The Blue Light Approach: Improving accommodation options for people with alcohol dependency and complex needs

Part One: Main report and information guides

ALCOHOL CHANGE UK

Acknowledgements

This work is the result of a partnership between Alcohol Change UK and 29 local authority partners, national experts and people with lived experience.

The contributors are listed in appendices 2 and 3. The authors are very grateful for their input, without whom this work would not have been possible.

All images within this report are stock photos used for illustrative purposes only and posed by models.

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To appropriately house dependent drinkers with complex problems, we need solutions that match that complexity.

About this report

Structure of the report

This report is the first part of our work to improve accommodation options for people with alcohol dependency and complex needs. It sets out a clear direction for local authorities, commissioners, housing providers, and partner agencies, building on Alcohol Change UK's Blue Light Approach, which supports those often excluded from services and whose needs are frequently unmet.

The second part of our work is a practical guidance document for frontline practitioners, *The Blue Light Approach: Improving accommodation options for people with alcohol dependency and complex needs. Part 2: The law, benefits, and national guidance.* It focuses on housing law and the welfare benefits system, aiming to strengthen understanding and support professionals in helping people who are alcohol dependent to access and maintain secure, appropriate housing.

Underpinning beliefs

A set of beliefs underpins the guidance:

- Everyone should have their own accommodation.
- Having a large homeless population is unhelpful to everyone.
- Work is required not simply to provide accommodation but also to keep people in accommodation.
- People will need time and support at every step of the pathway into, through and out of accommodation – whether successful or not.
- People must not be set up to fail with inappropriate accommodation.
- Expecting all dependent drinkers to fit a single type of accommodation will not work – a range of accommodation is required.
- Individuals may also require a series of accommodation options with changing levels of support as their needs change and develop.
- Accommodation needs to be safe and not to exacerbate risk to the individual or the community.
- Partnership working will be required to meet these needs.
- Unmet need and gaps and blockages in the pathway should always be flagged to commissioners.

Language and terminology

In presenting this report, we have tried to use non-stigmatising language that is both respectful and accurate, aiming to avoid reinforcing stereotypes and assumptions while clearly describing the experiences and needs of the people this report is designed to support.

- **Homeless / Homelessness:** While these terms can be viewed as contentious, they remain widely used by government. Their use here aligns with that convention for clarity and consistency.
- **Complex needs:** This term refers to people who have multiple and multifaceted needs, such as homelessness, substance use disorders, and mental disorders.
- **People that services find difficult to engage:** This phrasing is intentionally used in place of "difficult to engage individuals" to shift the emphasis from the person to the service providers, who have a responsibility to adapt and proactively engage those in need of their help.
- **Alcohol use disorders:** This is the internationally recognised term to cover all those who are experiencing harm or causing harm because of their drinking.
- **Dependent drinkers:** In the context of England and Wales, this refers to the estimated 600,000 to 650,000 individuals who are physically or psychologically dependent on alcohol.

Supportive housing has been shown to reduce pressure on our public services, saving money and **improving lives.**

Executive summary

This guidance has been developed to support local authorities, commissioners, housing providers, and partner agencies to improve accommodation options for people with severe alcohol dependency and complex needs. It builds on Alcohol Change UK's Blue Light Approach, which focuses on dependent drinkers who are often excluded from support, repeatedly come into contact with public services, and whose needs are frequently unmet.

> Without appropriate housing, dependent drinkers are highly unlikely to achieve greater stability or make progress towards recovery.

Why this guidance is needed

Without appropriate housing, dependent drinkers are highly unlikely to achieve greater stability or make progress towards recovery. They are among the most vulnerable people in society, yet often find themselves excluded from both mainstream housing and treatment. Their impact on services is disproportionate: high levels of hospital use, frequent contact with the criminal justice system, and repeated safeguarding concerns. Nationally, this group is estimated to cost public services billions each year, with individual annual costs frequently exceeding £50,000.

Despite this, provision is patchy and insufficient. Local strategies often overlook people with alcohol dependency, focusing instead on abstinence-based accommodation that only works for a small minority. The result is that many remain stuck in a cycle of homelessness, crisis, and escalating health and social care costs.

Key insights from this work

- **Scale of need:** An estimated 70,000 people in England and Wales are homeless with serious alcohol use disorders at any given time. Around 11% of dependent drinkers fall into this group.
- **Costs and return on investment:** Supportive housing has been shown internationally to reduce emergency service use, arrests, and hospital admissions, saving money as well as improving lives. UK estimates suggest annual costs of £60,000 per person for those with multiple complex needs, compared with significant savings when housing and support are provided.
- **Barriers and stigma:** Access is often blocked by rigid service rules, reputational judgements, or past behaviour. Low self-esteem, health complications, and lack of psychologically informed support make engagement harder. Stigma remains a major barrier at both strategic and frontline levels.
- **Gaps in provision:** Most areas lack a full spectrum of housing options. Facilities that accept ongoing drinking, Managed Alcohol Programmes, and residential care for people with alcohol-related cognitive impairment are scarce. Women, people leaving prison or hospital, and those with co-occurring mental health conditions often fall through the cracks.

> Supportive housing has been shown internationally to reduce emergency service use, arrests, and hospital admissions, saving money as well as improving lives.

What needs to change

- **Develop a system, not just units of housing:** People struggling with alcohol dependency need pathways into, through, and out of accommodation, with skilled support to prevent eviction or abandonment.
- **Expand the range of options:** Provision must include abstinent and non-abstinent housing, Housing First models, specialist facilities for women and people with cognitive impairment, and care homes able to manage alcohol use.
- **Invest in workforce development**: Housing and residential staff need training in substance use, safeguarding, trauma-informed care, and relevant legal frameworks.
- **Challenge stigma:** Local leaders must actively counter the idea that people with alcohol dependency are 'choosing' their situation, and ensure strategies reflect their complex realities.

Next steps

Local partnerships are encouraged to use the audit tool within this report to:

- **Assess local need and current provision**.
- **Map pathways** from homelessness to appropriate housing and onward support.
- **Identify and fill gaps**, especially around non-abstinent options, Managed Alcohol Programmes, and specialist care.
- **Build monitoring into commissioning**, including outcomes on housing stability, health, offending, and cost reduction.
- **Plan for funding opportunities**: While current resources are limited, clear strategies will ensure areas can act quickly when new funding streams emerge.

Conclusion

Housing dependent drinkers with complex needs is both a moral imperative and a financial necessity. Meeting their needs will save lives, reduce pressures on health, social care, and criminal justice systems, and support safer, more resilient communities. This report provides both the evidence and the tools to start that process.

Among the estimated 650,000 dependent drinkers, there exists a small group of vulnerable people with complex needs.

1. Introduction

Among the estimated 650,000 dependent drinkers in England and Wales, there exists a small group of highly vulnerable drinkers – shaped by their drinking, lifestyle and behaviour – who have a significant impact on their own wellbeing, as well as on public services.

While people within this group may sometimes appear resistant to change, they are often those who stand to benefit most from appropriate residential or accommodation options which are tailored to meet their specific needs in support of a longer-term recovery journey or period of positive change. This section sets out the rationale for such an approach, who this guidance is aimed at, and the people it's designed to support.

1.1 Why this guidance

> Without appropriate accommodation, dependent drinkers will find it hard to achieve any kind of reduction in harm or long-term recovery.

This guidance takes that message and applies it in the context of Alcohol Change UK's *Blue Light Approach. Blue Light* is a national initiative to develop alternative pathways for dependent drinkers who appear to resist change and have a significant impact on public services.

Its focus includes frequent hospital attenders, repeat offenders and people subject to multiple safeguarding concerns. In an average area with a population of 200,000, Alcohol Change UK estimates that there are around 250 dependent drinkers who fit the *Blue Light* criteria and who cost at least £16-17 million each year across a range of agencies.

Blue Light has set out positive strategies that can be used and has shown that this approach will save money and resources. The Blue Light manual outlining the core approach is available on the Alcohol Change UK website along with related publications on assertive outreach, safeguarding and cognitive impairment.

Perhaps more than any other group, these individuals could benefit from residential or accommodation-based options. Yet, too often, conversations about the accommodation needs of dependent drinkers focus on the provision of what have been called "dry houses": abstinence based accommodation often accompanied by rehabilitative approaches. Moreover, individuals are often required to demonstrate that they are able to engage with that type of accommodation.

These will only help those who are motivated, ready and able to change. The individuals who are the focus of the *Blue Light Approach* will need a more complex and varied range of residential options.

> The objective of this document is to support the planning and development of the wider range of accommodation options needed for people who will not meet the criteria for mainstream rehabilitation.

Its focus will include:

- the need for facilities where people can continue to drink (traditionally called 'wet houses'), residential care for people with cognitive impairment and accommodation for specific groups, e.g. women with children.
- community services that support people into, through and out of accommodation.
- the approaches that prevail in services, for example, are they trauma informed / psychologically informed environments?

Above all, it will highlight the need for a **system** of accommodation for this group. Meeting these needs will require an organised and strategic approach. The key message and belief underpinning this guidance is that for this group:

> Accommodation is a journey not a place – every local area needs a strategy to support dependent drinkers to move through a system of residential options.

This guidance will help partnerships develop an improvement plan to reach such an approach.

The methodology used and a note on the language used in this report can be found in the Appendices.

1.2 The people who are the focus of this guidance

This guidance focuses on adults: residential provision for children and young people is a vital but complex issue and it would be hard to bring both needs together in a single document. Much of the content will also be applicable to people who have drug use disorders. Indeed, many homeless dependent drinkers will also have patterns of illicit drug use. But that is not the focus of this report. Nor is it focused on everyone with an alcohol use disorder.

The focus of this report is the main *Blue Light* client group: people who are probably dependent on alcohol, who do not engage with (or benefit from) alcohol treatment and who are repeatedly in contact with public services. At the partnership level, alcohol-related accommodation strategies may focus on a wider group of drinkers. However, this guidance is clearly focused on ensuring that this specific group's needs are met in any local strategy.

1.3 The current situation

At one level this is a poor moment to publish this guidance. Acute shortages of accommodation exist up and down the country and even mainstream therapeutic accommodation is in short supply. Dame Carol Black's Independent Review of Drugs states that*: Local commissioning of…residential rehabilitation has decreased substantially in recent years, despite evidence of their effectiveness and importance for people with particularly complex needs.*[1]

Even people who are motivated to engage with supportive accommodation will find it hard to access a place.

This lack of facilities is having negative effects:

- Hospitals are at risk of becoming alternative accommodation
- Police forces are left managing people who have no other support
- Local communities are facing large homeless populations
- Vulnerable people are dying on the streets

However, if we simply accept the current situation, it will never change. This guidance aims to prepare the case for alternative and better accommodation for drinkers with complex needs, so that when opportunities arise, commissioners and providers have a framework on which to build.

1.4 A note of caution

Accommodation is vital. Indeed, it may be seen as a basic human right. Therefore, providing a homeless person with a place to stay could easily be seen as "a good thing". However, **a roof and a bed alone may not be enough and may make the situation more dangerous.**

Placing people in inappropriate situations may place vulnerable people at much greater risk or, if the tenancy fails, make it harder from them to find future accommodation.

This is not an argument for leaving people homeless. Rather, any strategy needs to make sure that people have **the right accommodation with the right support at the right time.**

1.5 How this document works: An Improvement Plan Audit Tool

The core of this document (section 7) is a partnership audit tool that can be used to review the local accommodation offer for dependent drinkers with complex needs and develop *an Improvement Plan*. This is structured around five themes which are reflected in the sections preceding it:

- Building the case for investment and change (section 2)
- The need for a system (section 3)
- Accommodation – options and models (section 4)
- Managing alcohol in existing care homes (section 5)
- Developing an Improvement Plan – commissioning a system of accommodation for dependent drinkers with complex needs (section 6)

Within each section is a series of audit questions which emerge from its content. These build into the partnership audit tool which forms part of the improvement process by helping partnerships to think about how they can improve the local response.

Note: The partnership audit tool is aspirational. It sets out a gold standard for the accommodation pathway. However, it is recognised that improving residential options is a long journey and this document simply aims to support partnerships to start developing an Improvement Plan.

Throughout the document are references to information sheets which contain examples of good practice. These can be found in Section 8.

1.6 The target audience

This document is primarily aimed at people who commission alcohol services, housing and some health services. It is a support to the wide range of people who become involved in planning and developing such services.

However, anyone who works with dependent drinkers or delivers accommodation to this group may benefit from some of the content, for example the evidence base. Alongside this document is a range of information sheets which will be of benefit to anyone working with dependent drinkers.

A separate part of this project – the reference document on housing law and benefits for dependent drinkers – will be of use to anyone working directly with drinkers.

2. Developing an Improvement Plan: Building the case for investment and change

This section brings together key evidence to build a case for investment in improving care for some of the most vulnerable people in our communities, while also reducing pressure on public services. It draws on national guidance, data on the scale and cost of this group, insights into barriers and stigma, and the voices of lived and professional experience. It also presents evidence on the potential return on investment, helping to build a clear and informed foundation for change.

Audit questions – Building the case for investment and change
Has the case been built locally for investing in meeting the accommodation needs of dependent drinkers with complex needs? (2.1)
Has there been an assessment of the numbers of homeless dependent drinkers requiring accommodation? (2.2)
Has there been a costing of the impact of homeless dependent drinkers on the community? (2.3)
Has evidence on the housing needs of dependent drinkers been sought from other sources e.g. people with lived experience, alcohol service providers, housing providers and local serious case reviews? (2.4 & 2.1.4)
Has there been work on reducing stigma by helping all professionals, including commissioners and elected decision-makers, understand the challenges this group experiences in accessing accommodation? (2.5)

> "Nobody in any borough I have ever worked in has said: this is the number of complex and chronic drinkers we have. This is the percentage of these people that are in housing and this is the percentage that are not. This is the cost to the local NHS etc..."

Specialist substance use and housing commissioner

Local authorities, and the commissioners of alcohol and drug services or housing in particular, face many demands on their resources. In developing an Improvement Plan, it will be necessary to develop the case for investment to meet these specific needs. This section provides various pieces of supportive evidence. It explores:

- National guidance on the need for residential services
- Statistics about the size and cost of this group
- Understanding barriers and challenging stigma
- Listening to the voices of lived and professional experiences
- Evidence on the potential return on investment

2.1 National guidance on the need for residential services for dependent drinkers

National guidance supports the need for development in this area:

- The Clinical Guidelines for Alcohol Treatment
- NICE Guidance
- Dame Carol Black's Independent Review of Drugs

In addition, individual serious case reviews and other related guidance are also highlighted.

2.1.1 The Clinical Guidelines for Alcohol Treatment

In October 2023, the UK Government, with the devolved governments in Scotland, Wales and Northern Ireland, published the draft *Clinical Guidelines for Alcohol Treatment*. These set out how alcohol treatment should be provided. One section (14) is dedicated to residential options and states that:

- *Most people can receive appropriate support in the community, but inpatient or residential services may be required for those with the most severe and complex needs.*
- *Residential and intensive day programmes are an important part of a recovery-oriented system of care.*
- *Residential treatment focused on abstinence should be available for people with the most complex needs, particularly people who are homeless.*
- *There should be as seamless a transition as possible into residential and intensive day programmes for people completing medically assisted withdrawal.*
- *It is important to prepare people for intensive programmes but not at the expense of making it hard for them to access.*
- *Attention should be paid to help the person integrate back into their local community before they leave the programme.*[2]

2.1.2 NICE

The National Institute for Health and Care Excellence (NICE) clinical guideline Alcohol-use disorders: diagnosis, assessment, and management of harmful drinking (high-risk drinking) and alcohol dependence (CG115 1.3.1.4) recommends residential treatment for people who are experiencing homelessness.

2.1.3 Dame Carol Black's Independent Review of Drugs

In 2019, Dame Carol Black was commissioned by the Government to undertake a thorough review of the response to drug and alcohol use disorders. Her report is a powerful driver for change, including in the residential sector. Her report notes that: *Drug dependence can be both a cause and a consequence of homelessness and rough sleeping. People who are dependent on drugs may struggle to retain accommodation due to financial difficulties, problems with behaviour or family relationship breakdown… Homelessness and rough sleeping can also be the route to becoming drug and alcohol dependent.*[3]

It goes on to comment that: *Currently local authority housing services do not systematically provide the support that is needed, and there are shortcomings in the availability of specialist housing support (for example 'supported housing', 'recovery housing' or 'floating support') tailored to meet the specific needs of the population in drug treatment.*[4]

It notes that to meet the needs of this client group: *Services which have diminished over the years, such as inpatient detoxification and residential rehabilitation, will need to be re-commissioned in a way that ensures national coverage.*[5]

Recommendation 23 in the report states that: *MHCLG*[6] *and DHSC*[7] *work together to gain better understanding of the types and levels of housing-related need among people with a substance misuse problem, with early findings feeding into the next Spending Review.*[8]

2.1.4 Safeguarding Adult Reviews and Domestic Homicide Reviews

At the local level, serious case reviews for example, Safeguarding Adult Reviews (SARs) or Domestic Homicide Reviews, as well as reviews into the deaths of homeless people and drug and alcohol death reviews, may reflect on the need for residential accommodation for vulnerable individuals. For instance, in the analysis of SARs published by the LGA/ADASS in 2024[9], 29% of the SARs focused on people with accommodation problems. These cases will provide evidence for action at the local, if not national, level.

2.1.5 Other national guidance

Other high level documents support addressing these needs:

- A recent Scottish government report[10] stated that: *Residential rehabilitation treatment for drug and alcohol problems is a well-established intervention acknowledged in the (UK's) Drug Misuse and Dependence National Clinical Guidelines as an important option for some people requiring treatment. A recently published international review…found evidence for the effectiveness of residential treatment in improving outcomes across a number of substance use and life domains.* It adds that: *European evidence[2] suggests that access to residential treatment is lower in the United Kingdom than in other European countries.*
- In 2019, the Advisory Council on the Misuse of Drugs (ACMD) report into homelessness and drug misuse found that treating homeless people for drug use is exceptionally difficult unless their housing needs are addressed at the same time. ACMD states that safe, stable housing is essential for people who are homeless and who have problematic drug use, and that it is associated with increased engagement with services.[11]

2.2 The size of the group

Alongside national guidance, commissioners will need estimates of the size of this group if they are to support change. This is a challenge because the Office for National Statistics does not publish data on alcohol and homelessness.[12]

The National Drug Treatment Monitoring System (NDTMS) provides data on the rates and risk of homelessness among people with substance use disorders who engage with treatment services. The data indicates that 30% of alcohol only and combined alcohol and opiate clients had no home at the start of treatment.[13] This figure is only of partial help because it is looking at the group of dependent drinkers who engage with services: a minority of the whole group. The subsequent sections attempt to provide a more focused estimate.

2.2.1 How many homeless people and how many have alcohol use disorders?

In 2024, Shelter published an analysis of Government data which estimated that, *at any one time*, there are 192,521 homeless adults in England.[14] On a pro-rata basis, this equates to 10,676 in Wales. The definition of homelessness used and the basis for the calculation is contained in the Shelter report on: Homelessness in England 2024.

The more relevant question for this guidance is: how many of these homeless people also have an alcohol use disorder? As there is no national data on this, various estimates of prevalence have been identified from the UK, the USA and Europe. These range from 8% to 59% of the homeless population. However, five of the estimates are in the range 29%–42%, with three of them in the mid 30-40% range. Therefore, in estimating the number of homeless drinkers, 35% has been used in this guidance.

2.2.2 Developing estimates

Shelter has also provided data on homelessness by each local authority area. Therefore, we have taken the Shelter data on homelessness by each local authority and applied the 35% figure from the previous section to provide an estimate of the number of homeless dependent drinkers. Children have been removed from the Shelter data. This data has also been weighted for differences in levels of alcohol dependency between local authorities by using National Statistics data on rates of alcohol specific mortality (to raise or lower the number of dependent drinkers).

This suggests that, on any given day, there are 70,580 homeless people with serious alcohol use disorders across England and Wales. This covers four categories of homelessness:

- Adults who have been accepted as homeless and now live in temporary accommodation arranged by their local council
- Adults who have been accepted as homeless and now live in temporary accommodation arranged by themselves or are living 'homeless at home' – meaning that they are legally homeless because it is not reasonable for them to continue to live in their home, but they are yet to be moved into temporary accommodation
- Adults who are sleeping on the streets
- Single adults who are homeless and living in hostel accommodation, but who are not counted amongst those in the statutory homelessness figures above.

The table below sets out national calculations of the actual numbers and provides examples of different types of local authority in England.

Table 1: National calculations of the number of homeless people with serious alcohol use disorders across England and Wales, and in certain representative local authorities within England

Area	Estimate
England	66,898
Wales	3,682
Manchester	1,703
Royal Borough of Kingston	161
Gloucestershire	113
Nottingham	88
Islington	509
Surrey	204

This table indicates a great variation in the proportion of the population of dependent drinkers who are homeless. This will reflect variations in need but also reflects challenges in the accuracy of the data.

However, on the basis of the four categories of homeless people given above, on any one day:

- 0.15% of the adult (18+) population of England and Wales may be homeless dependent drinkers.

This equates to:

- 11% of the dependent drinkers in England and Wales.[15]

It is important to remember that this is not about street homelessness alone. This data incorporates the much wider group of people who are having problems with their housing.

For a detailed breakdown of the steps taken to provide an estimate of the size of this group, please see Appendix 5.

2.3 The cost of this group and the potential return on investment

The impact of these individuals is disproportionate to their number. This group contains some of the most risky and vulnerable members of the community. An American Government report highlighted that a: *"very substantial body of research…has consistently demonstrated…the cost savings created through supportive housing…for those with the most complex needs and most significant challenges… dozens of studies…demonstrate that the costs of delivering supportive housing are offset in large part by reductions in the use of crisis services, including shelters, jails, ambulances, and hospitals.*[16]

Evidence quoted includes:

- In a Chicago study, homeless people who were receiving inpatient hospital care for chronic conditions were randomly assigned to receive usual care or access to recuperative care (respite) and supportive housing. The intervention group had 29% fewer hospitalisations, 24% fewer emergency department visits, and 24% fewer days in nursing homes.[17]
- An evaluation of a Los Angeles *Housing for Health Program* found a 60% decline in costs for public services the year after participants moved into supportive housing. These cost reductions reflected fewer emergency room visits and arrests, and shorter inpatient hospital stays.

In Britain, the first edition of the Blue Light manual estimated that dependent drinkers with multiple compound needs would cost public services an average of £48,000 per person per year. This equates to over £60,000 per year at current prices.

The success of the Housing First approach demonstrates that people who are housed and supported are often able to reduce their substance use:

- a notable increase in people's engagement with mental health services from the point of entry until the end of the first year with Housing First (23% to 39%) and this is sustained over the next two years
- a clear downward trend in substance use across the three years, alongside a steady increase in engagement with drug and alcohol services
- a clear reduction in antisocial and offending behaviours across the three years. 84% of people were involved in antisocial and offending behaviours at the point of entry, compared to 45% by the end of the third year[i]

People who don't have stable housing are more likely to use A&E provision and are at a higher risk of being incarcerated. Nearly 30% of people sleeping rough admitted to committing a "minor crime such as shoplifting or anti-social behaviour" in the hope of being taken into custody for the night, and a fifth of those questioned said they had avoided being given bail or committed "an imprisonable offence with the express purpose of receiving a custodial sentence as a means to resolving their housing problems". Further research showed that 30% of people released from prison have nowhere to live and that people who were homeless prior to custody had a one-year reconviction rate, which is much higher than that of the general population.[ii]

Unpublished analysis by Tower Hamlets (2018/19) of 97 people with complex needs suggested average annual public service costs of £18–19,000 per person, excluding housing. While not formally published, this local evidence suggests the potential scale of additional expenditure, with risks of much higher costs (e.g. £40,000+ per year in residential care).

A 2012 study from the Cyrenians in Northumberland found an average annual cost saving to services of around £30,000 per person with an alcohol use disorder through the provision of housing support services (compared with no such services).[18]

Local commissioners can readily undertake their own assessments of the costs and potential savings in this group by looking at their impact on, for example, 999 calls, hospital attendance and admissions, arrests, court proceedings, prison, safeguarding and then applying standard costings to those activities. Please see Information sheet 7 on costings data for more information in the final section.

i Homeless Link (2025) Research exploring holistic Housing First outcomes. Available here.
ii The Queens Nursing Institute (2013) Homelessness and the Criminal Justice System. Available here.

2.4 The voices of people with lived experience

At the local level, it will be necessary to listen to the voices of people who have experience of alcohol-related harm and, in particular, those dependent drinkers who also have experience of homelessness and attempting to access housing services.

There may also be useful evidence in the experiences of alcohol and drug service and housing service staff. Multi-agency meetings such as a Multi-Agency Safeguarding Hub (MASH), Multi-Agency Risk Management meeting (MARM), Multi-Agency Risk Assessment Conference (MARAC) or Multi-Agency Public Protection Arrangements (MAPPA) or other local equivalent can provide live evidence about housing problems in the local community.

2.5 Understanding barriers and challenging stigma

> "When times are tough, these aren't popular groups, particularly for local members to stand up and say 'we need to support this over here' – there is still a stigma where people say, they have caused their own problems."
>
> Local authority housing lead

A final element in building a case for investment and change may need to be challenging the negative stereotypes and beliefs associated with this group.

Expecting dependent drinkers with complex needs to follow the pathways other people take through the housing system is unrealistic. The public (and indeed practitioners) may feel that dependent drinkers *ought* to be able to turn up for their appointments, return forms or answer their telephone but, very often, that will not happen. As a result, it is easy to dismiss the needs of this client group because they are not engaging and, instead, to prioritise the needs of those who do engage.

This negativity will impact on strategic approaches just as much as on face-to-face interventions.

The Blue Light manual sets out the very real physical, psychological and social barriers that this group face to leading a stable lifestyle. It describes the "perfect storm" of physical conditions which make it harder and harder for them to access and engage with structured services. The impact of depression, cognitive damage, liver disease, poor sleep and, in some cases, fetal alcohol damage will mean that their ability to manage themselves is severely impaired. Beyond that, there will be many social, psychological and emotional barriers.

Unless local strategic partners start with the recognition of these barriers and challenges, the pathway will lead nowhere.

> If we are going to appropriately house dependent drinkers with complex problems we will need solutions that match that complexity.

Please see Information sheet 1 on barriers and stigma in the final section.

Meeting the housing needs of dependent drinkers is a journey, not a place, requiring system-wide collaboration and targeted support.

3. Developing an Improvement Plan: The need for a system of support

Meeting the housing needs of dependent drinkers is a journey, not a place. It requires more than simply providing accommodation. It demands a strategic, system-wide approach underpinned by local partnerships, specific pathways, and targeted interventions.

This section considers the local pathways that support dependent drinkers into, through, and out of housing, with a strong focus on prevention, outreach, and tailored support for those leaving specific settings such as prisons and hospitals. Guidance around the geography of the intervention – where and at what level action is taken – is also considered, along with the need for workforce development and sustainable funding.

Audit questions – A system of support
Do local Housing and Homelessness Strategies address this issue? (3.2)
Is there a housing strategy for dependent drinkers? (3.2)
Has consideration been given to the geography of any interventions? (3.3)
Is there a mapping of local pathways into, through and out of accommodation for dependent drinkers? (3.4)
Are there services that support people into, through and out of accommodation? (3.4)
Are there interventions that stop people becoming homeless in the first place (eviction and abandonment)? (3.5)
Are there outreach-type services that support people from homelessness to housing and back? (3.6)
Are there pathways from prisons and hospitals into accommodation for this group? (3.7)
Have the training needs of staff working with dependent drinkers been assessed in terms of housing related themes e.g. housing law? (3.9)
Are there performance indicators for this area of work? (3.11)

Figure 1: Strategic framework for a journey through specific pathways for dependent drinkers

3.1 A journey not a place

Meeting the housing needs of dependent drinkers is not simply about providing units of accommodation. It will require a system that:

- supports the person to access housing *and*
- supports them through the inevitable struggles once they have moved in *and*
- is able to respond positively when their tenancy falters or fails.

> Housing dependent drinkers is a journey not a place.

All of us require different types of housing at different points in our lives and this is just as much the case with this group. Dependent drinkers will require varying types of support as they move towards stability or recovery.

Therefore, we need a system that allows the inevitably static nature of housing to meet the dynamic nature of alcohol use disorders.

The visual representation above attempts to capture the complexities of the situation.

This section explores the structure of a system that will meet this complexity; this will not be about just providing access to units of accommodation but will require:

- a robust strategic framework
- a system of skilled support at every stage

3.2 A strategic framework

The Advisory Council on the Misuse of Drugs' report recommends that: *Housing policies, strategies and plans across the UK should specifically address the(se) needs... by: recommending evidence-based housing provisions, such as Housing First; enabling collaboration across departments and agencies to ensure these interventions have a chance to succeed.*[19]

Achieving this will require partnerships to take three steps:

- Ensuring that local Housing and Homelessness Strategies address the issue.
- Having a specific accommodation strategy for dependent drinkers.
- Developing local pathways into, through and out of accommodation for dependent drinkers.

These three steps are listed in a logical order. The first of these is the straightforward task of linking strategies together. The second is the whole purpose of this guidance: the partnership audit tool aims to generate such a strategy. Therefore, this section concentrates on the specific task of developing local pathways that support dependent drinkers into and through appropriate accommodation. However, prior to that, a fourth theme – the geography of intervention – will need to be considered.

3.3 A fourth step – The geography of intervention

A key question is at what geographical and 'political' level should work on meeting these accommodation needs be undertaken. In some cases, this will be existing, probably higher tier, local authority level. But in others cases, the size of the area, the scale of need or the level of investment might dictate the need for a regional or sub-regional approach.

Dame Carol Black's report (see 4.1) recommended that: *DHSC, NHSE and the Office for Health Promotion review... the commissioning and funding mechanisms for high-cost but low-volume services such as inpatient detoxification and residential rehabilitation. DHSC should introduce a regional or sub-regional approach to commissioning these services to ensure national coverage.*[20]

The commissioning configuration in any area will depend on a number of factors:

- Some services, especially support services that are supporting people through the system of accommodation are likely to be provided locally.
- Local authority statutory housing duty will largely be provided locally although temporary accommodation, for example, may be purchased out of area due to local cost or availability.
- Some authorities will have either the level of need or the size of population that means most services described in this guidance can reasonably be expected to be provided locally, e.g. Manchester or Kent.
- Some residential services will be used in low volume, e.g. residential placements for people with alcohol-related cognitive impairment, and will be spot purchased by each local authority with social care responsibility. For example, the service used may be based in Nottinghamshire but its customers may be from all over the country. Nonetheless, regional or national work will be required to ensure there are sufficient services.
- Some of these facilities will be best organised on a regional or sub-regional basis because the individual local authorities are geographically small, such as some Greater London or Greater Manchester authorities, or because demand is relatively low.

This guidance cannot dictate how this should operate in any particular local authority. This must be a question for local debate and must be considered as part of a strategic process.

However, it is important to note that moving people into other areas, even neighbouring areas, can pose significant risks to individuals. In the research, we encountered examples of very poor practice:

"...what happens is that under the housing model, if someone walks into a London borough housing department today, they don't have any housing and they don't have much temporary housing. So, they will give them the fare and they will phone a temporary housing unit on the coast and say that is the address you have to go to and this is your accommodation... but then these people will be having...impacts on hospital services, addiction services..."

Housing commissioner

Even a short move to a neighbouring authority can mean changes to health and social care support systems on which they rely. For instance, for people with diabetes, a move can complicate access to insulin and other resources. Out of area placements may also mask the problems in the local area, increase client isolation, and potentially leave people more vulnerable to exploitation.

It is unfortunate that people may have to move areas. Finding accommodation for some in this client group will be challenging and geographical compromises may be required. Nonetheless, this needs to be done in a strategic manner and all agencies need to consider very carefully the impact of out of area placements, especially on vulnerable people or those with specific health needs.

3.4 Developing local pathways into, through and out of accommodation for dependent drinkers

Section 4 considers the range of residential options required for complex dependent drinkers. However, to use a housing metaphor, those housing options are just the bricks, what is required is the mortar to hold them together – a pathway or system to support people through these options.

This will consist of:

- Work to stop people becoming homeless
- Supporting people from homelessness to housing – outreach support
- Specific pathways – prison and hospital
- Staff who are trained to support people through their accommodation journey

These are considered in the next sections. However, local partnerships will also need to map these pathways to ensure there is a consistent and coherent approach.

3.5 Developing local pathways – Stopping people becoming homeless

The best way to address homelessness is to prevent people from losing their homes in the first place. This will require work to prevent both:

- Evictions – where the person is asked to leave accommodation
- Abandonments – where the person leaves because they cannot cope with some aspects of the accommodation

These are closely linked but may require different approaches.

Preventing evictions will require clear guidance for housing and other staff on preventative approaches. This will cover themes such as *initial contact and induction, issuing warnings,* and *alternative responses.*

Preventing abandonment will require staff to be looking out for key indicators of this risk, for example, non-engagement with support or activities, spending significant time away from the premises, arrears or debts, or vulnerability to exploitation or abuse.

Please see Information sheet 2 on stopping people becoming homeless in the first place in the final section. This provides more detail on possible approaches and examples of good practice from Edinburgh and Carmarthenshire.

NOTE: If someone does leave accommodation, it will be necessary to think about ongoing support. A very simple example comes from Middlesbrough. It was recognised that if a person is evicted, they tend to leave instantly, with no support package or 'back up' plan. A local service developed 'survival packs' with emergency food, a blanket and a list of support services and where to access free food.[57] In Surrey, an outreach service provided storage space for homeless people to keep their belongings.

3.6 Supporting people from homelessness to housing and back – outreach support

People will need support to move from the street, or from temporary accommodation, into appropriate housing. Expecting people to make this journey without support will probably fail.

Equally, many individuals will require support once they have left accommodation and are homeless again.

Meeting this need will require practitioners who can support individuals through that system. Assertive outreach workers and peer mentors may be useful in motivating people forward. However, the system will also require specialist workers who can support dependent drinkers from a position of knowledge about housing law. Examples of such services include The Blue Light Assertive Outreach Project in Westminster or Bridge the Gap in Surrey.

Please see Information sheet 3 on outreach support for further information about these projects in the final section. You can also read the separate Alcohol Change UK guidance on:

- Assertive outreach
- Peer support

3.7 Specific pathways – Prison

In 2024, the number of people released from prison into homelessness rose by 30%.[21] A 2024 Prisons and Probation Ombudsman (PPO) investigation report into the deaths of those who died within 14 days of release from prison makes specific recommendations:

- Post-release support for substance use should be offered to anyone who has completed a detoxification programme in prison, even if they are not engaging with substance use services in prison at the time of their release.
- HMPPS should consider how to improve release-planning processes for those who may be released under an early release scheme or with short notice following a Parole Board hearing.
- HMPPS and local authorities need to work together to reduce the number of prisoners released homeless.

People coming out of prison will need a very specific pathway to support them on their journey. These pathways can be fraught with problems. For example, in one area it was commented that people who are released from prison need three months of sobriety to access accommodation: this will fail many people on short sentences.

There are schemes that work to support people from Prison into accommodation, such as the West Sussex Prison release accommodation scheme, and specific funding to support this pathway. Please see Information sheet 4 on prison pathways in the final section.

3.8 Specific pathways – Hospital

Many, if not most, homeless dependent drinkers will pass through the hospital system. This should present an opportunity to help these individuals. However, the research for this project suggested that, all too often, hospitals are still discharging people with no accommodation in place. Legislation and guidance exist in both England and Wales that addresses this problem and you can read about this in the law and benefits report. Local partnerships should ensure that this guidance is being followed in their area and whether staff are required to support this pathway.

3.9 Workforce development

> "I was shocked to find that staff... in temporary housing... are (not) trained in any aspect of substance misuse. So they don't know how to spot someone who is perhaps struggling with their drinking or at risk of relapse. Or drinking to the point that they are seriously harming themselves. How do you have that conversation? They don't know that."
>
> Substance use Commissioner

People working in housing or homelessness services will need training and professional development to respond appropriately to this client group. This training could encompass:

- Basic knowledge about alcohol and its effects
- Identification and brief advice
- More technical knowledge about the physical and psychological impact of alcohol, e.g. co-occurring mental health conditions, dealing with seizures
- Information on local alcohol services
- Trauma informed approaches
- Working with dependent drinkers who are resistant to change (e.g. Alcohol Change UK's Blue Light Course)
- Safeguarding vulnerable dependent drinkers – understanding the application of legal frameworks such as the Care Act and Mental Capacity Act to this group
- Cognitive impairment in dependent drinkers

In particular, this will need to challenge a culture of stigma and prejudice that drinkers can receive. For example, viewing dependency as a lifestyle choice, that people are "self-sabotaging" or that they are "unable to change".

Specialist staff in Alcohol and Drug Services will be assumed to have most of the competencies mentioned above. However, they will also benefit from:

- Legal literacy in housing law
- Understanding how the benefits system supports access to housing

Alcohol Change UK has developed separate guidance on this which can be accessed here.

3.10 Two further points – risk assessment and recording unmet need

Risk assessment – All work with this client group must consider risk – both risk to the individual and risk to others, including practitioners. This guidance is not the place for a detailed analysis of risk for dependent drinkers. This is covered in more detail in Alcohol Change UK's Blue Light manual and the Assertive Outreach guide.

Recording unmet need – No system of care is perfect, if gaps are identified, especially consistent or serious gaps, staff should have mechanisms for recording and reporting these to commissioners.

> Without evidence on unmet need, systems and services will not develop.

3.11 Performance indicators

Commissioning a system of accommodation will require performance indicators. This will need to cover:

- The number of people who are supported into different types of housing
- The number of people who were threatened with eviction but where this has been prevented
- The number of people who were at risk of abandonment where this has been prevented
- The number of people who have been evicted from, or have abandoned, properties who have been engaged into a system of support
- The number of people leaving prison homeless
- The use of the duty to refer by hospitals and other services
- The provision and uptake of training

3.12 Funding

All the interventions in this guidance will require funding. This will, of necessity, largely be the responsibility of local authority Public Health Commissioners and local authority Housing Departments. For some aspects, there may be criminal justice system funding or Health Service support – both of which will benefit significantly from the availability of better housing. All of these budgets will be limited but arguments can be developed that they should be used, at least in part, to support this area of need.

However, over time, various funding streams to support aspects of housing have been set up by different governments, for example, the Rough Sleeping Drug and Alcohol Treatment Grant 2022 to 2025. This was extended into 2026, but at the time of writing there is no certainly about its future. A Drug Strategy Housing Support Funding Allocation ran from 2022 to 2025 but has now ended. This highlights how statements made about governmental funding will go out of date very swiftly.

Therefore, the main purpose of this guidance is to ensure that local partnerships are ready to make the most of funding streams that emerge and have clear plans about how they will meet the needs of this group as and when funding does become available.

Homeless Link have a page on their website devoted to Grants, funding and investment which partnerships may find useful for some projects.

The diverse accommodation needs of dependent drinks require a more nuanced person-centred approach.

4. Developing an Improvement Plan: Accommodation options and models

This section explores a range of residential options required to meet the specific and complex needs of dependent drinkers – from abstinence-based accommodation to services that support ongoing alcohol use. It provides an overview of existing services across the UK, highlighting examples of good practice that may serve as referral points for local development.

It also addresses the needs of individuals with co-occurring conditions, cognitive impairments, and those requiring specialist pathways such as Housing First, or support linked to DoLS or Alcohol Treatment Requirements.

Importantly, it recognises the need for inclusive services for specific groups, such as women, people with a history of offending, and those with pets, ensuring that accommodation is both accessible and appropriate.

Audit questions – Accommodation options and models
Are dependent drinkers able to access the following types of accommodation:
Accommodation that requires abstinence ('dry houses')? (4.2)
Complex needs facilities, night shelters and general accommodation that takes people with alcohol use disorders? (4.3)
Temporary housing? (4.4)
Accommodation that specifically allows ongoing drinking by people with alcohol use disorders ('Wet Houses')? (4.5)
Managed Alcohol Programmes? (4.6)
Facilities for people with co-occurring disorders (dual diagnosis)? (4.7)
Residential care for people with cognitive impairment both short-term and long-term? (4.8)
Women-only facilities? (4.9)
Domestic violence refuges which accept people with alcohol use disorders? (4.10)
Housing first – Single person accommodation with support? (4.11)
Facilities that can accept people on a DoLS? (4.12)
Facilities that can accept people on an Alcohol Treatment Requirement (or Positive Requirement)? (4.13)
Services that can take people with specific needs? (4.14)
Are these services offering Psychologically Informed Environments (PIE)? (4.15)
Are there performance indicators for this area of work? (4.16)

4.1 Breaking down the range of needs

This guidance has emphasised the importance of a system of housing support. Nonetheless, any improvement plan will need to consider the various accommodation options that are required and whether they are available. These are the 'bricks' in the 'bricks and mortar' analogy.

Too often, meeting the accommodation needs of dependent drinkers with more complex needs has focused on the provision of 'wet' facilities that allow people to continue to drink; while more stable drinkers require abstinence based 'dry' facilities. Any strategy will need to move beyond this binary approach and consider the wide range of needs experienced, and facilities required, by this group. These needs will be many and varied.

This section considers:

- Accommodation that requires abstinence
- Accommodation that specifically allows ongoing drinking by people with alcohol use disorders
- Managed Alcohol Programmes
- Night shelters and general accommodation that takes people with alcohol use disorders
- Facilities for people with co-occurring disorders (dual diagnosis)
- Residential care for people with cognitive impairment both short-term and long-term
- Facilities for specific groups, e.g. women
- Single person accommodation with support, e.g. Housing First
- Facilities that can accept people on a DoLS
- Facilities that can accept people on an Alcohol Treatment Requirement (or positive requirement)
- Domestic violence refuges which accept people with alcohol use disorders
- Services that can take people with specific presentations, e.g. a history of violence, arson, sex offending, and those with pets.

The following sections and accompanying materials are not exhaustive and do not act as a service directory. Other bodies provide more comprehensive lists of accommodation:

- Homeless England | Homeless Link – provides a database of alcohol facilities including many for people with complex needs.
- Addiction Treatment Directory
- Alcohol Dependence Care Homes / Nursing Homes England | 39391 Reviews
- Find a care home – Care Quality Commission (cqc.org.uk)

This section aims to provide an overview of the range of services available, and some examples of services in the UK which *can* be referral points for individuals with specific needs but also represent good practice that can be considered as models for local development. (The support material contains a few international examples as further models). The final section considers the important cross-cutting theme of psychologically informed environments. Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.2 Accommodation that requires abstinence

Alcohol-free facilities, which are usually focused on rehabilitation, have long been the backbone of the residential response to alcohol use disorders. Longstanding examples include Kenward Trust (Kent) or Broadway Lodge (Somerset). Access to these facilities is supported by national directories:

- Drink and Drug News's Addiction Treatment Directory 2024
- Alcohol Dependence Care Homes / Nursing Homes UK | 23404 Reviews

This guidance acknowledges the importance of such facilities but they are not its focus. Nonetheless, some abstinence accommodation will be more helpful for this group than others. If a dependent drinker with complex needs does agree to abstinent rehabilitation, it will be important to consider:

- How the service deals with lapse or relapse into drinking?
- Is the service's programme able to meet the varying intellectual abilities of this group? Programmes which rely on groupwork may be challenging for people with even moderate levels of cognitive impairment.
- What is the maximum length of stay? People with complex problems will benefit from stability, so longer stays will be helpful.
- How quickly will local services be notified if someone is no longer resident?
- Does the service help resettle people back into the community?

It is also important that Commissioners ensure that access to these facilities meets the standards in the *Clinical Guidelines for Alcohol Treatment*, i.e. that there should not be unreasonable barriers to access.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.3 Complex needs facilities, night shelters and general accommodation that takes people with alcohol use disorders

Most of this section focuses on facilities which are specifically designed for people with alcohol or drug use disorders. However, any pathway will need more general, low threshold accommodation which can house dependent drinkers but which also houses people more generally. For example, the Salvation Army operates over 80 Lifehouses – supported accommodation services across the UK and the Republic of Ireland. These are places where people can get support with their housing issues – but also find support with other aspects of their lives such as addiction or mental health.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.4 Temporary housing

Temporary housing is a necessary but controversial part of the housing pathway. It provides accommodation to people in acute need who cannot be immediately placed in more permanent accommodation. It will include short-term placements in bed and breakfasts or hotels. However, in some areas, these placements may be out of area without an adequate support network or relying on support in other local authorities. This type of accommodation is necessary but it will be vital to ensure that support including outreach type support (see 3.6) is available.

4.5 Accommodation that specifically allows ongoing drinking by people with alcohol use disorders

Some residential facilities allow people with alcohol use disorders to drink on the premises or while living at the premises (albeit not on site). There may be some limitations on where or when people can drink, but essentially people can drink as they might in their own home.

This is a concept with a long history (they were formerly called 'wet houses') and can, therefore, often be seen as the key response to dependent drinkers with complex needs who are unable to engage with abstinent accommodation. Rather, they should be seen as one possible part of a system response. These facilities overlap with Managed Alcohol Programmes which are considered in paragraph 4.6.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.6 Managed Alcohol Programmes

Managed Alcohol Programmes (MAP) are a harm reduction approach that provides alcohol in measured, regular doses throughout the day, along with a range of other support. This can occur in multiple settings including day programmes, temporary and permanent housing.

They were initially developed in Canada for people with alcohol use disorders who find it hard to engage with higher threshold services. They also exist in Ireland. Several studies in Canada have shown positive results: fewer withdrawal seizures; reduced alcohol-related harms; improvements in relationships, quality of life, wellbeing and safety; lower alcohol intake and use of less harmful types of alcohol; ability to retain their housing; and less harmful patterns of use, alongside evidence of cost–benefits.[22] The Simon Community introduced Scotland's first Managed Alcohol Programme (MAP) in 2021.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.7 Facilities for people with co-occurring conditions (dual diagnosis)

A large proportion of people with alcohol problems will also have mental disorders. This group can present with very complex needs and is statistically associated with unstable housing settings.[23] A full response will require staff training, inter-agency protocols, agreed pathways and specialist community services.

However, there will also be a need for residential services. The draft Clinical Guidelines state that: *There is some evidence that outcomes are improved when residential settings offer treatment for both mental health conditions and substance use conditions...*[24]

A number of residential facilities that specialise in this area have been identified. Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

At the border between community and residential settings will be the need for community services that support people with co-occurring disorders in residential settings. For example mental health nurses who go into hostels and other generic residential settings and provide clinics and therapeutic input. South London and Maudsley NHS Trust have a psychology in hostels programme which is an example of this approach.

4.8 Residential care for people with cognitive impairment both short-term and long-term

A significant, and probably growing, proportion of dependent drinkers are being diagnosed with cognitive impairment as a result of either their drinking or the drinking lifestyle. These will be among the most complex presentations in the homeless community. For many, a period in residential rehabilitation may be the best approach, and for some a long-term placement in a residential care home for people with significant cognitive impairment will be a necessity.

Therefore, every area needs to know how to access such accommodation. This may not be local provision, but there needs to be access to a national network of provision.

On the other side, existing accommodation providers will need to be able to identify, support and plan care pathways for people with cognitive impairment. Some of this response will require community services that are reaching into hostels and other accommodation. One example of this is Change Communication in Westminster which works with people and organisations to better support those experiencing cognitive impairment in hostels and other settings.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.9 Women-only facilities

Women will need all the services identified within this section. However, it is very likely there will also be a need for specific women-only services. Some of these needs will be addressed by the services identified in paragraph 4.10 for survivors of domestic abuse. However, there are also other services. These are hard to categorise because they may meet varying needs, albeit they all work with women only. An extension of this will be services that work with women and children.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.10 Domestic violence refuges which accept people with alcohol use disorders

Domestic violence refuges have at times been reluctant to accept women who have an ongoing alcohol use disorder. This is likely to be because of concerns about the safety and emotional wellbeing of other women for whom alcohol use may be a reminder of very negative experiences. Nonetheless, this leaves a gap, particularly for those women who have been using substances to cope with the abuse. This pattern is changing and some services are being set up specifically to support women with alcohol and drug use disorders who are fleeing domestic abuse.

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.11 Housing First – Single person accommodation with support

This section of the guidance has concentrated on housing dependent drinkers in the context of multiple occupant accommodation such as hostels and rehabs. However, most people will prefer to live in self-contained accommodation. The best model for this is, arguably, the Housing First approach.

Housing First is a housing plus support approach which:

- Gives people who have experienced homelessness, chronic health problems, and social care needs, a stable home from which to rebuild their lives.
- Provides intensive, person-centred, holistic support that is open-ended.
- Places no conditions on individuals, however they should desire to have a tenancy.

The Housing First approach was first developed in New York and has been adopted internationally, demonstrating widespread success. Since 2010, a growing number of local areas have established Housing First services.[25]

Dame Carol Black's report of her Independent Review of Drugs states that: *Housing First has proved to be an effective evidence-based model for people with complex needs who sleep rough, providing a secure stable platform from which other issues can be addressed. Housing First should be scaled up and rolled out more widely...*[26] *Housing policies, strategies and plans across the UK should specifically address the needs of people who use drugs and are experiencing homelessness by: recommending evidence-based housing provisions, such as Housing First; enabling collaboration across departments and agencies to ensure these interventions have a chance to succeed.*

Please see Information sheet 8 on accommodation options for more information and examples of services in the final section.

4.12 Facilities that can accept people on a DoLS

Arguably, the most challenging gap in the array of accommodation for dependent drinkers is facilities, essentially residential care homes, that can hold a dependent drinker under a Deprivation of Liberty Safeguard. At times, this will be necessary to safeguard very vulnerable people. However, detaining a 54-year-old dependent drinker in a care home is far more challenging than detaining a 93-year-old woman with dementia.

Some care homes will take on this role but finding a care home at a point in time will be difficult and an individual home's ability to accommodate someone will probably vary over time, dependent, for example, on the current make-up of the resident group.

Commissioners will need to work with local care homes and identify facilities which may take on this role. This will be supported by reference to the local authority with social care responsibility's approved provider list and sites like carehome.co.uk which can provide a list of all the care homes that will work with alcohol dependence generally. (It currently lists over 1,000 such homes in the UK).

4.13 Facilities that can accept people on an Alcohol Treatment Requirement (or Positive Requirement)

Two legal disposals provide an alternative framework for moving someone into accommodation:

- Alcohol Treatment Requirements
- Positive requirements as part of a Criminal Behaviour Order or Civil Injunction

The Criminal Justice Act 2003 introduced the Alcohol Treatment Requirements. These are effectively probation orders with conditions of alcohol treatment.[27] They are, therefore, only applicable to people who have committed an offence that warrants a probation order. Once on an order, someone would receive a period of community treatment, most likely one to one interventions and / or groupwork. However, it is possible to require a period in a residential rehabilitation facility.

The Anti-social Behaviour, Crime and Policing Act 2014 introduced powers to support frontline agencies in tackling anti-social behaviour. These include the *Civil Injunction* which is a civil order issued by the courts and the *Criminal Behaviour Order (CBO)* which is available on conviction of any offence. These replaced, and represented a step change from, anti-social behaviour orders (ASBOs). The current orders not only allow courts to ban behaviours (e.g. drinking in a particular location) but also allow the imposition of *positive requirements* which will help encourage permanent change. Again, it would be possible to require a period in a residential rehabilitation facility.[28]

These powers are currently little used to drive residential options. Therefore, there is little evidence about which services will accommodate people under such approaches. This will require commissioners and staff in Probation or Anti-social Behaviour Teams to consider which services will accommodate dependent drinkers on this basis.

4.14 Services that can take people with specific needs

Three specific client characteristics will make individuals far more challenging to accommodate:

- People with a history of violence
- People with a history of sex offending
- People with a history or arson or accidental fire-setting

As with the previous two sections, it is likely to be a matter for negotiation with services about whether their current circumstances allow them to take a specific person with their individual history. Clearly someone with a history of sex offending or violence against the opposite sex may be better placed in a single sex project. They may also benefit from Probation managed accommodation.

However, two principles are useful here:

- Professionals need to work hard to understand the reality of the risk. How recent is the fire-setting or violence? What were the circumstances that led up to it? Are there protective factors that minimise the risk?
- Is education possible to minimise the risk? For example, in Surrey, those who have been convicted of deliberately starting a fire can now take a course which helps them avoid being made homeless.

Services that can take people with pets

NOTE: Another specific challenge is the need to accommodate a pet. This can be a challenge for providers, not least due to health and safety concerns e.g. allergies in other residents, the need to ensure that the pet does not have fleas or a similar problem. Again, this will require negotiation with providers.

4.15 Cross-cutting themes – Psychologically Informed Environments (PIE)

In considering the range of available options, the focus of the facility is not the only concern. Services will need to be sensitive to a range of cross-cutting themes, for example, age, gender and ethnicity. However, an essential element of all these services will be that they are trauma informed. This client group will need psychologically informed environments. The Clinical Guidelines emphasise that: *Services should be trauma-informed and have clear clinical governance structures and policies including for staff supervision.*

A Psychologically Informed Environment (PIE) in the context of housing is a setting that recognises the impact of trauma, psychological distress, and other emotional factors on individuals' behaviours and wellbeing. Developed initially for homelessness services, PIE has expanded into various sectors, including substance use services and housing support, to create supportive, understanding environments that facilitate recovery, stability, and resilience.

The PIE approach is especially relevant for individuals dealing with substance use, including alcohol dependency. By addressing the psychological and emotional needs of residents, a PIE can provide a structured yet compassionate space where individuals feel understood, accepted, and encouraged to make positive changes in their lives. PIE is crucial in breaking the cycle of dependency and homelessness by helping residents develop coping mechanisms, improve interpersonal relationships, and work towards long-term housing stability.

Please see Information sheet 9 on psychologically informed environments for more information and examples of services in the final section.

4.16 Performance indicators

Commissioning individual accommodation placements will require performance indicators. This will need to cover:

- The number of people who access different types of housing
- The average length of stay
- Changes in health, social wellbeing and criminality
- The number of people who move on into independent or supported accommodation
- The number of unplanned exits from services
- The number of unplanned exits who are linked successfully into other services.

Table 2: **Funding streams which support individual placements across a range of facilities**

Funding streams which support individual placements in the facilities listed in this section	
Care funding from the local authority plus Housing benefits	**Housing benefits payments alone**
Accommodation that requires abstinence	Complex needs facilities, night shelters and general accommodation that takes people with alcohol use disorders
Facilities for people with co-occurring disorders (dual diagnosis)	Temporary housing
Residential care for people with cognitive impairment both short-term and long-term	Accommodation that specifically allows ongoing drinking by people with alcohol use disorders
Women-only facilities	Housing first – Single person accommodation with support
Facilities that can accept people on a DoLS	
Facilities that can accept people on an ATR (or positive requirement)	
Services that can take people with specific needs	

4.17 Funding

From the individual resident's perspective, unless someone has their own resources, the funding streams that support their stay in any of the projects listed in this section will fall into two main types:

- Housing benefits payments
- Care funding from the local authority with social care responsibilities, possibly via Public Health, in combination with Housing benefits.

The table above sets out which service is likely to fit into which category. There may also be some exceptions to this, for example, Continuing Healthcare Funding, funding for people who are under Section 117 of the Mental Health Act. Note: Managed Alcohol Programmes are not included because they do not exist in England and Wales.

The exception to this is domestic violence refuges which accept people with alcohol use disorders. They will be funded via the Domestic Abuse Duty Safe Accommodation grant but will still require housing benefits payments.

4.18 Estimating the need for individual housing options

The most challenging question is: how many of each type of accommodation are needed in an area? This question can never be answered with anything other than a crude estimate. Recommendation 23 of Dame Carol Black's report recommends that: *MHCLG*[29] *and DHSC*[30] *work together to gain better understanding of the types and levels of housing-related need among people with a substance misuse problem, with early findings feeding into the next Spending Review.*[31] The outcomes of this recommendation should provide a more robust basis for estimating key elements of the local need.

However, in the absence of that data, Table 3 sets out the identified accommodation options accompanied by commentary on the level of need.

Table 3: **Accommodation options and associated requirements**

Facility	Commentary
Accommodation that requires abstinence	Dry accommodation is already being purchased by substance use commissioners and they will have the best idea of the local level of need. The key questions for the strategic lead will be: • Is there a route to residential care for those who require it that is appropriately speedy and without any unnecessary hurdles? This will ensure that the real level of need is visible. • Is data on unmet need being gathered and reported by those who manage access to these services?
Accommodation that specifically allows ongoing drinking by people with alcohol use disorders	This will be related to the size of the local homeless dependent drinking population as per section 2.
Managed Alcohol Programmes	These programmes are subject to piloting in Scotland. The Glasgow pilot is taking 10 people in a residential facility. However, in Canada the numbers in a single MAP can reach over 100. This may need to be provided regionally.
Night shelters and general accommodation that take people with alcohol use disorders.	This will be related to the size of the local homeless dependent drinking population as per section 2.
Residential care for people with cognitive impairment both short-term and long-term	Required infrequently and in small numbers. The local authority with social care responsibility / strategic lead simply needs to have a list of potential options and access to funding to make placements.
Facilities for people with co-occurring disorders (dual diagnosis)	Required infrequently and in small numbers. The local authority with social care responsibility / strategic lead simply needs to have a list of potential options and access to funding to make placements.
Facilities for specific groups e.g. women	Women make up a smaller proportion of people with alcohol use disorders than men. However, Government data suggests that 23% of the 608,000 dependent drinkers are women; this is still a large need.
Single person accommodation with support e.g. Housing First	This will be related to the size of the local homeless dependent drinking population as per section 2.
Facilities that can accept people on a DoLS	These will be required infrequently and in small numbers. Residential care homes that can take someone under a DoLS may require local research, negotiation about the care provided and possibly staff training.
Facilities that can accept people on an ATR (or positive requirement)	These will be required infrequently and in small numbers. Residential care homes that can take someone under an ATR or positive requirement may require local research, negotiation about the care provided and possibly staff training.
Domestic violence refuges which accept people with alcohol use disorders	Facilities for victims of domestic violence will be required in larger number. However, they will not be under the strategic oversight of substance use commissioners. Domestic abuse commissioners will be assessing the level of need. The main task from the substance use perspective will be to work with these local commissioners to ensure that people with substance use disorders can access refuges when required. Again, this may require the offer of training and development support to such services.
Services that can take people with specific presentations e.g. a history of violence, arson, sex offending, and those with pets.	Required infrequently and in small numbers. The local authority with social care responsibility / strategic lead simply needs to have a list of potential options and access to funding to make placements.

A key strand in improving the care home response to alcohol is training and professional development.

5. Developing an Improvement Plan – Managing alcohol in existing care homes

While much of this guidance focuses on accessing or developing appropriate accommodation for dependent drinkers with complex needs, it is equally important to consider how existing residential settings manage alcohol consumption. This is particularly relevant in care homes, where the ability to support individuals with ongoing alcohol use requires a good level of understanding of its effects. This section offers a brief reflection on this issue and shares examples of good practice to support care staff in managing this effectively.

Audit questions – Managing alcohol in existing care homes
Have the training needs of general housing/residential care staff been assessed in terms of alcohol-related competencies e.g. understanding the physical effects of alcohol?
Is relevant alcohol-related training available to these staff?

In January 2024, the University of Bedfordshire published a Good Practice Guide and two other documents on the management of alcohol use in care home settings. The guide aims to help care staff deliver a high standard of care in relation to alcohol. It is based on the findings of a research study which gathered the views and experiences of care staff, people living in care homes, their families and CQC inspectors. It takes account of legislation, CQC standards for care and codes of conduct for adult social care workers and nurses. The key documents are:

- Alcohol management in care homes – A good practice guide for care staff.
- Drinking alcohol in a care home – A guide for care home residents and the general public.
- Promoting good practice in relation to alcohol use in care homes for older people – a summary of the research on which the guidance is based.

This guidance will not repeat this material and recommends interested readers to consult these documents.

A private sector organisation, Care 4 Quality, has published a helpful blog, *Managing Positive Risk-Taking with Alcohol Consumption in Care Homes* on its website.[32] It suggests action in six areas:

- Resident Health and Medication
- Staff Training and Awareness
- Social and Environmental Factors
- Responsible Drinking Education
- Policy and Guideline Implementation
- Environmental Safety

Another private sector organisation *Shared Lives South West* have published a Smoking, Alcohol and Drugs policy. Again, this may provide useful pointers to best practice.

A key strand in improving the care home response to alcohol is training and professional development. The elements of such training are set out in section 3.8.

Delivering comprehensive support requires access to facilities for people at different stages of their journey towards safety and stability.

6. Developing an Improvement Plan: Commissioning a system of accommodation for dependent drinkers with complex needs

This section brings together the insights from earlier parts of the report and explores what a more effective local system might look like, along with how it can be implemented. Recognising that the accommodation requirements of dependent drinkers with complex needs are diverse, it addresses the need for a tailored response within each local context – shaped by population size, local need, and existing investment, and the tier of local authority.

A strategic starting point for many areas will be the establishment of a task and finish group, using the partnership audit tool central to this guidance. Delivering a comprehensive support system will require access to a range of facilities that can accommodate people at different stages of their journey towards safety and stability.

6.1 The starting point

This section brings together the material from the previous sections and considers what an improved local system would look like and how it can be implemented.

> "It needs to be acknowledged that for most Local Authorities there is insufficient funding to develop the ideal continuous system of care but without planning local systems will not improve. It may also be helpful if local partnerships flag up gaps in the system to the key Governmental Departments: the Ministry of Housing, Communities & Local Government and the Department of Health and Social Care."
>
> Housing commissioner

The accommodation needs of dependent drinkers with complex needs are not uniform and, of necessity, the response will vary from area to area. It will depend on population size, local need, and the existing investment. Most significantly, it will vary dependent on the tier of local authority. In current two-tier authorities, for example Surrey or Lancashire, alcohol interventions are commissioned at the county (upper tier) level and housing is commissioned at the borough and district (lower tier) level. This will impact on the leadership and organisation of any response.

The Government has announced plans to reorganise the structure of local government in England which will impact on the two-tier structure. However, the starting point for this work should be standard across each upper tier and single tier local authority.

Each of these areas should have a strategic group, for example a Combatting Drugs Partnership Board (CDP) or an alcohol strategy group, which will oversee the local work with people with alcohol use disorders specifically, or substance use disorders generally. This is likely to be the best point for leadership and oversight.

It is recommended that as a result of the improvement process set out in this document, each of these local authorities should have:

- A strategic statement on meeting the accommodation needs of dependent drinkers with complex needs. This might be a standalone strategy but could be part of a wider substance use or housing and homelessness strategy.
- An identified strategic / commissioning lead to initiate and oversee development with this group of needs. Again, this might be part of a wider commissioning portfolio.

We also recommend that:

- Each CDP should have a sub-group that looks at the accommodation needs of people with alcohol use disorders. (Given the remit of the CDPs this will need to cover drugs as well as alcohol). Such a group should have membership representing the range of agencies on the CDP including Police, Alcohol and Drug Services, Health Services and Adult Social Care. It will also need to have representatives from local Housing Departments (which may be a separate local authority) and key housing providers.

6.2 A Task and finish group

In moving towards this strategic framework, a useful starting point for most local authorities will be a task and finish group. This can take as its starting point the partnership audit tool which is at the heart of this guidance. This will help:

- Scope the accommodation needs of recovering drinkers *and* the needs of people who are struggling to recover by reviewing or commissioning evidence of local impact and need
- Map and understand the existing local provision
- Map the out of area provision that can be used to meet specific needs
- Identify areas of unmet need
- Consider the geography of interventions
- Support workforce development in the housing sector and the alcohol and drug sector

This will lead to **the development of the local strategic statement and identification of an ongoing strategic / commissioning lead.**

This group will then transform into a standing sub-group which monitors the implementation of the strategy. (The membership and frequency of meeting may need to change at this point to reflect the revised focus from development to monitoring implementation).

Please see Information sheet 5 on strategic frameworks for more information and examples in the final section.

6.3 Model comprehensive systems

A comprehensive system of support will require access to a range of facilities that can house people at various points in their journey to greater safety and stability. This will include:

- Places that can accommodate people when they are at their least stable into which they can move from the streets, or move back to if their situation becomes more unstable again e.g. a relapse.
- Units of accommodation with varying degrees of support to meet the stages (forwards and backwards) of a journey to greater stability.
- Practitioners and services to support them through this system.
- Longer term, probably single person units, in which they can achieve safety and stability with support.

Manchester and Westminster have been identified as local authorities having good examples of systems of care and support. Services such as Harbour Housing in Cornwall also provide a more comprehensive model within an agency. Other areas, for example Nottingham or Blackburn, have projects which bring multiple services together to provide a multi-agency response to this client group.

Please see Information sheet 6 on model systems for more information in the final section.

A system in practice – Manchester City Council (MCC)

Manchester has a well-developed accommodation system that comprises rough sleeper support, a triage and assessment centre, daily multi-agency panel meetings, the A Bed Every Night (ABEN) scheme, and a drug and alcohol housing support pathway. This multi-faceted approach has seen the cost to the council of temporary accommodation reducing over an 18-month period from £66k a night to approximately £1-2k a night.[43]

A Rough Sleeper Support Service

The Entrenched Rough Sleepers Social Work Team is made up of highly skilled social workers who apply a huge breadth of experience and theory to support some of Manchester's most severely disadvantaged, multi-excluded and traumatised people. Practitioners work with this highly complex cohort who have been sleeping rough over an extended period of time. These people often refuse to come indoors or find it difficult to stay indoors. They are known to key partners as the Target Priority Group (TPG).

"People do not choose to be entrenched rough sleepers. There is always a complex story behind the person. These people are living on the outskirts of society. They are constantly in survival mode, living hour by hour. They must consider how they will wash, eat, sleep, and manage their life on the streets – in that community. It is a highly intense and difficult way to live." Team member.

Their specialist social workers take a trauma informed and multi-disciplinary approach of professional curiosity and compassionate enquiry to find out what is going on for the person. They meet each person where they are at, without judgement to empower them to live the life that they choose.

A triage and assessment centre – Etrop hotel

An old hotel by Manchester airport has been converted to be a 72-bed quick access centre for triage and assessment of needs. The remit of the hotel is to get people off the streets so although some people are long term, for example if they've burned their bridges with other services, these residents are the minority. The hotel can increase capacity during pinch point times, for example through the provision of bunk beds in function rooms. Residents pay £7 a week and get offered 2/3 meals a day.

A multi-agency approach

Every morning a B&B panel convenes to discuss individuals case by case with the aim of ensuring that people are placed in accommodation that is appropriate to their needs. The Etrop manager will attend every panel and advise on the status of people residing there, and help develop an appropriate placement considering the many different variables such as the needs of the individual, the needs of the placement and the cohort in any given placement at any different time. The panel has sped up the process of moving people from housing related support to private rented sector accommodation.

A multi-agency complex panel convenes every Thursday to discuss hard to move on, very challenging cases. Consideration is given to what can be done for them, any changes that have occurred, and any liaison that needs to happen on their behalf.

A pathway model

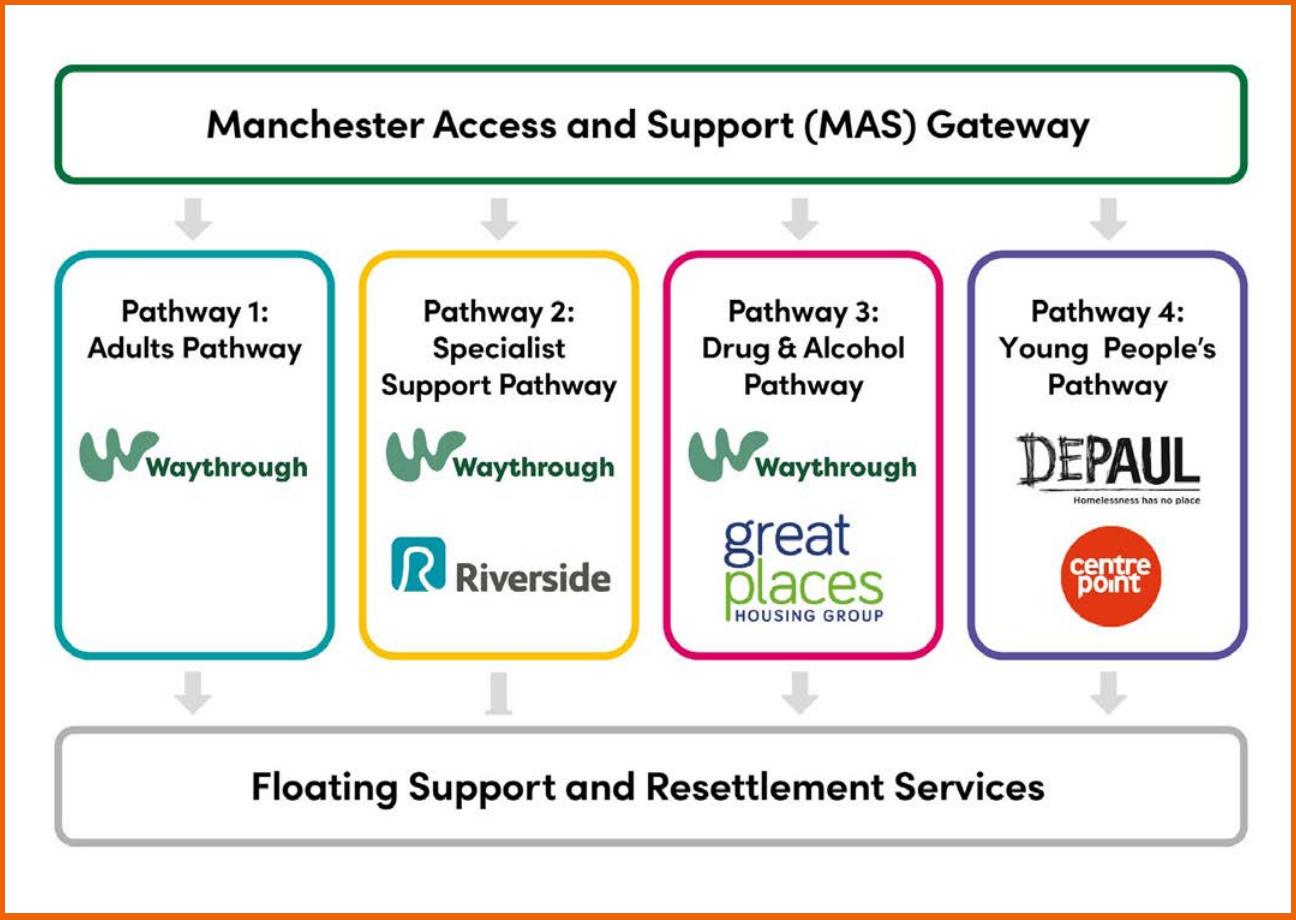
MCC's Housing Related Support is based on the principles of early intervention and prevention with the aim of re-establishing and maintaining independent living for vulnerable and socially excluded people.

They have commissioned a pathway model for short term housing related support, which was co-produced with partners and people who have personal insight into homelessness.

Each pathway has an accommodation-based service, and a resettlement/floating support service, and supports individuals to develop:

- Resilience and Recovery
- Practical Life Skills
- Relationships and Community Connections
- Personal Interests and Talents

All access to housing related support services commissioned by Manchester City Council is via the Manchester Access and Support (MAS) Gateway. The gateway is a decentralised system allowing access from multiple sites and by multiple agencies. It makes use of a single assessment to dynamically match individuals to the most appropriate services for their needs and generate referrals into these services.



For more detailed information please watch this video recording:

Learning From Systems in Westminster and Manchester

With better understanding and planning, we can drive change and improve accommodation options for this vulnerable group.

7. Developing an Improvement Plan: The complete partnership audit tool

The purpose of this document is not simply to improve understanding. Its aim is to drive change. This section provides the complete partnership audit tool that can be used to assess the quality of the accommodation offer for this group.

It is envisaged that this will be used by commissioners and strategic leads in partnership with local housing providers, and carried out under the oversight of a group such as the Combatting Drugs Partnership, Alcohol Strategy group or some other relevant body. The answers to these questions will help determine the next steps to be taken at the local level and help partnerships to develop an improvement plan. It should be noted that this is targeting the ideal system. That will not be possible in the short-term but it will help to build the case for investment and change.

Audit questions – Building the case for investment and change	Yes	No
Has the case been built locally for investing in meeting the accommodation needs of dependent drinkers with complex needs? (2.1)		
Has there been an assessment of the numbers of homeless dependent drinkers requiring accommodation? (2.2)		
Has there been a costing of the impact of homeless dependent drinkers on the community? (2.3)		
Has evidence on the housing needs of dependent drinkers been sought from other sources e.g. people with lived experience, alcohol service providers, housing providers and local serious case reviews? (2.4 & 2.1.4)		
Has there been work on reducing stigma by helping all professionals, including commissioners and elected decision-makers, to understand the challenges this group experience in accessing accommodation? (2.5)		
Audit questions – A system of support	**Yes**	**No**
Do local Housing and Homelessness Strategies address this issue? (3.2)		
Is there a housing strategy for dependent drinkers? (3.2)		
Has consideration been given to the geography of any interventions? (3.3)		
Is there a mapping of local pathways into, through and out of accommodation for dependent drinkers? (3.4)		
Are there services that support people into, through and out of accommodation? (3.4)		
Are there interventions that stop people becoming homeless in the first place (eviction and abandonment)? (3.5)		
Are there outreach-type services that support people from homelessness to housing? (3.6)		
Are there pathways from prisons and hospitals into accommodation for this group? (3.7)		
Have the training needs of staff working with dependent drinkers been assessed in terms of housing related themes e.g. housing law? (3.9)		
Are there performance indicators for this area of work? (3.11)		

Audit questions – Accommodation options and models (Section 4)	Yes locally	Yes but not locally	No
Are dependent drinkers able to access the following types of accommodation:			
Accommodation that requires abstinence ('dry houses')? (4.2)			
Complex needs facilities, night shelters and general accommodation that takes people with alcohol use disorders? (4.3)			
Temporary housing? (4.4)			
Accommodation that specifically allows ongoing drinking by people with alcohol use disorders ('Wet Houses')? (4.5)			
Managed Alcohol Programmes? (4.6)			
Facilities for people with co-occurring disorders (dual diagnosis)? (4.7)			
Residential care for people with cognitive impairment both short-term and long-term? (4.8)			
Women-only facilities? (4.9)			
Domestic violence refuges which accept people with alcohol use disorders? (4.10)			
Housing First – Single person accommodation with support? (4.11)			
Facilities that can accept people on a DoLS? (4.12)			
Facilities that can accept people on an Alcohol Treatment Requirement (or Positive Requirement)? (4.13)			
Services that can take people with specific needs? (4.14)			

	Yes	No
Are these services offering Psychologically Informed Environments (PIE)? (4.15)		
Are there performance indicators for this area of work?		

Audit questions – Managing alcohol in existing care homes	Yes	No
Have the training needs of general housing/residential care staff been assessed in terms of alcohol-related competencies e.g. understanding the physical effects of alcohol?		
Is relevant alcohol-related training available to these staff?		

8. Information sheets

Information sheet 1: Barriers and stigma

Barriers to change

Introduction

Dependent drinkers with complex needs face many barriers when trying to access accommodation. The most obvious barrier is that many units will require people to be abstinent. But there are many other challenges that need to be considered. These will inevitably be very individual, and this section can only give a sense of the range of issues that may prevent people from moving forward – from physical and mental health problems to prejudice and basic practical challenges.

However, all of these challenges create real barriers for this group, which can sometimes be mistaken for a lack of motivation.

Barriers – stigma

This can be an incredibly challenging group to work with and professional attitudes can sometimes be stigmatising or prejudicial. In the workshop, practitioners related negative comments that they had heard about this group, including:

- "They are on self-destruct mode"
- "They aren't able to change"
- "People cannot be helped when they are drinking"
- "They just won't engage"
- "Client is self-sabotaging"
- "Client continues this behaviour deliberately"
- "They are addicted to chaos"

However, the Blue Light Approach has shown us over the years that to help this group we need to 'build them up and not knock them down'. By understanding the very real barriers they face, we can help people to navigate them. Failing to do so contributes to the cycle of exclusion and disadvantage, which not only impacts the individual, but will ultimately place additional strain on other public services, including emergency services.

Barriers – The person

Past behaviour – Accommodation providers may refuse to accept people with previous breaches of tenancy agreements, for example, violence, anti-social behaviour, soiling a room, frequently calling 999 or inviting people back.

Reputation – reputation and hearsay can also play a part. However, people can and do change for the better and, where this happens, it needs to be communicated between services.

Vulnerability – People who are being abused or exploited will be difficult to accommodate if their abusers continue to target them in the new location. This may also cause problems for other residents or neighbours.

Self-esteem – People living on the streets are likely to have low self-esteem. They may find it difficult to accept help that they don't feel they "deserve".

Language – The language used by services will impact on individuals. For example, self-neglect being deemed a lifestyle choice.

Arson and fire-setting – A history of arson and fire-setting may be the most challenging barrier. Insurance problems for providers means that this issue is hard to resolve, even if they have the will to do so. However, it is important that there is a real assessment of the risk. Did the arson occur a long time ago, perhaps in childhood? Was it deliberate or was it an accident? Was it related to clumsiness when intoxicated? These factors may be more or less significant now, depending on the person's current situation.

Case example

A woman in her mid-40s with long-standing alcohol and drug dependency, combined with serious physical and mental health problems (including psychosis, depression, anxiety, liver disease, COPD, and limited mobility), had been sleeping rough for years in a woodland encampment with her also alcohol-dependent partner. Despite previous attempts at accommodation, repeated evictions led to all local providers refusing to house her. This illustrates how multiple barriers – health, history of eviction, and provider reluctance – can combine to leave individuals effectively excluded from all accommodation options.

Physical health

Health needs – 78% of homeless people report having a physical health condition compared with 37% for the general population.[iii] Mobility problems or visual impairments will obviously require adjustments or specific accommodation. However, less obvious needs will include people with diabetes, who require a fridge for storing insulin.

iii Homeless Link – Health Needs Audit – 2016

Byron – Byron was a 22-year-old homeless man who was difficult to house because of behaviour problems and an alcohol use disorder. He also had poorly managed diabetes. He sought housing and was placed in a hotel room because he required a fridge for his medication. However, he was very isolated, and no-one was monitoring his medication use. He was sadly found dead in the hotel room as a result of diabetic ketoacidosis.

Hygiene and continence problems – 'Alistair could not be housed in temporary accommodation due to continence problems. He was defecating in his room and in public places leading to eviction'. Other problems with personal hygiene, e.g. not washing or changing clothes, can also impact on people's tenancies.

Smoking – Smoking is an increasingly significant barrier. 79% of the homeless client group smoke according to Homeless Link. This may pose a challenge, but one that can be addressed with sensitivity e.g. the availability of outside space or encouragement to use e-cigarettes.

Mental health

Co-occurring conditions – respondents repeatedly talked about the problems of housing people with mental disorders. This reflects the situation in the community generally, where it is difficult to secure joint support for people with both conditions.

Cognitive damage – Alcohol-related brain damage (as a result of long-term heavy drinking) and brain injury (as a result of e.g. falls and fights which can be part of a drinking lifestyle) pose a particular challenge to housing providers.

'Steve is in his late 40s and is currently housed in a large, all male, hostel in the rough sleeping pathway in a large city. He moved there three years ago and has been evicted from other homeless hostels. He displays challenging behaviours due to excessive alcohol use. He has significant self-care issues (incontinence, not washing, changing clothes, eating), he misses health appointments and engages in high-risk behaviours (e.g. walking into roads, begging,) and threatens suicide. A brain scan showed that Steve had cognitive damage, and an assessment suggested that he may have difficulties executing what he wants to do in real life because of executive functioning impairments. For example, when he was sober in hospital, he made it very clear that he wanted to remain abstinent but relapsed as soon as he was discharged. It is unclear what accommodation Steve should live in or who should fund the care that he needs. The staff in the hostel report struggling to support him and stress how much time helping him consumed. Steve appeared to manage well when in a structured environment like hospital when he was supported to be abstinent from hospital. The psychologist report recommended this type of setting, but this was hard to find.'

DoLS – Finding a placement that can hold a dependent drinker under a Deprivation of Liberty Safeguard is a real challenge nationally.

Neurodiversity – People with ADHD and Autism are not mentally ill or cognitively impaired. Rather, their brains work in a different way to the majority of the population. Nonetheless, in dependent drinkers this may impact on meeting accommodation needs.

'Lou was a chaotic dependent drinker and an entrenched rough sleeper. He didn't engage with agencies except when he needed something specific from appointments. He was often aggressive with professionals and made threats to harm both staff, buildings and himself. He had suicidal Ideation and family loss through suicide. He was also at risk from unintentional overdose and seizures. PIP payments put him at risk of exploitation. However, when the case was discussed, multiple services said that they did not realise he was on the autism spectrum. It was acknowledged that they would have done things differently if they had known.'

Barriers – practical challenges

> "Josh was informed of the need to provide ID to the accommodation provider as part of the application process. Josh stated that he had no ID as it had been left in ...another area and that he could not go back there. The homeless advice coordinator reiterated that he would not be able to access self-funded accommodation without ID. Josh got agitated and left." [iv]

Josh provides just one example of a range of practical problems which can hinder individuals:

- Do they need money and benefits advice?
- Do they have a bank account?
- Will they need access to emergency funds to kickstart the process?
- Do they have a phone or other means of communication so that they can make appointments?
- Do they have access to the internet?
- Do they have a dog or other pet that will need to be accommodated?
- Are agencies who know the individual willing to pass information to housing services?
- Can they transport their belongings between accommodation?

iv Josh SAR Teeswide SAB 2019

- Can they store belongings between placements?
- Are there people in specific areas that pose a risk, or are vulnerable, to the individual.
- The challenge of rurality
- The challenge of two-tier authorities
- Private sector landlords set conditions
- Poor quality or inappropriate accommodation results in an increase in drinking
- Drinkers are often put together in accommodation and therefore drink more

Barriers – the system

Most fundamentally, the system into accommodation may be fraught with problems. This case study gives an example of these challenges.

Accessing housing from hospital

From the hospital there is only one way of accessing accommodation which is through the local Council Housing team. The Trust staff complete a duty to refer form with the patient. That is submitted to housing to arrange a telephone assessment. It will be about 72 hours before the telephone assessment is arranged. The person often doesn't have a phone so they have to use the ward phone. The assessment can take up to 1 1/2 hours, which is very frustrating. They find the interview challenging and difficult. They don't have access to required information such as ID. It is difficult for staff to give appropriate support as they haven't got the capacity or knowledge. The decision is not made immediately – normally the discharge team has to chase for a decision. Nine out of 10 are turned down so the person is then discharged to NFA, This can take between 10 to 12 nights in hospital. Then the whole process starts again.

Summary

By acknowledging and understanding the very real barriers that individuals can sometimes face, we will be better equipped to help them to navigate those barriers, so that they do not remain stuck in what can be a cycle of exclusion and disadvantage. Helping them move forward to engage with services and secure the accommodation that they need will ultimately reduce the strain on public services that are already stretched, including emergency services

Useful links and Resources

Alcohol Change UK provides information on challenging alcohol-related stigma and promoting understanding.

Drink Wise, Age Well offers practitioner guides on reducing alcohol stigma in services. Drink Wise, Age Well

NHS Inform – Challenging Drug and Alcohol Stigma

Groundswell – Stigma ACUK Blue Light Training

Encouraging a culture where the use of stigmatising language is not tolerated and person-centred language is promoted is also important. Terms like 'person with alcohol dependence' are preferable over labels such as 'alcoholic'. Faces and Voices of Recovery have created this useful graphic:

Recovery Dialects

	Mutual Aid Meetings	In Public	With Clients	Medical Settings	Journalists
Addict	✓	STOP	STOP	STOP	STOP
Alcoholic	✓	STOP	STOP	STOP	STOP
Substance Abuser	STOP	STOP	STOP	STOP	STOP
Opioid Addict	✓	STOP	STOP	STOP	STOP
Relapse	✓	STOP	STOP	STOP	STOP
Medication Assisted Treatment	STOP	STOP	STOP	STOP	STOP
Medication Assisted Recovery	✓	✓	✓	✓	✓
Person w/ a Substance Use Disorder	✓	✓	✓	✓	✓
Person w/ an Alcohol Use Disorder	✓	✓	✓	✓	✓
Person w/ an Opioid Use Disorder	✓	✓	✓	✓	✓
Long-term Recovery	✓	✓	✓	✓	✓
Pharmacotherapy	✓	✓	✓	✓	✓

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

SOURCE: Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. Drug and Alcohol Dependence, 189, 131–138.

Information sheet 2: Preventing evictions and abandonment

Introduction

The issue of eviction and abandonment isn't just about the loss of a home, it is also the negative impacts that losing that home can have on a person's health, wellbeing and social connections. Therefore, preventing evictions and abandonment is essential not only to ending homelessness but also to avoid these other negative outcomes.

This document has been created using information gathered from the 29 workshops that Alcohol Change held for the Housing Project, as well as drawing upon guidance from Homeless Link and other useful resources listed at the end of the document.

It outlines the key recommendations to help prevent evictions and abandonment, with a focus on early intervention, clear communication, and providing support and guidance to residents on, for example, financial planning. This helps to equip people with the skills they need to reduce the risk of eviction and abandonment, in line with UK homelessness prevention strategies (Homelessness Reduction Act 2017), and to support individuals towards independence.

The document also provides examples of successful programmes.

Whilst occasions will sometimes arise where eviction is necessary, this should always be viewed as a last resort, and providers should make every effort to prevent eviction and abandonment by creating a welcoming, constructive, and supportive environment for people.

Recommendations for preventing evictions and abandonment:

1. Initial contact and induction

Early and clear communication can empower residents to manage their tenancy. It is important that staff provide essential information from the outset. Tenants should be given general information, including a clear understanding of their tenancy agreement and the consequences of breaching these terms.

Additionally, advice on prioritising rent and how to access support services, including those for financial difficulties, should be a priority. This helps prevent future issues such as arrears.

Guidance from the Department for Levelling Up, Housing and Communities (DLUHC) underlines the importance of early intervention and support, recommending housing providers actively support residents at the start of their tenancy to reduce the risk of future homelessness.

2. Preventing evictions through behavioural support

Preventing eviction requires that residents respect rules and boundaries. Breaches may lead to warnings, but the focus should always be on addressing underlying issues before eviction becomes necessary. Providing support to help residents change behaviours and avoid future problems is key.

Early discussions and interventions, as promoted in The Homelessness Code of Guidance for Local Authorities, can often resolve issues without the need for formal warnings or eviction.

Engaging residents in support programmes can help improve long-term tenancy outcomes, and helps tenants maintain their tenancies, reducing the risk of homelessness.

3. Issuing warnings and providing support

Sometimes it will be necessary to speak to residents when rules have been broken, and residents should be informed not only how a rule has been broken, but why the rule is important.

When a warning is necessary, staff should meet with the resident to explain the issue and set expectations for improvement. Warnings should be given with a clear time frame (e.g. 28 days), during which the resident's progress should be reviewed. After this time, the warning can be maintained, amended, or removed entirely.

The type of warning should be specific to the seriousness of the incident, ensuring clarity in expectations, and residents should be given the right to appeal any warning, and have their appeal judged by someone other than the person issuing the warning, ensuring fairness in the process.

A structured approach to issuing warnings, combined with supportive follow-up, can often help resolve issues before escalation.

Whenever a warning is issued, consideration should be given to the wording, to minimise the risk of abandonment.

Alternative responses to warnings

- A discussion about the impact of the incident and how to move forward.
- Offering support for underlying issues
- Suspension of privileges or rewards

4. Managing arrears and financial difficulties

Rent arrears are a leading cause of eviction and we can help prevent arrears by offering early support and encouraging regular rent payments. Housing staff should not penalise residents for delays in Housing Benefit or Universal Credit payments, but they should give praise for payment of rent and offer flexible and manageable repayment plans which focus on adherence rather than amount.

It is essential to address arrears early to prevent escalation, involve residents in discussions, and offer support aimed at resolving financial difficulties before they lead to eviction.

5. Preventing abandonment through early support and engagement

Abandonment can often be prevented by identifying early warning signs, such as non-engagement with support services, time spent away from the property, arrears or debts, vulnerability to exploitation, abuse or exclusion, no local social networks, or signs of dissatisfaction with the living environment.

To help prevent abandonment, staff should offer additional support during the initial weeks of tenancy, such as encouraging participation in community activities and informal interactions with key workers. Individuals could also receive reward for positive engagement with, for example, refreshments, additional support, privileges and thank you notes.

Any communication about arrears or difficult behaviours should be supportive and solution focused. When residents feel supported and valued, they are more likely to remain engaged and less likely to abandon their homes.

Examples of Successful Programmes

The Community Alcohol Related Damages Service (CARDS) in Edinburgh.

The Community Alcohol Related Damages Service (CARDS) was set up in Edinburgh by Rowan Alba. It helps individuals with addictions and those in recovery to maintain stable housing, by providing regular social interaction and support using a network of approximately 90 volunteers who support people with regular social interaction in their own homes and communities.

CARDS offers a vital safety net for people with addictions and in recovery that reduces the likelihood of eviction or abandonment. It has successfully supported many individuals at risk of homelessness, becoming an effective homelessness prevention service, through helping some of the most vulnerable in their communities to maintain a settled lifestyle and live a more enriched life.

Carmarthenshire County Council's Pre-Tenancy Support Programme

Carmarthenshire County Council deliver an innovative pre-tenancy support programme, where the focus is on early prevention to stop tenancies failing, before a tenancy is even in place. It provides training on budgeting and finance, communication, and living with others. Since its inception in 2022, the programme has saved 1,800 households £2.4 million, and has prevented countless evictions by equipping individuals with the necessary skills to manage their tenancies successfully. The programme has now expanded to offer pre-tenancy support to individuals in prison, preparing them for a smooth transition back into society upon release.

Watch the video on the Carmarthenshire project.

Additional useful guidance and links:

- Early Intervention & Homelessness Prevention: The Homelessness Reduction Act 2017 requires local authorities to take a proactive approach to homelessness prevention. This includes providing support at the earliest opportunity to prevent evictions, particularly in cases of financial difficulties or behavioural issues.
- Homelessness code of guidance for local authorities – Guidance – GOV.UK
- Crisis Prevention of Homelessness Duties
- Homeless Link

Summary

Preventing evictions and abandonment requires proactive strategies and a commitment to supporting residents throughout their tenancy. By providing early intervention, clear communication, and tailored support, housing providers can reduce the risk of eviction and abandonment, ensuring that residents have the stability they need to thrive. Programmes like CARDS and Carmarthenshire County Council's pre-tenancy support, demonstrate how early and ongoing support can make a significant difference in preventing homelessness and improving long-term housing outcomes.

Information sheet 3: Outreach support

Introduction

Supporting homeless dependent drinkers into housing can be challenging, because of the multiple complex issues and barriers to change that this group can face. The Blue Light approach encourages the use of Assertive Outreach, since it offers a proactive, person-centred method that builds trust, addresses immediate needs, and fosters long-term stability. It is also evidence-based, with peer reviewed academic evidence from around the country, including Nottinghamshire, Wigan and Salford (Blue Light manual, first edition).

This approach focuses on meeting people where they are, both physically and emotionally, to provide tailored support that can help them transition successfully into housing. This will involve someone visiting the client at home or in the community, spending time with them and attempting to build a positive relationship which encourages change. In some cases, this could be achieved with the involvement of appropriately trained and supported volunteers or peer mentors.

What is Assertive Outreach?

- **Outreach:** Taking the service to the people who need it rather than waiting for them to come to the service. Many interactions will need to take place outside of traditional service settings.
- **Assertive:** Persistent and repeated attempts to contact people with an alcohol problem and to overcome barriers to engagement; often contact at least weekly, for a year.

Key elements of Assertive Outreach

- **Multi-disciplinary working**: An outreach service should always be part of a multi-pronged approach to meeting the needs of people. It cannot sit in isolation. It will need to link closely with mainstream alcohol treatment services, mental health services, housing services, and many other providers.
- **Holistic**: Understanding people's full range of needs, including health, social care, accommodation, meaningful activities, employment, and social contact.
- **Flexible**: Allowing for flexible and varied times when the service will engage with people, at times that suit them not the service, including allowing for unscheduled contacts.
- **Reliable and accessible**: Even if the people the service is engaging with are not always where they say they'll be, practitioners need to be. This is one important way that trust is built, and relationships deepened.
- **Non-threatening**: Recognising that people may be suspicious of authority and of offers of help, and that who is engaging with them may be as important as how. For this reason, peer outreach can be particularly powerful.
- **Honest and open**: Practitioners should be explicit with people about their goals from each contact.
- **Responsive**: Listening properly to what people want and acting on this. This means particularly what matters to them right now and what "success" would look like for them in the future.
- **Human**: Successful outreach depends above all on building human relationships. The people a service is working with need to know that practitioners value them as human beings. Ref – (Alcohol Change UK Assertive Outreach Handbook).

Case studies from workshops

Case study 1 – Westminster Assertive Outreach

GM is in his early 50's with a history of childhood trauma, rough sleeping and substance abuse. He is currently alcohol dependent. He received injuries from a Road Traffic Collision that meant he was no longer able to access accommodation on the Rough Sleeping Pathway. However, due to his complex presentation he would not have been able to sustain independent accommodation. He was placed in Assisted Living Accommodation.

He was referred to the local Blue Light Assertive Outreach Project because he was being brought back to the accommodation on multiple occasions by the police when intoxicated, he was causing ASB within the building and the provider was considering serving him a NOSP for rent arrears. The BLP continued to work with GM for over 18 months. They have supported him with multiple areas to help him meet his needs all of which should have been supported through his supported housing accommodation. For example, medical needs, but more specifically, applying for PIP which his Assisted Living scheme did not consider him to be suitable for, because of apparently prejudiced views about the appropriateness of someone with an alcohol use disorder being in receipt of benefits.

Case study 2 – Bridge the gap – Healthy Surrey

Aimed at improving outcomes for adults experiencing multiple disadvantages including homelessness, substance use, domestic abuse, mental health issues and contact with the criminal justice system. Bridge the Gap is a 'relational model' of long-term specialist community outreach, offering bespoke support via 22 Outreach workers. It

focuses upon a person's strengths rather than their issues and complexities. Taking a trauma informed approach, the service sees beyond a client's presentation and supports them towards their own personal goals. Many clients with substance use issues are also living with mental health challenges. Clients do not have to be abstinent from substances to receive support. Workers continually assess dynamic risks, offering a service which is risk aware, whilst providing a co-occurring condition support pathway and timely access to mainstream substance use and mental health treatment services.

'As part of the Changing Futures system change priorities we have been funded to provide an innovative approach to outreach in the community. Our service is called 'Bridge the Gap' and was coproduced with our lived experience community, and we commission 12 of our local VCSES to deliver trauma informed, relational outreach to residents experiencing multiple disadvantage. We have 22 specialist outreach workers embedded with the voluntary sector and are supporting approximately 100 residents at one time. The service is clinically supervised by a consultant clinical psychologist who ensures we remain trauma informed in our practice and oversees the wellbeing of the workforce. The service is consistently evaluated as part of the national MHCLG evaluation and independent local evaluations.

95% of our clients are experiencing both a mental health and substance use issue, predominantly alcohol, and accommodation challenges are standard.'

Evaluation of the Changing Futures programme – GOV.UK

Changing Futures – What is Bridge the Gap?

Bridge the Gap – Drink and Drugs News

Summary

An outreach approach is beneficial in supporting homeless dependent drinkers into housing, because it meets individuals where they are, both physically and emotionally. Outreach provides personalised, ongoing support, ultimately improving engagement, housing retention, and overall quality of life for homeless dependent drinkers. By focusing on building a relationship and trust, coordinating with other agencies and providing holistic, tailored support, we can help increase engagement.

Moreover, with consistent, ongoing engagement, outreach can increase the likelihood of long-term success in both sobriety and housing stability. Outreach workers are often able to offer continuous support, which improves the chances of individuals successfully navigating both the complexities of recovery, and life in stable housing.

Useful resources

Blue Light Manual

Assertive Outreach Handbook

Homeless Link – Principles for Rough Sleeping Outreach

Information sheet 4: Prison release and homelessness

Introduction

The successful reintegration of individuals leaving prison can be a complex challenge which requires a comprehensive approach that addresses their housing and support needs. Many ex-offenders face challenges in securing stable accommodation, especially those with a history of substance misuse or other complex needs, and without adequate housing, individuals are at risk of reoffending and returning to prison.

This document highlights the example of the West Sussex Prison Release Accommodation Scheme, to demonstrate how individuals can be supported upon their release from prison and helped to successfully transition back into the community, which can help break the cycle of homelessness, health deterioration, and reoffending.

Examples of Prison Pathways

West Sussex Prison Release Accommodation Scheme

The West Sussex scheme helps ex-offenders who are considered non-priority need, by working with local authorities to secure housing options in the private rental sector. Areas such as Chichester, Worthing, Crawley, Eastbourne, and Hastings have signed up to the Accommodation for Ex-Offenders (AFEO) scheme, allowing individuals leaving prison to access private rented properties. Stonepillow, a key local partner, works with clients who are not yet "tenancy-ready" due to issues such as substance misuse. In these cases, alternative accommodation options such as hostels and recovery houses are offered until clients are prepared to transition into their own homes. Once ready, clients are taught practical life skills such as budgeting, cooking on a budget, and maintaining a tenancy.

One of the key reasons the West Sussex scheme is successful is the strong partnership working between probation services, housing authorities, and other agencies. Monthly strategic meetings are held to discuss challenges, share solutions, and work collaboratively to overcome barriers. These meetings provide a platform for stakeholders to align their efforts and resources, ensuring that ex-offenders have access to the housing and support they need to reintegrate successfully into society.

Accommodation for Ex-Offenders National Scheme (AFEO)

The AFEO scheme, which is part of a national initiative, provides funding to local authorities to support ex-offenders at risk of rough sleeping and homelessness. The scheme helps provide accommodation in the private rental sector, and works in conjunction with other support services to prevent ex-offenders from becoming homeless upon release. This initiative is crucial in ensuring that individuals have stable housing, reducing the likelihood of rough sleeping and reoffending.

The Accommodation for Ex-Offenders scheme (AFEO)

Probation's Community Accommodation Service (CAS)

Probation has its own accommodation system – the Community Accommodation Service (CAS).

The CAS system is a tiered accommodation service that provides housing for individuals at different levels of risk.

- **CAS 1** is for the most high-risk individuals, providing approved premises.
- **CAS 2** is for individuals who need a bail hostel environment.
- **CAS 3** provides short-term housing with private landlords, typically for a period of 84 days. This system helps ensure that individuals at varying levels of risk are placed in suitable accommodation, providing them with the support they need while they transition into community life.

Ensuring that individuals are appropriately housed upon release from prison is crucial for their successful reintegration into society. Local authorities in the UK have specific responsibilities and guidance to support ex-offenders in securing accommodation.

Useful guidance

Early Referral to Housing Services

Prisoners should request a referral to their local council's homelessness team at least 8 weeks before release. This allows the council to assess housing needs and develop a personal housing plan.

Shelter

Through the Gate Services

For those serving sentences of 12 months or less, the "Through the Gate" service offers resettlement support, including assistance with housing. Prisoners should engage with housing or resettlement advisers to explore accommodation options.

Prison Reform Trust

Continuity of Care and Support

The Care Act 2014 mandates that local authorities assess and safeguard individuals needing care and support upon discharge, focusing on protecting dignity and quality of life through comprehensive assessments and appropriate services.

Procedures Online

System-Wide Protocols and Partnerships

Developing joint protocols between prisons, probation services, and local authorities is essential to address accommodation needs effectively. This collaborative approach helps prevent individuals from falling through the gaps and ensures a coordinated response to housing challenges.

Homeless Link

Other useful links

Integrated Offender Management – The Society of St James (ssj.org.uk)

SIG Pathways to Independence - Social Interest Group

Summary

Local authorities in the UK are encouraged to proactively engage with prisoners approaching release, to assess and address their housing needs. Early referrals, collaborative protocols, and dedicated funding schemes like AFEO are integral to supporting ex-offenders in securing stable accommodation.

Information sheet 5: Strategic frameworks

Introduction

A recurring theme during the workshops has been the need to work together in a coordinated and strategic way if we are to effectively address the complex relationship between alcohol dependence and homelessness. Comments about a lack of joined up working and information sharing were made in several workshops:

> "We all want the same thing, but there is no joined up working."

> "We want to work together. We would like to work more collaboratively. We need to communicate."

If a comprehensive and co-ordinated approach is taken, we can help to break the cycle of homelessness and alcohol dependence, and several examples of strategic frameworks were submitted to Alcohol Change UK to illustrate the impact that this approach can have.

COVID

During the research, a number of people mentioned the Covid restrictions as a point at which agencies had worked together very effectively, and people were keen to see similar joint working continuing into the future.

> "We should learn from the things we did during COVID. It all worked well and then we went back to how it was..."

> "Things learned from Covid should not be lost. Everyone worked together to ensure clients were housed."

> "We left our organisations at the door and just worked with the client in front of us."

> Work like this "got 95% of rough sleepers off the streets."

Further useful information:

Lessons Learnt by Councils During the COVID Pandemic

Supporting People Affected by Homelessness and Alcohol Dependency During the Pandemic

By bringing people together from, for example, Alcohol Services, Physical and Mental Health Services, Social Care, Housing providers, Employment and Educational Services, Criminal Justice and Legal Services, Community and Voluntary Sector organisations, (not an exhaustive list), we can more effectively address the complex and interconnected challenges that individuals with alcohol dependence face, such as:

- **Health Issues** – physical and mental health problems can make it difficult for people to maintain stable housing, to work and to maintain relationships. Homelessness exacerbates these issues because, without a stable home, individuals are less likely to seek treatment or adhere to medical advice, creating a vicious cycle where people become sicker and more vulnerable to the negative effects of alcohol abuse.
- **Social Exclusion** – People who are alcohol dependent may experience significant social isolation and stigma. This can result in difficulty accessing support services and connecting with others, leading to further exclusion. If someone is homeless, this can also contribute to a lack of employment opportunities, which again compounds their social exclusion.
- **Breaking the Homelessness and Alcohol Dependence Cycle** – Alcohol dependency often coexists with homelessness in a cyclical manner., i.e. being homeless can exacerbate alcohol dependency, and alcohol dependency can increase the likelihood of homelessness. The lack of a secure place to live can lead to further alcohol misuse, creating a vicious cycle that is difficult to break without strategic intervention.
- **Crisis Situations** – Alcohol-dependent individuals may face frequent crises such as eviction, domestic abuse, or other forms of instability, making it harder for them to maintain a stable home environment.

Working together can help to break this cycle by offering support and services that address physical and mental health problems, homelessness and addiction simultaneously.

Examples from workshops

Sussex

Sussex has set up a pan Sussex commissioning forum to bring commissioners together – *"There wasn't anywhere where commissioners regularly come together to talk about commissioning cycles / what is coming up. Providers have complained to us for quite a number of years now that we all commissioned services that overlapped to a certain degree in terms of the users but were all in different commissioning cycles. It is very difficult for them to have stable financial protection and thereby recruit and retain staff. It is very early days, and we are just exploring, looking at what services are there that could start this co-funding / co-commissioning – but that is quite a major step."*

The Oxfordshire Homeless Alliance

This is a partnership between 6 local housing charities, local councils and the Lived Experience Advisory Forum – LEAF.

Through LEAF, the Alliance includes people from the homeless community. The Alliance members have agreed to work together in new ways. Their aim is to prevent and resolve homelessness across Oxfordshire.

The alliance members are: A2Dominion, Aspire, Elmore Community Services, Homeless Oxfordshire, Connection Support, and St. Mungo (Somewhere Safe to Stay). A housing led approach – also called 'Housing First' and 'rapid rehousing' – operates under the belief that everyone has a right to a home.

The Plymouth Alliance

The aim of The Plymouth Alliance is to coordinate a complex needs system which will enable people to be supported flexibly, receiving the right care, at the right time, in the right place. The seven core providers of services are: BCHA, Hamoaze, Harbour, Livewell Southwest, Path, Shekinah, and The Zone.

Alliance partners provide housing advice and support, access to temporary and settled accommodation, treatment and support regarding substance use, including prescribing.

In addition to the core seven providers, they also have working arrangements with Plymouth City Council, Salvation Army, Livewest, UHP, Primary Care (GPs), and Local Pharmaceutical Committee.

Surrey

Surrey is a Changing Futures area and has been commissioned by MHCLG and the lottery for the last 4 years to provide a strategic systems change programme in Surrey, evidencing meaningful change for individuals experiencing multiple disadvantage as well as systems change at service and system level.

The government defines *Multiple Disadvantage (MD)* as people who are experiencing multiple concurrent and compounding complexities including substance use, mental health, homelessness (or risk of), contact with the criminal justice system and domestic abuse.

The joint strategic needs assessment is the second in the country to be published for MD and the first ever to be led by and co-produced by our lived experience community. From this piece of work and the research findings we are developing a strategy to action and embed the recommendations. We held a big event locally a couple of weeks ago with 60+ partners including elected members of the council, our Director of Public health and our Police and Crime Commissioner to begin this process. This is also being led by our partners with lived experience to ensure we shift the power to them to develop and hold the governance on all strategic work in Surrey to support and improve outcomes for our residents experiencing MD JSNA Multiple Disadvantage | Surrey-i.

Further information:

DDN_Feb_2025 DDN February 2025

Changing Futures – Power of Co-production

Essex was also mentioned – *'Essex have got such fantastic way of working together as groups of statutory agencies, – recognising that we can't all meet our pressures on our own. They even regard housing now as a county wide resource. Not one for one particular local authority.'*

Conclusion

By working together and sharing information to address both the underlying issues of addiction and the immediate need for stable housing, and co-ordinating prevention strategies, healthcare integration, housing support, social services, and employment opportunities, we can help individuals regain independence, improve their health, reintegrate into society, and break the cycle of addiction and housing instability.

Information sheet 6: Model systems

A system of housing options

To effectively work with chronic dependent drinkers, we need a system of support which includes a range of facilities that can house people and services that can support them at various points in their journey to greater safety and stability.

The range of facilities should include:

- Places that can offer immediate support in crisis situations. Places that people can move to from the streets when they are at their least stable or move back to if their situation becomes more unstable again e.g. a relapse.
- Units of accommodation with varying degrees of support to meet the stages (forwards and backwards) of a journey to greater stability.
- Units with differing expertise e.g. cognitive impairment
- Longer term options, probably single person units, in which people can achieve greater stability and safety with support.

Ideally, the system should be based around these principles:

- **Person-centred approach**: tailored to the needs and readiness of the individual, with no "one size fits all".
- **Harm reduction throughout**: support continues whether or not the person is abstinent.
- **Trauma-informed care**: recognises the high prevalence of trauma in this population and avoids re-traumatisation.
- **Continuity of relationships**: key workers or case managers follow individuals through different stages.
- **Multi-agency collaboration**: housing, health, addiction services, mental health and criminal justice working together.

> 'When you start to look at a housing pathway I would always look at mental health because the step down from hospital, the preparation for independent living, moving into more semi-independent and then where possible independent living – but also having crisis beds where people can go back to... We don't need cliff edges, and I think that often with homelessness, we give them a chance, but we only give them one.'
>
> Quote from a Housing commissioner

At the heart of this system is Edward Alsop Court (EA). In 2016 EA was a typical 78 bed spaces, male hostel with a standard hostel layout. However, the provider struggled to adequately support people with complex needs, which resulted in evictions and abandonments. In order to address this, a system of support services was commissioned, with an emphasis on PIE, complex needs, elastic tolerance, creative approaches etc. and a Multi-Disciplinary Team approach. It now has:

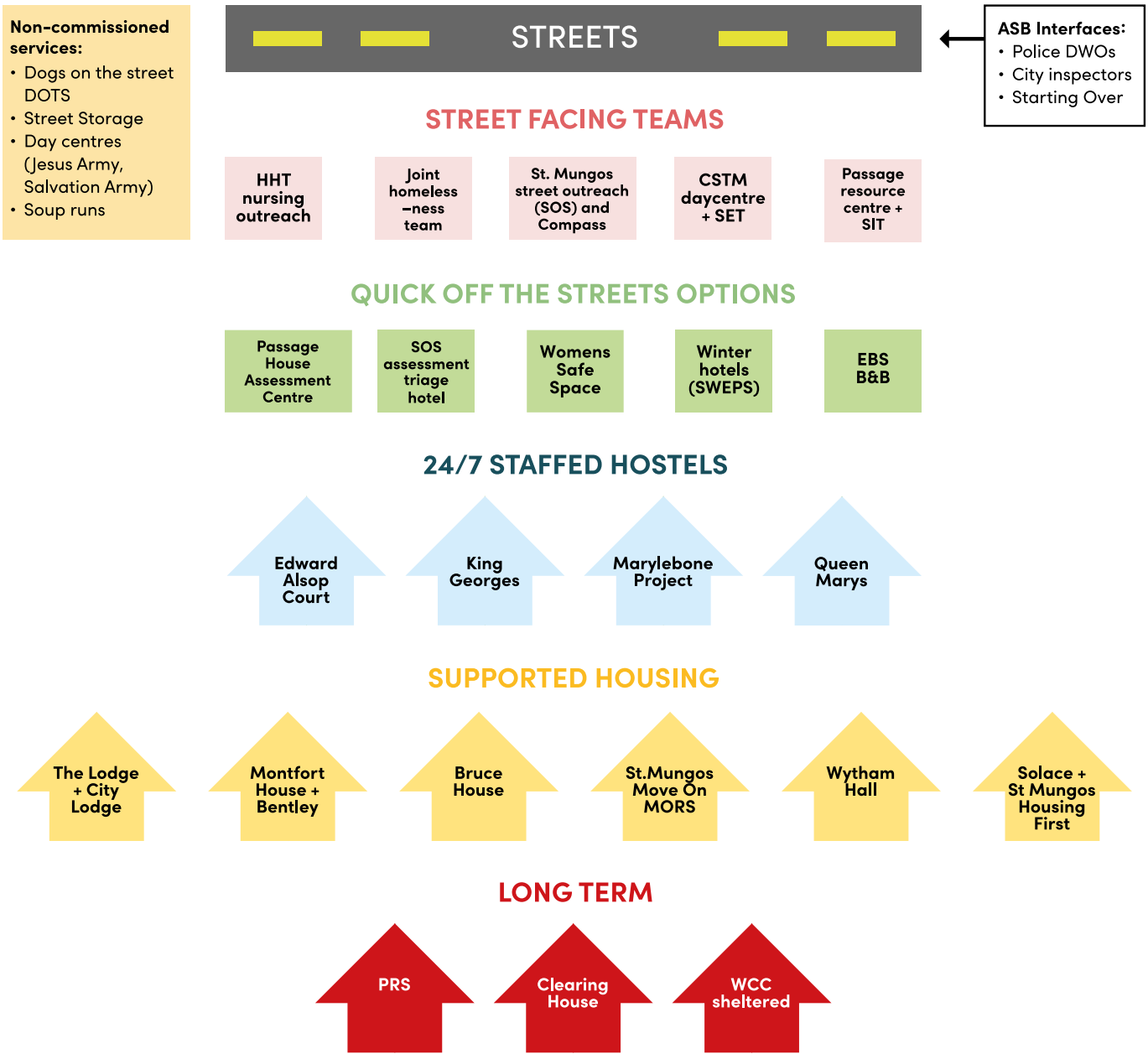
- **Psychology input** three days per week including reflective practice, team formulation, staff consultation, agency liaison, assessments, 1:1 therapy and wellbeing groups, Psychology appointments have an 85% resident attendance rate, which is a noteworthy engagement rate for a complex need population.
- **Art therapy**
- **Occupational Therapy clinic** three times per week. This gives access to City Council's equipment catalogue. OTs also provide guidance for key workers on action planning, support for statutory service involvement. 100% of staff reported the OT addressed the concerns about the client, 50% of staff reported a change in the client's behaviour after the OT visited and 84% of staff reported a change in their approach after the OT visited.

Examples of model systems of care and support

The main document sets out Manchester's approach as a case study of a model system. This information sheet links readers to other examples.

Westminster

This chart details the range of facilities in Westminster, which link together to address immediate, interim and long-term needs:



Other niche options:
- Veterans aid
- Scotcare
- Young adults or mental health
- Complex needs VAWG/DV refugees
- Out of borough swaps
- Hosting
- Heath beds
- Emmaus
- HB Funded abstinent houses – Kairos, Nehamish

Supporting health teams:
- JHT
- Turning Point
- CGL
- Groundswell
- Great Chapel Street
- Dr Hickeys
- Homeless Counseling service
- STEP
- SLaM PiH

Capacity building for the pathway:
- HHCP – directories/ training
- SLaM psychology
- Change communication
- Survivors UK
- EASL
- BCPS

Legislation to consider:
- Care Act
- Safeguarding
- MARAC
- Mental health act
- S.136
- Child protection

- **Nursing** is provided 4 days a week. which works from a dedicated and fully equipped clinical room. This offers health reviews, treatment (wound care, infections, chronic conditions) vaccinations, and a Vitamin B therapy pilot has been introduced. This has increased the number of MDT's, the number of residents with package of care, registration with a GP (now 100%). Three residents have been diagnosed with ARBD – all have been moved on to appropriate care-setting.
- **Speech and Language Therapy input.** This unique service offers Brain Injury Screening Index (BISI) screening, Time organisation kits (diaries, clocks, white boards). 57% of clients reported they had suffered a brain injury during their lifetime and 46% of clients reported they had experienced more than one head injury.

NOTE: A review of rough sleepers who died over the last 4 years has accessed GP records for 55 people. 45% of people experiencing homelessness (in the Westminster rough sleeping pathway) who died over the last 4 years experienced head injuries, of which 35% were diagnosed (typically scans in A&E contacts).

Transformation in care providers

As well as the Multi-Disciplinary Team approach, there has been a switch from a variety of carers coming in from different agencies with a specific time / task brief, to just one service being commissioned by the LA, delivered in house and with a person-centred approach. The carers have been provided with their own office in the building, which supports continuity, and they are there 7 days per week, which allows flexibility.

- Social worker once per week.
- A carer from "Look Ahead" comes in 6 days per week and helps with domestic tasks e.g. how to do laundry, keeping rooms clean.
- An Activities Worker who engages people, either one to one or in groups. They organise bingo, karaoke, cooking, quizzes, other weekly activities going outside, such as cinema, bowling, museums, fishing, walking. A chef cooks what customers want. They don't use frozen meals instead they provide home cooked food.

As a result, anti-social behaviour reduced by 57%. Complaints by residents and outsiders reduced by 98% and emergency service calls reduced by 68%.

For more detailed information please watch this video recording – Learning From Systems in Westminster and Manchester

Other models – Making Every Adult Matter (MEAM)

Making Every Adult Matter (MEAM) is the national charity supporting practitioners, policymakers and people with lived experience to transform services and systems for people facing multiple disadvantage. The MEAM Approach network is comprised of 50 areas across England working to improve services and systems for people experiencing multiple disadvantage and committed to sharing their learning along the way.

MEAM Approach areas consider seven principles, which they adapt to local needs and circumstances. Support is provided to the local partnerships as part of this process.

- Partnership, coproduction & vision – The right people at the table, a culture of coproduction, a shared understanding of the problem and a vision for change.
- Consistency in selecting a caseload – Agreeing a clear referral and selection process for the new intervention.
- Coordination for clients and services – The practical resource to link individuals to existing services and to broker engagement from local agencies.
- Flexible responses from services – Ensuring flexible responses from all statutory and voluntary agencies.
- Service improvement and workforce development – Seeking continuous improvement in local services.
- Measurement of success – A commitment to measuring social and economic outcomes.
- Sustainability and systems change – Making sure the intervention is sustainable through systemic change.

Other models – Harbour Housing, Cornwall

Harbour Housing provide a network of accommodation options for vulnerable people.

'Our primary aim is to offer accommodation to vulnerable homeless people. We have an alcohol tolerant approach. We recognise that our tenants have multiple needs and are drinking to deal with their social issues and trauma. We take a common-sense approach because the alcohol isn't the problem – the complexities are. We have an ethos of patience and tolerance, if people engage with the few rules'.

- Supported accommodation and outreach for the vulnerably housed.
- EVA project service for women escaping DA or SV.
- Hospital discharge accommodation for those at risk of homelessness.
- STAR project short term accommodation for people sleeping rough with intensive work to transition to longer term accommodation.
- Cold weather provision – intervention for people who would otherwise be homeless in winter months. Harbour Care, aimed at people with complex needs and physical care requirements, holistic domiciliary care services for people with unmet needs.

We also have a domiciliary care company. Many individuals have care needs, they may self-neglect, or lack bladder or bowel control etc. The care organisation can meet their care and support needs and then they come through our domiciliary care into our accommodation.

We have about 160 rooms across Cornwall from 1 bed flats to large 40 bed Houses in Multiple Occupations. The HMOs are not ghettoised, it's a community and it works really well – we have CCTV to keep people safe; we keep an eye on them every day so we're able to see what the state of the person is and their environment. We don't disperse. I know it's not popular to have a big house with lots of drinkers together but there's something about the community and camaraderie that helps. It helps to avoid alcohol withdrawal and people can support each other.

There are 'move on' opportunities: homes with slightly lower tolerance, we might move residents to lower support, a house where fewer people who are intoxicated. If they relapse at a dry house they can go back into high tolerance. There are different stages within what we offer but we do not think that alcohol dependence is a separate issue, there are so many issues that lead to it – neglect and abuse etc. and usually they've had no therapeutic support so there's not a pathway and it's really hard to get mental health support if you have substance use issues.

We have person-centred counsellors; and crisis support for staff and clients. We also work with 'With You', and they come in to us, we also have Health for Homeless, SU interventions, liver scanning etc. they all come in. It makes it easy for people to access these services and even if they don't use them, they know that it's available here if they do need it.

Other models

- Changing Futures Northumbria – working with people already accessing these services who have been identified as more complex or in need of more intense support.
- Changing Futures – Bridge the Gap | Healthy Surrey – improving outcomes for adults experiencing multiple disadvantage and to support them to lead better lives.
- **Base One – West Sussex –** Base One – Specialist Emergency Accommodation Provider and Intensive Housing Management (base-one.co.uk).

Examples of Multiple agencies working together

Nottingham

Nottingham City Wrap-around MDT

Exeter

https://www.colabexeter.org.uk/

Blackburn

The Phoenix Hub brings services together to provide a calm safe warm environment where people can access support from multiple agencies in one go.

Liverpool

Services / agencies have a database that hostel providers and housing officers and other services have access to. All of the information is in one place, so that people do not have to keep repeating their story or circumstances, which can re-traumatise them. The Liverpool database means that professionals update what has been said, so that the next service / agency / professional is aware.

Additional useful links

https://meam.org.uk/

https://www.tnlcommunityfund.org.uk/funding/programmes/changing-futures

Information sheet 7: Costings data

It is useful to have estimated costings and potential cost savings from interventions with dependent drinkers with complex needs. This helps to build a case for investment. There is no single source of data, and indeed for many of these costs, no single way of calculating a unit cost. Unit costs may also need to be adjusted for inflation because they can become outdated.

However, a very useful source of information is the Greater Manchester Combined Authority Cost Benefit Analysis data. This provides an excel spreadsheet with detailed costings for many aspects of health, social care, housing and the criminal justice system. Readers are recommended to look at this document.

Two other sources of information are:

- Buckinghamshire Blue Light Project Evaluation Final Report – June 2025 which offers the data below with information sources.
- The first edition of the Blue Light manual offers costings developed in 2014 – the Manual itself explains the origin of the data.

Unit / Metric	Description & Source	Link to Source Data	Original Unit Cost (at time the source data was published)	Revised for inflation[v]
Adult social care referrals	Unit cost estimate of referral only	Martin-Stevens-Costs-and-outcomes – https://www.ilpnetwork.org/wp-content/media/2016/10/Martin-Stevens-Costs-and-outcomes.pdf	£360	£466.90
Adult safeguarding referrals	Unit cost estimate of referral only	Martin-Stevens-Costs-and-outcomes – https://www.ilpnetwork.org/wp-content/media/2016/10/Martin-Stevens-Costs-and-outcomes.pdf	£360	£466.90
Presentations to substance misuse services (Episodes of Care)	Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE Clinical Practice Guidance 115), p.408	Greater Manchester Combined Authority Cost Benefit Analysis data	£2,334	£2,503.73
Welfare referrals/ Calls (Police)	Greater Manchester Combined Authority (GMCA) Research Team + NAO Analysis, based on CIPFA, Home Office, Ministry of Justice and Youth Justice Board Data.	NAO – The cost of a cohort of young offenders to the criminal justice system. 2011	£1,132	£1,214.32
Police crime reports	Greater Manchester Combined Authority (GMCA) Research Team + NAO Analysis, based on CIPFA, Home Office, Ministry of Justice and Youth Justice Board Data.	NAO – The cost of a cohort of young offenders to the criminal justice system. 2011	£1,132	£1,214.32
Arrests	"Field, S., Flows and Costs in the Criminal Process, unpublished document, Home Office, 1997 HM Treasury, Public Expenditure Statistical Analysis, 2000–01, CM 4601, 2000. Home Office, Statistics on Race and the Criminal Justice System, 1998, 1999"	Family Savings Calculator – Department for Education	£2,241	£4,025.05

v The original unit cost figures have been updated to 2023 values using the Bank of England's inflation calculator https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

Unit / Metric	Description & Source	Link to Source Data	Original Unit Cost (at time the source data was published)	Revised for inflation[v]
ASB Reports	The Economic and Social Costs of Anti-Social Behaviour: a review' (London School of Economics and Political Science, 2003), p.43	Greater Manchester Combined Authority Cost Benefit Analysis data	£780	£836.72
Probation Breaches	*Probation Trust Unit Costs Financial Year 2011-12 (revised) National Offender Management Service Ministry of Justice Information Release*	Probation trusts unit costs 2011-12	£2,640	£3,588.00
Probation Failed appointments	*Probation Trust Unit Costs Financial Year 2011-12 (revised) National Offender Management Service Ministry of Justice Information Release*	Probation trusts unit costs 2011-12	£255	£346.57

Unit costings from the first edition of the Blue Light Manual

Impact	Unit	Cost
Police call out [44]	One call out	£267.00
Arrest [45]	Per arrest	£490.00
Court appearance [46]	Per appearance	£1,672.00
Prisons stays (and length) [47]	Per week	£912.00
ASB incident (e.g. begging and street drinking) [48]	Per incident	£490.00
Ambulance callout [49]	One callout	£417.00
A&E attendance [50]	One attendance	£132.00
Hospital admission averaged across elective, non-elective, critical care and standard bed [51]	Per day	£1369.00
Safeguarding referrals [52]	One referral	£1,618.00
Mental health appointment [53]	Per appointment	£210.00
Substance misuse service appointments [54]	Per appointment	£134.00
Other health appointments (e.g. GP, outpatient clinic) [55]	Per appointment	£134.00
Cost of fire service call out [56]	Per call out	£417.00

Information sheet 8: Accommodation options

In this section:

In the context of accommodation for dependent drinkers, terms like wet houses, dry houses, and damp houses are commonly used but can sound clinical, stigmatising, or unclear to broader audiences.

We recognise the problematic use of these terms and the constant efforts of the sector to establish less stigmatising terminology. For the purposes of this section, we have used existing terminology to support people in their understanding of the different housing options as they are commonly discussed, but we have additionally suggested alternative terminology that people may wish to consider using.

Abstinence based housing

A Dry House is a substance-free, supported living environment, specifically designed for individuals recovering from alcohol dependence, where residents must abstain from substance use. Dry Houses are often part of a broader recovery programme intended to help people transition from intensive treatment to independent living, by providing a safe space for individuals to maintain sobriety while receiving ongoing support.

Alternative language options for *Dry House*:

- Abstinence Based Housing
- Recovery Oriented Housing
- Sober Living Residence
- Substance Free Housing
- Recovery Housing
- Supportive Abstinence Accommodation

Examples of Dry Houses

Complex needs facilities, night shelters and general accommodation that takes people with alcohol use disorder

These places are more general, low threshold accommodation where people can get support with their housing issues, but also find support with other aspects of their lives such as addiction or mental health.

Examples of positive practice include:

- Way Through's Red Bank in Manchester is a dry house that manages relapses well.
- The REBUILD (post-detox) Pathway | Mildmay Hospital
- Intermediate rehabilitation care beds for people who are sleeping rough or at risk of homelessness, following in-patient substance misuse detoxification or stabilisation.
- SIG Equinox – Churchfield and Cherington Supported Housing Accommodation – Social Interest Group
- Supported accommodation for individuals in Ealing, dealing with substance use and homelessness:
- Cherington is a 5-bed mixed-gender recovery hostel for people with medium support needs who have completed detox and abstain from drugs and alcohol and need help reintegrating back into the community.
- Churchfield is a 24-hour, 12-bed mixed-gender high-support service offering temporary accommodation for people experiencing homelessness with drug or alcohol dependency and working towards abstinence.

Alcohol tolerant accommodation

Traditionally called a Wet House, this is a type of supported accommodation for individuals with alcohol dependence, where alcohol consumption is permitted and managed on the premises, often with staff on-site. Unlike Dry Houses, which require abstinence, Wet Houses take a harm-reduction approach – they acknowledge that some individuals may not be ready or willing to stop drinking and instead aim to reduce the associated harms, and often include access to healthcare, mental health support, and social services.

Alternative language options for *Wet House*:

- Managed Alcohol Housing
- Alcohol Tolerant Accommodation
- Alcohol Managed Environment

- Harm Reduction Housing
- Low Barrier Supportive Housing
- Alcohol Permissive Residence
- Controlled Consumption Setting

Models exist in many parts of the country and it is possible to find models overseas, for example, New Zealand or the USA. Whilst Wet Houses do have benefits, such as allowing people to drink in a safe environment and cutting down on public drinking, they are not a solution for everyone.

Examples of UK wet facilities include:

- St Martin's Housing – Highwater House – Highwater House is a 22-bed dual diagnosis registered care home. It is a 'wet' unit catering for single men and women with ongoing mental health and issues with problematic substance use aged 18 – 65.
- Island Residential Home Sheppey – The Island Residential Home is a purpose built care home and is based on the Isle of Sheppey in Kent, and their aim is to offer residents the opportunity to enhance their quality of life by providing a safe, manageable and comfortable environment, and support to enhance their physical, intellectual, emotional and social capacity.
- SIG Equinox – Aspinden Care Home – Social Interest Group a unique CQC residential service specialised in harm reduction support for people with alcohol dependency and complex needs.
- Merevale House – a small-scale domestic living environment for people living with Dementia. With specialist, unique services for young-age (under 64), old-age (over 64), Alcohol Related Brain Damage (ARBD), Korsakoff's Syndrome and rehabilitation pathways.
- Camphill communities – offer opportunities for people with learning disabilities, mental health problems and other special needs to live, learn and work with others of all abilities in an atmosphere of mutual care and respect.
- St Mungo's Broadway – Hilldrop Road and Chichester Road. St Mungo's run two registered care homes aiming to provide a high level of care to older men with complex needs, including poor physical health. These care homes provide a long term secure environment for residents who have been homeless or slept rough during their lives.
- O' Hanlon House – O'Hanlon House is open around the clock and has 56 rooms, offering safety, warmth and specialist support. It is not dry or drug-free, but there is no use in communal areas. It is a mixed facility.

Managed Alcohol Programmes

A Managed Alcohol Programme (MAP) is a harm-reduction approach where alcohol is provided in measured quantities at set times, in a structured intervention. The controlled, regular doses of alcohol are usually dispensed by trained staff, such as nurses, keyworkers, or support workers, Typically, the person will live in supported accommodation, such as a Wet House or shelter that operates the MAP, where they will also receive other care such as healthcare, mental health care and social support.

Whilst MAPs allow drinking on the premises, this is subject to a detailed management plan, with the agreed alcohol being supplied via the facility. Many wet houses also have alcohol management plans with their residents. For example, the Docherty Project in Manchester offers specialist support and accommodation for men and women who need help maintaining accommodation because of difficulties related to alcohol use. They do not demand customers stop drinking alcohol; instead, the project uses a model of 'harm reduction', and individual 'drinking plans' are agreed with customers to stabilise alcohol consumption and sharing alcohol is discouraged. However, it is unclear whether this is formally a wet house.

The concept of the wet house does shade into Managed Alcohol Programmes, but MAPs are not about encouraging drinking – they're about reducing harm when total abstinence isn't currently achievable. For many, it's a pragmatic and compassionate step towards improved health, housing stability, and sometimes eventual recovery. So, whilst the boundary between the wet house and the MAP may be blurred at the edges, they are two distinct concepts, and the view of this guidance is that this remains an area for possible development in England and Wales.

Dr Hannah Carver at the University of Stirling and colleagues have published a number of papers that explore the potential benefits of this approach.

- A qualitative exploration of the relevance of training provision in planning for implementation of managed alcohol programs within a third sector setting
- The Potential for Managed Alcohol Programmes in Scotland during the COVID-19 Pandemic
- Exploring the Potential of Implementing Managed Alcohol Programmes to Reduce Risk of COVID-19 Infection and Transmission, and Wider Harms, for People Experiencing Alcohol Dependency and Homelessness in Scotland
- *It's like a safety haven'*: considerations for the implementation of managed alcohol programs in Scotland
- Investigating the need for alcohol harm reduction and managed alcohol programs for people experiencing homelessness and alcohol use disorders in Scotland

Co-occurring conditions

Accommodation for people with co-occurring conditions – also known as dual diagnosis – is specifically designed to support individuals who experience both substance use disorders, including alcohol dependence, and mental health conditions, such as depression, anxiety, schizophrenia, or PTSD. These conditions are often deeply interconnected and require integrated, specialist care.

Examples of positive practice include:

- Magic Life UK | Providing Support for people with a Dual Diagnosis – Bruce Grove Villas offers specialist support for up to 6 individuals with mental health and behaviours that can be deemed as challenging.
- Summit Lodge – Support for adults with mental health and substance misuse issues, 24/7-supported residential facilities in key locations across East London and Essex.
- SIG Equinox – Aspinden Care Home - Social Interest Group – A unique CQC residential service specialising in harm reduction support for people with alcohol dependency and complex physical and mental health needs.
- SIG Equinox – Lewisham Mental Health Supported Housing (MHSH) – Social Interest Group – Complex Mental Health Supported Accommodation and Assertive Outreach Service, supporting adults with mental health needs, often with secondary support needs around substance use, forensic histories and histories of homelessness.
- SIG Equinox SWAY – SWAY is a male-only service providing supported accommodation and a recovery approach resettlement programme, specialising in helping men with enduring mental health support needs and associated challenges with drug and alcohol use.
- Mary & Joseph House – part of The Joseph Cox Charity. Providing a safe, caring and stable environment to 41 gentlemen aged between 40 and 80 years old, looking to get back on their feet after alcohol dependency and mental health difficulties.
- Phoenix Futures – New Oakwood Lodge, Derby – New Oakwood Lodge is an enhanced Therapeutic Community, offering CQC-registered drug and alcohol residential care to people who are confronting their substance use.

Cognitive impairment

Accommodation for people with alcohol dependence and cognitive impairment is designed to meet the unique and often complex needs of individuals who have experienced long-term brain changes which can occur through chronic alcohol use. These impairments may include Alcohol-Related Brain Damage (ARBD), such as Wernicke-Korsakoff syndrome, memory problems, reduced executive function, and difficulty with communication or decision-making.

Examples of positive practice include:

- Porchlight in Kent – Porchlight offers a free telephone 24 hour helpline for people who are street homelessness, sofa surfing or about to lose their home. Porchlight are Kent's largest charity for homeless and vulnerable people. We're here for people who have nowhere to go and no-one to turn to.
- Brynawel House Wales – The Only Rehab in Wales offering specific interventions to support people with ARBD.
- Leonard Cheshire, Belfast – Alcohol Related Brain Injury Unit (ARBI) opened in January 2020. It is a specialised 14-bed rehabilitation unit for individuals with a diagnosis of ARBI.
- Notaro Homes – Providing care and support for individuals living with Alcohol Related Brain Damage such as Korsakoff's Syndrome and Wernicke Encephalopathy. When an individual comes to stay in one of their ARBD homes, they work with them to produce a care plan that seeks to enable them to return to the community and support them to live as independently as they can.
- Willowgarth – A 68 bed residential home, providing a tranquil environment, supporting rehabilitation and recovery for people with severe and enduring mental health needs. Providing 24-hour residential care for adults with mental health needs including alcohol related brain disease.
- SIG Equinox – Aspinden Care Home – Social Interest Group – support for people with alcohol dependency and complex physical and mental health needs. 25-bed CQC-registered Care Home for treatment-resistant adults using alcohol. Aspinden is a mixed-gender service whose national remit focuses on harm minimisation and reducing re-traumatisation, ensuring residents' safety, and improving their physical and mental health.
- Hengoed Park – Residential care for those who may be living with Alcohol Related Brain Damage, (ARBD), such as Korsakoff's and Wernicke's syndrome; Acquired Brain Injury (ABI); Dementia; Organic Mental Health and other co-existing conditions.
- High View Care Services Bromley – assessing, caring for and rehabilitating adults aged 18-65 with brain injury and co-morbid diagnoses often related to alcohol or substance misuse, mental health, challenging behaviour, and other complex needs.

In Scotland, the Glasgow City Health and Social Care Partnership (HSCP) has produced a Recovery Passport for people who are living with the impact of Alcohol Related Brain Damage (ARBD). It is a document that will support people's journey through services, helping them to clearly explain their diagnosis, and their experience of the condition. This will clearly be of benefit as the person moves through accommodation options.

Women only services

Accommodation specifically designed for women with alcohol dependence provides a gender-sensitive, trauma-informed environment tailored to the unique needs and experiences of women in recovery. Women can sometimes feel unsafe in mixed-gender settings, and women only settings can provide a safe and supportive environment for women to address their unique needs and the barriers they may face, such as increased stigma and shame around using substances or childcare issues. Women only spaces also make it easier for women to build connections with others who have similar experiences, fostering a sense of community and belonging.

Examples of positive practice include:

- SIG Equinox – Brighton Women's Service – Social Interest Group – Brighton Women's Service is a female-only residential project that provides vital temporary accommodation and support for up to 18 women in Brighton and Hove. They have two multi-bed sites staffed 24 hours for women with severe and enduring support needs, including drugs and alcohol, mental health, domestic abuse, history with the Criminal Justice System, and often experiencing long periods of homelessness. The average length of stay is two years.
- In Partnership (IPP) – Great Places – Blackburn. In Partnership provides support and accommodation for women aged 16 – 55 who are homeless and who also need help with drug or alcohol issues. They have 17 fully furnished, self-contained flats and communal facilities which include a lounge, training kitchen, gardens, well-being suite and training room.
- Manor Place- Homeless Link – Single homeless women with medium to high level support needs, including those with mental health issues, alcohol and/or drug use and women escaping domestic violence. Must have a local connection to Southwark and some basic life skills. 34 spaces. 18 – 60 aged women.
- Recovery Housing – Forward Trust – Support for women who have had issues with drugs or alcohol find somewhere safe to live. We provide accommodation for who need more freedom than is offered in supported housing but who are not yet ready to live independently.
- Ophelia House – The core principle of Ophelia House is that it is designed by women, for women. The women we support at Ophelia House come from diverse backgrounds and have individual life experiences. With an all-female staff team, Ophelia House is a Therapeutic Community offering CQC-registered drug and alcohol residential care to women. Accommodation for up to 22 residents in single rooms with ensuite bathrooms.

Other services

Although not necessarily female only services, some residential facilities offer help for families, often mothers and young children. An example is:

- Harper House – Specialist Family Service Scotland | Phoenix Futures (phoenix-futures.org.uk) This is the only drug and alcohol rehabilitation unit in Scotland that can support both parents to get sober while still having responsibility for their children.
- Accommodation for couples – (and other options) Manchester City Council – Woodward Court – Homeless England | Homeless Link

Services for women fleeing domestic abuse

The dual and often overlapping needs of trauma recovery and alcohol dependence may not be catered for by traditional domestic abuse refuges, which may not accept women with active addictions. Additionally, addiction services may not adequately address the trauma and safety concerns of survivors, and so specialised accommodation that integrates both is crucial.

Examples of positive practice include:

nia – North and East London based nia offers *accommodation* to women who often cannot access or have been excluded from other refuge provision. They specialise in providing refuge for women with problematic substance use, whether drugs, alcohol or a mixture of both, and women who are involved in prostitution or other forms of sexual exploitation.

They run two refuges:

- Emma Project is a pioneering refuge offering high level support and an outreach service for women who have experienced domestic and sexual violence including women who have been exploited through prostitution and who also use substances problematically.

- Daria House is a refuge for women who have been sexually exploited, with a particular focus on supporting women who been exploited through their involvement in prostitution. It can help women to access housing and welfare benefits, legal advice, healthcare, drug and alcohol services and other specialist services for women in prostitution.
- Harbour Housing in Cornwall run the EVA (Empowered, Valued, Aware) Project which is accommodation for women fleeing domestic violence, but which has a specific alcohol and drug element. Comprising twelve beds in a women-only property, the EVA project is designed to help our residents to recover from their experiences and trauma at a pace which is appropriate for them.
- For Women – The Haven (havenrefuge.org.uk) in Wolverhampton offers women who have been subjected to domestic abuse, specialist support including for those affected by substance abuse (drugs and alcohol)
- Greenwich Domestic Violence and Abuse Service run a substance misuse refuge providing specialist support for women who have experienced domestic abuse and are struggling with drug and alcohol addictions. The on-site drug and alcohol specialist provides holistic support to help residents get to the root of their addictions and plan drug and alcohol-free futures.

NOTE: People with pets who are fleeing domestic violence.

Both the Dogs Trust and Cats Protection run schemes that can accommodate pets for people who are fleeing domestic abuse Housing First.

The Housing First model is a transformative approach to supporting people with chronic homelessness and complex needs, including alcohol dependence, that offers unconditional, permanent housing as quickly as possible. The model prioritises immediate access to permanent housing without requiring sobriety or engagement in treatment as a precondition, and offers tailored, open-ended, wraparound support for the resident that emphasises choice and control.

Housing First is built upon the principle that housing is a human right and has been commissioned by local authorities in England since 2010.

Information on the Housing First Model

Traditional Hostel or Dry House	Housing First
Requires abstinence or treatment	No preconditions
Time-limited accommodation	Permanent housing
Group/shared settings	Independent tenancies
Eviction for rule breaches	Flexible, non-punitive
Support often ends with housing	Support continues long-term

Housing First models exist across the country e.g. Stoke, Manchester, Brighton or Camden. Details on these can be found on the Homeless Link website.

Similar models exist, such as housing in general accommodation with floating support, concierge type support, or single person accommodation with access to day support / day centre, can be found across the country. For example, For Futures in Cheshire West and Chester.

Ministry of Housing, evaluation of Housing First

'..the cost benefit analysis of the three Housing First pilots in England estimates the costs of support provided and the value of benefits delivered. The costs of delivering the Pilots averaged £7,700 per person supported per year to the end of 2022. The full benefits of the pilots will take many years to be seen but are expected to amount to £15,880 per person per year, through improvements in personal wellbeing and reductions in the public service costs of homelessness. More than half of the value of these annual benefits was estimated to have been realised 12 months after participants had entered the programme. The benefit: cost ratio is estimated at 2.1 (based on expected benefits) and 1.1 (based on estimated benefits after only 12 months). This suggests that the pilots have delivered good value for money.'[vi]

vi Ministry of Housing, Communities, and Local Government (2024) Evaluation of the Housing First Pilots. Available here.

Homeless Link have produced a series of **7-minute briefings** for professionals working in non-housing sectors. These briefings cover criminal justice, health, mental health, social care and substance use sectors, and aim to help people to understand what Housing First is and who it is for, why it is relevant to their work, the role they play in supporting Housing First teams, and the relevant support approaches, including trauma-informed care, being strengths-based and harm reduction.

Education to minimise fire risk

The Firesetters' Integrated Responsive Educational – Programme (FIRE-P), designed by Hampshire and Isle of Wight Fire and Rescue Service and the University of Portsmouth and held at various locations in Surrey, imparts crucial fire safety knowledge and addresses the long-term consequences of fire-setting behaviour. The FIRE-P course is a mixture of face-to-face workshops and homework, which results in a portfolio of work that can be shown to employers and landlords with the hope of securing work and long-term housing. (This was funded by Changing Futures in Surrey).

More information can be found here: Firesetters' Integrated Responsive Educational Programme (FIRE-P) | University of Portsmouth

Other Top of Form

While looking at these individual areas of need it is important to note that some services offer a range of these services e.g.

- The Society of St James (ssj.org.uk)
- Two Saints
- Keystage Housing
- Great Places Housing Group

Useful Information and links

https://homeless.org.uk/areas-of-expertise/housing-first/

https://homeless.org.uk/news/new-podcast-episode-discussing-specialist-care-homes-for-people-experiencing-homelessness/

Information sheet 9: Psychologically informed environments

Introduction

Understanding Psychologically Informed Environments (PIE)

A Psychologically Informed Environment (PIE) in the context of housing is a setting that recognises the impact of trauma, psychological distress, and other emotional factors on individuals' behaviours and wellbeing. Developed initially for homelessness services, PIE has expanded into various sectors, including substance use services and housing support, to create supportive, understanding environments that facilitate recovery, stability and resilience.

The PIE approach is especially relevant for individuals dealing with substance use, including alcohol dependency. By addressing the psychological and emotional needs of residents, a PIE can provide a structured yet compassionate space where individuals feel understood, accepted, and encouraged to make positive changes in their lives. PIE is crucial in breaking the cycle of dependency and homelessness by helping residents develop coping mechanisms, improve interpersonal relationships, and work towards long-term housing stability.

Key Principles of a Psychologically Informed Environment

The PIE framework is guided by several core principles that should be woven into housing and support services to create effective, compassionate environments:

Psychological Awareness:

Staff are trained to understand the psychological and emotional needs of residents, with a particular focus on the effects of trauma and alcohol dependency. This awareness allows staff to provide compassionate support, fostering a non-judgemental and inclusive atmosphere.

Relationship-Building:

A strong emphasis is placed on building trust-based, supportive relationships between staff and residents. Stable relationships within the housing environment contribute to residents' sense of safety, reducing anxiety and helping them feel more engaged in the process of recovery and change.

Person-Centred Care:

The PIE approach promotes person-centred care that recognises each individual's unique experiences, strengths, and needs. This might involve tailored support plans for residents that account for their specific challenges with alcohol dependency, ensuring that interventions are meaningful and achievable.

Staff Support and Training:

Implementing a PIE requires dedicated staff training on psychological issues, trauma-informed care, and substance use. Regular supervision and debriefing help prevent staff burnout and provide a space for reflective practice, allowing staff to continuously improve their approaches.

Reflective Practice:

Reflective practice encourages staff to assess their responses and interventions critically, ensuring they remain compassionate and effective. Regular team discussions and reflective sessions are key to maintaining a psychologically informed approach that adapts to residents' evolving needs.

Environmental Considerations:

A PIE considers the physical environment of accommodation settings to ensure it feels welcoming, safe, and conducive to residents' physical and mental health. Design elements such as private, quiet spaces for reflection or one-to-one sessions, calm colour schemes, and communal areas that encourage positive social interactions are vital.

Practical Implementation of PIE in Housing Services

Implementing PIE within housing services requires both structural changes and a commitment to the ongoing personal and professional development of staff. Here are several practical steps housing providers and commissioners can take to incorporate PIE into their services:

Comprehensive Staff Training:

Staff training should cover trauma-informed care, motivational interviewing, and other psychologically based approaches. For dependent drinkers, training on understanding the complexities of alcohol dependency and associated mental and physical health issues is particularly important.

Resident Involvement:

Residents should be involved in shaping their environment, such as contributing to house rules or activities. This can foster a sense of ownership and agency, crucial for dependent drinkers who may feel disenfranchised by their addiction.

Safety and Boundaries:

Clear, consistently enforced boundaries are essential in PIE, as they provide a sense of safety and structure. Boundaries should be communicated in a way that reflects understanding of the psychological needs of dependent drinkers, avoiding punitive language and emphasising respect.

Supportive Group Activities:

Group activities that encourage social engagement and provide structured peer support can help residents with alcohol dependency feel less isolated. Activities can be as simple as shared meals or structured support groups that allow residents to reflect on their experiences in a safe setting.

Crisis Support:

For residents experiencing acute episodes of psychological distress or relapse, it is important to have clear procedures in place for crisis management, with access to immediate support if needed. This may involve de-escalation strategies, access to mental health services, or temporary relocation to a quieter space within the accommodation.

Specific PIE Accommodation for Dependent Drinkers

For dependent drinkers, PIE accommodation presents specific challenges and opportunities. The emphasis on psychological safety and trauma-informed care is particularly relevant, as many individuals in this group may have experienced traumatic backgrounds or stigma around their addiction. A tailored PIE approach for dependent drinkers should consider the following additional points:

Tolerance and Harm Reduction:

Accommodation designed for dependent drinkers should adopt harm reduction principles. Recognising that some residents may not be ready or able to fully abstain from alcohol, a harm reduction approach can encourage safer alcohol use while still working toward positive behaviour change. Services may explore controlled consumption agreements, where residents are encouraged to manage their drinking within safe limits under supportive guidance.

Specialised Health and Support Services:

Collaborative working with health and substance use services ensures that residents have access to medical and therapeutic support, including detox and rehabilitation services if and when they are ready. Commissioners and housing providers should aim to integrate or coordinate these services within the accommodation setting.

Managing Triggers and Relapses:

Many dependent drinkers may experience periods of relapse, which can undermine their housing stability. In a PIE, relapse is addressed with understanding rather than eviction, ensuring residents feel supported to recover. Staff are trained to manage relapses constructively, using reflective practice to assess any additional supports the resident might need.

Routine and Purpose-Building Activities:

A structured yet flexible routine helps residents build stability and purpose. Regular activities, such as skill-building workshops or light physical activities, provide structure without creating pressure. The PIE approach values routines that encourage small achievements, which build residents' confidence and self-efficacy.

Non-judgemental Support Environment:

Creating a PIE for dependent drinkers means maintaining a non-judgemental, empathetic environment where residents feel valued regardless of their progress. An understanding approach fosters trust, allowing residents to feel safe exploring treatment options without fear of rejection or punishment.

Example from Housing Project Workshops

Oxfordshire Model

The Oxfordshire Health and Homelessness Inclusion Team has been operating since 2021, with the principal objective of avoiding or relieving rough sleeping and homelessness.

It is aimed at those over 18 who are within Oxfordshire and who are experiencing homelessness or are at risk of homelessness.

Half of the team works with getting people out of hospital safely, either mental health hospitals or general hospitals. They have housing officers in hospitals, and step down / respite accommodation, (33 beds), which is short stay of up to 6 weeks.

If a person was in hospital, until a year or so ago, their needs would be assessed in the hospital to see if they had ongoing needs.

The drive now is to discharge and assess. This means people are assessed back at home. This group do not have homes, so the team provides that place. They have an MDT that wraps around the service and makes sure that everyone's needs are assessed. This includes the psychologists importantly.

The other half of the team has a preventative focus, consisting of social workers, OT's, mental health practitioners etc. Essentially their task is to help increase access to services within the community and avoiding admissions into hospital.

As part of the work, two Psychologists visit hostels in Oxfordshire twice per week.

The benefits that the Psychologists bring to Oxfordshire:

They work directly with the people living there, either individually or in group sessions.

In the hostel there are people who have been in and around the system for decades, or a lifetime on the streets, in and out of hostels etc. with years of built-up trauma and barriers. This can make it difficult for them to build relationships and trust.

The psychologists have been effective at working with people individually and becoming that person they can trust.

The psychologists can get to the root causes of any trauma that an individual may have, and the cause of the addiction, and they can then provide staff with tools and ways of working with an individual.

They work directly with the staff and on workforce development, providing them with tools and the skills to work with people in the hostel.

The Psychologists work with and train the staff to give them the tools and skills that they need, and to help them, using reflective practice and some self-management tools, to keep up that barrier of objectivity, and professionalism. They also help them to see past the behaviour and see the trauma / life experiences that lie behind the behaviour.

Because the psychologists don't take on statutory cases, they have a lot more flexibility as to how long they can work with someone, and how quickly they can respond.

Opening doors to services that have been closed.

For example, if a GP surgery refuses to see someone because they have turned up intoxicated, the psychologists can help to open these doors again.

The psychologists may also have access to the medical records, which can make a difference, because support workers may need this information, but they are not able to access it.

Example – one individual had a lot of challenges, and it turned out that they had a diagnosis of Autism, that no one had known about. So reasonable adjustments were needed in terms of how people interacted with them. The psychologist worked with the teams of support workers and gave them skills to work with that person.

The psychologists can also help with the physical aspects of the buildings to make them more welcoming and less clinical / institutional.

For more information:

The Oxfordshire Health and Homelessness Inclusion Team

Conclusion

Psychologically Informed Environments (PIE) offer a promising framework for housing services that cater to individuals with complex needs, including those struggling with alcohol dependency. By prioritising psychological awareness, trauma-informed care, and harm reduction, PIE accommodation can provide dependent drinkers with a stable, compassionate setting that supports long-term recovery. For commissioners and housing providers, adopting a PIE approach means committing to continuous reflection, adaptation, and empathy to ensure that the accommodation genuinely serves residents' needs.

A PIE-based accommodation model can be a lifeline for dependent drinkers, helping them to stabilise, regain control, and move towards independence. As we look to the future of supportive housing, PIE serves as a reminder of the profound impact that psychologically supportive environments can have on vulnerable individuals' lives.

Appendices

Appendix 1: Methodology

This guidance and the accompanying resources were developed through a national multi-partner project initiated by Alcohol Change UK. This followed the innovative approach used to develop the *Blue Light a*pproach. Local authorities each contributed funding into a central pot to fund the development. In return, they received workshops, presentations, surveys and training. Twenty-nine local authority partners contributed; another 10 expressed interest in the project. This alone highlights the importance of this issue.

The partners are listed in Appendix 2. Alcohol Change UK is grateful for their support.

The development was overseen by an expert steering group made up of representatives of the partner areas and national experts (see appendix 3). Project management was undertaken by Alcohol Change UK.

The guidance was built through:

- Development workshops in each partner area where both the challenges and possibilities for work with this client group were discussed
- A national online survey which had over 600 responses
- Interviews with national experts and local stakeholders
- Desk research
- Discussions with the national steering group.

Appendix 2: Partner areas and steering group membership

Partner areas
Bath & NE Somerset
Blackburn
Bournemouth Christchurch & Poole
Buckinghamshire
Carmarthenshire
Cheshire West and Chester
Cornwall
Croydon
Gloucestershire
Hartlepool
Islington
Kent
Luton
Manchester
Medway
Newcastle
Newham
North Yorkshire
Nottingham City
Nottinghamshire
Oxfordshire
Royal Borough of Kingston
Royal Borough of Windsor & Maidenhead
Sandwell
Stoke on Trent
Sunderland
Surrey
West Sussex
Westminster

The national experts on the steering group	
Andrew Misell (Alcohol Change UK)	Andrew Brown (Department of Health)
Professor Michael Preston-Shoot (Emeritus Professor University of Bedfordshire)	Dr. Sarah Wadd (University of Bedfordshire)
Jo Prestidge (Homeless Link)	James Cofield (Lived experience)
Dr Hannah Carver (University of Stirling)	Jenny Ewells (DLUHC)
Ellie Atkins (Manchester City Council)	Mark Holmes (Alcohol Change UK)
Jennie Fortune (Westminster City Council)	Lauren Booker (Alcohol Change UK)
Fiona Palmer (Alcohol Change UK)	Kanishka Rathnayake (Alcohol Change UK)
Susan Laurie (Alcohol Change UK)	KP Sarvaiya (Alcohol Change UK)
Jane Gardiner (Alcohol Change UK)	Will Pearson (Salvation Army)

Appendix 3: Interviewees

The authors are grateful to the following people who so generously shared their time and expertise in order to support the development of this document.

Interviewee	Organisation
Ciaran Lynch	Manchester City Council
Victoria Aseervatham	Westminster City Council
Collette Le Van Gilroy	Public Health Surrey
Ellie Atkins	The Entrenched Rough Sleeper Social Work Team, Manchester City Council
Kiera Russell	Rowan Alba
Karen Casada	North Wales Housing Association
Jack Thomas	The Wallich
Kenny McCausland	The Wallich
Anthony Vaughan	The Wallich
Sian Yeoman	Pobl Group
Dr Hia Jordan	Royal Boroughs of Kensington, Chelsea and Westminster
Kate Moss	Harbour Housing
Kath Pink	Carmarthenshire Council
Maggie Gibson	North Yorkshire Council
Will Pearson	Salvation Army
Martyn Penfold	Independent Consultant
Mark Dow	West Sussex County Council
Helen Hodder	Stonepillow
Peter Moore	Oxfordshire Health and Homelessness Team
James Cofield	Expert by lived experience
Jeff Dawson	Expert by lived experience
Craig Walsh	Expert by lived experience

Appendix 4: The authors

Mike Ward is Senior Consultant at Alcohol Change UK. He comes from a social work background. He founded and led Surrey Alcohol and Drug Advisory Service and has worked for Cranstoun and Kent Council on Addiction. He was formerly Commissioning Manager (Mental Health & Substance Misuse) for Surrey Social Services. He is now a full-time consultant and trainer. Mike has worked in the substance misuse/mental health field for over forty years. He wrote the Department of Health/NTA guidelines on running drug death review systems and is one of the two key drivers behind the Blue Light project. He is the author of twenty-five Safeguarding Adult Reviews and co-wrote *Learning From Tragedies*.

Jane Gardiner is the Director of Consultancy & Training at Alcohol Change UK. She has overseen several key projects during her time at the charity, including the development of guidance on cognitive impairment in dependent drinkers, and the writing of the second edition of the Blue Light Approach Practice Guidance manual. She is a Safeguarding Adult Review author and sits on the Board of a homelessness service in Kent.

Susan Laurie joined Alcohol Change UK in 2021 as its Lived Experience Associate and went on to join the Consultancy and Training Team permanently in 2023. She is also an author and speaker and has contributed to the All Party Parliamentary Group on Alcohol Harm, as well as giving evidence at the House of Lords Commission on Alcohol Harm. She was recognised as a 'Woman of The Year' in 2020.

KP Sarvaiya is the Senior Consultancy and Training Manager at Alcohol Change UK, where he has been a key part of the department for over three years. In this role, KP has contributed significantly to the development and delivery of projects, including the national, multi-partner initiative to develop guidance on the assessment and management of cognitive impairment in dependent drinkers. He continues to support Alcohol Change UK's mission to improve treatment services by supporting training and project delivery.

Appendix 5: Calculating the size of the group

Commissioners will need estimates of the size of this group to support change. The National Drug Treatment Monitoring System (NDTMS) provides data on the rates of homelessness and the risk of homelessness among people with substance use disorders engaging with treatment services. The data indicates that 30% of alcohol only and combined alcohol and opiate clients had no home at the start of treatment.[33] This figure is only of partial help because it is looking at the group of dependent drinkers who engage with services: a minority of the whole group. This section describes the steps taken to provide an estimate relevant to those who are not engaging with services.

How many people experiencing homelessness and how many with alcohol use disorders

In 2024, Shelter published an analysis of Government data which estimated that, at any one time, there are 192,521 homeless adults in England.[34] On a pro rata basis, this equates to 10,676 in Wales. The definition of homelessness used and the basis for the calculation are contained in the Shelter report, which can be accessed here. It is important to note that this is wider than people who are simply street homeless.

The more relevant question for this guidance is: how many of these homeless people also have an alcohol use disorder? Various estimates of prevalence have been identified:

- **The Mental Health Foundation** – the most prevalent health problems among homeless individuals are substance misuse (62.5%), mental health problems (53.7%) or a combination of the two (42.6%).[35]
- **Homeless Link** – 29% of homeless respondents have or are recovering from an alcohol problem.[36]
- **U.S. Substance Abuse and Mental Health Services Administration** – 38% of homeless people were dependent on alcohol, and 26% abused other drugs.[37]
- **Gutwinski et al. (2021)** estimated prevalence rates of mental disorders in samples of homeless individuals. The most common diagnostic category was alcohol use disorders, at 36.7% (95% CI 27.7% to 46.2%).[38]
- **Bramley et al. (2015)** reported that half of the rough sleepers were defined as alcohol dependent (36% severely dependent).[39]

This collection of data suggests that the rates of homeless people with serious alcohol use disorders are likely to be of the order of at least 35%. This is a conservative estimate and has been used in later calculations of prevalence.

Developing estimates

This analysis estimates the number of individuals experiencing both homelessness and alcohol dependency, specifically focusing on single adults without dependent children. It combines local authority – level figures on homelessness with alcohol-specific mortality data, which serves as a proxy for alcohol-related harm. Children have been excluded from the Shelter data utilised in this analysis to maintain consistency with the target population.

- **Local homelessness data** — The starting point was the Shelter homelessness data[40] for each local authority. The estimate suggesting that 35% of homeless individuals are alcohol dependent was then used to generate estimates of the number of alcohol dependent individuals in each local authority area.
- **Focusing on single adults without dependent children** — To ensure the analysis was relevant to the target group, the data was refined further. Office for National Statistics[41] data on available demographic breakdowns (e.g. single adults with dependent children, couples with children) was applied to the Shelter data to develop data for single adults without dependent children.
- **Adjustment for geographical variation in the rates of alcohol use disorders** — The resulting data was adjusted to reflect geographical variation in alcohol use disorders using alcohol-specific mortality ratios derived from national statistics.[42]

This data has been used to generate the estimates below of prevalence in the partner areas to this project.

Region	Percentage of homeless people who are alcohol dependent	Est. number of homeless adults	Est. number of alcohol dependent homeless adults	Est. number of homeless single adults without dependent children	Est. number of alcohol dependent homeless adults without dependent children
England and Wales	35.00%				
England	34.75%	192,521	66,898	NA	NA
North East	52.12%	1,498	781	NA	NA
North West	45.58%	11,776	5,367	NA	NA
Yorkshire and The Humber	41.55%	5,247	2,180	NA	NA
East Midlands	36.51%	5,899	2,154	NA	NA
West Midlands	41.29%	13,508	5,578	NA	NA
East	25.68%	12,444	3,196	NA	NA
London	26.69%	95,843	25,581	NA	NA
South East	28.45%	20,292	5,774	NA	NA
South West	30.22%	7,896	2,386	NA	NA
Buckinghamshire CC	24.68%	467	115	389	96
Westminster	22.66%	4,683	1,061	3641	825
Kent	29.46%	3,202	943	2402	707
Ashford	25.94%	280	73	207	54
Canterbury	33.24%	154	51	128	42
Dartford	22.16%	561	124	377	83
Dover	25.18%	410	103	278	70
Folkestone and Hythe	32.48%	57	19	43	14
Gravesham	36.76%	362	133	259	95
Maidstone	31.47%	348	110	270	85
Sevenoaks	17.37%	86	15	58	10
Swale	38.02%	424	161	308	117
Thanet	43.81%	298	131	230	101
Tonbridge and Malling	21.65%	161	35	97	21
Tunbridge Wells	19.39%	61	12	57	11
Surrey CC	19.89%	1,502	299	1110	221

Elmbridge	20.14%	154	31	119	24
Epsom and Ewell	20.14%	335	67	259	52
Guildford	16.37%	81	13	64	10
Mole Valley	25.18%	60	15	49	12
Reigate and Banstead	23.92%	245	59	173	41
Runnymede	19.64%	65	13	47	9
Spelthorne	25.94%	252	65	171	44
Surrey Heath	13.35%	72	10	45	6
Tandridge	18.88%	63	12	46	9
Waverley	14.10%	11	2	8	1
Woking	21.65%	164	36	131	28
Cheshire West and Chester	34.24%	155	53	129	44
Newcastle on Tyne	52.63%	231	122	222	117
Newham	33.74%	9,477	3,198	6199	2092
Hartlepool	48.85%	22	11	19	10
Windsor & Maidenhead	27.70%	379	105	306	85
Cornwall	28.45%	1,030	293	872	248
Carmarthenshire	34.75%	20	7	N/A	N/A
Islington	39.03%	1,707	666	1422	555
Sandwell	55.40%	301	167	164	91
Medway Towns	35.25%	826	291	643	227
Sunderland	64.96%	200	130	177	115
Gloucestershire CC	31.73%	434	138	377	120
Cheltenham	43.56%	23	10	21	9
Cotswold	21.91%	26	6	24	5
Forest of Dean	35.50%	30	11	30	11
Gloucester	38.02%	277	105	240	91
Stroud	25.68%	55	14	43	11
Tewkesbury	25.68%	23	6	19	5
North Yorkshire	32.73%	436	143	343	112
Kingston Upon Thames	20.14%	1,228	247	1084	218

Croydon	23.92%	4,206	1,006	N/A	N/A
Luton	33.24%	1,807	601	1457	484
Bournemouth, Christchurch and Poole	37.01%	177	66	153	57
West Sussex	31.73%	2,220	704	1794	569
Adur	25.43%	185	47	159	40
Arun	46.83%	408	191	312	146
Chichester	29.71%	98	29	85	25
Crawley	30.47%	681	207	492	150
Horsham	23.17%	188	44	151	35
Mid Sussex	25.18%	126	32	113	28
Worthing	38.53%	534	206	462	178
Blackburn with Darwen	49.60%	72	36	65	32
Nottinghamshire	31.98%	435	139	303	97
Ashfield	36.76%	72	26	55	20
Bassetlaw	36.76%	78	29	53	19
Broxtowe	35.25%	16	6	9	3
Gedling	21.40%	170	36	120	26
Mansfield	41.04%	51	21	30	12
Newark and Sherwood	35.76%	32	11	N/A	N/A
Rushcliffe	17.37%	16	3	12	2
Manchester	50.86%	4,716	2,399	3905	1986
Stoke-on-Trent	52.63%	98	52	87	46
Oxfordshire	23.42%	588	138	479	112
Cherwell	29.71%	87	26	58	17
Oxford	26.19%	345	90	303	79
South Oxfordshire	17.63%	19	3	15	3
Vale of White Horse	19.14%	38	7	25	5
West Oxfordshire	25.94%	99	26	84	22
Nottingham	46.33%	1,198	555	1010	468
Bath and North East Somerset	27.45%	103	28	93	26

Scope and limitations

It is important to acknowledge that this analysis provides only a rough estimate and should be interpreted as such. A number of local factors that may influence rates of homelessness and alcohol dependence, such as the availability of hostels, proximity to coastal areas, or transport connectivity, are not accounted for in this model. Additionally, due to limitations in the available data, this estimate has not been broken down by gender or ethnicity.

This section is intended as a starting point to help local authorities gain an indicative sense of the scale of need within their area, rather than a definitive assessment.

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