



HOMELESS LINK

SUBMISSION TO THE 2010 DRUG STRATEGY CONSULTATION

SEPTEMBER 2010

Homeless Link is the national membership organisation for agencies working with people who are homeless across England. We have more than 490 members, whose services range from local authority housing services, day centres, outreach services, residential care homes, hostels, supported housing, floating support through to employment, training and education.

We welcome the publication of the Home Office consultation paper and the opportunity to engage with the proposals at this early stage of the reform. The delivery of drug policy in England is of key concern to our members. Our most recent survey of the sector showed that 91% of member agencies work with clients affected by drug problems. Drug misuse can be both a cause and result of homelessness, and due to the complexity of the needs, people who are homeless can face additional barriers to accessing the treatment and services they need.

To inform this response, we consulted with our member agencies and their service users via a short online survey. We draw on their experiences and views throughout this submission.

We have focussed our response on the questions which have most relevance on drug users who are homeless.

VISION FOR THE NEW STRATEGY

A1, A2 and A3: Priority areas for reducing drug use

We welcome the broad principles outlined in the strategy document. In particular, we welcome the focus on taking a holistic approach to drug use, with issues being tackled alongside housing, health and employment. We strongly believe that drug use cannot be tackled in isolation from these issues which often underline and interlink with an individual's drug problem. In particular, we feel it is very difficult to reduce, prevent or stop somebody's drug use without stable and appropriate accommodation to underpin their recovery.

This view was strongly held by our members who felt the focus on a holistic approach was the most important. They felt the next priority was a greater ambition for individual recovery alongside thorough treatment alongside reducing crime, whilst preserving harm minimisation techniques which have contributed prevention of hepatitis and HIV. We believe that future drug reform must place the individual and the package of support they require at its heart if it is to achieve the wider outcomes of reducing financial costs and the costs to our communities.

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Research¹ commissioned by Homeless Link looking at housing pathways indicated that when considering drug treatment for individuals, the location, appropriateness and stability of accommodation had a significant effect on treatment outcome and abstaining in the long term.

In a 2008 study, having 'reasonable accommodation' was cited as having a positive impact on clients ability to sustain recovery for 89.8% of the sample (17.6% helped a little, 26.1% quite a lot, 46.1% a lot).² In the same study housing mobility was also identified as a key factor for sustaining recovery with 83.9% of the sample stating that 'moving away from drug using friends' as a key element of continued recovery (5% a little, 18% quite a lot, 60.9% a lot).

This is a key issue which requires coordination of different government departments' policies. For example, the proposed reforms to housing benefit to be enacted by the Department of Work and Pensions, most notably the its link to the Consumer Price Index and the calculation of the maximum local allowance based on the 30th percentile of local property prices could see individuals in early recovery housed in areas that are entirely unsuitable to vulnerable individuals in the process of making profound changes to their lives. This is in addition to ongoing challenges around stigma (including 'not in my backyard' perceptions) faced by drug users in recovery.

PREVENTING DRUG USE

B1&B7: the most effective ways on preventing drug and alcohol use

We welcome the inclusion of a specific focus on preventing drug use. However, we urge the new strategy to give greater weight to the recognition that prevention strategies need to consider the full range of factors which lead to drug use. While interventions during adolescence are certainly important, many of the factors which cause drug problems are linked to wider factors such as domestic violence, poor housing, abuse and mental health. As such, we call on the new strategy to link into these wider agendas and ensure cross-cutting work is effective.

In terms of specific ways to prevent drug and alcohol use, the new strategy could consider the following:

- The ethos of the 'right services at the right time' should lie at the heart of prevention activity. While the prevention of drug use among young people is important, prevention activity must encapsulate a wider remit, in particular the prevention of relapse or escalation of drug use. Timely interventions are therefore needed at known 'trigger points'. It is vital that staff working with vulnerable people – within treatment or advice services but also wider support such as GPs or employment services – can identify these trigger points and provide effective support to enable the individual to access the right services. Simple signposting is frequently not adequate to engage a vulnerable individual with a substance use need. This needs to be recognised so that more intensive support can be resourced – engaging an individual early on will prevent far more costly impacts further down the line.
- Our members agreed that awareness campaigns have a role to play, but that these need to be targeted in the right way to people who may not be engaging with mainstream services or information channels. They stressed that any awareness activity needed to include harm minimisation, and that the

¹ Homeless Link (2007) *Clean Break - Development of integrated housing and care pathways for drug users – Research Report*

² Best. D (2008) *The Politics of Recovery*

involvement of peer mentoring and peer support can lead to more effective outcomes. Self help and peer support are highly effective and affordable techniques for addressing addiction. We would therefore recommend that the portion of the DIP Main Grant that is set aside for peer support and relapse prevention be protected.

- We support the call from a number of organisations in the sector to look at minimal pricing for alcohol, particularly 'super-strength' alcohol.

B2: Who (or which agencies) are best able to prevent drug or alcohol misuse?

Prevention activity must be seen as a role for a wide number of agencies which work with people at risk of drug use. We urge the strategy to consider the mutual benefits which prevention has on outcomes for other areas such as housing and criminal justice – as such it should be seen as a joint responsibility which cuts across local and national agencies. The new role for Local Authorities around public health and prevention as outlined in the NHS White Paper offers an opportunity to build on this work in partnership with local voluntary sector agencies.

Whichever agency an individual approaches should be equipped to respond effectively to potential risk factors - whether this be a GP, employment advisors or tenancy support worker.

This ethos underlines the 'no wrong door' principle which offers a valuable approach the future strategy should consider. This principle recognises that an individual may enter a range of community services and that 'proactive efforts' are needed so the individual accesses further treatment or support. *"Each individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services".*³

The homelessness sector is well placed for this role. However, we also believe more responsibility and training should be encouraged in mainstream services like GPs so that they can respond to an individual appropriately.

In delivering prevention activity, we also draw attention again to the role of former or current drug users who can offer peer support and education. Advice or support delivered by those with first-hand experience can have a greater impact, and many homelessness organisations offer training to 'peers' so that they can fulfil this role. The role peers can play merits greater recognition and resourcing in future prevention strategies.

B3: Which groups should prevention programmes particularly focus on?

As above, we believe prevention programmes should be targeted at those more at risk to drug use due to underlying social factors such as housing need, family breakdown, poor mental health, and sex working.

B8: What barriers are there to improving drug and alcohol prevention?

One of the key barriers to effective prevention activity is that much of it is delivered when the individual has already reached crisis point – activity needs to be moved more upstream.

As above, engagement between drug services and housing services is important to provide this. For example, somebody's drug use habit may impact on their ability to manage their tenancy or engage in employment. Effective cross working between

³ Croton G (2006) CSAT 2000a

these services can prevent escalation of a problem and provide a window of opportunity for earlier intervention. In addition, it must be recognised that returning to independent accommodation following treatment (and following prison) is a particularly delicate time and crucial in preventing relapse. This is why housing and drug pathways must be considered in tandem, not just when individuals are in treatment, but also when considering effective prevention activities.

Practical steps such as basing services within the same premises, or drop-ins from a drug advisor within a GP surgery can make it easier for the individual to access the information needed either before their problem develops or as early as possible.

STRENGTHENING ENFORCEMENT, CRIMINAL JUSTICE AND LEGAL FRAMEWORK

C4: What forms of community based accommodation do you think should be considered to rehabilitate drug offenders?

There are many examples of community based accommodation projects for drug offenders. Projects should holistically address treatment and recovery alongside other needs such as housing, training and employment in order to achieve longer term positive outcomes.

Particular models to consider for this vulnerable group of people are dispersed units with floating support available, focusing on support around finance and independent living skills. It is important that individuals are not placed in hostels with current drug users, even when this is on a temporary basis. Both offending and drug issues are worsened by being placed in accommodation that is in known drug using areas, this should be a consideration when homelessness applications are assessed and post treatment support plans are developed. In addition, there needs to be the recognition that many of the support services available are crucial to the recovery, and alternative delivery methods should be considered, such as outreach and flexible appointment systems.

C7: Which partners – in the public, voluntary and community sectors would you like to see work together to reduce drug related reoffending local to where you live?

Partnerships between, and within, each of these sectors is crucial to reducing drug related offending. While there have been improvements around joint working with both commissioning and delivering services, this is patchy and inconsistent across different areas.

Homeless Link recently started a project to research how the criminal justice and homelessness sectors can work better together to reduce reoffending.⁴ 81% of agencies in the homelessness sector work with offenders, and much of this offending behaviour relates to drug misuse. Effective partnerships between criminal justice and homelessness agencies should underpin the approaches every local area takes when trying to reduce drug related offending.

Recent Homeless Link research showed that clients with multiple needs – such as substance misuse, offending behaviour and homelessness, do receive support from a number of different services. In each service the client will have a lead professional or keyworker assisting them with their progress. Unfortunately, good multi-agency working is not always available and thus the client is likely to have a number of

⁴ This project is funded by the Monument Trust. Please see www.homeless.org.uk/criminal-justice-project for further detail.

support workers who are not in contact with each other. This situation is further complicated by the different models that different support agencies use. For example, probation tends towards a risk minimisation model which may not be compatible with the recovery models used by many homelessness services and drug treatment services. Integrated working needs to include agreement on the support model on offer so that it complements each support need, rather than to confuse or stifle.⁵

We strongly welcome the focus on integrated working at a local level. To date our project has highlighted that joint working practice is not embedded in some areas and that communication problems persist. A lack of information sharing protocols and a lack of active communication between the agencies which are working with the same offenders were perceived as major barriers. The principles of the Integrated Offender Management System which formalises partnership working and joint case management of an individual should be seen as recommended practice. Without involving all partners – including substance use services, health, housing and criminal justice agencies - it is difficult to offer the coherent package of support which addresses all an individual's needs.

C8: What results should be paid for or funded?

We urge the new strategy to consider that outcomes relating to harm minimisation must be seen as desirable and valid alongside those which relate to abstinence. We urge that funding is protected for these results. Results which reward harm minimisation are needed not only to reduce the health risks and costs to drug users and the community, but also to motivate the individual toward continuing their journey of recovery.

Payment frameworks must also consider the time needed to address somebody's drug use, particularly when these lie alongside other complex needs such as mental health related problems. Recovery is unlikely to follow a linear path, and can be a long process. Milestones should therefore be built into the framework which recognise 'softer' outcomes such as reduced harm to self, and increased motivation. Payment By Results (PBR) should be based on a recognition that clients have diverse needs and capabilities and should therefore use a distance travelled model for gauging level of remuneration.

It is impossible to separate recovery from drug use from other support needs and goals. A good model for monitoring this is the Outcomes Star, a comprehensive tool for exploring and measuring outcomes in the homelessness service setting. Originally developed by Triangle Consulting for St Mungo's, the Outcomes Star has been subsequently widely tested and revised for the London Housing Foundation. The Outcomes Star has ten "ladders" which cover an individual's journey along motivation and taking responsibility, self-care and living skills, managing money and personal administration, social networks and relationships, drug and alcohol misuse, physical health, emotional and mental health, meaningful use of time, managing tenancy and accommodation, and offending.⁶

We also ask that the strategy recognises that a PBS framework needs to carefully consider the wide number of factors and agencies which contribute to an individual's recovery. The homelessness sector provides a range of employment and training, meaningful activity, advice and other services – in addition to accommodation- which, for example, have a huge impact on reducing drug related re-offending rates. We

⁵ Homeless Link (Sep 2010) *Criminal Justice and Homelessness Project – Client Focus Group Findings* (to be published as part of project report in early 2011)

⁶ www.homeless.org.uk/outcomes-star

believe that only with continued investment in these services can sustainable and cost effective outcomes be achieved.

REBALANCE TREATMENT TO SUPPORT DRUG FREE OUTCOMES

D1: Thinking about the current drug treatment system, what works well and should be retained?

Treatment works well when it is integrated into the wider support which an individual may require. It cannot work in isolation from the other factors which will impact upon an individual's recovery such as housing and health. Treatment works well when problematic drug use is conceptualised as one factor of a multifactorial problem.

The Places of Change programme⁷ facilitated a step change in the culture, ethos and quality of services for homeless people. This programme not only invested in the physical environment of services, but in the clients and staff, instilling a set of values focussed around an individual's potential to succeed: dynamic service user involvement, active promotion to ETE, and engagement with the community alongside treatment based services led to vast improvements in move-on and recovery rates. The holistic approach should be echoed in the way treatment is delivered.

In addition, treatment which is provided in accessible venues – such as GP- led shared care clinics, by satellite services in hostels – can reduce the stigma which can prevent people accessing the treatment required.

D2: Thinking about the current treatment system, what is in need of improvement and how might it need to change to promote recovery?

In our member consultation, only one individual felt the current treatment system works well for homeless people. A lack of availability of detox and rehab services, inflexibility of services to work with more entrenched and chaotic users, and a lack of integrated move-on options for people post treatment were some of the key challenges raised.

In 2004 the Audit Commission pointed to an overemphasis on treating drug addiction and a lack of emphasis on providing the support needed to bring order to the often chaotic lives of drug users. It concluded that housing, social care and other services must provide users with support to maintain progress made during treatment and ultimately help them become employed, housed and more self sufficient.⁸

Below are some broad themes we feel the new strategy should address in order to bring positive changes to the treatment system. Some of these issues are referenced in more detail later on in this section.

- Aftercare needs to be better tied into move on accommodation: if appropriate housing is not available, this makes it very hard for an individual to sustain recovery or other improvements gained through treatment. In particular, accommodating clients in recovery within projects which house current drug users is hugely detrimental to their chances of abstaining.
- While a drug free lifestyle may be the ultimate aim of many drug users, we stress the need for the new strategy to value harm minimisation and continue investment in harm minimisation services. Minimising drug related harm is often the first step of addressing drug use; many individuals have complex

⁷ www.homeless.org.uk/places-of-change

⁸ Audit Commission 'Drug misuse 2004' www.audit-commission.gov.uk

and high levels of support and reduction or abstinence will be a far more long term goal. Focussing solely on this will cause more chaotic and entrenched users to drop out of treatment altogether.

- In this vein, while community and residential rehab offers a vital treatment pathway greater contingency must be given to those who don't complete a full course of treatment. The distance travelled should not be 'written off' and services must ensure these clients are linked into alternative forms of ongoing support
- Drug treatment needs to be far better integrated into mental health services. Many mental health services are unable or unwilling to work with clients who use substances, yet the majority of homeless people present with multiple needs and addressing them in isolation simply does not work. Drug treatment providers need to be empowered to provide low level interventions, and dual diagnosis needs to be better recognised so that clients are not excluded from or passed between services to the point where their needs are at crisis point.
- There is also a pressing need to address the stigma aimed at people experiencing problems with drugs. A recent report by the UKDPC found that 70 percent of employers would be unwilling to employ an ex-heroin or -crack user even if they were no longer using drugs and had suitable skills for the position.⁹ It would be good to see an amendment to the Disability Discrimination Act that explicitly protects the rights of individuals recovering from a substance misuse problem.

D3: Are there situations in which drug and alcohol services might be more usefully brought together or are there situations where it is more useful for them to be operated separately?

Addressing drug and alcohol misuse will often require treating the same behaviour or underlying needs which caused the misuse in the first place. The focus should be more on the individual's needs and less about the actual substance – if treatment is provided in a personalised and holistic way, this should form a key part of the approach.

A recent audit of over 700 homeless people across England showed very high rates of different substances were used.¹⁰ It found that 13% use heroin, and the same number use crack/cocaine. It also revealed a high rate of formerly less common drugs such as benzodiazepines among the homeless population. In addition, many of these people used drugs alongside alcohol. While we appreciate the questions D4 and D5 seek to prioritise which substances should be treated, these findings only re-emphasise the very high and complex patterns of drug and alcohol use. We would suggest that treatment should not favour particular substances but should be able to respond holistically to the multiple needs and dependencies with which a vulnerable person may present.

D7: What more can be done to build on the skills of the drug treatment and rehabilitation sector to ensure they can meet the needs of those seeking treatment?

We strongly welcome the focus on up-skilling sector staff. Staff who have a genuinely person-centred approach, and who actively listen to and value the views of the user are crucial to engaging and supporting an individual. In particular, we would like to see an extension of techniques such as Motivational Interviewing and CBT. We

⁹ UK Drug Policy Commission 'Sinning and Sinned Against – the stigmatisation of problem drug users' 2010 http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final.pdf

¹⁰ 727 homeless people participated in the pilot of a new audit tool to gather data about health need, substance use and service access. See www.homeless.org.uk/health-needs-audit

would also welcome more opportunities for joint training and learning between those in the treatment, homelessness and criminal justice sector to enhance staff understanding about the needs an individual may have beyond those most easily associated with drug or alcohol use. Work shadowing, joint forums, and joint training can all contribute to this goal and should be structured into staff development on a wider scale. Drawing on the experiences and expertise of those who have completed treatment as part of this learning, as well as recognising this as a potential volunteering or employment opportunity for service users, should be encouraged.

D9: How do you believe that commissioners should be held to account for ensuring that outcomes of community based treatments, for the promotion of reintegration and recovery, as well as reduced health harms are delivered?

Commissioners need to recognise that achieving the outcomes listed above will be dependent on how well the full range of agencies are supporting an individual, such as health and housing. We would welcome greater emphasis and accountability for joint commissioning of services – e.g. accommodation based services – to support this goal.

Commissioning should be measured against outcomes which reflect the cross cutting nature of work with drug users. Indicators which measure quality of life, independent living, and the positive contribution an individual can make in their community should be encouraged as they reflect the holistic outcomes commissioners are seeking to achieve. Linking commissioning to the priorities identified in other local strategies – in particular the Joint Strategic Needs Assessment (JSNA) – should help ensure accountability and support areas to see where jointly commissioned services make sense. Voluntary sector agencies and service users should be integral to the JSNA process and have the opportunity to review commissioning plans to improve the level of accountability. As the NHS reform seeks to place users and services at the heart of measuring results, so should this focus be at the heart of outcomes for those in drug services.

E1: What interventions can be provided to better support the recovery and reintegration of drug and alcohol dependent offenders returning to communities from prison?

As outlined above, the new strategy must consider the crucial role accommodation will play in helping offenders re-integrate into communities and reduce their risks of re-offending.

At a local level, the housing needs of prison leavers must be at the centre of any discharge or resettlement plans, alongside measures to support them to engage with meaningful opportunities to help them return to employment or training. Currently, a lack of consistent support post-release, poorly resourced housing advice services in prison – which often are offered too late to help an individual plan their accommodation sufficiently – and a lack of integrated working by agencies in the drug, housing, and criminal justice fields undermine ex-offenders' recovery. In E2 we discuss further the different accommodation based interventions which the strategy could consider.

We suggest the new strategy strengthens the provision of more intensive support where it is required post release. Studies have shown that stable accommodation reduces the risk of re-offending by about one fifth.¹¹ Given the links between offending and drug use there is likely a positive correlation between stable housing,

¹¹ Office of the Deputy Prime Minister, Social Exclusion Unit (2002) *Reducing reoffending by ex-prisoners*, p.7

reduced re-offending and reduced drug use. When effective drug treatment or personal recovery is found in prison the individual is very vulnerable at the time of release and in the early days in the community to returning to old environments and behaviours. Careful support of accommodation need at this time can support ongoing recovery.¹² 'Through the gate' support, in which individuals are supported whilst in prison and then into appropriate accommodation by a single service, has been proven to result in positive outcomes.¹³

The new strategy could mainstream some of the schemes and services championed in the homelessness sector, such as 'through the gate'. Although these and similar schemes have demonstrated positive outcomes in helping individuals stick to treatment plans and obtain housing and employment outcomes, many of these services continue to be underfunded.

E2: What interventions could be provided to address any issues commonly facing people dependent on drugs or alcohol in relation to housing?

At a most fundamental level, we would like to see a national strategy which recognises that those who use drugs or alcohol have a vast range of housing related needs.

The strategy should focus both on preventing tenancy breakdown and loss of homes for those using drugs and alcohol problematically (please refer to comments in B2, B3 and B8), and on providing appropriate accommodation for those who are in housing need, both prior to, during, and following any treatment they may be engaged with. Appropriate accommodation in this context means sustainable, affordable, supported where needed, in a healthy and functioning community with good access to open access support services.

The clients supported by our members have vastly different and complex needs relating to drug and alcohol use, in addition to other support needs. Some are entrenched users with long histories of harmful substance use; others may be at different stages of recovery. Three quarters of single homeless people have a history of problematic substance misuse¹⁴ (rising to more than 4/5 of rough sleepers¹⁵). Drug users are seven times more likely to be homeless than the general population¹⁶, and more than 2/5 of single homeless people cite drug use as the main reason for

¹² Homeless Link (Sep 2010) *Criminal Justice and Homelessness Project – Client Focus Group Findings* (to be published as part of project report in early 2011)

¹³ St Giles' Trusts' Through the Gates programme's was shown to cut re-offending by 40%, and it would be reasonable to assume similar figures for this cohort on reductions in drug use. See

www.stgilestrust.org.uk/News/446435/economic_study_shows_support_for_prison_leavers_cuts_crime.html

¹⁴ Office of the Deputy Prime Minister, Homelessness Directorate (2002) *Drug Services for Homeless People* Office of the Deputy Prime Minister

¹⁵ Fountain J and Howes S (2001) *'Rough Sleeping, substance misuse and service provision in London'* National Addiction Centre, London

¹⁶ Kemp P et al (2006) *'Homelessness amongst problem drug users: prevalence, risk factors and trigger events'* Health and Social Care in the Community 14 (4), 319-328

homelessness.¹⁷ Two thirds report increasing problem substance misuse after becoming homeless.¹⁸

Therefore the types of housing interventions provided by our member agencies to this client group are wide ranging. We would like to see a strategy that recognises the interconnectedness of drug use and homelessness and promotes the value of accommodation based interventions in all drug treatment pathways.

In particular we would like to make the following points:

- Accommodation based services need to be appropriate for each stage of drug users journey to recover. If not, the recovery of individuals will be significantly undermined. For example, our members tell us that frequently the only accommodation for homeless people in recovery is back in a hostel which houses other drug users, greatly increasing the risk of relapse. The strategy could therefore consider:
 - the need for high support accommodation for those with drug needs, so that effective outreach and engagement can take place to encourage support;
 - accommodation for 'continued use', where work can take place with those who are working toward reducing their use;
 - accommodation for those who have stopped using - 'clean' provision.
- Achieving this needs a local area to have a good understanding of local need, and a flexible approach to commissioning. Our Clean Break toolkit enables commissioners and providers to jointly identify suitable accommodation pathways for drug users.¹⁹ Such assessments should be explored in every area.
- Putting in effective accommodation responses requires more creative solutions which are not restricted by a solely local perspective. Jointly commissioned services with other boroughs or authority areas, cross-boundary referrals, and the provision of more innovative types of accommodation (e.g. utilising the Private Rented Sector) should be encouraged.

E3: How might drug, alcohol and mental health services be more effective in working together to meet clients' needs?

As in D2, it is crucial that mental health and substance use services work in tandem and overcome some of the barriers which currently prevent those with a dual diagnosis (DD) getting the service they need.

Rates of DD are difficult to quantify, but our members report significant prevalence, and a St Mungo's client survey showed:

- 32% of homeless people have an alcohol dependency
- 63% have a drugs problem
- 49% have a mental illness²⁰

¹⁷ Fountain J et al (2002) 'Who uses services for homeless people? An investigation amongst people sleeping rough in London'. *Journal of Community and Applied Social Psychology*, 12:71-75.

¹⁸ Chamberlain C et al (February 2007) 'Homelessness in Melbourne' RMIT University, Melbourne

¹⁹ See www.homeless.org.uk

²⁰ St Mungo's 'Homelessness: It makes you sick' September 2008

Such figures indicate a major overlap between conditions. Despite this, many health services exclude clients as they fall beneath or above the threshold of need that they are willing or able to work with, or because they have continued substance use. We stress that if mental health is not addressed alongside drug use, it is unlikely to lead to recovery.

To improve this, we would like to suggest the following:

- The drug strategy recognises users with a dual diagnosis as one of the most vulnerable groups who face some of the most chronic exclusion from the services they need. We hope the drug strategy will complement and integrate with the forthcoming mental health strategy which we will also urge to prioritise action to improve access and availability of DD services.
- At a local level, increased access of DD services can be supported by more effective joint commissioning between mental health and substance use which recognise the shared outcomes they are trying to achieve.
- Joint working alongside this on the ground, which could include the use of common assessment frameworks, joint protocols and training between the mental health and substance use sectors.

In the homelessness sector, St Mungo's have developed good practice in working with people with DD in their Brent Dual Diagnosis project²¹:

The Dual Diagnosis project in Brent is unlike others in that it takes a holistic approach to helping people by considering their social, physical and psychological needs together and integrating psychotherapists and other professionals into an in-house support team.

This means that the person benefits from a tailored and personalised service within an ethos of all-round recovery. Clients mainly move into the project on discharge from psychiatric hospitals. Since St Mungo's introduced this model of working two years ago, there have been no rehospitalisations, and 17 out of 18 moves on from the project have been to independent or less supported accommodation.

E4: Do appropriate opportunities exist for the acquisition of skills and training for this group?

We feel there is a range of accessible opportunities available for some drug users – however in our experience these are not widespread or appropriate for all clients.

Our latest sector survey showed that 98% homelessness agencies could provide Education, Training and Employment (ETE) services for their clients, ranging from literacy and IT skills development, to accredited training and employment guidance.²² Our survey also found an improvement in training and employment related outcomes for this group, with 86% supporting clients back into work, and 91% supporting clients to achieve their desired training or education. Given the high number of clients in the homelessness sector with drug problems it is likely that many of these clients achieving these outcomes will be currently or formerly affected by drug use.

²¹ See www.mungos.org/press_office/636_brent-dual-diagnosis-project-earns-st-mungo-s-an-award-nomination

²² Homeless Link (2010) *Survey of Need and Provision*, www.homeless.org.uk/snap

However, many services do this with minimal resources. 45% agencies report problems accessing ETE services, due to lack of adequate internal resourcing, inadequacy of external services in addition to client motivation. As funding pressures put voluntary sector agencies under increasing strain, it is vital that funding for this wider work is protected.

The Places of Change ethos (see D1) was driven by a vision that every individual has the potential to play a meaningful role in society and it recognised that activities like ETE services were central to this vision. We would welcome a similar ethos and commitment to protect funding for these services in the new strategy, so that those agencies who are well placed to provide opportunities, in a way which we know is effective for particularly excluded groups, can continue.

E5: Use of sanctions

The use of sanctions would need to be approached with extreme caution. There is significant likelihood that such measures would be counter-productive and, in fact, be a disincentive for engaging with services at any level, further minimising access to treatment. The stress and sense of being 'given up on' induced in the individual by such measures is most likely to lead to debt and increased drug use, with accompanying risk of crime.

A key step into recovery for an individual with a drug problem is the insight to see that they have a problem and require help with it. Benefit sanctions are unlikely to contribute positively to this process. In the context of understanding addiction as an illness, benefit sanctions for those not seeking treatment are essentially punitive and unproductive.

We would welcome additional support through the benefit system for people taking steps towards recovery. Removing the requirement for vulnerable individuals to seek employment while undertaking drug treatment could possibly be extended those in the first six months of recovery as this is a key period where individuals lay down a firm foundation for recovery. Requiring individuals to enter the work place before they have had time to build up the necessary hard and soft skills could be detrimental to their prospects of long term recovery.

E6: What if anything could Jobcentre Plus do differently in engaging with this client group to better support recovery?

We think more could be done to give JCP staff a better understanding of the needs of those with current or past drug related needs. As we have outlined, it is likely drug needs are a symptom of other needs so advisors need to be aware of the complexity of need (such as their housing need or mental health) and the additional support an individual may require to re-integrate with the workplace.

A recent report by one of our member agencies, St Mungo's, found that the majority of clients felt JCP staff did not understand their needs, had not offered them suitable work and only a minority (18%) had found JCP training useful.²³ This suggests a concerning picture for vulnerable individuals. Homeless people with drug histories are likely to face additional stigma when returning to work (see D2), alongside possible skills gaps, health needs and a lack of confidence. We would welcome measures in the new strategy such as more specialist advisors, who are better able to understand and respond to the needs of this client group. In addition, outreach and

²³ St Mungo's (June 2010) *Work Matters*, <http://www.mungos.org>

joint working with agencies in the homelessness sector should be more actively encouraged to foster links and share expertise.

E7&E8: What are the barriers to employment for this group, and what interventions are most effective?

The strategy should also consider the full range of interventions including volunteering, skills development and meaningful activity which support an individual's potential to work and see the value of these taking place before and alongside treatment, as well as at later stages of their recovery.

This is a principle underlining the approach many homelessness services already take as it motivates and focuses on somebody's assets, not just their needs. It is vital funding for such services is protected.

Employers have a critical role to play and we would welcome more efforts to mainstream opportunities to these clients. In some cases incentives and training are required so that employers are encouraged to take on those with drug needs and see the benefits that providing meaningful opportunities can have for both the individual, their organisation and the wider community. Government initiatives would be welcomed to help push forward this agenda.

Many homelessness services take the lead on working with clients to break down the barriers to employment. These schemes generally share a personalised and flexible approach which is often delivered in the accommodation service directly. Dedicated staff are able to provide one-to-one support especially where longstanding support needs have interfered with education and the development of core skills in literacy and numeracy. Such schemes will need dedicated support from the Department for Education and the Department of Work and Pensions to continue in a changing funding landscape.

ETE models which move ex-service users into employment in the sector have also proven successful. One such model, the Giving Real Opportunities for Work (GROW) Project, works with people who have had experience of homelessness to provide the training and support needed to enter employment in the sector. The model has two strands, beginning to work with service users and the organisations themselves to effect change:

- Identifying and overcoming the organisational barriers that previously prevented the employment of current and former service users, including revising employment policies and procedures and changing staff attitudes from an 'us and them' to an 'us and us';
- Developing routes into employment for service users including a volunteering scheme and traineeships.²⁴

Such models are eminently transferable and, indeed, already include people with a history of drug issues.

²⁴ The GROW Project is delivered by Thames Reach, with funding from the CLG and support from Homeless Link. Please see <http://www.thamesreach.org.uk/what-we-do/user-employment/national-grow-programme/>