

The Changing Pattern of Homeless Drug Use in Edinburgh and Sheffield

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Executive Summary

Introduction

The number of homeless people in the UK has increased since the financial crisis. Alongside this trend it has been observed that use of New Psychoactive Substances (NPS) and prescription drugs are appearing to be more commonplace (Ralphs et al 2017; Parsons, 2018; Ralphs and Gray, 2018). Furthermore, data from England and Scotland shows a clear rise in the numbers of homeless people that are dying from drug poisoning and overdoses (National Records Scotland, 2018; Office for National Statistics, 2018).

Whilst these trends are identifiable, little is known about the impacts of such changes upon services that provide support to homeless groups, or the individuals that are consuming a range of substances. Furthermore, less is known around the decision-making processes involved in drug use when an increasingly wide array of substances is available, particularly when a range of substances are used in combination.

This report details the findings of new small-scale primary research, aiming to build the limited evidence base on the changing patterns of drug use amongst homeless groups. The report examines how local organisations perceive and have reacted to the changing environment, as well as detailing the implications of these findings for service delivery. Furthermore, the research presents the narratives of homeless individuals who use drugs, particularly outlining their drug preferences and how they navigate the contemporary drugs market.

Research Approach

The research utilised a qualitative methodology, focusing upon the narrative of i) key informants, ii) frontline workers, and iii) homeless service users with experience of using a range of substances. The fieldwork for this project takes place in two locations – Edinburgh and Sheffield, this allows the research to take a comparative case study approach to review and highlight the differences between the two cities. Furthermore, this approach provides a comparative snapshot of drug markets, and a wider lens to review the potential impact of the drugs market on consumption and levels of harm.

Key Findings

Whilst the issues surrounding NPS were significant across the UK in the middle part of this decade, the problems associated with these substances appear to have waned in recent times. The New Psychoactive Substances Act of 2016 has greatly reduced the supply of NPS in the two cities (with the notable exception of 'Spice' in Sheffield).

Whilst the use of NPS has dropped in each city, drug use has shifted as prescription drugs have become desirable and commonplace. These substances come in the form of the 'legitimate' (tablets prescribed by medical professionals and subsequently sold on the black market) and 'illicit' (tablets that have been made in unlicensed laboratories that can contain a range of harmful ingredients). These substances are not used alone and are consumed strategically alongside 'traditional drugs' such as Heroin and Crack Cocaine to either enhance the 'high' or to help manage the 'come-down' associated with the traditional drugs. Moreover, despite the changes that have taken place in the drugs market in recent years, consumers all preferred to use the 'traditional drugs'. The more complex drug interactions (e.g. Heroin and Pregabalin) have posed significant issues to service providers and users due to the increased number of overdoses that occur. Furthermore, the administering of Naloxone to reverse the effects of overdoses is far less effective with complex combinations of substances.

Whilst changes have occurred to patterns of drug use, this report finds little evidence that the changes of drug use have materially altered the routes into homelessness. Broadly speaking, the causes of homelessness were traumatic events and a lack of familial/social support – this further underpins importance of family networks, friendships and relationships as structures to prevent homelessness.

Recommendations

- Co-ordinated intelligence sharing amongst organisations which provide homeless services to raise awareness and warn of harmful batches of drugs.
- Investment to seek an alternative to Naloxone which can treat complex drug interactions.
- Greater use of drug testing kits to help drug users establish the ingredients of illicit prescription drugs.

Recommendations for future research

- Further investigations into the motivations underlying the choices that homeless individuals make regarding their drug use, particularly around poly-drug use.

- A detailed nationwide study on the function and wider dynamics of the drugs market for homeless individuals.
- Additional studies of this kind to be conducted in major UK cities to gain a greater understanding of localised drug cultures and 'street knowledge' around drug use.

I. Introduction

In recent years, the homelessness services across the UK have reported that drug use has become increasingly more complex with the emergence of New Psychoactive Substances and prescription drugs (Ralphs and Gray, 2018; O'Hagan and Burns, 2019). The motivation for this study emanated from the researchers' PhD titled *'Disengaged youth? Exploring the lives of 'hidden NEETs' outside the welfare state.'* where around three weeks was spent in a homeless daycentre in Sheffield (July of 2017). During the research, NPS (particularly 'Spice') was causing significant challenges for the service providers and resulted in increased level of harm for the users of the drug.

This research distinguishes between two overarching groups of substances; i) 'traditional drugs' – Alcohol, Amphetamine, Cannabis, Crack Cocaine and Heroin, and ii) 'new drugs' – a range of New Psychoactive Substances (namely 'Spice' and Burst') as well as the prescription drugs of Pregabalin, Gabapentin, Xanax and Valium. However, despite changes taking place within the drugs market, the impacts of these changes on organisations and the decision-making processes of people who are homeless with the experiences of using a range of substances remains largely unexplored.

The specific research questions explored in this report are as follows:

- What is the temporal ordering of drug use (including alcohol) and experiences of homelessness in the life histories of people using 'new drugs'?
- Has the nature of drug use amongst homeless people changed over time, and what, if any, impact has the emergence of the 'new drugs' had on this?
- How, if at all, can service providers and policy makers better respond to the needs of homeless drug users?

To address this gap in knowledge this research focuses upon two distinct strands. The report will firstly present the perspectives of key informants pertaining to their observations on how drug consumption patterns have changed in recent years, the impact of legislation, and commentary on the wider drugs market for people experiencing homelessness. Subsequently, the perspectives of homeless service users with experience of using a range of drugs will be presented, initially on physical/mental illness, before moving on to outline their drug preferences and the underlying motivations for using different

substances. These themes are particularly pertinent in the current environment due to backdrop of statistical increases in drug deaths in the UK and the challenges posed to service providers in an age of austerity (Donovan and Durey, 2019; National Records Scotland, 2018; Office for National Statistics, 2018).

The report is structured as follows:

- Section 2 details the research design and limitations of the research.
- Section 3 presents the findings from the literature review, specifically focusing on the emergence of different drugs and impacts on homeless people.
- Section 4 outlines the perspectives from Key Informants, specifically in relation to the increase in problematic drug use among people experiencing homelessness.
- Section 5 examines the experiences of Service Users in the two cities, detailing how their experiences of homelessness interlink with patterns of drug use.
- Section 6 concludes and considers the implications of the study.

2. Research Design and Methods

Introduction

The research takes a qualitative comparative approach to explore the relationship between homelessness and drug use considering the rise of New Psychoactive Substances and prescription drugs over the last decade. Furthermore, the research specifically focuses on the experiences of individuals who experience 'core homelessness', defined as those who are:

| |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| • Rough Sleeping |
| • Sleeping in tents, cars, public transport |
| • Squatting (unlicensed, insecure) |
| • Staying in unsuitable non-residential accommodation e.g. 'beds in sheds' |
| • Hostel residents or users of night/winter shelters |
| • Domestic Violence victims in Refuge |
| • In unsuitable temporary accommodation (which includes bed and breakfast accommodation, hotels etc.) |
| • 'Sofa Surfing' – staying with others (not close family), on short term/insecure basis/wanting to move, in crowded conditions (this does not include students) |

(see Bramley, 2017; p.5)

Literature review

The first task of the research was to conduct a review of existing literature in relation to drug use amongst homeless groups, the emergence of New Psychoactive Substances (NPS) and the use of prescription drugs. Particular attention was paid to literature pertaining to England and Scotland, but also the wider UK and further afield where useful, and to published work in the period between 2008 and the present day as during this time homelessness in the UK increased alongside the emergence of NPS.

Location of Study and Timescales

The city of Sheffield was chosen as a research location considering the authors experience (Devany, 2019) and the changing profile of drug use in the city, with use of NPS among those experiencing homelessness seeming to be increasing and unexplored impacts on services. The researcher also has strong service networks in the city,

an important practical reason for focusing on Sheffield given the short time scale within which this study was completed. Edinburgh was selected as a comparator city given initial intelligence from contacts that the drugs landscape impacting on those experiencing homelessness and homelessness services was different to that observed in Sheffield, and due to the presence of existing relevant contacts who could help expedite the time limited research process. This comparative case-study approach was pursued to generate research findings that will be relevant to a wider range of policy makers and practitioners.

This research took place between April and September of 2019. Due to the limited geographical scope of this research it cannot be deemed representative of the wider UK. However, the findings of the research may resonate with other areas and assist organisations and service providers across the country to develop localised approaches to the matters addressed in this report. By comparing these two cities, it is anticipated that service providers, policy makers and researchers can see a nuanced and rounded snapshot of the drugs landscape, and most pertinently an understanding of how homelessness and contemporary drug use interacts from the perspective of service users and key informants.

Key informant interviews

The first element of the case study was semi-structured interviews with nine managers (five in Edinburgh and four in Sheffield) and three frontline staff members (one in Edinburgh and two in Sheffield) at organisations who were responsible for providing a range of support to people experiencing homelessness within the cities, including; medical support, the allocation of resources, street outreach to rough sleepers and day centres. The key informants were also selected due to their longevity within the sector and their ability to provide key insights into the organisational challenges caused by increasing levels of homelessness and an increase in numbers of service users with complex needs (commonly around problematic drug use).

A topic guide was developed to aid the discussion, covering the themes of; i) the prevalence of certain drugs and historical/current patterns of drug use, ii) the relationship between homelessness and drug consumption, and iii) determining how the organisations responds to such challenges. The initial intention had been to interview up to four frontline staff in each city, however this was not possible due to the intense workload of the staff and volunteers on the frontline at the time of fieldwork and the short time frame of the overall study.

Service user interviews

Semi-structured interviews were conducted with ten service users (five in Edinburgh and five in Sheffield) at two comparable organisations in each city which provided a range of support to homeless individuals through their daycentre and street outreach activities. The service users were of a wide age range across the two cities and included seven men and three women, all were White-British. It should also be noted that large groups of Eastern Europeans accessed services at the two homeless centres but could not be interviewed due to the researcher not having access to translators.

Each service user was provided with a £20 High Street Voucher to thank them for their time. These participants were purposively selected due to their histories of various forms of homelessness (rough sleeping, couch surfing, temporary accommodation) and experience of using a range of substances (including 'new' and 'traditional' drugs). At the time of interview the participants were either recently housed in permanent accommodation after a period of homelessness, sleeping rough, couch surfing or residing in temporary accommodation.

Service user interviews utilised visual methods to develop a timeline of participants' housing histories since their first experience of homelessness. This is a 'tried and tested approach' to qualitative research and was done via prompt cards of the most common forms of homelessness (couch surfing, rough sleeping, squatting and hostel) as well as social housing, hospital, prison and 'other' which was tailored to individual experiences where required/not covered by the provided prompt cards (see McMordie, 2018). Once the housing timeline was complete, it was overlaid with the participants' histories of drug use – these were prompt cards grouped into 'new drugs' (prescription drugs and NPS: Spice and Burst) and 'traditional drugs' (Heroin, Crack, Alcohol and Cannabis), there was also a prompt card for 'other'. Once the housing and drug-use timeline was completed the interviewee was asked a range of questions guided by a topic guide covering the themes of health, housing, homelessness and drug use.

Limitations

This is a small study undertaken during a six-month period in Edinburgh and Sheffield. This means that caution must be taken in extrapolating the findings to other towns/cities in England and Scotland. Service user interviews were only conducted with English-speakers and as such, the research cannot comment upon the experiences of the significant sub-set of Eastern European service users at each service. Some service users were excluded from the interview process due to intoxication at the time of the research – this limited the potential for the service users with the most severe addictions to participate. Finally, there was limited participation of frontline workers due to work pressures/narrow window in which work conducted. Despite these limitations, it is hoped however that the findings can usefully inform future research to explore these issues across different geographies and subgroups.

Conclusion

Using the research approach detailed here, this exploratory research aims to provide a contribution to knowledge pertaining to the use of NPS and prescription drugs amongst the homeless population of Edinburgh and Sheffield.

The research utilised a qualitative methodology, focusing upon the narrative of i) key informants, ii) frontline workers, and iii) homeless service users with experience of using a range of substances. It is hoped that such an approach will provide a nuanced understanding of the challenges and issues posed by contemporary drug use from the perspectives of all parties.

The next chapter presents the key literature related to homeless policy and drug use amongst this population, paying attention to the emergence of NPS and the use of prescription drugs.

3. Background to Homelessness and Drug Use

Introduction

This chapter specifically focuses on contextual literature relevant to this study. Firstly, it reviews the policy landscape linked to homelessness, specifically around welfare reform and the Homeless Reduction Act. Secondly, it presents data pertaining to the number of deaths in the UK linked to drug use amongst homeless groups, highlighting geographical discrepancies and the emergence of substances such as 'street benzodiazepine'. Thirdly, it outlines the broad context around the qualitative research conducted on drug use in homeless groups, in doing so, showing how drug trends have changed in recent years. Finally, it concludes by highlighting the most pertinent changes that have occurred and stresses the significance of such changes on the lives of people who are homeless and take drugs, as well as the service providers.

Changes to the drugs market

It has been long established that homeless individuals are far more likely than the general population to participate in the drugs market (see Spear, 1969; Carlen, 1996; Fountain et al, 2003; Wincup et al, 2003). In the 1960s the only drug of note that was consumed by homeless groups was Heroin, although this was largely centred in and around London (Edwards et al, 1966). Elsewhere alcohol (commonly in the form of methylated spirits) formed the basis of substance misuse across the UK (Hewetson, 1975). This remained relatively stable until the arrival of smokable brown Heroin in 1979 (Seddon, 2007). By the early 1980s major cities in the north of England and Scotland experienced significant outbreaks of Heroin use amongst their homeless populations (Power, 1988). In the mid-1990s the drugs market in the UK saw its most significant change with the influx of greater amounts of Heroin and the emergence of Crack Cocaine (Seddon, 2008). Around this period a small amount of research noted an increase in the use of Amphetamine and prescription substances (such as Benzodiazepines), however evidence suggests that use of these substances was largely peripheral in relation to the far more prevalent substances of Crack Cocaine and Heroin (Klee and Reid, 1998). Since 2010 the UK drugs market has seen significant changes due to the rise of prescription drugs (such as Benzodiazepines, Gabapentin, Pregabalin, Valium and Xanax) and NPS – research on these changes are presented in the penultimate section of this chapter.

Drug Related Deaths

Despite the challenges of qualifying drug harms, it has become clear in recent years that drug related deaths in the UK are increasing. In Scotland 1,187 people died of drug poisoning in 2018, this constitutes a year-on-year increase of 27% and an increase in the region of 400% compared to 20 years ago (National Records Scotland, 2019). Evidence suggests that the numbers of deaths from drug poisoning are now the highest in Western Europe. The greatest increase occurred within the 35-54 age range, with the rate of deaths amongst the younger age range remaining relatively stable (National Records Scotland, 2019). As with other datasets on drug use there were substantial geographical differences, for example, the rate of drug poisoning deaths in Glasgow were far higher than in Lothian. The data from Scotland does not disaggregate between the homeless and non-homeless populations. However, the drugs with the highest number of attributable deaths are the those commonly synonymous with the homeless populations – namely, Opioids and ‘street benzodiazepine’ (containing Etizolam) (Parks et al, 2015; Strang, 2015).

The data emanating from England and Wales does disaggregate between the homeless and non-homeless populations – across the homeless population in 2018 726 people died as a result of drug use, 294 of which were from drug poisoning. As in Scotland, there were great discrepancies based on geography, with London and the North East seeing the highest rates of drug related deaths among the homeless population (Office for National Statistics, 2018). Overall, the data shows that the number of homeless people dying from drug poisoning increased by 55% in one year, with the most deaths caused by Opioids, Cocaine, Benzodiazepines and Alcohol (Office for National Statistics, 2018). It should also be noted that whilst the data from Scotland and England/Wales provides a detailed picture relating to drug deaths, many substances are not screened during the autopsy process. Toxicology tests to determine the potential presence of Gabapentin, Pregabalin and ‘street Benzodiazepine’ are expensive and not deemed to be of value for money to the taxpayer (Public Health England, 2014).

Contemporary drug use amongst homeless groups

It is still accepted that the homeless population is more susceptible to problematic alcohol and drug use due to increased levels of trauma and deprivation (Bramley et al, 2019; Homeless Link, 2016; MacDonald et al, 2016; Marmot & Bell, 2012; Reeve, 2017; Rieger et al, 1990). By analysing national datasets which intersect both the homeless and drug using populations of the UK, Bramley et al (2015) found that around 50% of the single homeless population in England experience some form of substance misuse. Bramley et al (2019) determined that instances of problematic drug use were far higher amongst

sub-populations who were rough sleeping or frequently residing in night shelters compared with those staying in temporary housing (Manning and Greenwood, 2019). However, both studies presented geographical variations and highlighted the differing datasets employed across the UK. For these reasons it has been very difficult to adequately quantify the rate of problematic drug use amongst the homeless population in the UK.

Alongside increased use of prescription substances a new category of drugs has emerged – these have been labelled as ‘New Psychoactive Substances’ (NPS). Around 2009, ‘Head Shops’, newsagents, petrol stations and websites started to legally distribute what became labelled as ‘NPS’ or ‘legal highs’, commonly marketed as ‘Bath Salts’, ‘Spice’, ‘Burst’ and ‘Incense’. These substances were legal, not because they were harmless but because they were unknown to legislators and thus unregulated. For consumers the appeal of these substances was threefold; i) they could be purchased more easily than ‘traditional’ drugs which required interaction with dealers, ii) they were commonly cheaper than traditional substances, and iii) the Police were unable to seize the drugs or arrest users (Power, 2013).

After a large number of deaths were attributed to NPS the UK government acted in 2016 by bringing into force the Psychoactive Substances Act which imposed penalties on the possession and distribution of *“any substance which (a) is capable of producing a psychoactive effect in a person who consumes it, and (b) is not an exempted substance”*. There is much debate as to whether the NPS legislation was successful - Mentor UK (2019) cited data from the British Crime Survey and argued that the new legislation has *‘made a measurable difference in reducing harms’*, however it has been argued that the law has created a set of more complex challenges including supply being moved from ‘head shops’ to dealers and the legislation having no impact upon use in prisons (see Ralphs et al, 2017; Campbell, 2019).

Overall, noticeable changes to the drugs market have taken place in recent years due to the emergence of NPS and an apparent rise in the use of prescription drugs amongst homeless groups. The effects of these changes are difficult to discern due to the geographical nature of drugs markets and the associated complexities around individual drug preferences (Boland et al, 2018).

Conclusion

The drugs market for homeless groups has always been subject to fluctuations, however the changes that have taken place in the last decade have been very significant. Firstly, prescription drugs appear to be widely available on the streets due to illicit drug labs and overprescribing from medical practitioners. Secondly, the significance of NPS within the current homeless drugs market across the UK is contested. Furthermore, the success of legislation (the New Psychoactive Substances Act) aimed at reducing supply appears to be somewhat inconclusive. However, data clearly shows that the factors outlined above have contributed to a significant increase in the number of homeless people who have died as a result of drug poisoning in the UK, particularly in Scotland.

The next chapter focuses upon the findings of interviews conducted with Key Informants from the two cities, specifically on the impact of recent legislation concerning NPS, the use of prescription drugs and the impact of increasingly complex drug use.

4. Key Informant Perspectives

Introduction

This chapter seeks to present the views of Key Informants in relation to the overall drugs landscape in their city, specifically to obtain details of how drug consumption patterns have changed in recent years. The key strands of investigation were as follows; i) the use of NPS amongst their service users, specifically in relation to the success or otherwise of recent legislations, ii) the use of prescription drugs and their pattern of consumption, and iii) how the use of prescription drugs and NPS has changed the lived experience of homelessness. In presenting the qualitative data, this chapter aims to present accounts of the drugs landscapes for homeless people in Edinburgh and Sheffield. The chapter will initially focus upon NPS use among those experiencing homelessness, specifically highlighting the stark differences between Edinburgh and Sheffield, whilst also highlighting how the landscape has changed since the issues around NPS were at their height. Subsequently, the chapter will consider the impact of NPS legislation. It will then move on to discuss the role of illicit prescription drugs within the wider drugs landscape, before detailing the complex challenges faced by organisations that support the homeless. Finally, the chapter will conclude by discussing the continuing preference for 'traditional drugs' despite the availability of a greater range of drugs.

New Psychoactive Substances

The interviews with key informants indicated differences in the types of 'new drugs' that are consumed within the homeless population in Edinburgh and Sheffield. For example, 'Spice' is described as being a moderately popular substance in Sheffield, with two key informants estimating the number of regular users to be around 200 in comparison to around 4,000 regular users of Heroin, but appears to be far less popular in Edinburgh, with key informants stating that 'Spice' is low on the list of drugs of choice:

Spice has always been in Edinburgh, but it's kind of levelled out, and it's not the drug of choice of the street population. (Service Manager, Edinburgh)

A lot of them do spice but I'd suggest predominantly their drug of choice is crack or heroin or alcohol (Street Outreach Manager. Sheffield)

In Sheffield, 'Spice' is not as great an issue as it was in previous years but is still used by homeless people in the city. A significant issue around the consumption of 'Spice' pertains to the production processes

- as 'Spice' involves the active chemical (JWH compounds) being sprayed onto organic matter, the distribution of the drug within individual packets (and 'spliffs') can be very inconsistent:

The unfortunate thing with it was, is that people were taking spice like you take cannabis, so when they were buying it, they were using as much as you would in a spliff. However, with how potent it is, you literally need like the top of a needle for it to be the same strength as a normal spliff and I think they learnt that, and I don't know if that's also had an impact on the reduction. (Street Outreach Worker, Sheffield)

We've noticed that... three people can share a spliff (containing Spice) but only one of them might be knocked out because of the distribution of the chemical. It wasn't like that when it could be brought in shops. (CEO of homeless charity, Sheffield)

Aside from the dangers and impacts associated with direct use of 'Spice', this substance appears has garnered particularly negative public and media responses (Baumann et al, 2014), which exposes users to disproportionate stigmatisation from the general public in Sheffield. All of the Sheffield key informants brought up the term 'zombie' when discussing 'Spice', noting how users of other substances were stigmatised only for their homelessness, whereas 'Spice' users are subjected to a double-stigma of being both homeless and for their use of 'Spice', including from *within* the homeless population. The broad consensus was that this was primarily due to the public nature of 'Spice' use, with it being used out in the open and its unusual effects on the users (e.g. maintaining a slumped posture whilst standing and appearing unconscious) as opposed to Heroin and Crack which are used in safer or less public places:

a lot of social media people being very explicitly threatening of violence and nasty towards people using spice so we also tried to have a bit of a, shall we remember that these are human beings? (Commissioner, Sheffield)

Conversely, 'Burst' (an NPS officially named Ethylphenidate) was commonly used in Edinburgh and the Scottish Border region during the height of the NPS issues around four years ago but was not commonly used in Sheffield. The impact of 'Burst' was exceptionally severe in Edinburgh, not least because it is consumed by injecting it rather than smoking it, like Spice:

(Burst) it's a stimulant so obviously I suppose a quicker rush, probably more intense rush and the problem with that was, just like any stimulant... it's a different high that people are getting. It was cheap and it was available is the other thing and I think at that time the quality of heroin was pretty poor in that area, but the problem with any stimulant is that people are going to be injecting it more frequently which puts them at risk of harm with a skin or soft tissue infection or blood-borne virus. The levels of injecting frequency with that drug were really uncharted, so we'd seen people injecting ten, 20 and 30 times a day... people were also injecting into open wounds...there are bad drugs, but that was a particularly bad drug. (Scientist, Public Health Sector, Edinburgh)

The Impact of Legislation

The New Psychoactive Substances Act 2016 was designed to eliminate the supply of NPS, varied in its impacts in Edinburgh and Sheffield. In Edinburgh, a coordinated approach to the elimination of NPS was viewed by key informants to have been being broadly successful. In 2014 'Operation Redwall' a coordinated series of NPS seizures by Trading Standards in Scotland removed the substances from retailers. Overall, these measures were successful as the drugs did not reappear in large quantities through street dealers (Gillies, 2015). However, the opposite occurred in Sheffield where NPS distribution shifted from shops to street dealers:

... after Operation Redwall seized NPS from head shops and newsagents we saw a marked drop in the use of the drugs. (Service Manager, Edinburgh)

the big shift that we saw was in the new Psychoactive Substances Act 2016, so prior to that because people were selling these psychoactive substances in head shops legally... When it became illegal and then it wasn't sold in head shops any more it moved into the hands of dealers which was exactly what we said would happen during the consultation period, but government knows best! (Commissioner, Sheffield)

In Sheffield, the longitudinal effect of the Psychoactive Substances Act was to restrict NPS supply to a specific homeless group:

'the use of spice is (now) clustered in a really existing, vulnerable group of people but, nonetheless, what we - it is nowhere near the levels of heroin use. It's just how it plays out in the public consciousness, there's the real difference, I think. (Commissioner, Sheffield)

In Edinburgh and Sheffield it has been suggested that the inadvertent impact of the drug seizures was for the street dealers to reduce the price of Heroin whilst also increasing the purity to lure back their customers.

Illicit Prescription Drug Use

Alongside the issues related to NPS, key informants in both cities also noted that an increasing number of service users were misusing prescription drugs, namely Gabapentin, Pregabalin, Valium, Xanax and a range of Benzodiazepines. Broadly speaking, there appears to be a consensus that the issue first emerged as a result of individuals being over-prescribed these medications to alleviate pain. Individuals then sold their surplus tablets to others within the homeless population, creating a market from the medication. Subsequently, doctors were discouraged and reluctant to prescribe the medication in large quantities, thus restricting the supply of an 'in-demand' product:

All of a sudden the Heroin users started going to the Doctors complaining of bad backs and asking for Pregabs and Gabas. (Street Outreach Worker, Edinburgh)

... they were using Pregabs as a way to get off their face and obviously that's a prescribed drug and now doctors have come a little bit more savvy to it, it's harder for people to get hold of, etc., but they'll take each other's prescribed medication, if it means getting high, or being able to forget. (Street Outreach Manager, Sheffield)

In Edinburgh, the restricted supply of prescriptions led to illicit drug manufacturers manufacturing drugs that visually resemble the prescription drugs but can contain a range of dangerous substances (including Etizolam). The consumers of these illicit drugs only know if the purchased Gabapentin, Pregabalin, Valium or Xanax is manufactured legitimately if they notice any unexpected reactions or see the remnants of food colouring around their mouths after swallowing the tablets.

I know specifically these blocks of Xanax that are here, that are causing major problems, we've had two overdoses where people have come in here to keep themselves safe and just collapsed

basically when they got in here, gone over. They've suddenly arrived in the city with a batch of these drugs, and they've been putting those drugs out. (Service Manager, Edinburgh)

It's not prescribed by a doctor in any way, and people are buying large quantities of it and people are taking it not in isolation. They're taking it with typically some sort of opioid, whether it's Heroin or Methadone, and also with Alcohol. So most people in Scotland who die a drug-related death won't die from overdose of a single drug, it's usually a polydrug combination and the toxicity of that polydrug combination is what puts them at risk from overdose. So if you're taking Heroin, Alcohol and Etizolam, your potential for risk of anything from death to depression from taking those three depressants at the same time is just massively increased. (Scientist, Public Health Sector, Edinburgh)

One Key Informant in Edinburgh stated that a resident at a hostel was found in his room with a chemistry set making their own drugs from raw ingredients and had been 'testing' them on other residents. This is only one example but serves to demonstrate the unpredictability of the substances in comparison to previous years. However, despite the changes to the availability, consumption and associated risks of overdose from the emergence of 'New Drugs' in both cities, all of the Key Informants were clear that Heroin is still at the core of substance misuse issues.

The Role of 'Traditional Drugs'

Despite the changes to drug consumption amongst homeless groups in Edinburgh and Sheffield, the key informants were universal in their view that Heroin, Crack and Alcohol were still the most harmful substances to be consumed by their service users. This is somewhat surprising when this is considered alongside the media and public concern related to NPS in recent years:

Alcohol causes the most harm, which is not the drugs, obviously that we're talking about, but in terms of complication wise, alcohol causes much more harm, actually than drugs. (Scientist, Public Health Sector, Edinburgh)

People get more upset about the few hundred odd Spice users we've got in Sheffield versus the few thousand Heroin users. It's generally because they don't see Heroin users in the same way because it's not as visible. People aren't using on the street in the same way. Obviously, they are

sometimes, but I suppose the very visible symptoms of Spice use have disproportionately potentially guided how people view the homeless. (Commissioner, Sheffield)

As such, whilst the focus of this study is upon how drug consumption patterns have changed in recent years and their associated impacts, a key finding is that individuals in management positions and on the 'front line' view changes as being peripheral to the ongoing harms associated with Heroin, Crack and Alcohol.

Drug Combinations

The key informants noted how 'traditional' drugs continued to be the central concern but NPS/prescription drugs have complicated the picture and made it more challenging in terms of complex addictions, greater levels of harm, and engaging in more erratic behaviour. Furthermore, the key informants reported a rise in overdoses and harm to service users due to frequent and dangerous drug combinations. In Sheffield it was also reported that levels of violence between service users amongst the homeless population has risen in recent years due in part to more complex drug use. In both cities the informants stated that the 'height' of the NPS issue was the most challenging time of their careers (around 2015-6), but instances of violence and wider problematic drug use has decreased and stabilised since then. That said, experienced key informants stated that levels of challenging behaviour are currently well above those seen around 10 years ago.

Response from Services

Across both cities, the most pressing concern in relation to the evolving drugs market was the complex way in which they must now respond to drug overdoses. In previous years the service providers could confidently assume that an overdose was caused by Heroin and act accordingly. Due to the complexities surrounding poly-drug use, the standard emergency procedure of administering Naloxone for Heroin overdoses may not be effective or complicated by the addition of 'New Drugs';

In the 'good old days' if we had a service user who had overdosed we could safely assume that the issue was Heroin and give them Naloxone. Now it could be anything. It's a lot harder now. (Hostel Manager, Edinburgh)

So the vallies (Valium), people are just popping them like candy, they're taking 30, 40, 50 of them a day... they're so easy to get so if somebody can't get heroin... then they'll just go for the vallies and just take loads of them. Then if they take the heroin or the crack or something else on top, then it just tips them right over the edge. You can Naloxone someone when they're OD'ing from heroin, but it doesn't really do much for the Valium so they're still kind of out of it. (Street Outreach Worker, Edinburgh)

We've got Naloxone on site, but it's kinda useless if someone has taken a cocktail of drugs (Service Manager, Sheffield)

I've worked with entrenched users for a long time, so you've got behaviours that you deal with that you know when somebody's overdosed or what they've taken. I think it's about that cocktail and about people, the unknowns really, that's the bit that worries me that I think people take an overdose of heroin, they get Naloxone and they can come back round again. People who've got spice and if you don't know what the makeup of that is, how do you actually treat that? (Hostel Manager, Sheffield)

All the service providers now need to allocate time and resources to build their knowledge of each 'problem' drug user and individualise their response to overdoses. This becomes a complex and resources intensive task for already stretched services (Loopstra et al 2014). Whilst the potential for individual organisations to make a significant impact on the issues around homelessness and problem drug use is somewhat limited, organisations in Scotland are sharing intelligence and insight to respond to such challenges;

Government's backed us. They've given us money invested in the right areas, they've listened to what we've had to say... Every fortnight we take part in a conference call across Scotland, with advisors to the Scottish government minister. That conference call we feed back to other people. Right across Scotland we're coordinating our efforts and listening to new trends, and obviously looking for best practice in other areas... [that] we can implement. (Service manager, Edinburgh)

This approach appears to be successful as key informants across the city commonly spoke of the collegiate approach to limiting the harm of problematic drug use (particularly around 'bad batches' of

certain substances). Such an approach does appear to be taking hold in Sheffield, albeit to a lesser and informal extent as communication is decentralised and is reliant upon infrequent emails and phone calls.

Conclusion

The chapter highlights the change and continuity around drug supply and the challenges posed to professionals involved in supporting homeless groups. The emergence of NPS this decade resulted in a spike in deaths and levels of harm to homeless drug users in each city – however, the successful implementation of policies restricting supply (on a local and national level) appear to have limited the long-term availability of most NPS. The exception to this is Spice in Sheffield, with a comparatively small number of individuals still using the substance on a regular basis. Of the changes to the drugs market in recent years the greater demand for prescription drugs is the greatest concern to the key informants. Supply of these drugs come from two distinct sources; i) overprescribing and dealing amongst homeless groups, and ii) the manufacture of tablets in illicit laboratories. For the latter, it is suggested the tablets can contain a dangerous combination of substances that can be incredibly dangerous when taken alongside Opioids. The new combination of substances unfortunately limits the effectiveness of Naloxone as an emergency response to drug overdoses.

The complex range of substances now available has substantially increased the risk of service users becoming seriously ill. As such, organisations now need to invest greater amounts of time learning about the drug habits of each individual service user so that they can better respond when issues occur. Organisations in Edinburgh have responded to these challenges by placing a greater emphasis upon inter-agency intelligence sharing to ‘flag-up’ any potentially dangerous batches of drugs and the complexity of responding to those combinations, however, this does not appear to be occurring to the same extent in Sheffield.

The following chapter present the perspectives of homeless drug users in relation to their housing histories, drug use and wider issues that emerged from the research.

5. Service User Perspectives

Introduction

This chapter seeks to present the views of service users at homeless centres in Edinburgh and Sheffield. The chapter will initially focus upon their physical and mental health, as well as the broad themes emerging from the demographic data. The following section reviews their use of prescription drugs, specifically noting how they can be obtained from illicit or more legitimate sources. Subsequently, the chapter presents the narratives of participants in relation to their strategic combining of drugs.

Health, housing and drug use

The chart below presents a basic overview of the participants' current drug use, housing situation at the time of interview and brief housing history, as well as their physical/mental health and their demographic data:

Table 1: Overview of participant drug use, housing status and health issues

| City | Gender | Age | Physical/Mental Health | Housing history | Drug Use |
|-------------|---------------|------------|-------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Edinburgh | Female | 40-44 | Anxiety and depression after the death of two babies. | Social housing after being homeless. | Started taking Cannabis and Valium (prescribed) in teenage years due to childhood trauma. Currently taking Heroin, Crack, Cannabis, Gabapentin, Pregabalin, Valium and Hydrocodone. |
| Edinburgh | Male | 45-49 | Depression, anxiety and back pain. | Sleeping rough. Was previously in prison | Prescribed Hydrocodone and Diazepam after back injury. He then became addicted to them and switched to Heroin. Currently taking Heroin and Valium. |

| | | | | | |
|-----------|--------|------------|-----------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Edinburgh | Male | 40 - 44 | Post-Traumatic Stress Disorder, Attention Deficit Disorder and Hepatitis C. | Prison followed by sleeping rough, now a Bed and Breakfast. | Methadone, having previously taken Heroin, Xanax and Valium. |
| Edinburgh | Male | 35 - 39 | Depression. Anxiety (panic attacks). | Prison, then sleeping rough. | Diazepam (prescribed for anxiety), Valium (for depression), Crack and Heroin. |
| Edinburgh | Male | 45 - 49 | Epilepsy. | Social housing after sleeping rough. | Cannabis, Crack, Heroin and Valium. |
| Sheffield | Female | 35 - 39 | Severe back pain. | Women's refuge then couch surfing, now in social housing | Morphine, Xanax and Crack. |
| Sheffield | Female | 30 - 34 | Depression and anxiety. | Sofa surfing, now in social housing. | Prozac and Beta-blockers (prescribed). Alcohol, Amphetamine, Pregabalin (was first prescribed, but now illicit), Cannabis, Cocaine and Heroin. |
| Sheffield | Male | 18 - 24 | ADHD, autism and foetal alcohol syndrome. | Hostel, was previously sleeping rough. | Valium, Gabapentin, Cocaine, Cannabis, Spice, Heroin and Amphetamine. |

| | | | | | |
|-----------|------|---------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| Sheffield | Male | 30 - 34 | Borderline personality disorder, emotionally unstable personality disorder, anxiety, depression and skeletal injury. | Squatting. | Alcohol, Cannabis, Crack Cocaine, Amphetamine, Pregabalin, Gabapentin, Codeine, Dihydrocodeine and Tramadol. |
| Sheffield | Male | 55 - 57 | Trauma – death of child and relationship breakdown. | Homeless, hospital, then to housing association. | Methamphetamine, Crack, alcohol, cannabis and spice. |

The demographic data alongside details of their health issues and drug use highlight three key points:

- Poor physical and mental health, which for many appear closely linked to early experiences of trauma
- Complex poly-drug use
- Dynamic housing histories and a lack of stability.

The remainder of this chapter will develop these findings alongside the qualitative data, before concluding upon the key themes.

Physical and Mental Health

A key theme from the research was that for all participants' some form of drug use predated their first experience of homelessness. Whilst they were using drugs before becoming homeless, this drug consumption would be categorised as being 'recreational' or 'self-medicating' as opposed to 'problematic' or dangerous. For three interviewees the trauma of losing access to their children played a significant role in their use of drugs and alcohol to develop from 'recreational' or 'self-medicating' to

'problematic', subsequently resulting in homelessness. Moreover, the data suggests that drug use only reaches the problematic stage once a traumatic event has taken place:

I'd just lost [access to] the kids, so I just went on a mad one, got a flat to myself and just emptied it for growing it (Cannabis). Scrapped with someone on the street and got caught. Kicked my door in at half three in the morning, didn't even have time to get out, I was gutted... I just went off. I had my last child in 2015. That gap there was my clear gap. I went three years without drinking or anything, completely, total. It was quite mad. Then when they said I had no chance of anything, I started (taking drugs) again. (Female Service User, 30 - 34 Sheffield)

Yes, when he (former partner) beat me up... I moved into a women's refuge. After I moved in here because that woman's refuge triggered it up again, to help me forget what my ex-partner did and stuff. (Female Service User, 35 - 39, Sheffield)

Other service users described how their use of drugs and alcohol (concurrently) became exacerbated by other forms of emotional loss including the loss of parents:

*I lost my mum and dad in 2006... I bought a house on the insurance money. I had £210,000 away back then, but then I had people - I was vulnerable, my head was up my arse, I'd just lost my parents, the two of them in the space of 14 months with cancer. I was vulnerable, c***s were taking the piss out me, I had friends that I didn't even fucking know, but aye, that's them... I was a spoilt wee laddie, but – they (my parents) loved me to bits, my mum and dad were brilliant people, I just miss them so much, I'll never get over it. (Male Service User, 35 – 39, Edinburgh)*

All the service users interviewed had some form of mental or physical illness prior to their first experience of homelessness and drug use, with these illnesses exacerbating their addictions. Commonly, the physical and mental health issues lay undiagnosed for several years:

I wouldn't know if you'd call them illnesses, but I did get diagnosed with ADHD. And I recently found out, about five month ago, that I've also got autism and foetal alcohol syndrome as well... I never knew until I come here to have an appointment with someone, and that's when I found out. I've also got an appointment with my psychiatrist (Male Service User, 18 – 24, Sheffield)

Prior to receiving a formal diagnosis some service users self-medicated using Cannabis or Alcohol to relieve the physical and emotional pain. This was commonly their first experience of severe substance misuse and predates the use of harder 'traditional drugs' or 'new drugs'. However, there were exceptions to this observation as a small number of service users were prescribed substances from the doctor to alleviate pain or treat underlying conditions:

(I was prescribed) Morphine and gabas, they were like a pain relief because when I were on morphine that time, they changed it to gabas because I were pregnant, again, but I lost that baby, but that's different anyway. They put me back on morphine after, and I've stopped taking all them, because of me being pregnant now. Those were the only drugs I was taking. I used to take more than (than the prescribed dose) I did because they didn't work. So I took an overdose on them. (Female Service User, 35 - 39, Sheffield)

I was 16, I went to the doctor, she gave me Valium, I didn't ask for it, it was tablets, so I was on them from a young age, I had epilepsy, I was born with it, I was on Valium like as a bairn, like Valium, you know what I mean? (Male Service User, 40 - 44, Edinburgh)

I started using Gabapentin for... tooth ache, and it was in the shared house. Well, between shared house and subletting, and somebody had given me them, I was in agony, I had an abscess out here. They were like oh here, take one of them. It's for nerve damage and I liked the feeling (Female Service User, 30 - 34, Sheffield)

Alongside official prescribing from medical practitioners, service users also described being able to purchase substances, such as Valium and Xanax from street dealers. This market appears to have emerged for two distinct reasons. Firstly, interview data from service users suggests that medical practitioners are becoming more reluctant to prescribe substances such as Valium, Xanax, Pregabalin and Gabapentin as a reaction to overprescribing. Secondly, the reduced supply of prescription drugs subsequently acts to increase the 'street value' of these substances and encourages individuals with valid prescriptions to sell-on their tablets:

Male: Most people, when they do get it through their doctors, they just sell it, so they can go and get some of that (Spice), or treat themselves to crack or whatever. Some will keep a couple of tablets to themselves and sell the rest. That's what happens, they'll get a script for 40 tablets, they'll keep five or six and sell the rest, because they sell for £3 each... It's £120 if you sold

the actual lot.

Interviewer: If you want to take spice, then it makes it...

Male: Yes, so you've got money left and you're only spending £5 or £6. Literally, for spice, you spend £5 or £6, and that £5 or £6 will last you a day, and you'll get absolutely whacked out... £120 worth of spice, yes, that's about a month. (Male Service User, 55 – 59, Edinburgh)

The authenticity of drugs branded as prescription by dealers was questionable in many cases. Some tablets were purchased within foil packaging (indicating that they were authentic) whereas some service users describe buying tablets which visually resemble the authentic products in plastic bags, clearly creating doubt over their legitimacy and their ingredients. Some service users in Edinburgh described how blue Valium get their colour from chalk, whereas others believed that the blue Valium were authentic, and the white versions contained rat poison. The tablets contained within foil packaging were commonly far more expensive than those in plastic bags. Broadly speaking, this was not a concern to the service users who were willing to buy the 'fake' Valium despite the risks:

Male: real Valium are either blue or yellow and they've got the manufacturer's name on, whereas the fake ones, they can be white, they could be blue, but the blue, the dye would come off in your mouth.

Interviewer: You can tell pretty easily?

Male: Really, really easily, yes.

Interviewer: Would you always try and avoid the fake ones?

Male: No, because you very rarely get real ones these days, to be honest.

(Male Service user, 40 – 44, Edinburgh)

Conversely, service users were far more confident over the validity of Gabapentin, Methadone and Pregabalin, as they were invariably sold within the foil packaging. The supply of Gabapentin and Pregabalin came from other service users selling their prescriptions to street dealers, or themselves selling or trading their tablets with other service users:

if you're looking for Valium, go to the Valium head, if you're looking for... It's just like anything else, if you go to the shop, you go for vodka, you go to the vodka aisle, that's like people, they're like aisles. The Xanax, the gaba, methadone, it's just like aisles, just pick them up. Trust me, if you

want it, you'll get it, nothing will stop you, you don't even need money, you can just trade stuff.
(Female Service User, 40 - 44, Edinburgh)

Male: *(I take) Pregab, gabapentin, codeine, dihydrocodeine, tramadol, all that sort of stuff.*

Interviewer: *How did you get hold of that? Do you have the scripts or...?*

Male: *No, I don't. I know people, well, obviously people.*

Interviewer: *Is it easy to get hold of?*

Male: *Yes, which is why my doctor doesn't prescribe me that much anymore because I actually openly told him I'm buying it... (Male Service user, 30- 34, Sheffield)*

Combining Substances

When the service users became homeless, in part due to mental illness and/or trauma the prescription drugs were almost always used alongside 'traditional drugs' in a strategic and planned manner, typically as an *enhancer* alongside Heroin or Crack or make the 'come-down' more comfortable.

See, when you take the pregaba and the crack and that, they enhance it, that's an enhancer, whatever you take, the pregaba will enhance it so if you take a pipe, it enhances the gaba, they enhance each other, they bounce off each other, like they actually make it stronger... I'll tell you what you're going to die with, methadone and gaba you're going to die with. Anything with methadone, any mixture except with Valium, heroin. There's no point in taking heroin if you're on methadone, crack is fine, but see if you take the gaba and the spice, that's where you'll die with the methadone. (Female Service User, 40 - 44, Edinburgh)

I used to like... crack and heroin in one needle; it's called a snowball. It was good! Yes, but you would take Xanax as well to come down off crack. (Male Service User, 40 - 44, Edinburgh)

It's usually heroin and crack/alcohol and cannabis/spice and alcohol. That's the combinations. (Male Service User, 55 - 59, Sheffield)

I've always avoided pregabalin and alcohol together. Commonsense would set - I've tried heroin once, like I say, and I tried spice a couple of times. I'd never do them two together because of the similarities and how easy it is to go over on either one of them. Same with pregab, with them being slow release and stuff like that, when you're drinking alcohol and then having both with similar sort of effect. (Male Service User, 30 - 34, Sheffield)

Most fundamentally, the service users describe how they use prescription drugs merely to supplement 'traditional drugs' and are rarely as standalone substances. This strongly suggests that the increased demand for prescription drugs amongst homeless groups does not reduce the demand or desire for more 'traditional drugs', but instead highlights a more complex picture around illicit drugs use. Furthermore, the use of prescription drugs clearly contributes to a more dangerous pattern of drug use with greater risks of overdose and in the most severe circumstances, premature death.

New Psychoactive Substances

Whilst Spice was a significant issue for some of the Key Informants, it was not used frequently by the Service Users, with only four of the ten stating that they had ever used it¹. In Edinburgh, two Service Users smoked Spice whilst in Prison, but disliked how strong it was in comparison to Cannabis:

If you've smoked cannabis in your life, imagine smoking 300 joints in one go. You have it and you think that's nothing, and then 20 seconds later it's like "bang"! I can see why people lose their mind with it. Obviously, my mental health is a bit fragile as it is, I didn't want to play with it, so as I said, I had a couple of shots of that and that was it. (Male Service User, 37, Edinburgh)

I've smoked Spice, yes. I'd never touch it again ... I was in the jail, it was a jail drug... I've never smoked it outside - it's always been in the jail when I've smoked it. (Male Service User, 35- 39, Edinburgh)

A similar view was expressed by a service user in Sheffield who consumed the drug on one occasion:

¹ There were large number of Spice users in the Sheffield centre, but these potential participants could not be interviewed due to being intoxicated. The centre is open each day from early morning to around lunchtime. All the habitual Spice users consumed the drug before entering the centre in the morning, remaining intoxicated for a few hours afterwards.

Yes, and spice, I've tried once and that was there. I recently tried that and I don't like it either. That is horrible. (Female Service User, 30 - 34, Sheffield)

The only other Service User to use Spice was a male in Sheffield aged in his early twenties who used the drug alongside Cocaine, Cannabis and Amphetamine during bouts of severe depression and anxiety. The stigmatisation of 'Spice' users expressed by the Key Informants was mirrored by some of the Sheffield Service Users who described them as being 'zombies', looking like 'skeletons' or 'trampified'. Regarding NPS in Edinburgh, none of the service users had ever used 'Burst' or any other NPS since the Psychoactive Substances Act 2016 and 'Operation Redwall' as the substances were no longer available, and because NPS were low on their list of 'favoured drugs'.

The research also sought to determine the position of 'new drugs' in relation to the more established 'traditional drugs'. The ten interviewees were asked which drug they preferred, regardless of cost and supply. When answering this question most had a preference for the use of 'traditional drugs' – nine listed Amphetamine, Crack or Heroin as their 'favourite', with one unable to decide. This is potentially significant, demonstrating that despite the increased choices around drug supply over recent years, the patterns of preference remain largely unchanged. Furthermore, the role of NPS within the wider drugs market may be somewhat overhyped at the present time, and the role of prescription drugs is largely used as an aid to either enhance the high of 'traditional drugs' at a lower cost than simply buying more of their preferred drug or to manage the 'come-down'.

Conclusion

This chapter analysed findings from interviews with the ten people using homelessness services and with experience of drug use (five in Edinburgh and five in Sheffield). A key finding in relation to the chronologies of homelessness and drug use it was that recreational drug use developed into more problematic patterns of consumption once the individual became homeless. Moreover, it can be argued that drug use was not a significant contributing factor in the transition into homelessness. Instead, the catalyst to a state of homelessness was a traumatic event (most commonly the loss of family members of losing access to their children). Before being homeless some of the participants were prescribed substances such as Gabapentin, Pregabalin, Valium or Xanax to treat/medicate physical or emotional pain.

Once the participants become homeless their drug use became increasingly problematic and complex with the addition of prescription drugs. Whilst their 'drugs of choice' were the more traditional substances of Crack Cocaine or Heroin, they used prescription drugs strategically to manage their 'highs' and provide a little more equilibrium during the 'come-downs'. Participants described experiencing medical practitioners tapering their prescriptions (due the perception that the substances were being misused), this inadvertently resulted in the participants seeking alternative sources of the tablets, creating a 'black market' for 'illicit' and 'genuine' versions of the tablets. One participant stated how some homeless people in Sheffield were selling their entire prescriptions for up to the value of an entire months supply of Spice. Despite the Key Informants suggesting that some drug users could not tell the difference between the 'illicit' and 'genuine' versions of the tablets, the service users in this research stated that they could tell the difference.

Chapter Five: Conclusions, Policy Implications and Recommendations

Introduction

This concluding chapter provides an overview of the key findings of the study, addressing the research questions:

- What is the temporal ordering of drug use (including alcohol) and experiences of homelessness in the life histories of people using 'new drugs'?
- Has the nature of drug use and amongst homeless people changed over time, and what, if any, impact has the emergence of the 'new drugs' had on this?
- How, if at all, can service providers and policy makers better respond to the needs of those homeless drug users?

Finally, policy recommendations are made, aimed at central government, local government, other stakeholders and the research community.

Temporal ordering of drug use and homelessness

Overall, there is little evidence to suggest that changing patterns of drug use have materially altered the routes into homelessness. The drug histories of the participants suggest that the individuals were already using drugs prior to becoming homeless. Broadly speaking, the 'catalyst' to homelessness was a traumatic event which made relationships untenable, thus leading to homelessness due to a lack of support. This therefore underpins importance of family networks, friendships and relationships as structures to prevent homelessness. Their drug use only became 'problematic' or 'dangerous' once they were categorised as being 'core homeless' due to emotional pain. Evidence from this study suggests that the use of prescription drugs alongside 'traditional drugs' has created more complex addictions which may inhibit or restrict the possibility of 'moving-on' from homelessness, although further research is required to empirically demonstrate causation.

The impact of 'new drugs' and the nature of homelessness

This research clearly shows that the types of substances used within the sub-group of homeless drug users has expanded and become more varied in recent years. Key informants were unanimous in their view that problematic drug use has increased, largely due to the emergence of NPS and the greater use of prescription drugs. That said, the 'height' of the issues was around four to five years ago when use

of NPS was rife. In Edinburgh the use of intravenous stimulants caused incredibly high levels of erratic behaviour, whereas in Sheffield the primary issue was 'Spice'. Since the implementation of the New Psychoactive Substances Act of 2016 the supply of NPS in both cities has reduced significantly, of all the NPS available in the middle part of this decade only 'Spice' retains a place within the current drugs market (albeit not in Edinburgh).

The most significant and harmful trend around drug use is the increased use of prescription substances – literature cited in this report and the research presented above clearly shows how these substances are noteworthy contributors to the substantial increases in deaths through drug poisoning in the homeless population. Most pertinently, the availability of illicit prescription drugs is of most concern to key informants due to the unknown ingredients of the tablets and their potential to interact badly with Opioids such as Heroin. Furthermore, the participants in this research did not appear to be overly concerned regarding the 'authenticity' of the prescriptions drugs – if they had the money they would buy the more expensive (seemingly) authentic tablets within foil packaging, if not, they would buy the cheaper tablets from 'loose' bags. As noted, the prescription drugs were rarely taken in isolation, but typically alongside Heroin, Crack Cocaine or Amphetamine to better manage or enhance the effects of the traditional substances. This poses significant dangers of drug poisoning and overdoses due to the complex and unpredictable chemical interactions. As such, the typical treatment of Naloxone on service users who have overdosed is far less effective than simply treating Heroin alone. Whilst prescription substances are now consumed more widely than in previous years, it can be asserted that the changing pattern of consumption is modest and does not indicate that service users are wholly changing their drugs of choice away from the established Alcohol, Amphetamine, Cannabis, Crack or Heroin.

A key question emanating from the data in this study pertains to whether the findings of this research indicates a new long-term trend towards the combining of prescription drugs and 'traditional substances'. The quantitative data relating to drug deaths amongst the homeless population in chapter 3 suggests that trend of combining such substances is increasing rapidly. Additionally, the qualitative data from this study clearly shows that the use of 'traditional drugs' and prescription drugs in combination is highly strategic and can achieve the aim of gaining a greater 'high' at a lower cost than simply taking 'traditional drugs'. For this reason, it can be asserted that the use of prescription drugs amongst homeless groups is potentially linked to the cost of Heroin, Crack Cocaine and other substances. Thus, should the cost of these 'traditional drugs' decrease then the use of prescription drugs may also decrease. Conversely, an increase in the cost of 'traditional drugs' may inadvertently

result in a greater use of prescription substances, and in turn, a potential increase in the number of drug poisoning deaths.

The new Psychoactive Substances Act of 2016 (and Operation Redwall) appears to have been incredibly successful in removing NPS from the streets of Edinburgh and Sheffield, with the exception of 'Spice' in Sheffield. However, it should be noted that the success of the policy seems to be in part due to the lack of desire amongst homeless groups to choose NPS over 'traditional drugs'.

Policy and practice implications: how can they better respond to the needs of those homeless drug users?

Reflecting upon the findings of this research, the following three recommendations are proposed:

1. Investment in drug treatment and testing:

The changing patterns of drug use have clearly shown that the new combinations of substances have impacted upon the effectiveness/appropriateness of Naloxone as a treatment for drug overdoses. As noted, in previous years, services could inject individuals experiencing overdoses with Naloxone to reverse the ill effects of the Opioids, however Naloxone is far less suited to treating complex overdoses.

2. Co-ordinated intelligence sharing

The emergence of dangerous 'batches' of drugs has become a more frequent occurrence in Edinburgh and Sheffield. As such, local government and services should take a proactive approach to instigate information sharing across all homeless services organisations in any given city to highlight the dangers posed by certain substances. This need not be overly burdensome in terms of organisation – an email bulletin from which all services have the ability to contribute may suffice and could reduce the numbers of people dying from drug poisoning.

3. Drug testing kits

The complex make-up of illicit prescription drugs necessitates a greater usage of drug testing kits to ascertain the contents of the tablets. Substances such as Etizolam have been shown to be present in such tablets whilst reacting badly with Opioids such as Heroin.

Recommendations for future research

- Further investigations into the motivations underlying the choices that homeless individuals make regarding their drug use, particularly around poly-drug use.
- A detailed nationwide study on the function and wider dynamics of the drugs market for homeless individuals.
- Additional studies of this kind to be conducted in major UK cities to gain a greater understanding of localised drug cultures and 'street knowledge' around drug use.

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About the I-SPHERE/Oak Foundation Internship Programme

The Oak Foundation is an international philanthropic foundation funding projects in conservation, human rights, abuse, housing, learning disabilities, and other social justice issues. In its Housing and Homelessness Programme, the Foundation focuses on preventing homelessness by funding sustainable solutions that improve the economic and social wellbeing of marginalised youth, adults and families. The programme has three priorities: promoting economic self-sufficiency; increasing the availability and supply of affordable housing; and preventing homelessness. The Institute of Social Policy, Housing and Equalities Research (I-SPHERE) at Heriot-Watt University is a leading UK research centre in the fields of housing, poverty and social policy with a strong international reputation. I-SPHERE staff specialise in research on homelessness, destitution, complex needs and other forms of severe disadvantage. Oak Foundation and I-SPHERE run an internship programme to support the development of a stream of early career researchers to undertake high quality policy and practice applied research on homelessness. The dual purpose is to increase the availability of well-qualified researchers and to develop the evidence base for policy makers and practitioners on 'what works' in this sector.

About the Author

Chris Devany was the third I-SPHERE Oak Foundation intern, completing his internship between April and October 2019.

Chris Devany has a background in researching youth studies, welfare reform and education from his ongoing PhD studies. Following his Oak internship, Chris is now a Lecturer in Sociology at Sheffield Hallam University, specialising in youth studies, masculinity and drug use.

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