Working with people who use drugs

Guidance for homelessness accommodation services

Let’s end homelessness together

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Introduction

There is no legal requirement for homelessness services to provide specific support to individuals who use drugs, although it is common for people experiencing homelessness to be using drugs. Homelessness services vary in their tolerance to drug use, and the use of drugs can cause challenges for clients who are expected to adhere to organisational policies and procedures. This can be equally challenging for the organisation.

There is, however, an opportunity for homelessness services to work with people using drugs, in order to help reduce harm, improve future prospects and increase opportunities of re-integration in to wider society.

This guide aims to help managers and staff of homelessness services to:

- Increase their confidence in working with clients that use drugs
- Understand the legal framework around drugs
- Safeguard the organisation and create a therapeutic environment
- Increase the likelihood of clients overcoming problematic drug use and finding recovery
- Examine drug use from a health and harm reduction approach
- Understand of the benefits of joint working practices in meeting the holistic needs of clients who use drugs
- Understand how to increase levels of engagement and support, in order to achieve the best possible outcome for clients who use drugs
- Become familiar with drug-related harms and examine ways of reducing them
- Set up a peer support programme and appreciate the benefits that this can bring
- Gain a better understanding of drug treatment, pathways and interventions

This guide also outlines how to establish key local services (including drug treatment services), develop the correct policies and procedures, conduct comprehensive assessments, and understand effective keyworking practices.

Staff with the relevant training and skills will build confidence in how to effectively engage with clients that use drugs. In turn, this enables therapeutic relationships to be formed and increases the likelihood of achieving positive outcomes, both for the client and the organisation.

An understanding of the theories of addiction, how addiction is developed and, importantly, how to support individuals in overcoming their addictive behaviours will result in more effective practice and create a safer environment for hostel staff and clients alike.

Legal Framework

Controlled drugs are classified depending on the level of harm that they cause. There is a clear differentiation in law between the possession and supply of controlled drugs. Although the possession of drugs can lead to criminal sanctions, they are much greater for those who are producing, trafficking or supplying drugs.

Many of the criminal penalties associated with people who use drugs are in relation to the associated behaviours that some users may be involved in, such as shoplifting or other non-violent crime that people may commit in order to maintain their drug use.

The two acts of Parliament in the United Kingdom that make up this legal framework are the Misuse of Drugs Act (1971) and the Psychoactive Substances Act (2016). Section 8 of the Misuse of Drugs Act is of particular relevance to homelessness services, as it sets out the legal responsibilities of people managing premises (i.e. staff teams of hostels, day centres, night shelters etc) to prevent certain activities, such as supply of controlled drugs.[1]

The UK's most recent Drug Strategy was published in 2017 and this outlines how the Government plans to tackle drug use within society. Two of the main areas of this strategy are particularly relevant to homelessness services: i) smarter partnership approaches and ii) developing jointly owned outcome measures.

The legal framework should not restrict services in working with people that use drugs, instead homelessness services should be encouraged to have greater involvement in supporting clients that use drugs.

Types of Drugs Commonly Being Used

Cannabis is the most widely used illicit drug in the world. The UK has relatively high numbers of people that use heroin and crack cocaine, but has also developed a treatment system that is effective in engaging and support a large number of people who develop dependencies to such substances.

There has been an increase in the use of psychoactive substances, in particular synthetic cannabis which are being used disproportionately by homelessness and prison communities compared to other sections of society.

The use of prescription and over-the-counter medication should not be ignored. As with illicit substances, dependencies can be formed. Such drugs can be acquired legally, but also purchased from the illicit market. Typical such substances include Codeine, Gabapentin, Pregablin and Methadone (which is used to stabilise opiate users).

It is important to see beyond the drug, to the person behind the behaviour, in order to most effectively engage and offer support to them.

Theories of Addiction

There are many reasons that people use drugs. Some will use drugs socially and recreationally, while others will use drugs more harmfully – building dependencies that can be very difficult to overcome. One theory is called 'Set and Setting'. This theory explains that how a person is feeling, where they are and who they are will determine whether they continue to use the drug, or not.

Another theory links addiction to Adverse Childhood Experiences (ACE), where in adulthood people are affected by traumatic experiences that they experienced in childhood, such as physical and sexual abuse, poverty and destitution, a parent in prison etc.

No individual will start to take drugs with the intention of becoming addicted, but physiological changes can occur that result in addiction, whatever drug that they may be taking.

[1] For further information see Sample Drugs Policy guidance: www.homeless.org.uk/our-work/resources/supporting-drug-users

Effects and Harms of Drug Use

The use and effects of a drug on an individual can vary depending on a number of factors. We should understand the difference between 'recreational use' and 'dependency'.

- Recreational – occasional use of drugs, usually in a social setting
- Dependence – repetitive use of drugs resulting in feeling withdrawal symptoms

It is important that homelessness services are aware of the clients' history, type and pattern of drug use, as this will help in ensuring that the right support can be made available.

There are physical and psychological harms associated with illicit drug use. Health screening and access to required interventions are important in improving the overall health of individuals using illicit substances.

Some of the common harms associated with problematic drug use include:

- Dependence and addiction
- Committing crime to fund drug use (and mandatory requirements as a result of prosecution)
- Decrease in personal care
- Negative socio-economic circumstances
- Unstable accommodation and periods of homelessness
- Mental health problems
- Poor social networks and social isolation
- Difficulty making/keeping appointments
- Physical health complications
- Loss of life

Therefore it is important that an organisation has the following in place:

- Clear entry criteria, which should also be outlined in your organisation's policy and referral document.
- A comprehensive assessment – to determine the type of drug(s) being used, the frequency, history of use and type of administration (i.e. smoking, injecting, vaping, snorting).
- Risk assessments – based on the tolerance levels of your service and its set up, other clients, staff and the individual themselves.
- Regular keyworking sessions – keyworking plays an important part in understanding the client journey and can highlight changes in drug use (e.g. a switch from smoking to injecting, or change in the drug being used), understanding daily routine and offering an opportunity to gain feedback on the client's drug treatment journey (if they are engaged in drug treatment). Furthermore, it provides an opportunity to discuss overall motivation and long term planning.
- Correct and legal policies and procedures – to ensure that people that use drugs, as well as other clients and staff, are safe and supported appropriately, and that services operate within the law.[2]
- Good joint working arrangements – so that clients are able to be supported in a holistic manner. See section 'Embrace Partnership Working' below.
- Effective relationship with the Police – to enable safe working practices with a clear understanding, and joint ownership and support to be offered to people who use drugs.

[2] For further information see Sample Drugs Policy guidance: www.homeless.org.uk/our-work/resources/supporting-drug-users

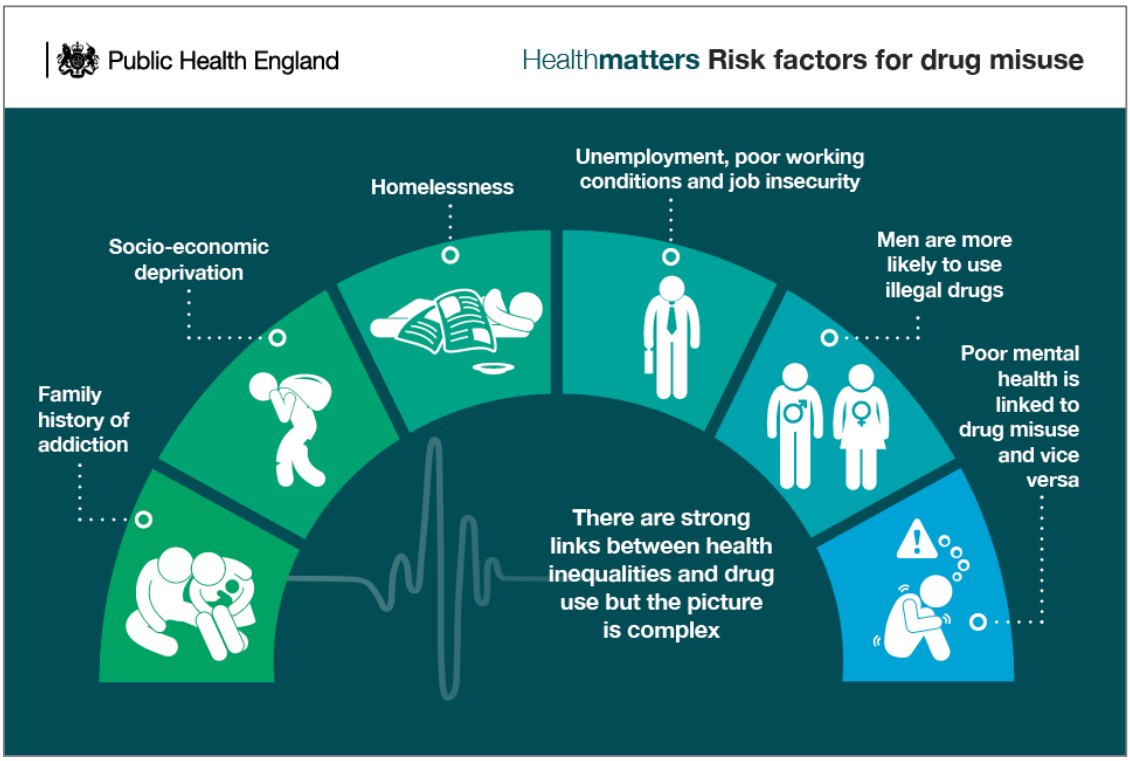
- Health and safety – making sure that this is regularly monitored and in line with other organisational policies and procedures, such as lone working practices. The health and safety of people who use drugs should be paramount, for example making sure that those that use drugs are offered regular health checks. For staff/volunteers, an example is immunisation for Hepatitis A and B.

Health Based Approaches

The landscape of homelessness is complex. If we examine drug addiction as a health matter, this can simplify some of these complexities.

Public Health England's resource on preventing deaths fom drug abuse[3] says:

> "Risk factors are all negatively associated with health status and there is a complex and reciprocal association between social factors and illicit drug use. Homelessness, for example, is a complex problem that occurs for many different reasons. Some individuals may later turn to addiction as a means to cope with their lack of a fixed home. However, it can be difficult to determine the extent that substance abuse leads to homelessness compared with the frequency by which homelessness leads to substance abuse.



> Drug misuse can cause social disadvantage, and socioeconomic disadvantage may lead to drug use and dependence. In addition, risk factors associated with drug misuse often lead to other adverse outcomes such as poor physical or mental health, offending or risky sexual behaviour."

[3] www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

Supporting People Who Actively Use Drugs

There are some key things that homelessness services can do when working with people who are actively using drugs.

Effective Care Planning

It is important that the support worker or keyworker builds good rapport with the client, so that they feel comfortable in discussing and disclosing problems that they are facing, including the use of drugs.

A holistic approach to care planning should include:

- Health checks (physical and mental)
- Tackling/reducing level of debt
- Exploring education and employability opportunities
- Improving social networks and relationships
- Building an increased understanding of rights and responsibilities
- Reducing or abstaining from substance use
- Improving housing resilience
- Promoting meaningful use of time

This should be facilitated by the staff member, with actions and goals identified and agreed by the client.

Care planning provides an excellent opportunity to discuss and, if appropriate, professionally challenge preconceptions, raise aspirations, discuss drug use and impart key harm reduction measures, as well as exploring aspects of wider community re-integration and overall well-being.

Provide Advocacy

Homelessness staff and volunteers can act as advocates for clients, ensuring that their clients are receiving the care and support that they require, particularly with external organisations. This includes making sure that clients are not being discriminated against and that appropriate processes and procedures are being followed. Advocacy can be provided over the telephone, by email or in person.

Promote Harm Reduction

Harm reduction can be described as the lifeboat that keeps drug users alive and well until they are ready to stop taking drugs (if they wish to – abstinence is not the goal for everyone). Keeping people who use drugs alive and addressing any health needs will allow the individual to maintain general well-being and allow services to work with him/her. The service can support harm reduction by displaying relevant posters within the communal areas of the building, including leaflets within induction packs, and by ensuring that staff understand the value of harm reduction and are relaying messages to clients on an ongoing basis. Download (for free) and print awareness posters to display in your service: www.harmreductionworks.org.uk/3_posters/hiv_new_injectors.html

Promote Mutual Aid and Other Self-Support Groups

Mutual aid groups such as Narcotics Anonymous (NA) have been established for many decades. They provide an opportunity for anyone who has a desire to stop using drugs to join a global fellowship of people who have encountered similar problems with drugs. Meetings are held locally, in places like community centres, and participants share thoughts and experiences with others in a safe environment. NA follows a 12-Step

methodology, based on spirituality. Another form of self-help group, which is scientifically based, is called SMART Recovery. Both are free to attend, with members being asked to provide a small donation if they are able to do so.

Find out where and when your local NA meeting is: https://ukna.org/meetings/search

Find out where and when your local SMART Recovery meeting is: https://smartrecovery.org.uk/

Overdose Prevention

The use of drugs carries a risk of side effects, including overdose. An overdose can either be intentional or accidental. People who use opiates like heroin will be risking overdose each time that they use the drug, because there is no way of knowing the quality of the product until after it has been used.

Another factor in relation to opiate overdose is the person's level of tolerance. For example, if someone has been abstinent after recently detoxing then their tolerance levels will be low, meaning that if they use again and to a similar level that they would have used previously, they will be at greater risk of overdosing.

A potential risk factor is the use of synthetic opiates like Fentanyl which, while not yet a common issue, some drug dealers may be mixing with heroin in order to make their product stronger. Combinations of opioids, alcohol and sedatives are often present in fatal overdoses.

Some of the signs of an overdose include:

- Pinprick pupils
- Unconscious or drowsy
- Severe difficulty breathing, shallow breathing or cessation of breathing
- Blue lips or fingers
- Snoring or gurgling – in this case it may be that their airway is obstructed, so in this situation place the person in the recovery position

Even if you are unsure whether an overdose has taken place, if you have concerns for smeone's welfare you should call 999 immediately, administer naloxone (where available) as guided by the operator, and then wait with the person until the emergency services arrive.

All incidents (including near misses) should be logged and reviewed by the service regularly.

Store and Administer Naloxone

Naloxone is an antidote to counteract an opiate (e.g. heroin, fentanyl or methadone) related overdose situation. Naloxone temporarily reverses the effects of such an overdose, which gains vital time before paramedics arrive. The effects of naloxone are temporary, so the person may overdose again. Another administration may be required and so on until the emergency services arrive.

Naloxone is a prescription-only medication but can be supplied by a drug treatment service, for example to a homelessness service. The accompanying training is short and explains how to recognise an overdose situation and how to administer naloxone (which is by an intra-muscular injection or, more recently, an intra-nasal spray).

For further information on naloxone, please refer to the following Homeless Link Guidance Naloxone in Homelessness Services: www.homeless.org.uk/naloxone

Refer to Drug Treatment Services
Drug treatment services can support people in controlling and eventually overcoming their addiction to drugs. Although drug treatment is not a mandatory service (i.e. there is no legal requirement to commission them), many local authorities commission drug treatment services to tackle the impact of drug use on their communities.

Contact your local drug treatment service to find out what they offer and the referral pathways to use. If you are finding it difficult to find out who your local service provider is, then contact your local public health team, who are based within your local authority and have responsibility for commissioning drug treatment services.

Find information and contact details for regional and local public health teams:
www.gov.uk/guidance/contacts-phe-regions-and-local-centres

Embrace Partnership Working
There will be a range of services and organisations operating within you locality that will be of value in collaborating with, in order to most effectively support clients who use drugs. By proactively searching for them (based on the needs of the client group) and encouraging and supporting access, there will be joint ownership of care.

It is important to ensure that your service is co-ordinating and monitoring these pathways on an ongoing basis.

Some examples of the type of services that you should consider approaching include:

- Drug and alcohol treatment services
- Local volunteer centres
- Primary and secondary care services
- Education and training providers
- Mutual aid and peer support groups
- Employment support services
- Local government departments
- Welfare assistance services
- Debt support agencies
- Housing support services

Staff should be encouraged to make strong links with external services and organisations. Perhaps consider inviting external organisations in to your service to deliver presentations to staff and clients on a regular basis, to share information on what is on offer.

Reduce Stigma and Discrimination
The Harm Reduction Coalition[4] state that:

> "For individuals who use or have a history of using drugs, the impact of stigma can permeate nearly every aspect of their life – including relationships with family, friends, employers and health care

[4] https://harmreduction.org/issues/drugs-drug-users/stigma-drug-use/

providers. While a great number of expectations are often placed on drug users to change their behaviours, the social context that creates and reinforces drug-related stigma is rarely explored or further challenged.

A greater understanding of ways in which internalised stigma can lead to harmful behaviours is valuable in working more effectively with drug using clients. In addition, through evaluation of one's own potential role in perpetuating drug-related stigma, support staff can develop new strategies for building more authentic and more productive relationships with clients."

Participate in Campaigns and Awareness Days

There are a number of campaigns and awareness days that take place throughout the year. Homelessness services could play a role in raising awareness and partaking in days that are dedicated to drug-related causes.

Some examples of campaigns and initiatives:

- International Overdose Awareness Day – 31st August
  www.overdoseday.com/
- UK Recovery Month – the whole month of September
  www.facesandvoicesofrecoveryuk.org/uk-recovery-month-toolkit-2/
- Support Don't Punish Campaign – day of action on or around 26th June
  http://supportdontpunish.org/
- World Aids Day – 1st December
  www.worldaidsday.org
- World Hepatitis Day – 28th July
  www.worldhepatitisday.org/
- United Nations World Day of Social Justice – 20th February
  www.un.org/en/events/socialjusticeday/

Strategic Involvement and Representation

There are strategic boards and meetings that take place most localities, where drug use (among other topics) will be discussed. This provides an opportunity to understand what is currently being talked about and what the future plans may be. It is an excellent opportunity for homelessness services to be involved, and to influence these discussions and strategic plans. You may also have an opportunity to raise any concerns relating to drugs that other stakeholders might not be aware of.

Some examples of relevant strategic meetings and boards include:

- Health and Wellbeing Boards
- Homelessness Partnership Boards
- Local Drug and Alcohol Partnership Boards
- Community Safety Boards
- Local Enterprise Partnership (LEP) Boards
- Police and Crime Boards

Training, Skills and Qualifications

Supporting people who use drugs can require patience, perseverance and empathy. It is important that the person being supported does not feel judged or patronised.

Therefore the person who is offering the support must be aware of how the person is feeling on that day and take a genuine interest in their short, medium and long-term well-being.

There are courses and qualifications that may help in ensuring that staff and volunteers have the skills required in order to effectively support clients who people who are current or former users of drugs.

Examples of training and qualifications that may assist include:

- Overdose Awareness
- First Aid Training
- Safe Injecting Practices
- Blood Borne Virus Awareness
- Welfare (Benefits) Training
- Drug Awareness Training
- Counselling and Mentoring Qualifications
- IAG (Information, Advice and Guidance) Qualifications
- Motivational Interviewing Techniques Training
- Training in Solution Focused/Trauma Informed Approaches

Training and awareness courses are usually available through local educational providers (such as colleges, or adult education services), independent training providers, not-for-profit organisations and other private training providers.

The financial cost of training and qualifications is normally based upon the circumstances of the learner(s) and the provider (i.e. there may be funding available for volunteers who are claiming means tested benefits).

Homeless Link offers a range of training courses: www.homeless.org.uk/products/training

Drug Consumption Rooms

Drug Consumption Rooms (DCRs) or Supervised Drug Consumption Facilities are specific spaces where illicit drugs can be used under the supervision of trained staff. They have been operating in Europe for the last three decades. These facilities primarily aim to reduce the acute risks of disease transmission through unhygienic injecting, prevent drug-related overdose deaths and connect high-risk drug users with addiction treatment and other health and social services.

There are no DCRs currently in the United Kingdom, but there is a growing movement made up of health professionals, service users, police and crime commissioners, politicians and members of the public, asking the Government to allow DCRs to be established. This is partly due to the growing number of drug-related deaths and the spread of blood borne viruses (such as HIV).

This type of facility would allow illicit drugs to be consumed in a safe space under the watchful eye of health professionals and allow easy access to other support (such as drug treatment, social care and housing).

In 2019 the 'Back Yard' report was published by VolteFace, a drug policy think tank, on the feasibility of establishing drug consumption rooms in the UK. The report states that drug consumption rooms are effective in reducing risky behaviours associated with injecting drugs (such as sharing needles), engaging with highly marginalised target populations, reducing drug-related deaths, increasing uptake of detoxification and drug dependence treatment and decreasing public injecting.

Full report: http://volteface.me/publications/back-yard/

Drug Treatment Pathways and Options

> "The effectiveness of well-delivered, evidence-based treatment for drug misuse is well established. UK and international evidence consistently show that drug treatment – covering different types of drug problems, using different treatment interventions, and in different treatment settings – impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses. For a significant proportion of those entering treatment this results in long-term sustained abstinence."[5]

If a person needs treatment to tackle their drug addiction, they are entitled to NHS care in the same way as anyone else with a health problem. A GP is often a starting point. The GP can either initiate treatment themselves, or refer to a specialist drug treatment service. Alternatively, a direct pathway can be created from another service (such as a homelessness service) to the local drug treatment service.

Please note that, to enter a specialist drug treatment service, a client must be registered with a GP in the locality.

Community Drug Treatment
Community drug treatment services normally operate from a central base, but can also deliver services from satellite clinics, such as GP surgeries. The frequency that someone will need to attend will depend upon their individual circumstances.

Initial Appointment
At the first appointment for drug treatment, staff will ask about drug use. They will also ask about work, family and housing situation. A urine or saliva sample may be taken and analysed. Staff will talk through all of the treatment options and agree a treatment plan for the client to sign. They can also explain local support groups for drug users and their families or carers. A keyworker will be allocated, who will provide support throughout the treatment journey.

What Does Drug Treatment Involve?
This depends on the personal circumstances and what substances the client is addicted to. The keyworker will work with the client to plan the right treatment support for the client.

Treatment options may include:

- Talking therapies - such as cognitive behavioural therapy (CBT), help to see how thoughts and feelings affect behaviour. These can be delivered on a one-to-one, or group basis

[5] www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

- Treatment with medicines - if there is a dependency to heroin or another opioid drug, a substitute drug may be offered, such as methadone or buprenorphine. This means people can get on with treatment without having to worry about withdrawing or buying street drugs.
    - Please note that medication is titrated, meaning that the desired dosage may take time to be achieved as there is usually a lower starting dose that is gradually increased until the client is comfortable with the dose and is not feeling withdrawal symptoms. Clients may be asked to take medication in front of a staff member (supervised consumption) until they have abstained from illicit use.
    - Medication is either provided directly from the drug treatment premises, or from a local Pharmacy.
- Detoxification (detox) – for people who want to stop taking opioid drugs like heroin completely. Detox can be offered in the community, in a primary care setting (hospital in-patient) or within a residential rehab environment. Please note that certain criteria must be met in order to consider this as an option, which is usually decided by a multi-disciplinary panel made up of drug treatment senior staff and local authority commissioners.
- Shared Care – this is when treatment is transferred to primary care settings and delivered jointly by a professional from the drug treatment service and a GP.
    - This option is available once the client has achieved stability with their treatment regime and heavily reduced or abstained from any illicit drug use

Family members, friends and professionals can be added to the clients' confidentiality agreement, so that information on treatment progress can be discussed, but note that this is only if the client agrees.

Through and Aftercare

Clients who are progressing with treatment should be supported in engaging in positive activity at every conceivable opportunity. For people who have managed to successfully complete drug treatment, it is just as important that there is a comprehensive plan after they leave the treatment service. This may be directed by the drug treatment service, but ultimately it is up to the client to decide what they would like to do in order to preserve and sustain their long term recovery.

Some of these options include:

- Volunteering
- Undertaking qualifications
- Building bridges with family members, or non-drug using friends
- Engaging with mutual aid and self-support groups
- Entering abstinence-based recovery housing
- Employability activities
- Finding a hobby or taking up a sport
- Leisure/social activities

Only by being aware of the situation that the client is in (as well as having knowledge, or searching for opportunities and resources that are available) can the relevant support be provided.

If your service has a number of individuals either accessing drug treatment or that have successfully completed treatment, you may want to consider a setting up a ‘Recovery Support Group’, so that clients can discuss their individual experiences with their peers in a safe and therapeutic environment.

Needle Exchange Programmes

Needle exchange programmes or NSPs are free, harm reduction, social programmes that allow people who inject drugs intravenously, to obtain sterile injecting equipment. NSPs can be delivered by specialist services (such as drug treatment services) or in community settings (mostly Pharmacies). Homelessness services can work with drug treatmet services to deliver needle exchange in hostel settings.

At both outlets, clients should be offered a range of equipment, such as different sized syringes and needles, sterile cups, vitamin C sachets, condoms, filters, sharps boxes and other essential equipment.

The person using drugs is encouraged to access drug treatment (if not already doing so) and other health related matters can be discussed with the lead pharmacist or dispensing staff. Consultation rooms should always be used to discuss confidential matters and to dispense the equipment.

If the see the following sign, then a needle exchange service is being operated from that premises:

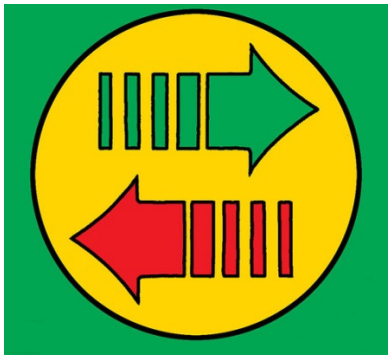


Image Rights https://sheffielddact.org.uk/drugs-alcohol/needle-exchanges/

Developing a Peer Support/Volunteer Programme

There is great merit in providing involvement opportunities for individuals with lived experience of addiction within homelessness services. If done correctly (and resourced where possible), an effective peer support programme can add value to the reputation of an organisation, its governance and performance.

The involvement of people with lived experience will add additional credibility with clients and embrace the therapeutic value of one individual with lived experience of addiction helping another, which can lead to positive outcomes for all involved.

A vibrant peer support/volunteer programme can play a role in supporting clients, gaining feedback through consultation, raising awareness, representing the organisation, setting up new initiatives and gaining a much deeper understanding of the issues that clients are facing.

Here are some practical tips for setting up a programme:

- Ensure 'buy in' from key individuals within the organisation (e.g. trustees, managers and clients themselves)
- Convene a meeting with prospective peer supporters
- Create, review and/or update the organisational volunteer and expenses policies
- Highlight at least one lead staff member
- Provide regular supervision to peer supporters
- Decide on the requirements of the organisation and clients
- Develop a needs analysis and professional development regime
    - Note: There may be local training providers offering funded qualifications for people in receipt of means tested benefits. They may include qualifications such as – Mentoring Level 1 & 2 & Counselling Level 1 & 2 etc.
- Ensure that the peer supporters activity is monitored and recorded
- Promote the programme as part of staff and client inductions
- Ensure that peers are invited to attend team/management meetings and have a dedicated agenda item for feedback

There is a useful toolkit available, which was developed by The Skills Consortium for Substance Misuse, on setting up a peer support programme:
www.williamwhitepapers.com/pr/dlm_uploads/Peer-Support-Toolkit-2015.pdf

Co-Production

'Co-production' describes a concept. This concept, in its simplest form, is when people who access a service (clients) work alongside those that deliver the service (professionals) in order to make sure that the service is meeting the needs of the client and that any proposed changes are made in collaboration with the beneficiaries. There are related terms, such as Service User Involvement or Client Participation but, currently in the homelessness sector, Co-Production differs in that it describes moving beyond consultation to actually sharing power and joint decision-making between people, setting aside their 'client' and 'professional' roles.

The Social Care Insitute for Excellence[6] key principles of co-production are described by NDTI as:

- Equality – co-production starts from the idea that no one group or person is more important than any other group or person. So everyone is equal and everyone has assets to bring to the process.
- Diversity – diversity and inclusion are important values in co-production. This can be challenging but it is important that co-production projects are pro-active about diversity.
- Accessibility – access needs to be recognised as a fundamental principle of co-production as the process needs to be accessible if everyone is going to take part on an equal basis. Accessibility is about ensuring that everyone has the same opportunity to take part in an activity fully, in the way that suits them best.
- Reciprocity – 'reciprocity' is a key concept in co-production. It has been defined as ensuring that people receive something back for putting something in, and building on people's desire to feel needed and valued.[7]

Ensuring that homelessness services are co-produced will ensure that clients feel part of the organisational structures and processes, that the client experience matches the organisational values, and that the mission statement is achieving its intended purpose.

For further guidance and case studies of co-production, see Homeless Link's toolkit, which is itself co-produced: www.homeless.org.uk/co-production-toolkit

[6] www.scie.org.uk/publications/guides/guide51/what-is-coproduction/principles-of-coproduction.asp
[7] www.ndti.org.uk/our-work/our-projects/coproduction/the-core-principles-of-co-production

FAQs

Situation	Solution
What if my client is not honest about their drug use?	It can take time to build trust. Create an environment where the client feels comfortable divulging personal information without fear of judgement or persecution.
How can I offer support, if I am not an expert in drug use?	Ensure that training levels are assessed and offered at induction, and then reviewed regularly. Speak to the clients themselves about the drug(s) that they are using, how they make them feel and the impact of using them. Re-iterate that you are there to help. Know where to signpost to when people are ready to engage with specialist services/treatment.
What should I do if I came across a client that has overdosed?	Go on overdose awareness and Naloxone training (provided for free by the local drug treatment service). Administer Naloxone if available, call the emergency services and make sure that you stay with the person until emergency services arrive, repeating administration of naloxone if required. Record the incident in the accident report book and inform the management team.
I don't have all of the answers, how can I help someone?	No single individual or organisation can address all of the problems related to drug use by themselves. Therefore build strong working relationships with a wide range of services and continue to build your knowledge and understanding.
What if I say, or do the wrong thing?	Approach with care and compassion. Adopt a non-judgmental attitude and try your best to understand and support your client. Never make assumptions.
What if my client does not want to stop using drugs?	Endeavour to help to reduce the harm to the individual. Encourage them not to use alone, to try to cut down on the quantity (and frequency) that they are using, if they are an injecting drug user, re-iterate to always use sterile injecting equipment and signpost them to the local needle exchange service. Also continue promoting drug treatment services (if they are not accessing them) and mutual aid support. Look at a person's interests and aspirations – as other activities or networks increase, drug use may decrease.
If a client has overcome their addiction to drugs, what can I do to help ensure that they are not drawn back in to using drugs, by others?	You can assist clients in sustaining recovery by helping them to build resilience and by promoting different opportunities to help them to fill their time constructively, away from their historical drug using peer groups. In addition, co-production opportunities could be offered, as well as involvement in mutual aid groups (such as Narcotics Anonymous or Smart Recovery) which can help to ensure positive social networks remain in place. Develop move on protocols that are responsive to people making progress with their recovery who may need an abstinence base environment, whether supported or independent housing.

Case Studies

Lotus Sanctuary (Wolverhampton)

Established in 2018, Lotus Sanctuary supports an array of female presentations - from rough sleepers, to victims of domestic violence, sexually-exploited women and those seeking to break free from drug and alcohol addictions.

We operate on a two year stay, which gives us time to address any current issues and arm our residents with the skills needed to live independently. The majority of the women we come into contact with are homeless and have ongoing issues with drugs. We never reject women for our accommodation if they have drug issues; instead we assess their needs and gauge the individual's willingness to walk a path of recovery.

We identify the needs of the individual through a two level assessment. The first part of the assessment is a brief phone call or informal face to face meeting with the person in question to gently ask them the circumstances that have led to their situation of needing accommodation. Once the circumstances are known and if a support need is identified, the person is asked to come back for a full assessment.

As part of the full assessment we delve deeper into the past and ongoing issues, historical housing issues, drug and alcohol use etc. Once a person is accepted into the accommodation, we work with them to develop a support plan, tailored around their primary support need. Our support staff are always very non-judgmental in their approach. We find that a more relaxed and open approach is always best, as it allows the service user to open up more about themselves.

We have zero tolerance on residents using drugs inside the houses. The driving force behind this is to safeguard other residents, given that all our properties are shared accommodation. That being said, we cannot enforce these rules once a resident leaves the house itself. We also understand that relapse can be a part of recovery, and if a resident is using drugs outside of the house we continue working with them to address the issues leading to their use. This is where our harm reduction strategy kicks in, the first of which is a basic awareness conversation between support worker and resident. Part of the strategy is then to sign post to relevant local drug services, namely 'Recovery Near You', who can further the support. We also encourage the person to attend Narcotics Anonymous meetings. The residents' support worker will always take the individual to the Recovery Near You appointments and will also accompany the individual to their first Narcotics Anonymous meeting.

We rehoused four women with major drug issues in the past three months. The need for treatment was identified via the assessments we conducted and by having an open conversation with them about their drug use. If the choice of drug is heroin, we have a policy that the resident must engage with local recovery services and a methadone or buprenorphine prescription must be put in place.

We do allow residents to move in before a prescription is in place, to give them the best chance of recovery once engaged in the maintenance and reduction programme. Once the prescription is in place, a support worker takes the resident to the pharmacy on a daily basis. This happens for around a month, until trust can be built and responsibility passed over to the resident.

In January we were referred a woman who was being treated in hospital. She had been admitted after being street homeless for a year and was immediately put on a methadone prescription. She had no fixed abode to be discharged to. Changing Lives, an organisation who work with the most vulnerable women in our locality,

made the referral to us. After assessing her as an in-patient and accepting her for accommodation, we worked with the referral partners Changing Lives and also Recovery Near You to make sure she was signed up to a doctors surgery which is near the house.

We also ensured that a prescription was in place for when she left hospital, at a pharmacy that was in close proximity to the house. Upon her discharge, a support worker from Changing Lives firstly took her to her new doctors, then to the pharmacy to collect her prescription, then brought her to the house where we were waiting to help settle her in.

By avoiding gaps in her receiving treatment, her chance at sustaining abstinence from drugs and staying on a prescription was increased massively.

In order for us to achieve results we must avoid time gaps in accessing services, especially gaps in getting onto a maintenance prescription.

We have demonstrated that this can be achieved, but it was only achieved through partnership work. In the example given, the three organisations all had massive roles to play. Lotus Sanctuary as the housing provider, gave the individual a safe base to start recovery after hospital discharge. Changing Lives assisted by making the initial referral and helping in getting the individual to her appointments from the hospital and to the house from there. Recovery Near You played their part in ensuring that a prescription was ready once the individual was discharged from hospital.

Of the four women we rehoused with drug issues in the past three months, one is currently still in our accommodation and still on a methadone reduction programme, after initially presenting as a rough sleeper with a heroin addiction. Currently, she is engaging with her support worker, attending regular Narcotics Anonymous meetings and engaging with local recovery services.

We operate on a two year stay. Our move on policy starts around 18 months into an individual’s stay, where a support worker will start to help the individual look for suitable accommodation.

Over the two years, support is gradually lessened. Our main aim is to equip women with the skills needed to live independently. For drug users we put a huge emphasis on the need to continue engaging in mutual aid recovery groups. The added support of a fellowship of likeminded people (mutual aid) will help an individual massively in avoiding the circumstances that led to them coming to us in the first place.

Kaleidoscope Project, Cairn House (London)

The names and initials of the resident have been changed in order to maintain their anonymity in this case study.

Background

BB is a 45 year old heterosexual white male. His father died when he was aged two and his substance abuse started at the age of 10 years old. BB had a history of offending behaviour which included drug related, burglary and theft. He also had an ABH (actual bodily harm) order issued and was currently waiting trial for drug-related offences. The trial was concluded while he was at Cairn House resulting in a DRR (drug rehabilitation requirement) order lasting two years. His substance abuse is Heroin and Cocaine. He receives 35ml of methadone and manages his GP prescription independently, but whether he was compliant with all prescribing regimes was unknown. He drinks alcohol regularly but states he is not dependent.

He has three children from a previous relationship and has little contact with the children. He attends the Kingston Wellbeing service. His social and community circles are other substance users.

Referral and Assessments

BB was referred in July 2108, by a local Wellbeing Drug Services and presented with an Adult Social care Assessment (conducted in July that year). He did not attend two appointments during that period. He was then assessed by Cairn House Hostel staff in early August and was accepted to Cairn House and entered the hostel a few days later.

BB has a history of substance abuse and is currently engaged with drug treatment for his abuse. The reason behind the referral was that Adult Social Care assessment raised alerts and risks about his use of his home and the threats from other substance users/dealers. BB was living in a one bedroom property on a large estate where he had accumulated a debt with drug dealers. He had been raided by police resulting in drugs being seized, and he was then physically assaulted by associates of the dealer, which led to him fleeing the property.

At the time of the assessment he was sofa surfing in a friend’s place.

The assessments also highlighted that he had not managed the property well as he was in arrears with his utility bills. In terms of his condition of health he had ongoing COPD (Chronic Obstructive Pulmonary Disease), was underweight, and had undergone TB (Tuberculosis) treatment last year at Kingston Hospital. He also has Hepatitis C, cirrhosis of the liver and an ongoing history of self-harm.

During the Adult Social Care assessment it was discovered that he had bruising over his body but refused to have it raised as a safeguarding issue. He presented unkempt and declared that he was not able to maintain his own nutritional needs.

BB was offered a place due to his physical/mental health issues, substance abuse and his overall level of vulnerability within the community – particularly the risk of intimidation and physical abuse from other substance users/dealers.

The assessments also pointed out that due to his health needs he was vulnerable and unable to protect himself from physical abuse from other substance users/dealers. So the assessments concluded that supported accommodation would offer a safer environment and support his engagement with his treatment regime. In addition it would provide the support for him to manage his finances, nutrition and physical health

thus improving his quality of life.

BB's move on plan was drawn up with BB considering rehab after the risk of harm is reduced and that he has successfully engaged with local drug treatment services.

Occupancy
Initially BB settled in well at Cairn House and interacted positively with other residents and Staff.

After a month he started presenting under the influence of substances and on two separate occasions staff had to call emergency service because BB had overdosed. Over the next 6 months we saw a gradual improvement with BB's engagement with service provision. He attended hospital appointments regarding further investigations with his COPD. There was increase in engagement with the local drug service. He also attended court for an outstanding offence that occurred last year and, due to his improved engagement, his license was not recalled and he was not returned to prison.

In terms of his medication regime he has improved and is currently sticking to the prescribed dose of methadone. The concerns raised about him maintaining his medication regime were correct but with support from staff who discussed it with his GP and treatment centre we were able to negotiate regular pickups of prescribed medication, which BB then handed in at the reception. This reduced any illicit use or selling of his prescription.

Outcome
BB is now meeting the requirements of his mandated DRR (drug rehabilitation requirement) order, by attending all his appointments with probation and with the drug service provision. Before his attendance with them was 50%, this has improved to 100%.

He had reduced his illicit drug use and is now more reliant on his methadone and treatment regime. He has continued to attend his appointments with the hospital, though the prognosis has not been good, he has still managed to improve aspects of health. He has increased his weight. He has also attended the Recovery Hub and taken part in recovery events. He has also started to budget for shopping. He has also reduced his GP's Pregablin prescription, which has reduced the likelihood of him selling the medication. He has not had another overdose incident.

Further information

The Drugs Wheel: A New Model for Substance Awareness - www.thedrugswheel.com/

Drink and Drug News (DDN) - https://drinkanddrugsnews.com/

Rehab Online (Directory) - www.rehab-online.org.uk/

Adfam: Families Affected by Drugs and Alcohol - https://adfam.org.uk/

Support Don't Punish (Campaign) - http://supportdontpunish.org/

Global Commission on Drug Policy - www.globalcommissionondrugs.org/

SMMGP (Substance Misuse Management within General Practice) – www.smmgp-fdap.org.uk/

Alcohol and Drug Misuse Treatment Statistics - www.gov.uk/government/collections/alcohol-and-drug-misuse-and-treatment-statistics

Release (Drugs, The Law and Human Rights) - www.release.org.uk/

Society for the Study of Addiction (SSA) - www.addiction-ssa.org/commentary/where-to-find-useful-statistics-and-information

BBC Article – 'Drug and Alcohol Services cut by £162m as deaths increase' - www.bbc.co.uk/news/uk-england-44039996

Collective Voice: A voice for the Drug and Alcohol Treatment Sector - www.collectivevoice.org.uk/

BBC Three – 'Drugs Map of Britain' Series - www.bbc.co.uk/programmes/p03nydkc

DrugFam: Drug and Alcohol Addiction Families Support - www.drugfam.co.uk/

European Centre for Drugs and Drug Addiction (EMCDDA) - www.emcdda.europa.eu/emcdda-home-page_en

DS Daily (Subscribe for daily updates on Drug Related News and Information) - www.dsdaily.org.uk/

TED Talk: 'Everything You Know About Addiction is Wrong', by Johan Hari - www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong?language=en

Labour Campaign for Drug Policy Reform - www.labourdrugpolicy.com/about

Centre for Social Justice (CSJ) - www.centreforsocialjustice.org.uk/

Volteface - http://volteface.me/

homeless link

What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless or live with multiple and complex support needs. We work to improve services and campaign for policy change that will help end homelessness.

Let's end homelessness together

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