which are integrated with drug and homeless service strategies, along with inter-agency working.[98] The guidance also prescribes that local areas should have provision for homeless within both mainstream drug services and specialist services. Access to mainstream services and co-ordinated care planning were highlighted as particular problems.[99] The guidance also stresses that it is essential for DATs in England to plan suitable accommodation for this group based on assessment of individual needs.[100]

Further guidance 'Housing Support Options for People who Misuse Substances' was published in 2005.[101] It focused on similar issues as the 2002 guidance, acknowledging that substance misusers are a vulnerable group and that their housing needs must be addressed as part of a package of interventions. It guides services to work together to remove barriers to tenancies that problem drug users face and, once they find accommodation, help them sustain it by providing housing support.[102]

The Department of Communities commissioned an evaluation of local authorities homelessness prevention in 2007. This identified key factors for sustained tenancy; flexible and client centred provision, close liaison between key agencies and timely intervention, commitment and staff experience.[103]

In 2009[104] a Home Office guide noted that there was no common structure that brings homeless and drug and alcohol services together at local level. It also

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[95] Home office (2010) *2010 Drug strategy consultation paper*, found at: http://www.homeoffice.gov.uk/publications/consultations/cons-drug-strategy-2010/drugs-consultation?view=Binary , p. 2

[96] Drugscope, op. cit.

[97] ibid., p. 10

[98] ibid., p. 20

[99] ibid., chapter 4

[100] ibid., chapter 5

[101] Office of the Deputy Prime Minister and Home Office (2005) *Housing Support Options for People who Misuse Substances*

[102] ibid., p. 7

[103] Pawson et al., op. cit., p. 14

[104] Home Office (2009) *'A Guide to Improving practice in housing for drug users'.* Home Office: London

discussed the spectrum of needs; this is the idea that the homeless and drug service needs of the homeless drug user change over time, independently of one another, requiring services to be responsive and flexible.[105]

3.2 Barriers

The link between substance misuse and homelessness is crucial to providing appropriate support. As the ODPM put it, 'people without accommodation are unlikely to be offered treatment, and those leaving treatment without suitable accommodation and support are very likely to relapse'.[106] 40% of drug users in one study reported that lack of stable housing was the main barrier to them achieving their treatment goals,[107] and conversely a quarter of participants in Grinman's study identified substance misuse as an impediment to acquiring stable housing.[108]

Gaining access to services, advice or even information on what is available continues to be a problem for homeless people.[109] This is hindered further by inefficient referral mechanisms and lack of joint working between agencies.[110] There is a perception amongst this group that there is no service to help them[111]. Corr (2002) suggests that rough sleepers stick together and avoid services.[112] The chaotic lifestyles of the homeless can make it difficult for them to get help and to engage with a service or treatment programme, they can find it difficult to keep appointments and follow care plans.[113] For access to methadone maintenance treatment a lack of permanent address, harsh sanctioning for failing urinalysis and problems in attending daily clinics can all be especially problematic.[114] Fountain and Howes also found amongst their participants a lack of motivation to change.[115] Lack of aftercare for homeless people who have attended drug services leaves them susceptible to relapse.[116]

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[105] ibid., p. 10

[106] Drugscope, op. cit., p. 48

[107] Homeless Link, op. cit.

[108] Grinman et al., op. cit.

[109] Scottish Government and Convention of Scottish Local Authorities, op. cit., p. 32; Drugscope, op. cit., p. 26; and Neale and Kennedy, op. cit.

[110] Scottish Government and Convention of Scottish Local Authorities, op. cit., p. 32; Rosengard A., Laing I., Ridley J., and Hunter S. (2007) *A Literature Review on Multiple and Complex Needs*. Scottish Government: Edinburgh, para 5.14

[111] Neale and Kennedy, op. cit.

[112] Corr, op. cit., p. 3

[113] Scottish Advisory Committee on Drugs Misuse Integrated Care Working Group, op. cit., p. 34; and Drugscope, op. cit., p. 26

[114] Lawless and Corr, op. cit., p. 20

[115] Fountain and Howes,op. cit., p. 24

[116] Lawless and Corr, op. cit., p. 20

Having a substance misuse problem can be a barrier to accessing help with homelessness as well. Substance users can be excluded from using hostels or other accommodation because of the service's 'No drugs or alcohol' policy,[117] or banned after entry to accommodation due to behaviour related to their substance problem.[118]

Homeless Link noted some specific problems with homeless accommodation in respect of recovery from substance misuse problems. Firstly, people at different stages of recovery are housed together inappropriately and secondly, while friendships with other users trying to recover can be a positive support it can also be a negative influence and can sometimes result in financial arrangements to buy drugs that the person then finds it impossible to escape from.[119]

Negative staff attitudes, particularly in primary health care, towards the homeless drug users can deter them from seeking help.[120] Lack of staff training and knowledge about working with drug users has also been found to be an issue.[121]

3.3 Good Practice

The review of literature revealed many examples of good practice for treating homeless substance misusers. This section begins with a look at perceptions of what makes good practice then examines the effectiveness of some particular models and lastly, it will give examples of how some of the barriers identified in the previous section have been addressed.

3.3.1 Perception

Neale and Kennedy[122] conducted case studies of 3 drug agencies and 3 homeless agencies, using interviews with service users and staff. Both groups came up with a list of what they considered good practice in working with homeless drug users. Many factors were suggested (the interviewees received no prompting) – the most common factors were:

- Staff who are non-judgemental and respectful (7 out of 8 staff interviewed and 5 out of 36 clients interviewed);
- Individualistic way of working with clients (8 staff);

[117] Neale and Kennedy, op. cit.; and Corr, op. cit., p. 7

[118] Lawless and Corr, op. cit., p. 19; Fountain and Howes, op. cit., found this was in fact more of a problem where the dependence was on alcohol not drugs

[119] Homeless Link, op. cit.

[120] Corr, op. cit., p. 9; Neale and Kennedy, op. cit.; Scottish Advisory Committee on Drugs Misuse Integrated Care Working Group, op. cit., p. 34

[121] Lawless and Corr, op. cit., p. 19; and Deloitte MCS Ltd., op. cit., para. 8.1.2

[122] Neale and Kennedy, op. cit.

- Help with general things (shopping, budgeting) (14 clients and 3 staff);
- Emotional support (13 clients);
- Good atmosphere – friendly, relaxed, clean (9 clients).

Neale identified that while both groups made suggestions in the same broad categories there were some differences between what staff and service users felt were most important. Neale suggested that good practice is hard to define as it is an extremely complex concept and is dependent on each individual's standpoint. The author emphasises the importance of what they termed 'intangible' or 'qualitative' elements, such as staff attitude or agency environment, in the results.

3.3.2 Models

Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review[123] identifies 5 types of service for this group from the literature review:

1. Joint working or case management models based on interagency working delivering floating support to people in general needs housing.

   Joint working is where most of the Scottish research focuses[124] but generally it seeks to address the problems of joint working, there is little hard evidence that this approach has enhanced effectiveness at providing lasting solutions for this group.[125] The main drawbacks occur, and the service effectiveness starts to decline, when any service input is unavailable or when the user must wait for it[126].

2. Fixed-site clinics, counselling centres and residential detoxification models.

   US evidence suggests these models have limited success[127] due to a focus on the drug problem and the strict rules of the service, including total abstinence.

3. One-site transitional housing and staircase/Continuum of Care models.

   Single site type is most common in the UK.[128] In Scotland there is Jericho and CrossReach Cunningham House. They are utilised as part of care management arrangements. In staircase models, used in the US and EU, the person is progressed through a series of residential settings each one more independent than the last. There has been no detailed evaluation of

[123] Pleace, op. cit.

[124] ibid., p. 28

[125] ibid., p. 30

[126] ibid., p. 28

[127] ibid., p. 31

[128] ibid., p. 34

UK single sites. The evidence from the US shows a high attrition rate, though with success for some individuals. Reasons given for the attrition include constant change, the service user not having enough control and expectation of progress by all at same speed.

4. Permanent supported housing.

   This appears rarely, and where it exists only alcohol use is tolerated not drug use. There is limited evidence as to its effectiveness. Though one study found that staying in supportive housing reduced the use of Emergency Rooms (A&E) and inpatient services.[129]

5. 'Pathways' models that provide dedicated specialist workers and offer open ended support.

   The main example of this is the Pathways Housing First in the US. The person can choose the house and what other support services they use. They are given intensive floating support (available 24/7 from an inter-disciplinary in-house team). Abstinence is not required and each person has a service co-ordinator. The scheme is open-ended. Some aspects of this are already present in Scotland but others would be innovative, such as the use of former homeless as workers, the open-endedness, and the choice-based system. This model is based on the acceptance that not everyone will become abstinent or manage fully independent living and is primarily suitable for high needs those with complex needs.

3.3.3 Access

Fountain and Howes study[130] showed that knowledge of services increased along with time spent homeless so information at the point of homelessness needs to be improved. Dundee City Council created a booklet with basic information on all the services available to homeless people for staff at all agencies to make them aware of what is available and how to access it.[131]

A common example of how to tackle the access problems is to create a 'one-stop shop' where homeless people can go and get access to other services they need. For example in Scotland there is the Homeless Access Point in Edinburgh and Hunter Street Homeless Health in Glasgow.[132] One example which is particularly highlighted is The Matrix in South Tyneside. It is a young person centre with a drugs action worker, arrest referral worker, health and housing reps, mental

[129] Martinez, T.E. and Burt, M.R. (2006) Impact of Permanent Supportive Housing on the Use of Acute Health Services by Homeless Adults. *Psychiatric Services,* Vol. 57, pp. 992-999

[130] Fountain and Howes, op. cit., p. 12

[131] Scottish Housing Regulator Dundee City Council Inspection Report 2009. Available at: http://www.scottishhousingregulator.gov.uk/stellent/groups/public/documents/webpages/shr_dundeecitycouncilinspectio.pdf para. 6.9

[132] Rosengard, op. cit., para. 6.22

health nurse and a link to an information and advice service all under the same roof.[133]

In the Midlands Turning Point set up partnerships with mainstream services such as hostels and tenancy support agencies, satellite services in local homeless services and had drop-in sessions at their own clinic with the aim of providing advice and information about substance misuse services.[134]

The 'Connected Care' model was trialled in Hartlepool first of all but has now been rolled out to 7 different areas. Again it is a one-stop shop partnership between the primary Care Trust and Turning Point which provides a worker to navigate them through services and round-the-clock support.[135]

Also in Cardiff a scheme was set up whereby if the police found a street drinker who they felt needed some substance misuse support they would refer them to the support service rather than arresting them.[136]

Outreach, either from the drug or housing side, is another way of ensuring access for this group. They seek out the 'hard to reach' groups and work with them to get them into centre-based services.[137] It has shown some success in the past.[138] In Bristol, for example, Shelter was commissioned to run a housing advice clinic at the local health centre in an area which had a high concentration of people affected by substance misuse in an attempt prevent homelessness.[139] Glasgow provides an outreach service for homeless people who have complex and multiple needs which tries to ensure they receive consistent and continuous support.[140]

One notable point from Fountain and Howes was that the study populations' use of drug services was centred around harm reduction, the authors felt that very few of the sample had accessed services which would treat their addiction and help them get off drugs.

In terms of housing for substance misusers studies have suggested increasing hostel accommodation for drug users and having wet hostels.[141] The ODPM also

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[133] ibid., para. 6.18

[134] Drugscope, op. cit., p. 31

[135] Scottish Government and Convention of Scottish Local Authorities, op. cit., p. 135

[136] Deloitte MCS Ltd., op. cit., para. 5.3.1

[137] Scottish Government and Convention of Scottish Local Authorities, op. cit., Chapter 6; Corr, op. cit., p. 11

[138] Corr, op. cit., p. 11

[139] Pawson et al., op. cit., para. 3.22

[140] Scottish Housing Regulator (2009) *Glasgow City Council Inspection Report,* para. 4.28

[141] Corr, op. cit., p. 11; and Fountain and Howes, op. cit., p. 23

suggested quotas within the social rented sector to accommodate those leaving rehabilitation or entering treatment.[142]

3.3.4 Joint Working/Case Management

The joint working model is typical in Scotland[143] but as noted above it can work inefficiently at times. The *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review* particularly identifies the arrangements in Glasgow, Edinburgh, Fife and Highland – those needing help are drawn in, usually through the homeless services, and are then referred to services (such as specialist substance misuse services) that they need.[144]

There are a number of elements to good joint working with homeless substance misusers; increased co-operation between agencies, developing integrated strategies,[145] single integrated assessment[146] strong links into aftercare[147] and training, particularly training of staff from different agencies jointly.[148]

The Connected Care model mentioned above provides a good example of this type of working. They have common assessment and information sharing procedures, shared training, managed transitions and continuing support.[149]

To counteract possible transition problems one service in West Euston has a system where the worker follows the person from the young person to the adult service and the funding of the worker moves to the adult service to ensure continuity for the service user.[150] The Link Worker service in London worked solely to act as a navigator through services for ex-prisoners with particular needs, such as substance misuse or mental health. This hard to reach group were therefore not lost between services and were referred to the services they needed.[151]

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[142] Drugscope, op. cit., p. 53

[143] Pleace, op. cit., p. 20

[144] ibid., pp. 24-27

[145] Deloitte MCS Ltd., op. cit., para. 5.8

[146] Rosengard et al., op. cit., para. 94

[147] Lawless and Corr, op. cit., p. 22

[148] Rosengard et al., op. cit., para. 6.82

[149] Scottish Government and Convention of Scottish Local Authorities, op. cit., p. 135

[150] ibid., p. 85

[151] ibid., p. 75

3.3.5 Holistic Support

Services that recognise and address the complex relationship of substance misuse and homelessness means that holistic support is crucial to helping homeless substance misusers. The Pathways Housing First model mentioned above provides an example of this holistic support. It provides help with housing issues, employment, education, physical health and general wellbeing as well as emotional and practical support.[152]

Initiatives for helping substance misusers into housing, including arrangement for payment of arrears, certificated courses for substance users to demonstrate they have learned new coping skills, rent deposit and rent guarantee schemes, drug awareness training for landlords and generic housing workers and risk assessment protocols for landlords and tenants.[153] This provides help in wider areas so that the housing and substance misuse can then be tackled.

Aftercare is important to the recovery of this particular group, a return to the streets could easily mean a return to substance misuse. The Alcohol Recovery Project in London provided shared support housing for those leaving treatment or rehabilitation. They still get individual help through a support plan to help them work towards living independently and they can stay for up to 18 months if not longer to get the preparation they need.[154]

3.3.6 Family/Social Support

Neale concluded that good practice was not simply about providing permanent accommodation or ensuring abstinence, homeless drug users should be helped to achieve stability, feel safe and secure, meet new friends and grow in confidence and self respect.[155] Additionally Kemp et al's examination of the risk factors associated with homelessness amongst drug users showed the importance of social capital in preventing homelessness and the potential value in supporting users' families.[156] The ODPM identifies supporting the user's family network as a way of increasing motivation, treatment engagement and retention and reducing relapse risk.[157]

Stein et al's study into psychosocial and situational variables that influence problem substance misuse in homeless people found that lower self-esteem predicted greater emotional distress, lower positive coping, greater negative coping and more alcohol use and having social support predicted less emotional

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[152] Pleace, op. cit., para. 3.121

[153] Office of the Deputy Prime Minister and Home Office, op. cit.

[154] ibid., p. 18

[155] Neale and Kennedy, op. cit., p. 204

[156] Kemp et al., op. cit., p. 327

[157] Office of the Deputy Prime Minister and Home Office, op. cit., p. 13

distress and more positive coping. Therefore they felt that treatments should address both self-esteem and negative coping patterns as well as the person's situational factors, like housing.[158]

Kertesz et al[159] (2006) studied the factors which indicate levels of treatment utilization in homeless and housed urban poor. The main things which were shown to spur the cohort into treatment were personal consequences, support for abstinence from their social network and motivation for treatment. The authors suggest the use of Motivational Interviewing approaches and cultivating social network support for abstinence to enhance treatment-seeking.

3.3.7 Prevention

Kemp et al's examination of risk factors and trigger events for homelessness identified that a recent injecting drug use was a risk factor in homelessness. The authors recommend helping individuals to resist and move away from injecting could help with preventing and responding to homelessness.[160] Additionally targeting housing assistance at drug users leaving prison or with mental health problems is identified.[161]

The 'Effective Services' literature review discusses services for preventing homelessness. There are some in Scotland but usually they are aimed at all potentially homeless not just substance misusers, for example supported transitional housing for young people. Previous evaluation (Pawson, Davidson et al 2007) suggests these services are small and still evolving. In order to be effective, prevention has to focus on wider issues which are important in supporting people in either situation.[162]

Tenancy support services which provide intensive support for those assessed as vulnerable [163], such as the Brighton and Hove project (identified in *Drug Services for Homeless People),* can be helpful in preventing homelessness occurring in the first place.[164] Prevention can also take the form of tackling the issues which lead to people becoming homeless, for example by way of family mediation.[165]

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[158] Stein et al., op. cit.

[159] Kertesz et al., op. cit.

[160] Kemp et al., op. cit., p. 326

[161] ibid., p. 327

[162] Pleace, op. cit., para. 3.176-3.190

[163] Drugscope, op. cit., p. 56

[164] Deloitte MCS Ltd., op. cit., para. 5.6

[165] Fountain and Howes, op. cit., p. 19

3.4 Key Findings

- A holistic approach to meet the needs of each person is required. Services need to work together to alleviate homelessness and improve the health of homeless people.
- Access to healthcare must be equitable in that being drug or alcohol free must not be a pre-requisite to accessing health services.
- Recovery from substance misuse is most effective when the service users' needs and aspirations are placed at the centre of their care and treatment.

Section 4: Accessibility of Services

4.1 Introduction and Aim

This section explores the views of homeless/housing service managers, staff from substance misuse services and service users who are homeless substance users. The purpose of this section is to review the particular needs of this client group and to establish to what extent they are able to access services that address these needs. A number of themes are presented below, some which were discussed at the stakeholder interviews and some which have emerged from the staff and client surveys.

For the purpose of this section, homelessness/housing service managers will be referred to as stakeholders and staff are those from substance misuse services.

4.2 Barriers to Access

Various factors were identified from the stakeholder interviews, staff surveys and clients' surveys as possible barriers to clients accessing services. These were,

- Outreach
- Service waiting times
- Information provision
- Networks
- Attending appointments
- A10 Migrants and BME groups

4.2.1 Outreach

There was a general feeling from stakeholders that people who are not engaged with services are much more 'chaotic' and hard to reach. These people may be those who are rough sleeping on the streets, living with family/friends, or 'couch surfing'. It was suggested that this hidden population is not aware of what services are available to them and services are not aware of them individually. The majority of stakeholders felt that outreach is the most effective solution. They felt that services need to go to the clients and engage with them initially to encourage them to access drug and alcohol services, rather than waiting for them to come to services. Streetwork was identified as the main service that provide outreach to homeless people on the streets in Edinburgh, however, it was agreed by many stakeholders that there is a need for more assertive outreach, particularly by drug and alcohol services, to identify and engage with homeless substance users living in hostels and other forms of temporary accommodation. One stakeholder stated that young people (16-21 years) in particular benefit from outreach, because they are sometimes scared or lack the confidence to engage with services.

A few staff (11%) also agreed that outreach is crucial in terms of engaging with the small minority of homeless people described as the 'hard-to-reach' client group. They felt that outreach can enable them to provide more appropriate health services which is based on the clients' terms, and this in turn can increase the chances of clients engaging with services.

Service users were given the opportunity to comment on any changes they would like from services and 5% (3 respondents) felt that they could benefit from more outreach work. These comments are presented below:

> *'(Need) more people on streets doing drug work.'*
>
> *'I think more outreach workers should be more used to getting homeless and street begging drug users off the streets and into supportive accommodation.'*
>
> *'More outreach.'*

Focus group participants suggested that having someone from the drug and alcohol services who was regularly around the hostels would become a 'known face' and people would be more likely to approach them within this familiar environment rather than to go to a place that they didn't know. They felt that the relationship should be built with a person not with a service.

4.2.2 Service Waiting Lists

The interviewees identified waiting lists as a barrier to accessing services (counselling and substance misuse services in particular). Several stakeholders felt that it is very difficult for this client group to reach that point of wanting to change, and a long wait to access support may demotivate them and cause them to relapse.

A minority of service users (17%; 10 respondents) also commented on the issue of long waiting lists. Some of these comments are presented below:

> *'Some services put you on a long waiting list when you are referred ... in the meantime the problem grows and gets worse so I think it better to deal with the problem as quickly as possible.'*
>
> *'Waiting times for scripts are too long.'*
>
> *'Would like to get appointment faster as most of the time you wait up to 18 months for one.'*
>
> *'Speed up the time it takes to get on a substitute prescription.'*

Within the focus group there were mixed views on the length of time a person would have to wait to be seen by drug or alcohol services. All agreed that this information was 'word of mouth' and that no-one could be sure that they had an up-to-date picture of this.

4.2.3 Information Provision

Several stakeholders felt that to a certain extent, homeless people who have substance misuse issues are not aware of what services are available to them, especially those who are 'rough living' on the streets and living in Bed and Breakfast services. One stakeholder suggested that providing information in the form of leaflets and posters at places like bus stops would be a good idea.

Several stakeholders felt that many staff in substance misuse services are unaware of the range of services available to clients with housing problems. They felt that due to this, clients are being pointed in the wrong direction and they end up going to inappropriate services. In some cases, staff are not aware of what services they should be referring clients to at all. Several stakeholders suggested that there needs to be a change of attitude and service provision should be more individual-directed rather than outcome-directed. For example, they felt that some clients are discouraged from accessing healthcare as the reception towards them can quite hostile in the reception rooms of mainstream general practitioners.

Several stakeholders also felt that there is very little contact between specialist services (Homeless and Substance Misuse services) and Bed and Breakfast services (B+Bs), where homeless people temporarily reside. Therefore, these people receive very little information on what services they can engage with. Stakeholders felt that there needs to be more effort put into promoting contact between specialist services and B+B services in the future.

However, the views of staff and service users differed from those of stakeholders in terms of information provision. Staff from substance misuse services were asked to rate the statement 'We provide enough information about our service to help service users decide whether to come along'. The majority (78%) agreed that they provide enough information to help clients engage with their service. A small proportion (16%) answered 'don't know' and 5% chose not to answer the question. None of the respondents disagreed with the above statement.

Similarly, service users were asked to rate the same statement with regard to information provision. The majority of service users (70%) also agreed that services provide information about their services to help clients engage with them. However, 15% disagreed with the statement and 13% chose 'don't know'. Additionally, three respondents (5%) also provided comments on the lack of information provision. The comments are presented below:

> *'More awareness on how to find drug/alcohol meetings and addresses.'*
>
> *'Could do with more information on alcohol services.'*
>
> *'Should put info outside a shop (like off-licence, not only GPs).'*

4.2.4 Networks

Stakeholders were asked whether they felt that chronic substance misuse in homeless people was a static or dynamic problem. The broad view was that, in their experience, they have seen a 'vicious cycle'. In their opinion, there was a cycle of people going in and out of services and relapsing even over long periods of time, and they felt that perhaps this maybe due to the network they are in. If they go into rehabilitation or prison and come out, they don't have a supported network, but are surrounded by factors that may trigger them to relapse. There was a sense that this group of people are 'stuck' in their state as they don't have many options of post-recovery communities which give them that transition of moving on. Several stakeholders felt that LEAP is a great service but there needs to be more places like LEAP. One stakeholder felt that:

> *'There needs to be more places like LEAP in Edinburgh but including more options than just the 12-step programme as this may not work for everyone.'*

4.2.5 Attending Appointments

All of the stakeholders agreed that attending appointments is a big issue for this client group. Although the vast majority of homeless people do not experience rough sleeping and resolve their homelessness relatively quickly there is a minority for whom their 'chaotic lifestyle' is a major factor that needs to be considered. Due to their lifestyle of being moved around temporary accommodation and substance use, attending appointments may not be in the list of priorities of a relatively small number of people who experience homelessness and they may forget their appointment date/time. When discussed in the focus group one participant explained:

> *'They send me appointments that I don't attend and then they send me another letter with another appointment so that they can ask me why I don't attend appointments. I didn't attend that appointment either!'*

Several stakeholders felt that services need to be more flexible with this client group, for example some services will put people to the back of the waiting list if they miss one appointment. However, most of them agreed that with the current funding cuts and lack of staff, this may be difficult for services to do.

The majority of stakeholders felt that attending appointments may be less of an issue if people are engaged with homeless/housing services, as the staff will accompany them to appointments and provide them with advice of where to go.

Some examples of good practice were identified from stakeholder interviews. A few stakeholders suggested that the idea of text reminders could be useful with this client group rather than sending out letters to them. One stakeholder mentioned that this group of people may have literacy issues, thus sending out letters may not be an effective way of scheduling appointments. Another

stakeholder stated that their service has addressed this issue by tying in appointments with prescription pickups. For example, by trying to ensure that the client has to pick up the prescription the day before his/her appointment date and thus they maintain regularity so that the client becomes used to it. A further example of good practice was an online notice board through which services can track the attendance of clients. This can also allow social workers to track their clients and contact them or accompany them if required.

4.2.6(a) A10 Migrant group

The A10 migrant group includes people from: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia. A third of the stakeholders (31%) had concerns regarding the provision of services for this A10 group. They have come across a large number of people from the A10 countries, who are homeless and misusing substances, mostly alcohol. In addition to their language barrier, they have no entitlement to funding/resources and services can do very little for them. One stakeholder stated:

> *'One in four of our clients are a group who are in A8/A10. They have no access to funds, accommodation or entitlements and they have complex needs including addiction, mostly alcohol. They come to Edinburgh for whatever reason, lack of work, and spiral into addiction and homelessness. They are on streets, die on streets, and live in overcrowded flats. Their primary needs are met by EAP, but (they) have limited access to secondary health care ... Their only route out is to get work, which is easier for the younger people. But it is much harder in this employment climate; there are limited types of jobs for them, and with low pay, cash in hand possibly. This group needs to be acknowledged.'*

Focus group participants stated that they experience significant numbers of Eastern European people living on the streets. Many of them said that they now stay away from a lot of the night-time services because there have been tensions and in some cases reports of violent clashes between the Scottish homeless population and the 'Eastern Europeans'.

4.2.6(b) Black and Ethnic Minority (BME) Group

One stakeholder stated that access to services such as healthcare, counselling and support services is an issue for people from BME groups. They felt that this was mainly due to a language barrier, partly from the clients who are not fluent in English and partly because services do not provide multi-lingual facilities. As such, it is necessary for them to be accompanied to appointments, and Edinburgh doesn't have sufficient multi-lingual services for this purpose either.

Another particular issue was that of substance misuse denial; according to one stakeholder:

> *'The majority of service users in the BME group generally don't misuse substances, however if they do, they would not admit to doing so as it would bring shame on them and their families, so it's an honour thing'*.

However, it was mentioned that amongst BMEs, those who have an indefinite stay in the UK can access public funds and the language barrier is not a huge issue for them. Those who are not eligible to access public funded services, have immigration issues and language barriers are affected the most by homelessness and substance misuse issues.

4.3 Specific Access Issues

4.3.1 General Healthcare

The majority of stakeholders (71%) considered access to general healthcare to be an issue for this client group. Most of them felt that clients neglect their general health and hygiene needs and don't consider this to be a priority in their lives.

However, there was a general agreement that if clients are engaged with services, they are provided with the support to access healthcare. This tied in with the need for more outreach to engage with those who are on the streets as they may not be aware of where to go to address their health needs. The issue of funding cuts was also mentioned as having a big impact on services. There was agreement that services are doing the best they can with the funding they have.

Edinburgh Access Practice (EAP) was identified as the service that most stakeholders (88%) were aware of which addresses the health needs of homeless and substance misusing individuals. Other services mentioned included: Homeless Outreach Project (HOP), Community Drug Problem Service (CDPS), Harm Reduction Team (HRT) and Midpoint (MP). Several stakeholders mentioned that there is a need for more specialist services that address the health needs of homeless people who are also misusing substances.

Additionally, several stakeholders mentioned that access to healthcare becomes difficult when people move on from homeless services to their own tenancy. They then loose the support and have to move onto accessing mainstream services on their own. As such, it was suggested that there needs to be continuity of care in order to make this transition easier and more sustainable.

4.3.2 Counselling and Support

The majority of stakeholders (76%) felt that gaining access to counselling was difficult for this client group. While this may be due to a number of factors including their state of readiness, apprehension/fear or geographic availability

stakeholders perceived long waiting lists to be a major factor contributing to this difficulty. Some stakeholders also felt that services need to be more flexible with appointments and understand that this client group have a very challenging lifestyle.

On one hand some stakeholders stated that there is limited provision of counselling in Edinburgh for this client group, while some others stated that there is sufficient provision; however it was agreed that there is a lack of outreach and engagement with the client group. Most stakeholders were aware of ELCA, SH, EAP, HOP, HYPE, CREW, SW and TP as some of the services that provide counselling in Edinburgh. Despite this, several stakeholders suggested that there needs to be more specialist services available for this client group.

In terms of support services, there was general agreement that there is adequate support available to this client group. Most homeless/housing services stated that they provide support such as tenancy and financial support. However, a few felt that the funding cuts have had an impact on the provision of these services.

4.3.3 Injecting Equipment

Stakeholders were invited to discuss any issues around access to clean needles for homeless people who are using drugs. The majority of stakeholders (88%) felt that this was not an issue in Edinburgh at present. They stated that the provision of and access to clean needles has improved significantly over the last 10 years and that there is currently sufficient provision of clean needles for this client group. However, a few stakeholders had some concerns with injecting equipment. They expressed concern that although access to clean needles is not an issue, there is an issue of safe disposal of needles. Most services provide sin bins for safe disposal; however they are not always being used. They also felt that homeless people are still engaging in risk behaviours at night time when they don't have access to clean needles.

In terms of services, most stakeholders were aware of Harm Reduction Team, Streetwork, HOP and CDPS as services that provide clean needles. They were aware that HRT and SW provide clean needles via outreach. Other services that they were aware of who provided clean needles include: EAP, TP, NEDAC and CHAI. A few stakeholders (20%) also mentioned that clients can access clean needles from the chemist/pharmacy.

4.3.4 Education and Employment

All of the stakeholders felt that access to education and employment is difficult for this client group. The majority felt that this may be because this group of people are not physically and mentally ready for employment and don't fit into the criteria. Just over half of the stakeholders also mentioned that due to their

clients' history, they have low confidence and self-esteem, and services could be doing more to help them build that confidence.

A few stakeholders felt that it is important to provide this client group with training, volunteering and employment opportunities early on in order to give them motivation towards recovery.

Stakeholders were asked if they were aware of any services that provide education and employment opportunities for this client group. The majority were aware of Transition as a service that help build confidence, general skills such as computer skills and provide clients with training, education, and employment opportunities. Other services that were mentioned include Passport, Spectrum, Apex, BCC, STRADA, Know Your Rights, Foursquare and SACRO.

Other statements relating to delivery of care that staff were asked to rate included: 'we help service users get ready for work, training, and volunteering'. The majority (81%) agreed with this statement, with only 14% disagreeing with it. In terms of support with training/work, just under half of the service users (48%) felt that drug and alcohol services help them get ready for work, training or volunteering. However, 20% did not agree with this and 30% answered 'don't know'. One respondent (2%) did not rate the statement.

4.3.5 Legal Services

Just under half of the stakeholders felt that lack of access to legal services for was an issue for this group of people, but the others felt that it was not an issue if they were engaged with services, because they would refer them onto legal services. Those who felt it was an issue also suggested that most homeless people who are using substances on the streets are associated with criminal activity and as a result, they are often linked in with the legal system. However, it is difficult to access legal aid with regard to other problems such as family issues, child welfare, and housing and finance issues.

Stakeholders were not aware of any specific services that provided legal services. However, most of them mentioned that Streetwork used to have a lawyer who would go out to the streets and offer legal services with regard to criminal activity, family, housing and finance issues. They were of the view that this is not available anymore due to funding cuts, but would like to see something similar as there is a need for it.

4.3.6 Emergency Accommodation

Nearly all of the stakeholders (94%) felt that this is an issue that clients are faced with. Some stated that this is particularly an issue if people initially present themselves in a 'bad state' (heavily under the influence of alcohol/drugs). As such, there was general agreement that there is a need for more varied accommodation. Some felt that there needs to be emergency

accommodation that are more tolerant of substance using, while others felt that there needs to be more accommodation that are free of substance use. They argued that people who are coming out of rehabilitation or prison need to go to places that are free of drugs/alcohol in order for them to continue their recovery.

Almost half of the stakeholders felt that there needs to be more accommodation in Edinburgh. They stated that provision of accommodation is low in Edinburgh, not only for this client group but in general. One stakeholder of a women's service felt that there is less bed spaces and choice of accommodation services for women only when compared to male only and mixed gender accommodation services. Another stakeholder of a young person's service (16-21 years) felt that this was also true for their client group; young people may not feel safe in accommodation that is filled with older people.

A few stakeholders were concerned that there are people who are not homeless using hostels; this is an issue as it provides less space for those who are homeless.

The stakeholders identified Dunedin Harbour Hostel, Cunningham House and Castle Cliff as places that provide direct access to accommodation. Most other services require referral, assessments and interviews.

In addition, a small minority of service users (3%; 2 respondents) felt that there should be less bed and breakfast services and more hostels:

> *'No more B+ Bs and more hostels.'*
>
> *'They should stop using B+B accommodation and have more hostels.'*

4.3.7 Access to Substance Misuse Services

Integrated Care for Drug Users: Principles and Practice[166] identifies accessibility as a key element in the provision of integrated care. It defines important service characteristics in relation to access to include referral processes, location of services and opening times. These issues were put to staff working in drug and alcohol services and service user through self-completion questionnaires. The results are set out in the tables below.

Questionnaire statement: Drug and alcohol service referral criteria make it difficult for homeless people to attend		
Group	Strongly Agree	Agree

[166] Rome A, Morrison A, Duff L, Martin J, Russell P. Integrated Care for Drug Users: Principles and Practice. Scottish Executive, 2002. Available at: http://www.drugmisuse.isdscotland.org/eiu/intcare/intcare.htm (accessed on 4th February 2011)

Service Users	10%	27%
Service Providers	0%	11%

Questionnaire statement: The location of drug and alcohol services are accessible to homeless people		
Group	Strongly Agree	Agree
Service Users	20%	55%
Service Providers	30%	60%

Questionnaire statement: Drug and alcohol service opening times reflect the needs of homeless people		
Group	Strongly Agree	Agree
Service Users	15%	33%
Service Providers	14%	51%

One third of service users felt that the referral criteria made in difficult for homeless people to attend. Only one in ten service staff shared this view. Four staff members (11%) chose not to rate the statement and 5 people (13%) said 'don't know'.

There was broad agreement from staff (90%) and service users (75%) that the locations of services were accessible. However, nearly a quarter (23%; 14 respondents) of the service users commented that there should be more services in Edinburgh and amongst them, 43% (6 respondents) wanted more services in town.

Half of service users (48%) and two thirds of staff (65%) agreed that opening times reflected the needs of homeless people; twenty two percent of staff and 37% of service users disagreed.

Three respondents provided additional comments on service opening hours. These comments are presented below:

'More accessibility (to services) during weekends.'

'(Services) open at weekend.'

'No facilities open in the morning.'

Service users were also asked to rate the statement 'Drug and Alcohol service referral criteria make it difficult for homeless people to attend'. Unlike the staff agreement ratings, only 18 service users (30%) disagreed with it while a slightly higher number (37%) agreed. The remainder (33%) answered 'don't know'.

The question of whether there is adequate service provision to meet need was addressed in the Alcohol and Drugs Needs Assessment[167] conducted in 2010 which made the following findings:

- The ratio of need for alcohol services in relation to the provision of services is 1:16. This is equivalent to 6.2% of people in need accessing service. This is lower than both the regional and the national rate. By North American standards, this would equate to a low level of access.
- The ratio of need for drug services in relation to the provision of services is 1:3.2. This is equivalent to 34.4% of people in need accessing services. The medium (mean) level of access to drug services, according to NTA and SACDM, would be a PSUR of 1:2, or 50% access rate. By comparison Edinburgh would have a low/medium level of access.

4.4 Key Findings

- There was general agreement amongst respondents that there is a need for more assertive outreach into hostels and other forms of temporary accommodation in Edinburgh in order to identify and engage with homeless substance users; to provide advice and information and to support them in accessing appropriate health and social care.
- It was identified that there is a lack of aftercare support available to this client group especially when they move to their own tenancy.
- Stakeholders felt that the 'chaotic' lifestyle that this client group lead make it difficult for them to access healthcare, counselling and to make it to appointments on time.
- The provision of, and access to injecting equipment in Edinburgh is not considered to be a problem for this client group. However, the safe disposal of injecting equipment continues to be an issue.
- All of the stakeholders and 81% of staff working in substance misuse services felt that access to education and employment is difficult for this client group, partly because it is not a priority for them, and partly because they lack the confidence and self-esteem. However only half (48%) of service users agreed that services helped them get ready for work, training or volunteering.
- Just under half of the service users (48%) felt that drug and alcohol opening times reflect the needs of homeless people. This was much lower than the 65% of staff who agreed with the statement.

[167] Rome et al., op. cit., p. 74

Section 5: Assessment and Delivery of Care

5.1 Aim and Method

The purpose of this section is to explore the processes of assessment and delivery of care which services provide to clients who are homeless substance users. A number of themes are presented below, mostly which have emerged from the staff and client surveys, and some of which were discussed at the stakeholder interviews.

5.2 Assessing Needs

It was identified from stakeholder interviews that EAP was an example of good practice in terms of attending to the health care needs of this client group. They assess general health needs as well as mental health needs, and they have an in-house team which includes general practitioners, CPNs, specialist nurses who deal with substance misuse, psychologists, optician, dentist, paediatrician and dietician.

5.2.1 Substance Misuse Related Needs

Staff from substance misuse services were asked to rate the statement 'Our assessment process effectively identifies the substance misuse related needs of homeless people'. Nearly all of the respondents (92%) agreed with this statement. With regard to meeting these needs, the majority of staff (81%) felt that their services worked effectively to meet the substance misuse related needs of homeless people.

When asked whether drug and alcohol services identify clients' substance misuse related needs, just over half (57%) of service users agreed. Amongst the remaining respondents, 18% disagreed and 25% answered 'don't know'. In terms of meeting these needs, over half of the service users (68%) agreed that substance misuse services work effectively to meet their substance-misuse related needs while 18% disagreed, and 13% answered 'don't know'.

5.2.2 Health Care Needs

Staff from substance misuse services were asked to rate the statement 'Our assessment process effectively identifies the health care related needs of homeless people'. Nearly all of the respondents (92%) agreed with this statement compared to just over half of the service users (62%).

5.2.3 Social Care Needs

The majority of staff (89%) agreed that their assessment process effectively identifies the social care needs of homeless people. The views of services users with regard to services meeting their social related and accommodation needs were different to those of staff. In terms of social related needs, just under half of the service users (48%) agreed that services effectively identify these needs. However, 28% disagreed and 22% answered 'don't know'. One person (2%) chose not to answer.

In addition, all but one of the staff who responded (97%) felt that their assessment process effectively identifies the accommodation needs of homeless substance users. However, only half (48%) of the service users felt that drug and alcohol services effectively identify their accommodation needs, 37% disagreed, and 13% answered 'don't know'.

5.3 Delivery of Care

5.3.1 Information provision

Several stakeholders stated that in addition to providing information about their own service they also provide information about other services that maybe of relevance to this client group. They provide this information in the form of leaflets and by word of mouth either when clients attend services, or when workers go out onto the streets.

Staff from substance misuse services had a similar viewpoint to those of stakeholders. They were asked to rate to what extent they agree or disagree with the statement 'we provide good health advice and information, and help homeless service users to find health providers such as GP, dentist and optician'. The majority (92%) agreed with this statement and only 5% (2 respondents) disagreed.

Similarly, service users were asked to rate the extent to which they agree or disagree with the statement 'Drug and alcohol services provide good health advice, and information, and help me find health providers'. The majority (71%) agreed with this statement while a small proportion (10%) disagreed. However, 13% answered 'don't know' and 5% did not rate the statement at all.

5.3.2 Delivery of services

Several stakeholders mentioned that they provide services such as housing and tenancy support as part of their service for homeless clients. Some services also provide support with general skills such as computing skills and help clients to get involved in group work.

Staff from substance misuse services were asked to agree or disagree with a number of statements relating to delivery of care, the first of which was 'we are good at adapting the way in which provide services to homeless service users when their needs change'. The majority (78%) agreed with this statement, but a small number of respondents (11%) disagreed. One respondent (3%) did not rate the statement and 8% rated 'don't know'.

Staff were also asked comment on whether they provide support for homeless service users with tasks such as shopping and budgeting. Just over half (51%) agreed with this, while 35% disagreed with it. Two respondents (6%) answered 'don't know' and 8% did not rate the statement at all.

The statement which related to emotional support provision produced 95% positive responses, implying that nearly all of the substance misuse services that responded provide emotional support for their clients.

Similarly, service users were asked to rate to what extent they agree or disagree with statements relating to the above themes, but in terms of service provision. However, they produced lower levels of positive ratings. Just over half (55%) agreed with the statement 'Drug and alcohol services are good at adapting the way in which they provide services when my needs change'. Amongst the remainder, 13% did not agree with the statement and 30% chose to answer 'don't know'. One respondent (2%) did not rate the statement at all.

The statement 'Drug and Alcohol services help make my situation better' produced 65% positive responses, while 13% felt this was not true and 20% answered 'don't know'. One respondent (2%) chose not to rate the statement.

Additionally, four respondents (7%) commented that the services they use are very helpful and a further six respondents (10%) said that there is nothing they would change about the services that they use.

Finally, the majority of staff (89%) agreed that clients are made to feel safe and comfortable when they attend services, and that services are good at finding ways of improving the service that they provide. The majority of service users (75%) agreed that they are made to feel safe and comfortable when attending drug and alcohol services. A small proportion of respondents (10%) did not agree with this, and 15% answered 'don't know'. Over half (60%) of the service users who responded agreed that drug and alcohol services are good at finding ways of improving the service that they provide. Seven people (12%) disagreed with this and fifteen people (25%) answered 'don't know'.

5.3.3 Safe storage of prescription drugs

Over half of the stakeholders (65%) felt that safe storage of prescription drugs such as methadone is an area of concern for homeless substance users. Among these stakeholders, just under half (41%) stated that they were aware of hostels that provide storage of methadone, while the other 53% stated that they were

not aware of services that provided safe storage. There was general agreement that storing of methadone in hostel premises is a 'grey area' in terms of legality, as there can be a very thin line between storing and dispensing. Just over half of the stakeholders stated that in order to avoid this legal issue, clients are usually asked to pick up their daily prescriptions from the chemist.

A few stakeholders mentioned that the idea of supervised consumption can be used an example of good practice to tackle this issue of methadone storage.

Staff from substance misuse services were asked to agree or disagree with the statement 'we ensure safe storage of methadone/other substances for clients who do not have stable accommodation'. Nearly half of the respondents (49%) disagreed with this statement, while a smaller proportion of 29% agreed with it. Amongst the remaining 22%, half said 'don't know' and the other half did not rate the statement at all.

Staff were also given the opportunity to provide any additional comments regarding the steps that are taken to ensure safe storage of methadone/other substances for this client group, and 81% (30 people) responded. Several respondents (20%) stated that they safely store and provide daily supervised consumption of controlled substances. Amongst the remaining 80%, the majority stated that they would provide their clients with the support and information required to collect their prescriptions from their chemist. A few mentioned that they provide advice on safe storage if clients live with children or vulnerable adults. Finally, just under half of the respondents stated that either safe storage was not part of their criteria or that the question was not applicable to their service.

Service users were also asked to rate the extent to which they agreed or disagreed with the statement 'Drug and alcohol services take steps to ensure safe storage of methadone/other substance'. Over half of the respondents (60%) agreed with the above statement, but 20% disagreed and 18% answered 'don't know'. One respondent (2%) chose not to rate the statement.

5.4 Barriers

A majority of stakeholders from homeless services and staff from substance misuse services agreed that there is a lack of continuity of care for this client group. Stakeholders felt that there is a need for long term supported accommodation to aid people to maintain sobriety and change their lifestyle. Similarly, staff felt that it would be useful to have aftercare services available to clients in order to help them sustain recovery.

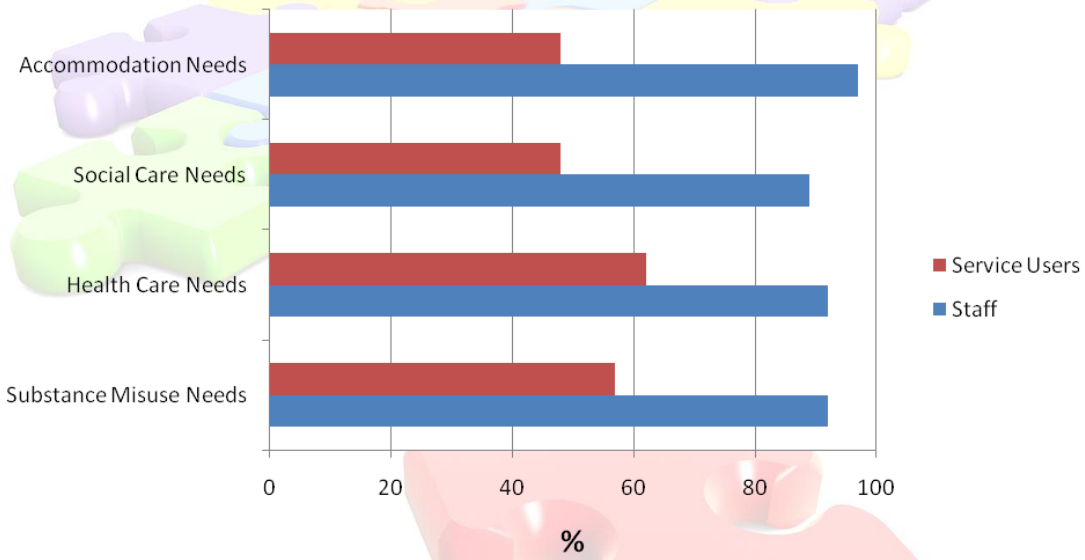
Additionally, five service users commented that they would like to see more rehabilitation and detoxification services in Edinburgh, of which one person felt

that rehabilitation services could have a more flexible approach.[168] Several stakeholders and staff also agreed that there is a need for more residential rehabilitation and detoxification services in Edinburgh.

5.5 Key Findings

- There are clear differences observed between the perceptions of staff working in drug and alcohol services compared to those of service users in relation to the extent to which health and social care needs are effectively identified. These perceptions are displayed in Figure 5.1 below:

Figure 5.1: Perceptions of Service User needs being identified

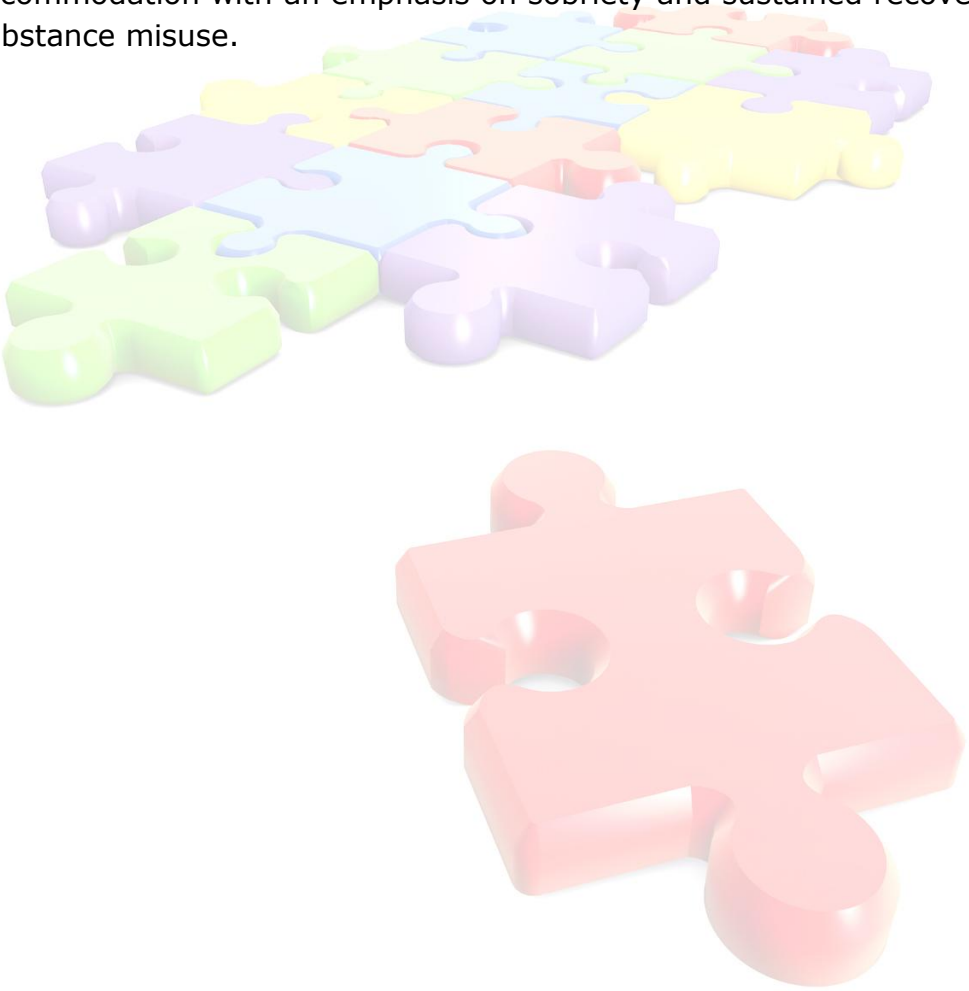


  - Almost all staff (97%) felt that they effectively identify service users' **accommodation needs** compared to less than half (48%) of service users.
  - Almost all staff (89%) felt that they effectively identify service users' **social care needs** compared to less than half (48%) of service users.
  - Almost all staff (92%) felt that they effectively identify service users' **health care needs** compared to 62% of service users.
  - Almost all staff (92%) felt that they effectively identify service users' **substance misuse needs** compared to just over half (57%) of service users.
- Three quarters (78%) of staff in substance misuse services felt that they were good at adapting the way that they provide services to homeless

[168] Service users did not specify whether rehabilitation and detoxification referred to should be residential or community based.

service users when their needs change in contrast to just over half (55%) of service users who shared that view.

- The safe storage of methadone for homeless clients does not appear to be well structured across the city. Only 30% of staff working in drug and alcohol services agreed that they ensure safe storage of methadone for clients who do not have stable accommodation and the majority of stakeholders viewed the storing of methadone in hostel premises as a 'grey area'.
- There was a perception amongst stakeholders and staff from substance misuse services that there is a need for a focus on long term supported accommodation with an emphasis on sobriety and sustained recovery form substance misuse.



Section 6: Joint Working

6.1 Aim and Method

The purpose of this section is to explore to what extent homeless/housing services and substance misuse services in Edinburgh work effectively with each other. Areas requiring improvement will also be discussed. A number of themes are presented below, some which were discussed at the stakeholder interviews and some which have emerged from the staff and client surveys.

6.2 Communication

Stakeholders were asked to comment on the extent to which substance misuse services and homeless services work effectively together. The majority of respondents (76%) felt that there could always be improvement in this area of joint work but overall the situation is better than it was ten years ago. The remainder (24%) felt that the joint work between services is good.

With regard to communication, over half of the stakeholders (70%) discussed the level of communication between their service and substance misuse services, half of whom felt that it was good while the other half felt it could be improved.

Among those who felt that communication between services could improve, three stakeholders in particular pointed out that the homelessness sector is making an effort to keep up to date with what substance misuse services are available to clients in Edinburgh, yet they don't feel that the same effort is made by substance misuse services with regard to awareness of homeless services. One stakeholder stated:

> *'In general there are fantastic services available, and homelessness services make a huge effort but it's not done the other way around ... I see myself and homeless colleagues at substance misuse events (conferences, meetings) but rarely see them at our events. We have a majority of our patients with an addiction issue, but in places like 'X Substance Misuse service', I think their clients who are homeless are a minority, so maybe this is where the problem lies.'*

A quarter of the stakeholders felt that homeless services and substance misuse services are not as aware of each other as they should be. As a result, clients are not always referred onto appropriate services.

Staff from substance misuse services were presented with three statements with regard to their communication with homeless services, with which they were asked to agree or disagree with on a scale of 1-5. With regard to effective communication, the majority (86%) felt that they communicate effectively with homelessness/housing services. With regard to planning and delivery of care, again the majority (84%) agreed that their service works effectively with

homelessness/housing providers in the planning and delivery of care. And finally, with regard to reviewing of care, 78% agreed that their service routinely consults with homelessness/housing providers when reviewing a person's care.

Service users were asked to rate to what extent they agreed or disagreed with the statement 'Drug and alcohol services work effectively with homelessness/housing providers in the planning and delivery of care'. Just over half of the respondents (52%) agreed with the above statement while 17% disagreed and 28% chose to answer 'don't know'. Two respondents (3%) chose not to rate the statement.

6.3 Information Sharing

Just under half of the stakeholders (41%) raised the issue of information sharing between services. Amongst them, the majority (71%) felt that there is a lack of information sharing between services, while the minority (29%) felt that information sharing between services is good.

Some stakeholders believed that it would be useful if substance misuse services share client information indicating areas of particular difficulty prior to referring them on. One stakeholder stated:

> *'We would like to get a bit of notice so we can identify something to match their needs.'*

6.4 Barriers to Joint Working

All of the stakeholders felt that joint working between homeless and substance misuse services in Edinburgh can be improved. Various factors were identified from the stakeholder interviews, staff surveys and clients' surveys as possible barriers to joint working between services.

6.4.1 Communication with Bed and Breakfast Services

Just under half of the stakeholders (47%) felt that there is very little communication between specialist and B+B services. As a result, homeless substance users who live in B+B services get very little support and information on what services are available to them. B + B services don't meet the needs of these people and stakeholders suggested that B+B services should be provided with more information on homeless and substance misuse services, and workers should be allowed to visit clients in B+B services.

6.4.2 Edinburgh Common Client Outcomes monitoring system

A number of stakeholders commented positively about the ECCO system, emphasising its record planning advantages and the majority of stakeholders felt that the ECCO system could be used to better effect by services.

There was a view expressed by a minority of stakeholders that the data requirements of the system had resulted in their services becoming 'outcome oriented' rather than 'client oriented' and that there was a tendency to become 'possessive' with their clients and that this can have a detrimental effect on joint working.

The research team was of the view that these comments were indicative of the concerns around recent commissioning activity and relevant to express here but were contrary to the ethos of the ECCO system which is to support joint working by sharing information between services working with the same person.

6.5 Key Findings

- Half of service users felt that drug and alcohol services work effectively with homelessness/housing providers.
- While there are pockets of good practice across the city there is a lack of structured communication between housing/homelessness services and substance misuse services in Edinburgh. Of particular note is the deficit in communication between substance misuse services and the B&B sector.
- All of the stakeholders felt that joint working between homeless and substance misuse services in Edinburgh can be improved.
- Most homelessness service managers and substance misuse service staff were keen to see more joint work and joint commissioning between their services.

Section 7: Conclusions and Recommendations

7.1 Overview

The aims of this study were:

1. To estimate the prevalence of substance misuse problems amongst homeless people (including people rough sleeping, those in forms of temporary accommodation, and those taking up settled accommodation) in Edinburgh;
2. To identify the substance-misuse related needs of homeless people; and
3. To examine to what extent existing substance misuse services work effectively with homeless people and the homelessness/housing services that support them and suggest recommendations to how this can be improved.

This section brings together the key findings of the report and discusses the implications of these within the context of the stated aims above.

7.2 Prevalence

Although the number of homeless people with alcohol and/or drug problems in Edinburgh cannot be accurately measured in finite terms there are reasonable proxy measures which allow estimations to be drawn. These are,

- The number of people assessed as being homeless by Edinburgh City Council and provided with a level of temporary accommodation
- A rate of between 1:3 (problem drinking) and 1:4 (drug dependence) within this population.

From these data, of the 4658 people assessed as homeless in Edinburgh in 2009/10, approximately 1500 would be problem drinkers and 1150 would be drug dependent. From the estimations of service managers, over 1000 (23%) of these would have problems with drugs and alcohol.

In terms of the 'In treatment' population, the Edinburgh Needs Assessment identified approximately 1644 people currently accessing drug services and a further 1267 accessing alcohol services in the city.

The data from prevalence studies and the available data on treatment seekers from Scotland and England suggest rates of homelessness of 1:6 (drug dependent) and 1:9 (problem drinkers).

This would equate to approximately 140 people currently in contact with alcohol services and 274 people currently engaged with drug services being homeless.

Although these figures are based on estimates, and given the limitations set out in Section 1, it is reasonable to suggest that there is a sizeable majority of

homeless substance users outside of drug and alcohol services. This is not necessarily a negative statement; some people will not be in a position where they are ready to make changes in their drug or alcohol use, others may have chosen other methods of addressing their problems e.g. mutual aid groups.

It does suggest however that there are some unanswered questions about these issues. The utilisation of existing assertive outreach resources, as suggested by stakeholders and service users, could better explore these and would help to signpost people towards services and community groups appropriate to the needs and wishes of the individual.

7.3 Meeting the needs

Many key features of policy and good practice guidance are common to the homelessness sector and the substance misuse sector in Scotland; these are holistic care, needs-led services, joint working, communication with the service user at the heart and equity of access.

On an individual level all of these exist in Edinburgh however issues such as equity of access, joint working and communication need to be systemic across the city to meet the standard required.

Due to the nature of homelessness and the erratic lifestyle that often accompanies it word of mouth and perceptions about the quality of service provision are strong antecedents of behaviour change. People will often hold on to pieces of information relating to waiting times, referral criteria and other peoples' experiences of services that they have heard about, without validation, and form a perception of what support options are available and/or desirable to them. As these determinants of decision making are often based on subjective measures, or as situations change, updates are not always readily available and so people continue to make decisions based on inaccurate or out-of-date information.

7.3.1 Access to services

In broad terms there appears to be sufficient resource across the city, both in terms of accommodation and the provision of substance misuse services. This was evidenced by the views of stakeholders and those accessing services as well as the information drawn from Edinburgh City Council and the gap analysis conducted as part of the drug and alcohol needs assessment in 2010. The perceptions of a small number of stakeholders regarding reduction in resources were not supported by the evidence from other sources. What was observed by the research team was a re-distribution of resources to meet changing trends.

The challenge appears to be in mobilising that resource to ensure that it meets a range of needs and being flexible enough to meet the changing needs of sub-populations.

This changing need has been characterised in this report by the identification of emerging gaps in provision including the need for a range of emergency facilities for those tolerant of ongoing use of alcohol and other substances and substance-free accommodation to support people in their recovery, the provision of aftercare to people who are moving towards independent living with their own tenancies and age-appropriate accommodation for younger people, although the size of demand for these remains undefined.

Two-thirds (65%) of staff from substance misuse services felt that opening times reflect the needs of this client group a view shared by half (48%) of service users, some of whom suggested a need for support at weekends. While it is not clear exactly how the current provision fails to meet the need, there appears to be sufficient levels of disagreement to merit further investigation.

It is clear from the evidence of stakeholders and staff that access to education and employment is a key part in laying the foundations for recovery. Stakeholders recognised both the importance of ensuring access as well as the difficulty some clients might have in engaging with these. The data suggest a difference of opinion between staff and service users as to how routinely this is offered in practice; 81% of staff state that they help service users get ready for work, training and volunteering, a view shared by only 48% of service users.

7.3.2 Identification and assessment of needs

From the data it is clear that there are differences in perception, between staff working in substance misuse services and service users, with regard to how well these services identify and assess problems relating to substance misuse, general health needs, social care needs and accommodation needs (see Figure 5.1). Almost all staff agreed that they effectively identify these needs compared to just over half of service users.

This raises four possible scenarios:

1. Staff in services are not as effective at identifying these issues as they believe.
2. Service users are working on perceptions that are not accurate (i.e. staff are good at identifying these issues but service users don't know this).
3. That there is a difference between staff and service users in their expectations i.e. what are the outcomes of assessment?
4. A combination of these scenarios.

These scenarios raise issues that will require further exploration if service users are to have the confidence in services to adequately help them to identify and address their needs.

7.3.3 Safe storage of prescribed drugs

Methadone was reported in 35 (43%) of the 81 drug-related deaths in Lothian last year. Although methadone is rarely the single cause of death, its detection at post-mortem toxicology suggests that it is at least a contributory factor. Within this context it is important that all reasonable measures are taken to ensure safe storage and consumption of methadone by those for whom it is prescribed.

It is noteworthy that only 30% of the staff from substance misuse services stated that they ensure safe storage of methadone for clients who do not have stable accommodation and the majority of stakeholders viewed the storing of methadone in hostel premises as a 'grey area'.

Six of the 11 staff who stated that they do ensure safe storage of methadone were from NHS services (HRT [2], DTTO [2], LEAP [2]) and remaining 5 were from Bethany Christian Centre [2], Hype, [1], NEDAC [1] and HOP [1].

Given the 'grey area' regarding legality and the clear risks associated with diversion and overdose, the question arises of whose responsibility it is to ensure safe storage of methadone and other prescribed drugs; prescribers (doctors), dispensers (pharmacists), housing providers or all services involved with an individual.

7.4 Good Practice in Joint Working

The relationships between substance misuse services and housing and homelessness services are often the determining factor in ensuring that people with complex needs are provided with access to services that can assist them in meeting these needs.

During the course of this work the research team collected evidence from a range of service providers and service users who cited examples of good joint working practices across a range of agencies in Edinburgh.

In particular the Edinburgh Access Practice has a unique role in providing that 'hub' service where service users know they can access a range of health and social care interventions. The policy of inclusiveness ensures that everyone has access to general medical services regardless of their housing/homelessness status. The service is well known by service providers and service users alike and has a very positive reputation from both.

Similarly, the relationship between the LEAP programme at Malta House (NHS Lothian) and the Randolph Crescent hostel (City of Edinburgh Council) works particularly well for client attending LEAP in no small measure because of the willingness of management and staff in both services to look at how they can work together to support individual clients in these early stages of their recovery journey.

Both these examples elucidate the evidence of good practice set out in Chapter 3.

7.5 Recommendations

This study is a supplementary report to the Edinburgh Drugs and Alcohol Needs Assessment Report and should be read in that context. The limitations to this study are set out in Section 1. The number of responses received from drug and alcohol service staff was too small (n=38) to be representative and therefore many of the conclusions drawn above should be regarded as indicative. In light of this the following recommendations are orientated towards conducting thorough audit and further research rather than at service re-design:

6. There needs to be better linkages between services for people with alcohol and drug problems and homelessness services. This could be achieved by:
   - The ADP and Services for Communities should make reference to services for people who are homeless and have substance misuse problems in their respective commissioning strategies
   - Joint training for managers and frontline staff
   - Agreements over joint working arrangements between substance misuse services and homelessness services (e.g. conducting joint assessments, identifying link workers and developing information sharing protocols where required).
   - Piloting the provision of peripatetic substance misuse services in hostels and other settings for homeless people

   (Section 4.2 & 6.4)
7. Alcohol and drug services need to better understand the provision of housing services and how to support clients access these services; as do homelessness services in terms of considering the needs of drug and alcohol users who are making steps towards recovery and ensuring the provision of accommodation which seeks to support these aspirations. Joint training should be considered as well as setting out clear training requirements in Service Level Agreements and Contracts. This needs to include housing support services that are provided to people who live in Bed and Breakfast and other temporary accommodation.

   (Section 2.4)
8. There are a number of protective/risk factors to both homelessness and alcohol and drug misuse including employment status, mental health, family relations. Alcohol and drug services and homeless services need to ensure that these issues are addressed as a part of care plans for their client groups. Consideration should also be given to carrying out an audit to accurately

identify the extent to which this is embedded to routine care and identify aspects of good practice.

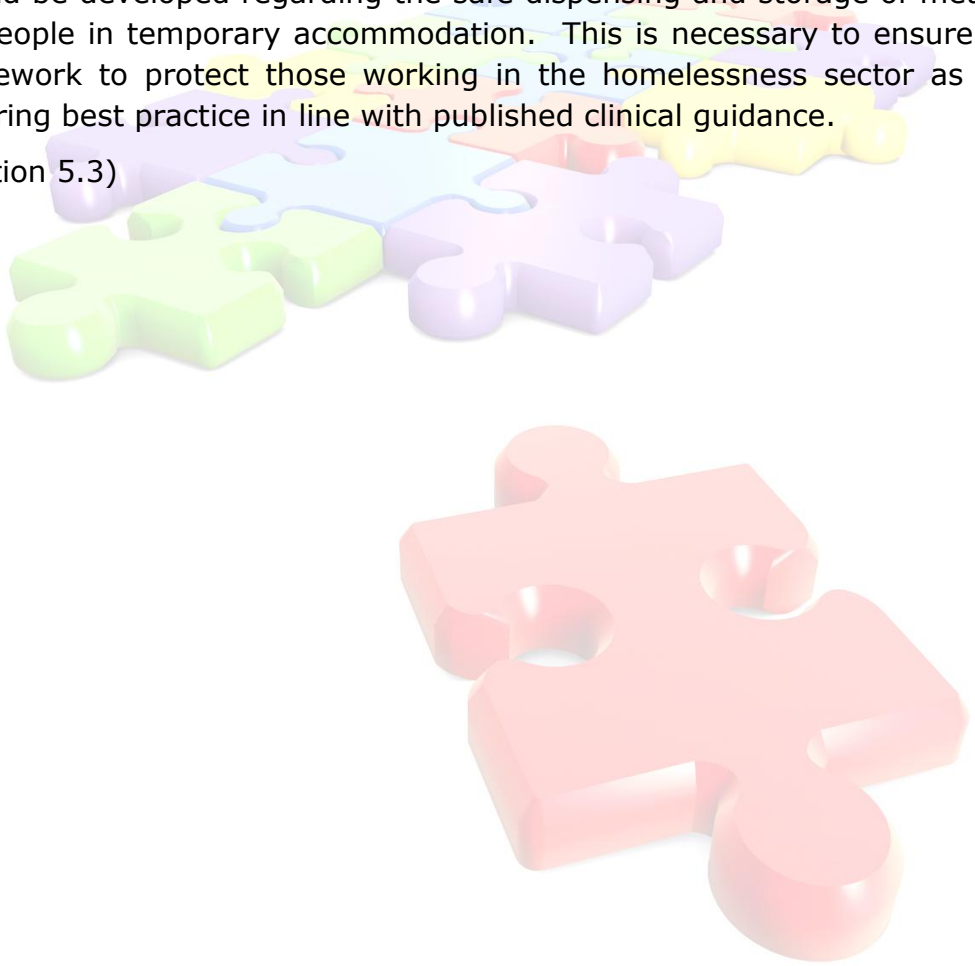
(Section 3.3 & 5.2)

9. Commissioners of substance misuse services and homelessness services need to communicate decisions about strategy, investment and current performance clearly to service providers to avoid misperceptions about service provision.

   (Section 6.4)

10. Where these are not clearly in place and followed multi-agency protocols should be developed regarding the safe dispensing and storage of methadone for people in temporary accommodation. This is necessary to ensure a legal framework to protect those working in the homelessness sector as well as ensuring best practice in line with published clinical guidance.

    (Section 5.3)



Appendix I

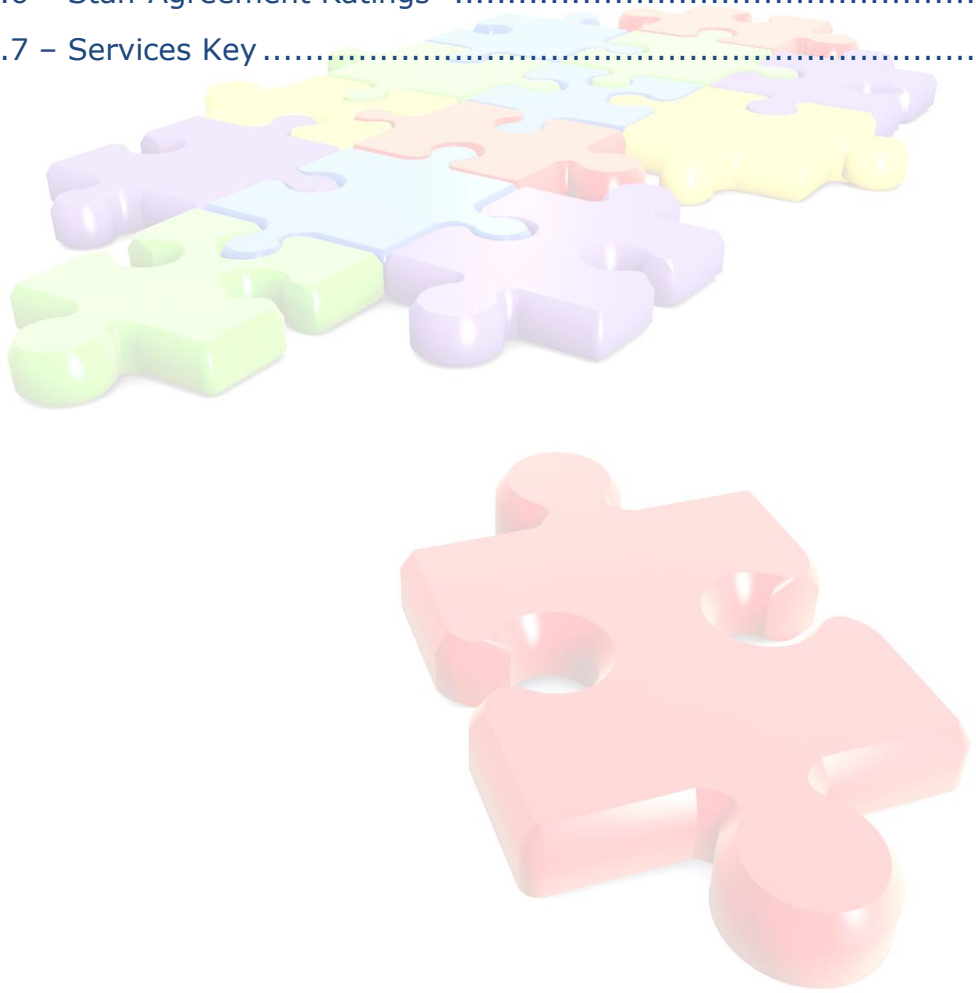


Table AI.1: Staff Survey Responses

NAME OF SERVICE	Staff Survey (Total: 37)
Aberlour Outreach (Edinburgh)	1
Adult Resource Team Addictions & HIV (Drug Referral Team)	1
Adult Resource Team Addictions & HIV (Residential Rehabilitation Referral Team)	0
Bethany Christian Centre	5
Castle Project	2
CHAI Substance Misuse Support Service	0
Circle (Harbour Project)	1
Community Addiction Recovery Service - CARS	0
Community Drug Problem Service	2
Crew 2000	1
Drug Treatment & Testing Order - DTTO	5
Housing Support	1
Harm Reduction Team	2
Homeless Outreach Project Addiction Team/Edinburgh Access Practice Substance Misuse Team	1
Hype	1
Lothian & Edinburgh Abstinence Programme - LEAP	6
Leith Project, Turning Point Scotland	1
Midpoint, Turning Point Scotland	2
NEDAC (North Edinburgh Drug Advice Centre)	4
SACRO Arrest Referral Service	0
Simpson House Counselling	0
Anonymous	1

Table AI.2: Stakeholder Interviews

Service	Stakeholder	Date of Interview
Dunedin Harbour Hostel	Kevin Brodie	7th September 2010
Bethany Christian Trust	Andrew Murray	7th September 2010
Hillcrest/Gowrie	Lorna Gunn	8th September 2010
Edinburgh Cyrenians	Amy Hutton	8th September 2010
CEC Access to Homelessness and Support	Brian Stewart	9th September 2010
Streetwork	Claire Gibson	9th September 2010
Crossreach	Andy Cashman	9th September 2010
Edinburgh Housing Advice Partnership- CHAI	David Gardner	9th September 2010
Four Square	Rick Murray	14th September 2010
Midpoint Accommodation Support	Laura Wright	14th September 2010
The Access Point	Tracey Connor	15th September 2010
Castlecliff Hostel	Martin McNaughton	15th September 2010
Homeless Outreach Practice	Andy MacAleavy	30th September 2010
Orchard and Shipman	Carola Donald	30th September 2010
Edinburgh Access Practice	Digby Thomas	4th October 2010
The Access Point	Colin Langley	20th October 2010
Cranston Street Hostel	Rose Turnbull	22nd October 2010
Stopover and Number Twenty	Linda Mugadza	5th November 2010
Shakti Women's Aid	Girijamba Polubothu	11th November 2010

Table AI.3: Client Survey Responses

NAME OF SERVICE	Client Survey Total Sent: 514	Client Survey Total Received: 60 (12%)
Edinburgh City Council (Hostels and Temporary Accommodation)	100	0
Foursquare	50	0
Bethany Christian Trust	10	0
Cunningham House	41	5
Cyrenians	20	0
Move On	25	0
Streetwork	30	21
Orchard Shipman	50	0
EHAP-CHAI	70	0
Access Point	0	0
Castlecliff	18	5
Dunedin Harbour	30	13
Midpoint	40	8
Hillcrest	15	0
Homeless Outreach Project	15	8

Table AI.4: Services used by client survey respondents

Service	Number of respondents who use service
EAP	30
HOP	23
CDPS	19
HRT	15
DTTO	13
GP	12
TPS	12
NEDAC	8
APS	8
ELCA	5
LEAP	3
SWAT	3
OXGANGS	2
CHAI	2
CARS	1
HYPE	1
AA	1

Table AI.5: Service User Agreement Ratings

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	No Answer
Drug and alcohol services work effectively to meet the substance-misuse related needs of homeless people	31.7	36.7	13.3	11.7	6.7	0
Drug and alcohol service opening times reflect the needs of homeless people	15.0	33.3	15.0	25.0	11.7	0
The location of drug and alcohol services are accessible to homeless people	20.0	55.0	11.7	13.3	0	0
Services provide enough information about their service to help me decide whether to come along	13.3	56.7	13.3	13.3	3.3	0
I am made to feel safe and comfortable when I attend drug and alcohol services.	21.7	53.3	15.0	6.7	3.3	0
Drug and alcohol service referral criteria make it difficult for homeless people to attend	10.0	26.7	33.3	25.0	5.0	0
Drug and alcohol services effectively identify my substance misuse related needs	15.0	41.7	25.0	13.3	5.0	0
Drug and alcohol services effectively identify my accommodation needs	21.7	28.3	13.3	30.0	6.7	0
Drug and alcohol services effectively identify my social care needs	11.7	36.7	21.7	25.0	3.3	1.7
Drug and alcohol services effectively identify my health care related needs	15.0	46.7	20.0	15.0	1.7	1.7
Drug and alcohol services are good at adapting the way in which they provide services when my needs change	13.3	41.7	30.0	8.3	5.0	1.7

Drug and alcohol services help to make my situation better	13.3	51.7	20.0	6.7	6.7	1.7
Drug and alcohol services help me to get ready for work, training or volunteering	6.7	41.7	30.0	11.7	8.3	1.7
Drug and alcohol services provide good health advice and information, and help me to find health providers (e.g., GP, dentist, optician)	25.0	46.7	13.3	6.7	3.3	5.0
Drug and alcohol services take steps to ensure safe storage of methadone/other substances	21.7	38.3	18.3	13.3	6.7	1.7
Drug and alcohol services work effectively with homelessness / housing providers in the planning and delivery of care	16.7	35.0	28.3	13.3	3.3	3.3
Drug and alcohol services are good at finding ways to keep improving the service they provide	15.0	45.0	25.0	10.0	1.7	3.3

Table AI.6: Staff Agreement Ratings

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	No Answer
This service works effectively to meet the substance-misuse related needs of homeless people	40.5	40.5	10.8	5.4	0	2.7
Our opening times reflect the needs of homeless people	13.5	51.4	10.8	18.9	2.7	2.7
The location of our service is accessible to homeless people	29.7	59.5	0	8.1	0	2.7
We provide enough information about our service to help service users decide whether to come along	32.4	45.9	16.2	0	0	5.4
People who are homeless are made to feel safe and comfortable when they attend this service	45.9	43.2	2.7	5.4	0	2.7
Our referral criteria makes it difficult for homeless people to attend	0	10.8	13.5	40.5	24.3	10.8
Our assessment process effectively identifies the substance-misuse related needs of homeless people	43.2	48.6	5.4	0	0	2.7
Our assessment process effectively identifies the accommodation needs of homeless substance users	37.8	56.8	2.7	0	0	2.7
Our assessment process effectively identifies the social care needs of homeless substance users	29.7	59.5	5.4	2.7	0	2.7
Our assessment process effectively identifies the health care related needs of homeless substance users	35.1	56.8	2.7	2.7	0	2.7
We are good at adapting the way in which we provide services to homeless service users when their needs change	27	51.4	8.1	8.1	2.7	2.7
We help service users who are homeless to get ready for work,	32.4	48.6	2.7	10.8	2.7	2.7

training or volunteering						
We provide good health advice and information, and help homeless service users to find health providers (e.g., GP, dentist, optician)	48.6	43.2	0	5.4	0	2.7
We provide support for homeless service users with tasks such as shopping and budgeting	11.1	41.7	5.6	30.6	5.6	8.1
We provide homeless service users with emotional support	37.8	56.8	0	2.7	0	2.7
We ensure safe storage of methadone/other substances for clients who do not have stable accommodation	13.5	16.2	10.8	32.4	16.2	10.8
Our service communicates effectively with homelessness/housing services	40.5	45.9	10.8	0	0	2.7
Our service works effectively with homelessness/housing providers in the planning and delivery of care	37.8	45.9	5.4	8.1	0	2.7
Our service routinely consults with homelessness/housing providers when reviewing a person's care	37.8	40.5	8.1	10.8	0	2.7
We are good at finding ways to keep improving the service we provide	35.1	54.1	8.1	0	0	2.7

Table AI.7 Services Key

Dunedin Harbour Hostel – DHH

Cross Reach- CR

Castle Cliff – CC

Access Point – AP

Edinburgh Access Practice – EAP

Homeless Outreach Project – HOP

Street Work- SW

Hillcrest – HC

Midpoint – MP

Edinburgh Housing Advice Partnership – EHAP

Orchard + Shipman – OS

Edinburgh Cyrenians – EC

Bethany Christian Centre – BCC

Four Square- FS

Edinburgh City Council – ECC

Aberlour Outreach (Edinburgh) -AO

Adult Resource Team Addictions & HIV (Drug Referral Team) – ARTA (DRT)

Adult Resource Team Addictions & HIV (Residential Rehabilitation Referral Team – ARTA(RRRT))

Castle Project - CP

CHAI Substance Misuse Support Service -CHAI

Circle (Harbour Project) - HP

Hype -HYPE

Community Drug Problem Service - CDPS

Crew 2000 - CREW

Drug Treatment & Testing Order - DTTO

Housing Support -HS

Harm Reduction Team - HRT

Homeless Outreach Project Addiction Team/Edinburgh Access Practice Substance Misuse Team -

Community Addiction Recovery Service - CARS

Lothian & Edinburgh Abstinence Programme - LEAP