

6. PATTERNS OF SUBSTANCE MISUSE AMONG HOMELESS PEOPLE

6.1 Introduction

This section sets out the findings of the interviews with homeless people in relation to their substance use. It includes analysis of the prevalence of substance use and dependency, as well as discussion of risk behaviours associated with substance use and their impact on health.

It is important to note the following:

- prevalence and dependency analysis is based on a survey of homeless people living in temporary accommodation and using emergency homelessness services. A sample frame was constructed to ensure broad representation across the various types of accommodation available and during interviews assurances of confidentiality were given. However, the research relied on self selection, and it is possible that the nature of the sample achieved and potential selection bias may have impacted on the findings in this area;
- prevalence rates for drugs and alcohol have been compared to figures from NI wide surveys and other surveys of homeless people. Also, alcohol dependency within our sample has been compared to that for NI as a whole based on Health Promotion Agency research. No suitable comparisons were available for drug dependency. A similar research project into homelessness and substance use has recently been completed by the Merchant's Quay Initiative (MQI) on behalf of the National Advisory Committee on Drugs in the Republic of Ireland. The MQI research included the same drug and alcohol screening tools as the current study so would provide useful comparative data. However at the time of writing, results from the survey were not yet approved for release. Caution must be taken when comparing results from the various research studies as each used different questionnaires and sampling methods;
- service providers were asked to indicate the prevalence of substance use among their homeless clients. Comparison of the prevalence rates reported by providers and directly by homeless people showed that provider estimates of drug and alcohol use were considerably lower. However, the responses to these questions have not been included in the analysis below for the following reasons:
 - providers did not always have systematic records of their client's substance use and may not have had a sufficiently close relationship with their clients to allow them to comment on their substance use. Also homeless people may be reluctant to provide information on their substance use to accommodation providers in case it impacts negatively on their access to housing. Therefore, while providers gave their best estimate of substance use among clients for the survey, this may not be accurate and it may underestimate the scale of the problem;
 - responses to the various questions on substance use posed in the provider survey were inconsistent within many of the questionnaires returned. Therefore, the data was felt to be unreliable; and

- homeless people in our interview programme were found to be very open across the range of topics under discussion and it seems reasonable to assume that the information they provided on substance use is an accurate reflection of their behaviour and an appropriate basis upon which to determine the problem under investigation.

6.2 Prevalence of Drug and Alcohol Use

One hundred and fifty-four homeless people were interviewed for this research. Of these:

- 106 (69%) drank alcohol on a monthly or more frequent basis;
- 106 (69%) had used drugs at some stage in their lives;
- 78 (50%) drank alcohol and had used drugs; and
- 20 (13%) had never used drugs and did not currently drink.

Further details of alcohol and drug use are outlined in the following sections.

6.2.1 Alcohol Use

Of the 154 homeless people that were interviewed, 106 (69%) drank alcohol on a monthly or more frequent basis. Of these, 57 (54%) were male and 49 (46%) were female. Forty-eight (45%) were aged between 26 and 59 and 43 (41%) were aged between 18 and 25.

More homeless women than men under 25 drank alcohol however the majority of these women drank 2 to 4 times a month or less. Males were twice as likely to drink on a weekly basis, with 26 males drinking between 2 and 4 or more times a week, compared with 13 females. Of the 39 who drank on a weekly basis, the majority (37), were currently living alone and 19 of these were living in a direct access hostel.

Table 6.1 shows the gender and age ranges of those that drank alcohol.

Table 6.1
Gender and Age Ranges of Alcohol Users

	16-17	18-25	26-59	60+	Total
Male	7	18	32	0	57
Female	6	25	16	2	49
Total	13	43	48	2	106

Forty-eight of those interviewed advised that they were not taking alcohol at the time of the interview. There was an even gender split between those not drinking and 36 (75%) were aged between 26 and 59. Forty-four of the 48 advised that they had drunk in the past. Half of these (22) had drunk more than 4 times a week with 21 of the 22 having drunk seven or more alcoholic drinks per day. Only four interviewees had never taken alcohol at all. Of the 48 that advised that they were not taking alcohol at the time of the interview, the duration of their abstinence varied considerably, with some only having stopped for as little as three weeks while others had not drunk for 10 years. This suggests the need for services that support homeless individual's choice to abstain from alcohol use.

6.2.2 Drug Use

Of the 154 homeless people that were interviewed, 106 (69%) had used drugs at some stage in their lives (i.e. were lifetime users). Of these 106, 62 (58%) were recent users (had used drugs in the past year), and 57 (54%) were current users of one or more substance. As a proportion of all those interviewed 69% were lifetime users, 40% were recent users, 37% were current users and the remainder did not use drugs.

Table 6.2 and 6.3 provide information on the gender and age of the drug users interviewed. The details show that:

- men were more likely than women to have used drugs irrespective of prevalence and were more than twice as likely to be currently using drugs;
- women were more likely to be lifetime users rather than recent or current users;
- 48% of lifetime users were aged between 26 and 59; and
- 46% of current users were aged between 18 and 25.

Table 6.2
Gender of Drug Users

	Lifetime	%	Recent	%	Current	%
Male	61	58	40	65	39	68
Female	45	42	22	35	18	32
Total	106	100	62	100	57	100

Note: % totals do not sum due to rounding.

Table 6.3
Age Range of Drug Users

	Lifetime	%	Recent	%	Current	%
16-17	10	9	8	13	7	12
18-25	45	42	27	44	26	46
26-59	51	48	27	44	24	42
60+	0	0	0	0	0	0
Total	106	100	62	100	57	100

Note: % totals do not sum due to rounding.

Substances Used

Table 6.4 details the substances used by interviewees and whether they reported being lifetime, recent or current alcohol users. The figures show that:

- cannabis was the most commonly used drug among all types of users, with 67% of the sample having used the substance at some stage;
- the three drugs most commonly used by lifetime users were cannabis, ecstasy and amphetamines. However, among recent and current users, this changed to cannabis, tranquillisers and ecstasy; and
- ten percent had used heroin at some stage and 1% reported being current users.

Table 6.4
Substances Used

	Life time	Percentage of Total	Recent	Percentage of Total	Current	Percentage of Total
Cannabis	103	67	59	38	51	33
Ecstasy	68	44	33	21	19	12
Amphetamines (e.g. speed)	55	36	25	16	11	7
Tranquillisers, Benzodiazepines (e.g. valium, temazepan)	52	34	35	23	22	14
Hallucinogens (e.g. LSD, PCP, Magic Mushrooms, Ketamine)	45	29	13	8	4	3
Amyl Nitrate (poppers)	43	28	19	12	9	6
Solvents (e.g. gas, glue, inhalants)	41	27	7	5	4	3
Other Opiates (Codeine, dihydrocodeine, morphine, solphadine, co-codamol etc.)	37	24	18	12	13	8
Cocaine	32	21	11	7	1	1
Substitute Opiates (methadone, buprenorphine, DF118)	20	13	9	6	3	2
Heroin	15	10	5	3	2	1
Crack	13	8	5	3	1	1
Anabolic Steroids	7	5	2	1	1	1
Any Drug	106	69	62	40	57	37

Note: Lifetime, Recent and Current figures are cumulative. Respondents were asked to select all drugs used, therefore multiple responses were allowed.

Prevalence Among Drug Users

Table 6.5 details the four drugs most commonly used by drug users in the sample (n=106) and provides details of prevalence by gender. The information shows that cannabis and ecstasy use was broadly similar between men and women lifetime users. However, men were more likely to be recent or current users of these drugs and more likely to have used amphetamines or tranquillisers whether currently, recently or in the past. The gender difference is most striking as regards tranquillisers, where male usage rates are double that of female regardless of prevalence. Tranquillisers are commonly used by those with alcohol dependency problems.

Table 6.5
Substances Used – by Prevalence and Gender

	Lifetime		Recent		Current	
	Percentage Male	Percentage Female	Percentage Male	Percentage Female	Percentage Male	Percentage Female
Cannabis	97	98	64	44	57	36
Ecstasy	66	62	38	22	25	9
Amphetamines	57	44	28	18	15	4
Tranquillisers, Benzodiazepines	62	31	43	20	26	13

Note: male (n=61), female (n=45)

Table 6.6 details the four most common drugs used by each age group. The information shows that:

- cannabis usage is highest among lifetime users with between 96 and 100% having used the substance. Usage decreases significantly among recent and current users;
- irrespective of prevalence, ecstasy and amphetamine usage is highest among 18 to 25 year olds than any other age groups; and
- tranquilliser usage is highest among those aged 26 to 59 for lifetime and current users.

Table 6.6
Substances Used – by Age (Percent)

	Lifetime %			Recent %			Current %		
	16-17	18-25	26-59	16-17	18-25	26-59	16-17	18-25	26-59
Cannabis	100	98	96	80	58	49	40	58	41
Ecstasy	40	84	51	40	47	16	20	31	6
Amphetamines	20	62	49	20	33	16	10	18	4
Tranquillisers, Benzodiazepines	40	47	53	20	38	31	10	20	24

Note: 16-17 (n=10), 28-25 (n=45), 26-59 (n=51)

6.2.3 Comparison of Results with Drug and Alcohol Use among the General Population in Northern Ireland

In order to contextualise the results of the research with homeless people we have made comparisons in the section below with prevalence rates of drug and alcohol use among the general population. We have used key figures from the Northern Ireland Drug Prevalence Survey (NACD, 2004), and the Northern Ireland (NIO, 2003) and British Crime Surveys (Condon & Smith 2003) as a comparison.

The Drug Prevalence Survey was conducted in 2002/3 with 8,442 private households in the Republic of Ireland and Northern Ireland. In Northern Ireland 3,517 people were interviewed. Of this sample 45% were male and 55% were female, 40% were aged between 15 and 34 and 60% between 35 and 64.

Table 6.7 compares key statistics from the Northern Ireland section of the survey (n = 3,517) with the results from the interviews with homeless people. The comparison shows that:

- a significantly higher proportion of the homeless people interviewed were lifetime, recent or current users of drugs compared to the Northern Ireland average. More than 10 times the proportion of homeless people in this research reported being current drug users than did the Northern Ireland population in the DHSSPS research;
- cannabis was the most common drug used by homeless people, however tranquillisers/benzodiazepines are the most commonly used drugs among the general population; and
- lifetime alcohol use is higher among homeless people interviewed than the Northern Ireland average, but current alcohol usage levels are broadly similar.

Table 6.7
Comparison of Alcohol and Drug Use in Northern Ireland

	Deloitte Research ¹	Drug Use in NI ²	Deloitte Research ¹	Drug Use in NI ²	Deloitte Research ¹	Drug Use in NI ²
	Lifetime		Recent		Current	
Any illegal drug ³	68.8	20.4	40.3	6.2	35.7	3.3
Cannabis	66.9	16.8	38.3	5.3	33.1	2.9
Heroin	9.7	0.2	3.2	-	1.3	-
Substitute Opiates	13.0	0.1 ⁴	5.8	-	1.9	-
Other Opiates	24.0	17.9	11.7	7.9	8.4	4.1
Cocaine	20.8	1.7	7.1	0.5	0.6	0.1
Crack	8.4	0.2	3.2	-	0.6	-
Amphetamines	35.7	3.9	16.2	0.8	7.1	0.2
Ecstasy	44.2	5.9	21.4	1.7	12.3	0.5
Hallucinogens	29.2	4.5 ⁵	8.4	0.1	2.6	-
Solvents	26.6	2.9	4.5	0.2	2.6	0.1
Amyl Nitrate	27.9	5.6 ⁶	12.3	0.5	5.8	0.2
Anabolic Steroids	4.5	0.8	1.3	0.3	0.6	0.1
Tranquillisers, Benzodiazepines	33.8	22.1 ⁷	22.7	12.5	14.3	9.8
Alcohol	97.4	88.4	not available	79.4	68.8	67.7

Notes:

¹ n=154, age range 16 to 65

² n=3,517, age range 15 to 64

³ Cannabis, Ecstasy, Amphetamines, Crack, Cocaine, Heroin, LSD, Solvents, Poppers and Magic Mushrooms

⁴ The results for methadone usage have been used as a comparison

⁵ The results for LSD usage have been used as a comparison

⁶ The results for poppers have been used as a comparison

⁷ The results for Sedatives, Tranquillisers and Anti-depressants have been used as a comparison

The Northern Ireland and British Crime Surveys also record prevalence of drug use among the general population through surveys conducted in a representative cross-section of private households each year. The surveys record drug prevalence in a similar way (i.e. lifetime, recent and current use) and therefore the results can be used to compare prevalence rates. Key figures from these surveys are outlined in Table 6.8. The statistics show that recorded levels of drug use are broadly similar between the Drug Prevalence Survey and the NI Crime Survey. The Crime Surveys include additional drugs that are considered to be ‘illegal’ and therefore prevalence rates for usage of ‘any illegal drug’ are slightly higher. The comparison also shows that cannabis usage is considerably higher in Britain. When the results are compared to those for the homeless people interviewed, prevalence rates are still considerably higher among the homeless population than the general population.

Table 6.8
Comparison of Drug Use

	Deloitte Research ¹	Drug Use in N.I. ²	NI Crime Survey (2001) ³	British Crime Survey (2002/03) ⁴
Any illegal drug – lifetime	68.8	20.4	26.0 ⁵	36.0 ⁵
Any illegal drug – recent	40.3	6.2	11.0	12.0
Any illegal drug – current	35.7	3.3	7.0	7.4
Cannabis – lifetime	66.9	16.8	18.0	29.0
Cannabis – recent	38.3	5.3	7.0	10.9
Cannabis – current	33.1	2.9	4.0	6.7
Ecstasy – lifetime	44.2	5.9	6.0	-
Ecstasy – recent	21.4	1.7	-	2.0
Ecstasy – current	12.3	0.5	-	0.9
Heroin – lifetime	9.7	0.2	2.0	-
Heroin – recent	3.2	-	-	0.1
Heroin – current	1.3	-	-	0.1
Most frequently used illegal drug	Cannabis	Cannabis	Cannabis	Cannabis

Notes:

¹ n=154, age range 16 to 65

² n=3,517, age range 15 to 64

³ n=2,037, age range 16 to 59

⁴ n=23,586, age range 16 to 59

⁵ It has not been possible to directly compare the research findings with the NI and British Crime Survey results. The crime surveys consider an “illicit drug” to be amphetamines, cannabis, cocaine, crack, ecstasy, heroin, LSD, magic mushrooms, methadone, tranquillisers, amyl nitrate, anabolic steroids and glues (BCS only).

6.2.4 Comparison of Results with Studies of Drug Use among the Homeless

Several studies have been conducted with homeless people in the UK and Ireland in recent years in order to assess drug and alcohol usage. These studies have not focused exclusively on drug and alcohol usage and have used varying methods of recording usage. However, their key results can be used as an illustration and comparison for this research and are shown in Table 6.9 overleaf. The results are variable, but generally indicate a high level of substance use among this population. The comparison studies are as follows:

- **Home and Dry** (Fountain and Howes, 2002) – this study involved interviews with 389 homeless people in London, many of whom were sleeping rough at the time of the research (58% had slept rough at least once in the month before they were interviewed);
- **Evaluation of Fáiltíú** (Merchant’s Quay Ireland, 2003) – this study involved interviews with 40 clients of MQI’s Fáiltíú service which provides advice to homeless people and those threatened with homelessness;
- **National Advisory Committee on Drugs** (O’Gorman, 2002) – this study drew together available evidence from other research projects as to the extent of drug use among the homeless population. The studies all explored the health needs of homeless people in temporary accommodation in Dublin, rather than focusing on substance use.

Table 6.9
Comparison of Drug Use Across Homelessness Research

Percentage	Deloitte Research ¹	Home and Dry ²	Merchants Quay Ireland ³	Holohan ⁴	Feeney et al ⁵	Condon et al ⁶	Smith et al ⁷
Any illegal drug – lifetime	68.8	94.0 ⁸	90.0 ⁹	27.0	55.0	38.0	64.0
Any illegal drug – recent	40.3	88.0	-	-	35.0 ¹⁰	26.0 ¹⁰	41.0 ¹⁰
Any illegal drug – current	35.7	83.0	72.5	-	-	-	-
Cannabis – lifetime	66.9	86.0	-	-	51.0	-	41.0
Cannabis – recent	38.3	73.0	-	-	-	-	-
Cannabis – current	33.1	65.0	-	-	-	-	-
Ecstasy – lifetime	44.2	-	-	-	-	-	-
Ecstasy – recent	21.4	-	-	-	-	-	-
Ecstasy – current	12.3	-	-	-	-	-	-
Heroin – lifetime	9.7	67.0	-	-	18.0	-	47.0
Heroin – recent	3.2	55.0	-	-	-	-	-
Heroin – current	1.3	47.0	-	-	-	-	-
Most frequently used illegal drug	Cannabis	Cannabis	-	-	Cannabis	-	Cannabis
Alcohol – lifetime	97.4	93.0	-	-	-	-	-
Alcohol – current	68.8	68.0	-	-	-	-	-

Notes:

¹ n=154, age range 16 to 65

² n=389, age range under 18 to 51+

³ n=40, mean age 32.6

⁴ n=502, aged 18+, 42% aged under 35 (O’Gorman)

⁵ n=171, all male, 50% aged 35-54 (O’Gorman). Lifetime prevalence figure for the 18-34 age group in the sample was over 80%.

⁶ n=234, 73% aged over 35, 90% male (O’Gorman)

⁷ n=100, 75% aged 18-34, all women (O’Gorman). Lifetime prevalence figure for the 18-34 age group in the sample was 83%.

⁸ The results for “any drug (excl alcohol)” have been used as a comparison, although a definition of what is covered by this term is not provided

⁹ Illegal drugs for this research were described as including cannabis, amphetamines, cocaine, heroin, hallucinogens, LSD and ecstasy. Figures for use of each individual drug were not available although the research identified the primary substance of choice. Heroin was the primary drug of use for 23% of those interviewed and methadone was the primary drug of use for 33%. Sixty-three percent were polydrug users, i.e. used more than one drug.

¹⁰ In these studies use of illegal drugs within the last year was termed ‘recent use’. Definitions of the substances considered as ‘drugs’ in these studies were not provided.

6.3 Dependency

6.3.1 Alcohol Dependency

The Alcohol Use Disorders Identification Test (AUDIT) was used to measure alcohol dependency among the 106 interviewees who advised that they drank alcohol.

The tests were scored and interpreted using the guidelines created by Babor et. al. (2001) for the World Health Organisation.

A total score of eight or more on the test indicates hazardous and harmful alcohol use, as well as possible alcohol dependency. Based on the sample of 106, 70 (66%) were using alcohol in this way. Of these 48 (69%) were male and 22 (31%) were female. Table 6.10 details the test scores by gender.

Table 6.10
Alcohol Dependency - by Gender

Score \ Gender	<8	8 to 15	16 to 19	20 to 29	30-39	Total Scoring 8+
Male	9	15	10	14	9	48
Female	27	14	4	2	2	22
Total	36	29	14	16	11	70

Further research carried out by Miller (1992) found that AUDIT scores in the range of 8 to 15 represented a medium level of alcohol problems whereas scores of 16 and above represented a high level of alcohol problems. This would indicate that among those interviewed, males were more likely to be using alcohol in a hazardous or harmful way as the test scores showed that:

- 31% of males and 64% of females had a medium level of alcohol problems (scoring 8 to 15); and
- 69% of males and 36% of females had a high level of alcohol problems (scoring 16+).

Table 6.11 outlines the test scores by age range. Of those scoring more than 8 on the test (70 interviewees), 30 (43%) were aged between 26 and 59 and 28 (40%) were aged between 18 and 25.

Of those showing a medium level of alcohol problems (scoring 8 to 15), over half were aged between 18 and 25. High levels of alcohol problems were most common among those aged between 26 and 59, with 20 scoring over 16 points, and 17 scoring more than 20 points.

Table 6.11
Alcohol Dependency - by Age Range

Score \ Age	<8	8 to 15	16 to 19	20 to 29	30-39	Total Scoring 8+
16-17	1	3	6	2	1	12
18-25	15	16	5	6	1	28
26-59	18	10	3	8	9	30
60+	2	0	0	0	0	0
Total	36	29	14	16	11	70

As outlined above the AUDIT test aims to measure three domains: hazardous alcohol use, dependency symptoms and harmful alcohol use. The test results are interpreted below for each of these domains.

Hazardous Alcohol Use

A score of one or more on Questions 2 and 3 can indicate consumption of alcohol at a hazardous level. Based on this scoring:

- 101 interviewees (95%) indicated that they drank three or more alcoholic drinks on a typical day when drinking (Question 2);

- 89 (84%) had more than 6 drinks (women) or 8 drinks (men) on one occasion (Question 3) indicating problematic drinking behaviour; and
- 87 scored one or more on both questions.

Table 6.12 outlines the scores for Questions 2 and 3.

Table 6.12

Question 2 and 3

Score	0 (1 or 2 drinks)	1 (3 or 4 drinks)	2 (5 or 6 drinks)	3 (7,8 or 9 drinks)	4 (10 or more drinks)
Question 2	5	23	22	18	38
Score	0 (Never)	1 (Monthly or less)	2 (2-4 times a month)	3 (2-3 times a week)	4 (4 or more times a week)
Question 3	17	38	18	23	10

Dependence Symptoms

Points scored above 0 on Questions 4 to 6 imply the onset or presence of alcohol dependence, especially for those who drink weekly. Based on this scoring:

- 43 interviewees (41%) indicated that during the last year they were not able to stop drinking once they had started;
- 41 interviewees (39%) indicated that during the last year they had failed to do what was normally expected of them because of drinking; and
- 23 interviewees (22%) indicated that during the last year they had needed a first drink in the morning to get themselves going after a heavy drinking session.

Table 6.13 outlines the scores for Questions 4 to 6. For all three questions men scored considerably higher than women – e.g. only 22% of women were not able to stop drinking once they had started, compared with 56% of men.

Table 6.13

Questions 4, 5 and 6

Score	0 (Never)	1 (Monthly or less)	2 (2-4 times a month)	3 (2-3 times a week)	4 (4 or more times a week)	Total No. scoring >0
Question 4	63	15	7	10	11	43
Question 5	65	14	12	9	6	41
Question 6	80	7	7	6	6	26
Average	69	12	8	8	7	-

Harmful Alcohol Use

Points scored on Questions 7 to 10 indicate that alcohol-related harm is already being experienced. Based on this scoring:

- 41 interviewees (39%) indicated that during the last year they have felt guilt or remorse after drinking;
- 60 interviewees (57%) indicated that during the last year they were unable to remember what happened the night before because of drinking;
- 33 interviewees (31%) indicated that during the last year someone else had been injured as a result of their drinking; and
- 33 interviewees (31%) indicated that during the last year a relative, friend, doctor or other health worker had been concerned about their drinking or suggested that they should cut down.

Table 6.14
Questions 7 and 8

Score	0 (Never)	1 (Monthly or less)	2 (2-4 times a month)	3 (2-3 times a week)	4 (4 or more times a week)	Total No. scoring >0
Question 7	65	21	8	7	5	41
Question 8	46	32	9	14	5	60

Table 6.15
Questions 9 and 10

Score	No	Yes, but not in the last year	Yes, during the last year	Total No. stating Yes
Question 9	58	15	33	48
Question 10	65	8	33	41

Summary

Seventy interviewees scored a total of 8 or more points on the AUDIT test. This overall scoring indicates hazardous and harmful alcohol use, as well as possible alcohol dependency. When analysed further using individual questions to measure the three domains (hazardous alcohol use, dependence symptoms and harmful alcohol use) the results indicate that:

- a high number of interviewees recorded scores in Questions 2 and 3 - 87 scored 1 or more on both questions compared with 70 scoring 8 or more points overall indicating consumption at hazardous levels;
- a lesser number indicated symptoms of dependency with an average of 35 interviewees scoring one or more points on these questions; and
- a similar number (average of 41 interviewees) indicated symptoms of harmful alcohol use.

These results indicate that the majority of those interviewed used alcohol in a hazardous way rather than having high dependency or using alcohol in a harmful way.

6.3.2 Comparison with Alcohol Problems among the General Population

Research into the drinking trends of adults in Northern Ireland was published by the Health Promotion Agency in 2002. The research recorded information about alcohol consumption and drinking patterns of 1,752 people in Northern Ireland. Of those interviewed, 42% were male and 58% were female. Interviewees were aged between 18 and 75, with 19% aged 18-29, 33% aged 30-44, 26% aged 45-59 and 22% aged 60 to 75.

Alcohol Problems

The research used the CAGE tool to screen for alcohol problems among interviewees. CAGE consists of four questions which focus on Cutting down, Annoyance by criticism, Guilty feeling and an Eye opener (drinking first thing in the morning), making the acronym CAGE.

The results indicated that of those screened (n=922), 7% of people who drank in the week prior to their interview responded positively to at least two CAGE questions, therefore indicating a possible alcohol problem. The AUDIT test (see Section 6.2.1) indicated that 70% of the sample of homeless people interviewed had possible alcohol problems (i.e. were using alcohol in a hazardous and harmful way). Although caution must be exercised when comparing these figures as they involve use of two different screening tools.

Binge Drinking

The Health Promotion Agency also assessed binge drinking². The results indicated that 48% of men and 35% of women had participated in at least one heavy drinking session or binge in the week prior to the survey. Question 3 of the AUDIT asked homeless interviewees how often they had more than 6 drinks (women) or 8 drinks (men) on one occasion (comparable with binge drinking). Results indicated that 84% of interviewees had exceeded this limit.

Although the results discussed above are not directly comparable because of the different measures of assessment, they seem to indicate much higher levels of alcohol problems among the homeless people interviewed than the population in general.

6.3.3 Comparison with Alcohol Problems in other Homeless Research

O’Gorman’s (2002) review of literature relating to substance use among homeless people in Ireland, reports on a study by hostel dwelling men in Dublin. It found that half of the 171 men interviewed were alcohol dependent, with over a quarter (29%) having a severe alcohol dependence. The means by which dependency was tested is not specified.

² Binge drinking is defined as the consumption of roughly half the recommended weekly limit in a single drinking session (i.e. 10 units for men and seven units for women).

6.3.4 Drug Dependency

Drug dependency was measured among interviewees who advised that they had used drugs during the last 12 months. This equated to recent and current drug users, of which there were 62.

In order to measure drug use, the Drug Abuse Screening Test (DAST) was used. The version used was the 10-item (question) DAST which is a shortened version of the original 28-item test, but it does provide highly correlated results to the original measure.

Interviewees are asked to respond “Yes” or “No” to 10 questions. Each “Yes” answer is scored as 1 and a “No” as 0. The total score for the ten questions is then calculated.

Bohn, et. al. (1991) advise using a cut-off score of 3 to determine individuals who have had a drug abuse problem in the last 12 months. The DAST test was completed with 61 of the 62 drug users, and all 61 scored over 3 points. Table 6.16 and 6.17 outline the scores by gender and age.

Table 6.16
DAST Scores - by Gender

Gender	Male	Female	Total
Score			
3 to 5	8	10	18
6 to 9	26	9	35
10 to 11	6	2	8
Total	40	21	61

Table 6.17
DAST Scores - by Age

Age	16-17	18-25	26-59	Total
Score				
3 to 5	5	6	7	18
6 to 9	2	16	17	35
10 to 11	1	5	2	8
Total	8	27	26	61

The scores show that while all interviewees would be considered as having a drug abuse problem:

- males had a higher level of abuse with 32 (80%) scoring 6 or more points, compared to 52% of females; and
- the majority of those scoring between 6 and 9 points were aged between 18 to 25 and 26 to 59.

The above 62 drug users were also asked questions that had been selected from the Severity of Opiate Dependence Scale (SODQ), which was adapted to measure drug use in general. No cut-off point has been agreed for this scale, but the results

provide additional information about the drug abuse and dependency of those interviewed.

Table 6.18
SODQ

		Never or almost never	Sometimes	Often	Always or nearly always	Total
A	Did you ever think your use of drugs was out of control?	26	16	10	9	61
B	Did the prospect of missing a smoke/snort/turn make you very anxious or worried?	28	13	7	13	61
C	Did you wish you could stop?	20	16	13	7	59
		Not at all	A little	Quite a lot	A great deal	Total
D	How much did you worry about your use of drugs?	21	25	8	7	61
		Not difficult	Quite difficult	Very difficult	Impossible	Total
E	How difficult would you find it to stop or go without drugs	22	16	13	7	58

Note: C: two missing answers, E: two missing answers

The results reinforce the results of the DAST as they show that:

- 69% of interviewees never or only sometimes thought their drug use was out of control;
- 61% never or only sometimes wished they could stop using drugs; and
- 75% did not worry or only worried a little about their drug use.

However, only 38% would find it easy to go without drugs. This seems to indicate that despite having problem drug use interviewees do not recognise it as a problem. This is an important finding as regards the type of substance misuse service that are provided to this group as many may not recognise that they need the services or the impact their substance use is having on their lives.

6.4 Risk Factors

The interviews also explored risk factors in relation to homelessness, and the links with substance use in particular.

6.4.1 Link between Homelessness and Substance Misuse

For the majority of those interviewed their use of alcohol and drugs had started before they became homeless.

For those interviewees using alcohol, 93% were drinking before they became homeless. Table 6.19 shows there is a strong correlation between the age interviewees had their first drink and the age they became homeless as:

- 79% of those who had their first drink at age 12 or under were homeless by the age of 17;
- 65% of those who had their first drink between the ages of 13 and 15 were homeless by the age of 17; and
- 82% of those who had their first drink between the ages of 18 and 25 were homeless by the age of 25.

Table 6.19

Age of First Drink – Age Became Homeless

Age became Homeless \ Age of First Drink	<15	16-17	18-25	26-59	60+	Total
12 or under	8	7	3	0	1	19
13 to 15	12	18	9	1	6	46
16 to 17	6	9	6	0	1	22
18 to 25	2	1	14	0	0	17
26+	0	0	1	1	0	2
Total	28	35	33	2	8	106

Eighty-two percent of interviewees who currently use drugs (n=57) advised that they had been using them before they became homeless, while 18% had only started to take drugs after they became homeless.

The majority of the 57, (34, 60%), whose drug use predated their homelessness advised that the first drug they ever used was cannabis. In addition 87% of the 57 had used their first drug by the age of 17. As with alcohol use, there is a clear correlation between the age that their first drug was used and the age of becoming homeless as:

- 80% of those who used their first drug at age 12 or under were homeless by age 17;
- 74% of those who used their first drug between the ages of 13 and 15 were homeless by age 17; and
- 83% of those who used their first drug between the ages of 16 and 17 were homeless by the age of 17.

Table 6.20

Age of First Drug – Age Became Homeless

Age became Homeless \ Age of First Drug	<15	16-17	18-25	26-59	60+	Total
12 or under	5	3	1	0	1	10
13 to 15	12	8	5	0	2	27
16 to 17	4	6	1	0	1	12
18 to 25	0	1	1	0	0	2
26+	0	3	2	0	0	5
Total	21	21	10	0	4	56

Note: 1 missing answer

6.4.2 Reasons for Becoming and Remaining Homeless

All interviewees were asked to state what they thought were the ‘main’ and ‘other’ reasons for them first becoming homeless. Table 6.21 shows the five most commonly given ‘main’ reasons why interviewees thought they had become homeless and the number citing these as ‘other’ reasons.

As regards the impact of drug or alcohol use, a total of 21 interviewees (14% of the sample) stated that their ‘main’ reason for becoming homeless was either their personal drug or alcohol use. This comprised 15 people who thought their alcohol use was the ‘main’ reason and 6 who thought their drug use was the main reason. A further 34 people (22% of the sample) stated that personal alcohol use (22 people) or personal drug use (12 people) was an ‘other’ reason for their becoming homeless.

Additional ‘other’ reasons included being asked to leave by family (18), money problems (15) and family alcohol use (14).

Table 6.21

Reasons for Becoming Homeless – Main and Other Reasons

	Main Reason (frequency given)	Other Reason (frequency given)
Family conflict	48	19
Relationship breakdown	20	17
Leaving Institution/Prison	15	4
Alcohol Use – Personal	15	22
Paramilitary Intimidation	11	10

Interviewees were also asked to state what they thought were the ‘main’ and ‘other’ reasons for them still remaining homeless. Table 6.22 shows the five most commonly stated ‘main’ reasons why interviewees thought they were still homeless and the corresponding number of people who gave these as ‘other’ reasons.

In relation to alcohol use, 5 people felt that their continuing alcohol use was the ‘main’ reason for them remaining homeless. This was given as an ‘other’ reason by 7 interviewees. Only 2 people stated that the ‘main’ reason they remained homeless was because of their drug use and 4 cited this as an ‘other’ reason. No one stated their reasons as being as a result of the lack of drug or alcohol treatment available. This may seem surprising given the level of substance use among the sample. However as noted above even those with dependency problems did not recognise them as such and therefore may not attribute their homelessness to substance use. In addition, the research indicates individuals had a complex range of problems, which make it difficult to isolate cause and effect as regards their homelessness.

Additional reasons provided were mainly concerned with interviewees perceived barriers to accessing permanent social housing, for example, being unable to get accommodation in the right area, having a relatively low number of points on the Housing Selection Scheme and being on bail and therefore ineligible to apply for housing.

Table 6.22

Reasons for Remaining Homeless – Main and Other Reasons

Reason	Main Reason (frequency given)	Other Reason (frequency given)
Cannot access housing (NIHE)	56	10
Family conflict	15	10
Money problems	13	25
Common Selection Scheme	9	2
Continuing Alcohol Use	5	7

6.5 Risk Behaviours and Health Impacts

6.5.1 Injecting Drug Users

Thirteen interviewees (12% of drug users or 8% of the total sample) advised that they had injected drugs at some stage. Of these eight were male and five were female. Five of the males had first injected at age 17 or under whereas all five females had injected at age 17 or older. Drugs that had been injected were heroin (five), amphetamines (four), ecstasy (two), substitute opiates (one) and tranquillisers benzodiazepines (one).

Three (two female and one male) had injected drugs in the last four weeks. Two of the three commonly injected themselves in the arm (one always and one sometimes). The third respondent never injected themselves. Two of the three injected in the home of family or friends (i.e. with others), while the third usually injected alone in parks. Each had either shared spoons/filter, given someone their injecting equipment or had used others injecting equipment. One person had used a needle after someone else had already used it more than 10 times.

O’Gorman (2002) reported on various research projects with homeless populations in Dublin that investigated intravenous drug use. Feeney et al (O’Gorman, 2002) found that 12% of the 171 homeless men interviewed had injected drugs and of these 67% had shared needles in the past. Condon et al (O’Gorman, 2002) found that of the 234 homeless people they interviewed, 24% had injected drugs and 58% of these had shared needles. Finally, the Smith et al study also reported in O’Gorman’s paper found that of the 100 women interviewed, 39% had injected drugs and 33% of these had shared needles. The higher rates of injecting behaviour can be explained by the higher prevalence of heroin use among these samples than in the current research. As shown in Table 6.7, 9.7% of the current sample had lifetime use of heroin, compared to 18% in the Feeney et al study and 47% in the Smith et al study.

6.5.2 Risk Behaviours

Interviewees who had used drugs or alcohol were asked if they had been involved in activities that put their health or safety at risk due to their substance use. Table 6.23 outlines the responses received.

Table 6.23
Risk Behaviours

Risk Behaviours	Frequency	Percentage of all drug and alcohol users (n=134)
Suicidal Behaviour	52	38.8
Unsafe Sex	50	37.3
Criminal Behaviour	48	35.8
Self Harm	44	32.8
Intravenous Drug Use	15	11.2
Commercial Sex/Prostitution	9	6.7
Sharing Needles	8	5.9

Note: multiple responses allowed

Additional critical incidents that occurred as a result of substance use included:

- fights/beatings (14 incidents);
- personal injury and/or suicidal behaviour (14 incidents);
- robberies (eight incidents); and
- drink driving/car crashes (six incidents)

Table 6.24 provides an analysis of the four most common risk behaviours by gender. The information shows that men are more likely to be involved in risk behaviours, in particular criminal behaviour; however levels of self harm are similar between the genders.

Table 6.24
Risk Behaviours – by Gender

Risk Behaviours	Percentage of all males (n=74)	Percentage of all females (n=60)
Suicidal Behaviour	44.6	31.6
Unsafe Sex	40.5	33.3
Criminal Behaviour	50.0	18.3
Self Harm	32.4	33.3

Note: multiple responses allowed

Table 6.25 provides an analysis of the four most common risk behaviours by age bracket (note that sample sizes are small in some age groups). Risk behaviours are carried out by similar proportions of each age group except for self-harm which was more common among younger homeless people.

Table 6.25
Risk Behaviours – by Age

Risk Behaviours	Percentage of all aged 16-17 (n=13)	Percentage of all aged 18-25 (n=51)	Percentage of all aged 26-59 (n=68)
Suicidal Behaviour	30.7	35.3	44.1
Unsafe Sex	30.7	43.1	35.3
Criminal Behaviour	23.1	33.3	41.2
Self Harm	61.5	31.4	29.4

Note: only two people were aged 60+, therefore they have been excluded from the above table.

These findings in relation to risk behaviours suggests a need for information and support services for homeless people, particularly about mental health issues (suicide and self-harm), safe sex and criminal activity.

6.5.3 Reported Health Problems

Ninety-seven interviewees (63%) reported having health problems at the time of the interview. These problems included those discussed in the following sections, as well as conditions such as asthma, arthritis, bronchitis and cancer.

6.5.4 Hepatitis and HIV

Of the 154 interviewed, 150 were willing to discuss their hepatitis and HIV status.

Nineteen had received a vaccination for Hepatitis B, 19 had had a Hepatitis B test and 20 had had a Hepatitis C test. The length of time since their last test varied from one month to 10 years. No-one was currently Hepatitis B positive, and only two were Hepatitis C positive. Neither were receiving treatment. Twenty-four interviewees advised that they had had a HIV test. Of these 23 advised that they were HIV negative and one did not know their status.

The proportion of interviewees being tested for these diseases is a further indication of the involvement of homeless people in behaviours that put them at risk of contracting blood-borne diseases.

6.5.5 Mental Health Issues

Ninety-seven interviewees (63% of the sample) stated that they had concerns about their mental/psychiatric health. Of these, 55 were male and 45 were female. The majority (60) were aged between 26 and 59.

The main concerns stated in relation to mental/psychiatric health were depression (40 responses), suicidal thoughts (10 responses), nervousness (5 responses) and anger management (5 responses).

Seventy-two of the 97 (74%) had sought help for these concerns. In addition:

- 59 (61%) had undergone a psychiatric assessment;
- 35 (36%) had been admitted to a psychiatric hospital; and
- 34 (35%) had been diagnosed with a psychiatric illness.

Forty-one were currently receiving treatment for a psychiatric illness. Of these 41:

- 12 (29%) were receiving counselling;
- 34 (83%) were receiving prescribed medication; and
- 6 (15%) were receiving community psychiatric services.

These findings suggest mental ill-health is a very significant issue among homeless people for which ongoing support must be provided.

7. REVIEW OF SERVICE PROVISION

The review of service provision for homeless people with problem substance use is based on the interviews undertaken with homeless people, supplemented with information from surveys of providers of treatment and homeless services and consultation with key stakeholders. The following sections report on:

- the feedback from homeless interviewees and service providers in relation to substance misuse services (Section 7.1);
- the feedback from service users and providers in relation to homelessness services (Section 7.2); and
- the feedback from key stakeholders in relation to the degree to which policy, strategic thinking and operational practice is co-ordinated to meet the needs of this group (Section 7.3).

7.1 Substance Misuse Services

7.1.1 Services for Alcohol Users

Very small numbers of those who reported using alcohol also reported having used alcohol services. Of the 106 interviewees that used either alcohol only or both alcohol and drugs, 12 had used any one of the services suggested. This again suggests a lack of insight into services needed by these individuals or unwillingness by the individuals to use the services of which they are currently aware. Table 7.1 shows the number using services in the month prior to the interview.

Table 7.1
Number of Alcohol Users in Contact with Alcohol Services in Previous Month

Service	Number of Alcohol Users	Percentage of Alcohol Users
Counselling	12	100
Drop in Centres	10	83
Alcoholics Anonymous	8	67
Community Addition Teams	7	58
Homeless Support Team	6	50
In-Patient Detox	5	42
Community Psychiatric Nurse	5	42
Community Detox	2	17
Outreach Team	1	8
Voluntary Agency Counselling	1	8
Dual Diagnosis Teams	0	
Other	10	83

Note: N=12, multiple responses allowed. 'Other' included Northlands (2), Gransha Addiction Unit (2) and St Lukes Hospital (1). multiple responses allowed

Only 4 out of 106 clients who were alcohol users reported having had difficulties accessing alcohol services. These difficulties related to lack of information about availability of services (three respondents), lack of specific services for homeless people (three respondents), having no fixed address (two respondents), the location of services (two respondents), appointment systems in place (two respondents),

waiting times (two respondents) and lack of confidence in the system (two respondents).

Interviewees were also asked about any contact with other non-alcohol specific services, and if this contact related to their alcohol use or not. There had been similarly low levels of contact with these services in relation to alcohol (e.g. 10% had recent contact with their GP), but much greater contact with these services in relation to matters other than the interviewees' alcohol use. The contact figures are shown in Table 7.2. It illustrates that the services with which interviewees had most contact are GPs, Accident and Emergency, PSNI, hospital clinics and social workers. This contact was not specific to their alcohol use but suggests contact points at which alcohol services could intervene where appropriate.

Table 7.2
Number of Alcohol Users in Contact with Other Services in Previous Month and Reason for Contact

Reason for Contacting Service	Alcohol		Other Reason	
	No.	%	No.	%
Accident and Emergency Services	6	6	24	23
PSNI	5	5	21	20
General Hospital Clinics	4	4	21	20
Psychiatric Clinic	3	3	7	7
Community Psychiatric Nurse	3	3	5	5
Social Worker	3	3	19	18
GP Services	11	10	63	59
Dual Diagnosis Team	1	1	3	3
Local Council	1	1	6	6
Homelessness District Nurse	0	0	0	0

Note: total number alcohol users = 106, multiple responses allowed.

The interviews sought the views of homeless people as to how services for people with alcohol problems could be improved upon to cater for the homeless and what kind of services they would like to see exist. A total of 55 suggestions were made and these were analysed to identify the key themes. The suggestions fell into the following categories:

- **providing alcohol services in homeless accommodation** (11 comments) – interviewees suggested that more active support needs to be provided for people with alcohol problems while they are staying in hostels. This would include prevention work, individual counselling and group sessions, AA meetings and floating services such as alcohol counsellors and psychiatrists. It was also suggested that people who have been through the detox and rehabilitation process should be involved in service delivery. Comments included;

“have groups in hostels talking about drink and how it affects the other people in the hostel”

“offer more support like counselling in the hostels and shelters. Provide the alcoholics and others with the knowledge of what it can do to you and ways to think positive and not depend on drink”

“should have a community psychiatrist to help people 24/7”

“have somebody coming to hostels who has been through detox and recovery telling us stuff rather than someone who has never been addicted”;

- **more staff training and more positive attitudes** (10 comments) - some of those interviewed felt that staff in hostels have insufficient training to deal with alcohol misuse and others felt that staff in alcohol service providers hold negative attitudes towards homeless people. Comments included;

“people shouldn’t look down on alcoholics – not everyone can handle their less than perfect life”

“people who work in the services don’t seem to acknowledge you if you are homeless and have a drink problem”

“service providers should be more open minded...people get tarred with the same brush and not treated as individuals”

“shouldn’t be treated like dim-witted. It’s an illness, there’s always a good reason”

“people with drink problems are left too long and when they (the staff) realise how bad it is it’s too late”

“more understanding by staff, e.g. pouring alcohol down the sink when caught only winds people up”

- **dry or wet accommodation policies** (17 comments) – some interviewees focused on the policies in place in hostels, either suggesting that they be stricter to encourage people to control their alcohol use or that they be more understanding of the needs of alcoholics. The former group suggested that more regular checks of rooms etc. be completed to ensure hostels stay alcohol free for the benefit of those trying to recover. It was also suggested that hostels make taking part in counselling a mandatory requirement for residents with problem alcohol use. Those who advocated that policies be more understanding of alcohol users’ needs noted that hostel places are not always open to drinkers and suggested that more dedicated places be made available. They consider that strict enforcement of non-drinking policies result in people being pushed out of accommodation. A number of comments were made about the importance of segregating continuing drinkers from recovering alcoholics, families and other non-drinkers;
- **providing diversionary activities** (4 comments) – some suggested that other activities should be provided to keep homeless people with alcohol problems occupied, for example, employment schemes, community projects, day centre provision or ‘outings’;

- **improve access to services** (six comments) – three interviewees suggested outreach as a means to improve alcohol services for homeless people and three stressed the need to have services available when required rather than having to wait for an appointment and running the risk of demotivation;

Others were non-specific about how services could be improved but felt that more help and support should be available (five comments). One interviewee commented on the need for more information on services and another on the need for more detox places.

Interviewees made specific suggestions as to the kind of alcohol services they thought should be available for homeless people. These suggestions flowed from the improvements summarised above, focusing on specialist residential help for homeless people with alcohol problems, outreach/clinic services, and move-on services to help people to sustain any progress they make. Figure 7.1 shows examples of the types of services interviewees would like to see exist (based on 43 specific suggestions).

Figure 7.1
Alcohol Services Homeless People would like to see

Specialist Accommodation (22 suggestions)

“hostels for people to dry out” and “more hostels with detox centres”

“more places for people to stay who have alcohol problems”

“places for people to go with trained people to deal with their issues”

“somewhere like a crash room for people to put their heads down for a couple of nights and a place to go during the day”

Active Support in Non-Specialist Accommodation (3 comments)

“support should be given by staff in hostels”

“staff that are trained to cope with addiction – getting the right info – having support workers”

“more counselling”

Day Time Provision (7 comments)

“somewhere to drink during the day and stay out of the wet”

“more drop in centres for them to talk about your problems and more dry clinics”

“outdoor sporting activities to help people take their mind off things – the hostels should arrange these”

Outreach and Floating Services (8 comments)

“a psychiatric nurse who works with the community addiction team should call around the hostels to help keep people focussed and strategies developed for individuals”

“go out into the community”

“people should come into the hostels to help people get off the drink - counsellors”

“maybe AA – they only seem to visit here when there is a threatened suicide but the problems are building up beforehand”

Joined-Up Services (1 comment)

“more hostels with move on flats, more hostels with detox centres – once programme finishes you have nowhere to go and end up back on the street”

Social Services Support for Families (2 comments)

“social services to do more for children – children not being washed or fed”

“social services should be on the premises”

As regards the information available on alcohol services, 13 interviewees perceived that there is sufficient information available for those who need help but were sceptical about the impact of providing such information. As one person put it:

“people don’t listen to the info that is provided and if they do they don’t act on it”.

However, approximately 50 comments were made suggesting how information on alcohol services could be improved. Some of these related to the type of information that should be promoted. It should include:

- information on the services available, their location, how to contact them, what help they provide and what to expect from them;
- information on the impact of alcohol in terms of physical and mental health, breakdown of relationships and homelessness; and
- information on how to reduce alcohol dependency and ultimately, how to stop drinking altogether.

Homeless people suggested a variety of channels should be used to get this information across and that several formats should be used. Suggestions included the following:

- preventative information in schools, workplaces, pubs, off licences;
- advertising campaigns using billboards, bus advertising, newspapers and television;
- leaflets and posters providing information in places homeless people might be such as chemists, GP surgeries, social security offices, police stations;
- a phone line people can ring when they need support and information (like the smoking cessation phone line);
- information in hostels including posters and leaflets, presentations from specialists and peers/recovering alcoholics; and
- direct information from staff in hostels and other services including police and health services.

7.1.2 Services for Drug Users

Interviewees who reported being current (within the past month) or recent (within the past 12 months) drug users (62 people) were also asked about the services they had used, barriers faced and suggested service improvements. As with alcohol services, reported use of these services was low, with at most nine (15%) of current drug users accessing any one service. The drug services accessed are shown in Table 7.3.

Interviewees who reported being current (within the past month) or recent (within the past 12 months) drug users (62 people) were also asked about the services they had used, barriers faced and suggested service improvements. As with alcohol services, reported use of these services was low, with at most nine (15 %) of current drug users accessing any one service. The drug services accessed are shown in Table 7.3.

Table 7.3
Number of Current and Recent Drug Users in Contact with Drug Services in Previous Month

Service	No	Percentage
Counselling	9	100
Drop in Centres	7	77
Community Addition Teams	7	77
Community Psychiatric Nurse	5	55
Narcotic Anonymous	4	44
Homeless Support Team	4	44
Needle Exchange	3	33
Outreach Team	3	33
Community Detox	2	22
In-patient Detox	1	11
Residential Drug Programme	1	11
Dual Diagnosis Teams	1	11
Voluntary Agency Counselling	1	11
Other (Chill Programme)	1	11
Drug Arrest Schemes	0	0

Note: N=9, multiple responses allowed

Five of the homeless people interviewed who were current or recent drug users had experienced difficulties in accessing drug services. The barriers were reported to be the lack of services tailored for homeless people (four), the lack of integration of drug services with other services (three), appointment systems (three), having no fixed address (two), an unhelpful response from a GP (two), inflexible programme design (two), lack of confidence in the system (two), literacy skills (two), fear of social services intervention (two) and a perceived stigma around homelessness (two).

Recent and current drug users (62 people) were also asked about their contact with other services in relation to their drug use. There was greater use of GP services by recent and current drug users in relation to their drug use than of any dedicated drug service. Just over a quarter of recent and current users had had contact with GP services in the last month in connection with their drug use suggesting this is an important intervention opportunity for homeless drug users. Little contact was

reported with other services by lifetime drug users. Reported contact with these services is shown in Table 7.4.

Table 7.4
Number of Recent and Current Drug Users in Contact with Other Services in Previous Month and Reason for Contact

Service	Current and Recent Users		Former Users	
	No	Percentage	No	Percentage
GP Services	16	26	3	7
General Hospital Clinics	5	8	0	0
Accident and Emergency Services	2	3	1	2
Psychiatric Clinic	2	3	0	0
Community Psychiatric Nurse	5	8	0	0
Multi-disciplinary Team (Dual Diagnosis)	0	0	0	0
Social Worker	4	7	0	0
Local Council	0	0	0	0
PSNI	5	8	0	0
Homelessness District Nurse	1	2	0	0

Note: Number Current and Recent Users = 62, multiple responses allowed

As with alcohol services, wide ranging suggestions were made by recent and current drug users as to ways in which drug services could be improved to cater for the homeless. The key themes were:

- **provision of information** – 15 of the 40 suggestions made referred to the perceived need for information about drug services and the harm drugs can do (15 comments). Comments included:

“making people aware of what is available and what a programme can do for a person”;

“more drug info and awareness especially for prescription drugs because they mess my head”;

“addicts should be shown the price of the way they are living on themselves and loved ones”;

- **specialist facilities for drug addicts** – eight people considered that more specialist hostels, drop in centres and treatment facilities need to be made available for homeless people with drug problems. For example,

“more specialised centres/hostels to provide info and support for drug users”;

“places to help people go off drugs and not look down on them”;

- **trained staff in hostels** – 7 comments related to the role of hostel staff in providing support to drug users and the need for them to be appropriately trained to deal with drug issues. It was suggested that ex-users should be employed in support roles as they have a better understanding of the difficulties of drug addiction. Comments included:

“more advice on drugs given by people who work in the hostels, train the staff to deal with drug issues”;

“recognition of someone who is doing too many drugs – staff need to know how to handle people. They are not always helpful in relation to accessing counsellors and giving advice...”

“recovered drug addicts can help better so they should be in the hostels”;

- **counselling services** – six people mentioned the need for counselling services for drug users, especially one to one counselling rather than group sessions;

- **harm reduction and detox provision** – the need for more detox support, substitute prescribing and needle exchange services was mentioned by three current drug users. One person commented that:

“heroin addiction is not recognised in Belfast, you hear of detox clinics in England and Scotland”; and

- **focus on ‘hard’ drugs** – two interviewees suggested that hostels should relax their policies on cannabis use and focus on supporting those using ‘hard’ drugs instead.

While one or two interviewees felt that there were sufficient services available for those motivated to give up drug use, many other recent and current drug users (34 in total) made specific suggestions as to the kind of drug services they thought should be available for homeless people. These clearly related to the improvements listed above, focusing on educating people about the effects of drug use, providing one to one support, providing support in mainstream hostels and specialist residential services for drug users, and minimising the risks to people caused by their continuing drug use.

Figure 7.2 shows examples of the types of drug services interviewees who are recent and current drug users would like to see exist (based on 33 specific suggestions).

Figure 7.2

Drug Services Homeless People would like to see

Education (Seven suggestions)

“better education facilities – most info shows the person using the drug and the end result but not all that happens to people in between”

“set up small unit that goes around hostels and street sleepers educating staff and residents on drugs”

“have the info beside the phone so that people can use it as they need it and not have to ask staff”

One to One Support (Seven suggestions)

“probably mostly need someone to talk to who can relate to their experience”

“more counselling services and confidential services”

Specialist Units (Seven suggestions)

“should be somewhere to help people come off the drugs if they are hard on them every day”

“more detox hostels”

Services in Hostels (Four suggestions)

“more reformed drug users coming into hostels talking to people, I want to know what to do when over this”

Harm Reduction Services (Five suggestions)

“more needle exchange centres”

“people on heroin should have somewhere to go instead of chucking dirty needles around the streets”

“shooting galleries – somewhere drug users can inject that’s safer than on the street”

Non-Judgemental Attitudes (Three suggestions)

“places to help people go off the drugs and not look down on them”

“people who don’t look down their nose at you”

“I think people are afraid to say in case they get in trouble for it”

As with information about alcohol services, some interviewees (six) were of the opinion that there is sufficient information about drug services available. However, 38 of the 62 current and recent drug users interviewed made suggestions as to the type of information that should be made available. Again, information requested included both education about the harm caused by drugs and details of the services available for drug users. A range of public advertising was suggested to increase understanding of the impact of using drugs (particularly to discourage their use by young people) and to increase the tolerance of the general public towards people with drug addictions. It was noted by some interviewees that full information should be provided, for example:

“tell the whole truth about drugs in stead of making them all look bad when they’re not if used in moderation”.

Feedback suggested that information should be provided in a range of locations including schools, youth clubs, GP surgeries and police stations. In particular, current users thought that information for homeless people should be provided both in hostels and on the streets by outreach teams.

7.1.3 Homelessness Provider Feedback on Substance Misuse Services

The survey of homelessness providers sought organisations’ views on access to substance misuse services and perceived barriers.

Twenty-four of the 45 providers responding stated that they thought that homeless people did face barriers in accessing substance misuse services. The key barriers identified are shown in Table 7.5. The most commonly identified issues (mentioned by 23 providers each) were not being registered with a GP, waiting

times to get on a programme, lack of tailored programmes and mental health problems.

Table 7.5
Barriers to Accessing Substance Misuse Services Perceived by Homelessness Providers

Barrier	No Providers perceiving issue as a barrier
Not being registered with a GP	23
Waiting times to get a place on programmes	23
Lack of services tailored for homeless people with substance misuse problems	23
Client's mental health problems	23
Unhelpful response from GP	21
Having no fixed address	20
Lack of information about availability of services	19
Entry/eligibility criteria for services	19
Location of services	18
Clients' lack of confidence in service providers and 'the system'	18
Substance misuse services not integrated with other services	17
Perceived stigma around homelessness	17
Client's literacy skills	16
Client's learning, physical or sensory disability	12
Fear of social services intervention	12
Programme design	11
Opening hours	10
Policy of 'barring' clients from services	10
Appointment systems	9
Fear of partner's response to seeking help	9
Others	9
Lack of childcare facilities	8
Requirement for support worker to accompany client	4

Others comments made regarding barriers included the following:

- lack of services for substance misuse in relation to the family;
- no in house services;
- no services provided locally;
- poor communication skills on the part of the client;
- feelings of isolation – no communication with other family members;
- lack of commitment; and
- lack of insight into extent of their problem.

Respondents were also asked if they thought that gaps existed in the range of substance misuse services for homeless people and 25 providers agreed. Gaps were considered to be the following:

- need for immediate access to professional support;
- clients' health problems not communicated to the hostel;
- lack of drop in centres open outside of office hours;
- lack of facilitated support groups;
- severe criteria and waiting time prior to accessing accommodation;
- lack of drying out clinics with professional support;
- lack of educational background on the dangers of drug/alcohol abuse;
- no immediate call out to advise clients after moving out of accommodation;
and
- no integrated approach for all agencies.

Thirty-two homelessness providers reported the view that homelessness and substance misuse services are not adequately integrated. Recommendations to enhance the integration and co-ordination included:

- greater accessibility to services for people who are homeless;
- greater communication between services and relevant agencies;
- greater exchange of relevant information on clients;
- more accommodation;
- wider provision of floating support;
- greater training and education in substance misuse;
- enhanced outreach and aftercare of those who have undertaken treatment;
- substance use providers should take referrals from providers of hostel accommodation;
- drop in centre staffed by counsellors – out of hours;
- follow through with clients – more feedback;
- housing and substance misuse services forum group; and
- greater on call medical support for hostels.

7.1.4 Substance Misuse Provider Feedback on Substance Misuse Services

Eight substance misuse providers responded to the survey. Their views were sought as to the barriers for homeless people trying to access substance misuse services. All those responding agreed that barriers existed, with the most frequently mentioned issues being having no fixed address, not being GP registered and programme design (all mentioned by seven providers).

The main gaps in substance misuse services for homeless people and issues affecting their successful treatment were identified as follows:

- assertive outreach services that meet the needs of homeless users;

- practical information given about the harm of drugs/overdose to all users;
- refusal of housing to drug users increases risk;
- perceived that housing is offered to alcohol dependent clients before substance users;
- clients who are homeless see their homelessness as the top priority. To address their substance misuse issues, services should be designed to fit around accommodation needs;
- having no housing on completion of residential treatment or returning to environment where drugs/alcohol use is present can lead to a relapse – half way accommodation is essential; and
- no support services for young people with substance misuse problems in the community.

All of the substance misuse providers felt that being homeless has either ‘significant’ or ‘some’ impact on the success of substance misuse treatment. Table 7.6 shows the most common impacts that being homeless has on the success of a client’s substance misuse treatment. The most common reason being the impact of transience on the service provider’s ability to keep in touch with the client.

Table 7.6
Impact of Homelessness on Clients’ Substance Misuse Treatment

	No of Clients
Transience makes it difficult for service provider to keep in contact with the client	7
Transience means there is little or no continuity from one treatment episode to the next	6
Clients present with multiple problems – lack of focus on substance misuse treatment	6
Living in temporary accommodation with other drug/alcohol users while in treatment is unhelpful	6
Having no housing on completion of residential treatment programme may lead to relapse	6
Can be hard for clients to keep appointments	5
Clients present at crisis point with respect to their substance abuse	5
Clients are more concerned with addressing housing needs than addressing substance misuse problems	4
Difficulties in establishing relationship with the individuals accommodation provider	2
Other – location of housing offered in emergency will often impact on treatment – daily supervision of medication is often required at a local pharmacy	1
It can be hard for clients to commit to treatment requirements due to chaotic lifestyle	0

None of the providers felt that homelessness and substance misuse services are adequately integrated.

7.2 Homelessness Services

7.2.1 Contact with Homelessness Services

All respondents were asked about their contact with homelessness services in the month prior to the interview. Interviewees had accessed homelessness services more than substance misuse services, reflecting the common need among the sample population for accommodation support. Table 7.7 shows the number using each service. It indicates that the most frequently used services were the NIHE Housing Advice Centre or District Offices and direct access hostels, used by 44% and 40% of interviewees respectively.

Table 7.7
Contact with Homelessness Services in Previous Month

Service	No	Percent
HAC/NIHE District Office	68	44
Direct Access hostel	61	40
Day Centre	26	17
Move-on Accommodation	16	10
Night Shelter	15	10
Family Hostel	12	8
Tenancy/Floating support/Aftercare	10	7
Outreach Team	6	4
Foyer	6	4
Refuge	2	1
Food run/Street Services	0	0

Base – all respondents (154)

Just less than half of the sample reported that they had experienced difficulties in accessing homelessness services at some point (45%). The difficulties most often perceived related to waiting lists or lack of information about services. More than a quarter (29%) reported having to wait for suitable accommodation to become available (both permanent and temporary accommodation). There was some evidence of the substance misuse policies of homelessness service providers acting as a barrier – 12% reported this as a difficulty. Table 7.8 summarises the difficulties reported by interviewees.

Table 7.8
Barriers to Accessing Homelessness Services

Reason	No	Percent
Waiting lists	45	29
Lack of information about the availability of services	21	14
Entry/eligibility criteria for services (e.g. must not be current user of substances)	19	12
Location of services	6	4
Lack of confidence in service providers and ‘the system’	4	3
Barred from service	4	3
Lack of child care facilities	3	2
Mental Health Problems	2	1
Fear of social services intervention (of losing custody of children)	2	1
Literacy skills	1	1
Disability – Learning	1	1
Disability – Physical	0	0

Base – all respondents (154)

The views of the sample were sought with respect to the homelessness services available. They were asked what features of the services they currently use they like, and how services could be improved. Numerous comments were made in respect of the positive features of hostels, move-on accommodation, night shelters and day centres. Figure 7.3 summarises the most commonly mentioned features.

Figure 7.3

Positive Features of Homelessness Services

Hostels and Move-on Accommodation

Quality of Staff Support – *“staff friendly and helpful – treat us like human beings” “always there to help you out” “staff talk to you if you have problems” “staff very helpful”*

Safety, Security and Anonymity – *“I like that this hostel has cameras, it makes you feel safer” “no-one knows where I am – there are buzzers so no-one can break in” “because I had to leave home due to intimidation it feels safe here”*

Help to Move On and Aftercare – *“give a step up for the future, help you to become more independent and move on” “good because it’s low support – gives you an idea of what it will be like when you move out” “pushed me to get a routine, budget money, cooking etc.” “they teach you things you wouldn’t have known had you gone straight into a flat by yourself”*

Communal Living – *“get to mix with people in communal kitchen” “meet people in similar circumstances” “it provides a good support network”*

Privacy/Own Space – *“you have your own living space but there’s always someone here that can help you” “like the way you have your own flat and don’t have to share with other people”*

The Rules – *“it’s good that you can’t have alcohol in here” “the fact that it’s quite strict – that’s what’s needed”*

Freedom – *“own front and back door – don’t have to account for comings and goings – it’s just like your own home”*

Accessibility Compared to NIHE or Private Rented Housing – *“don’t have to pay deposit for a flat” “benefits people who need temporary accommodation – with Housing Executive it takes forever to get you a place” “Housing Executive don’t do anything – as far as they are concerned as long as you are in here you have a roof over your head”*

Continued overleaf...

Figure 7.3

Positive Features of Homelessness Services Contd.

Day Centres/Drop In Centres

Company and Something to Do - *“company makes you feel part of something”*

Range of Services Available - *“help available here, alcohol, drugs, social worker, but you have to ask people. If you don’t present major issues on the outside and are trying to deal with it yourself you don’t get help” “good place to have because ex-residents just sit in house with no-one to talk to, so I like the company and going on trips”*

Night Shelters and Street Services

Meeting Basic Needs – *“it’s warm, dry, good food, facilities for washing and drying your clothes” “your meals are made. If you are on the drink you sometimes don’t bother with food” “outreach team come round and give you sleeping bags and soup”*

Supportive Staff to Help with Range of Problems - *“staff help sort your head” “helping me with getting bereavement counselling” “staff speak on your behalf to NIHE if living on street. They will get somewhere to stay”.*

Help with Addictions – *“staff show concern and are willing to help you with addictions”*

Family Hostels

Keeping the Family Together - *“at least all the family is together”*

The majority of those interviewed had comments to make on how homelessness services could be improved (122 comments were made). The main theme was the provision of more housing, but comments also related to the type of housing that should be available, the groups that should be catered for and other support required by homeless people. The main suggestions were as follows:

- **make more accommodation available for homeless people** (approximately 40 comments) - the majority of comments related to making more temporary and permanent places available for homeless people. The length of time spent on waiting lists for permanent accommodation was highlighted and the NIHE points system was criticised as being unfair. Typical comments included:

“lots of boarded up houses in housing executive estates – they should be fixed up for people to live in”

“why are there housing executive buildings boarded up when there are people living in hostels and people sleeping on the street”

“it’s a very slow process. I thought I would only be here for a month but I’ve been homeless for three or four years. I need to know how to increase my points to help me get somewhere”

“priority list is wrong – takes you to be pregnant and getting abused before you are considered”

“they should cater for people who have no children – we seem to get pushed to the back”

- **Match Provision to the Needs of Different Groups** – there was a view that more accommodation should be provided to fit the needs of different groups. For example, separate hostels for those who want to drink and do not want to drink, separate provision for men and women, more hostels for young people, more for families and more for older people. Typical comments were as follows:

“went to NIHE on Friday and they put me in X. It was all people drinking and I’m only 17. They didn’t even know I was coming. I ended up living on the street”

“hostels could be geared towards younger people, especially those under 18”

“if a person goes to a hostel with drink and can’t get in they phone other hostels and tell them and you don’t get in. A man still needs somewhere to stay”

“more dry places for people who want to stay off drink”

“should be hostels for different age groups – I shouldn’t be stuck in with old alcoholics”

- **Better Service from the NIHE** – a range of comments were made in relation to experiences with the NIHE. Some of these were positive, but there were also many cases where homeless people had found the service provided to be inefficient and lacking in sympathy for their situation. For example:

“Housing Executive should be more understanding and sympathetic to the alcoholics – they don’t care”

“Housing Executive should give you more info about where to go to – where hostels are”

“Housing Executive should deal properly with people’s claims – according to them I had not returned necessary documentation but I have done”

“if only Housing Executive offices communicated better between districts”

- **Better Support While in Hostels** – interviewees felt that more assistance should be given to homeless people while they are in hostels. Examples of the type of support they consider should be available included counselling, health support, support with finding work or training and activities inside and outside the hostel. For some, it was a question of having sufficient staff in hostels to ensure they had time to talk to and help residents:

“don’t give people enough time – sit them down and explain to them what they need to do to change their lives”

“staff should make sure someone experienced can talk to you about your problems”

“more things to do in hostels to occupy your mind”

- **Better Facilities in Hostels** – while many interviewees praised the quality of facilities in hostels comments were made regarding certain issues. For example, it was suggested that there should be more single rooms and private areas, better security, places for children to play, better food and more games facilities. A few also suggested that hostels need to be renovated. For example:

“single rooms would be better because the crash room (dormitory used until a room becomes available) is very intimidating when you first arrive”

“security (CCTV) in hostels – safe from people outside but no protection from other hostel users”

- **More Drop-In Centres, Night Shelters, Day Centres and Outreach Services** - the important role of these services was stressed by some interviewees, particularly in relation to meeting the needs of street drinkers. Suggestions included the following:

“just more places like the Ormeau Centre – they have done marvellous things in getting me off the drink”

“more shelters and day centres – I’ve only heard of the Ormeau Centre and Brunswick Street. Once they get barred from Brunswick Street they have no-where else to go”

“people are dumped out of hostels during the day – need staff to care for them during the day, stop temptation to drink”

- **Fewer Strict Rules** – a small number expressed their view that rules should be relaxed in hostels to make stays there feel more like independent living. For example, no curfews, relax drink bans, allow friends to stay and ensure residents have input into decisions made about life in the hostel;

- **Tackle the Stigma of Homelessness** - finally, two interviewees felt that services could only be improved if attitudes towards homeless people were better. As one put it:

“the government agencies don’t listen or support homeless people – there is a stigma attached to being homeless”.

7.2.2 Provider Feedback on Homelessness Services

The provider surveys also explored the issues around access to services for homeless people with problem substance use.

Homeless service providers were asked about:

- their policies on use of substances and impact on homeless people’s access to accommodation;
- critical incidents as a result of substance use;
- capacity to deal with substance misuse issues; and
- perceived gaps in homelessness services for those with substance misuse services.

The survey showed that 72% (31) of the 43 centres participating had policies that allowed current substance users access but forbade the use of substances on the premises. Sixteen percent (seven) of providers only accept clients who are not using any form of drugs or alcohol, i.e. ‘dry’ hostel. One provider targeted its services particularly at those with substance misuse problems and the other did not have a policy in place.

Twelve providers (29%) reported that substance use is one of the reasons used for not accepting clients. Three had refused people access to their services on this basis in the quarter specified (1st April 2003 to 30th June 2003). This resulted in 13 cases where alcohol users were refused services, two cases where people using drugs and alcohol were refused services and one occasion where a drug user was refused services.

Of 42 providers responding, 27 (64%) reported that between 1st April 2003 and 30th June 2003, they had untoward/critical instances where substance misuse was a factor. There were 80 incidents involving alcohol, 45 involving alcohol and other substances, and 14 involving substances other than alcohol. Just over half of these providers (14) stated that the critical incidents resulted in clients being excluded – a total of 30 individuals and 11 families.

Seventy-three percent (N=41) of providers stated that it is more difficult for a homeless person who has a substance misuse problem to access accommodation. A number of explanations were given by respondents as to why it was more difficult for a homeless person who has a substance misuse problem to access accommodation. A common theme was that some hostels are dry, family orientated, consideration needs to be given to the health and safety of both residents and staff, increased risk of anti-social behaviour, perceived difficulties which accompany an individual with misuse issues and also those with substance misuse issues are perceived to have access to greater services and to attract a higher priority with the Housing Executive.

Homelessness providers were asked about their capacity to deal with the substance misuse issues of their clients. Just over half of responding providers (24) had staff trained in substance misuse issues, the majority having undertaken in-house training (20). Twelve have staff whose role focuses particularly on substance misuse.

As regards the range of accommodation available, nine respondents stated that they did not consider there to be sufficient accommodation to meet the needs of homeless people who have substance misuse problems. The primary gap identified was a lack of hostels providing dedicated support. Examples included:

- lack of appropriate therapeutic based accommodation;
- lack of resources for clients with behavioural problems;
- lack of childcare facilities for mothers who require treatment;
- lack of appropriate and supported accommodation for clients that have left care;
- limited number of facilities;
- lack of professional and special needs hostels, specialised units, residential treatment places;
- lack of suitably qualified and professional staff for individual needs; and
- lack of direct access emergency accommodation or young homeless 16 – 18 year olds.

Substance misuse service providers were also asked for their views on access to homelessness services for people with substance misuse problems. Seven of those responding to the survey (note that one respondent did not answer this question) agreed that people with substance misuse problems faced problems in accessing homelessness services, and five felt that there are gaps in the range of homelessness services available for this group. Barriers noted by providers related to the perceived stigma attached to those with substance misuse problems and reluctance on the part of homelessness services to accept people who are current substance users. They considered that there is insufficient specialist accommodation for substance users who are homeless.

7.3 Perceived Current Needs

At the time of the interview, the main need people expressed was stable accommodation (71%). The other key needs identified were employment and training (21%) and support services (15%). Despite the prevalence of substance use and mental ill-health among the sample there was further evidence of a lack of priority placed on addressing substance use and its impact on their current situation - only 9% and 7% respectively considered they need support in these areas. At most, 6% of the sample identified various detox services as their main need. These figures are summarised in Table 7.9.

Table 7.9
Perceived Current Needs

Needs	No	Percentage
Stable Accommodation	109	71
Employment/Training	32	21
Support Services	23	15
Treatment – Drug or Alcohol	14	9
Treatment – Mental Health	11	7
Health Care Counselling	8	5
Harm Reduction Services	6	4
Legal Services	5	3
Emergency Accommodation	3	1
Benzodiazepine Detox	3	2
Inpatient Detox	2	1
Alcohol Detox	2	1
Community Based Detox	1	1
Opiate Detox	1	1

N=154

Interviewees also mentioned needs they have that they felt were not described under the categories above (70 comments). Eleven of these comments related to substance use, with three stating the need to access their substance of choice. There was a sense that getting accommodation would allow them to address their substance use and some had already started to deal with their problem. For example, one person’s plan was to “stay off drink, get re-housed and start again” and another wanted to “stay off drink and get my kids back”.

Two were keen to access help for their drug use but did not want to go into residential detox, they said:

“need some help from experts to get off cannabis but don’t want to go into somewhere” and

“getting off heroin, but would rather do it alone than go to detox service – less hassle”.

These findings suggest a clear need for prevention and key working services to address the mismatch between the perceived and actual needs of homeless people.

7.4 Stakeholder Consultation

The aim of this part of the research was to explore with policy makers and strategists the issues relating to policy formulation and service delivery in the arena of homelessness, supported housing provision and substance use. A wide spectrum of individuals were interviewed from health and social services and the housing and public service field who were in a position to influence policy direction. The interview guide is attached in Appendix VIII and the list of consultees is attached in Appendix IX. The interviews revealed a myriad of various themes ranging from community safety and policing, preventative work with families and young people to the interaction between treatment services and supported housing.

7.4.1 Strategic Landscape

The major policies referred to in the interviews were:

- the Supporting People Framework;
- the NIHE Homelessness Strategy;
- Promoting Social Inclusion;
- Policing in Partnership;
- Joint Implementation Strategy for Drugs and Alcohol;
- Investing in Health; and
- Mental Health Review.

Perception of the Issue

The participants came from a diverse range of agencies. The perception of the links that connected substance use and homelessness was influenced by the area in which the individuals operated and how pertinent issues impacted upon their responsibilities and agencies. For example, a NIHE focus was on whether there was a correlation between the upsurge in drug and alcohol use in specific areas and the amount of single people presenting as homeless. PSNI highlighted a need for police officers to more readily access information and emergency accommodation for those who sleep rough. Some Health and Social Services representatives raised issues relating to community cohesion and the role alcohol and drugs had in family violence and the pathway to homelessness. PBNI raised issues relating to the successful reintegration of offenders, who had substance use issues, into the community. Other health professionals talked about the lack of outreach services for homeless individuals. The themes that surfaced are discussed in detail below.

Interaction of Drugs and Alcohol and Housing Policy

There was a general feeling among those interviewed that housing and drugs and alcohol strategy and policy did not interact well. It was acknowledged that at an operational level housing and health professionals at times did work effectively together to deal with casework issues. It was also considered that there were innovative pieces of operational work being conducted throughout Northern Ireland which were cross sectoral by nature. However this interaction was not necessarily reflected in the formulation of strategy or the formal links or mechanisms between agencies. It was stated by many of the interviewees that there was a gap in the policy framework that was not conducive to an integrated approach to homelessness, housing and substance use. One participant remarked that:

“frontline staff are out there creating relationships with other agencies and carrying out effective work. However, if it is not modelled from the top, through interdepartmental co-operation the overall impact of the work can be lost. Promoting Social Inclusion is a good opportunity to achieve this interdepartmental approach to homelessness and substance use”.

It was noticeable that with some marked exceptions each sector did not have a great knowledge of each other’s policy strands. However individuals were frank

about this lack of knowledge stating that more work had to be conducted for strategists to appreciate other relevant areas of work. It was conceded that the present structure of public administration did not lend itself to an easy translation of policy frameworks. Interviewees did acknowledge that housing and substance use had many commonalities that needed to be reflected in how strategies were applied and translated at operational level. Some stated that there was a need for different pieces of strategy to have reference to each other. Individuals did indicate a desire for a cross departmental approach to substance use and homelessness and some identified the need for appropriate mechanisms to achieve this.

Joint Implementation Model for the Drugs and Alcohol Strategies

It was noted on numerous occasions that there is no explicit reference to homelessness within the Regional Joint Implementation Model for Drugs and Alcohol Strategies. Some questioned whether it was the role of the strategy to assume some responsibility for this issue, considering the possible resource considerations. However, one argument that surfaced was that the strategy should be required to have an overarching perspective on the impact that drugs and alcohol has on all aspects of public service delivery including housing and homelessness.

The overall consensus was that because there were many correlates between drugs and alcohol and the issue of homelessness that the review of the Joint Implementation Strategy should take a broader view to include actions on housing and homelessness. Concerns did exist that the resources that were currently supporting current drug and alcohol activities funded by the Joint Implementation Strategy could not support homelessness activities.

Drug and Alcohol Co-ordination Teams

It was also noted that local Drug and Alcohol Co-ordination Team Strategies do not have a substantial reference to homelessness issues.

Stakeholders felt that the representation from the NIHE on the four Drug and Alcohol Co-ordination Teams has been inconsistent in the last number of years. However, in the last six months there appears to be a move to improve the housing sector representation on local teams. This was particularly important as interviewees made consistent calls for greater involvement from the NIHE. Their involvement is seen as being crucial not only in issues such as homelessness but also in issues such as street drinking and community safety. The Northern Drug and Alcohol Co-ordination Team have set up a housing sub group to improve operational issues in respect to housing and substance use issues.

This is a significant move, as the Drug Action Teams, in England and Wales, the equivalent of DACTs, have a role in planning how supported housing and drug and alcohol services interrelate.

Supporting People Strategic Framework

The Supporting People strategic framework was continually referred to as being a significant policy initiative which sets the framework for housing planning. It was pointed out that Health and Social Services could have a greater opportunity to get involved with their housing partners in the structures to plan supported housing in respect of substance misuse issues and homelessness. Already there was evidence

of greater communication between Health and Social Services since the initiation of Supporting People. The placement of a senior HSS representative in the Regional Supporting People team was also seen as a significant step forward to enable integration.

However Supporting People was not seen as a panacea by all and questions were posed by housing professionals on how the involvement of Health and Social Services in homelessness issues and supported housing could be encouraged and fostered to a greater extent.

There were issues raised relating to whether Health and Social Services or Supporting People should take primary responsibility for the funding of particular services or how this division could be managed. The model of service was a key determinant in this discussion and was related to the demarcation between the definition of the care and support function. Some functions such as therapeutic counselling within supported housing scenarios was seen as a care function and therefore clearly the responsibility of Health and Social Services. Questions were also asked on how primary care lead services, such as detoxification and harm reduction interventions, could be integrated into supported housing models both from a financial management and operational perspective. It is clear that much work is required to be conducted in respect of these issues.

One opinion was that the Supporting People Strategic Framework had not got the power or structures to fully co-ordinate the integration of supported housing and substance use services. Its primary responsibility is the planning and commissioning of supported housing and floating support services. It has not got control over how services such as Community Addiction Teams, rehabilitation hospitals, detoxification services or primary care outreach services interrelate with the supported housing and homelessness sector. Examples were given of some supported housing services that were out of the loop of drug and alcohol oriented services. The question was posed if the Supporting People framework had the capacity, or should be the place, to co-ordinate the required interaction between the substance use sector and housing.

NIHE Homelessness Strategy

The approach to health and substance use issues within the Homelessness Strategy is influenced considerably by the report “Housing and Health -Towards a Shared Agenda” and has specific action points in respect of substance use issues including the setting up of the multi-disciplinary Assessment Team, dealing with the issue of rough sleepers and setting up floating support for substance users.

However, respondents did remark that the strategy did not make reference to the Drugs and Alcohol strategies and didn't express any strategic intent in fostering relationships with DHSSPS agencies on substance use issues. An argument was made that any future review of the strategy should encompass an intent to achieve an integrated approach to the issue of homelessness and substance use.

7.4.2 Bridging Mechanisms

The review of good practice (Section 4) has highlighted that the integration of services between housing and health and social services is essential to ensure effective service delivery to those who are homeless. Various respondents have

already highlighted the gap in the strategic process, which does not encourage this integration. One respondent from the Health and Social Services expressed a view that

“housing strategy and substance use strategy do not interact, neither has prioritised the other. There is a requirement for an overall strategy drawn from homelessness and substance use.”

The consensus amongst the interviewees was that there was a need for bridging mechanisms at a strategic level to deal specifically with substance use and homelessness/housing issues. It was considered that there were enough correlates between substance use and homelessness issues in Northern Ireland to merit a specific strategic approach. Some proposed a Regional Strategy Implementation Mechanism to ensure coordinated planning and implementation between homelessness/housing and substance use services. A proposal was made that the PSI working group on homelessness was a possible means by which to promote the need for integration. *‘Investing In Health’* in particular was mentioned as a significant policy framework which might be beneficial in providing an overall framework by which closer working relationships could be structured and managed.

Examples were also given of the attempts to strengthen current mechanisms at Drug and Alcohol Co-ordination Team level. It has been mentioned already that Housing Executive representation has been strengthened on the DACTs.

A sub-group of the Northern DACT has been created to deal with housing and substance use. The Children’s Planning Process set up in the Health and Social Services Board was given as an example of where a sub-group system had worked well to deal with specific issues such as youth homelessness on a cross departmental level.

It was argued that a sub regional group that deals specifically with substance use and housing, and has associations with the DACT, such as in the Northern Board, could be a useful tool. It could be used to analyse need, map and co-ordinate resources and highlight service gaps in respect to preventive measures, community safety issues, supported housing and the interaction of social and health care at a local level. It was argued that they could be in a position to feed into the Supporting People framework and the larger Drug and Alcohol Co-ordination Teams.

Devolved Government and the Review of Public Administration was seen as having a role in the better co-ordination of services and better enablement of interdepartmental working.

7.4.3 Prevention

The evidence from this study strongly suggests that substance use is a major factor in people becoming homeless and this view was also held by consultees. Participants urged a more proactive approach to the prevention of homelessness relating to drug and alcohol use. One participant stated that housing service providers are in a key position to detect problems such as rent arrears and problems with neighbours before they get to a chronic stage. Floating Support

Services were highlighted as a way in which interventions could be offered to deal with these issues.

Reference was continually made to the role that drugs and alcohol had in issues such as family break up, domestic violence and community safety issues. Early intervention from family support services was a recurrent theme. It was argued that generic support services had a part to play in supporting families, single parents and young people who encounter difficulties that are the result or lead to substance misuse difficulties and ultimately homelessness.

Pre-disposing factors to homelessness and substance use was also a recurrent theme. It was argued that the family support services could emanate from a family support or community development perspective and shouldn't be seen as the premise of the drug and alcohol strategy or Supporting People. Some cited the Children's Planning Process as having a part to play in this overall preventative approach to family and community cohesion in ensuring that vulnerable families had the support that was needed to avoid homelessness or a deterioration of their substance use.

The role of the Leaving and Aftercare Bill was also regarded as having a significant part to play in assisting young people leaving care to be involved in a planning process which could assist them in preventing homelessness particularly where substances are involved.

The citizenship elements of the National Curriculum were cited as having an important role in highlighting the issues to young people relating to preventing homelessness and substance misuse.

PSNI saw community education through peer education schemes as a method by which vulnerable young people could be informed of the risks of homelessness and substance use. Indeed other participants considered that generally there needed to be a public education programme to address attitudes to homeless individuals who use substances in order to foster a greater understanding of the issues.

7.4.4 Legislative Issues

Concerns were expressed that the introduction of the Housing (Northern Ireland) Order 2003 may prejudice some individuals with substance misuse problems. Under the Order the eligibility for social housing will change. Consultees felt that the onus will be on the applicant for housing to prove that they are eligible for housing rather than the NIHE proving that they are ineligible.

They queried if a substance use history may be used in such a way as to prevent access to social housing and confine individuals to the private rented sector or temporary accommodation.

All new allocations of the NIHE tenancies will be on a 12-month trial basis. Quick re-possession of properties may occur if problems arise. Although it is unclear how these rules will be applied, consultees fear this may result in those who have substance use issues being excluded from social housing. Whilst it was accepted that other resident's rights must be protected it was suggested that supportive rather than punitive measures could be effective in such scenarios. It was pointed out that individuals with substance misuse issues had to reside somewhere.

The Drugs Misuse Act 1971 was brought up as an issue that may influence service providers ability to provide accommodation for active illicit drug users who are homeless. The Act determines that service providers must not knowingly permit or suffer certain drug using activities on premises that they control. One opinion was that the Act caused some accommodation providers to be overly cautious and punitive when drug use was discovered. Others thought that the Act could be worked with to continue to accommodate vulnerable homeless drug users.

7.4.5 Funding

The ODPM Drug Service for Homeless People Strategy (described in Section 5.2) recommends an integrated tiered service that ensures integration between supported housing and treatment services. The services which are required to provide an effective integrated service are funded by a number of funding streams in Northern Ireland:

- **Health and Social Services Funding** - Mainstream core funding which is translated through the core Mental Health Programme. It funds:
 - community addiction teams;
 - substance misuse treatment hospitals;
 - dual diagnosis workers;
 - Homeless Support Team Belfast; and
 - contributions to voluntary agencies such as Carlisle House, NICAS Dunlewy Substance Abuse Service.
- **Joint Implementation Model for the Drug and Alcohol Strategies Fund** - a range of projects are currently funded through this programme covering a range of services from community interventions to dual diagnosis workers;
- **Supporting People** - the funding stream which funds temporary accommodation for those who are homeless, specific supported accommodation for those with drug and alcohol problems and floating support services for those with drug and alcohol problems who are at risk of homelessness or who are reintegrating into the community;
- **Homelessness Funding** - This fund is administered through the Housing and Regeneration Department of the NIHE and supports projects such as the Rough Sleeper Outreach Teams in Belfast; and
- **Community Safety Unit Funding** – the last round of challenge competition funding administered by the Community Safety Unit in NIO was awarded in May 2004. The fund has been used to support local education projects and an outreach service for rough sleepers. While there is currently no more funding available through this route, it is possible that additional Community Safety Strategy monies may become available in the future;

There was a call for additional funding from DHSSPS for specific projects dealing with substance use and homelessness such as Dual Diagnosis Workers, specialised District Nursing intervention, and detoxification services. Clearly if the Drug and

Alcohol Strategy Review regards homelessness as a priority for action then this will have financial implications for DHSSPS.

The above analysis demonstrates the difficulties in coordinating service provision. A social services representative remarked that the DHSSPS expenditure is closely tied to the *'Priorities for Action'* published each year. Therefore this stakeholder considered that there is a need to clarify how needs are identified and demonstrate the importance of strategic planning at government level. If Northern Ireland considers that there should be a greater integration of service provision between treatment and homelessness services, mechanisms will need to be created to enable this harmonisation, as it appears impractical to attempt to merge funding streams. A more common sense approach may be to reach an accommodation between agencies and sectors within a strategic framework that enables services to harmonise.

7.4.6 Gaps in Services

Integration of Services

It was remarked consistently that there is a clear lack of a co-ordinated approach to service provision for those at risk of homelessness or who are homeless with substance misuse issues between Health and Social Services, the NIHE and voluntary agencies. A respondent from the Western Health and Social Service Board Area stated that there was a basic requirement to conduct a mapping exercise to examine the level of service provision in the homelessness and substance use sectors, examine how they interact and identify the gaps.

There were consistent calls for mechanisms to link the sectors strategically and operationally. It was again argued that treatment services and supported accommodation was organically linked and that any future developments had to be planned in tandem.

Outreach Services

How homeless individuals were targeted by treatment services featured consistently in the responses. There was a concern that there was still a pervasive attitude in substance treatment services that individuals should come to services. An increase in outreach as a method was urged. One example given was the South Belfast Outreach Team (supported by South and East Belfast HSST), which targets intravenous drug users, including homeless individuals and those in temporary accommodation from a harm reduction perspective. Another example was the Extern Homeless Support Team, which supports individuals residing in temporary accommodation in substance use issues.

Assessment

Participants highlighted the imminent introduction of the Multi-Disciplinary Assessment Team in Belfast as a key service development. Indeed the PBNI considered that their service users would benefit considerably by being able to avail of this gateway service. Assessment is seen as a crucial tool in operationally bridging the gap that can exist between health and social services and the Supported Housing Sector and the Probation Board.

It was conceded that moves had to be made in the rest of Northern Ireland to match the Belfast development. It was also argued that the effectiveness of the

Assessment Team would be curtailed if the complementary support services were not developed, such as appropriate temporary accommodation for specific groups of substance users, floating support services, detoxification, harm reduction and rehabilitation services. Consultees queried how effective assessment would be if there was no services to refer individuals to.

Roles of GPs

GPs were mentioned as instrumental gateways to health services for homeless people with substance use issues. Some criticism was levelled at them for not targeting or tailoring their services enough to such vulnerable groups. One respondent underlined the role that contractual arrangements have in ensuring that excluded groups receive appropriate services from GPs.

Training

It was remarked that there is a clear gap in appropriate training for Housing Executive frontline staff in recognition and awareness of complex issues such as substance use. Other respondents such as the PSNI also highlighted the need for comprehensive foundation training and ongoing professional development for police officers and all professionals dealing with this issue. Staff in temporary accommodation were also highlighted as being in need of comprehensive substance use training.

The Council for the Homeless Northern Ireland provides a programme of training for voluntary sector homeless service providers across NI. The training available includes courses in dealing with substance misuse issues. However, attendance at these courses is often low; thought to be as a result of difficulties faced by voluntary providers in releasing staff for training.

Appropriate temporary accommodation.

Some participants identified gaps in supported housing provision. The gaps identified varied geographically. For example in Belfast there was a gap identified for those who misuse heroin intravenously and continue to use chaotically. Others expressed the view that supported housing needs also existed for individuals with complex substance use issues in the Northern Board area.

Two major points surfaced in this discussion. The model of service arrived at in any area of need had to be properly researched and agreed between various stakeholders. Some argued that hostel type accommodation was not always appropriate for service users with complex substance use issues. Others argued that some individuals need the intensive support that hostel type accommodation could provide.

The second theme was that any new supported housing model dealing with complex substance use issues had to be integrated with the appropriate health and social service support. The point was made that supported housing was an intrinsic part of the substance use treatment continuum e.g. supporting those who were leaving rehabilitation or detoxification facilities. It was also pointed out that health and social services had a crucial role in complementing temporary housing providers in performing their role in maintaining individuals in tenancies. For example providing a primary health service or support in substitute prescribing arrangements.

Substitute Prescribing

The guidelines for substitute prescribing for opiate dependency were issued in February 2004 (DHSSPS, 2004). Some respondents regarded the guidelines as adequate to meet the needs of homeless people. Others argued that the guidelines must be examined from a homelessness perspective. There were some criticisms levelled at the guidelines for not specifically mentioning the needs of the homeless or roofless population.

The role of temporary accommodation providers was also mentioned. It was felt that the expertise does not currently exist within the sector at the moment to support those on substitute prescriptions.

It was also argued that temporary accommodation provision, which is willing to work in shared care manner, is essential for those who are roofless or sleeping rough who require substitute prescribing. It was argued that medical personnel may be reluctant to prescribe if the person is not residing in a supported environment.

Information issues

Some of the consultees highlighted a gap in information sharing between the NIHE and health and social services authorities and advocated that a formal mechanism of sharing information and comparing information existed between health and social services on substance use issues.

7.4.7 Examples of Good Practice

Despite the perceived gaps in services described above, consultees identified current good practice in Northern Ireland as regards projects that provide dedicated services for homeless people who also have substance use problems. However, they were keen to note that these projects are delivered on a local basis and are therefore only accessible to homeless people in particular areas. Examples of good practice projects cited by consultees were as follows:

- **Homeless Support Team (Extern)** – This is a team comprising of social work, nursing and support staff who offer training and support to all hostels in Belfast on addictions and mental health issues. It also intervenes directly with residents on these issues. It is funded by the NIHE, North and West Belfast HSS Trust and South and East Belfast HSS Trust;
- **Multi-Disciplinary Homelessness Assessment Team (NIHE)** –a multi-disciplinary team model is currently in development and it is hoped that the team will become fully operational later in 2004. The team will provide an assessment service at the point of contact for those with complex needs including drug and alcohol issues. It aims to ensure that individuals receive a professional assessment, which will then ensure that the full range of their needs are met by the appropriate supporting housing or social care service. The team will be funded by EHSSB, Probation Board for Northern Ireland and NIHE;
- **Solace Project (Irvinestown)** – this project provides a support centre for heavy drinkers in the Irvinestown area, where users can meet basic dietary,

sanitary and recreation requirements. The centre also provides family support and counselling. The Project is funded through The Northern Ireland Drug and Alcohol strategies;

- **South Belfast Drugs Outreach Team (South and East Belfast HSS Trust)** - this team provides a harm reduction service to drug users in the South Belfast area, particularly heroin users. It currently comprises of 3 workers. Part of their role is to support homeless individuals in their attempts to access and maintain temporary hostel accommodation;
- **Drug Referral Scheme (Homefirst HSS Trust)** - This team based in Ballymena provides a fast track assessment and treatment service for heroin users appearing before the courts. It offers community based treatment services and aims to meet other needs that individuals may have including homelessness issues;
- **Homelessness District Nursing Service (North And West Belfast)** - North and West Belfast HSS trust has a district nursing service which focuses exclusively on those sleeping rough or in temporary accommodation. It offers a crucial primary care link and gateway for those with mental, physical health or addiction issues. South and East Belfast HSS have also introduced a similar service this year;
- **Dedicated Substance Use Hostel Workers (Simon Community Northern Ireland)** – each Simon Community hostel has one support worker whose task it is to gather relevant information and knowledge on drug and alcohol issues as a resource for the rest of the team and the resident group; and
- **Street Drinkers Project (Foyle Haven L/Derry)** – this drop in centre opened in December 2001, in response to an identified need to provide a range of services to street drinkers in the Londonderry area. It was developed through an inter agency partnership comprising representatives from Derry City Council, City Centre Initiative, Foyle HSST, PSNI, NIHE and voluntary agencies. In addition to funding from the NIHE, funding has been provided by Londonderry Regeneration Initiative, Western Health and Social Services and voluntary bodies. Floating support officers provide street drinkers with advice and practical support across a range of issues including, housing, health, safety, substance use, and benefits.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

The key conclusions emanating from the research are set out in the sections below.

8.1.1 The Scale of the Problem

The research leads to the conclusion that substance misuse is a significant issue among homeless people in terms of both prevalence of use and dependency. Risk behaviours were associated with substance use and the incidence of mental ill-health among the population was high. The research also indicates that substance use is a factor in becoming homeless, repeat homelessness and remaining homeless. Key findings that must be addressed are as follows:

- The majority of alcohol use among the homeless sample is at hazardous levels and around 23-27% indicated symptoms of dependency and harmful alcohol use. Northern Ireland-wide studies indicate a lower level of hazardous use among the population as a whole;
- The prevalence of drug use among the study's homeless sample is much higher than for NI as a whole – two-thirds have used drugs and more than a third are current drug users;
- Almost all drug use was found to be at problem levels and tests indicated symptoms of dependency. The lack of priority placed by drug users on addressing their substance use is concerning;
- In the sample, most drug and alcohol use began before individuals became homeless and there was a strong connection between age of first substance use and age of first homelessness. However there was also evidence of people beginning to use substances after they became homeless, more limited evidence of people stopping substance use and some had never engaged in substance use at all. There is therefore a need to provide support for homeless people that prevents non-substance users from starting to use substances, reduces the harm caused by those who are already using substances, supports those who wish to stop and respects the wishes of those who have always abstained;
- There was a high level of risk behaviour generally among those taking part in the research – around half reported suicidal behaviour and practicing unsafe sex, and two-fifths each were involved in criminal behaviour and self-harming;
- In addition, while only three people in the sample reported that they were currently engaging in intravenous drug use, all of these were involved in high risk injecting behaviour and 15% of the sample had been tested for blood-borne diseases suggesting their involvement in behaviours that put them at risk; and
- There was a high incidence of ill health among the sample, in particular mental ill-health – 35% had a diagnosed psychiatric illness and 22% were receiving treatment for psychiatric illness.

8.1.2 Service Provision, Use and Access Issues

There is a requirement to address the range of services available to homeless people with problem substance use, both in terms of treatment and homelessness provision. The key findings were that:

- Few interviewees had accessed substance misuse services despite the prevalence of substance use, suggesting that their priority is to secure accommodation as the key to stabilising other life issues, rather than to address their drug and alcohol problem;
- Homeless people strongly urged the need to improve substance misuse and homelessness services to better meet the individual needs in terms of the range and specialisation of services available, information provided on services and the quality of support available from staff to deal with the joint problem of homelessness and substance misuse;
- Prevention was stressed as an important issue to address. A greater need for information would appear to exist highlighting the harmful effects of drugs rather than alcohol, but the mismatch between perceived and actual requirement highlights a need for information and prevention work across all substances;
- Interviewees were much more likely to have accessed homelessness services and other general health services, compared to treatment services. However, almost half of the sample reported problems in accessing homelessness services and some of these access problems related to their substance use (e.g. hostel policies on substance use);
- Homelessness providers confirmed that substance misuse is a key factor in accepting clients and in exclusions. However, only half of the providers responding to the survey had staff who were trained to deal with substance misuse issues;
- The level of contact homeless people have with accommodation and other services presents untapped opportunities to intervene in relation to their substance use; and
- Substance misuse providers confirmed the negative impact of homelessness on successful treatment.

8.1.3 Policy and Strategy Level Issues

The issues of homelessness and substance misuse are not well integrated at a policy and strategy level, although there has been some evidence of effective integrated practice at operational level. A number of joint policy and working structures already exist which have a part to play in addressing this issue (for example, PSI Working Group on Homelessness, Homelessness Strategy Partnerships, Supporting People Partnerships and the Model for the Joint Implementation of the Drug and Alcohol Strategies).

However, their current remits, structures and funding mechanisms are not easily mapped in relation to the issue under review. Therefore, a specific bridging mechanism is required to bring various strategies and structures together at a regional level and to identify and meet needs at a local level.

8.2 Recommendations

The primary recommendation is that the findings of this research and the issue of substance misuse and homelessness be disseminated widely and that an appropriate coordinated response to the problem be developed. The response should span change in both policy and practice including the following:

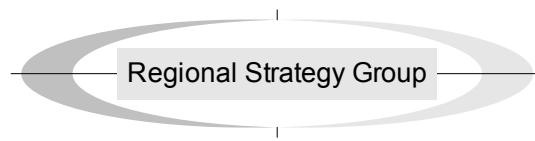
8.2.1 Policy and Strategy

The research indicates that the interrelationship between the problems of substance misuse and homelessness is sufficiently significant to merit the development of an enhanced strategic structure to deal with the specific issues. Therefore, mechanisms should be put into place to develop a regional strategy for an integrated housing, homelessness and substance use service, both from a preventative and reactive perspective.

A possible model for the strategy is set out in Figure 8.1. It suggests a two-tier approach, with a Regional Strategy Group whose role is to set policy and oversee service integration, and four Area Groups whose role is to identify and meet local needs. The Area Groups could be sub-groups of the existing DACTs and would feed into the Supporting People Area Partnerships to ensure maximum coordination with existing structures and best use of existing funding. It is recommended that if adopted, this model should include statutory and voluntary sector representation from across health, housing and justice/community safety, at a senior strategy level on the regional group and at a senior operational level on the area groups. Suggested representatives are shown in Figure 8.1.

In addition to the establishment of this model, reviews of existing strategies should ensure also that the issue of homelessness and substance use is given appropriate weight. For example, any further review of the Regional Drugs and Alcohol Strategy should recommend that specific objectives and actions regarding homelessness and housing are made in the plan, and any further review of the NIHE homelessness strategy should include a strategy intent to create an integrated service with Health and Social Service Agencies on homelessness and substance use issues.

Figure 8.1
Proposed Model for Homelessness and Substance Misuse Strategy



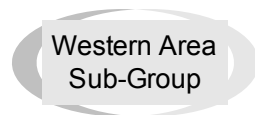
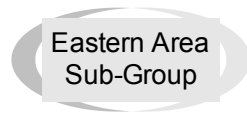
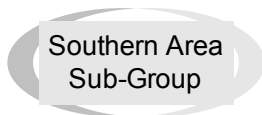
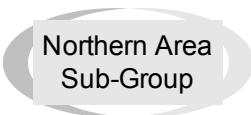
ROLE:

- to develop and oversee a regional approach to integrated services for homelessness and substance use.

MEMBERSHIP:

Senior level representatives including:

- Regional Drug & Alcohol Strategy Co-ordinator
- Regional Homelessness Strategy Co-ordinator
- Representation (health and housing) from Supporting People Regional Planning Group
- Representative of voluntary sector treatment providers
- Representative of voluntary sector homelessness providers
- Representatives from Probation, Youth Justice & Community Safety
- Representative of Health Promotion Agency



ROLE:

- to map local services & identify gaps/local needs
- to devise integrated models of service and joint working protocols
- to recommend improvements to current service delivery
- to monitor the implementation of local service changes
- to feed into local structures for Supporting People & Regional Drug and Alcohol Strategy

MEMBERSHIP:

Suggested members in each area are as follows:

- Drug & Alcohol Co-ordination Team Co-ordinator
- Area Homelessness Strategy Co-ordinator
- Chair of Area Supporting People Partnership
 - NIHE Area Senior Housing Manager
 - Statutory sector treatment provider
 - Voluntary sector treatment providers
 - Voluntary sector homelessness providers
- Probation, Community Safety & Youth Justice representatives

8.2.2 A Service Continuum

Feedback from homeless people through this research highlights a clear need to ensure that homeless people across Northern Ireland have access to a continuum of integrated services in relation to substance misuse and homelessness. This continuum should be appropriate to different groups with different needs, consistent with the good practice set out in the literature review and the findings of this research, and should include:

- a co-ordinated range of temporary accommodation to meet the needs of current and former substance users and those who have not engaged in substance use, including accommodation to meet the needs of intravenous drug users;
- outreach services for rough sleepers and comprehensive drop-in services ('one-stop shops') that provide non-judgemental information and support to those with more chaotic lifestyles;
- outreach treatment services including harm reduction and other treatment services designed to be more accessible to homeless people;
- detoxification services; and
- better integration between treatment/accommodation services including formal links between the NIHE, other homelessness providers and treatment providers on the exchange of information.

An agreed baseline model of service provision should be developed for the region and further analysis should be undertaken to identify needs at an area/board basis. This model may not require significant additional funding resources as the key objective will be to redesign existing services to better meet the needs of the target group.

8.2.3 Information and Prevention Services

This research shows that two main groups need health promotion support and preventative services – those in temporary accommodation and those threatened with homelessness due to their substance misuse.

Those in temporary accommodation need support to deal with substance misuse and its impact on both their health and their capacity to move into more permanent accommodation. In particular, the research shows that mental health problems and risk behaviours (including behaviours that put people at risk of blood-borne diseases) should be targeted. The research showed a significant problem with substance use among homeless people but a lack of recognition into its impact on individual's current situation, with low numbers perceiving substance use services as a current need. Therefore, information and prevention services must be designed to be more accessible to those in temporary accommodation, for example, through greater provision of outreach services, clinics in hostels and other on-site support.

Those under threat of homelessness where substance misuse is an issue also need support, and mechanisms should be put in place to ensure early intervention that prevents these individuals from becoming homeless.

The role of primary health care, housing, police and other public services in providing early intervention services should be explored.

The Joint Model for the Implementation of the Drug and Alcohol Strategies and the PSI Working Group on Homelessness have a remit to explore ways in which drug and alcohol harm and homelessness respectively can be prevented.

8.2.4 Training

Feedback from homeless people and providers highlights a training need for those working with homeless people and substance misuse issues. This includes those working in temporary accommodation, frontline housing staff working for the NIHE and those working in treatment services. Training needs include awareness raising regarding the needs of those with substance use problems generally, how to identify issues, when to refer people onto other services, appropriate referral points and in-depth specialist assessment.

It is recommended that steps be taken to ensure that those in accommodation services working with homeless people can access a programme of training in substance use issues. The Council for the Homeless offers training in this area for voluntary sector providers but uptake has been poor. If resources can be made available, this offering should be augmented to improve uptake and to ensure that all those providing non-statutory temporary accommodation have access to regular training and support. This should include support to hostels with structuring policies and procedures on drugs and alcohol, offering advice on harm reduction methods and provisions needed and offering advice on Section 8 issues.

As regards NIHE staff, the introduction of the Multi-Disciplinary Assessment Team should meet some of the organisations' needs as regards specialist assessment, but there is also a need for more general awareness raising and training for those coming into contact with homeless people who may have a substance misuse issue.

The training needs of those working in treatment services who may have contact with homeless people should also be considered and a regional programme of training or set of guidelines be delivered.

In developing training, reference should be made to existing guidelines and publications, such as those highlighted in the literature review in Section 5 (e.g. Drugscope (2001) guidance for dealing with substance use in temporary accommodation). Guidelines on substitute prescribing that include specific guidance in relation to working with homeless individuals with opiate dependency, should also be disseminated.