What Works Evidence Notes

01 Drugs and Alcohol

Evidence from across the world on solutions to homelessness
What Works Evidence Notes

This series draws together research evidence from across the world of what we know about how best to relieve and prevent homelessness. The notes are deliberately short to provide a summary for busy people of findings of research from different fields. They will be updated regularly as our knowledge of what works advances.

About the Centre for Homelessness Impact

The Centre for Homelessness Impact champions the creation and use of better evidence for a world without homelessness. Our mission is to improve the lives of those experiencing homelessness by ensuring that policy, practice and funding decisions are underpinned by reliable evidence.

Topics in this series:

01 Drugs and Alcohol
02 Prevention
03 Welfare and Single Homelessness
04 Immigration Status
05 Legislation
06 Institutional Discharge
07 Employment
08 Mental Health

Evidence from across the world on solutions to homelessness
Purpose

This paper provides an overview of the evidence on the relationship between homelessness and substance and alcohol use. It captures recent trends and identifies what we know about what works for whom. We conclude with some initial thoughts on implications for policy and practice.

Overview

Evidence suggests that drug and alcohol use can cause homelessness, but it also shows that the experience of homelessness can also lead to substance use.\(^1\)

Public perception often views drug and alcohol use as a leading cause of homelessness, but evidence suggests that this is more prevalent among those who are street homeless than other forms of homelessness, such as family homelessness. Even with street homelessness, there is often an unclear pattern of cause and effect, as whilst substance misuse can be a contributory cause of homelessness, it often develops and worsens as a direct consequence of sleeping out. One survey conducted among a group of people experiencing homeless had substance use as the cause of homelessness for only 5% of the survey cohort.\(^2\)

Apart from the fact that drug and alcohol use can have serious harmful effects to one's physical and mental health, if an individual experiences homelessness or is at risk of homelessness, it can make a difficult situation a lot worse, making it a lot harder to exit homelessness for good. While the proportion of people experiencing street homelessness who have a substance or alcohol need is high, some of the data we have suggests that it is declining, at least in England.\(^3\) In contrast, for statutory homelessness, while the proportion is much lower, it seems to be on the rise, possibly due to an increase in the proportion of single people approaching local authorities in recent years. Data suggests that substance and alcohol use might be increasing among some sub-populations that had lower prevalence in the past such as women.

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3. See section about key trends on drugs and alcohol and homelessness.
The Challenge: key issues and recent trends

Substance use is disproportionately high among people who are street homeless or vulnerably housed. Those with substance use issues often also struggle with poor mental health, and offending behaviours which can compound the barriers they face.

An Ipsos MORI survey for CHI shows that the public estimates that 50% of the population experiencing homelessness has a substance use problem. This estimate is a slight overestimate of the figure for people experiencing street homelessness. In London in 2020/21, 47% of people sleeping on the streets were recorded as having support needs for some combination of alcohol or drugs. A study published in 2021 in Wales showed that 30% of people experiencing street homelessness cited substance misuse as a contributing factor to their homelessness.

The proportion of people experiencing all types of homelessness who have a substance use problem is much lower, as demonstrated in the existing homelessness assessment data. In the first quarter of 2021, 7% of households owed a homelessness duty had a drug dependency support need and 5% had an alcohol dependency support need in England, up from the earliest data in Q2 2018, when the number of households with a drug dependency was 5% and alcohol dependency was 4%. Of those assessed in Scotland, 11% had a drug or alcohol dependency, up from 10% in 2008, which is the earliest data available. Surveys of the homeless population in Wales show that from 2014 to 2020, about 17% had an alcohol abuse issue and 11% had a drug dependency. While the proportion of households assessed as having alcohol and drug support needs have increased in the last few years, it is still much lower than what the general public assumes.

Outreach data also suggests that the problem is more prevalent among those who are street homeless. In London in 2020/21, 47% of people were recorded as having support needs for some combination of alcohol or drugs. A study published in 2021 in Wales showed that 30% of people experiencing street homelessness cited substance misuse as a contributing factor to their homelessness.

The length of homelessness is also connected to alcohol or drug support use. More than a third of people who experience intermittent and long-term street homelessness had substance or alcohol support needs but that proportion is much lower among those who are new to the streets (alcohol 15% and substance 14%).

Also, substance use is most common among those who have previously served time in prison, but is rising in groups with previously lower levels of substance use. Notably, the portion of women who reported drug or alcohol problems increased by 16% since 2014-15, from 40% of women surveyed to 56%, whereas the number of men only increased by 9%, from 54% to 63%. This indicates that substance use may be rising faster in populations where it was previously less common.

Access to Services

Access to health and substance use services can be challenging, often due to negative past experiences, discriminatory services, healthcare costs, and other administrative barriers. This can lead to delayed treatment or even no treatment. St Mungo’s estimated that in 2018-19, about 12,000 people in England who were street homeless did not receive vital drug or alcohol treatment.

In Wales, it is typical for someone experiencing street homelessness to wait 12 to 26 weeks for a methadone prescription, a delay that can seriously affect a person’s chances at recovery.

Lack of care for substance use issues can contribute to other health problems. There is evidence showing an increase in diseases like Hepatitis-C and HIV, most likely caused by drug use. The rates of injected-related health issues are higher in the population experiencing homelessness than compared to the general, drug-using population in the UK.

Poor access to care also contributes to higher death rates in the homeless population due to drug use. In 2019, 37% of 778 deaths of people experiencing homelessness were caused by drug poisoning compared to only 0.8% of deaths in the general population.

It is therefore important to understand the most effective ways of engaging and retaining people in services to ensure their needs can be met appropriately. The evidence highlights the potential of peers and the use of incentives with particular groups of people who are homeless and who use drugs.
What we know about what works

Much of the available evidence comes from systematic ‘review of reviews’ of research evidence from North America, much of which focuses on opioid use. This is particularly relevant because, as reported in the 2020 RSQ report, one third of the street homeless population used crack cocaine and/or opioids in the past three months. We also report on interim findings from our forthcoming systematic review on drug and alcohol interventions.

1. Harm reduction interventions

Harm reduction interventions have been found to lead to decreases in drug-related risk behaviour; and co-delivery of multiple harm-reduction approaches can lead to even better outcomes than single harm reduction interventions. Harm reduction interventions, which vary in terms of evidenced effectiveness, include:

a. Managed Alcohol Programmes (MAPs)

b. Opioid Substitution Therapy (OST)

c. Take-Home Naloxone (THN)

d. Supervised Consumption Facilities (SCFs)

We discuss these in turn:

a. Managed Alcohol Programmes (MAPs) typically provide accommodation, health and social support alongside regularly administered sources of beverage alcohol to stabilise drinking patterns and replace use of non-beverage alcohol (i.e. liquids that contain alcohol which are not intended for consumption). Studies examining MAPs were largely conducted as case studies and small sample pilot projects so they need to be considered with caution, but individuals participating in MAPs demonstrated fewer hospital admissions and a 93% reduction in emergency service contacts. MAPs can also contribute to improved or stabilised mental health and medication adherence. They can also facilitate stabilisation by providing a safe space that decreases the risks associated with substance use, promote social and cultural reconnections, and provide an environment that fosters self-change.

b. Take-home naloxone (THN). Naloxone is an opioid antagonist that can rapidly reverse the respiratory depression induced by heroin and other opioids. Timely administration of naloxone can prevent deaths from opioid overdose. Recent literature continues to highlight the importance of naloxone in averting opioid overdose-related deaths, with evidence supporting the effectiveness of take-home naloxone. Drug users in the UK could be trained and permitted to carry naloxone for use among their peer group.

c. Opioid Substitution Therapy (OST) is a harm reduction intervention for people with injectable drug dependencies, particularly those who are not ready to achieve abstinence or are not responding sufficiently to other treatments. It allows people to consume drugs in a regulated and safer manner. In Ireland, OST is provided in various settings, including community treatment services, specialised general practices and prison drug services, with methadone and buprenorphine the most common substitutes for heroin. Evidence from systematic reviews suggest that OST is more effective in reducing drug use in prisons compared with no OST, and that high-dose methadone treatment is more effective than low-dose treatment. Multiple RCTs, including one conducted in the UK, demonstrate that supervised injectable heroin can lead to increased adherence to treatment and a reduction in use of street heroin.

d. Supervised Consumption Facilities (SCFs) are legally sanctioned facilities which "provide a space for people to consume pre-obtained drugs in controlled settings, under the supervision of trained staff, and with access to sterile injecting equipment. Participants can also receive health care, counselling, and referrals to health and social services including drug treatment." The facilities are designed to reduce the health and public order issues often associated with public injection of drugs such as opioids and crack cocaine. A recent systematic review highlights that SCFs for opioid consumption had positive impacts on fatal overdose prevention, public injecting and other high-risk consumption, and mortality. Additionally, SCFs can act as a bridge to other health and social services.

20 Miller et al. (2020). What treatment and services are effective for people who are homeless and use drugs? A systematic ‘review of reviews’. PLoS ONE 16(7).
23 For example, full harm reduction, defined as receiving both opioid substitution therapy (OST) and high needle and syringe programme (NSP) coverage, are associated with a 48% reduction in self-reported needle sharing, and a reduction in mean injection frequency by 20.8 injections per month. 100% versus <100% needles per injection.
24 Ezzed et al. (2015). Feasibility of a Managed Alcohol Program (MAP) for Sydney's homeless. Foundation for Alcohol Research and Education and St. Vincent's Hospital Sydney.
27 Mushke et al. (2012). Managed alcohol as a harm reduction intervention for alcohol addiction in populations at high risk for substance abuse. Cochrane Database of Systematic Reviews, 12.
28 Evans et al. (2013). “This place has given me a reason to care.” Understanding ‘managed alcohol programmes’ as enabling places in Canada. Health and Place, 33.
37 Magnus et al. (2020). The effectiveness of substance use interventions for homeless and vulnerable housed persons: A systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder. PLOS ONE 15(1).
Harm reduction strategies: additional considerations

Evidence suggests that five components were important for effective implementation: 1) the provision of a facilitative service environment; 2) compassionate and non-judgemental support; 3) adequate time in treatment; 4) choices regarding treatment; and opportunities to (re)learn how to live; and 5) with these being delivered within the context of good relationships, person-centred care, and an understanding of the complexity of people's lives. Longer treatment duration and stability was also valued, particularly by women. The working group for a review, made up of 84 experienced healthcare practitioners and 76 people with experiences of homelessness, agreed that focusing on safe consumption sites (e.g. SCFs and MAPs) and medications to manage opioid use disorder should be the priority interventions.

2. Housing-led interventions

Reviews of the evidence around housing interventions suggest neither a positive nor a negative impact of Housing First (HF) or other supportive housing interventions on substance use, but it was deemed potentially helpful for stabilisation, which is important if the aim is to reduce homelessness. This is consistent with other reviews including CHI’s review of accommodation-based interventions which suggest the intervention is more effective in improving housing stability compared to no intervention, but has less pronounced impacts on other outcomes such as improving health.

Therapeutic communities are abstinence-based interventions in which people with problematic substance use issues access structured programmes in a residential setting. Research on the impact of housing that was contingent versus non-contingent on sobriety indicates that sobriety might not be critical to sustaining housing. However, a study found some evidence of the effectiveness of recovery housing in the USA, especially the Oxford House intervention model. Oxford House recovery homes are peer-led, rented ordinary family houses. They have between six to 15 residents, often with shared bedrooms. To use the title ‘Oxford House’ they must be democratically self-run, financially self-supporting, and the residents must immediately expel any resident who returns to using alcohol or illicit drugs. Residents are usually required, or at least strongly encouraged, to engage with the 12-step Alcoholics Anonymous recovery programme. A cost-benefit analysis found that treatment costs were roughly $3,000 higher in the Oxford House group compared with usual care over a 24-month period. However, Oxford House participants exhibited a net benefit of $29,022 per person, suggesting that the additional costs associated with the approach were returned nearly tenfold in the form of reduced criminal activity, incarceration and drug and alcohol use as well as increased employment earnings.

Also, a review from 2013 and one primary study on women experiencing homelessness, found that therapeutic communities were effective in reducing psychological distress and healthcare use, improving self-esteem, and reducing drug and alcohol use within some limitations.
3. Intentional Peer support and case management

There was evidence of Intentional Peer Support (the type of peer support that is fostered and developed by professional organisations) reducing overall harm related to substance use, relapse rates and amount of money spent on substances, and number of days using drugs and alcohol. Sexual Health Promotion interventions have been found to increase knowledge of drug-related harm and short term reductions in drug use (longer term effects were mixed).

Findings for Assertive Community Treatment (ACT), which usually involves a multi-professional team based in mental health services, were largely non-significant or inconsistent in terms of substance use.

Intensive Case Management (ICM) was found in a study to result in substantial reductions in both drug and alcohol use, but the evidence regarding substance use remains limited. ICM has been found to reduce the number of days spent homeless but had no significant effect on the number of days spent in stable housing compared to usual services. We also found mixed effects on mental health and hospitalisation outcomes, while its impact on income and employment outcomes were small.

Successful Implementation is Key

How treatment is provided can be as important than the particular interventions people receive. Ensuring that people receive treatment in a facilitative environment, with staff who are non-judgemental, compassionate and respectful is critical. More needs to be done to support effective implementation of programmes in this space. Opportunities to develop skills and to (re)learn how to live a life away from homelessness and substances further support effective treatment. Treatment and care should be provided for as long as is required by an individual, with continuing support or aftercare post-treatment.

Motivation for, and maintenance of, behaviour change was reported as a central factor for success in community-based services for people experiencing homelessness with ‘Co-occurring serious mental health problems and alcohol/drug use’ (COSMHAD), with respect for client choice and client involvement in programmes facilitating this.

 Provision of a more supportive, less intensive approach in residential programmes for people with COSMHAD was found to be a key to success.
Implications for policy, practice and research

Drugs and alcohol use have a role both as a cause and a consequence of homelessness and may also hinder people’s access to other services that are necessary for their recovery such as housing and mental health support. Housing might not result in a reduction in substance misuse, especially for people with long histories of homelessness, but it can nevertheless play a vital foundation for stabilisation in consumption and result in fewer episodes of homelessness.

Our initial thoughts for how to use the existing body of knowledge to drive improvements in policy, practice and our understanding of what works include:

- Introducing (and rigorously evaluating) harm-reduction approaches that have been extensively proven to be effective in other contexts, particularly Supervised Consumption Facilities (SCFs)
- Rigorously test and scale other harm reduction approaches aimed at stabilising use. This includes heroin substitution therapy instead of methadone treatment for people with longer histories of opioids use; and Managed Alcohol Programmes (MAPs) that provide accommodation, health and social support alongside regularly administered sources of beverage alcohol to stabilise drinking patterns and replace use of non-beverage alcohol.
- Rigorously test and scale abstinence-based therapeutic communities for people who are ready to commit to an abstinence goal – this could be particularly relevant for some cohorts such as women.

- Governments at local and national levels should also build on the lessons from the COVID-19 pandemic, in which many people with extensive histories of street homelessness and problematic substance use were provided with self-contained accommodation, food and multi-agency support which enabled them to make a transition to a more settled life-style. This model should be maintained on a smaller scale for the specific client group where it is most effective and proper evaluation should be carried out to determine which are the key elements leading to success.