ACMD

Advisory Council on the Misuse of Drugs

Chair: Dr Owen Bowden-Jones
Recovery Committee Secretary: Robert Wolstenholme
ACMD Secretary: Zahi Sulaiman
4th Floor (NE), Peel Building
2 Marsham Street
London
SW1P 4DF
ACMD@homeoffice.gov.uk

Rt. Hon. Sajid Javid MP
Home Secretary
2 Marsham Street
London, SW1P 4DF

19 June 2019

Dear Home Secretary,

Re: ACMD Report - Drug-related harms in homeless populations and how they can be reduced

In July 2017 the then Home Secretary submitted a letter to the Advisory Council on the Misuse of Drugs (ACMD) to commission a programme of work following the publication of the Drug Strategy. In line with the Government's commitment to a targeted approach for those most at risk of drug misuse, this commission sought advice from the council on the factors that make people who experience homelessness susceptible to drug-related use harms and how can these harms could be reduced.

The ACMD's Recovery Committee set out to address this priority area and I am pleased to enclose their report. This report follows on from the 2018 ACMD report *'Vulnerabilities and substance use'* which explored high priority groups most at risk from substance use and the related harms[1].

This report finds that there is increased risk of problematic drug use associated with people who experience homelessness. There is a higher rate of drug-related deaths, infections among people who inject drugs, and multiple morbidities. People who experience homelessness and use substances have particularly complex circumstances and additional risks which require intensive long-term support. An integrated health, social care, and community care approach to the recovery and housing needs of people who are homeless would provide the optimal model of service

[1] https://www.gov.uk/government/publications/vulnerabilities-and-substance-use-acmd-report

delivery. This must include a focus on safe, stable housing and evidence-based harm reduction initiatives.

Conclusions

- Expert evidence concluded that drug using homeless populations suffer a lack of social connectedness and their personal safety is at greater risk. In addition, a high proportion of people who are homeless and who have drug use issues have experienced multiple adverse childhood experiences (ACEs). The implementation of Universal Credit, the pursuit of localism and the lack of affordable housing add to the risk of homelessness amongst drug users.
- People who are homeless, including those presenting as homeless to services and local authorities, those deemed statutory homeless, and numbers who are rough sleeping have increased substantially with some variation across the UK since 2010. Whilst the problems are proportionally greater in inner city and urban areas it is also clear that the issue has become increasingly prevalent in rural areas.
- The UK and devolved governments have statutory responsibilities regarding homelessness, although it is not entirely clear how this relates to drug users who are homeless. For all who present as homeless, a system of ‘priority need’ operates in England, Wales and Northern Ireland. However, Scotland has removed this differentiation via legislation in 2014 thereby expanding the definition to all who are in need not just those groups prioritised according to need or vulnerability.
- The needs of people who are homeless, particularly rough sleepers, are not well met by mainstream benefit, health and social care and some drug services. Current regional and local initiatives to address rough sleeping have increased in number and capacity across the UK, but most policy initiatives require initiation or completion of formal evaluative measures.
- Due to different methodologies employed across the UK, it is difficult to assess the extent of drug use among homeless populations. However, there is evidence that suggests a strong reciprocal association between being homeless and having an increased risk of problematic drug use.
- Drug use patterns and trends vary across the UK with different areas showing higher prevalence for some substances than others – for example, SCRA use in Manchester, Newcastle and Cardiff. Evidence also suggests that there is a high proportion of injecting heroin users who have been homeless in Glasgow, an area that has also witnessed a rise in HIV cases within this group.
- There is a higher rate of drug-related deaths among homeless populations compared with the general population. The number of drug-related deaths

among homeless populations has increased in recent years. Mental ill-health is strongly associated with homelessness as both a cause and a consequence.

- There has been a rise in serious bacterial infections amongst injecting drug users and there is evidence that homeless populations are over represented in these infected groups. In addition, levels of HIV and HCV in drug users who are homeless are high. In Scotland there are high levels of long-term conditions such as chronic obstructive pulmonary disease (COPD) among homeless drug users.
- There is strong evidence of high rates of multiple morbidities, i.e. severe mental illness and long-term physical health conditions among homeless people who use drugs and alcohol.
- There are many and varied subpopulations in the homeless sector who have drug use issues, including women, older people, young people, sex workers, offenders and ex-service personnel. The report focused on three of those groupings as they were highlighted during the evidence-gathering sessions across the UK. It is apparent that they have particularly complicated and multi-faceted circumstances, which require intensive support on a long-term basis.
- Women who are homeless experience multiple oppressions and discriminations and many of them report domestic violence prior to being homeless. A substantial proportion of females who are sleeping rough have reported sexual, physical and verbal assaults whilst on the streets.
- The risk of being homeless and having a drug use problem is much greater for offenders than for the general population.
- Ex-service personnel who are homeless have increased risk of problematic substance use although it appears that the greatest risks are related primarily to alcohol.
- An integrated health, social care and community care approach to the recovery and housing needs of people who are homeless would provide the optimal model of service delivery. This is particularly important for individuals with co-morbid disorders, including mental health and substance use and who are at the greatest risk of homelessness. In addition, safe, stable housing is essential for people who are homeless and who have problematic drug use and is associated with increased engagement with services.
- Harm reduction work within the homeless and drug use sectors in the UK utilises a holistic, pragmatic and supportive approach to encourage individuals to consider and reduce the harms related to their substance-using behaviour. Evidence-based Harm Reduction models in the UK include assertive outreach programmes, education, counselling, health promotion, peer support, user fora, needle exchange schemes, administration of Naloxone and opioid substitute prescribing. There is international evidence to support the effectiveness of ‘safe

injecting sites' to engage with and maintain contact with highly marginalised target populations and to prevent overdose deaths.

- Structurally, there must be an increase in the current support provided to the homeless population, including active drug users, with immediate and comprehensive assistance to reduce the risk of drug use and increase access to treatment.
- There is evidence to support the effectiveness of the 'Housing First' model in Europe and the US. The UK government is supporting the implementation of the model in several designated areas in England. An alternative model of abstinence-based housing has showed promising results which suggest that the abstinence-based approach has some success for some people where abstinence is the goal.
- Local statutory and non-statutory organisations must maintain an active awareness of the multiple stigma, oppressions and discriminations experienced by their service users. Professional values of respect and non-judge mentalism married with a warm empathic and compassionate approach were perceived as foundational to working with vulnerable people who are homeless and have drug use issues. Furthermore, service providers must endeavour to empower homeless people who experience harms related to drug use. One method of realistically achieving this goal this would be to involve service users in the design and implementation of services.

Recommendations

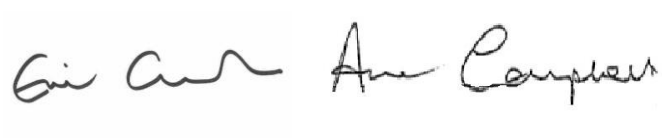
1. Housing policies, strategies and plans across the UK should specifically address the needs of people who use drugs and are experiencing homelessness by: recommending evidence-based housing provisions, such as Housing First; enabling collaboration across departments and agencies to ensure these interventions have a chance to succeed.
2. Services at a local level must be tailored to meet the specific needs of substance users who are currently experiencing, or have recently experienced, homelessness – including evidence-based and effective harm reduction and substance use treatment approaches with the capacity, resource and flexibility to reach them. Services need to consider people who are experiencing multiple and complex needs and adopt psychologically-informed approaches.
3. Substance use, mental health and homelessness services to use evidence-based approaches such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments such as opiate substitution treatment.
4. Service providers should be aware of the levels of stigma experienced by people who are homeless and are engaged in substance use treatment or who choose

not to engage due to the experiences of stigma and oppression they have had. Respect, choice, dignity and the uniqueness of the person should be at the core of the design and delivery of the service provision in respect of substance use and homelessness services.

5. The workforce in substance use and other services which have contact with the homeless need to have skills in dealing with complexity and in retaining homeless drug users in treatment.

We welcome the opportunity the discuss and present this report to the Drug Strategy Board.

Yours sincerely,



Dr Owen Bowden-Jones
Chair of ACMD

Dr Emily Finch and Dr Anne Campbell
Co-Chairs of ACMD Recovery Committee

ACMD

Advisory Council on the Misuse of Drugs

Drug-related harms in homeless populations and how they can be reduced

Table of contents

1. Introduction

This report has been produced by the Advisory Council on the Misuse of Drugs (ACMD) to provide advice to Government in response to the Home Secretary's commissioning letter to the ACMD in July 2017. The letter requested that the ACMD examine factors that make vulnerable people misuse drugs and how drug-related harms can be prevented among homeless people:[2]

"The Drug Strategy sets out the Government's commitment to a more targeted approach for those most at risk of misusing drugs, and to tackle the threats of a changing drug scene in the UK. In this context, I would like to understand more about the factors that make vulnerable people misuse drugs and what we can do to prevent misuse and protect these groups from the associated harms. This issue has been the subject of much interest and debate in recent months, focusing on the use of new psychoactive substances (NPS) among rough sleepers and homeless people. In light of this interest, I would particularly welcome your advice, during 2018, on the following questions:

- *What are the risks and factors which make people susceptible to substance misuse problems and harm?*
- *How can drug-related harms in homeless populations be reduced?"*

The response to the first question (ACMD, 2018) (see summary in Chapter 2 below) is the foundation for ACMD reports on population groups that may be susceptible to substance use-related disorders and associated health harms. This report looks at drug-related harms among homeless populations.

This report was written by the ACMD Recovery Committee, chaired by Annette Dale-Perera until January 2019 and co-chaired by Dr Emily Finch and Dr Anne Campbell thereafter.

The methodology used to gather evidence for this report included:

- A review of published literature and data, including evidence from a scoping review of peer reviewed research and government and policy documents from the four nations which provide statistics and policy contexts relative to homelessness, drug use, drug-related mortality and morbidities.
- Two public evidence gathering sessions in Manchester and Edinburgh which included presentations and discussion from researchers, academics, clinicians and people working with

[2] For the purposes of the report the term 'drug use' is used interchangeably with 'substance use' as the latter is often referred to in the published research evidence and within the evidence-gathering sessions.

homeless populations and identified as having expertise, research or evidence relating to homelessness and drug-related harms.

- A roundtable with policy makers, representatives from the Public Health Agency in Northern Ireland and statutory and voluntary sector organisations that work with people who experience problematic drug use and homelessness.
- A summary report by a Welsh homeless charity and third sector substance use organisation delivering services in Wales.

See Appendix A for more detail.

Strength and quality of evidence

Range of evidence sources

This report drew on evidence from peer reviewed literature, policy reports and reports from individuals with lived experience of homelessness and drug use and people with experience of working with homeless drug users. The evidence used was mainly from the UK but international evidence was used where it was considered sufficiently generalisable.

Quality of evidence (design, limitations, bias)

The evidence presented was largely descriptive using small samples. Some reports were of larger scale survey data. Some were examining larger national data sets (such as mortality data and hospital episode statistics).

Applicability to report questions

Much of the evidence answered questions about homeless drug users specifically.

Determination of causality (using for example the Bradford Hill criteria[3])

Very little evidence determined causality although it could be inferred from the evidence from those working with drug users as small populations were studied in great detail.

[3] The Bradford Hill criteria is a group of 9 principles, established in 1965 by the English epidemiologist Sir Austin Bradford Hill. The principles are used in establishing epidemiologic evidence of a causal relationship between a presumed cause and an observed effect. The 9 principles are: strength (effect size); consistency (reproducibility); specificity; temporality; biological gradient; plausibility; coherence; experiment; analogy.

Definition of homelessness

Definitions of homelessness vary across the UK for legal and policy reasons. In the process of gathering evidence for this report, the ACMD has looked at "homeless populations" which includes rough sleepers at its core but does not exclude other populations in the broader definition of homeless.

Homelessness can cover a range of circumstances and the most obvious examples are when people are sleeping rough in public places or staying in temporary accommodation. They may be described as experiencing:

a) rooflessness (without a shelter of any kind, sleeping rough);

b) houselessness (with a place to sleep but temporary, in institutions or a shelter);

c) living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends – 'sofa surfing');

d) living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).[4]

The statutory definition in the UK of a homeless person is:

"(1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he - (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court, (b) has an express or implied licence to occupy, or (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.

(2) A person is also homeless if he has accommodation but- (a) he cannot secure entry to it, or (b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.

(3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy." (Housing Act 1996)

The charity, Shelter, summarise this, stating "you may be homeless if you're sleeping rough, don't have rights to stay where you are, or you live in unsuitable housing." (england.shelter.org.uk)

[4] Source: European Typology of Homelessness and Housing Exclusion (ETHOS) developed in 2005 by the European Federation of Organisations Working with the Homeless (FEANTSA).

Rough sleeping is the most visible form of homelessness, tending to be more prevalent in urban areas and the government's recent Rough Sleeping Strategy (MHCLG, 2018) uses the same definition as the Office for National Statistics:

"People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or "bashes" which are makeshift shelters, often comprised of cardboard boxes). This definition does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers." (ONS, 2018)

In Scotland, a person should be treated as homeless, even if they have accommodation, if it would not be reasonable for them to continue to stay in it. (Housing (Scotland) Act 1987)

The following chapters will consider the background risk factors for homelessness and drug use, the extent of homelessness across the UK, the policy responses to homelessness, drug use among homeless populations, mortality, morbidity, additional complex needs for specific groups and consider solutions to the problem of homelessness and substance use.

2. Background

The ACMD report 'What are the risk factors that make people susceptible to substance use problems and harm?' provided a background to the ACMD's work programme on high priority groups most at risk from substance use and related harms (ACMD, 2018). The report focused on how risk and vulnerability are commonly understood in practice and presented a relevant framework that placed them within broader social determinants of health and wellbeing. It is useful to consider trajectories of drug use from a life course perspective and to its reciprocal relationship with homelessness. This helps to facilitate an understanding of how and why patterns of drug use might progress along a continuum from initiation to experimental use, moving to harmful and dependent use requiring treatment and towards cessation and possible relapse. This journey is also affected by key life factors (either risk or protective factors), including periods of unemployment, becoming a parent, relationship breakdown/reunion, periods of mental health crisis/recovery and loss/acquisition of housing.

A socioecological perspective on substance use was introduced, whereby individuals are considered to be integrated within a larger social system (including the social, built, institutional, and political environments). This approach encourages a view of substance use that emphasises the interactions between the choices, behaviours, and histories of individuals, with the complex system of external

characteristics that influence them. Considering substance use in this way focuses attention away from just the individual, and towards factors outside of their 'control' that they can often do little about.

The model presented in the 2018 ACMD report specified five important levels of action: intrapersonal factors; interpersonal processes; institutional factors; community factors; and public policy (ACMD, 2018).

To identify risk and factors that make homeless people susceptible to substance use problems and harm, this report refers to the categories personal/individual risks (interpersonal and intrapersonal), community factors, structures/institutions and public policy. Homelessness, in its many forms, increases people's susceptibility to substance use problems, and 'rough sleeping' is associated with magnification of substance-related risk and harm (including substance-related death).

Personal and individual risks (inter and intrapersonal factors)

The ACMD heard evidence of a lack of social connectedness, family and friends among homeless substance using populations. These groups also experience higher levels of displacement and transitions between leaving care, prison and temporary housing (ACMD, 2019a). There are changes in the level of safety among homeless populations and increase in abuse (Ralphs et al, 2018; Kalk *et al*, 2016). There is more sexual violence, violence, theft, especially after people are "spiced up", i.e. intoxicated with synthetic cannabinoid receptor agonists (SCRAs) (Greater Manchester Police contribution, 2018; Manchester Metropolitan University contribution, 2018).

The status of being homeless places enormous stress on individuals and some people use substances just 'to cope' with a difficult and unpleasant situation (Birmingham & Solihull Mental Health Foundation Trust contribution, 2018; University of Stirling contribution, 2018).

Adverse childhood experiences (ACEs)

The association between experiencing multiple adverse childhood experiences (ACEs) and adverse adult health and increased likelihood of substance use problems was described in the ACMD report on risk factors (ACMD, 2018). Childhood exposure to chronic stress caused by ACEs (and particularly multiple ACEs) may lead to chronic psychological damage. ACEs can include: childhood physical, emotional, psychological, verbal, or sexual violence; household substance use, criminality, mental illness and domestic violence; parental separation or divorce, neglect, family financial problems, discord or conflict, death of a parent or close family member or separation from the family and serious childhood illness or injury (Hughes *et al*, 2017).

Higher levels of ACEs are found among populations more vulnerable to substance use problems including homeless populations (Roos *et al*, 2013). As ACEs can be self-perpetuating and can lead to adversity in the children of adults who have suffered ACEs – this has implications for the children of people with substance use problems (Hughes *et al*, 2017; De Venter *et al*, 2013), are homeless, or both. A study conducted by Anda *et al* (2006) used the ACE Study (Felitti *et al*, 1998) as an epidemiological "case example" of the conjunction between epidemiologic and neurobiological evidence of the effects of childhood trauma. Results indicated a significant relationship between early adverse experience and 'substance use/abuse' (including illicit drugs) in later years. Substance use and abuse also increased as the number of ACEs increased. The risk of illicit drug use, and injected drug use were increased 4.5-, and 11.1-fold, respectively, for persons with more than 4 ACEs (Anda *et al*, 2006). Moreover, findings from a Californian study of older homeless men found that childhood adversities are associated with poor mental health outcomes including depression, suicidality and psychiatric admissions with a greater number of adverse events associated with worse outcomes (Lee *et al*, 2017).

Similarly, Larkin *et al* (2018) examined a range of ACEs among a sample of 224 people experiencing homelessness. Eighty-seven percent reported at least 1 of 10 ACEs prior to age 18, whilst over half (53.2%) reported 4 or more ACEs. ACEs were significantly correlated with one another. The association between ACEs and substance use amongst people experiencing homelessness and mental health issues cannot be overstated and it is clear that the risk and protective factors for these complex and interrelated issues must be addressed within a trauma informed response (National Health Care for the Homeless Council, 2019).

There is evidence that homeless populations also have significant histories of trauma associated with other mild-to-moderate mental illness. In homeless people in Nottingham, those surveyed reported that mental health issues were typically triggered by a specific event or ongoing trauma rather than developing independently of life experiences. This study also found that pre-existing but 'managed' mental health issues were further exacerbated, or brought to crisis, by life events including stress, trauma and homelessness (Reeve *et al*, 2018).

Community factors

The ACMD heard evidence of community factors that put homeless substance users at risk. The diversity of substance use and homeless population needs in different parts of the country is rapidly shifting. Some areas have a lack of opportunities for work and a lack of affordable public housing. Reductions in substance use and homelessness services mean there is less coverage and access (Birmingham & Solihull Mental Health Foundation Trust contribution, 2018; Faculty for Homeless and

Inclusion Health contribution, 2018). Availability of different drugs (heroin, cocaine, SCRAs) and cheap alcohol varies from area to area (Manchester Metropolitan University contribution, 2018; Scottish Drugs Forum contribution, 2018; Birmingham & Solihull Mental Health Foundation Trust contribution, 2018).

Homeless people who use SCRAs users are less likely than before (when heroin was pre-eminent) to support each other because of the chaotic lifestyle the drug causes early in its use. SCRAs have taken a very different toll on the substance misusing population to heroin (Manchester Metropolitan University contribution, 2018; Greater Manchester Police contribution, 2018).

Statutory/institutional factors (including health and social care)

A common theme during the evidence-gathering events and in research studies (for example the Scottish study, Supporting Harm Reduction through Peer Support (SHARPS)) is that the needs of people who are homeless, particularly rough sleepers, were not well met by mainstream benefit, health and social care and some substance use services.

Barriers included difficulties in accessing benefits, health and social care, and substance use treatment through not having an address or permanent address and 'official' documents.

The 'digital exclusion' caused by an inability to access or use internet and/or have a stable mobile phone was also named as a significant barrier to people getting help and resources and maintaining contact with services (including social security benefits systems like Universal Credit and healthcare services) (Dorney-Smith and Gill, 2017).

This difficulty in accessing healthcare led to increased utilisation of emergency healthcare and a potentially high cost implication to the NHS. The Health and Homelessness in Scotland project found a large increase in emergency healthcare utilisation after becoming homeless. (Scottish Government, 2018c)

Public policy

The ACMD heard evidence of the detrimental impact of some current public policies, which appeared to be increasing both the numbers of people experiencing homelessness and difficulty in accessing basic financial support, healthcare, and social care. The evidence was that drug users were particularly affected by these policies. Some aspects of public policy in the UK are contributing to an increase in homelessness and, once homeless, people are struggling to get access to financial support, health and social care and treatment for substance use (Faculty for Homeless and Inclusion Health contribution, 2018; Edinburgh Access Practice contribution, 2018).

Universal Credit

Changes to the UK welfare system were passed under the Welfare Reform Act 2012 and the Welfare Reform and Work Act 2016, including the phased introduction of Universal Credit (UC), a social security benefit that replaces and combines six means-tested benefits. A report from the National Audit Office (NAO) on the roll-out of UC stated that many people suffered hardship because of the way that UC works (NAO, 2018). Furthermore, the NAO stated that the system struggled to identify and track those deemed vulnerable and had significantly overestimated the percentage of people who verify their identity online. A significant minority (40%) of claimants were suffering financial hardship and an increase in rent arrears had been seen in local authorities, housing associations and landlords following introduction of the UC full service. The reduction in direct payments to landlords particularly reduces individual access to housing, The ACMD heard reports from multiple speakers about the negative impact of UC on populations vulnerable to homelessness (including debt and eviction) and those already homeless in the evidence-gathering.

"(UC) is just taking too long to process payments. Service users are struggling to navigate the new payment systems and professionals are struggling to guide them" (The Wallich, 2018b).

Localism and local authority budgetary constraints

A 2018 UN report referenced reductions to local authority budgets. "These cuts have had concrete effects on people in poverty as it has meant housing support services funded by local authorities for those in living poverty… have now either reduced their service, handed them over to voluntary groups, or have disappeared completely due to budgetary difficulties". This makes drug users in unstable housing more likely to become homeless (UN Human Rights, 2018).

The ACMD has previously reported on the extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery. The report concluded that "drug and alcohol treatment appears to be facing disproportionate decrease in resources, likely to reduce treatment penetration and the quality of treatment in England." (ACMD, 2017)

Lack of affordable housing and public housing policy in relation to substance use

There are several housing policies that are thought to have led to the current lack of affordable housing in some (but not all) areas of the UK. These include: the sale of public housing combined with a lack of creation of new public housing; the freeze on Local Authority housing allowance; the lowering of the Benefits cap and introduction of the shared accommodation rate to social and affordable

housing (LGA, 2017). The urgent and growing lack of affordable housing in many parts of the UK is also thought to be a driver of the increase in homelessness.

The ACMD also heard evidence of other aspects of housing policy that were negatively impacting are potentially driving increases in homeless and substance use problems among vulnerable groups. This included the loss of automatic housing priority for those leaving prisons in Wales (introduced in the Housing (Wales) Act 2014) despite subsequent efforts and targeted projects to ameliorate this. Substance use as an exclusion criterion for some homeless shelters and by public and private landlords was also thought to contribute to lack of access to temporary shelter and temporary and permanent housing. Participants at one evidence-gathering event stated there was still fear and reluctance among the housing sector to provide accommodation for active drug users following the 'Wintercomfort' trial almost 20 years ago, that convicted and sentenced two managers of a homeless charity for offences under the Misuse of Drugs Act 1971 'knowingly permitting' use of drugs (heroin) on their premises (The Wallich, 2018b).

Whilst not specifically focused on people who use drugs, a recent review by Homeless Link (2018) similarly reported the detrimental impact of welfare reform, budgetary constraints at a local level and lack of access to housing on the ability of local authorities to implement the Homelessness Reduction Act 2017.

Summary and key points

- Expert evidence concluded that drug-using homeless populations suffer a lack of social connectedness and their personal safety is at greater risk. This is particularly true for people who use SCRAs.
- High levels of ACEs are found in homeless substance users.
- The needs of people, who are homeless, particularly rough sleepers, are not well met by mainstream benefit, health and social care services.
- Universal credit, localism and the lack of affordable housing add to the risk of homelessness amongst drug users.

3. The extent of homelessness across the UK

Data included in this and subsequent sections attempts to represent homelessness (and drug use, mortality and morbidity among homeless populations) across the UK. Much of the data are not easily comparable from nation to nation, and are variable in quality because of different data collection methodologies and definitions.

England

The NAO estimated 77,240 households were in temporary accommodation at March 2017, while the latest official statistics (at time of press) reported 4,677 rough sleepers (based on counts and estimates) on a single night in autumn 2018 (MHCLG, 2018). Although a 2% drop on the previous year's figures, the latest numbers are 165% higher than in 2010. These figures do not include people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation, i.e. 'hidden homeless'.

Although homelessness is mainly associated with urban settings, research published by the Institute for Public Policy Research (IPPR) in 2017 found that 6,270 households were accepted as homeless in 91 mainly or largely rural local authorities in England in 2015-16, an average of 1.3 in every 1,000 households. From 2010 to 2016, "mainly rural" local authorities recorded a 32% rise in cases of homelessness. In areas that are "largely rural", in the same period, there was an increase of 52%, and an almost doubling in "urban areas with significant rural" (97%) (Snelling, 2017).

Scotland

There were 34,972 homelessness applications made to local authorities in Scotland in 2017-18, 402 (1%) higher than the number of applications received in the same period in 2016-17. To make a homeless application in Scotland you do not necessarily need to be sleeping rough but could be:

- staying with friends;
- living in rundown accommodation;
- staying in a refuge, hostel or B&B;
- or at risk of violence or abuse at home (Scottish Government, 2018a).

There were 2,682 people reported as having slept rough on at least one occasion in the three months before registering as homeless (Scottish Government, 2018a).

Wales

Local authorities estimated that 345 people were sleeping rough across Wales in the two weeks at the end of October 2017. This is an increase of 10% compared with the exercise carried out in October 2016 (Welsh Government, 2018).

During July to September 2018, 2,655 households were assessed as threatened with homelessness within 56 days. This was 9% higher than the previous quarter and 12% higher than the same quarter in 2017 (Welsh Government, 2018).

Northern Ireland

In 2017-18, 18,180 households presented as homeless to the NI Housing Executive, with 11,877 being accepted as full duty applicants (Department of Communities NI, 2018). Between January and March 2018, 4,988 people were reported as homeless, an increase of 1,089 (27.9%) from the previous quarter (3,899).

The Housing Executive for Northern Ireland together with community-based organisations conduct an annual count of rough sleepers using a cross-sectional count method on one night in November each year. The annual snapshot follows the standard practice of establishing the number of rough sleepers across Europe and the UK. On 7 November 2018 the annual count recorded 16 rough sleepers in comparison with 5 in the previous year (Department of Communities NI, 2018).

Summary and key points

- Homelessness, including those presenting to services and local authorities as homeless, those deemed statutory homeless, and numbers who are rough sleeping have increased substantially since 2010.
- In all the regions of the UK, with different measures applied and varying data quality, there has been a continued increase in homelessness.
- Rural areas have also witnessed a substantial increase in numbers of homeless.

4. Policy responses to homelessness

This section provides an overview of homelessness policy across the UK. Over the past two decades, some important differences have emerged as the devolved nations have had the opportunity to develop distinctive policy responses to addressing homelessness. Each country has policies in place for providing access to housing for those in need alongside more targeted policies to tackle rough sleeping.

Providing accommodation for those in need

Since the National Assistance Act 1948, UK local authorities have had responsibility for providing accommodation to those in urgent need – although in Northern Ireland the Housing Executive is responsible for helping people presenting as homeless. Access to housing has always been provided on a restricted basis.

The Housing (Homeless Persons Act) 1977 offered a new legislative framework, which continues to form the basis of current homelessness legislation in England. It defined homelessness in terms of having no legal right to accommodation reasonable to occupy but specified that local authorities only had responsibilities to help those judged to be in priority need, homeless through no fault of their own (i.e. not intentionally homeless) and with a local connection to the area they were applying for accommodation in. Further legislation – the Housing Act 1996, Homelessness Act 2002 and Priority Need Order 2002 – has clarified these responsibilities. Consequently, local authorities in England are now expected to provide accommodation to the following groups:

1. pregnant women and people with responsibility for children aged under 16, or aged under 19 if still in full-time education;
2. people who are homeless due to an emergency e.g. fire or flood;
3. young people i.e. all 16 and 17-year olds and care leavers aged 18-20;
4. people who are vulnerable[5] due to old age; mental illness; or physical or learning disabilities; "*In considering whether such applicants are vulnerable, authorities will need to take account of all relevant factors including the relationship between the illness and/or disability and other factors such as drug/alcohol misuse, offending behaviour, challenging behaviour, age and personality disorder". (Ch8 para 25* MHCLG, 2018);
5. people who are vulnerable due to time spent in care, prison or the armed forces, or who are fleeing violence (ibid).

In addition, young people are specified as a vulnerable group and are entitled to 'Foyer' housing, a specific provision that provides temporary accommodation, training and support. If the person or household is not entitled to automatic priority need they may still be deemed as priority need if they are able to prove that they would be less able to cope as a homeless person than the average person because they are vulnerable in some way. The vulnerable categories include age over 60 years, recently left care or prison or addiction issues (Housing Rights NI, 2019).

Wales, similarly, restricts housing to priority need groups but following the implementation of the Housing (Wales) Act 2014 has adopted a more inclusive definition of priority need; for example,

[5] Individuals in these categories are not automatically deemed to be vulnerable. A vulnerability test is used to decide whether there is a special reason why an individual may be less able to cope with street homelessness or be exposed to greater harm when compared to an 'ordinary' individual facing the same circumstances.

responsibilities towards young people aged 18-20 extend beyond care leavers to those at risk of sexual or financial exploitation (Wilson, 2018).

A very different approach is now in place in Scotland. A seminal amendment was introduced in the Homelessness (Scotland) Act 2003 via the removal of the threshold for homelessness based on 'priority' and 'non-priority' need, thus widening eligibility. The omission of the priority classification was enacted through the Homelessness (Scotland) Act 2003, but only came into effect through the Homelessness (Abolition of Priority Need Test) (Scotland) Order 2012. The duty to provide accommodation was provided for all housing applications rather than just those groups considered as vulnerable, including children, older people, people with mental health problems or other groupings, which is still the case in England, Northern Ireland and Wales.

Consequently, local authorities are now tasked with providing housing to all those deemed not to be intentionally homeless either through the provision of social housing or private sector accommodation with tenancies of at least 12 months.

Tackling rough sleeping

Rough sleeping has featured significantly in government policy over the past two decades. A report published in 1999 by the Social Exclusion Unit drew attention to the vulnerability of rough sleepers and set an ambitious target to reduce the number of rough sleepers in England by two-thirds. Subsequently, a Rough Sleepers Unit was established, tasked with implementing a strategic approach to rough sleeping (Social Exclusion Unit, 1998).

The validity and reliability of official counts of rough sleeping has been a source of debate but a review published a decade later suggested that the target had been met and outlined a vision to end rough sleeping by 2012 (Department for Communities and Local Government, 2008).

Since then, the number of rough sleepers has more than doubled,[6] resulting in cross-party support for renewed efforts to reduce rough sleeping. In 2018, the Conservative government carried out its 2017 General Election manifesto commitment and published a rough sleeping strategy, setting out its vision to halve rough sleeping by 2022 and end it by 2027 (MHCLG, 2018). The strategy outlines its vision to prevent homelessness, intervene to tackle rough sleeping, and to support the recovery of former rough sleepers.

[6] The initial increase was due in part to a change in the methodology used to count rough sleepers (see Wilson, 2018).

In England, Northern Ireland and Wales, many of those who become rough sleepers are not eligible for local authority housing unless they meet the criteria for being in 'priority need'. As a result, the strategy outlined a programme of action separate from the homelessness duties imposed on local authorities in England and Wales.

In Northern Ireland, the Housing Executive's homelessness strategy, Ending Homelessness Together, published in April 2017, provided strategic direction for addressing homelessness in Northern Ireland through to March 2022. Following the death of four rough sleepers in Belfast, a trilateral Ministerial Group (comprising the Ministers for Communities, Health and Justice) was initiated in 2016 to consider the issue of street homelessness in Belfast and highlight actions to address the concerns. The group agreed to enhance inter-departmental collaboration for homelessness services in Belfast and increase hours of funded street outreach and numbers of additional crisis bed facilities in Belfast. In addition, the Chief Medical Officer for Northern Ireland is leading a new initiative looking at primary care access for homeless individuals with a task and finish group set up alongside a new homelessness hub currently being designed for implementation in Belfast.

Enhanced efforts to prevent homelessness should also benefit many people who are sleeping rough.

Preventing homelessness

The prevention of homelessness is an integral part of homelessness policy across the UK. Local authorities in England, Scotland and Wales and the Northern Ireland Housing Executive have a duty to produce homelessness strategies to assist the prevention of homelessness.

In England, Scotland, and Wales recent legislation has strengthened this responsibility. In England, the Homelessness Reduction Act 2017 extends the group of people who are eligible for advice and information, permits earlier intervention with individuals threatened with homelessness and encourages multi-agency working (Wilson, 2018). It has the potential to enhance support to individuals who are homeless or at risk of becoming homeless who are not eligible for direct assistance with housing. In Northern Ireland the primary piece of legislation relevant to homelessness is The Housing (NI) Order 1988. This imposes a duty on Northern Ireland Housing Executive (NIHE) in relation to persons who are found to be homeless or threatened with homelessness and empowers the NIHE to purchase of houses evacuated in consequence of acts or threats of violence and for the carrying out of emergency repairs to houses.

This legislation mirrors earlier developments in Wales which were introduced in 2015 when the Housing (Wales) Act 2014 came into force. In Scotland, enhanced preventative efforts have been legislated for, via the removal of the priority need categories. In Northern Ireland, advice is provided

to all, even if they are assessed as not having priority need or being eligible for housing assistance, but legislation has not been implemented to strengthen this duty.

New policy frameworks on reducing homelessness have emerged in all four countries. This renewed emphasis is welcome, but it is too early to judge whether these policies are meeting their aims.

Summary and key points

- The UK governments have statutory responsibilities regarding homelessness but how they apply to drug users is not entirely clear.
- A system of 'priority need' operates in England, Wales and Northern Ireland. However, Scotland has removed this differentiation via legislation in 2014, thereby expanding the definition to all who are in need not just those groups prioritised according to need or vulnerability.
- The current initiatives regarding rough sleeping have increased in number and capacity across the UK, but the majority of policy initiatives require initiation or completion of formal evaluative measures.
- Since the Government's Rough Sleepers Unit was established twenty years ago the numbers decreased initially but are currently rising at a rapid rate, with some variability across the four nations.

5. Drug use among homeless populations

England

There are several methodological considerations to take into account when considering estimates of substance use among homeless populations.

Gill *et al* (2003) stated that estimates derived from research in one subpopulation are unlikely to generalise to other subpopulations. Gill *et al* (2003) reported the prevalence of drug and/or alcohol dependence in an Office of Population Censuses and Surveys (OPCS) study of four distinct groups of homeless people in England: hostel residents; people (predominantly families) housed temporarily; people staying in night shelters; and rough sleepers who visited day centres. Rates of substance use among people in temporary accommodation, who account for the bulk of the homeless population estimated by the NAO (2018), were much lower than those among other homeless groups and were comparable to those observed in private households. Those in temporary housing are mainly families (LGA, 2017).

More recently, Bramley *et al*., (2015) analysed a series of administrative datasets, including records from Supporting People, homelessness service providers, and the National Drug Treatment Monitoring System, on the basis of which they estimate that during 2010-11 there was a minimum of approximately 92,000 individuals in England who experienced both homelessness and substance misuse and that the homeless population numbered a minimum of approximately 186,000 people. If correct, this would indicate that approximately half of homeless people in England experience substance misuse. The Bramley *et al*., (2015) study suggests higher substance use problem prevalence rates than observed in earlier work (Gill *et al*, 2003) among people in temporary accommodation who compromise most homeless people when using conventional definitions. Gill *et al* (2003) estimated prevalence as: 3% for alcohol use; 7%, for any drug use; and 1% for drug use other than cannabis.

Gill *et al* had previously found that half of rough sleepers were defined as alcohol dependent (36% severely dependent) as were similar proportions (44% and 31%) of night shelter residents. Sixteen percent of hostel residents were defined as alcohol dependent (10% severely dependent), compared to just three percent of people housed temporarily (a similar proportion to that observed in private households as part of the same survey of psychiatric morbidity). This study found much greater severity of substance misuse problems among rough sleepers and night shelter residents than those in temporary housing.

In this study, variation in the prevalence of drug dependence (defined as using a drug every day for two weeks or more in the past 12 months) showed a similar pattern, from seven percent of people in temporary accommodation to 29% of night shelter residents. However, with cannabis excluded the range was from just one percent (persons in temporary accommodation) to approximately 23% (night shelter residents).

Further to traditional opioid and crack use among homeless populations, there have been numerous reports in recent years around an increase in the use of SCRAs (known as Spice) in the homeless populations in some areas – particularly in some cities such as Manchester (DrugWise, 2017). Anecdotal reports from evidence taken from England, Scotland and Northern Ireland as well as information collated by DrugWise (2017) indicate that Spice use among homeless populations was characterised by hazardous or dependent use and had been reported as more prevalent in younger populations, including those leaving care. There were also regional reports (Manchester Metropolitan University contribution, 2018; Greater Manchester Police contribution, 2018; Simon Community Northern Ireland contribution, 2018) of people using Spice due to its accessibility and low cost. Furthermore, there were reports of people from all age groups transitioning from Spice to heroin use (DrugWise, 2017).

Scotland

A recent Scottish government publication (Scottish Government, 2018c) considered 435,853 people who had been in households assessed as homeless or threatened with homelessness between June 2001 and November 2016. There was evidence of drug and/or alcohol-related interactions for 19% of those who had ever been homeless compared with the control groups; most-deprived cohort (MDC) 5.1%, least-deprived cohort (LDC) 1.2%. Of the 19% of those who had ever been homeless, the clear majority (94%) also had evidence of mental health issues. The report also considered the number of substance use assessments for those who had ever been homeless with a group classified as the 20% MDC, but not homeless. In total, those who had ever been homeless had ten times more assessments in the Scottish Drug Misuse Database compared with the MDC (10.3 times for males, 10.1 for females) and over 100 times more assessments in the Scottish Drug Misuse Database compared with LDC (125 times for males, 155 times for females). It was also clear that people who go on to become homeless appear to have more substance use assessments, even several years prior to their first homeless assessment (Scottish Government, 2018c).

According to data from the Needle Exchange Surveillance Initiative (NESI), there has been an increase in the percentage of people who inject drugs and have ever been homeless. However, 'recent homelessness' among this group has remained at around 25% over the past decade. This is a predominantly male group (around 75%) and an ageing cohort (35% were over 35 in 2008, while 57% were over 35 in 2018). Around 90% were using heroin in the West of Scotland (70% in Glasgow and 50% in Lanarkshire) – almost all were polydrug users. Injecting cocaine use among this group is a relatively recently observed phenomena and is thought to be a driver of increased risk of blood-borne virus transmission – particularly HIV in Glasgow (Health Protection Scotland contribution, 2018; Scottish Drugs Forum contribution, 2018).

Wales and Northern Ireland

There was no specific data on drug use among homeless populations equivalent to that from Scotland and England.

The Council for the Homeless (NI) conducted a census of residents within temporary accommodation. Results indicated one in three (450 individuals) had mental health issues and one in four had a drug or alcohol issue (NIAO, 2017).

A homeless centre in Cardiff reported that of 53 rough sleepers in the city, around 70% were using Spice.[7]

Summary and key points

- Due to different methodologies it is difficult to assess accurately the extent of drug use among homeless populations.
- There is evidence of an association between being homeless and an increased risk of problematic drug use.
- Drug use patterns and trends vary across the UK with different areas showing more prevalence for some substances than others – for example, SCRA use in Manchester, Newcastle and Cardiff.
- Evidence also suggests that there is a high proportion of injecting heroin users who 'have ever been' homeless in Glasgow and other areas in the West of Scotland, which has also witnessed a rise in HIV cases within this group.

6. Mortality among homeless populations and substance-using homeless populations

Homeless people have higher rates of premature mortality than the rest of the population with drug related deaths and deaths from suicide and unintentional injuries, as well as an increased prevalence of a range of infectious diseases, mental disorders, and substance misuse (Fazel *et al*, 2014).

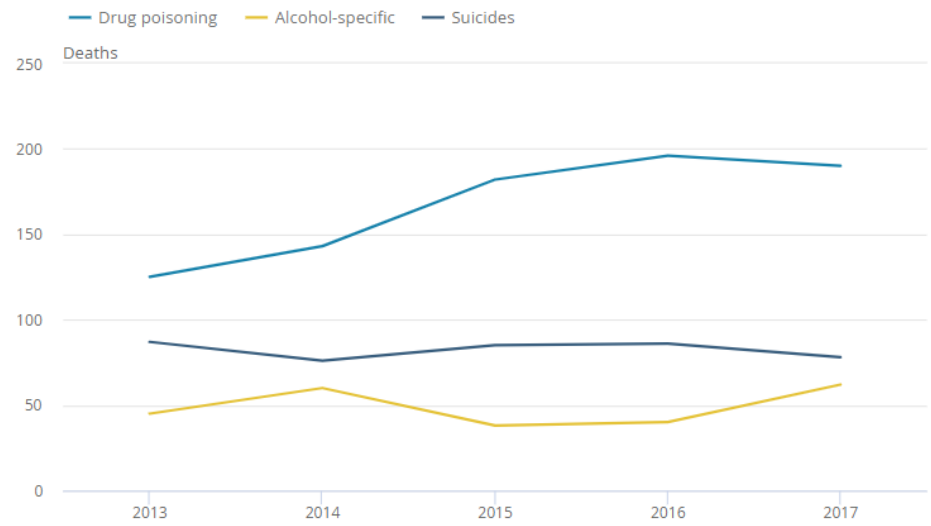
England and Wales

The Office for National Statistics (ONS) reported that in 2017, of the estimated 597 deaths of homeless people in England and Wales, over half were due to drug poisoning, liver disease or suicide. Drug poisoning alone made up 32% of the total number of deaths of homeless people. For comparison, drug poisoning accounts for less than 1% of all deaths in the general population in 2017 (ONS, 2018).

Records showed that 115 out of the 151 drug poisoning deaths registered (76%) included mention of heroin or morphine on the death certificate (ONS, 2018).

[7] https://www.bbc.co.uk/news/uk-wales-45410766

Drug-related deaths of homeless people increased by 52% between 2012 and 2017. This is a slightly higher increase than that for drug poisoning deaths overall in the same period which increased by 45% (ONS, 2018).



Source: Office for National Statistics – Death registrations

Figure 1: Deaths of homeless people identified by selected cause of death category, persons, 2013 to 2017, in England and Wales

Scotland

The Scottish Government's Health and Homelessness report, matching data from between June 2001 to November 2016, showed that almost a quarter (23%) of deaths among the "ever-homeless" cohort were due to drug-related conditions – the largest subcategory of cause of death – while 18% of the female "ever-homeless" cohort were due to drug-related conditions (Scottish Government, 2018c).

Northern Ireland

There were no comparable data available for Northern Ireland.

Summary and key points

- There is a higher rate of drug-related deaths among homeless populations compared with the general population.
- The number of drug-related deaths among homeless populations has increased in recent years.

7. Mental health and physical health harms among homeless populations and substance-using homeless populations

Mental ill-health

Homelessness can be both a cause and a consequence of mental illness and homeless populations experience different types and severities of mental illness (Perry and Craig, 2015). Mental illness is associated with substance use in all homeless populations.

The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) was reported at 25–30% in the street homeless population and those living in direct-access hostels. Homelessness was also associated with higher rates of personality disorder, self-harm and attempted suicide (Rees, 2009).

Many people who sleep rough or in hostels experience more multiple health conditions – including mental health problems – than those who are statutorily homeless or living in temporary accommodation. St Mungo's homeless charity reported in 2009 that 76% of interviewees who lived on the streets had some form of mental health problem either diagnosed by a doctor (65%) or self-identified (11%) (St Mungo's, 2009). Those with a diagnosed mental health problem reported turning to drugs or alcohol to cope "because it is easier than coping with my life" (St Mungo's, 2009).

Another survey of a homeless population in Nottingham found that 1 in 5 had been sectioned under the Mental Health Act 2007. Many respondents in this study reported experiencing mental health issues (not always diagnosed) for numerous years, often since childhood or adolescence (Reeve *et al*, 2018).

Physical Health Harms

Blood-borne viruses and other infections

Scottish data shows that people with previous experience of being homeless are twice as likely to have a blood-borne virus (BBV). One of the best predictors of having a BBV in the homeless was if injecting equipment was reused. This trend for sharing injecting equipment seems to be increasing among homeless and stimulant users (Health Protection Scotland, 2018).

There is a strong association between hepatitis C and tuberculosis (TB) infection among homeless people, which is associated with opiate and crack use (Aldridge *et al*, 2018).

In England there have been substantial increases in episodes of serious bacterial infection (measured by hospital episode statistics) among people who have injected drugs since 2012, across all age groups

and for both men and women (Lewer *et al*, 2017). This trend for bacterial infections mirrors that for opiate overdose-related deaths (ONS, 2018). The ACMD heard expert evidence that this rise has been seen in homeless populations (Faculty for Homeless and Inclusion Health contribution, 2018; University College London contribution, 2018; Health Protection Scotland contribution, 2018).

The same expert evidence indicated that the homeless are over-represented in hospitalisations due to bacterial infections (Ly *et al*, 2019, Fazel *et al*, 2014). Injecting-related health issues are more common in the homeless than the drug-injecting population generally, with high but stable levels of hepatitis C and in some areas of the country rising levels of HIV. Other injecting complications such as abscesses, ulcers and other infections are also more common. Serious infections such as endocarditis, necrotising fasciitis, septic arthritis and osteomyelitis leading to sepsis are also seen in the street homeless (Lewer *et al*, 2017).

In Scotland, the difficulty in testing and treating hepatitis C is added to by the high levels of poly substance use in the homeless population, especially from high alcohol consumption levels. This results in high levels of alcoholic liver disease resulting in premature mortality from cirrhosis and liver cancer (Edinburgh Access Practice contribution, 2018; Scottish Drugs Forum contribution, 2018; Health Protection Scotland contribution, 2018).

HIV is increasing in Lothian and more startlingly in Glasgow and Greater Clyde where the 2015-16 outbreak has continued in 2017-18 There have been 119 new diagnoses since 2014 (Scottish Drugs Forum contribution, 2018; Health Protection Scotland contribution, 2018).

Other physical health harms

The population of people in Scotland who are homeless and who use substances are generally getting older, which is associated with higher levels of physical morbidity generally (Health Protection Scotland contribution, 2018). This reflects the drug-using population generally who are also getting older (Public Health England, 2018; ACMD, 2019b).

There are high levels of chronic lung damage, including chronic obstructive pulmonary disease (COPD) among some homeless populations. This is associated with the high levels of smoking tobacco (which some estimate to be four times the rates in the general population), and/or smoking drugs such as heroin and crack (Rash *et al*, 2018).

Urban homeless populations in the UK have been shown to have high rates of active TB and latent tuberculosis infection (LTBI). These individuals are frequently coinfected with HCV and HIV and may be treatment resistant (Aldridge *et al*, 2018).

There is evidence that women who are homeless and use drugs risk poor health associated with not receiving cervical or breast cancer because services are hard for them to access (Birmingham & Solihull Mental Health Foundation Trust contribution, 2018). Women and men involved in sex work may also be at enhanced risk of contracting a range of sexually transmitted diseases (Moravac, 2018).

Multiple morbidities

There is good evidence of significantly higher rates of multiple morbidities and premature death within the homeless population in comparison with the general population, with the most commonly cited co-morbidities such as schizophrenia relating to mental health, COPD with physical health problems and substance use problems (Budd, 2018).

The 'tri morbidity' of substance use, mental health disorders such as schizophrenia and chronic physical health illness among homeless populations is often aligned to increased hospital admissions, multiple emergency department admissions and increased use of respite care (O'Connell *et al*, 2005; Luchenski *et al*, 2018; Budd, 2018; Hwang and Burns, 2014; Stafford and Wood, 2017).

A meta-analysis of studies that measured rates of death and disease in homeless people, people who use drugs, sex workers and prisoners showed an increased risk of morbidity and mortality in all these excluded groups. Among women who were homeless, this risk was far higher than for men and is deprivation-related (Aldridge *et al*, 2018).

Barriers to care

For homeless people, getting access to evidence-based psychological therapies for depression and other common mental illnesses has been reported to be particularly difficult, with individuals without stable addresses to receive letters and access to primary care are excluded from (Crisis, 2002).

Many homeless people with a need for treatment are not engaged with drug treatment services and have limited access to harm minimisation interventions, including BBV and TB testing and a poor level of access to primary care services (Lewer *et al*, 2017; Birmingham & Solihull Mental Health Foundation Trust contribution, 2018; Faculty of Homeless and Inclusion Health contribution, 2018; University College London contribution, 2018; Manchester Metropolitan University contribution, 2018; NHS Fife contribution, 2018; University of Stirling contribution, 2018; Scottish Drugs Forum contribution, 2018; University of Leeds contribution, 2018).

Drugs services were frequently described as too bureaucratic or 'inflexible' and not sufficiently tailored to the needs of people who were homeless, resulting in difficulties in access and retention in services. Homeless people, particularly rough sleepers, are often poor at attending drug services and

need flexible approaches such as assertive outreach. Services already struggling to cope with demand from housed clients may not have the resources to extend 'special' services to homeless people. Hostel-based clinics, assertive outreach and other targeted approaches are effective but need extra resources (Faculty for Homeless and Inclusion Health contribution, 2018; Dunn, 2006). The absence of a substance use treatment offer was particularly noted for people who were homeless and using SCRAs. This is partly because of services not targeting them and partly because of a genuine lack of evidence-based effective treatment interventions (Ralphs, 2018).

People who are homeless may be reluctant to go to hospital for fear of being treated poorly, stigmatisation and inadequate opioid substitution (Birmingham & Solihull Mental Health Foundation Trust contribution, 2018; Simon Community Glasgow contribution, 2018; Edinburgh Access Practice, 2018; University of Stirling contribution, 2018; Faculty of Homeless and Inclusion Health contribution, 2018). Lack of engagement with health services can result in homeless people who use drugs not being assessed or treated for developing health issues. Emergency or late presentation can occur when the person has developed significant health problems. This pattern can result in delayed treatment of cardiovascular disease and malignancy and premature morbidity.

Summary and key points

- Mental ill-health is strongly associated with homelessness as both a cause and a consequence.
- Levels of HIV and HCV in drug users who are homeless are high.
- There has been a rise in serious bacterial infections amongst injecting drug users and there is evidence that homeless populations are over-represented in these infected groups.
- There are high levels of long-term conditions such as COPD among homeless drug users.
- There is good evidence of high rates of multiple morbidities, i.e. severe mental illness and long-term physical health conditions among homeless people who use drugs and alcohol.
- There are multiple and specific barriers for homeless populations getting access to psychological therapies and acute hospital services.
- Drug services are difficult for homeless people to access due inflexibility and reduced resources, despite effective treatment models being available.

8. Additional factors and subgroups in substance-using homeless populations

In addition to mental and physical health issues, there are several other factors and complexities, for example gender-specific variables that are strongly correlated with homelessness and drug use.

Women

Women are typically initiated into drug use at a later age than men (SAMHSA, 2016). However, once they have commenced drug use, women tend to increase their use of cannabis, cocaine and opioids at a more rapid rate than their male counterparts (UNODC, 2018). This has been consistently reported among women who use drugs and is sometimes referred to as "telescoping". Women account for 33% of drug users globally and for 20% of the estimated number of people who inject drugs (PWIDs) worldwide. Women also have a greater vulnerability than men to blood-borne infections including HIV and hepatitis C, particularly young women who have recently initiated intravenous drug use (UNODC, 2018).

Research methods included a cross-sectional survey, site visits to service providers, focus groups and semi-structured interviews with stakeholders and service users regarding the multiple disadvantages that women who were homeless experience. The results indicated that 94% of respondents reported that they 'sometimes' or 'often' support women with problematic substance use. 69% of respondents reported they had seen an increase in the numbers of women with multiple disadvantages, presenting to their service over the last two years. Women who are homeless also have higher likelihood of complex needs, including being a parent with dependent children, mental health issues, and experience of domestic violence. Women's homelessness is highly correlated with domestic violence and the majority of studies over the last three decades have reported that, while it is not always a direct cause of homelessness, experience of domestic violence is almost always reported by women who become homeless (Mayock *et al*, 2016). In addition, over 30% of female rough sleepers have experienced sexual assault while being homeless (MOJ, 2018). In a recent rapid review undertaken by the University of York, the findings highlighted that women experienced extremely high levels of stigma and oppression, verbal and physical assaults and an elevated risk of violence and sexual abuse while sleeping rough. Often sleeping rough meant taking great care to ensure a level of safety, which subsequently increased the hidden status of women as they concealed themselves or were forced to move constantly during the night (Bretherton and Pleace, 2015). These issues should be taken into account when considering risks and how to ameliorate risks, including the need for safe housing for women and children (Luchenski *et al*, 2018).

Offenders and prison leavers

There is strong evidence of higher rates of substance use problems and homelessness among people who offend in the UK (ACMD, 2018a; MOJ & PHE, 2017; MHCLG, 2018; MacRae *et al*, 2006; Dore, 2015). On release, the risk of homelessness is increased as tenancies have been terminated due to imprisonment or difficulties securing housing are exacerbated due to ex-prisoner status. These difficulties are further compounded by drug use problems, which may have continued during sentence and which may increase with greater access to drugs on release into the community. A longitudinal cohort study of 1,435 UK adult prisoners sentenced to between one month and four years in prison in 2005 and 2006 considered drugs and alcohol as a factor in relation to homelessness prior to prison and housing needs when leaving prison. Findings indicated that individuals who stated that they were homeless before incarceration and who also reported needing assistance for drug/alcohol problems were more likely to state that they required help with housing after completion of sentence (Williams *et al*, 2012).

In addition, UK Ministry of Housing, Community and Local Government guidance states

> *"People with an offending history are over represented among single people who are homeless and sleep rough, and a lack of accommodation is likely to have a negative impact on prospects for successful resettlement and rehabilitation. Female offenders often have complex needs which affect their access to suitable and sustainable accommodation on release from custody."* (MHCLG, 2018 pg 174)

Ex-service people

There is some evidence in the UK (and beyond) of an increased prevalence of ex-service people among those people who are homeless and those who are homeless with substance use problems (Social Care Institute for Excellence, 2018; Tsai *et al*, 2013).

Although outdated, a national audit in 2007 provided a historical benchmark for the consideration of a number of variables relevant to service personnel leaving the armed forces. The estimations of homelessness in the forces found that 5% of almost 5,000 respondents reported that they had experienced a period of homelessness since returning to civilian life. Of this proportion, 21% stated they had been homeless for less than four weeks, 53% underlined that they had been homeless between one and six months, 14% between seven and twelve months, and 12% over a year (NAO, 2007).

There is also evidence that ex-service people report higher levels of problematic alcohol use rather than drug use in relation to homelessness. It is acknowledged that the high levels of alcohol use

originate from a traditional military drinking context combined with stringent armed forces policies that enforce zero tolerance to drug use, random drug testing and the risk of dishonourable discharge arising from a failed drugs test (Pardoe and Ronca, 2017; The Futures Company, 2013).

Summary and key points

- Women who are homeless are more likely to have multiple and highly complex needs including those associated with drug use.
- A number of women have experienced domestic violence prior to being homeless and a substantial proportion of females who are rough sleeping have reported sexual, physical and verbal assaults together with multiple oppressions and discriminations.
- The risk of homelessness and concomitant drug use is higher for offenders than for the general population, particularly for those who have completed prison sentences.
- Ex-service personnel who are homeless have increased risk of problematic substance use, although it appears that the greatest risks are related primarily to alcohol.

9. How can drug-related harms in homeless populations be reduced?

There is a plethora of evidence to support specific interventions with individuals who are homeless and in relation to interventions with those who have substance use problems and co-morbidities (for example substance use and mental health problems). However, there is a gap in recent published research to support 'what works best' with those who experience the chronic problems associated with both homelessness and drug use. The following is a summary of a number of approaches at the structural/policy level as well as those which make reference to specifically named interventions such as Housing First, drug outreach projects (including harm reduction approaches), assertive outreach and other interventions.

Public policy

It is widely recognised that policy at national and regional levels must address issues related to access to housing, range of housing options and making social housing available to all who are homeless. Additionally, authorities must increase and diversify outreach services for those who are perceived as rough sleepers, but who find it difficult to remain in housing or simply do not wish to maintain a tenancy. This is relevant to all categories of those deemed in need and is particularly urgent for those most vulnerable who have multi-faceted chronic needs associated with drug use harms and homelessness (for example, prisoners with drug use issues). It is also necessary to employ appropriate national and local government initiatives for those who are at risk of homelessness and concomitant

drug use problems due to family breakdown, leaving care, or for others who have multiple morbidities including physical and mental health problems.

A rapid review undertaken by PHE (2017) considered outcomes of drug treatment in England and reported on several essential components of a homelessness response for drug users.

- Appropriate housing should be made available for individuals who have drug issues particularly when it is obvious that failure to do so will result in homelessness, failure to engage in treatment or relapse.
- An integrated health, social care and community care approach to the recovery and housing needs of the person should be tailored to the needs of the individual.
- Housing stability is a positive outcome correlated with more stable use and increased engagement with services. It is particularly crucial for people who are 'rough sleeping' and those with highly complex needs.

This will only happen if government encourages local areas to have an integrated approach at a policy level to address homelessness with local government, health services and other agencies committing to a clear vision to reduce it. Housing policy needs to increase the current support provided to homeless people, including active drug users, with intensive support to reduce the risk of drug use and increase access to treatment, whilst employing an overtly non-exclusion approach to services in the housing sector for those who continue to use drugs. A greater emphasis needs to be placed on supporting local authorities to fulfil their duties under the Homelessness Reduction Act 2017 which include tailored support for vulnerable groups such as drug users.

Housing First

Housing First originates from US and European interventions comprising non-conditional and stable housing environments for people who have multiverse and critically complex needs in relation to housing, physical and mental health and substance use concerns. The initiative indicated great success in various regions across the US (Lockard *et al*, 2011; Mares *et al*, 2004) and other European countries (Pleace and Bretherton, 2015; Hopp, 2019).

Housing First in the UK also employs the principle of using stable housing as a foundation for those who have many and complex needs in multiple formations to include one or more of the following: drug and alcohol issues, entrenched street homelessness and other homelessness categories, physical health and mental health problems, domestic violence issues or involvement in the criminal justice system.

According to research by Bretherton and Pleace (2015), Housing First in England was at that time in a strong position to follow the successes of the model rolled out in North America and other European countries, and that there should be further implementation of Housing First approaches with accompanying research evaluations across the UK. Results from their study of nine projects across England indicated that 70-90% of Housing First residents stay in their homes and that this subsequently has a positive impact on their physical health and emotional wellbeing (Bretherton and Pleace, 2015).

In a report that considered future funding for Housing First Services in England, Rice (2018) reported findings from a Homeless link (2017) survey which stated that the majority of Housing First users have issues related to drug or alcohol use (Rice, 2018). In 2013, a pilot Housing First service was implemented in Belfast (NI). Results from a research evaluation found that 19 of the 24 people who were housed in 2014 remained in tenancy at the end of the year. The greatest health and social care benefits for the individual included higher levels of self-care and life skills. The cost of Housing First per service user, per week was £80 in 2015. This compared to £217 per unit per week for accommodation-based services for single homeless people (North Harbour Consulting, 2016). The UK Government has recently invested in the initiative and in May 2018, the Ministry of Housing, Communities and Local Government (MHCLG) announced three Government funded pilot projects in Greater Manchester, Liverpool and the West Midlands. Evidence from the information session in Edinburgh highlighted that "Rapid re- housing is essential by taking the principles from Housing First and applying it to all homeless" according to needs on a seasonal basis (Simon Community Glasgow contribution, 2018).

Harm reduction

Harm reduction is both an ideological framework and a set of strategies that aims to reduce the harms associated with substance use problems whilst not necessarily dependent on reducing the levels of substance use (International Harm Reduction Association). Through this mode of working, staff support people in a holistic, pragmatic and supportive manner to encourage them to consider and reduce the harms related to their substance-using behaviour. Harm reduction is vital for homeless populations who are exposed to more harms, less able to protect themselves from harm, and less likely to experience protective factors of being in treatment, stable accommodation.

Harm reduction may also encompass outreach, education, psychological interventions and health promotion aimed at maintaining and improving physical and mental health and wellbeing. Peer support programmes, support groups and user forums are also main components of harm reduction

approaches for people who use substances (Health Protection Scotland contribution, 2018; University of Stirling contribution, 2018; Faculty of Homeless and Inclusion Health contribution, 2018).

Information from an evidence day in Belfast highlighted that the "median waiting time for substitute prescribing in the Belfast Health and Social Care Trust had reduced from 36 weeks in July 2017 to 10 weeks in July 2018. The mean waiting time for substitute prescribing had also reduced from 40 weeks in July 2017 to 14 weeks in July 2018" (Public Health Agency Northern Ireland contribution, 2018).

Intensive pragmatic harm reduction services, which focus on reducing drug-related deaths and the reduction of risk behaviours associated with the transmission of blood-borne disease have demonstrated good effectiveness via needle exchange programmes (Palmateer *et al*, 2010; Ritter and Cameron, 2006) provision of take-home naloxone (Langham, 2018; and Irvine *et al*, 2018) and opioid substitution therapy (NICE 2007; Amato *et al*, 2005; March *et al*, 2006).

Furthermore, the use of supervised injection sites is often most effective for the hardest to reach homeless drug users providing a safe space for safe injecting practice, medical attention, prevention of overdose and engagement with health care service. The effectiveness of safer injection rooms to engage with, maintain contact with and act as access points for housing and other social services for highly marginalised target populations (including homeless populations) has been widely documented (Hedrich *et al*, 2010; Potier *et al*, 2014). The EMCDDA fully supports the use of safer injecting sites to prevent overdose deaths. In 2016, there were 78 drug consumption rooms operating in 6 EU countries and Norway and 12 operating in Switzerland (EMCDDA, 2018).

One of the most important structural factors in the harm reduction approach to working with homelessness and drug use is the supply of 'safe housing', particularly with a specific focus on the availability and accessibility to social housing alongside non-tokenistic consumer choice for vulnerable people who have complex needs associated with drug use (Pauly *et al*, 2013).

Co-ordinated care for homeless who experience co-morbidity of mental health, physical health and substance use

The evidence gathered by the ACMD highlighted that individuals with co-morbid disorders, including mental health and substance use and who are at the greatest risk of homelessness have the most successful outcomes when treated via an integrated service model of service provision (Hwang and Burns, 2014). Practitioners should be enabled to work effectively with mental health and substance use disorders simultaneously for homeless people who experience complex and multi-faceted problems as this can increase effectiveness, whilst at the same time enhancing efficiency and lowering

costs. Moreover, early detection and treatment can improve treatment outcomes and the quality of life for those most in need of a holistic programme of intervention.

In a 2005 review by Hwang *et al*, the authors considered 73 studies to provide guidance for the development of improved healthcare outcomes for homeless people. They concluded that the provision of co-ordinated treatment and support for adults with homelessness who had substance use problems or mental health problems or both, showed greater improvements in health-related outcomes than those recorded for usual care. It was noted that the comparison of two different treatment modalities often did not produce significant differences in results between control and participant groupings and therefore did not identify the most effective treatment modality. However, the results did show that programme developers and policy makers should focus on holistic and integrated treatment programmes which were tailored to the specific needs of the homeless populations (Hwang *et al*, 2005).

This presents an opportunity where integrated teams can provide general medical care, mental health care, addiction treatment and housing services for those most in need. In addition, one of the main recommendations of a paper for local and national policy makers from Homeless Link (2016) was that *"People who commission or provide drug, alcohol and mental health services to follow principles outlined by Public Health England (PHE, 2017) and National Institute for Health and Care Excellence Guidelines (NICE, 2016) so that there is no 'wrong door' for people with co-occurring conditions".* This allows homeless people to have the maximum opportunities to access integrated and coordinated treatment and support. (Homeless Link, 2016 pg. 5)

In practice in the UK this means ensuring that commissioned responses are properly tailored to the needs of the local homeless population. Substance use services need to be well resourced and provided as part of an integrated care team where possible. They need to include harm reduction strategies and/or recovery pathways embedded within in a person-centred and individual needs led approach. The pathways, both harm reduction and recovery should be made clear to Individuals who may or may not be currently engaged in services.

The service should provide good quality drug treatment where the individual has timely access to a range of interventions and staff who have the appropriate skill sets and who are proficient in their specialist areas (including professionally trained health and social care staff who have experience in working with substance use, harm reduction and recovery techniques and knowledge of community drug and alcohol use programmes and the relevant referral pathways and/or local knowledge of relevant statutory and community based housing (Department of Health, 2017)).

Local statutory and non-statutory organisations need to understand the needs of those who are homeless and present with drug-related harms to ensure that the approaches and attitudes of staff do not encourage the stigmatisation of homeless drug users. The evidence gathered across the UK suggests service users particularly welcomed staff who treated them with respect and understood the uniqueness of their situation whilst being welcoming, compassionate and most importantly, non-judgemental: "When people who are homeless access mainstream health of substance use service, their needs are not well met. They can experience stigma, negative attitudes from staff and encounter inflexible services." (University of Stirling contribution, 2018).

Assertive outreach

Specialist targeted approaches for mental health, physical health and substance use are effective in reaching the homeless. Assertive outreach has been key to providing an effective service for hard-to-engage drug-using populations who are homeless. Despite the need there has been a reduction in the number of established outreach health and social care programmes as traditionally homeless people and particularly those with chronic and complex needs often avoid or are unable to access, due to previous evictions or not meeting the eligibility criteria, shelters and hostel accommodation where they could avail of medical assistance, food and shelter.

Outreach staff are also in the position to provide further opportunities to engage with people to assess mental and physical health needs and provide harm reduction advice (where applicable). Specialist models of holistic outreach care have been exemplified in the 'Pathway' model within the UK for homeless people who have been admitted to hospital. The model brings community service organisations and homeless medicine GPs to the hospital bedside and provides a continuum of care beyond the hospital discharge (Luchenski *et al*, 2018).

Hewett (2018) reported that active engagement and outreach should primarily focus on reaching out to people and adopting a person-centred approach to practice. In terms of mental health care, Hwang and Burns (2014) also outlined several points in relation to working with homelessness, substance use disorders and mental health needs and recommended a more collaborative working model for outreach services that work with homeless populations who are hard to reach.

Other interventions

There are specific treatment interventions that may improve treatment outcomes. A review of the treatment modality with homeless individuals who had problems with crack cocaine indicated that abstinence rates from the drug were significantly higher for those receiving contingency management and day care than for those receiving usual day care (Schumacher *et al*, 2007).

A systematic review of the effectiveness of interventions to improve the health and housing status of homeless people considered a number of studies in relation to homeless people with substance use issues. Three studies indicated that the provision of housing was an effective means of reducing substance use in participants as well as decreasing their utilisation of medical services over time. Two of the three studies suggested that abstinence-based housing supports longer-term abstinence (where this was a primary study outcome) in comparison with non-abstinence-contingent housing (Fitzpatrick-Lewis *et al*, 2011). It is notable that the results from the studies cited above show some clear evidence that abstinence-based housing has indicated levels of success for some people where abstinence is the goal. This suggests a need for either a mixture of services, or a flexible model which can accept when harm reduction and semi-independent living are the only realistic goals but can also pursue abstinence and independent living as appropriate, with further adaptations for rural areas (Pleace, 2008). Therefore, whilst the UK government is committed to investing in the Housing First model, which indicates positive results on national and international levels, it is also important to consider alternatives for individuals who wish to choose an abstinence-based housing option.

Mechanisms to increase social networks and contacts for homeless substance users can increase social integration and improve relationships that will support recovery. These can be done in a variety of ways including well-supported outreach especially that using peers and also facilitating mutual aid solutions such as access to Alcoholics Anonymous and Narcotics Anonymous tailored to homeless populations.

Empowerment of homeless drug users may be realistically attainable via their involvement in the design and implementation of services in a co-production model. The ACMD heard from a programme in Scotland (Supporting Harm Reduction through Peer Support (SHARPS)) where this had been successful (University of Stirling contribution, 2018; Parkes *et al*, 2019). Services need to be designed to be flexible in a manner that ensures homeless people can both access them and be retained long enough to benefit and not be excluded. It is critical to identify and evidence the most effective forms of intervention for the disengaged and fluid subsection of homeless people who experience multi-faceted and chronic exclusion and subsequently transfer the knowledge into practice. Where there is a lack of operational collaboration, highly vulnerable individuals are often ‘shunted’ from one service to another and experience very poor health outcomes (Canavan *et al*, 2012).

Summary and key points

- An integrated health, social care and community care approach to the recovery and housing needs of people who are homeless would provide the optimal model of service delivery. An integrated service model is particularly important for individuals with co-morbid disorders, including mental health and substance use and who are at the greatest risk of homelessness.
- Safe, stable housing is essential for people who are homeless and who have problematic drug use and is associated with increased engagement with services. There is evidence to support the effectiveness of the 'Housing First' model in Europe and the US, and the UK government is supporting the implementation of the model in several designated areas in England. However, there is also research evidence to suggest that abstinence-based housing has indicated levels of success for some people where abstinence is the goal. However, abstinence as a condition for housing or continued housing may exclude vulnerable populations from these services.
- Structurally, there must be an increase in the current support provided to people who are homeless, including active drug users, with immediate and comprehensive assistance to reduce the risk of drug use and increase access to treatment. Harm reduction work within the homeless and drug use sectors in the UK utilises a holistic, pragmatic and supportive approach to encourage individuals to consider and reduce the harms related to their substance using behaviour. Evidence-based harm reduction models in the UK include assertive outreach programmes, education, counselling, health promotion, peer support, user fora, needle exchange schemes, administration of naloxone and opioid substitute prescribing.
- There is international evidence to support the effectiveness of safe injecting sites to engage with and maintain contact with highly marginalised target populations and to prevent overdose deaths.
- Local statutory and non-statutory organisations must maintain an active awareness of the multiple stigma, oppressions and discriminations experienced by service users. Professional values of respect and non-judgmentalism married with a warm empathic and compassionate approach were perceived as foundational to working with vulnerable people who are homeless and have drug use issues. Service providers must endeavour to support homeless people who experience harms related to drug use. One method of realistically achieving this goal this would be to involve service users in the design and implementation of services.

10. Conclusions

- Expert evidence concluded that drug using homeless populations suffer a particular lack of social connectedness and their personal safety is at greater risk. This is particularly true for users of synthetic cannabinoid receptor agonists (SCRAs). In addition, a high proportion of people who are homeless and who have drug use issues have experienced multiple adverse childhood experiences (ACEs). The implementation of Universal Credit, the pursuit of localism and the lack of affordable housing add to the risk of homelessness amongst drug users.
- People who are homeless, including those presenting as homeless to services and local authorities, those deemed statutory homeless, and numbers who are rough sleeping have increased substantially with some variation across the UK since 2010. Whilst the problems are proportionally greater in inner city and urban areas it is also clear that the issue has become increasingly prevalent in rural areas.
- The UK and devolved governments have statutory responsibilities regarding homelessness, although it is not entirely clear how this relates to drug users who are homeless. For all who present as homeless, a system of 'priority need' operates in England, Wales and Northern Ireland. However, Scotland has removed this differentiation via legislation in 2014 thereby expanding the definition to all who are in need not just those groups prioritised according to need or vulnerability.
- The needs of people who are homeless, particularly rough sleepers, are not well met by mainstream benefit, health and social care and some drug services. Current regional and local initiatives to address rough sleeping have increased in number and capacity across the UK, but most policy initiatives require initiation or completion of formal evaluative measures.
- Due to different methodologies employed across the UK, it is difficult to assess the extent of drug use among homeless populations. However, there is evidence that suggests a strong reciprocal association between being homeless and having an increased risk of problematic drug use.
- Drug use patterns and trends vary across the UK with different areas showing higher prevalence for some substances than others – for example, SCRA use in Manchester, Newcastle and Cardiff. Evidence also suggests that there is a high proportion of injecting heroin users who have ever been homeless in Glasgow, an area that has also witnessed a rise in HIV cases within this group.
- There is a higher rate of drug-related deaths among homeless populations compared with the general population. The number of drug-related deaths among homeless populations has increased in recent years. Mental ill-health is strongly associated with homelessness as both a cause and a consequence.
- There has been a rise in serious bacterial infections amongst injecting drug users and there is evidence that homeless populations are over represented in these infected groups. In addition, levels of HIV and HCV in drug users who are homeless are high. In Scotland there are high levels of long-term conditions such as chronic obstructive pulmonary disease (COPD) among homeless drug users.
- There is strong evidence of high rates of multiple morbidities, i.e. severe mental illness and long-term physical health conditions among homeless people who use drugs and alcohol.
- There are many and varied subpopulations in the homeless sector who have drug use issues, including women, older people, young people, sex workers, offenders and ex-service personnel.

The report focused on three of those groupings as they were highlighted during the evidence-gathering sessions across the UK. It is apparent that they have particularly complicated and multi-faceted circumstances, which require intensive support on a long-term basis.

- Women who are homeless experience multiple oppressions and discriminations and many of them report domestic violence prior to being homeless. A substantial proportion of females who are sleeping rough have reported sexual, physical and verbal assaults whilst on the streets.
- The risk of being homeless and having a drug use problem is much greater for offenders than for the general population.
- Ex-service personnel who are homeless have increased risk of problematic substance use although it appears that the greatest risks are related primarily to alcohol.
- An integrated health, social care and community care approach to the recovery and housing needs of people who are homeless would provide the optimal model of service delivery. This is particularly important for individuals with co-morbid disorders, including mental health and substance use and who are at the greatest risk of homelessness. In addition, safe, stable housing is essential for people who are homeless and who have problematic drug use and is associated with increased engagement with services.
- Harm reduction work within the homeless and drug use sectors in the UK utilises a holistic, pragmatic and supportive approach to encourage individuals to consider and reduce the harms related to their substance-using behaviour. Evidence-based Harm Reduction models in the UK include assertive outreach programmes, education, counselling, health promotion, peer support, user fora, needle exchange schemes, administration of Naloxone and opioid substitute prescribing. There is international evidence to support the effectiveness of 'safe injecting sites' to engage with and maintain contact with highly marginalised target populations and to prevent overdose deaths.
- Structurally, there must be an increase in the current support provided to the homeless population, including active drug users, with immediate and comprehensive assistance to reduce the risk of drug use and increase access to treatment.
- There is evidence to support the effectiveness of the 'Housing First' model in Europe and the US. The UK government is supporting the implementation of the model in several designated areas in England. An alternative model of abstinence-based housing has showed promising results which suggest that the abstinence-based approach has some success for some people where abstinence is the goal.
- Local statutory and non-statutory organisations must maintain an active awareness of the multiple stigma, oppressions and discriminations experienced by their service users. Professional values of respect and non-judgmentalism married with a warm empathic and compassionate approach were perceived as foundational to working with vulnerable people who are homeless and have drug use issues. Furthermore, service providers must endeavour to empower homeless people who experience harms related to drug use. One method of realistically achieving this goal this would be to involve service users in the design and implementation of services.

11. Recommendations

Recommendation 1

- Housing policies, strategies and plans across the UK should specifically address the needs of people who use drugs and are experiencing homelessness by: recommending evidence-based housing provisions, such as Housing First; enabling collaboration across departments and agencies to ensure these interventions have a chance to succeed.

Recommendation intended for:

Ministry of Housing, Communities and Local Government (MHCLG), and equivalent relevant government departments with authority for housing policy across the four nations; local authorities.

Measure of implementation:

Increase (% or actual) in local spending on evidence-based housing provisions, such as Housing First, in conjunction with the number of housing units; additional funding from MHCLG.

Metric for assessing intended effect:

Whether evidenced-based housing provisions, such as Housing First, can sustain housing for people who use drugs and are currently, or have recently experienced, homelessness.

Recommendation 2:

- Services at a local level must be tailored to meet the specific needs of substance users who are currently experiencing, or have recently experienced, homelessness – including evidence-based and effective harm reduction and substance use treatment approaches with the capacity, resource and flexibility to reach them. Services need to consider people who are experiencing multiple and complex needs and adopt psychologically-informed approaches.

Recommendation intended for:

Clinical commissioning groups and equivalent bodies (health), local authorities and public health, local voluntary sector and police, led by local authorities.

Measure of implementation:

Level of local spend on services for people who are currently experiencing, or have recently experienced, homelessness as a proportion of overall spend.

Metric for assessing intended effect:

Length of time sustained in treatment, and an increase in the proportion of the overall treatment population for people who were experiencing homelessness at the time of starting treatment.

Reductions in people who are currently experiencing homelessness, combining data from sources including:

  - Numbers in substance use treatment who are homeless; physical health (Hospital Episode Statistics) and mental health (National Mental Health Minimum Dataset) and homeless outreach service datasets
  - Data on prevalence of blood borne viruses in drug users who are homeless

Recommendation 3:

- Substance use, mental health and homelessness services must use evidence-based approaches such as integrated and targeted services, outreach, and peer mentors to engage and retain homeless people in proven treatments such as opiate substitution treatment.

Recommendation intended for:

Voluntary sector and NHS substance use treatment providers, and relevant commissioners involved in funding services for people experiencing homelessness

Measure of implementation:

Numbers in substance use treatment and retention in treatment for people who use substances and are currently experiencing, or have recently experienced, homelessness.

Metric for assessing intended effect:

Improved access to and retention in substance use treatment for people with current experience of homelessness but also an increase in the numbers of these people being accommodated.

Recommendation 4:

- Service providers should be aware of the levels of stigma experienced by people who are homeless and are engaged in substance use treatment or who choose not to engage due to the experiences of stigma and oppression they have had. Respect, choice, dignity and the uniqueness of the person should be at the core of the design and delivery of the service provision in respect of substance use and homelessness services.

Recommendation intended for:

Voluntary sector and NHS substance use treatment providers, and relevant commissioners involved in funding services for people experiencing homelessness; generic health and care services.

Measure of implementation:

Numbers in substance use treatment and retention in treatment for people who use substance and have experience of homelessness in treatment data.

Metric for assessing intended effect:

Improved retention in substance use treatment and additional qualitative studies of satisfaction with substance use treatment services. To have considered the views of those with lived experienced of homelessness in design and delivery of services.

Recommendation 5:

- The workforce in substance use and other services which have contact with the homeless need to have skills in dealing with complexity and in retaining homeless drug users in treatment.

Recommendation intended for:

Voluntary sector and NHS substance use treatment providers, their commissioners and other commissioners involved in funding services for homeless people.

Measure of implementation:

Numbers in substance use treatment and retention in treatment for homeless substance users in national treatment data across the four nations.

Metric for assessing intended effect:

Improved retention in substance use treatment of people who have recently experienced homelessness and increased number of people in treatment experiencing homelessness and moving into accommodation.

References

ACMD (2017) *Commissioning impact on drug treatment*. London: Home Office

ACMD (2018) *What are the risk factors which make people susceptible to substance misuse problems and harm?.* London: Home Office

ACMD (2019a) *Custody-Community Transitions*. Home Office, London

ACMD (2019b) *Ageing cohort of drug users*. Home Office, London

Aldridge R, Hayward A, Hemming S, Yates S, Ferenando G, Possas L, Garber E, Watson J, Geretti AM, McHugh TD, Lipman M, Story A. (2018) 'High prevalence of latent tuberculosis and bloodborne virus infection in a homeless population', *Thorax* 73(6): 557 - 564

Aldridge R, Story A, Hwang SW, Nordentoft M, Luchenski SA, Hartwell G, Tweed EJ, Lewer D, Katikireddi SV, Hayward AC. (2017 > SHOULD BE 2018) 'Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis', *The Lancet*, 391(10117):241–50

Amato L, Davolia M, Peruccia CA, Ferria M, Faggiano F, Mattick RP. (2005) 'An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research', *Journal of Substance Abuse Treatment*, 28(4):321-9.

Anda R, Felitti V, Bremner J, Walker J, Whitfield C, Perry B, Dube S, Giles W. (2006) 'The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology', *Eur Arch Psychiatry Clin Neurosci*. 2006 Apr;256(3):174-86.

Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F. & Watkins, D. (2015) Hard Edges: Mapping Severe and Multiple Disadvantage. (London: Lankelly Chase Foundation).

Bretherton, B and Pleace, N (2015) Housing First in England – an evaluation of nine services, Centre for Housing Policy, University of York

Boyle, F and Palmer, J. (2016). *The efficiency and effectiveness of the Housing First support service piloted by Depaul Ireland in Belfast, funded by supporting People: An SROIevaluation. North Harbour Consulting*. October 2016

Burkinshaw, P, Knight, J, Anders, P, Eastwood, B, Musto, V, White, M, and Marsden, J (2017) An evidence review of the outcomes that can be expected of drug misuse treatment in England, Public Health England.

Budd, J (2018) Complexity and Coherence – Edinburgh Access Practice :Presentation to the ACMD, Edinburgh, August 2018

Bywaters, N., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., Steils, N., 2016. The relationship between poverty, child abuse and neglect: an evidence review. Joseph Rowntree Foundation, York, UK.

Canavan R, Barry MM, Matanov A, et al. (2012) Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. BMC Health Serv Res 12: 222.

Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. www.gov.uk/government/publications/drug-misuse-and-dependence-ukguidelines-on-clinical-management

Conell J, Mattison S, Judge C, Allen J,& Koh, H. (2005) A Public Health Approach to Reducing Morbidity and Mortality Among Homeless People in Boston. Journal of Public Health Management Practice 11: 4.

Crisis (2002) Critical Condition: Vulnerable single homeless people and access to GP www.crisis.org.uk/data/files/document_library/policy_reports/gp_policybrief.pdf

Department for Commnunities and Local Government (2008), No One Left Out: Communities ending rough sleeping, 18 November 2008

Department of Communities NI and Northern Ireland Statistics and Research Agency (August 2018) *Northern Ireland Housing Bulletin 1st January – 31st March 2018,* Belfast, NISRA

Department of Health (2018) Statistics from the NI Substance Misuse Database 2016/17, Belfast DOH

De Venter, M., Demyttenaere, K., Bruffaerts, R. (2013) 'The relationship between adverse childhood experiences and mental health in adulthood. A systematic literature review', *Tijdschr Psychiatr*, 55(4): 259–268

Dore E (2015) Insights: Prison leavers and homelessness. Glasgow: IRISS. 2005. Available: www.iriss.org.uk/sites/default/files/insight29_prisonleavers.pdf

Dorney-Smith, S and Gill, N. (2017). Improving digital health access for excluded groups. *British Journal of Healthcare Management.* 2017; 23(8): 354- 356. [Online]. Availible at : www.pathway.org.uk/wp-content/uploads/BJHCM_2017_23_8_354-356_COMM_Dorney.pdf

Down and Out? The final report of St Mungo's Call 4 Evidence: mental health and street homelessness December 2009 | Full Report

DrugWise (2017) Highways and buyways: A snapshot of UK drug scenes 2016

Dunn, L. B., Mowrangi, M. A., Palmer, B. W., Jeste, D. V., & Saks, E. R. (2006). Assessing decisional capacity for clinical research or treatment: A review of instruments. American Journal of Psychiatry, 163, 1323–1334.

EMCDDA (2018) Drug consumption rooms: an overview of provision and evidence

Fazel, S; Geddes, J.R; and Kushel, M. (2014) The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. The Lancet. 2014 October 25; 384(9953): 1529–1540.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences Study', *Am J Prev Med*, 14(4):245–258

Fitzpatrick, S., Bramley, G., Johnsen, S., 2013. Pathways into Multiple Exclusion Homelessness in Seven UK Cities. Urban Studies 50(1), 148-168.

Fitzpatrick-Lewis D, Ganann R, Krishnaratne S, Ciliska D, Kouyoumdjian F, Hwang S (2011) Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. BMC Public Health201111:638

Gill, B., Meltzer, H., & Hinds, K. (2003), The prevalence of psychiatric morbidity among homeless adults, International Review of Psychiatry, Vol. 15, No. 1-2, pp. 134-40.

Health Protection Scotland (2018), Needle Exchange Surveillance Intiative report 2018

Hedrich, D., Kerr, T. and Dubois-Arber, F (2010) Drug consumption facilities in Europe and beyond. In: Rhodes, T. and Hedrich, D. (2010) Harm reduction: evidence, impacts and challenges. EMCDDA Monograph 10. Luxembourg: Publications Office of the European Union.

Hewett, N (2018) Pathway Presentation to the ACMD August 2018, Edinburgh, Faculty for Homeless and Inclusion Clinical Network & Pathway Charity

Homeless Link (2016) Making Housing First an effective intervention

Homeless Link (2017) Support for single homeless people in England Annual Review 2016. Homeless link, Policy and Research Team.

Homeless Link (2018) Young and Homeless.

House of Commons Welsh Affairs Committee (2013) *The impact of changes to housing benefit in Wales* Available from: publications.parliament.uk/pa/cm201314/cmselect/cmwelaf/writev/housing/housing.pdf [Accessed 15/11/2018]

House of Commons Work and Pensions Committee (2017) *Universal Credit: the six week wait* Available from: publications.parliament.uk/pa/cm201719/cmselect/cmworpen/336/336.pdf [Accessed 15/11/2018]

Housing Rights NI (2019) The Northern Ireland Housing PrIority Need Test www.housingadviceni.org/priority-need-test Accessed 12/5/19]

Hopp , J (2019) Eradicating homelessness in Finland: the Housing First programme, Centre for oublic Impact www.centreforpublicimpact.org/case-study/eradicating-homelessness-finland-housing-first-programme. Accessed 15/6/19

Hughes, K., Bellis, M.A., Hardcastle, K.A., Sethi, D., Butchart, A., Mikton, C., Jones, L., Dunne, M.P. (2017) 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', *The Lancet Public Health*, 2(8):356-366

Hwang SW, Tolomiczenko G, Kouyoumdjian FG, Garner (2005) Interventions to improve the health of the homeless: a systematic review. Am J Prev Med. 29 :4

Hwang S, & Burns T, (2014) Health Interventions for People who are Homeless. The Lancet : 9953: 25-31.

Irvine, M. A., Buxton, J. A., Otterstatter, M., Balshaw, R., Gustafson, R., Tyndall, M., ... & Coombs, D. (2018). Distribution of take-home opioid antagonist kits during a synthetic opioid epidemic in British Columbia, Canada: a modelling study. *The Lancet Public Health*, *3*(5), e218-e225.

Johnsen, S, Jones, A & Rugg, J 2008, *The Experience of Homeless Ex-Service Personnel in London*. Centre for Housing Policy, York

Kalk N, Boyd A, Strang J, Finch E. (2016) 'Spice and all things nasty: the challenge of synthetic cannabinoids', *BMJ,* 355(5639)

Langham, S., Wright, A., Kenworthy, J., Grieve, R., & Dunlop, W. C. (2018). Cost-effectiveness of take-home naloxone for the prevention of overdose fatalities among heroin users in the United Kingdom. *Value in health*, *21*(4), 407-415.

Larkin H, Lee E, Esaki N, DeMasi M, Trifoso S, Briar-Lawson K, Dean E, Weldon P, Park J, Bowen L, Benson D, Cortese A, Gettman WT, Hathaway T, Hulihan T, LaFrenier A, MacFarland N, Marcal SD, Oberlander H, Wallace D, Wolff B, Yusko JA. (2018). Langham *Social Work in Health Care*. 2018 May; 57(7): 548-562.

Lee C, Mangurian C, Tieu L, Ponath C, Guzman D, Kushel M. (2017) Childhood Adversities Associated with Poor Adult Mental Health Outcomes in Older Homeless Adults: Results From the HOPE HOME Study. *Am J Geriatr Psychiatry*. 2017 Feb; 25(2):107-117.

Lewer, D; Harris, M; Hope, V (2017) Opiate Injection-Associated Skin, Soft Tissue, and Vascular Infections, England, UK, 1997-2016. Emerging infectious diseases, 23 (8). pp. 1400-1403.

Local Government Association (LGA). (2017) Housing Our Homeless Households

Lockard Edens E, Mares A, Rosenheck RA (2011) Does active substance use at housing entry impair outcomes in supported housing for chronically homeless persons? Psychiatric Services Volume 62 Issue 2. February 2011. Pages 171-178

Luchenski S, Maguire N, Aldridge R, Hayward, A, Story A, Perri P, Withers J, Clint S,, Fitzpatrick S, Hewett N, (2018) What works in inclusion health: overview of effective interventions for marginalised and excluded populations. The Lancet :10117 :20-26

Ly TDA, Hadjadj L, Hoang VT, Louni M, Dao TL, Badiga S, Tissot-Dupont H, Raoult D, Rolain J-M, Gautret P (2019) Low prevalence of resistance genes in sheltered homeless population in Marseille, France, 2014–2018. Infect Drug Resist. 2019; 12: 1139–1151.

MacRae, R.; McIvor, G.; Malloch, M.; Barry, M. And Murray, L. (2006) Evaluation Of The Scottish Prison Service Transitional Care Initiative, Scottish Executive Social Research. Edinburgh: Scottish Executive.

Mar, M.Y., Linden, I.A., Torchalla, I., Li, K., Krausz, M., 2014. Are childhood abuse and neglect related to age of first homelessness episode among currently homeless adults? Violence Vict 29(6), 999-1013.

March, J., Oviedo-Joekes, E. and Romero, M. (2006), 'Drugs and social exclusion in ten European cities', European Addiction Research 12, pp. 33–41.

Mares AS, Kasprow W, Rosenheck R (2014) Outcomes of supported housing for homeless veterans with psychiatric and substance abuse problems. Mental Health Services Research, 6 (4) (2004), pp. 199-211

Mayock, P.; Bretherton, J. and Baptista, I. (2016) Women's Homelessness and Domestic Violence: (In)visible Interactions, in Mayock, P. and Bretherton, J. Women's Homelessness in Europe, London: Palgrave Macmillian, pp. 127-154.

McAuley A, Palmateer NE, Goldberg DJ, Trayner KMA, Shepherd SJ, Gunson RN, Metcalfe R, Milosevic C, Taylor A, Munro A, Hutchinson SJ (2019) Re-emergence of HIV related to injecting drug use despite a comprehensive harm reduction environment: a cross-sectional analysis. Lancet HIV. 2019 May;6(5):e315-e324.

Ministry of Housing Communities and Local Government (MHCLG) (2018) Rough Sleeping Strategy 2018.

Ministry of Housing Communities and Local Government (MHCLG) (2018) Homelessness code of guidance for local authorities . Accessed 12/5/19 Available**:** www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/overview-of-the-homelessness-legislation

Ministry of Justice. (2018). Female Offender Strategy. London: MoJ

Ministry of Justice, and Public Health England (2017) The impact of community-based drug and alcohol treatment on re-offending

Moravac C (2018) Reflections of Homeless Women and Women with Mental Health Challenges on Breast and Cervical Cancer Screening Decisions: Power, Trust, and Communication with Care Providers

National Audit Office (2018) Rolling Out Universal Credit
www.nao.org.uk/wpcontent/uploads/2018/06/Rolling-out-Universal-Credit.pdf

National Audit Office (2007) Ministry Of Defence: Leaving the Services, a Report by the Comptroller and Auditor General. HC618 Session 2006-2007. Available through:
www.nao.org.uk/wpcontent/uploads/2007/07/0607618.pdf

National Assembly for Wales Equality, Local Government and Communities Committee (2018) *Life on the Streets: preventing and tackling rough sleeping in Wales* Available from:
www.assembly.wales/laid%20documents/cr-ld11517/cr-ld11517-e.pdf [Accessed 15/11/2018]

National Health Care for the Homeless Council. (2019). Non-Opioid Substance Use, Mental Health, & Homelessness. *Healing Hands*, Spring 2019; 23(2). Nashville, TN. Available at: www. nhchc.org

NICE (2007) Methadone and buprenorphine for the Methadone and buprenorphine for the management of opioid dependence management of opioid dependence

North Harbour Consulting (2016) The Efficiency and Effectiveness of the Housing First Support Service Delivered by Depaul Northern Ireland , Funded by Supporting People: An SROI Evaluation, North Harbour Consulting, June 2016.

Northern Ireland Audit Office (2017) Homelessness in Northern Ireland. Belfast: NIAO

O'Connell JJ. (2005). Premature Mortality in Homeless Populations: A Review of the Literature. Nashville, TN: National Health Care for the Homeless Council; 2005.

Office for National Statistics (1993-2017) *Deaths related to drug poisoning in England and Wales* Available:
www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/previousReleases [Accessed 15/11/2018]

Office for National Statistics (2018) Deaths of homeless people in England and Wales: 2013 to 2017

Palmateer N, Kimber J, Hickman M, Hutchinson S, Rhodes T, Goldberg D. (2010) Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews. Addiction. 2010;105:844–859.

Pardoe and Ronca (2017) Research into the housing-related support needs of homeless veterans: Final Report to Alabaré 13 February 2017

Parkes, T; Matheson, C; Carver, H; Budd, J; Liddell, D; Wallace, J; Pauly, B, Fotopoulou, M; Burley, A; Anderson, I; MacLennan G; Foster, R (2019) Supporting Harm Reduction through Peer Support (SHARPS): testing the feasibility and acceptability of a peer-delivered, relational intervention for people with problem substance use who are homeless, to improve health outcomes, quality of life and social functioning and reduce harms: study protocol. Pilot and Feasibility Studies 2019 5:64

Pauly B, Reist D, Belle-Isle L, Schactman C (2013) Housing and harm reduction: What is the role of harm reduction in addressing homelessness? The International journal on drug policy 24(4) · April 2013

Perceived Microaggressions and Mental Health in a Sample of Black Youths Experiencing Homelessness Maurice N. Gattis Andrea Larson Social Work Research, Volume 41, Issue 1, 1 March 2017, Pages 7–17,

Perry J, and Craig, TK (2015) Homelessness and mental health

Pleace N, (2008) Effective services for substance misuse and homelessness in Scotland: evidence from an international review. Scottish Government Social Research, 2008.

Pleace, N and Bretherton, J (2013) The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness European Journal of Homelessness, 7(2), 21-41

Pleace, N and Bretherton, J (2015) Housing First in England An Evaluation of Nine Services. February 2015, Centre for Housing Policy, University of York

Potier C, Laprévote V, Dubois-Arber F, Cottencin O, Rolland B (2014) Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 2014 Dec 1;145:48-68

Public Health England (2017) An evidence review of the outcomes that can be expected of drug misuse treatment in England. London: PHE

Public Health England (2018) Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS). London: PHE

Ralphs R, Gray PM, Norton A (2017). *New Psychoactive Substance Use in Manchester: Prevalence, Nature, Challenges and Responses*. Manchester Metropolitan University, Manchester City Council.

Rash, Carla J. Petry, Nancy M. Alessi, Sheila M (2018), A randomized trial of contingency management for smoking cessation in the homeless: (2018) Psychology of Addictive Behaviors 2018 32: 141-148

Rees S. (2009) Mental ill health in the adult single homeless population: a review of the literature. Crisis. Public Health Resource Unit, 2009.
www.crisis.org.uk/data/files/publications/Mental%20health%20literature%20review.pdf

Reeve K, MCarthy L, Pattison B, Parr S, Batty E, Maye-Banbury A, Bashir N. (2018). The mental health needs of Nottingham's homeless population: an exploratory research study. Project Report. *Sheffield, Sheffield Hallam University.* July 2018.

Rice B (2018) Investigating the current and future funding of Housing First in England: Exploring innovation and identifying opportunities to sustain and expand Housing First services. Huosing First England

Ritter, A., & Cameron, J. (2006). A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. Drug and Alcohol Review, 25, 611-624.

Roos L, Mota N, Afifi T, Katz L, Distasio J, Sareen J. (2013) ' Relationship Between Adverse Childhood Experiences and Homelessness and the Impact of Axis I and II Disorders', *American Journal of Public Health (AJPH)*, 103(Suppl 2):275-281.

Schumacher J, Milby J, Wallace D, et al. (2007) Meta-analysis of day treatment and contingency-management dismantling research: Birmingham Homeless Cocaine Studies (1990–2006) Consult Clin Psychol, 75: 823-828

Scottish Government (2018a), Homelessness In Scotland: 2017 to 2018

Scottish Government (2018b), Ending Homelessness: The report on the final recommendations of the Homelessness and Rough Sleeping Action Group

Scottish Government (2018c), Health and Homelessness in Scotland

Shelter Cymru (2015) *Settled: Good practice in homelessness prevention among prison leavers* Available from: sheltercymru.org.uk/wp-content/uploads/2015/02/Settled-Good-practice-in-homelessness-prevention-among-prison-leavers.pdf [Accessed 15/11/2018]

Snelling, C. (2017). Right to home? Rethinking homelessness in rural communities. *Institute of Pulic Policy Research (IPPR)*. July 2017.

Social Care Institute for Excellence (2018) A rapid evidence assessment of what works in homelessness services Authors: Sanah Sheikh and David Teeman, 2018, SCIE

Social Exclusion Unit (1998), Rough Sleeping: Report by the Social Exclusion Unit, Stationery Office, London.

Stafford, A and Wood, L. (2017) Tackling Health Disparities for people who are Homeless? Start with Social Determinants. International Journal of Environmental Research and Public Health 14: E1535.

Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality (2016). Treatment Episode Data Set (TEDS): 2004-2014. National Admissions to Substance Abuse Treatment Services. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016. wwwdasis.samhsa.gov/dasis2/teds_pubs/2014_teds_rpt_natl.pdf.

Theodorou, N., Johnsen, S., 2017. Homelessness and Adverse Childhood Experience (ACE) Homeless in Europe Winter, 4-8.

Torchalla I, Strehlau V, Li K, Krausz M (2011) Substance use and predictors of substance dependence in homeless women. Drug Alcohol Depend. 2011 Nov 1;118(2-3): 173-9

Transform (2017) Heroin Assisted Treatment (HAT): *Saving lives, improving health, reducing crime* Available from: www.tdpf.org.uk/blog/heroin-assisted-treatment-hat-saving-lives-improving-health-reducing-crime [Accessed 15/11/2018]

Transform. (2018). *Commission on Justice in Wales Call for Evidence 2018.* beta.gov.wales/sites/default/files/publications/2018-08/Submission-enhanced-harm-reduction-group-for-wales.pdf

Tsai AC, Weiser SD, Dilworth SE, Shumway M, Riley ED (2015) Violent Victimization, Mental Health, and Service Utilization Outcomes in a Cohort of Homeless and Unstably Housed Women Living With or at Risk of Becoming Infected With HIV. American Journal of Epidemiology, 2015. Vol. 181: 817-826

Tsai J, Kasprow W, Rosenheck R, (2013) Alcohol and drug use disorders among homeless veterans: Prevalence and association with supported housing outcomes. Addictive Behaviours, 2014. Vol. 39:2: 455-460

The Futures Company, 2013. The Tranistion Mapping Study [pdf]. Available at: www.fim-trust.org/wp-content/uploads/2015/01/20130810-TMS-Report.pdf

The Wallich (2018a) *Rough sleeping statistics.* Available from: thewallich.com/rough-sleepers-statistics/ [Accessed 15/11/2018]

The Wallich (2018b) Internal research carried out by The Wallich – a series of interviews carried out with Wallich staff

The Wallich (2018c) Internal research carried out at The Wallich – internal evaluation of the BOSS Project, with staff being interviewed

United Nations Office on Drugs and Crime (UNODC) World Drug Report 2018. Women and Drugs: Drug use, drug supply and their consequences (United Nations publication, Sales No. E.18.XI.9).

Unitted National Human Rights Office of the High Commissioner (UN Human Rights) (2018) Statement on Visit to the United Kingdom, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?LangID=E&NewsID=23881

Welsh Government. (2018) Rough Sleeping Action Plan. *Welsh Government.* Februrary 2018.

Welsh Government *Housing First (HF) – National Principles and Guidance for Wales* Available from: gov.wales/docs/desh/publications/180206-housing-first-en.pdf [Accessed 15/11/2018]

Welsh Government *National rough sleeping count.* Available from: gov.wales/statistics-and-research/national-rough-sleeping-count/?lang=en [Accessed 15/11/2018]

Williams, K., Poyser, J. and Hopkins, K. (2012) Accommodation, homelessness and re-offending of prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) Survey. Ministry of Justice Research Summary 3/12.

Wilson, W. (2018) Rough Sleeping (England). London: House of Commons Libray Briefing Paper researchbriefings.files.parliament.uk/documents/SN02007/SN02007.pdf

Wright N, Tompkins C, Oldham N, Kay D (2004) Homelessness and health: what can be done in general practice? J R Soc Med 2004 97: 170-173

Appendix A – Stakeholder engagement and Quality of Evidence

The ACMD wrote to stakeholders requesting oral or written submissions.

Evidence gathering sessions were arranged through public invitation and nomination from the ACMD. The evidence sessions included presentations and discussion from researchers, academics, clinicians and people working with homeless populations and identified as having expertise, research or evidence relating to homelessness and drug-related harms. The first evidence gathering day took place in Manchester on 3rd July 2018 and, following a collective submission from professionals in Scotland, a second event was held in Edinburgh on 25th July 2018.

Both evidence gathering days were open to members of the public to observe the day's proceedings and ask questions of speakers and members of the ACMD's Recovery Committee.

Oral evidence was received from the following in Manchester:

- Dr Emma Wincup: Centre for Criminal Justice Studies, School of Law, University of Leeds
- Sue McCutcheon: Substance Use Nurse, Birmingham & Solihull Mental Health Foundation Trust
- PC Andy Costello: Greater Manchester Police
- Dr Rob Ralphs and Dr Paul Gray: Senior Lecturers in Criminology, Manchester Metropolitan University
- Dr Al Story: Clinical Lead, Find&Treat Service, University College London Hospitals
- Dr Nigel Hewett: Medical Director, Pathway, Faculty for Homeless and Inclusion Health
- Dr Neil Hamlet: Consultant in Public Health Medicine, NHS Fife
- Barry Sheridan: independent researcher

Oral evidence was received from the following in Edinburgh:

- Dr Andrew McAuley: Senior Research Fellow, Glasgow Caledonian University; Principal Scientist, Health Protection Scotland
- Dr Hannah Carver: Salvation Army Centre for Addiction Services and Research, University of Stirling
- Lorraine McGrath: Chief Executive, Simon Community Glasgow
- Emma Hamilton: National Training and Development Officer, Scottish Drugs Forum
- Dr John Budd: GP, Edinburgh Access Practice (EAP); Co-ordinator, Lothian Deprivation Interest Group (DIG)*et*
- Dr Tessa Parkes: Director, Salvation Army Centre for Addiction Services and Research, University of Stirling/ Deputy Convenor, Drugs Research Network Scotland

A roundtable meeting was also convened in Belfast on 8th August 2018 to gather evidence from Northern Ireland. The following made contributions:

- Iain Cameron: Co-ordinator, Extern Northern Ireland
- Tracey Colgan: Senior Health and Wellbeing Improvement Officer, Public Health Agency, Northern Ireland
- Jo Daykin-Goodall: Director of Operations, The Welcome Organisation
- Michael Foley: Senior Social Worker, Belfast Health & Social Care Trust

- Gary Maxwell: Health Development Policy Branch, Department of Health Northern Ireland
- Chris Rintoul: Manager, Extern Northern Ireland
- Michael Owen: Health and Social Wellbeing Improvement Manager, Public Health Agency, Northern Ireland
- Eoin Ryan: Head of Health & Wellbeing, Simon Community Northern Ireland
- Richard Stewart: DePaul, Northern Ireland

Written evidence was received from Lindsay Cordery-Bruce from The Wallich, the Welsh Homeless Charity, and Caroline Phipps, Chief Executive of Barod, a third sector organisation delivering a range of services and interventions to individuals and families with substance misuse issues across south Wales.

In addition to written and oral evidence submitted, this report also draws on evidence from peer reviewed literature, independent reports, and policy evaluations. Most evidence used was from the UK, but some international examples are referred to. Evidence gathered was considered in line with the ACMD's standard operating procedure for quality of evidence.

Appendix B – ACMD's Recovery Committee membership

Annette Dale-Perera Chair of ACMD's Recovery Committee and ACMD member (until January 2019)

Dr Emily Finch Co-chair of ACMD's Recovery Committee (from January 2019) and ACMD member

Dr Anne Campbell Co-chair of ACMD's Recovery Committee (from January 2019) and ACMD member

Professor Harry Sumnall ACMD member (until January 2019)

Professor Tim Millar ACMD member

Rob Phipps ACMD member

Dr Kostas Agath ACMD member

Rosalie Weetman ACMD member

Mike Ashton Editor, Findings

Mark Gilman Managing Director, Discovering Health

Chris Lee Public Health Specialist – Behaviour change, Lancashire County Council

Dr Tim Leighton Director of Professional Education and Research, Action on Addiction

April Wareham Independent consultant

Dr Emma Wincup Senior Lecturer in Criminology and Criminal Justice, University of Leeds

Appendix C – List of abbreviations used in this report

ACE	Adverse Childhood Experience
ACMD	Advisory Council on the Misuse of Drugs
BBV	Blood-Borne Virus
COPD	Chronic Obstructive Pulmonary Disorder
DRD	Drug Related Deaths
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
LDC	Least-Deprived Cohort
LGA	Local Government Association
LTBI	Latent Tuberculosis infection
MDC	Most-Deprived Cohort
MHCLG	Ministry of Housing, Communities, and Local Government
MoJ	Ministry of Justice
NAO	National Audit Office
NESI	Needle Exchange Surveillance Initiative
ONS	Office for National Statistics
PHE	Public Health England
SCRA	Synthetic Cannabinoid Receptor Agonist
SHARPS	Supporting Harm Reduction through Peer Support
TB	Tuberculosis
UC	Universal Credit

Appendix D – ACMD membership

Dr Kostas Agath Consultant Psychiatrist (addictions), CGL Southwark

Dr Owen Bowden-Jones Chair of ACMD, Consultant psychiatrist, Central North West London NHS Foundation Trust

Dr Anne Campbell Lecturer in social work and Co-Director of the drug and alcohol research network at Queens University Belfast

Mr Mohammed Fessal Chief Pharmacist, CGL

Dr Emily Finch Clinical Director of the Addictions Clinical Academic Group and a consultant psychiatrist for South London and Maudsley NHS Trust.

Mr Lawrence Gibbons Head of Drug Threat – NCA Intelligence Directorate – Commodities

Dr Hillary Hamnett Senior Lecturer in Forensic Science, University of Lincoln

Professor Graeme Henderson Professor of Pharmacology at the University of Bristol

Dr Carole Hunter Lead pharmacist at the alcohol and drug recovery services at NHS Greater Glasgow and Clyde

Professor Roger Knaggs Associate professor in clinical pharmacy practice at the University of Nottingham

Professor Tim Millar Professor of Substance Use and Addiction Research Strategy Lead at the University of Manchester

Mr Rob Phipps Former Head of Health Development Policy Branch, Department of Health, Social Services and Public Safety, Northern Ireland

Mr Harry Shapiro Director - DrugWise

Professor Alex Stevens Professor of Criminal Justice, University of Kent

Dr Richard Stevenson Emergency Medicine Consultant, Glasgow Royal Infirmary

Dr Paul Stokes Senior Clinical Lecturer in mood disorders, King's College, London

Dr Ann Sullivan Consultant physician in HIV and Sexual health.

Professor Matthew Sutton Chair in Health Economics at the University of Manchester and Professorial Research

Professor David Taylor Professor of Psychopharmacology, King's College, London

Professor Simon Thomas Consultant physician and clinical pharmacologist, Newcastle hospitals NHS Foundation Trust

Dr Derek Tracy Consultant Psychiatrist and Clinical Director, Oxleas NHS Foundation Trust

Miss Rosalie Weetman Senior Commissioning Manager of Substance Misuse