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▶ Effective services for substance misuse and homelessness in Scotland: evidence from an international review.

Pleace N.
Scottish Government Social Research, 2008.

Comprehensive and thoughtful review of the UK-relevant literature warns that services which impose rigid and unrealistic expectations of abstinence or independent living on homeless addicts would deny treatment and housing to vulnerable adults with complex needs.

Abstract A rapid evidence assessment of international literature on effective substance misuse services for homeless people was conducted to review best practice in other countries and determine if there were any lessons for Scotland. The review found that:
• There is strong evidence that experience of homelessness increases the risk of substance misuse among previously abstinent people, while entering into substance misuse also increases the risk that someone will become homeless. Also, when someone is homeless and involved in substance misuse, each problem compounds the other.
• In Scotland, England and elsewhere, young or lone homeless people and people with experience of sleeping rough are characterised by higher rates of substance misuse than the general population. However, parents and children in homeless families are either only a little more likely, or no more likely, to be involved in substance misuse than parents and children in the general population.
• In Scotland, England and elsewhere, there is a strong association between mental health problems or severe mental illness among homeless people and substance misuse problems.
• Services aimed solely at promoting abstinence among homeless substance misusers tend to meet with quite limited success. Many either cease contact with these services before treatment or rehabilitation is complete, or avoid them to begin with. Attempts to use short-stay detoxification services with homeless people have proven particularly unsuccessful.
• Rather than insisting on total abstinence, when services pursue harm reduction or harm minimisation policies, they are able to engage with homeless people with a substance

misuse problem more effectively. In particular, US floating support models based on harm reduction can promote and sustain stable living arrangements and ensure contact with services.

- Homeless people with substance misuse problems have a range of needs that can include: support with daily living skills; mental health services; and support in managing substance misuse. Their needs are often complex and services which focus on any one element, be it substance misuse, mental health or housing-related support, are less successful than services designed to support all their needs.
- The three main models of resettlement for homeless people with a substance misuse problem are: **1** The *Continuum of Care* or *Staircase* approach, which uses a series of jointly occupied supported housing settings, intended to slowly progress service users towards independent living and abstinence. This model meets with limited success; **2** More successful and cost effective is the model referred to in the USA as *Pathways Housing First*, offers intensive floating support services to clients who have been housed in ordinary accommodation, with a strong focus on service user choice of accommodation and services and a harm reduction approach to substance misuse; **3** A package of floating support provided through case management and joint working, which is standard practice across Scotland. The evidence base on this approach is less developed than for some other models, though it follows the logic of the flexible packages of support and harm reduction methods of model 2 and of the more successful services.
- There is no strong evidence on the effectiveness of preventive services to counteract potential homelessness among people with a history of substance misuse. Most prevention models aim to counteract the risk of homelessness across many groups, including people with a history of substance misuse.
- The evidence base on alcohol misuse by homeless and potentially homeless people was very rich until the early 1980s, when street drugs started to become much more widespread among street homeless populations. Since then research has tended to cover all forms of substance misuse, rather than solely alcohol. There is some evidence that older street homeless and hostel dwelling populations are more likely to misuse alcohol rather than street drugs. Younger homeless people use of alcohol alongside street drugs and other substances.

The review noted that the effectiveness of service models for homeless people with a history of substance misuse had been defined in the service's own terms, so needs to be interpreted in the light of the service's goals. For example, while in the USA flexible, comprehensive services with a harm reduction focus are more 'successful' than services aiming for abstinence, their goals are also less ambitious. Generally lacking is information about the extent to which successful outcomes are maintained over time. Only in the United States is there a tradition of longitudinal or 'tracking' research that looks at outcomes over time and compares different types of services to which clients have been randomly allocated. Gathered in large, robust studies that take years to complete, this evidence was one of the drivers behind the adoption of flexible, comprehensive services that encompass greater user choice and harm reduction approaches. The same research methods raised questions about the efficacy of detoxification and rehabilitation services which did not offer homeless people housing related support, access to accommodation, or help with mental health problems.

The review offered a series of broad recommendations including:

- realistic service outcomes need to be set; these will be higher for some service users

than others;
• harm reduction/harm minimisation models appear to meet with more success, though their goals are more limited;
• the evidence base suggests a need for a mixture of services;
• longitudinal monitoring of service outcomes should be undertaken where possible;
• the evidence base suggests that service interventions may need to go on for some time, creating a need for a secure funding base;
• modification of generic services may be the best option in areas with few homeless people with a history of substance misuse.

One of the messages from the review is that the pursuit of abstinence, independent living and paid work for all homeless people with a history of substance misuse may not be realistic. Some are highly vulnerable and have ongoing health, personal care and other support needs which may demand long term interventions and preclude independent living or secure paid work. Harm reduction models are also more effective at retaining engagement with homeless people with a substance misuse problem than services which insist on abstinence. However, services which pursue abstinence do succeed with at least a minority. 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.

FINDINGS Unlike some other 'rapid' reviews, this thoughtful analysis did not rely on prior reviews, but dug down to the several thousand source research documents. The focus was on relevance to the Scottish context, so the evidence was confined to studies in developed western nations.

Key passages address the debate at the heart of US policy on housing homeless substance misusers:
• On the one hand, it is argued that access to a home of their own should be contingent on the client's success (as judged by clinicians) in resolving their substance misuse and other problems and developing life skills through rehabilitation and education programmes. During this process they live in transitional and usually shared accommodation controlled by the treatment provider. Without first gaining stability and skills, the concern is that clients who are not 'housing ready' will in any event lose their tenancies and fail to pay their mortgages.
• An alternative view which has gained ground in the USA, is that a home of your own (and, within normal constraints, of your own choice) is a right regardless of whether you have accepted help with – still less succeeded in – resolving substance misuse and other problems. In this 'housing first' model, access is provided or facilitated to permanent housing usually rented by the resident, and intensive wrap-around support services are offered which they are largely free to accept or reject, without this directly affecting their housing. In the core model such support is open-ended and adjusted according to the needs of that individual at that particular time.
Though not an essential feature, in the US context the contingent housing model usually judges clinical success in terms of abstinence, while the housing first model is above all concerned with maintaining housing stability and is willing to accept ameliorations of substance misuse problems which enable the resident to sustain their tenancy. In all these models, typically the caseloads also suffer from serious mental health and other

medical problems, partly because in the US system these open up access to welfare payments which can help fund accommodation.

A recent US review argued that enthusiasm for housing first approaches is based on research which has yet to show these work for severely addicted populations, as opposed to the substance using mentally ill caseloads recruited in to the studies. This means, it was argued, that routine application of those approaches to addicted populations would be premature and possibly risky. It was also argued that the failures of treatment-based contingent housing models to achieve long-term housing stability may be less to do with the effectiveness of those treatments, than with the failure of public and private housing sectors to accommodate former problem drinkers and drug users.

While the featured review sees a place for both traditions, variations on the housing first model are seen as generally the most appropriate and cost-effective approach for homeless substance dependent adults, and one more in line with current UK practice. In particular, insistence on abstinence as a condition for housing or continued housing is seen as excluding vulnerable populations from these services, and condemning many who do access them to failure and consequent loss of accommodation. The consequence seen in some of the studies is that housing first models particularly score in terms of improved stability of housing, even if substance misuse may be relatively unaffected. But since either type of approach, and shades in between, may be best for an individual at a particular stage, the review ends up calling either for flexibility within a service, or for a range of services built on different models. There is, however, a clear rejection of predetermined requirements or predetermined goals which risk being unrealistic for many actual or potential service users.

Whatever the approach adopted, the context is one of substantial need but restricted access to decent affordable housing. Across English harm reduction and treatment services, in 2006 a survey found that just under half the responding clients were living in their own homes and 38% had sought help with housing. Around 60% said their housing situation had improved since attending the service. The figures were similar (except that just a fifth had sought help) in 2007 at harm reduction, prescribing and counselling services. Not surprisingly, need was most acute at inpatient and residential services, where in 2007, 54% of responding clients had not been in settled or permanent accommodation before entering treatment, including 20% in temporary accommodation and 15% of no fixed abode. Among the 151 services which responded to the survey, just four were supported housing services. These surveys were dependent on services and clients choosing to respond. A more representative national sample found that before starting drug addiction treatment in 2006, 40% of patients had been living in unstable accommodation; some of the remainder were living with friends and family or in hostels rather than in a home of their own. In Scotland a similar national survey in 2002 recorded 26% of treatment starters as homeless; among the heroin users, 35% had recent accommodation problems.

In the context of a shortage of suitable housing, difficulties in securing national and local investment in response to these needs are seriously impeding the English national drug policy's reintegration agenda, and housing is seen as the single greatest obstacle to securing treatment gains through aftercare provision. Across the UK housing is a major barrier to reintegration of substance users through employment. Scotland has been

relatively energetic in both tackling homelessness among substance users and other vulnerable groups, and in preventing homelessness, but coordination between treatment services and housing departments has remained a concern.

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