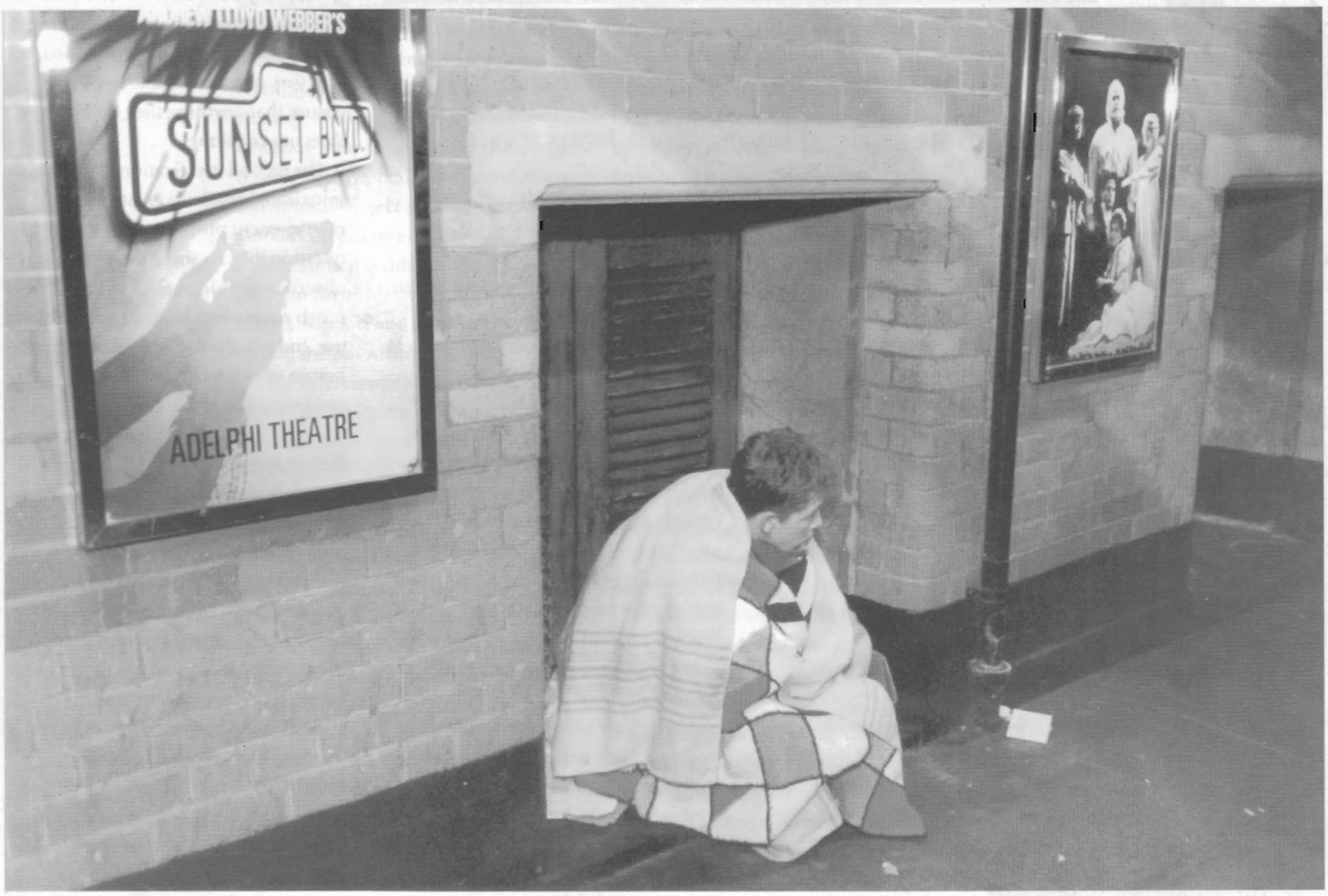
Toby Seddon

Out in the cold

Drugs, homelessness and social exclusion



Good things come in threes. *Tackling Drugs to Build a Better Britain* positioned drugs firmly in the context of social exclusion. Then, the ACMD's *Drug Misuse and the Environment* report had a chapter on housing and homelessness. And now, Keith Hellawell has a buddy – the homelessness czar. Proof, if ever it was needed, that drugs and homelessness are irrevocably linked. So the policy's there – but what about the practice? Here, Toby Seddon draws on new research to examine some of the practical issues faced by homelessness and resettlement services when faced with drug-using clients

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Homelessness is the sharp end of social exclusion. Lack of housing is often compounded by exclusion from health services, employment and many of the other things we consider central to a decent quality of life.

It is widely believed that levels of drug use are exceptionally high among young homeless people. The research evidence for this, however, is both scarce and equivocal. Although some studies have found extremely high prevalence rates,[1,2,3] others suggest that levels of use are pretty much the same as for comparable groups with a

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home.[4,5] But 'raw' prevalence is perhaps not the best indicator of a problem: there is some evidence that whatever the prevalence rate, levels of consumption are higher among homeless people.[6] In other words, homeless drug users take more than other drug users and have more problems. What is certainly clear is that hostels and other homelessness services come into contact with significant numbers of people with drug problems.[7,8,9]

As for any association between drugs and homelessness, while everyone agrees that somehow they are connected, the precise nature of this link – do homeless people try to blot out the world or do chronic addicts end up on the streets? – is uncertain. No UK research has focused fully on this question but the indications are (as would be expected) that the relationship is a complex and interactive one.

Nobody wants me

That said, in practical terms, for most homeless people with drug problems, especially those sleeping rough, meeting housing needs is the immediate priority. Once a stable housing situation is assured, then – and only then – can a drug problem even begin to be addressed.[10] However, a qualitative study of resettlement projects has found that for drug users, getting access even to temporary or emergency accommodation can be difficult. And with well under a dozen spare beds in the capital at any one time, the system is already operating at full capacity.

This research, carried out by the National Homeless Alliance, shows that direct access hostels often have strict screening procedures which exclude anybody identified as a drug user. Many also have exclusion policies for residents which mean that any use, dealing or possession of drugs leads to eviction.

The consequences of such policies are swift and significant. Firstly, they result in many homeless people with drug problems being denied access to resettlement and rehousing services, leaving them on the streets. There is plenty of evidence, for instance, that street living is an extremely unsafe environment for drug injectors, with a radically increased risk of contracting and transmitting blood-borne viruses.[6]

Secondly, they encourage hostel applicants and residents to deny drug problems which means that they will not receive the support they need should they eventually be offered housing. The risk of subsequent tenancy breakdown, costly in both economic and human terms, is thus increased.

Excuses, excuses . . .

Service managers interviewed by the researchers gave two main justifications for such policies – neither of which are entirely convincing.

The first is the belief that hostels cannot legally permit illicit drug taking on their premises. In fact, the legal position allows some room for manoeuvre.[11] Hostel managers can be criminally liable for the supply or production of any drug or the smoking of cannabis or opium on their premises – but only if they 'knowingly permit' such activities. They are under no obligation to exercise vigilance (although they cannot just turn a blind eye). In other words, they need not be concerned with what goes on in individual hostel bedrooms or dormitories provided that they take reasonable steps to ensure that anything they do discover does not continue.

The second justification is that intoxicated residents create a management problem. This too is questionable. As some interviewees observed, problems with violence are much more often related to alcohol use. Indeed, the use of some drugs, like heroin or cannabis, can make residents calmer than usual.

Not in my surgery

But while drug use can act as a barrier to housing services, so too can homelessness act as a barrier to medical services. Many homeless people are not registered with a GP. Largely for financial reasons, many surgeries are unwilling to take on people who they believe may make great demands on resources or may soon move on out of the area.

As for drug treatment, the new research has found that it is not easy for homeless people to access specialist drug services. One hostel worker described how the manager of the local Community Drug Team refused to take referrals from the hostel as he believed that they would 'disappear' before finishing any course of treatment. Such a level of prejudice is probably exceptional, but there are other difficulties.

The principal one has already been touched on: people are reluctant to disclose drug use to homelessness workers for fear of being excluded from the project or denied access to housing. And with no disclosure, there will be no chance of treatment. Such fears will for some be based on past experience of being barred from

hostels or day centres. One study of direct access hostels, for example, found that over half those who had ever been refused access were rejected for drug or alcohol related reasons.[12] Bringing in drug workers to hostels to provide a 'satellite' service has had some success in overcoming this problem and several interviewees felt this was an effective mechanism for accessing specialist services.

But others argued that it is an imperfect solution. Unless the satellite service can take place in a completely unobservable space, people are still going to be reluctant to access it. Some interviewees also noted that it raised a dilemma concerning information sharing: on the one hand, to avoid deterring people from using the service it must be completely confidential; on the other, if project resettlement workers do not receive any information it is difficult for them to perform their role of coordinating clients' support and care packages during the rehousing process.

One interviewee argued that this type of difficulty stems from trying to combine 'accommodation management' and 'care' functions. He proposed that hostel and day centre staff should be solely concerned with the former – in other words, with the basics of running the project. The resettlement function should be carried out by external visitors who would also need to have some drug expertise.

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Bad attitude

This leads on to what was perhaps the most striking theme to emerge from the study. Many of the difficulties faced when trying to help homeless drug users stem from the attitudes of housing projects and their staff towards drug use. A mixture of fear, ignorance and moralising seemed to lie behind many of the issues discussed with project workers. In some instances, interviewees explicitly acknowledged that some of their colleagues were judgemental – in a climate of scarce resources, people who choose a self-destructive and 'deviant' lifestyle are not as deserving of housing as others.

This distinction between the 'deserving' and 'undeserving' (familiar to historians of welfare provision) has been noted in other studies of homelessness agencies.[13] And the upshot is that homeless drug users end up excluded from the resettlement process. However, all those interviewed also believed that people with drug problems were capable of maintaining tenancies provided they received appropriate support. The clear implication is that attitudinal change is essential if the drug/homelessness link is to be tackled effectively.

Grasping the nettle

As should by now be clear (and despite the recent fillip given by the recognition of the drug/homelessness link) the current response to that link is extremely poor. It undermines both harm reduction and any effort to help people stop using drugs. More broadly, it is also clear that present service responses are exacerbating the economic and human waste of social exclusion rather than alleviating it.

However, the research discussed in this article did indicate some clear and relatively cost-free steps that can be taken to improve things significantly for this particular highly-marginalised group. They are all straightforward but will require some courage and commitment to implement, especially from managers of homelessness projects. The costs of not grasping this nettle, however, remain enormous:

Policies: All homelessness projects, especially hostels and day centres, need to develop coherent and non-judgemental drug policies in which exclusion is the last resort.

Planning: Every Drug Action Team should include the director of housing (as recommended by both the ACMD and Keith Hellawell). All Drug Reference Groups must include representatives from local homelessness and resettlement workers' forums.

Training: Homelessness workers should receive regular drug awareness training. Drug and homelessness agencies should consider exchanging and sharing training as a way of building links between the two sectors.

Information sharing: Homelessness and drug projects must develop a flexible and pragmatic approach to information sharing.

Access to services: Drug and homelessness projects need to work together to establish accessible and efficient pathways for homeless people into specialist drug services. Health authorities also need to look at ways of increasing GP registration rates amongst homeless people.

These five steps are only the start, but they do provide a structure within which good practice can flourish. They may also help us all move towards an environment in which attitudes to the homeless drug user *can* change, an environment which, it has been argued, is essential if this most extreme form of social exclusion can ever be addressed ■