# Working in isolation

The links between homelessness and drug abuse are damaging, self-perpetuating and well-documented. Yet homeless drug users often find their escape route hindered by a divided system. **Esther Sample** investigates.

It's that time of year when people are making ambitious resolutions for the New Year: quitting smoking, losing weight, exercising every day. But when on New Year's Day people sober up to the commitment they have made, they should spare a thought for the government, who in 2008 committed to the ambitious target of ending rough sleeping by 2012, and now have only two years to go.

With the festive period over and the Christmas shelters closing, another year begins and many frontline homelessness workers will face the same frustrations as last year, as they try to support their clients with drug and alcohol problems through treatment and into housing.

A report published last year by the charity Homeless Link found that 42 per cent of people attending homelessness projects have a drug problem, and 39 per cent have an alcohol problem.

But while a large proportion of drug users say a lack of stable housing is the main barrier to breaking addiction, most mainstream housing providers will not take on this client group. Whether rough sleeping, 'sofa-surfing', living in squats, temporary accommodation or hostels, the reality is that homeless people with substance misuse issues often remain stuck in the homelessness system, unable to work towards recovery.

The government's rough sleeping strategy includes a welcome commitment to support the development of 'joined-up solutions to help drug misusing clients to access treatment and the wider health, housing and other support they need to re-establish their lives'. Improvements have been made over recent years and many drug, alcohol and homelessness services have built strong partnerships.

For example, Turning Point's Hungerford Drug Project provides a satellite service of advice or treatment in a number of homeless day centres and hostels in London. Some organisations, such as drug and alcohol service Foundation66 – which has housing and homelessness services as part of its treatment provision – have also developed integrated services

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However, the annual update report released in November 2009 makes no mention of progress against the 2012 target. The problem of hostels becoming 'silted up', because of the lack of move-on accommodation available to residents still remains, and the patchy coordination between the drug sector and homelessness or housing providers plays a key part in this scenario.

Dan works in one of London's busiest hostels and has been working with homeless drug users for 15 years. He says more help is needed from treatment providers for preparation work with clients at the 'pre-detox' stage. It is usually a hostel worker that a resident will first talk to about detox, usually 'on a bad day'. And it is at that point, says Dan, if the resident is ready, that hostel workers need swift support from drug and alcohol services – so that treatment can be set in motion.

Unfortunately, most people have little choice but to return to their hostel following drug detox, where, according to Dan, "nine out of ten" clients will relapse because of triggers within the hostel environment. Progress is hindered further by the rise of poly-drug use among the homeless population.

"There are very few places where clients can stabilise their alcohol use while containing the chaos of the crack and heroin use," Dan points out. "For people who can be injecting six times and drinking anything up to five bottles of sherry a day, you need to have a safe environment to take away one of these addictions first, to have a chance to addressing the others."

Many residents who manage to access alcohol detox end up returning to their hostel only to use crack – and to ease the comedown – heroin and alcohol. "Within 48 hours of returning to the hostel, they are walking around with a can in their hand," says Tracey, who works at another hostel in the capital. She says drinking does not immediately go back to pre-detox levels, but adds that within six months of their return to the hostel, many service users will be "back

to square one".

Despite the revolving door between hostel and detox, there have been some success stories of people getting treatment and then moving into their own housing. These mainly involve those, post-detox, who want to go on to rehab and whose funding comes through quickly.

Dan says that local authority coordination around housing following treatment has improved. Now, if an individual accesses rehab outside their authority area, within six months they will be seen to have a 'local connection' and their 'vulnerable adult' status will allow them to access social housing or private rented sector schemes in the new authority.

But if someone relapses and is excluded from residential treatment, the safety net disappears. When someone goes for detox, the hostel holds the bed for that person. Yet if they enter the longer process of residential treatment, their bed is forfeited. So when the treatment fails, "in the majority of cases they are then out on the street", says Dan. They will usually end up sleeping rough for a while and then apply to get a bed at the hostel again.

"There is nothing worse than residents who may not have had any positivity in their life, trying treatment – but then being excluded," says Dan. "The amount of people who come back to the hostel full of anger, self-hatred and loathing, feeling that they have failed, and thinking 'right, that is all I am, I am a junkie and an alcoholic', is shocking." Dan says often his clients fail "not because they are not ready, but because the treatment is not specialised to that client group's needs".

There is a general feeling among those working with homeless people that drug and alcohol services are set up mainly for those with less chaotic lifestyles. For example, drug and alcohol service workers often have high expectations in relation to money management and travelling to specific appointments, which might not be so easy for someone who has lived on the street for a long time. It can be the case that less chaotic residents receive their script from a nearby GP, while those with higher support needs, some who have multiple leg ulcers, have a 40 minute walk to a more intensive treatment centre.

If there is no scope for specialist scripting services to be developed closer to certain areas of homelessness provision, then arrangements are clearly

needed around funding for taxi fees or specialist transport. Equally there is a need for increased coordination around weekend care. If a resident misses their script on a Friday, they then can become very ill over the weekend and the hostel workers can be powerless to help. People can resort to street methadone and other drugs and put themselves at risk of overdose. This is a particular issue for new residents who arrive at the hostel on a Friday evening, something that is common with people who have just been discharged from prison.

Rough sleepers with dogs have for a long time faced extra barriers in trying to access services, because hostels do not permit pets. Now, many hostels have a certain number of beds allocated to people with dogs. But despite this, the dilemma still persists. "I've got a client who wants to access treatment services and is ready to do so," says Tracey. "However, she will not leave her dog as it is all she has. The local authority substance misuse team suggest that if she wants treatment bad enough, she can put her dog into kennels, but I know this is something she will never accept."

There is clearly a need for improved cross-sector working on the frontline, as well as at strategic level. This need is particularly pronounced in London, where according to an official street count carried out in September last year, more than half of Britain's rough sleepers can be found. A new London Councils-funded second tier support project delivered by the London Drug and Alcohol Network (LDAN – part of DrugScope), Shelter and Homeless Link seeks to foster new partnerships between homelessness and housing and drug and alcohol organisations in London.

Paul Anderson, head of Homeless Link's London team says: "Alcohol and drug misuse issues are two of the most prominent causes and effects of homelessness. We believe that our new working relationship with LDAN/DrugScope under the London Councils funding programme will mean we can, as a partnership, support front-line agencies to provide the full range of services to vulnerable people who face both accommodation and substance misuse problems."

LDAN's key role in the project is to coordinate a drug and alcohol peer support forum for homelessness workers. At the first forum meeting in October last year, around a third of workers attending felt that they did not have a good level of awareness of the drug and alcohol services available to their clients. The forum aims to facilitate cross-sector knowledge sharing and partnership development, and to help homeless people with drug and alcohol problems work towards housing, social re-integration and recovery.

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