Issues in Recovery

Housing and Recovery

Adfam
Families, drugs and alcohol

1. Overview and statistics

In September 2015, the Recovery Partnership held a roundtable discussion on housing and recovery in Newcastle, with participants present representing substance use and housing related services in the North East of England. This paper begins with an overview of the topic, examines the relevant policy context, and presents quotes, key themes and issues discussed at the roundtable, along with information and commentary from research literature.

Homelessness prevalence

Homelessness exists in several forms, from rough sleeping at the most extreme, to households considered statutory homeless and provided with temporary assistance by local councils, and the 'hidden homeless' who are able to stay with family or friends, 'sofa surfing', or squatting. According to government statistics, the number of rough sleepers in England has risen dramatically in recent years, from 1,768 in 2010 to 3,569 in 2015, an increase of over 100%. Every region of England apart from the North West had an increase in rough sleeping over that period, but the most dramatic rises were in the South East (167%) and London (127%), which also had the highest numbers (827 and 940) of people sleeping rough in 2015, respectively[1].

By Adfam on behalf of the Recovery Partnership

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Many more people are statutorily homeless than sleep rough. In 2015, 29,050 homeless applications were made to local authorities, and a total of 68,560 households were housed in temporary accommodation, a rise of 13% on the previous year[2].

It is likely that the number of people experiencing 'hidden homelessness' – meaning they are legally homeless but living outside mainstream housing provision, often staying in squats or sleeping on friends' sofas – is higher than those for statutory homelessness or rough sleeping. Research has estimated that 62% of all homelessness is hidden[3].

Homelessness, drugs and alcohol

Homeless people experience extremely significant health harms, and die on average 30 years younger than the general population. For homeless men, the median age of death is 47, compared to 77 in the general population. For homeless women, the difference is even starker, with the median age of death 42 compared to 83 in the general population[4].

Drug and alcohol-related health harms figure prominently among the homeless population – including being implicated in over a third of all deaths[5].

Problematic drug and alcohol use can both lead to people becoming homeless, and be a response to the difficulties of homelessness, used as a coping mechanism to relieve distress, pain and cold. As a result, rates of problem drug and alcohol use are high among homeless people; amongst rough sleepers in London, 53% have an alcohol problem and 39% a drug problem[6].

Among the homeless population in England, 27% report having or recovering from an alcohol problem, and 39% report taking drugs or recovering from a drug problem, while two-thirds of homeless people report drinking more than the recommended amount each time they drink[7]. Rough sleepers are much more likely to report an alcohol problem (44%) than those in hostels (31%), sofa-surfing or squatting (25%), in supported accommodation (21%) or emergency or temporary accommodation (18%). Using drugs or being in recovery from drug use is similarly more common among rough sleepers (54%) than those in hostels (46%), sofa-surfing or squatting (45%), supported accommodation (35%) or emergency or temporary accommodation (26%).

Housing situation in drug and alcohol treatment

In 2014/15, 141,646 people newly presented to adult drug and alcohol treatment services, of whom 9,055 (7%) had an urgent housing problem, with no fixed abode[8]. A further 16,009 (12%) had a current housing problem – for instance they were staying short-term as a guest with family or friends or in a hostel[9]. People seeking treatment for opiate problems were the most likely to have no fixed abode (12%) or a housing problem (15%), while those seeking treatment for an alcohol problem alone were the least likely – with 7% having no fixed abode and 12% a housing problem[10].

18,349 young people received drug or alcohol treatment in 2014/15, of whom 14,750 (82%) lived with parents or family. The remainder mostly lived in care (7%) or supported housing (6%), with 93 young people having no fixed abode (1%)[11].

Poor quality housing

Less is known about the impact of poor quality or insecure housing on rates of problem drug or alcohol use than outright homelessness, although this topic is attracting increasing attention. Research has linked housing conditions such as overcrowding, damp and mould, indoor pollution, infestation, cold temperatures, a poor state of repair and noise with a variety of both physical and mental health impacts, including anxiety and depression[12]. Given this known relationship, a link with drug and alcohol use may also be possible — anxiety and depression are the most common metal health problems associated with substance use, and can both follow from and precipitate substance use – whilst around 40% of mental health service users use drugs or alcohol problematically[13].

Over 14 million people in England live in homes that are either overcrowded or classed as non-decent, representing 29% of the population, with privately rented homes more likely to be overcrowded or non-decent (40%) than socially rented (31%) or owner occupied (25%)[14]. Homes in London were the most likely to be overcrowded or non-decent (35%), with the West Midlands and South West having the next worst rates (31%), and over 3.5 million children (30%) in England living in overcrowded or non-decent homes[15].

2. Policy context

2010 Drug Strategy

The 2010 Drug Strategy, whose successor document is expected to be published in spring 2016, is the current overarching government drugs policy strategy, and details the government's plans and efforts to address three core areas; reducing the demand for drugs, restricting the supply of drugs, and building recovery in communities[16]. The strategy calls for a 'whole system approach' to recovery, with local commissioners and services working together to deliver support throughout the recovery journey, and recognises that recovery from problem drug use will involve housing services among a range of broader services including employment, education, family support and criminal justice. The strategy acknowledges both that homelessness and poor quality accommodation are more common among people with drug or alcohol problems, and that housing support improves treatment outcomes. The strategy also highlights that a failure to provide individuals dependent on drugs and alcohol with housing can have additional negative consequences for local communities, for example, drug-related crime, street drinking and begging[17].

The 2010 Drug Strategy states: "Evidence suggests that housing, along with the appropriate support, can contribute to improved outcomes for drug users in a number of areas, such as increasing engagement and retention in drug treatment, improving health and social wellbeing, improving employment outcomes and reducing re-offending"[18].

2012 Alcohol Strategy

The 2012 Alcohol Strategy is the most recent overarching government alcohol policy statement[19]. There is little focus given to alcohol dependency, treatment

and recovery, with the document instead focusing attention on alcohol-related crime and disorder, the night-time economy, young people, and binge drinking[20]. Accordingly, there is very little mention of housing, the only exception being a reference to the then new Health and Wellbeing Boards and their ability to work to improve the wider social determinants of health[21].

Supporting People

In housing policy, the Supporting People Programme; known formally as Housing Related Support, was first introduced in 2003 to provide 'a better quality of life for vulnerable people to live more independently and maintain their tenancies'[22]. Initially, the programme was financed by a £1.8 billion annual allocation to local authorities around the country, and resulted in the provision of housing related support to 1.2 million vulnerable people[23]. This included assistance for young people leaving care, people leaving institutional settings such as prisons, and those who had previously been homeless, and was designed to help them to learn new skills and adjust to living independently[24]. While definitive criteria were not set, examples of potential beneficiaries of the scheme provided by the government included those with drug or alcohol addiction. Supporting People Programme funding fell almost every successive year from its inception until 2014/15, by which time it was just below £1.6 billion[26].

Recent homelessness policy

Unlike with drugs and alcohol, there is no one current overarching government policy strategy on homelessness. Under the 2010-2015 coalition government an inter-ministerial working group on homelessness produced policy reports including 2012's *Making every contact count: A joint approach to preventing*

Case Study: Housing First England – Homeless Link

Homeless Link is the national membership body for the homelessness sector in England. We support and represent over 550 organisations providing services to single homeless people.

We know that people with chronic substance use needs, who are not usually found eligible for housing under statutory homelessness legislation, also struggle to access or sustain other forms of accommodation. They regularly end up entrenched on the street, stuck in cycles of repeat homelessness or living in other precarious situations. The current system which expects a level of 'housing readiness', or willingness and ability to engage with support to obtain housing, does not always work for these individuals.

Housing First is an approach widely used across North America that provides accommodation directly to the individual regardless of their level of engagement in addressing any other needs they might have. The housing is not conditional on the individual addressing their substance use needs but intensive support is offered and provided for as long as they need it.

Housing First England is a new project which aims to embed Housing First as a viable, widespread and evidence-based housing option across the country. We will support local and national partners to deliver, evaluate and replicate Housing First and encourage a cultural change in service provision for the most disadvantaged.

Jo Prestidge, project manager, Homeless Link, said: "We are really keen to ensure there is a variety of housing options available to all single homeless people in England. We know that some people are not ready, or able, to tackle their substance use before they are housed. The Housing First model offers people security and stability from which to begin their recovery".

For more information and to sign up for the mailing list, please visit:

www.homeless.org.uk/our-work/national-projects/housing-first-england

homelessness, which detailed prevention approaches[27]. Other recent efforts to combat rough sleeping include StreetLink[28], a government funded project administered by Homeless Link and St Mungo's to allow the public to alert local services when they see people sleeping rough, and No Second Night Out[29], a project in London first piloted in 2011 and then rolled out nationally, which aims to ensure a rapid response when people begin to sleep rough.

In 2015/16, a £40 million capital fund was announced for new programmes aimed at addressing homelessness, divided into 'Homelessness Change' projects to improve hostel accommodation and healthcare services for rough sleepers, and 'Platform for Life' projects aimed at helping young people at risk of homelessness[30]. Eight million pounds was also invested between 2014 and 2016 as part of the Help For Single Homeless scheme, which aimed to improve support for people not eligible for the main homelessness duty – primarily single people without dependents[31].

3. Key themes and issues from the roundtable discussion

Regional differences and housing location

Roundtable participants noted the importance of regional differences in housing availability and markets – not just between the major regions of the country, but also at a more micro level. For example, it was noted that in Northumberland, a serious lack of affordable one bedroom housing presented difficulties securing accommodation for people with drug or alcohol problems, whilst in Middlesborough there was a surfeit.

Participants recognised that the lower costs of accommodation in the private rented sector compared to London and the South East meant that this sector was a viable avenue for finding housing for people in recovery, and productive relationships with private landlords had been built.

Understanding these regional differences and effectively tailoring service response was felt to be key. The previously mentioned difference between Northumberland and Middlesborough has led to people being transferred from the former to the latter. This may cause negative effects: loss of contact with local services, a loss ofpositive social relationships, for instance, which may impede to recovery or lead to transiency.

The potential impact of 'hyper-localism' was noted – with for example important policy differences between the nearby local areas of Gateshead, Sunderland, Newcastle, Durham and Middlesborough meaning that services may be unable to continue working with clients who have moved a short distance away.

The precise location of housing was also felt to be key. Simply ensuring that someone with experience of drug and alcohol problems has a roof over their head is not enough; it is essential to consider other location-based factors. People who have positive and supportive peer group and family relationships will benefit from living nearby, while some may benefit from living further from potential relapse triggers such as substance using peers.

Psychologically informed environments and trauma

Psychologically and trauma informed approaches to housing were also discussed. Since perhaps a majority of clients suffer trauma at some point, if their environments do not take this into account they may be 'set up to fail' in their recovery journey. Certain groups, including survivors of domestic violence and people who have been involved in sex work will be particularly likely to have experienced significant trauma, and staff will need to be able to use a trauma informed approach in supporting them. This involves the workforce behaving non-judgmentally, understanding the psychology of trauma and having the confidence to address it – even if workers do not have specific expertise in mental health or allied fields. Working in an area where they may be exposed to traumatic experiences regularly, staff themselves also need to be able to offload stress, address their own issues and access a support network[32].

A lack of psychologically and trauma informed environments can present a particular barrier to women accessing treatment – with one participant noting that there is a growing recognition of the number of women in substance use services who have been sexually exploited. Addressing this had required housing workers to both acknowledge the issue and change their approach.

Complex needs and services working together

The issue of service users with multiple and complex needs was discussed throughout. Continuing difficulties with getting services to accept people with a dual diagnosis of substance use issues and mental ill health remain – with the

work of Making Every Adult Matter and Fulfilling Lives in addressing this highlighted as crucial. There was a consensus that when clients do have multiple needs, these must be addressed in the round, and to do this, different agencies must work closely together.

"You need to get everyone in the room together, discussing one person and their needs."

Some participants noted that labels such as 'hard to reach' should not be accepted unquestioningly, and that services should think about whether they are in fact 'hard to access' for certain groups.

Some substance use and housing services had found it hard to work with refuges which specify that women entering the service must be drug and alcohol free, leaving little support for women with substance use issues.

Housing in the early stages of treatment and recovery

Previous research has identified a particular lack of suitable accommodation for people in the early stages of treatment and recovery – a time when it is especially fundamental[33]. Roundtable participants noted that early recovery may be fragile, and can be especially threatened by a lack of appropriate housing. This could well pose a problem, since in 2014, 40% of accommodation projects refused access to people who were intoxicated by drugs and alcohol, an increase from 22% in 2012[34].

"If the type and location of housing support is inappropriate, recovery gains can easily be lost. So housing needs must be assessed at every stage."

Many treatment services have historically insisted on a condition of abstinence from drug and alcohol use – or at least significant engagement with treatment services and some progress towards recovery – before supporting clients to access housing services.

One initiative that takes an opposite approach is Housing First. Originally developed in the USA, and now being used or explored by many UK services, Housing First focuses solely on a service user's accommodation situation and does not require them to address any wider social issues, including substance use or employment[35].

This reversal – treating housing before substance use needs – is partly evidenced by findings that interventions requiring or promoting abstinence tended to have higher dropout rates and lower success rates than those with less strict conditions[36].

"Most areas are not following Housing First type approaches, so substance use does lead to tenancies being terminated."

On the spectrum between approaches requiring abstinence before addressing housing needs, and Housing First type approaches, are harm reduction or stepped approaches. These acknowledge that some level of substance use can be expected, and services may attempt to manage and reduce substance use related harms without removing people from housing, with an emphasis on a step-by-step process, working towards recovery. Shelter have adopted an approach that accepts the inevitability of substance use in homeless hostels, but does not take a laissez-faire approach; instead aiming where possible to reduce substance use and harm without excluding people who use drugs or alcohol[37].

Access and barriers to housing

Welfare benefit changes were mentioned by many roundtable participants as threatening access to housing for people in recovery, with benefit sanctions and a lack of flexibility seen to be affecting both housing and wider recovery outcomes.

Financial pressures on local authorities were also cited as having a negative impact on housing availability, and there were marked concerns about the future availability of social housing decreasing due to policy changes including an expansion of Right to Buy. It was felt that in many cases it may be left to the voluntary sector to respond creatively to these pressures.

"There is actually an opportunity in the cuts to get services to work together – the motivation may be cost savings but if housing workers are also doing substance misuse and mental health then that can be a good thing."

Case Study: Fulfilling Lives Newcastle Gateshead

Fulfilling Lives Newcastle Gateshead provides a 'navigation model', directed at navigating people from service to service across substance use, mental health, offending and homelessness sectors. The service includes 12 navigators, who sit within one of six charities across the area, and three system brokers who sit with each of the three core partners.

The work of the navigators is to enhance current provision by supporting people with multiple needs to engage effectively with multiple services. Whilst we do not provide interventions that would duplicate work, we communicate with services to enhance understanding and expectations from a client perspective. and at the same time communicate service expectations and limits to service users.

Whilst navigating the system, navigators identify 'blockages'; which is where the broker role comes in. The broker role is a two part role; partly operational, involving daily contact with navigators, and partly strategic, involving liaising with service managers, communicating with commissioners and feeding into Heath and Wellbeing Boards. Blockages range from local area connection, a lack of provision for older people with multiple complex needs to dual diagnosis and statutory services not engaging with clients who present with overlapping needs.

We start with a referral by contacting all the different services and finding out if the client is already known to them or not. Thirty-three per cent have been known to homeless services, 97% to substance misuse, 94% to mental health and 35% to offending.

We currently have three reference groups. Number one is our Experts By Experience group, of people with lived experience who head up the programme, constantly evaluating the system and feeding into practice. Second is our operational group, of service managers and team leads from across the area involved within all four silos. The aim of this group is to both explore blockages identified and consult on how better future working together would look. Third is the strategic group, of Chief Executives from both statutory and voluntary sectors, who have the ability to change policy if needed.

Richy Cunningham

www.fulfillinglives-ng.org.uk

A major barrier to those in recovery accessing housing can be the lack of a successful tenancy history, with failed tenancies or a history of anti-social behaviour making housing providers wary. An inability to meet the administrative requirements of housing services can also cause difficulties, with people moving frequently and being unable to provide essential documents or recall information such as occupancy dates[38]. A lack of appropriate housing was also cited as problematic, in particular for women who had previously been victims of domestic violence, being unable to access women-only housing.

Standards, behaviour and boundaries

Participants discussed how to address the risk of people in recovery losing tenancies after breaching conditions related to their behaviour.

Many noted the importance of continuing to provide support after people had been placed in housing, rather than 'walking away' after a referral had been made.

While the importance of setting boundaries for behaviour and challenging tenants was noted, it was stressed that people should not have tenancies automatically removed as soon as a rule is broken. Instead, a 'braver' approach can work well, with service users being given the opportunity, space and understanding to re-examine their attitudes and behaviour.

"You need to set boundaries, but expect them to be tested. Challenging tenants can lead to resentment but be worth it in the long run – if this can be done by peers with lived experience it makes a big difference."

Roundtable participants had experienced success in reducing failed tenancies by liaising closely with landlords and housing providers – including estate agents and the private rented sector – building up relationships, and providing reassurance that tailored support was available for tenants that would help address any substance related issues that arose, and in doing so could alleviate landlords' concerns.

Nonetheless, expectations may also need to be managed. For those with complex needs or chaotic lifestyles, practitioners should work with landlords to

ensure they do not have unrealistic expectations that those accessing their housing will become ‘model tenants’ overnight.

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Appendix

The roundtable discussion to inform this briefing took place on 29 September 2015 at the Castle Gate in Newcastle, with a regional focus on North East England. Other roundtable meetings in this series focus on learning from London, North West England, South East England and the West Midlands. We would like to thank the participants of the roundtable for their valuable contribution to this briefing, and Maya Dhokia for her research and literature review.

Attendees:

Richy Cunningham, Fulfilling Lives

Hannah Taylor, Changing Lives

Charlotte Hunter, Changing Lives

Lindsay Henderson, Homeless Link

Dot Turton, Hope North East

Carole Windsor, Hope North East,

Andrew Burnip, Crisis Skylight Newcastle

Rob Bailey, Tyne Group

Debbie Farquarson, First Contact Clinical

Caroline Shaw, Neca Family Carers

Brian Hindmarsh, Counted4/The Birchtree Practice

Steven Elliot, Lifeline Project

John Liddell, Public Health England

Kerry Anderson, Stockton Council

Mark McCaughey, Gateshead Council

Claire Thew, Gateshead Council

John Doohan, Phoenix Futures—Tyneside Resettlement Service

Mark Roberts, Lifeline Project

Leanne Kelly, ESCAPE Family Support

Mark Tunney, Fulfilling Lives

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About Adfam and the Recovery Partnership

Adfam is the national charity working to improve life for families affected by drugs and alcohol. Adfam provide information and training to practitioners and local authorities and our work also concentrates on piloting and disseminating good practice, representing the views of family members to decision makers and influencing local and national policy. Adfam is a registered charity (number 1067428).

More information on Adfam's work may be found at www.adfam.org.uk

DrugScope, the Recovery Group UK (RGUK) and the Substance Misuse Skills Consortium formed the Recovery Partnership in May 2011 to provide a new collective voice and channel for communication to ministers and officials on the achievement of the ambitions set out in the 2010 Drug Strategy. Following the closure of DrugScope, Adfam joined RGUK as a lead delivery organisation of the Recovery Partnership's programme of work. The Recovery Partnership is able to draw on the expertise of a broad range of organisations, interest groups as well as service user groups and voices.

Further information is available at: www.recovery-partnership.org

For further information about this briefing please contact:

Oliver Standing

Director of Policy and Communications

o.standing@adfam.org.uk