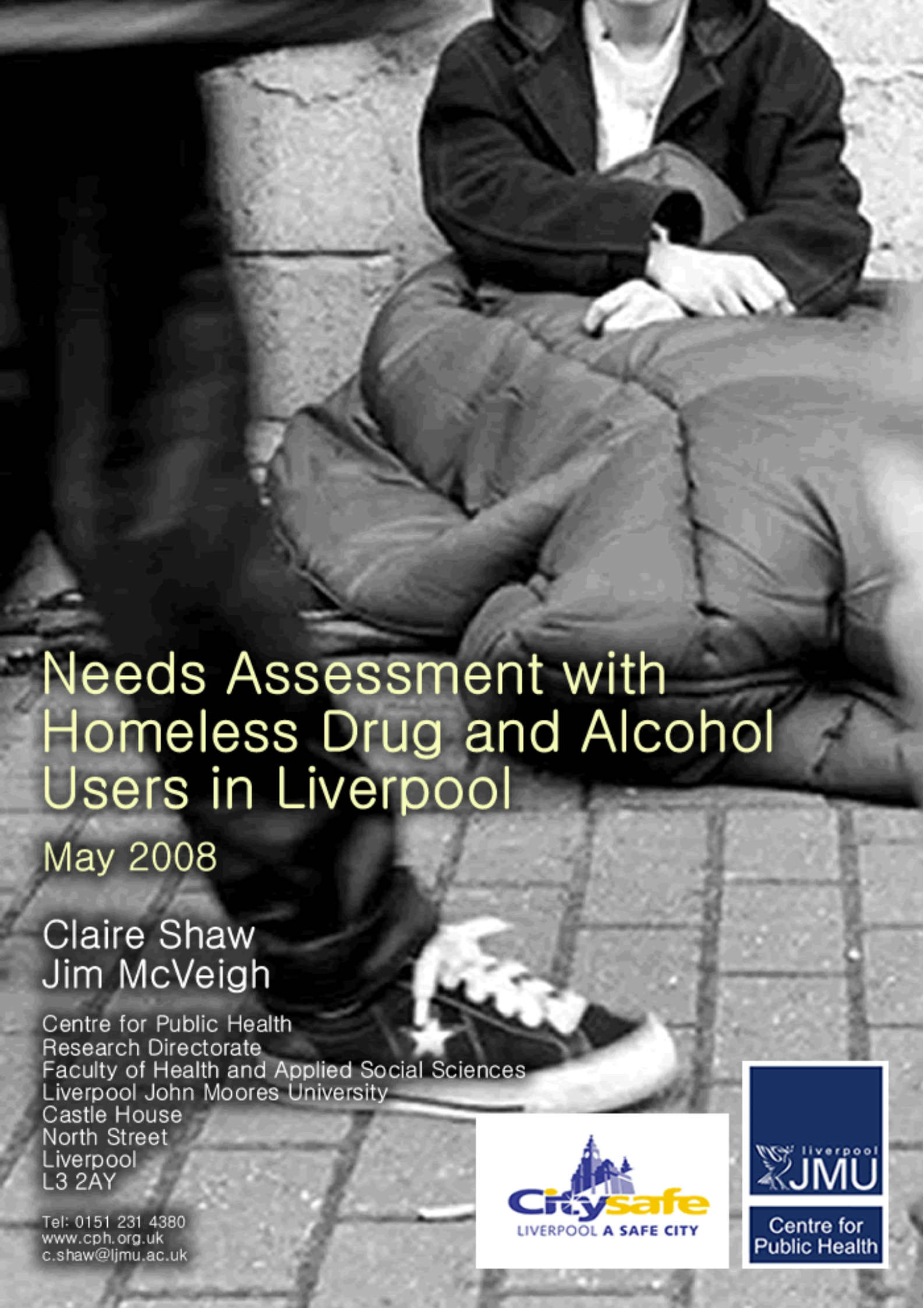

Needs Assessment with Homeless Drug and Alcohol Users in Liverpool

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Contents

Executive Summary

The primary aim of this needs assessment was to gather information on the service users demographic profile, drug use and health profile and most importantly their health and social needs both within the context of their substance use and from a wider holistic perspective.

Three services that work directly with homeless drug and alcohol users in Liverpool were chosen as the host sites where the research was undertaken. The sites were utilised to engage with a large sample of homeless drug and alcohol users in different accommodation situations i.e. rough sleeping, staying at hostels, staying with friends/relatives.

Service user participants were randomly sampled at each of the three services in Liverpool. Stakeholders from local services were also interviewed as part of the needs assessment. Semi-structured discussion guides were developed for use with service users and stakeholders.

Findings from the Service User and Stakeholder Needs Assessment Interviews

Fifty homeless substance users (aged 18 to 66 years, mean age=36 years) were interviewed, of which 82% were male. Drugs and/or alcohol were cited as an initial cause of their homelessness by 38% of participants and a quarter (26%) indicated that a relationship breakdown led to their homelessness. All participants reported that they had slept rough at some point since becoming homeless and the majority (68%) had slept rough on the night prior to their interview.

When asked about why they had slept rough on the previous occasion 50% of participants indicated that it was because they had no accommodation or no other choice. Twelve percent indicated that there was no available hostel accommodation, 6% indicated that it was because they were under the influence of drugs or alcohol and therefore would not be permitted to stay in hostel accommodation and 4% reported that they would not leave their partner although they could have accessed single-sex accommodation on that occasion.

Eighty-two percent of participants had been to prison, of which two-thirds (66%) had been sentenced more than five times. The vast majority of participants indicated that their health had changed since becoming homeless (88%). When asked how it had changed only one participant reported that their health had improved since becoming homeless (2%). Ninety-four percent reported at least one health problem from the list provided and 86% reported at least one untreated illness. Participants indicated that they currently had varying levels of health problems. Identified health problems included dental problems (58%), weight issues (42%), joint/muscular problems (38%), asthma (32%), hepatitis (28%) and headaches (28%). The high levels of untreated illness among this group highlighted the need to enhance their knowledge regarding appropriate health services and how to access them.

The vast majority (94%) indicated that they smoked every day and only 6% reported that they smoked less than 10 cigarettes a day. Three-quarters of participants drank alcohol (76%) and of those who had drank alcohol in the past seven days, 9% to

hazardous levels[1] and 76% were drinking to harmful levels[2]. Males and females reported similar patters of alcohol consumption in the previous seven days. Analysis of responses to the CAGE Questionnaire (Ewing, 1984) indicated that two-thirds of participants who used alcohol had a clinically significant result indicating that they are at risk of problem drinking and alcoholism (66%).

Three-quarters of participants reported lifetime use of cannabis (74%). More than two-thirds of participants had used crack cocaine (70%) and heroin (68%) at least once. More than a third of participants were currently using crack cocaine (38%) and heroin (42%). Analysis of the frequency of crack cocaine and heroin use of the current users indicated that over three-quarters were using these drugs daily. Crack cocaine, heroin and methadone were the most commonly used drugs in the previous month. Low levels of use of other stimulants (cocaine, amphetamines and ecstasy) in the previous month were recorded.

More than two-thirds of those receiving a methadone prescription reported that they had used heroin and/or crack cocaine in the previous month. Based on analysis of current drug use, 50% of participants who had ever used drugs met the Home Office definition of problem drug use (PDU) (Hay et al., 2006). The vast majority (82%) of current PDUs were simultaneously using heroin and crack cocaine.

Analysis of reported injecting illustrated that half of participants had injected at some point in their life (50%). Approximately one-fifth of participants (22%) had injected in the week prior to interview. One-fifth of participants who had ever injected (20%) indicated that they had shared a needle or syringe and two-thirds (64%) had shared a spoon, water or filter with someone else.

Participants were asked to identify barriers to engagement with treatment services for homeless people and how services could be improved. Barriers included:

- *Lack of understanding/fear about treatment*
- *Treated like second class citizens*
- *Their environment/escapism from the environment*
- *Circumstance – lack of housing/job etc.*
- *Difficulties in accessing services*

The ideas for improvement to services and to enhance treatment engagement cited by participants corresponded directly with the barriers to engagement. Ideas for improvement included a change in the attitude of staff at certain services, respect, consistent support throughout treatment journey, financial support and easier access to services.

When asked to identify the main priorities of homeless people with substance use problems, 70% mentioned accommodation, 47% substance use treatment and 19% self-esteem and confidence building.

[1] Hazardous drinking is defined as 22-50 units per week for males and 15-35 units per week for females.

[2] Harmful drinking is defined as over 50 units per week for males and over 35 units per week for females.

The findings from the stakeholder interviews indicated that there was much work undergoing across the agencies and organisations to promote their services to homeless drug and alcohol users and to engage and retain this group in treatment. Specifically, services indicated that there has been a culture of change in the attitude and support offered by local services and that the changes needed to be disseminated to service users and potential service users. Stakeholders identified good working partnerships across the area, but, they also suggested areas for improvement to enhance services for the client group.

Conclusions

The in-depth analysis of the client and stakeholder interviews indicated that the needs of homeless drug and alcohol users are extensive and complex. Specific needs were identified for homeless drug and alcohol users in relation to:

- Barriers to treatment
- Appropriate accommodation
- Accessing health care services
- Information dissemination amongst local agencies and organisations
- Vulnerable groups
- Funding and resources
- Re-education of homeless drug and alcohol users

Approaches to tackle identified needs are outlined in conjunction with supporting evidence in Section 4 of the report. Based on the identified needs a number of methods to improve services for homeless drug and alcohol users in Liverpool were noted. These include:

- Research and monitoring
- Peer education and open discussion
- Improved communication and training in local services
- Increased availability of appropriate accommodation

1. Introduction

Homelessness & Substance Use

Research indicates that there is a link between social exclusion and substance use (Eaton et al., 2007; HPA, 2007). The reason(s) behind a person's homelessness is rarely clear cut and typically may include a combination of mental health problems, substance use, unemployment, criminality, chaotic lifestyle, family problems, relationship breakdown and domestic violence (ODPM, 2005a).

Findings from the Office of the Deputy Prime Minister (ODPM) (2005a) indicate that one in three problem drugs users are homeless or in need of housing support. Government strategies have reiterated their commitment to reducing the number of rough sleepers and those classed as statutorily homeless. In *Sustainable Communities: Homes for All* (ODPM, 2005b) the government set targets to reduce the number of rough sleepers to as close to zero as possible and to halve the number of households living in temporary accommodation by 2010.

The most up to date estimate of rough sleepers in England in 2007 is just under 500 based on rough sleeping counts conducted by local authorities in partnership with local homeless agencies. The recent estimate is a 73% reduction from estimates in England in 1998 (Communities and Local Government, 2007). Estimates of rough sleepers, however, do not take into account those who are statutorily homeless, in June 2007 around 84,900 households were accepted as homeless (ONS, 2007). The number of non-statutorily homeless will be higher still.

Research comparing drug use within hostels, private leased accommodation, night shelters and amongst rough sleepers (using day centres) reported that overall drug use was much more prevalent among the adult homeless compared to adults in a private household. The research indicated that 57% of young men in hostels were users of a drug compared with 19% of men of the same age in the private household survey. Opiate use tended to be more prevalent within night shelter residents compared to private sector residents. One in seven night shelter residents had injected at some point in their lives (Gill et al., 1996).

Research conducted by the homeless charity Crisis (Fountain and Howes, 2002) reported that 83% of homeless people interviewed had used a substance other than alcohol in the last month. Two-thirds of the sample cited drug or alcohol use as a reason for becoming homeless and four out of five said that they had started using at least one new drug since becoming homeless.

The link between homelessness and drug use is so important that the first key message in the 2007 update of *Shooting Up* (HPA, 2007) is concerned with the increased injecting risk and risk of infection of homeless drug users. *Shooting Up* (HPA, 2007) reports that homeless people are more likely to report sharing needles, to have had an injecting wound and have had hepatitis C infection.

Homeless Women

Research findings from Crisis (Reeve, Casey & Goudie, 2006) indicated that among homeless women there are high levels of vulnerability, including mental-health, history of care, drug and alcohol addiction and physical and sexual abuse. It was reported that homeless women were typically less visible than homeless men and they would go to great lengths to ensure that they were not recognised as homeless, sometimes to their detriment as in order to conceal their homelessness they would not access the services that could potentially help them to find appropriate accommodation. The report indicated that a significant proportion of women who become homeless form unwanted sexual partnerships (paid and unpaid) or resort to street sex work in order to have a place to stay.

Interventions and Outcomes for Homeless Drug and Alcohol Users

Models of Care 2006 Update (NTA, 2006) emphasised that the requirement for a joined up approach to drug treatment is particularly important for vulnerable groups such as homeless and sex workers. In order to tackle the complex needs of homeless drug and alcohol users Edmonds et al. (2005) reported measures which could significantly reduce drug-related harm including:

- early intervention
- highlighting the dangers of poly drug use
- highlighting health risks including safer injecting practices
- promoting skills to cope with accidental overdoses
- one to one work
- formal prevention activities

Rough sleeping is currently at the forefront of the Government's housing agenda and there are plans to update the rough sleeping strategy during 2008. A recent discussion paper from the Department for Communities and Local Government (DCLG) (2008) indicates that the government focus is shifting from the reduction in numbers of rough sleepers to improving the outcomes of this group with a focus on health, employment and skills. The discussion paper also highlights the growing issue of migrants sleeping rough, particularly those from Eastern Europe who have come to the UK seeking employment.

Generally in the UK there is a lack of services specifically to support, help and treatment for street drinkers. Research with wet centres (those which allow alcohol to be consumed on the premises) has indicated that they can play a vital role as a support service for those who are excluded or disengaged from other services (Kings Fund, 2003). The wet centres also play an important role as a host for other specialist services such as substance use treatment, housing and health services.

Homelessness in Liverpool

In 2005/06 2,917 people presented to Liverpool City Council as homeless of which 39% were accepted by the Council as homeless. Counts of rough sleepers based on local authority street counts undertaken in June 2007 found that Liverpool had

twelve rough sleepers, the highest number of rough sleepers in the North West and the sixth highest number in England (Communities and Government, 2007). Research undertaken by homeless outreach workers in Liverpool suggest that this number is an underestimate and the actual figure is about 50 (Gosling, 2007). During 2005/06 1,933 individuals who were homeless or had a housing need actively engaged with The Whitechapel Centre indicating that the homeless problem in Liverpool is more substancial than the government counts illustrate.

An audit of homeless patients registered at Brownlow Practice in Liverpool found that almost three-quarters of homeless patients were men, the majority were between the ages of 30 and 45, over a quarter were alcohol dependant and over a third were drug users (Brayford, 2006).

In 2007, a Housing Needs Assessment of Liverpool found that there is a short-fall of over 2,000 dwellings in the Liverpool City Council area (Fordham Research, 2007). Furthermore, the research indicated that homeless people were provided with poor accommodation offers, their expectations were low are there was a lack of appropriate hostel accommodation and move on accommodation (Fordham Research, 2007).

In response to the Housing Needs Assessment Liverpool City Council updated Liverpool's Homelessness Strategy 2008-2011 (LCC, 2008), the document sets out how the Council intends to further reduce rough sleeping, respond to the findings of the Housing Needs Assessment and ensure that they reduce the number of people placed in temporary accommodation by half, in line with the Government's strategy. The Strategy acknowledges many of the common reasons for homelessness and is working strategically to prevent homelessness.

1.1 Needs Assessment

Needs assessment is a process designed to establish the health requirements of a particular population. The primary aim of this needs assessment was to gather information on the service users demographic profile, drug use and health profile and most importantly their health and social needs both within the context of their substance use and from a wider holistic perspective.

1.2 Needs Assessment Aims

The objectives of the needs assessment were to:

- Identify the health and social care status and needs of problematic drug users and problematic alcohol users engaging with The Whitechapel Centre, The Basement Night Drop-In Centre and Armistead Street.
- Ascertain the current and previous service contact with drug services and other health and social care agencies and identify reasons for disengagement.
- Identify barriers to engagement with drug services and other health and social care agencies from personal experience, perceptions and shared information from peers.
- Identify methods to overcome barriers and perceived barriers to engagement.

1.3 The Services

Three services that work directly with homeless drug and alcohol users in Liverpool were chosen as the host sites where the research was undertaken. The sites were utilised to engage with a large sample of homeless drug and alcohol users in different accommodation situations i.e. rough sleeping, staying at hostels, staying with friends/relatives.

The Basement Night Drop-In Centre

The Basement offers an evening service for people experiencing homelessness. The service offers support to find accommodation, crisis counselling, referral to detoxification and rehab, and shower and laundry facilities (The Basement Night Drop-In Centre, 2007). The Basement is located in Liverpool City Centre where many homeless people gather and has an informal and relaxed environment. The Basement staff also work in close partnership with other agencies to support homeless individuals discharged from hospital or released from prison.

The Whitechapel Centre

An organisation set up in 1975 to tackle Liverpool's growing homeless problem in the inner city. The Whitechapel Centre works to deliver long term solutions to homelessness through the many programmes and facilities they offer including day centre services, hot meals, outreach, resettlement activities, supported housing services, laundry and washing facilities and education and training. The service is also a host for the Merseycare Rapid Access Homeless Outreach Clinic (RAHOS).

Armistead Street

Armistead Street is a support service for female street sex workers which was established in 1995. Armistead street aims to; provide a confidential assertive outreach and support service to women involved in street sex work and support those wishing to exit, deliver a flexible accessible and quality harm reduction service, refer and actively support street sex workers to access health, drugs, social care services and training/employment services. Armistead Street is part of the Armistead Centre within Liverpool Primary Care Trust. The service is also a host for the RAHOS which is held at Armistead Street, one afternoon per week specifically for women involved in street sex work.

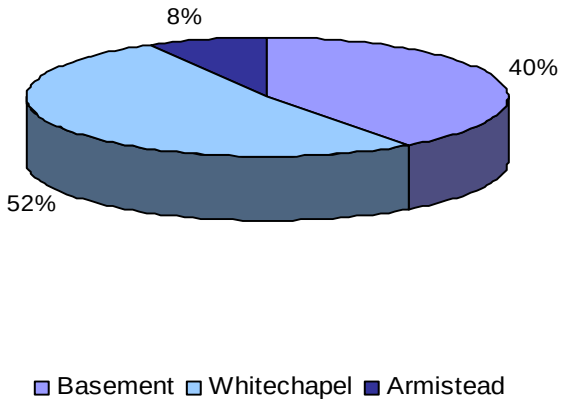

Figure 1: Location of interviews

1.4 The Participants

Participants were randomly sampled at each of the three services in Liverpool. Service users who were present on the days that the research was carried were invited to participate in the needs assessment. The specific days that the research was carried out were chosen in collaboration with each service to ensure a large potential sample and minimum disruption to the services regular activities e.g. dinner, syringe exchange clinics etc.

As typically, many of the participants use more than one of the services mentioned above, attributable data were collected at the beginning of the needs assessment interview. The initials, date of birth and gender of each participant were recorded to control for double interviewing of clients.

1.5 Incentives

Each participant received an incentive of £10 cash upon completion of the needs assessment questionnaire. Cash was provided as an incentive as not to do so raises a fundamental question of discrimination against drug users on the grounds of who they are (Seddon, 2005).

1.6 Ethical Approval

Ethical approval was sought and granted by the Liverpool John Moores University Ethics Committee.

2. Methodology

A semi-structured questionnaire was developed for the needs assessment (Appendix 1). The questionnaire consisted of both closed and open-ended questions. The questionnaire was structured around relevant topics including:

- Demographic information
- Initial reasons for accommodation problems and current housing situation
- Contact with GP and dentist
- Health questionnaire
- Smoking
- Alcohol
- CAGE Questionnaire[3]
- Current and past substance use (including injecting)
- Requirement for support from health and social care services
- Barriers to engagement with drug and alcohol agencies
- Homeless peoples priority of needs

Each interview lasted approximately 25 minutes.

A semi-structured discussion guide was designed and a member of staff from each host site and other relevant key stakeholders were interviewed (Appendix 2). The semi-structured discussion guide covered topics relating to organisation background, staff training, training offered, the needs of homeless drug and alcohol users, good practice and partnership working.

Interviews were conducted with a representative of the following organisations:

- The Basement Night Drop-In Centre
- The Whitechapel Centre
- Armistead Street
- Brownlow Group Practice Homeless Team
- The Big Issue in the North
- Liverpool PCT
- Liverpool Drug (and Alcohol) Action Team (D(A)AT)
- Lighthouse Project
- Merseycare
- The Royal Liverpool and Broadgreen University Hospitals (A&E)

Analysis of the needs assessment interviews and stakeholder interviews was undertaken and the results are shown in Section 3.

[3] The CAGE Questionnaire is a tool used to test for problem drinking and alcoholism (Ewing, 1984). A score of 0-1 on the CAGE questionnaire indicates no problem with alcohol, a score of 2+ is clinically significant and indicates that the person is at risk of problem drinking and alcoholism.

3. Results

3.1 Results from the Service User Needs Assessment Interviews.

3.1.1 Participant Demographics

Fifty participants were interviewed, 82% were male (n=41) and 18% (n=9) were female. Participants were aged between 18 and 66 and the average age was 36.18 years. The age range of the male participants was from 24 to 66 years and for the female participants was from 18 to 42 years. The vast majority (96%, n=48) described their ethnic origin as White.

Figure 2 shows where the participants reported that they had grown up. Over half of participants (54%, n=27) had spent the majority of their life up to the age of 16 in the Liverpool city area. When the response of 'Liverpool' and 'Merseyside' were combined the findings indicated that three-quarters of participants (78%) were from the Liverpool/Merseyside area indicating that the majority of participants had not moved far from where they grew up (note that the 'Other Merseyside' area category below excludes Liverpool). The 6% (n=3) who reported that they were from outside the UK came from Ireland and Eastern Europe.

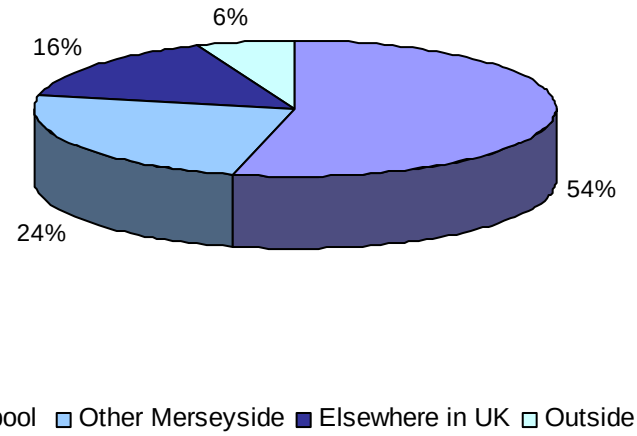

Figure 2: Where participants spent most of their life up to the age of 16

None of the participants were currently employed and 32% (n=16) reported that they had never been employed. Of those who had been previously employed, only 15% (n=5) had been employed at some point in the previous year and 42% (n=14) had not been employed for more than 6 years.

3.1.2 Accommodation

Participants were asked about the initial cause of their accommodation issues. The results were categorised and are shown in Figure 3 below. The majority of participants (38%, n=19) cited drugs and/or alcohol as the initial cause of homelessness. Over a quarter (26%, n=13) stated that relationship breakdown was the initial cause of their accommodation problems, this included a breakdown of relationship with a partner or family. Almost one third (30%, n=15) indicated that something else was the initial cause of their homelessness, this included prison, moving city, problems with neighbours, financial difficulties and problems finding employment.

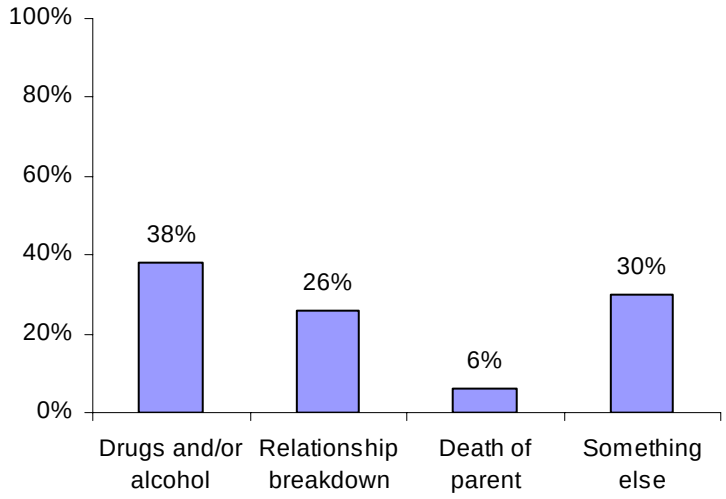

Figure 3: The initial cause of accommodation issues

All participants reported that they had slept rough at some point since becoming homeless and the majority (68%, n=34) had slept rough on the night previous to their interview. Four participants (8%) reported that they had not slept rough for a year or more.

When asked about why they last slept rough, half of participants (50%, n=25) reported that it was because they have no permanent accommodation and no other choice (Figure 4). Twelve percent (n=6) indicated that they had tried to get into a hostel on that occasion but that they were all full. Two male participants (4%) reported that on the last occasion they slept rough they would have been able to get accommodation in a men-only hostel, however, they did not want to leave their girlfriend alone on the streets overnight.

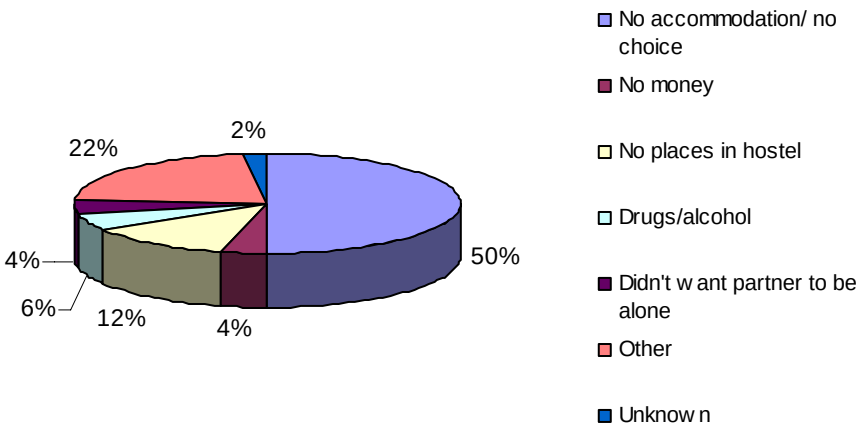

Figure 4: Reason for sleeping rough on last occasion

Other reasons that were reported included the inability to get into the house where they were staying and 'just didn't go home'. Problems at hostels were mentioned by a number of participants, specifically these included with other residents and an unwillingness to share a hostel room with strangers.

Figure 5 indicates that in the previous six months the majority of participants had slept rough (88%, n=44), almost half had stayed with friends/relatives (46%, n=23) and just over one third didn't bed down (38%, n=19). Thirty-six percent (n=18) had been in prison or a police cell and 18% (n=9) had been in hospital.

A third of participants had stayed in a hostel (32%, n=16) and 10% or less had stayed in their own accommodation (council tenancy, housing association property and private rental).

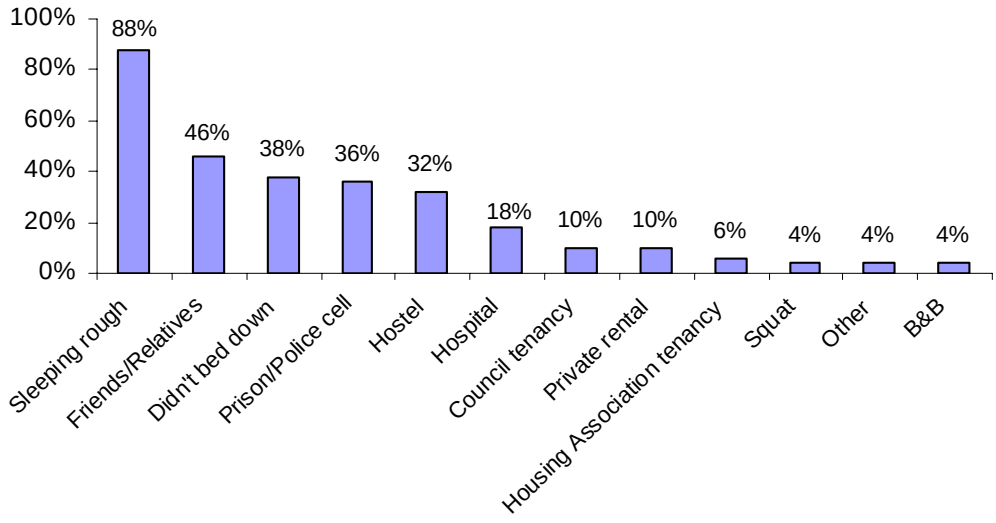

Figure 5: Places where participants had stayed in previous 6 months[4]

[4] Note percentages add to more than 100% as the majority of participants had stayed in one or more types of accommodation in the last six months.

When asked where they had slept on the previous night approximately two-thirds had slept rough (64%, n=32) and 16% (n=8) had stayed with friends/relatives. Figure 6 shows how long the participants had been staying in the accommodation they had stayed on the previous night. Thirteen of the thirty-two who stated they had slept rough on the previous night had been in their current situation for more than a year. Of those who reported sleeping rough on the previous night, the range of time in this situation was from 2 nights to 12 years, with an average of 2.1 years.

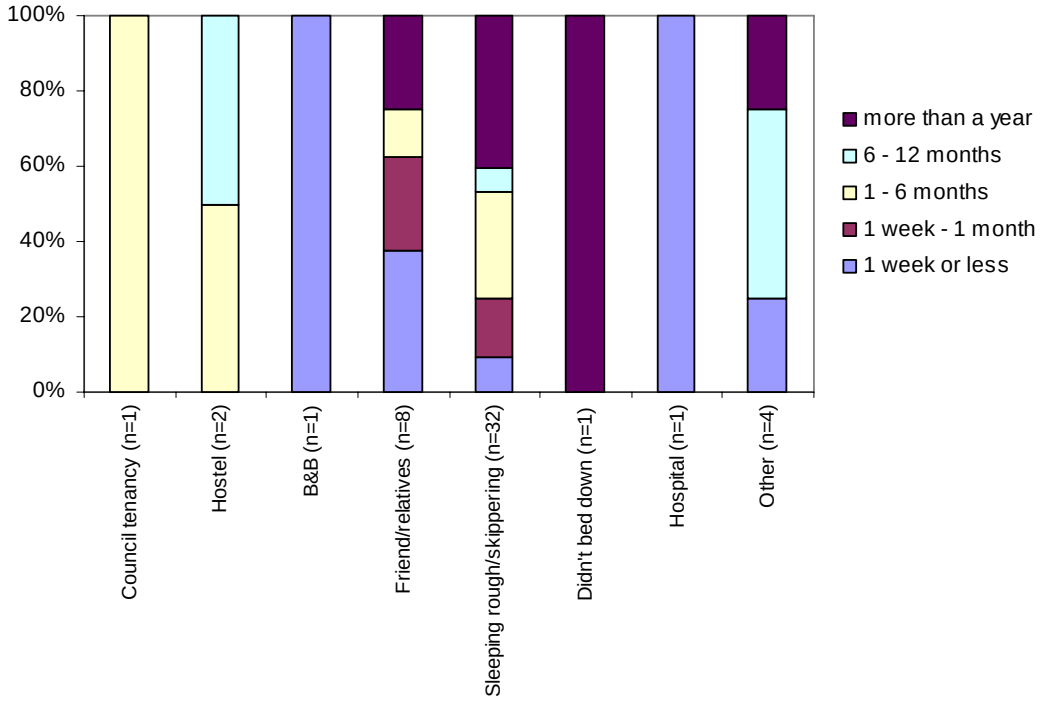

Figure 6: Breakdown of where participants stayed on the previous night & how long they had been living in that situation.

3.1.3 Prison

Eighty-two percent (n=41) of participants had been in prison. Of those who had been to prison two-thirds (66%, n=27) had been sentenced more than 5 times and one-third (34%, n=14) had been sentenced more than 10 times.

3.1.4 GP Contact

Sixty percent (n=30) of participants had been in contact with a GP in the previous month. Only 12% (n=6) had not been in contact with a GP for more than a year. The high percentage of participants who had been in recent contact with a GP may be due to the outreach clinic run by Liverpool Drug Dependency Unit (DDU) at The Whitechapel Centre and Armistead Street and the outreach work at Brownlow Group Practice. Many of the participants reported that they were receiving a

methadone prescription from the DDU outreach clinic or Brownlow Group Practice (see section 3.1.6).

The majority of participants (84%, n=42) were currently registered with a GP and of those registered 78% (n=32) were satisfied with the GP services provided to them. Of those who were not satisfied (22%, n=9), reported methods to improve the services included better attitudes and understanding from staff, surgeries at more convenient and flexible times and easier routes into detoxification.

A third of participants who had tried to register with a GP since becoming homeless (33%, n=7) had experienced problems whilst trying to do so. The difficulties reported included the attitude of staff and doctors at surgeries treating participants 'like second class citizens' and problems relating to a lack of address or medical card.

Participants were asked what they would do in an emergency situation if they or someone else needed to see a doctor or urgent medical attention. The majority indicated that they would go to the nearest A&E department (46%, n=22). A significant proportion of respondents responded that they would do nothing (13%, n=6).

3.1.5 Dentist Contact

A quarter of participants had seen a dentist in the previous 12 months (26%, n=13), however, the majority had not seen a dentist for more than 2 years (n=30, 60%) and one participant (2%) reported that they had never seen a dentist.

Only a quarter of participants reported that they were currently registered with a dentist (24%, n=12), however, the vast majority (88%, n=44) indicated that if they went to the dentist tomorrow they would need treatment.

3.1.6 Health Profile

Figure 7 illustrates the participants responses when asked to rate their health on a scale from very bad to very good. The majority of participants (38%, n=19) rated their health as fair. Sixteen percent (n=8) rated their health as good, notably no one rated their health as 'very good'. Almost half of participants (46%, n=23) reported their health in the 'bad' category (based on the total of 'very bad' and 'bad').

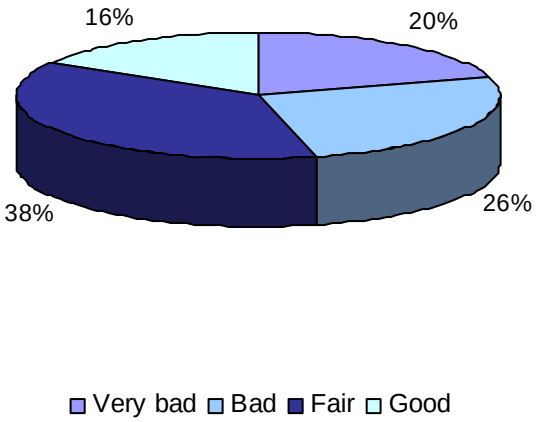

Figure 7: Participants ratings of general health

Participants were asked about a range of specific illnesses and health problems that are typically associated with homelessness and substance use including hepatitis, asthma, bronchitis, foot problems, bladder/kidney infections etc. The vast majority of participants (94%, n=47) reported at least one health problem from the list provided and 86% (n=43) reported at least one untreated illness.

Figure 8 illustrates the range of illness and health problems that the participants reported. Over half of participants reported that they had dental problems (58%, n=29) and just under half (42%, n=21) reported that they had weight problems, mostly underweight. Over a quarter of participants indicated that they had hepatitis (28%, n=14) and the majority of these indicated that they were not receiving treatment (85.7%, n=12). Other illnesses, such as bronchitis, epilepsy, diabetes and painful periods, were reported by less than 10% of the participants.

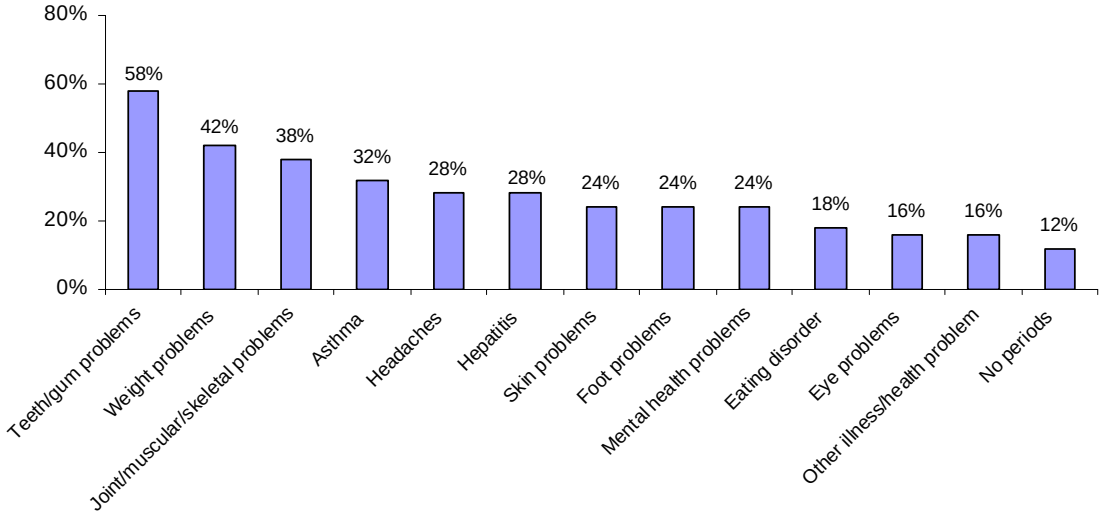

Figure 8: Illnesses and health problems[5]

[5] Note percentages add to more than 100% as the majority of participants reported more than one illness.

The participants were asked to rate how frequently they felt stressed and depressed. Marginally more participants reported *always* feeling stressed (22%, n=11) than *always* feeling depressed (18%, n=9). Fourteen percent (n=7) of participants indicated that they *never* felt depressed compared to only 4% (n=2) who reported *never* feeling stressed. Figure 9 and Figure 10, below, show the distribution of responses to the stress and depression questions.

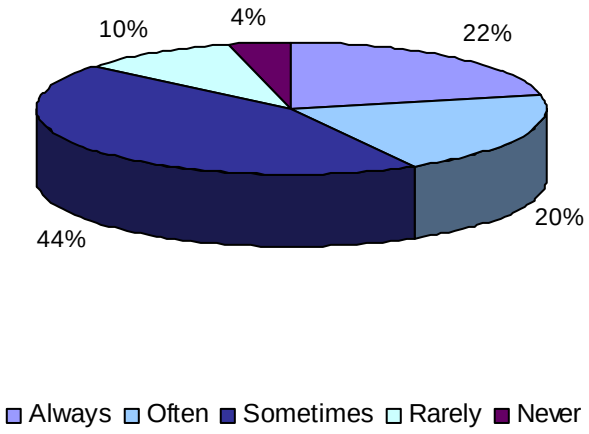

Figure 9: Frequency of feeling stressed

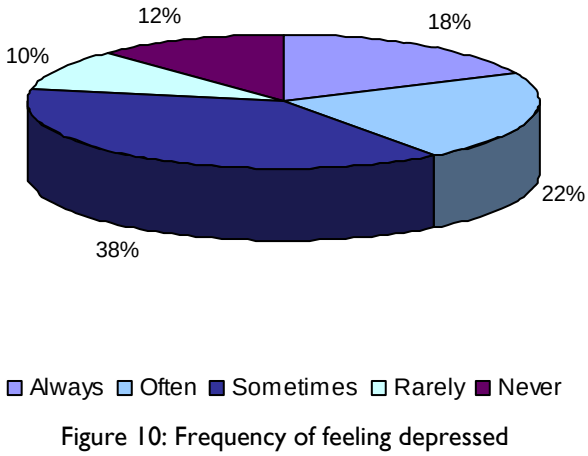

Figure 10: Frequency of feeling depressed

Almost one quarter (24%, n=12) of participants admitted that they had tried to deliberately harm or injure themselves at some point in their life. Of these participants, half had self-harmed in the past year (n=6) and two had self-harmed in the past week. The majority of participants who reported self-harming had spoken to a health professional about this behaviour (8 of the 12 participants).

Figure 11 illustrates the prescribed medications that the participants were currently using at the time of interview. Approximately two-fifths of participants reported that they were taking prescribed methadone (42%, n=21). Painkillers and inhalers for

chest problems were used by 24% (n=12) and 22% (n=11) of participants respectively.

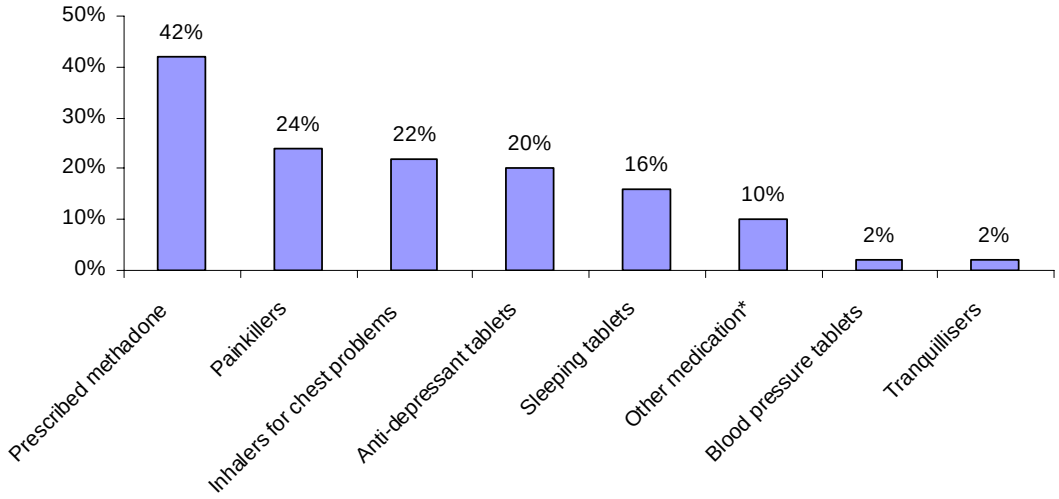

Figure 11: Current prescribed medications[6]

*'Other medication' includes antibiotics, epilepsy medication and parenteral thiamine.

When asked about medical services that they had been in contact with in the previous year (Figure 12) 18% (n=9) indicated that they had no contact with medical services. Of those who had contact with medical services the majority of participants reported that they had attended Casualty/A&E (62%, n=31) and drug treatment agencies (52%, n=26). Participants were least likely to have had contact with psychiatric hospital (8%, n=4) and psychological outpatient clinics (2%, n=1), however, 24% (n=12) indicated that they had mental health problems.

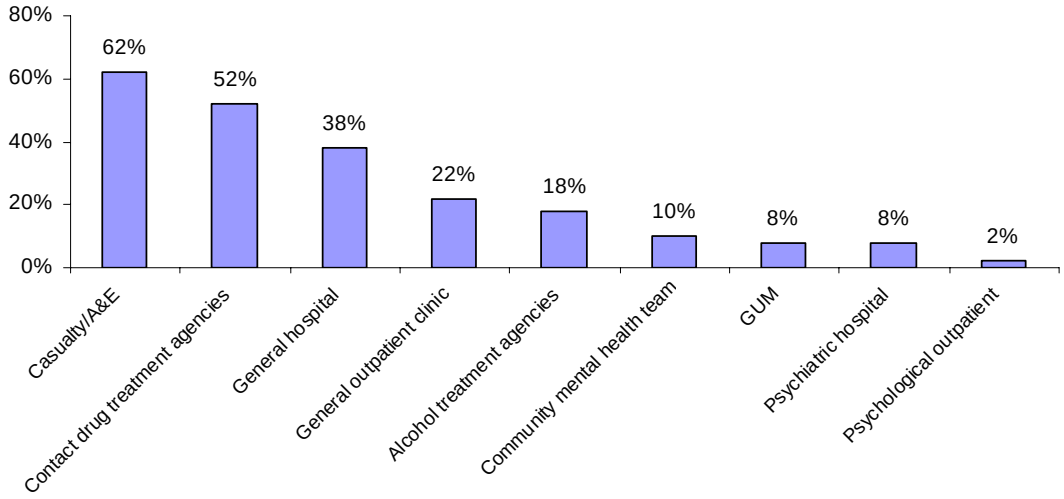

Figure 12: Medical services attended in the previous year[7]

[6] Note percentages add to more than 100% as some participants reported using more than one medication.
[7] Note percentages add to more than 100% as some participants reported contact with more than one medical service.

Almost one quarter (24.4%, n=10) of those who had contact with medical services in the previous year indicated that they had had a problem with the services attended. The reported problems included discrimination and 'being treated like a second class citizen', problems with registration at drug and alcohol agencies and problems with methadone prescribing.

3.1.7 Food and Nutrition

Figure 13 illustrates that approximately half of participants (52%, n=26) indicated that their diet was healthy (based on addition of 'mostly healthy' and 'sometimes healthy').

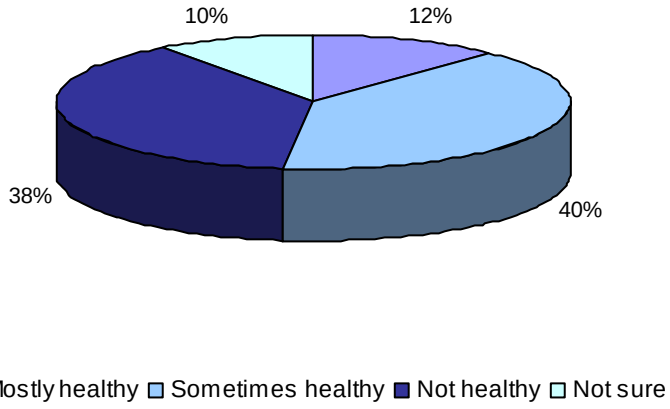

Figure 13: Description of diet

Figure 14 illustrates the percentage of participants who reported eating each of the food group 'never' and 'daily'. The majority of participants (64%, n=32) reported eating carbohydrates daily and 44% (n=22) reported eating meat/chicken/fish daily. Approximately a quarter of participants indicated that they never ate fruit (28%, n=14) or vegetables (22%, n=11). A high percentage of participants indicated that they never ate fried food (30%, n=15) and convenience food (44%, n=22).

Considering the lack of access to cooking facilities that this group have their reported diet is reasonably balanced. Many participants indicated that they were aware of the various homeless services that offer food and made use of these services regularly.

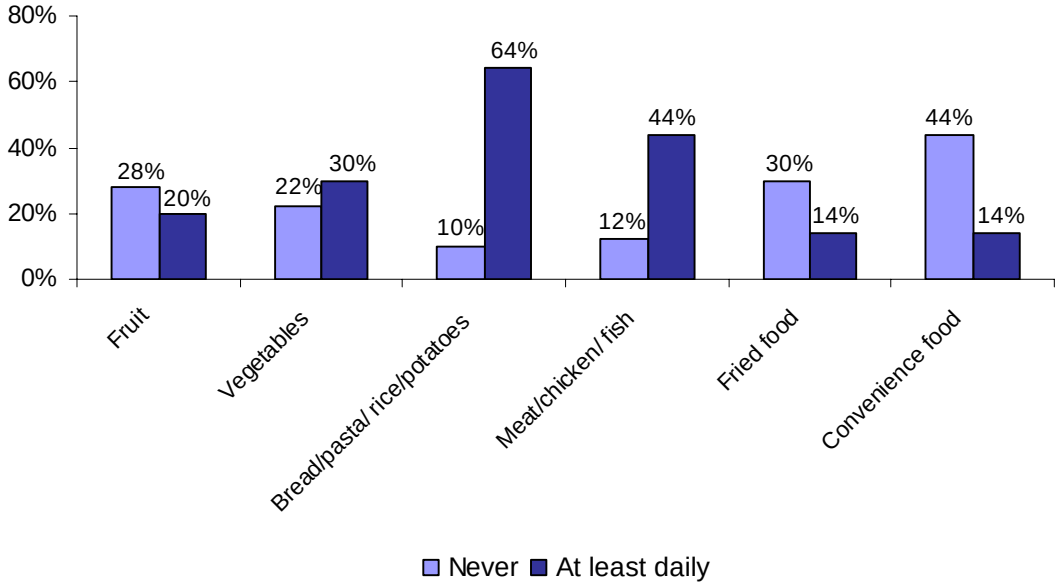

Figure 14: Percentage of participants who ate each of the food groups never and daily

3.1.8 Smoking

All participants reported that they had tried smoking and the vast majority (94%, n=47) indicated that they smoke every day. When asked about their smoking habits only 16% (n=8) reported that they usually smoked cigarettes, 40% (n=20) indicated that they usually smoke hand-rolled cigarettes and the other 40% (n=20) usually smoked a mixture of the two types[8]. Of those who indicated they smoked both most participants mentioned that which type of cigarettes they smoked depended on their financial situation.

Figure 15 illustrates the amount of cigarettes[9] smoked daily by participants (n=48). Only 6.3% (n=3) of participants who smoked indicated that they typically smoked less than 10 cigarettes per day.

[8] Note that the number of participants for whom smoking habits are reported include those who said that they smoke every day (n=47) and who said they smoke some days (n=1).
[9] Hand-rolled and pre-rolled cigarettes.

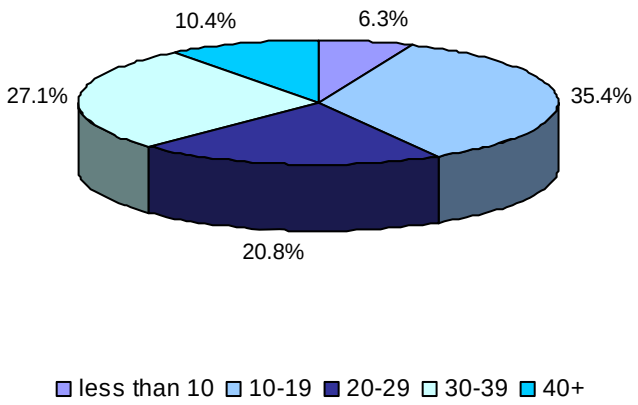

Figure 15: Typical daily number of cigarettes smoked by participants who reported smoking daily or some days

3.1.9 Alcohol

Seventy-six percent (n=38) of participants indicated that they drank alcohol and of these, 86.8% (n=33) reported that they had drank alcohol in the seven days prior.

Of those who had drank alcohol in the past seven days over three-quarters (75.8%, n=25) reported drinking to harmful levels[10] and 9.1% (n=3) reported drinking to hazardous levels[11]. Figure 16 illustrates the levels of drinking for males and females in the previous seven days. Similar patterns of drinking were observed among males (n=26) and females (n=7), the majority of each gender reported drinking to harmful levels.

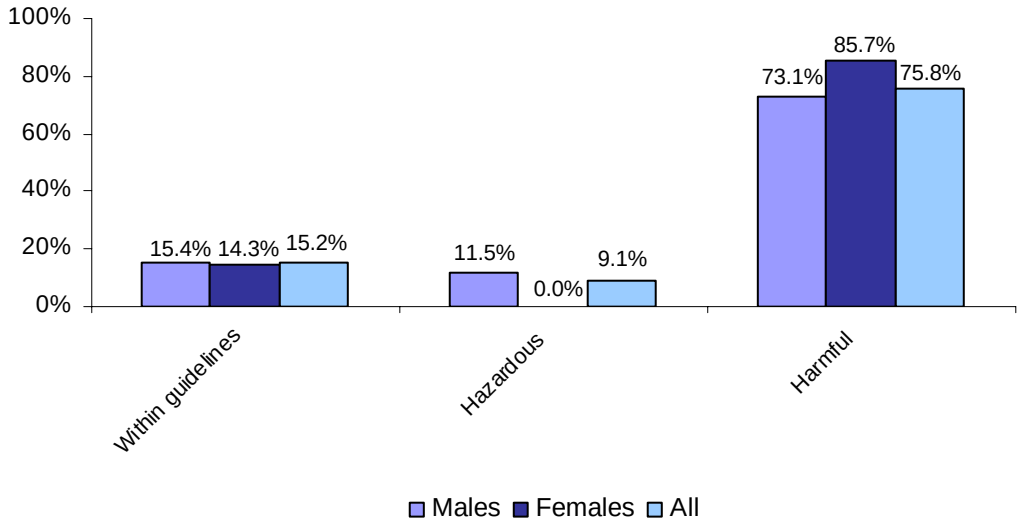

Figure 16: Levels of alcohol consumption in the past 7 days by gender

[10] Harmful drinking is defined as over 50 units per week for males and over 35 units per week for females.
[11] Hazardous drinking is defined as 22-50 units per week for males and 15-35 units per week for females.

Figure 17 illustrates participant's responses when asked to compare their alcohol consumption in the previous week with their typical weekly alcohol consumption (Figure 17). Of those who reported hazardous drinking levels (n=3) the majority (66.7%, n=2) indicated that their alcohol consumption was less than usual.

The majority of those who reported harmful levels of alcohol consumption (64%, n=16) reported that this was their usual weekly alcohol consumption and a quarter 24% (n=6) of this group indicated that their alcohol consumption was more than usual.

The majority of those who said that their alcohol consumption in the previous week was less than usual indicated that the reduction in alcohol use was due to a lack of money.

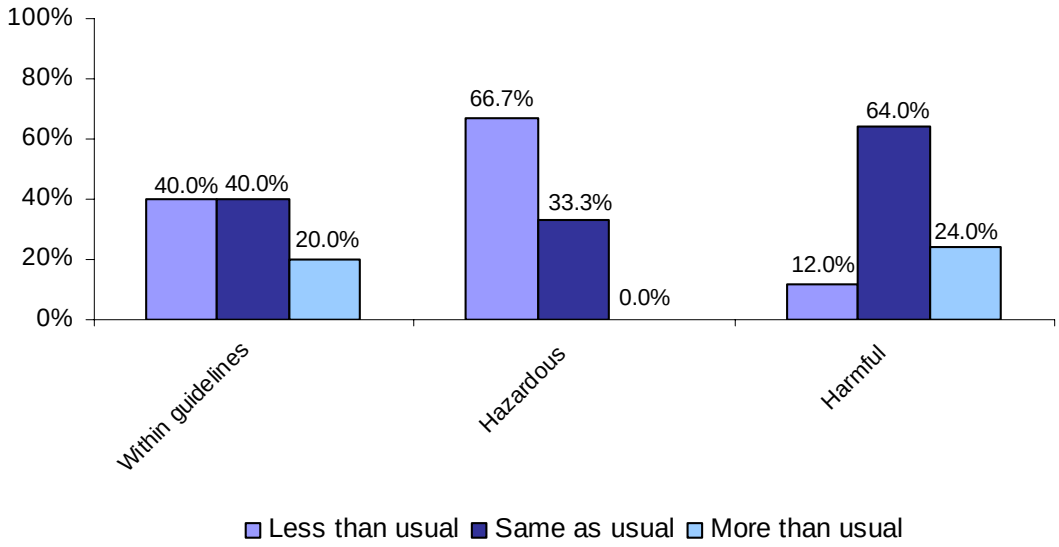

Figure 17: Comparison of self-reported alcohol consumption to usual weekly consumption levels

Participants who indicated that they drank alcohol completed the CAGE Questionnaire.

Almost three-quarters (n=28, 73.7%) reported that they had been advised to cut down on their drinking at some point. The health services were the most frequently cited source of advice on reducing alcohol consumption, 50% of participants indicated that they had received this advice from a doctor (n=14) and 21.4% from another health professional (n=6).

Analysis of responses to the CAGE Questionnaire indicated that two-thirds of participants who used alcohol had a clinically significant result indicating that they are at risk of problem drinking and alcoholism (n=25, 65.8%).

3.1.10 Substance Use

Twelve percent of participants (n=6) indicated that they had never used drugs, however two of these participants had a clinically significant CAGE Questionnaire score.

Figure 18 illustrates the patterns of lifetime and last month use of drugs. Three-quarters of participants (74%, n=37) reported lifetime use of cannabis. Over two-thirds of participants had used crack cocaine (70%, n=35) and heroin (66%, n=34) at least once.

High lifetime prevalence was also reported of other stimulant drugs (cocaine, ecstasy and amphetamine) with at least half of participants indicating that they had used these drugs at least once. The high levels of lifetime use of drugs typically prescribed to drug users, such as methadone, benzodiazepines, antidepressants and barbiturates, should be interpreted carefully as many participants were referring to use of these drugs as prescribed medication rather than illicit use.

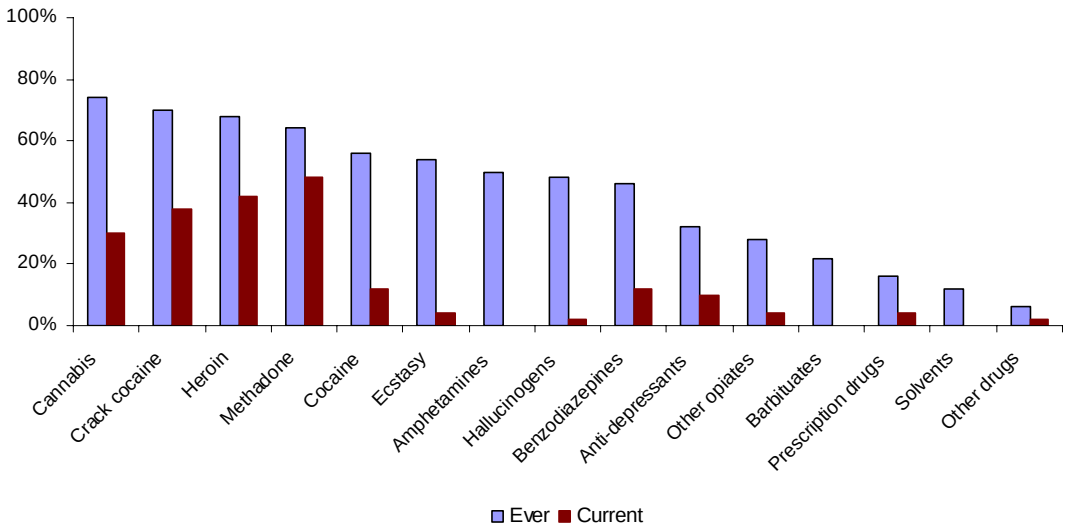

Figure 18: Lifetime and current prevalence of drug use

Table 1: Lifetime prevalence, current use and daily drug use.

	Lifetime use %	Current use[12] %	Daily use %
Cannabis	74	30	12
Crack cocaine	70	38	30
Heroin	68	42	34
Methadone (prescribed)	64	48	46
Cocaine	56	12	4
Ecstasy	54	4	0
Amphetamines	50	0	0
Hallucinogens	48	2	0
Benzodiazepines	46	12	4
Anti-depressants	32	10	10
Other opiates	28	4	4
Barbiturates	22	0	0
Prescription drugs	16	4	4
Solvents	12	0	0
Other drugs	6	2	2

Table 1 and Figure 18 illustrates that methadone (prescribed), heroin and crack cocaine were the most commonly used drugs in the previous month and the substances most commonly used on a daily basis.

The percentage of participants who indicated that they were currently using methadone was marginally higher than those who indicated that they were currently prescribed methadone (see section 3.1.6). Twenty-one individuals indicated that they were currently receiving a methadone prescription and 24 reported that they had used methadone in the previous month. Considering that all methadone participants indicated that they were using prescribed methadone the discrepancy in these figures may be explained by, (1) some individuals did not report their methadone prescription or (2) some individuals had been prescribed methadone during the previous month but were not receiving a methadone prescription at the time of interview.

Further analysis of participants who were not receiving a current methadone prescription indicated that (58%, n=29) of these:

- 20.7% (n=6) had never used drugs;
- 17.2% (n=5) met the definition for PDU;
- 13.8% (n=4) currently using heroin;
- 13.8% (n=4) currently using crack cocaine; and
- 10.3% (n=3) had received prescribed methadone during the previous month.

Further analysis of those receiving methadone prescription (42%, n=21) indicated that in the previous month the majority had used heroin (81.0%, n=17) and crack cocaine (71.4%, n=15).

The Home Office describes problem drug use (PDU) as the 'use of opiates and/or the use of crack cocaine' (Hay et al., 2006). Based on analysis of current drug use 44% of participants (n=22) met the Home Office definition of problem drug use. The

[12] Current use is based on use in the previous month.

vast majority of those who met the definition of PDU were simultaneously using heroin and crack cocaine.

Analysis of the weekly spends of current heroin and crack cocaine users of the drugs showed similar average weekly spend. The reported weekly spend by current heroin users ranged from £25 to £1000, with average weekly spend of £209.43. The reported weekly spend by crack cocaine users ranged from £20 to £700, with an average weekly spend of £208.58. The similar patterns in weekly spend may be due to the high levels of simultaneous use of heroin and crack cocaine. Many users of both drugs indicated that they tended to spend equal amounts of money on each drug.

Lifetime prevalence of injecting showed that 50% of participants (n=25) had injected at some point in their life. Figure 19 illustrates that almost half of participants who had ever injected had done so in the previous week (44%, n=11). Approximately a quarter of participants had not injected for at least a year (24%, n=6).

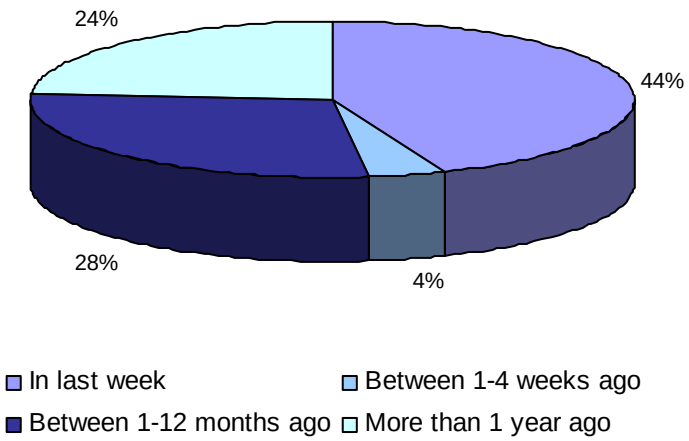

Figure 19: The last time participants injected

Figure 20 illustrates the percentage of participants who had shared injecting equipment or paraphernalia with someone else. One-fifth of participants who had ever injected (20%, n=5) indicated that they had shared a needle or syringe and two-thirds (64%, n=16) had shared a spoon, water or filter with someone else. All of those who had shared a needle or syringe had also shared other injecting paraphernalia. All but one of the clients who had injected reported that they had used a syringe exchange (96%, n=24).

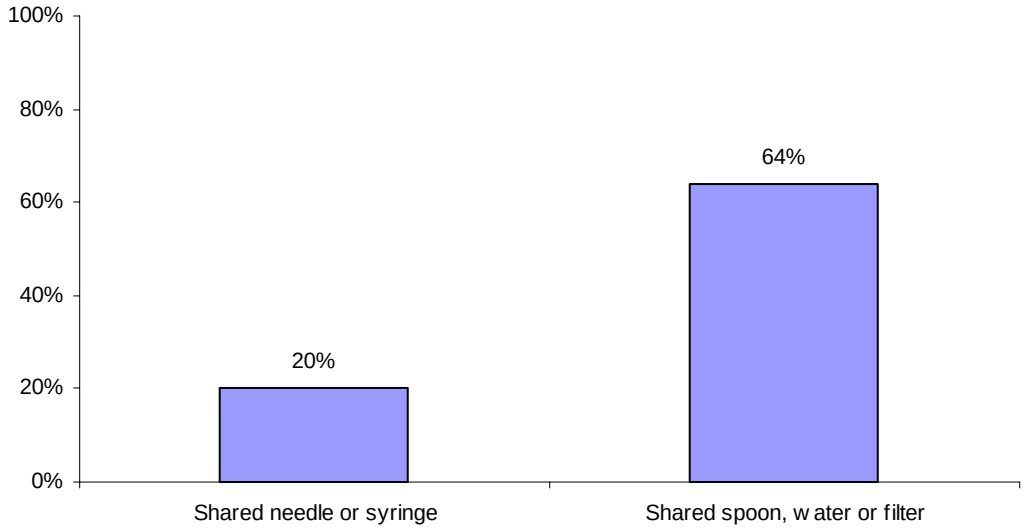

Figure 20: The percentage of participants who had shared injecting equipment and other paraphernalia

3.1.11 Treatment Profile

Figure 21 illustrates the types of treatment services that participants have ever used and the services that they had used in the previous month i.e. current use. More than half of participants indicated that they had used specialist prescribing services (56%, n=28) and 40% (n=20) had used this service in the previous month. Inpatient detoxification and residential rehabilitation had been used by 12% (n=6) and 6% (n=3) of the participants respectively.

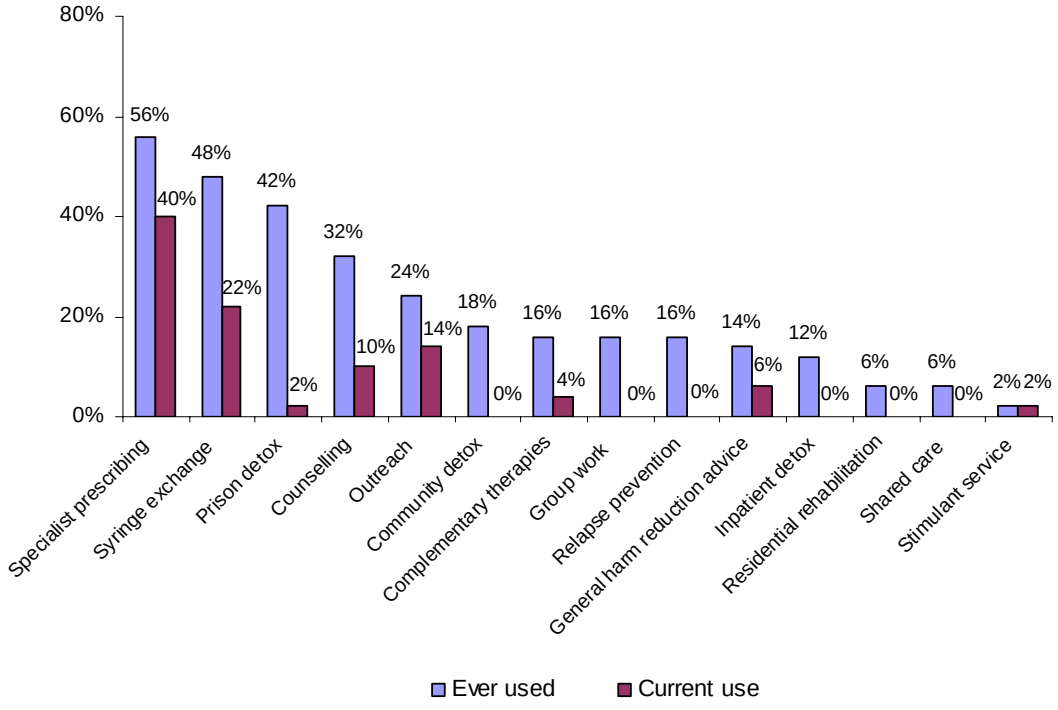

Figure 21: Treatment services accessed by participants

Participants who indicated that they had used a service but no longer used it were asked to expand on why they no longer used the service. The majority of reasons for no longer using a service were due to circumstance and included:

- No longer using drugs;
- No longer injecting (this reason was specific to syringe exchange);
- Received the service whilst in prison;
- Received the service whilst on probation;
- Moved away from area where service was attended;
- Lack of interest from staff at the service;
- Long waiting lists; and
- No funding for detoxification.

When asked about what they considered were the main barriers to substance use treatment for homeless people a variety of responses were recorded. Analysis of the responses indicated a number of common themes, a sample of comments made by clients are show in italics below along with the themes.

- Lack of understanding/fear about treatment

  "Homeless people need an awareness of how it will be to get off drugs"
  "Don't know where to go for treatment"

- Treated like second class citizens

  "Because homeless people look rough and they are judged"
  "Because we're on the streets we get looked down on. Don't get a chance."

- Their environment/escapism from the environment

  "Because people are doing the 'scene', they are on the streets so they continue to do drugs. It is a type of escapism."
  "Homeless people go back to using drugs to escape their problems"

- Circumstance – lack of housing/job etc.

  "Don't know where you are going to be. The priority is staying safe on the streets….can't make plans"
  "Need an address to get into treatment"

- Difficulties in accessing services

  "Services are there but the waiting times are too long. People get disinterested whilst waiting."
  "There isn't help straight away. You have to go through lots of different agencies."

The responses to the barriers to treatment question indicate that a lot of misinformation about treatment still exists among homeless people and they feel that their circumstance excludes them from treatment.

The participants were asked an open question regarding ways to enhance retention of homeless people in drug treatment services. Similarly to the questions on barriers responses indicated common themes and also corresponded to the barriers question.

Examples of participant's responses are shown under themes below.

- Experienced/Credible drug workers

  "Being treated by people with first hand experience of substance use"
  "Train people who have been homeless as treatment workers, it would help to have someone to relate to who has been through it"

- Support throughout treatment

  "Getting the right support from them (services). Knowing what is on office from services"
  "Continued support throughout treatment"

- Respect

  "Being treated the same as the next person"
  "Not treated like scum"

- Accommodation

  "Getting a place"
  "Need accommodation and detoxification places ready for people who want to get off drugs"

- Enhance self-esteem/confidence

  "Courses, hobbies, confidence building, work opportunities, something to build on and give me hope"
  "Teach trades in prison, people are more likely to help themselves when they have down time away from drugs"

- Financial support

  "Help with travel costs"
  "Offer them money for treatment"

- Easy access to services

  "Make it easier for people to access and regular appointments"
  "Get to see the doctor more often"

3.1.12 Support and Services

Participants were asked if they required help with a variety of problems. Half of the participants (50%, n=25) indicated that they required help improving their self confidence (Figure 22). Forty-four percent of participants (n=22) indicated that they required help with alcohol and drugs problems and nutritional advice.

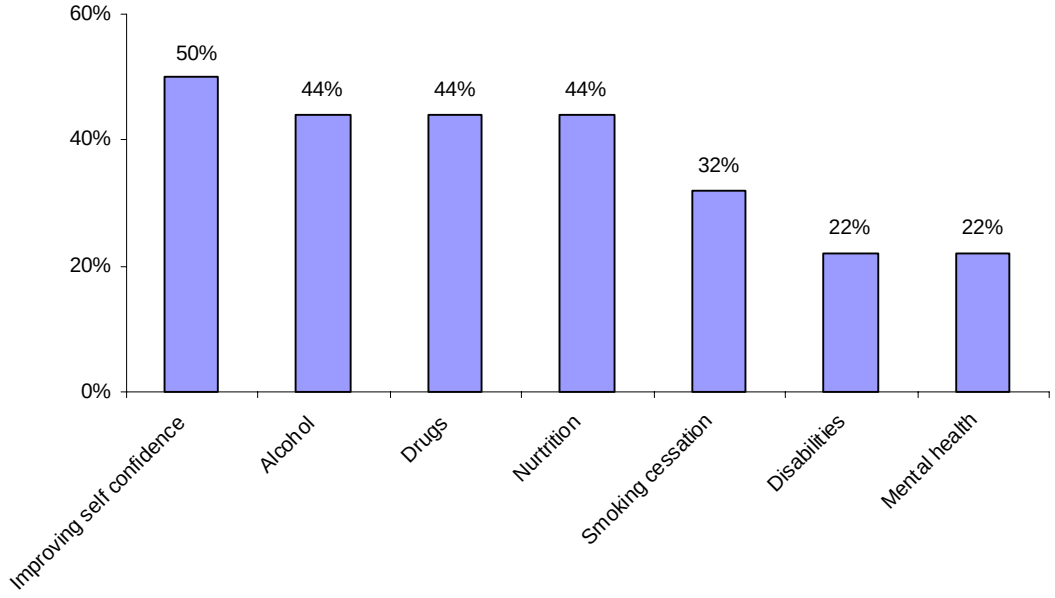

Figure 22: Problems that participants required help with

When asked about specific services that they needed help to access, the majority of participants indicated that they needed help to access the dentist (60%, n=30) (Figure 23). Forty percent indicated that they required assistance accessing alcohol agencies (n=20).

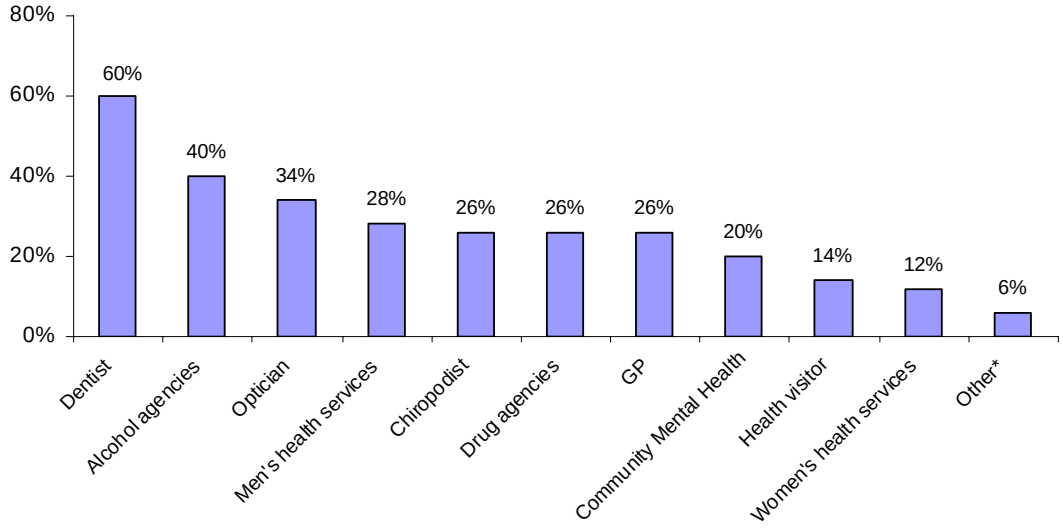

Figure 23: Services that participants required help to access

*Other responses included accommodation and counselling.

3.1.13 Participants Opinions

The vast majority of participants indicated that their health had changed since becoming homeless (88%, n=44). When asked how it had changed only one participant reported that their health had improved since becoming homeless (2%). Reasons for poorer health since becoming homeless included increases in drug/alcohol use, respiratory problems, weight loss and unhealthy eating habits.

When asked how their substance use and homelessness had contributed to each other, similar patterns were observed in response's to each question. Two-thirds of participants (66%, n=33) indicated that their substance use contributed to their homelessness and 64% (n=32) indicated that their homelessness had contributed to their substance use. Over half of participants (54%, n=27) responded affirmatively to both questions indicating that their homelessness and substance use were inextricably linked.

Participant's explanations of how substance use and homelessness were linked indicated that many participants had been asked to leave their accommodation as a result of drug use and had increased their drug and/or alcohol use since. Other participants indicated that they were evicted from rented accommodation as they could not afford the upkeep on their residence because they spent their money on drugs/alcohol. Reasons for an increase in drug/alcohol use since becoming homeless included boredom, depression, escapism and peer influence.

Participants were asked an open question asking what, in their opinion, were the main priorities of homeless people with substance use problems. Forty-seven participants gave a response. The responses were categorised and are shown in themes below (Figure 24). The vast majority of participants indicated that accommodation was a main priority (66%, n=33) and almost half (44%, n=22) reported treatment/health as a priority.

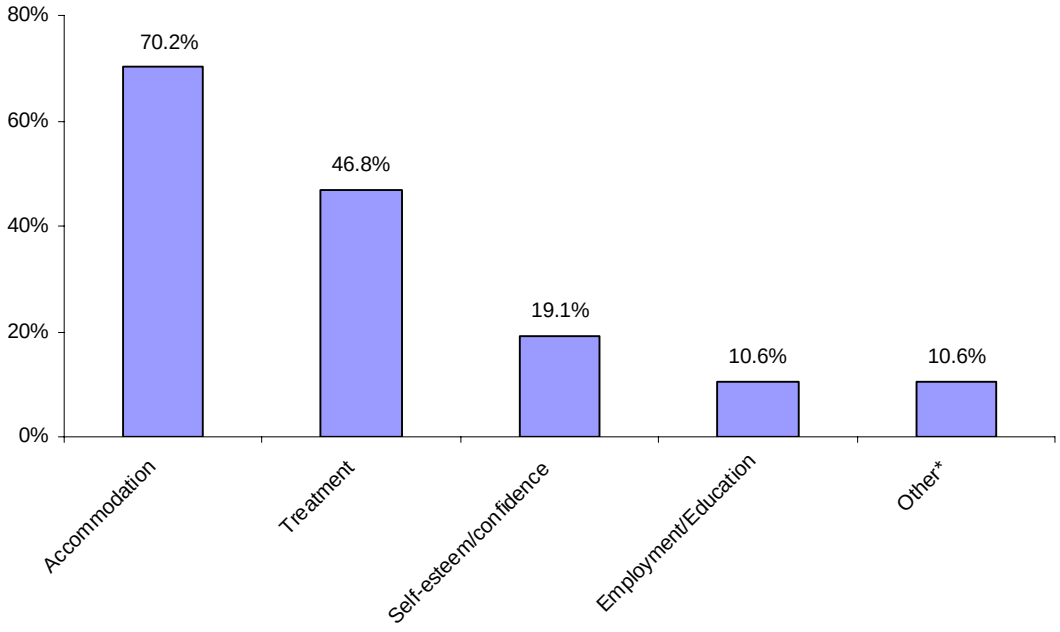

Figure 24: The main priorities of homeless people with substance use problems

*'Other' responses included someone who has been through homelessness and substance use problems to talk to, support and help with benefits.

At the end of the interview participants were given the opportunity to make additional comments about treatment services or health services in Liverpool. Thirty-three participants gave additional information. Due to the detailed nature of some comments they have not been cited fully to protect the confidentiality of the participants. The comments were recorded as positive, negative or ideas for improvement and the breakdown are shown in Figure 25 below.

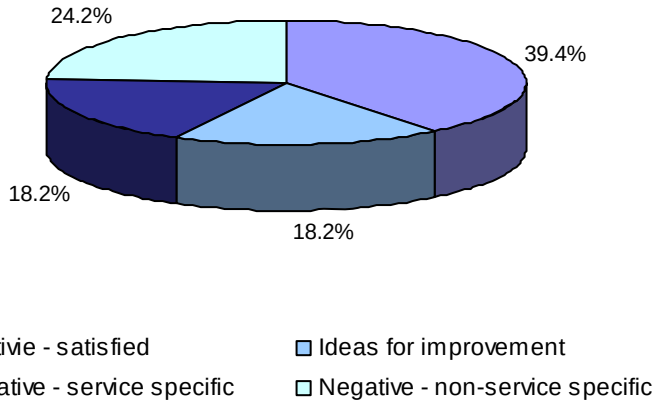

Figure 25: The nature of additional comments made by participants

The majority of the positive comments related to the support received from the homeless organisations in Liverpool, such as the Basement, Whitechapel, Sisters of Charity and other charity organisations. Negative comments related to how services distributed their funding, attitude of staff at treatment services, lack of accommodation in Liverpool and a general lack of 24/7 support for the homeless. Ideas for improvement included more and better hostel accommodation and more women-only services.

3.2 Analysis of Stakeholder Interviews

Interviews were held with a representative of the host sites and other key organisations. The interviews were guided by a semi-structured interview guide (Appendix 2).

Interviews were conducted with representatives from:

- The Whitechapel Centre
- The Basement Night Drop-In Centre
- Armistead Street
- Brownlow Group Practice Homeless Team
- The Big Issue in the North
- Lighthouse Project
- Merseycare
- Royal Liverpool and Broadgreen University Hospitals (RLBUH) (A&E)
- Liverpool PCT
- Liverpool DAAT

All stakeholders except Liverpool PCT and Liverpool DAAT were considered 'front-line' organisations whose main function is to provide services for homeless people or would have contact with homeless people on a regular basis.

Typically the front-line organisations provide a range of support and interventions, including:

- Drug and alcohol treatment;
- Housing support;
- Outreach services;
- Advocacy;
- Harm reduction advice;
- Clean injecting equipment and/or safer sex paraphernalia;
- An address for benefits agencies etc. to contact clients;
- Referral to other agencies (drug and alcohol treatment, mental health, medical services etc); and
- A host site for other agencies to conduct interventions and/or provide services i.e. dental services, Homeless Outreach Team (HOT), alternative therapies, counselling etc.

Stakeholders reported that the needs of homeless drug and alcohol users are often complex and multidimensional. The front-line organisations reported that they

approached each individual's issues in a 'person-centred' and holistic way, and worked in partnership with other agencies to address all needs of each individual.

Liverpool PCT and Liverpool DAAT work on a strategic level, commissioning services and developing policy related to homelessness in Liverpool.

The responses to the semi-structured interview questions were analysed thematically and are presented in themes below.

Appropriately trained staff in post at all agencies

Credibility with their client group was considered an important factor to encourage engagement among the organisations. Most front-line organisations provided their staff with training specifically relating to drug and alcohol and/or homeless issues. As most of the services worked directly with either homeless or individuals with substance use problems they received training to ensure appropriate holistic responses to individual needs. Many of the organisations indicated that previous experience with either homelessness or drug/alcohol issues was a pre-requisite for gaining employment with the service. Staff at the drug and alcohol treatment agencies held a range of qualifications including CBT, counselling and social work.

In order to ensure staff received appropriate and up-to-date training to respond to a variety of issues additional training was supplied in-house or often through the training organisation HIT. Members of staff from front-line organisations were also undertaking structured qualifications including the MSc in Drug Use & Addiction at Liverpool John Moores University and Drugs and Alcohol National Occupational Standards (DANOS) qualifications.

Furthermore, organisations had a range of training for service users to enable them to become qualified or accredited and many ex-service users were currently employed by the organisations. Examples include The Basement Volunteer Programme and Armistead Street's Fixers Programme.

Education of other relevant agencies regarding the specific needs of homeless drug and alcohol users

In addition to ensuring that staff within their own organisations were appropriately trained, many stakeholders reported that they provided training services to other relevant local agencies. Education of other local agencies was viewed as important to breaking down barriers to engagement of this client group and ensuring that they received fair and considered treatment when in contact with other relevant organisations.

Training topics with local relevant agencies have included homelessness, drug and alcohol awareness and issues, infection control and street sex work. Specifically training sessions have been provided to[13]:

- Medics & volunteers (*The Basement*)

[13] The name of the organisations that provided the training is shown in italics in brackets after the training topic.

- Contraception and Reproductive Health Services, Abacus clinics (*Armistead Street*)
- A&E staff at Royal Liverpool and Broadgreen University Hospitals (*Armistead Street*)
- Brownlow Group Practice Staff (*Armistead Street*)
- Merseyside Police (*Big Issue in the North*)
- Liverpool City Council (*The Whitechapel Centre*)
- Local hostels *(Brownlow Group Practice)*
- Supporting People *(Brownlow Group Practice)*

Partnership working and quality communication amongst local agencies

An appropriate holistic approach and joined up working amongst relevant organisations and agencies was identified as a method to enhance client stabilisation and treatment journeys ensuring the best possible outcome. The front-line services recognised that working together is particularly important as many clients engage with many services simultaneously.

Many stakeholders indicated that they believed that better communication across local organisations was required to provide the best possible service for homeless drug and alcohol users. Data protection policies and protocols were recognised as important, however, there was concern that sometimes information that should be shared is held back to the detriment of the client/service user. In addition, it was indicated that when a client moves from one service to another it would be helpful if the referral agency was updated with the client's progress and/or outcomes.

The range of training delivered by local organisations in Liverpool to partnership agencies indicated an encouraging picture of good relations amongst local services and proactive attempts to breakdown stereotypes and barriers to engagement of homeless drug and alcohol users.

Stakeholders were asked to identify working partnerships and many mentioned other organisations who were interviewed as part of this research indicating that there are good levels of partnership working across the most relevant local services.

In addition, other services/organisations were identified as part of local working partnerships. These included:

- Merseyside Police
- Benefits Office
- Job Centre Plus
- HOT mental health team
- Salvation Army
- Local hostels
- NSPCC
- SHARP
- Independence Initiative
- Huyton Alternatives
- Irish Community Care

- The Faith Network
- Registered Social Landlords
- City Council
- IMPACT (University of Liverpool)

Although partnership working is improving in Liverpool, there was also concern among stakeholders that information regarding new services or interventions is not always appropriately disseminated. A D(A)AT co-ordinated newsletter was suggested as a method to improve information dissemination of new services or initiatives.

Issues relating to partnerships between criminal justice services (CARAT/DIP and prisons) and local stakeholders were reported. Many stakeholders indicated that improvements in these partnerships were required as many clients will be in contact with criminal justice organisations and they can be utilised to promote treatment engagement. Specifically, improvements in communication from prison services when a homeless prisoner is due to be released were required to ensure that the homeless support services can prepare appropriately for the individuals return to the community.

It was recognised that whilst there have been improvements in partnership working between local agencies and the RLBUH, it was reported that the level of joined up working was inconsistent. Stakeholders praised RLBUH for their flexibility on occasions, however, it was reported that on occasions unsafe discharge of homeless clients from RLBUH had taken place leading to a potentially risky situation for the individual. These issues were also acknowledged by RLBUH and are currently under review via the draft policy regarding admission and discharge of homeless individuals which seeks to prevent unsafe hospital discharges.

Appropriate referral routes

Referral between organisations was common. The services indicated that they refer into all levels of drug and alcohol treatment services. The RAHOS low-threshold prescribing service run by Liverpool DDU at Armistead Street and The Whitechapel Centre was praised by many services as it offers open, easy access to specialist prescribing services. The 'fast track' service to detoxification through Mersey Care was also noted by interviewees as beneficial for homeless individuals who had made the decision to stop using drugs and wanted to access detoxification as soon as possible. Some of the organisations indicated that before the 'fast track' was developed, when necessary, they could refer straight to drug detoxification services which was extremely helpful to and beneficial for their clients, however, this was not normal practice. It was acknowledged that the 'fast track' should enable more direct access to detoxification on a more regular basis. For some of the larger organisations, referral within their own agencies was proposed as an approach to enhance the client's treatment journey through the provision of a seamless service.

The homeless support stakeholders regularly referred their clients to other organisations for specialist support services i.e. drug/alcohol treatment or support to exit street sex work. These stakeholders, where possible, maintained contact and

provided ongoing support for their clients whilst they were in contact with other services i.e. drug/alcohol treatment and to maintain their tenancies when they move into more permanent accommodation.

It was reported that referral into DIP services could also be made if necessary, and was praised by the stakeholders as helpful to clients, however, stakeholders indicated that they were cautious of referring into a criminal justice based agency when no crime had been committed.

Other services and organisations identified as useful for referring homeless drug and alcohol users to included the Homeless Outreach Team (HOT) for individuals with mental health issues, social workers, the Sisters of Charity and the Mens/Womens Direct Access.

Holistic support

A holistic response to the needs of homeless drug and alcohol users was considered important by stakeholders. It was recognised that drug and alcohol problems contributed to homelessness and vice versa, therefore it is ineffective to only act upon one aspect of an individual's problems.

Referral from homeless specific services into drug/alcohol treatment is not necessarily made on a clients first contact with the organisation. The homeless specific services indicated that before referring a client to treatment services, they will first ensure that the client is ready to engage with mainstream treatment services to prevent against unsuccessful treatment and a loss of confidence from the client.

Improved alcohol services

A significant gap in service provision in Liverpool is in relation to alcohol services. In addition to homeless primary alcohol users, it was reported by stakeholders that there is an increasing trend of alcohol abuse amongst ex-drug users. For clients with specific alcohol problems, most stakeholders referred to Community Integrated Care or the Windsor Clinic. There was a general consensus among the stakeholders that alcohol problems were more difficult to respond to than drug problems and there was a general lack of services in the Liverpool area. In addition clients association with other known problem drinkers in the Windsor Clinic was identified as a risk factor to treatment engagement at this service. One service indicated that where possible they try to find appropriate alcohol detoxification places outside of the area to minimise peer pressure as a risk factor.

Stakeholders indicated that the additional alcohol–specific services required in Liverpool include a day service which offers support, harm reduction initiatives and life skills training. 'Wet' accommodation and 'wet' support services were suggested as a method to encourage homeless alcohol users to get off the streets and encourage them to engage in treatment.

Planned Care

Stakeholders indicated that even with the most chaotic homeless drug and alcohol users it was important to ensure that care and support services are planned. All front line services indicated that they utilised care or action plans to plan and monitor clients progress through their stabilisation and or treatment journey against short and long-term goals. Generally, the plans were based on an initial in-depth discussion with the client regarding their needs and reviewed formally and informally regularly. Many organisations indicated that they use SMART principles to set goals with their clients.

Appropriate accommodation services

Accommodating and flexible hostel accommodation was identified as a priority for homeless drug and alcohol users. In particular, the rigid exclusion criteria employed by many hostels was cited as a barrier to engagement with this group. Stakeholders reported that many clients were banned from hostels for having drugs or injecting equipment in their possession although they presented no behavioural problems. Stakeholders acknowledged that possession of drugs and/or injecting equipment was against the rules of most hostels, however, this should be considered reason for a warning from a hostel, but not immediate exclusion if the client has caused no other problems. The stakeholders indicated that exclusion from hostels exacerbated the health, social care and substance use issues of many homeless clients and contributed to worsening long-term problems.

Furthermore, it was reported by stakeholders that when a client has a previous history of exclusion with a hostel this can act as a barrier for them to access accommodation and limit their options. Sometimes an individual's reputation will preclude them from accommodation at certain hostels and further restricts their already limited options. In addition, stakeholders indicated that the number of homeless people in the Liverpool area had increased due to policing of squats and ASBOs.

Although the majority of homeless drug and alcohol users are men, there is a lack of small-scale women-only hostels. Stakeholders suggested that accommodation of this type would be particularly useful for housing vulnerable women, such as street-sex workers and young women. In addition, the lack of accommodation for couples was cited as an issue as stakeholders were aware of couples who remain on the streets or in squats because they cannot find accommodation together.

Stakeholders identified a lack of emergency or crisis accommodation in Liverpool. Stakeholders reported that there was a need for easily accessible accommodation for homeless drug and alcohol users in crisis or an emergency situation. It was suggested that a Service-Level Agreement (SLA) with Liverpool City Council or Registered Social Landlord(s) (RSLs) potentially could provide this service. Furthermore, there is a requirement for short-term accommodation made available for individuals exiting drug and alcohol detoxification units or residential rehabilitation. The lack of structured service level agreements with some or all of the RSLs and Liverpool City Council has caused difficulties with working in partnership

for the stakeholders, as the Council and RSLs are under no obligation to provide accommodation which further exacerbates homelessness.

Where a client comes from, prior to their homelessness, was identified as a barrier to gaining accommodation and treatment engagement. Services provided by Liverpool City Council such as the Direct Access hostels are only funded for Liverpool resident clients and will not accept people who have no ties to Liverpool. This is particularly problematic as many homeless people in the Merseyside area migrate towards Liverpool as a result of the lack of temporary accommodation services in boroughs surrounding Liverpool such as Sefton and Knowsley. Stakeholders indicated that in situations such as this, funding should be given priority to a person's essential need for shelter.

In addition, stakeholders acknowledged that some clients are reluctant to stay at hostels that they know will have high levels of drug and alcohol use within them as they do not want to expose themselves to that environment whilst trying to get clean or upon exit from detoxification.

Fair, equal treatment

Respect and pride was not only identified as a significant issue during the client interviews, but it was also identified as an important aspect of the clients treatment and stabilisation journey during the stakeholder interviews.

Stakeholders freely acknowledged that they need to be aware that their reputation and service uptake is dependent upon a clients experience, which they share with other drug and alcohol users. It is important that all clients receive an appropriate, positive and supported service from each organisation. Stakeholders reported that there has been much change in the last few years to try and change the image of some of the services generally perceived more negatively by homeless drug and alcohol users. Stakeholders suggested that in order to ensure everyone was aware of the changes it would be useful to share positive and negative experiences among homeless drug and alcohol users and allow services to respond to experiences.

A&E at the Royal Liverpool and Broadgreen University Hospitals (RLBUH) was indicated as the place where individuals with an urgent medical problem would be referred to. It was noted by a number of stakeholders that many homeless drug and alcohol users were reluctant to attend A&E at the RLBUH due to previous poor experiences and their general bad reputation among homeless individuals. However, many of the services noted the marked effort that the A&E department at RLBUH has made in the last year to change its working practices and how it is perceived by homeless individuals. Staff from A&E at RLBUH had undergone training sessions in drug awareness, street sex working and homelessness to ensure that all staff can respond appropriately to the patients needs. Furthermore, staff on the reception desks at A&E had been trained to identify hostel addresses so that they could flag a person's housing situation with clinicians, without causing undue discomfort to the homeless individual attending A&E.

Stakeholders acknowledged that partnerships between A&E and The Whitechapel Centre and The Basement have improved the reputation of services among

homeless individuals, however, there is still more work to be done to improve the situation. Furthermore, a homeless patient liaison officer has been appointed at RLBUH to liaise with the different hospital departments and homeless services to ensure that each patient receives a holistic service whilst at hospital and ensure that appropriate organisations are aware of and can prepare for homeless individual's hospital discharge. In addition, the draft policy for admission and discharge of homeless patients is currently in its final drafting stages.

Further investment in outreach services

Continued and enhanced outreach services were identified among stakeholders as a significant need for homeless drug and alcohol users. The general lack of weekend services was noted as an issue that required addressing. Outreach services that are currently in place in Liverpool were praised by the stakeholders. However, it was indicated by stakeholders that the current outreach services were at capacity yet there was a requirement for extended outreach services.

Easily accessible and frequent treatment services

Immediate and easy access to drug and alcohol treatment services is a main priority for this group. Many stakeholders noted that when a homeless drug or alcohol user decides to make a change and attend treatment they want the process to start as soon as possible. Quick and easy access to a range of services was required. It was reported that clients become frustrated and disillusioned when they are made to wait a long time to engage with services. Services such as the Rapid Access Homeless Outreach Service (RAHOS) and Merseycare 'fast track' should facilitate this requirement. The need for quick and easy access to a methadone prescription should not be discounted and therefore open access services need to be provided with long-term funding to ensure the future of these services.

The lack of 24 hour, 7 days a week support for homeless drug and alcohol users was reported as a barrier to engagement with appropriate services. There was a need for night shelters and additional weekend support for this group.

Health services

The stakeholders acknowledged that there are homeless specific health clinics at Brownlow Group Practice, however, there was a general consensus that this service needs to be expanded and run on at least a weekly basis (it is currently fortnightly due to restricted resources). Some stakeholders indicated that their clients were not keen on attending general health services, such as walk-in centres and A&E, and consequently often delay seeking medical attention when required.

Stakeholders indicated that there is a requirement for additional mental health services in Liverpool. It was recognised by the stakeholders that many homeless drug and alcohol users have dual diagnosis issues, however, at times it can be problematic obtaining the required diagnosis. There is a need for mental health and drug/alcohol treatment services to further work in partnership for dual diagnosis individuals to ensure they are not passed unnecessarily between agencies.

A shortfall in dental services is a current public health issue affecting not only the homeless but also the general population. All stakeholders indicated that for dental health they refer clients to The Gateway, however, it was noted that this service gets very busy, very early and there are difficulties with getting homeless clients to the service early enough to be seen. Furthermore, the service at The Gateway only provides dental services for individuals with drug problems therefore there is no provision locally for homeless alcohol users. It was suggested that this service requires expansion to cope with current demand and should include alcohol users also.

Interaction with prisons

Different levels of contact and communication with prison services were cited by stakeholders. The homeless specific services indicated that they were not consistently informed of the prison release of homeless individuals. There were occasions when homeless individuals presented at homeless services upon release, causing difficulties relating to accommodation, methadone prescriptions and benefits. Stakeholders acknowledged that the RAHOS has helped in providing a methadone prescription to help stabilise individuals recently released from prison, however, without this service it would be much more difficult. Treatment services were more likely to be informed of a prisoners release on a regular basis and were able to put into place support services for the individual.

Young People

Young people exiting care are particularly vulnerable to homelessness. Drug and alcohol use can cause or contribute to the homelessness of young people or can be caused by homelessness. It was suggested that in order to address this issue there is a requirement for a slower transition for Looked After Children (LAC) from leaving care to independent accommodation to minimise the risk of homelessness. It was reported by stakeholders that there is a shortfall in young person specific homeless services and young people face additional accommodation problems as many are too young to access some of the hostel accommodation. There is floating support provision for 16-19 year olds at The Whitechapel Centre which aims to establish the housing need of the young person and where possible try to return them to their original housing situation. However, if this is not possible the floating support team will source appropriate accommodation.

In order to ensure that all young people who are homeless or at risk of homelessness can easily and quickly access appropriate accommodation there is a requirement for short-term emergency accommodation as typically the hostel environments are unsuitable.

Offenders

Stakeholders agreed that accommodation was key to retaining offending drug and alcohol users in treatment. Stakeholders reported that problems occur with offenders as all Merseyside bail hostels are located in Liverpool which encourages prison leavers to migrate towards the city and causes additional resource and funding issues.

Migrants

Stakeholders indicated that there is an increasing trend among migrants presenting to homeless services and substance use treatment agencies. Specifically, these agencies have an increasing clientele of Eastern European background. Stakeholders reported that, typically, these individuals have additional needs as they may not have a local support network of friends and family and are often embarrassed regarding the stigma attached to homelessness and substance use.

4. Conclusions

The in-depth analysis of the client and stakeholder interviews indicates that the needs of homeless drug and alcohol users are extensive and complex. The conclusions of the needs assessment and specific needs are detailed below.

Barriers to treatment

Despite concerted efforts by many local Liverpool homeless, health and substance use treatment services many barriers to substance use treatment engagement still exist among homeless drug and alcohol users. Specifically, discrimination against this group continues to be an issue. Client interviews detailed examples of discrimination by local organisations, however, some clients acknowledged that the attitude of many services is changing and improving and reported examples of positive engagement with local organisations.

Misinformation continues to exist among homeless drug and alcohol users in relation to waiting times, treatment entry requirements (i.e. address, identification) and expected experience. Much of this misinformation is passed via peers and other homeless drug and alcohol users. The high levels of training among the stakeholders and other relevant organisations further demonstrated the concerted effort locally to ensure that organisations have appropriately trained staff prepared to respond to the needs of homeless drug and alcohol users and ensure they have positive experiences when in contact with local organisations. It is encouraging that many of the problems cited by clients regarding access to health, social care and substance use treatment services were among the issues currently being addressed by local organisations.

The lack of accommodation was a significant barrier to engagement with treatment services. Responses to the client interviews indicated that the homeless drug and alcohol users personal environment was an important issue, particularly when sleeping rough. The use of drugs and alcohol to block out their situation, forget problems and keep warm was cited as a contributory factor to maintaining homeless status.

Client responses to initiatives that would enhance retention in treatment followed directly from the reported barriers to treatment engagement. The findings indicate that it is important for local organisations to ensure that initiatives to encourage homeless drug and alcohol users to engage and remain in treatment, also tackle the barriers to engagement as a priority.

Need 1: To change the reputation and perception of local services among homeless drug and alcohol users. This could be achieved through the re-education of homeless drug and alcohol users and the sharing of positive and negative experiences in an open forum that would allow local services to respond to feedback.

Hostels

Access to hostels was cited as problematic by clients and stakeholders for a number of reasons. Clients suggested that the current hostel accommodation should be improved and that there is a need for more hostels suited for specific purposes (i.e. women, those exiting rehabilitation/detoxification etc). The inability to book hostel beds in advance was reported as an issue for homeless drug and alcohol users leaving hospital, prison and detoxification units.

The hostel environments were reported as unsuitable for couples, those wishing to abstain from use of drugs or alcohol and in some cases women. It was indicated that, particularly, for those wishing to make changes to their drug and/or alcohol use hostels were unsuitable due to the widespread use of substances amongst other residents. In a small number of cases, it was reported that initiation into injection happened in hostels.

During the interviews it emerged that the lack of hostel accommodation for couples led to homeless couples remaining sleeping rough as they did not wish to be housed separately. Furthermore, some clients indicated that they did not like the dormitory style sleeping arrangements of hostels as they felt unsafe and did not trust other residents with their possessions. Hostel accommodation was noted as unsuitable for vulnerable women, particularly those exiting street sex work, as in hostels they were at risk of harassment and mistreatment.

Many of the local services praised the work of the hostels and acknowledged that they work with a chaotic client group, however, a common issue concerned clients exclusion from hostels. The exclusion criteria of many hostels were considered very rigid and in some cases the reputation of certain individuals precluded them from accessing hostel accommodation. It is clearly understood that when an individual exhibits behaviour that is risky, threatening or violent towards hostel staff or other residents they should be excluded, however, each exclusion case should be made on a case by case basis and policies should be appropriately flexible.

Need 2: Further research into the influence of hostel accommodation and hostel residents on substance use, with a specific focus on initiation into drug use.

Need 3: More specific-purpose hostel or temporary accommodation spaces (i.e. women-only, couples and those exiting residential rehabilitation/detoxification).

Need 4: Flexible approaches to exclusion policies for hostel residents.

Royal Liverpool and Broadgreen University Hospitals

The Royal Liverpool and Broadgreen University Hospitals (RLBUH) has a particularly bad reputation amongst homeless drug and alcohol users. It was recognised by a small number of the clients that there has been progress within the hospital departments, and particularly with A&E, in relation to their reputation and promoting a positive experience for homeless individuals. The RLBUH has drafted an Admission and Discharge Policy that is currently under review with the Liverpool

Homeless Strategy Working Group and many of the A&E staff have received training in drug and alcohol awareness and street sex worker issues. The recent initiatives to change the reputation of the RLBUH have made an impact, however, there is a need to re-educate service users and for more recent positive experiences to be shared among this group.

Furthermore, a Homeless Hospital Liaison Post has recently been filled at RLBUH. The aim of this post is to provide a liaison link for homeless individuals between A&E, other hospital departments and local organisations to ensure that each individual receives the best possible care and not only their health needs are addressed.

Need 5: Promotion of the changes at RLBUH among homeless drug and alcohol users.

Information dissemination among front line services

It was noted that information sharing amongst organisations was not always as easy or timely as necessary. Organisations respected data sharing protocols and client confidentiality, however, it was indicated that improvements in information sharing could benefit homeless drug and alcohol users, improve access to services and reduce duplication of effort. Furthermore, the many homeless working groups and consortiums in Liverpool were praised as useful methods for information sharing. However, to ensure timely information dissemination it was suggested that a monthly email newsletter to inform services of new interventions and/or significant changes to other local services would be useful and enhance service uptake and access.

Need 6: Improved communication between local organisations.

Registered Social Landlords

It was recognised that Registered Social Landlords (RSL) have an important part to play in improving access to appropriate quality accommodation for homeless drug and alcohol users. However, RSLs were also viewed as the most difficult housing providers to access by homeless drug and alcohol users and that they do not have the required focus on responding to the specific issues and needs of this group. It was reported that homeless drug and alcohol users felt discriminated against by many RSLs and were automatically labelled as 'risky tenants' due to their current housing situation.

Need 7: Further examination of the homeless polices and practices of RSLs in Liverpool.

Need 8: Appropriately trained housing officers among RSL staff, who are equipped with the required skills and understanding to address the needs of homeless drug and alcohol users.

Young People

A number of the clients interviewed were aged under 25. Most of the young people interviewed indicated that they had never been employed and had left home due to relationship/family problems. The focus of this project was on adult homeless drug and alcohol users and therefore no one aged under 18 was included in the client interviews. During observations at the homeless services the research team noted that young people under the age of 18 were among those utilising homeless support services. Given the vulnerable nature of young people who leave home prematurely or suddenly and the risk of homelessness among young people leaving care it is important that this issue is given further consideration.

Need 9: A needs assessment specifically focussed on young people (aged under 25) who are homeless.

Funding/Resources

Concern was raised among clients and stakeholders regarding funding cuts and the shortfall in appropriate resources for homeless drug and alcohol users. Specifically, stakeholders were concerned about the sustainability of services and staff due to uncertainty of funding and resources.

Need 10: Improved communication from commissioners to local services in relation to long-term plans and to ensure stability in service development.

Street sex workers

Street-sex workers are over-represented amongst homeless women. Armistead Street is the only specific support service for this group in Liverpool and although they provide outreach there is a need for additional support services and funding. Male-dominated hostel accommodation is inappropriate for those wishing to exit from street-sex work and there is a requirement for additional small-scale women-only hostels to support women through the transition.

Need 11: Additional support and appropriate accommodation for homeless street-sex workers.

Efficient response

An issue that was noted during both client and stakeholder interviews was the need for a quick response to a client's decision to make a change to their drug and/or alcohol use. Specifically, clients indicated that long-waiting lists and unnecessary 'red tape' is a hindrance to treatment engagement. Initiatives such as the RAHOS and Merseycare 'Fast Track' have made a significant difference to engagement of this group, however there is a need for continuing promotion of these services to ensure continued uptake.

Need 12: Timely and rapid responses to clients need for drug and/or alcohol treatment.

Lack appropriate discharge and crisis beds

In addition to a quick response to a clients decision to engage in treatment there is a simultaneous need for appropriate accommodation provision to be provided in a timely manner. Continuing to stay in insecure accommodation or sleep rough is a risk factor for treatment retention and positive treatment outcomes identified by both clients and stakeholders. Provision of emergency short-term accommodation or crisis beds could make a significant difference to homeless drug and alcohol users. Children and vulnerable adults should be given priority for emergency or crisis accommodation. It was suggested that emergency and crisis accommodation could be provided through RSLs and Liverpool City Council.

Need 13: Provision of emergency discharge and crisis beds for homeless drug and alcohol users (through an SLA with Liverpool City Council and/or RSLs).

Health

The evidence from the client and stakeholder interviews indicated that homeless drug and alcohol users tend to neglect their health needs. Worryingly, when asked what they would do in an emergency 13% of clients indicated that they would do nothing. There is a requirement for homeless drug and alcohol users to be appropriately referred to services and encouraged to access A&E, NHS walk-in centres and GP services as required.

Need 14: Promotion of local health services and encouragement of homeless drug and alcohol users to recognise and attend to their health needs.

Peer Education

Peer education has been shown as an effective method to encourage drug and alcohol users to engage with treatment services (Shaw, Salmon & McVeigh, 2007). The needs assessment findings indicate that utilisation of a model of peer education and training with homeless drug and alcohol users would be welcomed by service users and professionals alike. Responses from the client interviews indicated that information gained through peers is very important and is very influential in the decisions of homeless drug and alcohol users to access particular services or organisations. A significant issue was identified in relation to the high proportion of participants who indicated that they would fail to seek attention in a medical emergency situation. Furthermore, a high percentage of participants indicated that they had at least one untreated illness. These findings suggest a need for homeless drug and alcohol users to be educated in emergency responses, basic first aid and health promotion.

Need 15: Development of a peer education training programme for homeless drug and alcohol users to encourage health promotion, the dissemination of factual information and challenge misinformation in relation to risky substance using behaviour. The programme should also be developed to encourage engagement with treatment and other support organisations.

Women

There were a small number of women interviewed as part of the client research, however, they presented with specific needs and stakeholders acknowledged that they have different issues to homeless men. Research indicates that women are more likely to try to conceal their homeless status and participate in paid and unpaid sexual relationships in return for accommodation. Issues specific to women interviewed related to suitable accommodation with partners, reluctance to stay in male-dominated hostels and street sex work.

Need 16: Further investigation of the specific needs of female homeless drug and alcohol users (and a focus on those in unstable accommodation).

Migrants

Four percent of the homeless individuals interviewed were Eastern European migrants who had recently moved to the UK in search of employment. Typically these individuals had been employed more recently than the UK nationals and exhibited lower levels of drug use. Stakeholders reported increased levels of engagement among migrants and the differing problems that these individuals face.

Need 17: Continued monitoring of the demographics, behaviours and health and social care needs of homeless individuals is required. Particular consideration should be given to the trends of migrant homeless drug and alcohol users and the issues specific to this group in relation to barriers to treatment engagement. Continued monitoring should ensure a rapid response to changing trends.

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Appendix 1: Working Examples

During interviews with clients at homeless services and stakeholders in Liverpool a number of instances of working examples from the local Liverpool area and elsewhere were identified. Further information on these services is provided in this section.

Local Liverpool services

The Whitechapel Centre

For additional information on the main functions of The Whitechapel Centre see section 1.3.

The Whitechapel Centre has a YP Floating Support Team which aims to address the issues specific to homeless young people (aged 16-19) and assist in reinstating them in their previous accommodation situation, if appropriate, or settle them in other appropriate accommodation. The team is funded by Supporting People.

http://www.whitechapelcentre.co.uk/index.html

The Basement Night Drop-In Centre

For additional information on the main functions of The Basement Night Drop-In Centre see section 1.3.

http://www.basementdropin.org.uk/

Sisters of Charity

The Sisters of Charity operate a drop-in and night shelter for homeless people in Liverpool city centre. They also provide food and outreach services.

Rapid Access Homeless Outreach Service (Liverpool, DDU)

The Rapid Access Homeless Outreach Service (RAHOS) is a low threshold service commissioned to engage 'hard to reach' substance users in treatment, principally aimed at homeless drug users. It is located in two host sites, The Whitechapel Centre and Armistead Street. It provides easy access substitute prescribing, harm reduction advice and acts as a transitional service for referral into the mainstream Liverpool DDU.

The Big Issue in the North

The Big Issue in the North is an organisations that provides a source of employment for homeless people. Along with the opportunity to earn a legitimate income The Big Issue in the North also provides support in relation to accommodation, substance use, education and health for each vendor.

http://www.bigissueinthenorth.com/

Brownlow Group Practice Homeless Team

Brownlow Group Practice operates a specific homeless team made up of a clinical lead and two homeless outreach nurses. The aim of the Homeless Team is to provide an enhanced service for homeless individuals and liaise with other relevant local agencies. The Homeless Team runs a health clinic specifically for homeless individuals fortnightly.

http://www.brownlowgrouppractice.org/

Mersey Care 'Fast track'

Mersey Care offer a wide range of addiction treatment services. They are currently promoting a new 'fast track' to treatment or detoxification service for drug users via a 'Get clean' social marketing campaign. The campaign aims to provide individuals with a phone number which will allow them to speak to a staff member. The staff member in turn will signpost them to the most appropriate service to meet their needs. As part of the process Mersey Care NHS Trust also put additional resources into the Gateway project with the aim of speeding up or 'fast tracking' the movement into detoxification and treatment.

http://www.merseycare.nhs.uk/services/clinical/drug_and_a/default.asp

Armistead Street

For additional information on the main functions of Armistead Street see section 1.3.

Lighthouse Project - Peer to Peer Programme

The Peer to Peer Programme (P2P) was developed by Lighthouse Project to deliver a programme of training to drug users in order to challenge misinformation and increase awareness and knowledge of safe practice. P2P aims to educate and involve service users in the complete process, ensuring they have the skills and confidence to pass on the information to their peers in an opportunistic setting and therefore taking service user involvement to its pinnacle.

http://www.lighthouseproject.co.uk/

Other services that provide for homeless individuals

Crisis – 'SmartMove' (Nationwide)

SmartMove is a nationwide network of local organisations delivering a model deposit scheme for non-statutory homeless and vulnerably housed. The service is hosted by Crisis and directly provided by local organisations embedded in the community.

SmartMove offers private landlords a guarantee in replace of a monetary deposit on behalf of non-statutory homeless and vulnerably housed people. It also provides tenants with the necessary support and advice to ensure they sustain their tenancies.

http://www.crisis.org.uk/page.builder/about_smartmove.html

Shelter – 'Off The Streets'

A review report, rather than a specific initiative, which details the need for supported accommodation for female street sex workers. The report recommends how specialist services can integrate with mainstream service providers to ensure the complex needs of homeless female street sex workers are met. It also recommends a 'welfare-based approach' to deal with all of the individuals issues including housing and drug addiction should be employed to help the women exit street sex work.

http://england.shelter.org.uk/policy/policy-825.cfm/plitem/226

Streetreach (Doncaster)

This service provides a variety of initiatives including outreach, drop-in, drug treatment and education and employment training for those involved in, at risk of, or wishing to exit prostitution. Specific accommodation services for under 16s and under 25s are offered, and also support for adults to maintain tenancies.

http://www.streetreach.org.uk/

Safe Project (Birmingham)

A service which provides support to sex workers in Birmingham, specifically the service provides outreach, harm reduction, housing advice and support, drop-in and sexual health clinics. The outreach service is in partnership with housing officers to ensure individuals can access emergency accommodation immediately. Safe Project has a service level agreement with the city council housing services for 5 places for women per month.

http://spintemp.boxuk.net/server.php?navId=002001007002

The Well (Bristol)

The Well is a supported accommodation service in a small-scale (5 bedroom) house in Bristol that provides services specifically to female street sex workers with drug issues who wish to exit street sex work. Constant support and supervision is provided along with drug treatment, structured day programmes, referral to relapse prevention services and support to fund stable accommodation.

http://www.caringinbristol.org/organisations/260/

The Booth Centre 'Wet' Garden (Manchester)

The Booth Centre is a drop-in and activity centre for homeless people. The 'Wet' Garden was developed to safeguard and extend the Booth Centre's work with street drinkers through providing a garden where people can drink in a supervised and supportive environment. Support and advice are offered in the 'Wet' Garden from trained staff and street drinkers are encouraged to tackle their problems. The service is also used as a host site for other organisations and services such as mental and general health.

http://www.boothcentre.org.uk/

Crisis 'Skylight' (London and Newcastle)

The Skylight programme assists homeless people to enhance and build on their skills. At the skylight centres homeless people can take part in workshops to develop and enhance their skills, including workshops in bicycle repair to performing arts. It also provides an environment to meet new people and learn from others.

http://www.crisis.org.uk/page.builder/CrisisSkylight.html

Appendix 2: Client Needs Assessment Questionnaire

Needs Assessment at The Basement Project & The Whitechapel Centre Clients

Discussion Guide

INTRODUCE YOURSELF AND ASK IF THE PERSON HAS ALREADY BEEN INTERVIEWED AS PART OF THE SURVEY. IF NOT, PROCEED WITH THIS INTRODUCTION…..

Liverpool Drug and Alcohol Action Team would like to have a better understanding of the health and social care needs of substance users engaging with The Whitechapel Centre and The Basement.

This survey is being conducted in order to understand your health and social care needs. I would like to ask you questions on a range of health topics relating to your recent experiences and questions relating to your past and current drug and alcohol use.

It should take about 30 minutes. I would like to stress that your replies will be treated in the strictest confidence and will not be used for any purpose other than that stated above.

Your name will not be recorded anywhere on this form and any views you give will be completely anonymous, however, your initials and DOB are recorded to help us identify duplicate responses.

Section A: About You

This section asks questions about you.

A1. Initials

A2. Date of Birth

dd	mm	yyyy

Age (if DOB is not known)

A3. Gender

Male	Female

A4. Looking at this card, which of the following best describes your Ethnicity? *(show list)*

A5. Where did you spend the majority of your life up to the age of 16? *(postcode if possible or area of city or town)*

A6. Are you currently employed?

Yes	No

If yes, what kind of work do you do?

If No, when were you last employed (years/months) and what kind of work did you do?

Section B: Your Accommodation Status

Now I am going to ask you some questions about your homelessness

B1. What was the initial cause of your accommodation problems?

B2. Have you **ever** slept rough?

Yes	No *(Go to QB5)*

B3. When did you last sleep rough?

	Nights/ weeks / months / years ago *(delete as appropriate)*

B4. On the last occasion that you slept rough, why was it?

B5. Looking at this card, in which types of accommodation have you lived in the past 6 months? *(Tick all that apply)*

1	Council Tenancy	☐
2	Hostel	☐
3	Housing Association property (e.g. LHT, Riverside)	☐
		☐

4	Bed and Breakfast	
5	Staying with friend/relative	☐
6	Sleeping Rough/Skippering	☐
7	Didn't bed down	☐
8	Prison cell/Police Cell	☐
9	Hospital	☐
10	Other accommodation (Please specify below)	☐

B6. Looking at this card, where did you stay last night? *(show list – enter one code in box below)*

	If 'Other' please specify where.

B7. How long have you been living in the above situation?

	Nights/ weeks / months / years *(delete as appropriate)*

B8. Have you ever been in prison?

Yes	No *(Go to Section C)*

B9. How many times have you been in prison….

	No. of times
On remand?	
Sentenced?	

Section C: General Practitioner (GP) & Dentist

Now I am going to ask you some questions about seeing a doctor

C1. When was the last time you saw a GP?
(Prompt as necessary - Tick one box only)

Within the past month	☐
2-6 months ago	☐
7-12 months ago	☐
More than a year ago	☐
Not sure	☐

C2. Are you currently registered with a GP?

Yes*(Go to C3)*	No *(Go to C5)*	Not sure *(Go to C5)*

C3. Are you satisfied with the service provided by your GP?

Yes *(Go to C5)*	No *(Go to C4)*	Don't know *(Go to C4)*

C4. What would make this service better for you?
(Tick all that apply) (Prompt only if participant struggles to respond)

Other (please specify below)	☐
Surgeries held at more convenient times	☐
Surgeries in a more convenient location	☐
No need to make an appointment	☐
Better attitudes from staff	☐
Not sure	☐

C5. Since becoming homeless, have you tried to register with a GP?

Yes (please go to C6)	No (please go to C7)

C6. Did you experience any problems?

Yes (please go to C6)	No (please go to C7)

If yes, what were the problems you experienced?

C7. What would you do if you needed to see a doctor but were unable to get the services of a GP? (*Do not prompt *Tick one box only)*

Call an ambulance	☐
Go to a casualty department	☐
Do nothing	☐
Not sure	☐
Other (please specify below)	☐

Now I am going to ask some questions about seeing a dentist.

C8. When was the last time you saw a dentist? *(Prompt as necessary *Tick one box only)*

Less than 12 months ago	☐
Between 12 and 15 months ago	☐
Between 16 and 24 months ago	☐
More than 2 years ago	☐
Have never been	☐
Not sure	☐

C9. Are you currently registered with a dentist?

Yes	No	Not sure

C10. If you went to the dentist tomorrow, do you think you would need any treatment?

Yes	No	Not sure

Section D: Health Profile

Now I am going to ask you some questions about your health

D1. How is your health in general?

1	2	3	4	5
Very bad	Bad	Fair	Good	Very good

D2. Do you have any of the following illnesses? *(Read each out in turn) (Show list)*

		Tick if yes	Receiving treatment? (Y/N)	Where treatment received?
1	Asthma	☐		
2	Diabetes	☐		
3	Bronchitis (recurrent chest infections)	☐		
4	Epilepsy (fits)	☐		
5	Tuberculosis (TB)	☐		
6	Hepatitis (Hep B, Hep C)	☐		
7	Weight issues	☐		
8	Eating disorder	☐		
9	Painful periods	☐		
10	No periods	☐		
11	Foot problems	☐		
12	Headaches	☐		
13	Bladder/kidney infections	☐		
14	Skin problems	☐		
15	Eye problems	☐		
16	Problems with teeth/gums	☐		
17	Joint, muscular or skeletal problems	☐		
		☐		

18	Mental Health problems (please specify below)			
19	Other illnesses (please specify below)	☐		

D3. Are you ever stressed?

Always	Often	Sometimes	Rarely	Never

D4. Are you ever depressed?

Always	Often	Sometimes	Rarely	Never

D5. Have you ever deliberately harmed or injured yourself?

Yes	No (Go to D8)

D6. When did this last happen?

Nights/ weeks / months / years ago *(delete as appropriate)*

D7. Have you ever talked to a health professional about this?

Yes	No

D8. Do you take any of the following **prescribed** medicines? (Read out each in turn)

1	Blood pressure tablets	☐
2	Painkillers	☐
3	Sleeping tablets	☐
4	Tranquillisers	☐
5	Prescribed methadone	☐
6	Anti-depressant tablets	☐
7	Inhalers for chest problems	☐
8	Other prescribed medicines (please specify below)	☐

Comments about prescribed medication

D9. In the past year, have you…. *(Read out each in turn)*

		Tick if yes	How many times?
1	Been to a casualty or A&E Department	☐	
2	Been to a general out patient clinic	☐	
3	Stayed one or more nights in a general hospital	☐	
4	Been to an outpatient clinic for psychological problems	☐	
5	Stayed one or more nights in a psychiatric hospital	☐	
6	Been in contact with a Community Mental Health Team	☐	
7	Been in contact with any drug agencies	☐	
8	Been in contact with any alcohol agencies	☐	
9	Been in contact with services for sexually transmitted infections	☐	

If participant answered yes above, would they like to give any more detail?

D10. Have you had any problems with these services?

Yes	No (Go to Section E)

D11. If Yes, what were the problems?

Section E: Food and Nutrition

Now some questions about your diet.

E1. How would you describe your diet?

Mostly healthy	☐
Sometimes healthy	☐
Not healthy	☐
Not sure	☐

E2. How often do you eat the following? *(Tick one box for each food category)*

		Never	Once a week	2-6 times a week	Daily	More than once a day
1	Fruit (fresh, frozen or tinned)	☐	☐	☐	☐	☐
2	Vegetables (fresh, frozen or tinned)	☐	☐	☐	☐	☐
3	Bread, pasta, rice, potatoes (not chips)	☐	☐	☐	☐	☐
4	Meat, chicken, fish	☐	☐	☐	☐	☐
5	Fried food (including chips)	☐	☐	☐	☐	☐
6	Convenience food (e.g. microwaveable)	☐	☐	☐	☐	☐

Section F: Smoking

I am now going to ask you some questions about cigarette smoking

F1. Which of the following best describes you at present? *(Tick one box only)*

I have never smoked tobacco	☐	(Go to Section G)
I have tried smoking once or twice	☐	(Go to Section G)
I have given up smoking	☐	(Go to Section G)
I smoke some days	☐	(Go to F2)
I smoke every day	☐	(Go to F2)

F2. How much do you smoke per day

	None	Less than 10	10-19	20-29	30-39	40+
Cigarettes	☐	☐	☐	☐	☐	☐
Hand-rolled cigarettes	☐	☐	☐	☐	☐	☐

Section G: Alcohol

I am now going to ask you some questions about alcohol

G1. Do you drink alcohol? *(Circle one response only)*

Yes	No (Go to Section H)

G2. Have you drank alcohol in the past 7 days?

Yes	No (Go to G4)

G3. In the past 7 days, on which days did you drink alcohol and how much did you have?

Circle each day that the participant has drunk alcohol on & insert how much of each alcoholic drink participant has consumed in the appropriate box. Circle specific drinks in the categories on the left.

Alcohol drunk….	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Lager/beer/bitter/cider etc… Usual brand? …….							
Alcopops							
Spirits. Vodka/Gin/Whiskey/ Rum Single/double/bottle 10cl 1L							
Wine Small glass/large glass/bottle							
Fortified wine Sherry/Port/Martini/ Buckfast							
Other drinks (please specify) …… ……							

G4. Considering your alcohol use in the past 7 days, would you say this is…… *(tick one box only)*

		Why is this?
More than usual	☐	
The same as usual	☐	
Less than usual	☐	

G5. Have you ever been advised to cut down on your drinking?

Yes	No

If yes, by whom?

G6. Have people ever annoyed you by criticising your drinking?

Yes	No

G7. Have you ever felt bad or guilty about your drinking?

Yes	No

G8. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Yes	No

Section H: Substance Use

Now some questions about your drug use.

H1. Drug Use

Drug	**Ever used?** (Y/N)	**Current use?** (Y/N)	**Frequency of use** (Daily, 2-4 times a week, 5-6 times a week, weekly, fortnightly, monthly)	**Usual route of administration** (smoke, inject, oral, sniff, other)	**Weekly spend** (£)
Heroin *(H, skag, brown)*					
Methadone *(juice, green)*					
Other opiates *(morphine, codeine, buprenorphine)*					
Benzodiazepines (*Diazepam, Temazepam)*					
Amphetamines *(speed, whiz, base)*					
Cocaine *(charlie, Coke, C)*					
Crack *(rocks, gravel, wash)*					
Hallucinogens *(acid, LSD, mushies)*					
Ecstasy *(E, pills, tablets, eckies)*					
Cannabis *(dope, blow, draw, hash)*					
Solvents *(gas, petrol, lighter fluid)*					
Barbiturates *(barbies, blue devils, sleepers)*					
Major tranquillisers *(antipsychotic drugs)*					
Anti-depressants *(Prozac)*					
Prescription drugs					
Other drugs (*sedatives, naltrexone, steroids)*					

H2. Have you ever injected any substance? *(If participant has already said yes to injected above there is no need to ask this question)*

Yes	No *(Go to Section I)*

H3. When did you last inject?

	Days/ weeks / months / years ago *(delete as appropriate)*

H4. Have you ever injected with a needle or syringe used by someone else?

Yes	No

H5. Have you ever injected using a spoon, water or filter used by someone else?

Yes	No

H6. Have you ever used a syringe exchange?

Yes	No

Section I: Treatment Profile

Service	Ever used/received? (Y/N)	Currently using/receiving? (Y/N)
Specialist prescribing		
Syringe exchange		
Stimulant service		
Complementary therapies		
Counselling		
Relapse prevention		
Outreach		
Shared care		
Community detox		
Inpatient detox		
Residential rehabilitation		
Group work		
General harm reduction advice		
Prison detox		

I2. If there are any services listed above that you used to use, please can you tell me why you no longer use them?

I3. In your opinion, what are the main barriers to substance use treatment for homeless people?

I4. In your opinion, what would help to retain homeless people in substance use treatment?

Section J: Support and Services

J1. Do you need help or support for any of the following? (Read out each in turn)

Mental health problems	☐
Alcohol problems	☐
Drug problems	☐
Disabilities	☐
Eating healthy foods	☐
Advice on stopping smoking	☐
Improving self confidence	☐

J2. Do you need any help to see any of the following? (Read out each in turn)

GP	☐
Dentist	☐
Optician	☐
Health Visitor	☐
Drug Agencies	☐
Chiropodist	☐
Women's health services	☐
Men's health services	☐
Community Mental Health Team	☐
Alcohol Agencies	☐
Other (please specify below)	☐

Section K: Your Opinion

K1. Do you think your health has changed since becoming homeless?

Yes	No

If yes, how has it changed?

K2. Do you think your substance use has contributed to your becoming homeless?

Yes	No

If yes, how has it contributed?

K3. Do you think your homelessness has contributed to your substance use?

Yes	No

If yes, how has it contributed?

K4. In your opinion, what are the main priorities of need of homeless people with substance use problems?

K5. Have you any other comments about homeless services, treatment services or health services in Liverpool?

Appendix 3: Stakeholder Discussion Guide

Needs Assessment Within The Whitechapel Centre and The Basement Projects

Discussion Guide for Stakeholders

Your Service

Can you provide a brief description of your service?
(Target audience, Interventions)

How does your service cater specifically for the needs of homeless drug and alcohol users?
(Any specific outreach services, Tiers)

Do you have staff who are directly involved with providing services to homeless drug and alcohol users?
(Job titles, What do they do)

What training have you/your staff received to respond specifically to the needs of homeless drug and alcohol users?
(Completion of DANOS units or formal qualifications)

Does you organisation provide training to other services?

How do the clients move through the service?
(Referral to and from services, Retention in the service, Criteria for referral)

Do you care plan clients?

What do you do if a client presents with a primary care need?
(i.e. abscess, cut/wound etc)

The Needs of Homeless Drug & Alcohol Users

In your opinion/the opinion of your service, what are the needs of homeless drug and alcohol users?
(Specifically health & social care needs)

Are there any examples of good practice from anywhere else that you are aware of?

Partnership working

What other services/organisations does your organisation work in partnership with? How does this partnership work (treatment? Housing services?)? Any difficulties/barriers?

Are there any key partnerships missing?
(i.e. Benefits office, GP, mental health, substance misuse services)

The NA results from client interviews have shown that the vast majority of clients have been in prison at some point. What type of relationship do you have with prison and probation services? How do you interact with DIP?

What barriers has you service faced when providing interventions/assistance to homeless drug and alcohol users?

Any contact with dental services? If not, why not?

How do referrals to detoxification for homeless drug and alcohol users work from your service? Any difficulties with referrals?