THE RELATIONSHIP BETWEEN HOUSING AND PROBLEMATIC DRUG USE: A STUDY OF THREE AREAS IN THE NORTH OF ENGLAND

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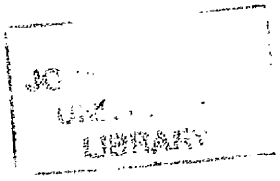

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ABSTRACT

This research builds upon two research traditions in housing studies and drugs misuse. It aims to show connections between the two that have previously attracted insufficient attention. It focuses on problematic drug use rather than so-called 'recreational' use, and outlines connections between certain housing forms and locations and the use of drugs problematically. Its approach is a multi-levelled one, moving from the economic and regional geography of housing through the social and domestic level of people's housing arrangements, to the individual level whereby housing status can affect identity and prospects for successful treatment outcome. It aims to re-position housing in the debate around drugs misuse, approaching it not as mere background to other social processes but as a key environmental factor influencing behaviour within a complex web of other neighbourhood factors.

It is based on a combination of qualitative and quantitative methods: semi-structured interviews and a structured questionnaire with forty current and former problematic drug users across three locations in the North of England, and semi-structured interviews with over twenty drug and housing agency staff in the respective areas. It also uses drug use and housing biographies of the sample in order to capture dynamics over time.

It locates the sample of problematic drug users in the poorest parts of the housing sectors in their respective areas and suggests that their access to housing is dependent upon the structural factors of housing provision in those areas, but also upon factors of human agency that disadvantage drug users in the competition for housing. It suggests that the commodity nature of housing is positioned within the wider economy of drug use and relates to the operation of drug markets in other ways. It suggests that there may be a 'hierarchy' of housing whereby certain housing forms may be related to high levels of drug use, and where communal living arrangements ease the diffusion of drug use It suggests that housing that acquires a negative status can contribute to the 'spoiled identity' of drug users, and that good quality housing can aid the construction of a new non drug-using identity and facilitate positive treatment outcomes.

It concludes by re-affirming the contribution that housing studies can make to the analysis of drugs misuse, particularly a form of analysis that takes account of both structure and agency. This would be an analysis combining the economics of the private housing market and the bureaucratic structures of social housing provision, combined with an acknowledgement of the motivations of individuals and the meanings that they attach to their housing and drug use. By this analysis housing can be seen as either a constraint on the lives of drug users, or as an opportunity for transformation.

DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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CHAPTER ONE

INTRODUCTION

1.1 Drugs and housing: research and policy agendas

Even the most casual television viewer must be aware of the plethora of programmes depicting housing as an investment and lifestyle choice. These programmes depict housing as the repository and generator of aspirations both in materialistic and status terms. A rise in status and value through one's housing has always been depicted as climbing a 'ladder' and these programmes provide advice on how to climb the ladder using knowledge of capital accumulation through a judicious reading of the market based on the estate agents' mantra "location, location, location."

If a position at the top of the housing ladder is an expression of consumerist aspiration and lifestyle, a sign to the world that one has either 'arrived' or 'made it', how then can the housing situations of the drug users described in this research, typically the least desirable parts of the social and private rented sector, be seen as anything other than a very public badge of their failure, not only as consumers but as human beings? How do they feel about their housing? To what extent do drug users in the sample feel themselves to be stigmatised by their housing? Do they see their housing and their drug use as in any way related? These are among the questions I address in the thesis.

The main research aim is to examine whether there needs to be a greater consideration of the role of housing in the production and maintenance of problematic drug use. It aims to retrieve housing from its perception as a mere container of other social processes and put it centre stage for consideration as an influence in its own right. To do this it examines whether problematic drug use is associated with certain housing situations and forms of social exclusion such as homelessness. It looks

at whether there exists what in the literature is described as a 'hierarchy' of housing and drug use whereby high levels of drug use are related to certain housing situations and whether there can be said to be a 'drift down' effect whereby as drug use increases people come to occupy poorer, more insecure forms of housing.

By investigating a sample of drug users in the North of England the research examines how housing functions to shape the family relations, local economies and social networks of problematic drug users. It looks at how negative housing characteristics are related to crime and drug markets, and the possibility that positive housing characteristics may be related to successful treatment outcomes and the construction of new personal and social identities. In this way a person's housing situation may be seen either as a constraint that undermines their recovery from problematic drug use or as an opportunity to move on literally and psychologically from a drug-using identity.

As well as looking at how housing structures affect people's opportunities in terms of local and national provision and policy, the research looks at human agency and how people's actions and attitudes shape their differential ability to make housing choices, take advantage of housing opportunities and negotiate the structural constraints of the private and public housing systems.

The preoccupation of the media with housing is in contrast to its perception, unlike drugs research, as not being a 'sexy' research area. Drug research, and social science research generally, has mirrored the view that housing is only a physical container and, "the built environment in urban theories is generally treated as a passive backdrop to other social processes." (Ball, 1986: 447). Giggs et al. (1989:1473) pointed out the failure of environmental research to deal adequately with drug issues: 'Of all the academic specialisms which have addressed the subject [drug use prevalence] one in particular is conspicuous by its absence, namely geography'.

British housing policy debates since the war have been dominated by a concern with differentiation in tenure and the mismatch between supply and demand within the wider context of a changed welfare state (Murie, 1997a). Housing research, largely dominated by economists, has until recently concentrated on markets and institutional structures. These structures of building provision have formed the basis of a type of housing research that concentrates on housing institutions and their relation to government policy against a background of changing governance (Clapham, 2002).

More recently, housing analysis has been influenced by Giddens' structuration theories and is now more sensitive to human agency (Giddens, 1984). There is now a greater attention paid in housing studies to how people's day to day lives reproduce systems of power in a reflexive way through the housing system – for instance reproducing, particularly through owner occupation, employment structures, consumerism, gender divisions and domestic arrangements for those who are socially included and reinforcing social exclusion in terms of poor housing or no housing for those who are not included. These reinforcements take place in a highly ideological way since they operate below the level of consciousness, so that housing structures appear 'natural.' Routine behaviour takes place within demarcated limits and serves to strengthen structures of power by the day-to-day observance of those limits. Consequently behaviour does not need to be coerced but is entered into freely. This is why housing is said to be such a powerful but unacknowledged influence over behaviour, why it is treated as 'background.' It has the ability, by its very familiarity, to escape critical analysis because it is so much a part of everybody's day-to-day landscape,

> Most people, most of the time, take the built environment for granted. This [relegation of built form to the unquestioned frame] is the key to its relations to power. The more that the structures and representations of power can be embedded in the framework

> of everyday life, the less questionable they become and the more effectively they can work (Dovey, 1999: 2).

Attempts to bring the built environment back into the frame and link it with human behaviour have been unfashionable since the failure of utopian housing schemes to bring about hoped-for changes in community, and are sometimes discredited by charges of environmental or architectural determinism (Hillier, 1996). Some critics assert that it is social, cultural and economic factors that most strongly influence drug use and that the effects of the built environment are negligible. How could buildings affect behaviour such as drug use? And if one accepted that there is an influence, what are the mechanisms through which this influence takes place? Still further, how can these influences be measured, since the number of social variables affecting behaviour are so many and combine in such complex patterns that to isolate housing as an independent variable seems an impossible ambition. Yet, to argue against any kind of influence of the built environment on human behaviour,

> Leads to the odd proposition that it does not matter at all how environments are designed, since they are behaviourally neutral. This proposition seems even less credible than architectural determinism.
> (Hillier 1996: 184).

However, nobody today would say that physical design and housing standards were the most important keys to behaviour. Nevertheless, more modest claims of the enabling or constraining effects of possibility by the location and condition of housing can still be made. To link housing to problematic drug use the thesis aims to combine approaches from housing studies and drugs research. It combines and utilises two research traditions that have largely remained separate, although more recently there are signs of recognition at both a policy and research level that they may have many common areas of interest.

In contrast to the traditional emphasis on structures and markets in housing studies, drug use research has, if anything, been focussed away from social and economic structures and been more preoccupied with the human agent. Although the spatial patterning of drug use has drawn some research attention there has been a general lack of attention to the effects of the external environment, in favour of the individualisation of drug use at a psychological or physiological level. This has been reinforced by the location of drug treatment within the orbit of the psychiatric and medical profession. More recently, at a policy level, drugs issues have occupied a context located uneasily between a criminal justice and a public health perspective with a criminal justice approach currently in the ascendant (Shapiro, 1998; Bean, 2002).

Whilst many practitioners working in the fields of housing provision, drugs treatment, health and criminal justice operate on a day-to-day basis that there is a relationship between drugs and housing, there is no unequivocal evidence base to make the case in either causal direction, either that poor housing conditions lead to problematic drug use or that problematic drug use leads to people occupying poor housing. The difficulty of locating the causes of drug use in seemingly non-proximate areas such as housing is both a methodological and a conceptual one.

At a methodological level the challenge researchers have faced is to clarify whether the relationship of housing to problematic drug use is that

- Housing is a precursor of drug use, independent of other antecedents
- Housing is a mediating link, for example between environmental stress and drug use as a coping mechanism
- Housing is a moderating influence on individual risk factors associated with drug use, either as a protective factor or as a magnifying influence

- Housing is a correlate of something separate and previously unidentified and unmeasured
- A combination of some or all of the above

Similarly, research has been confronted with the challenge of whether problematic drug use is

- A cause of someone being located in particular housing types and areas
- A mediator linking other causes such as psychological health or life course by, for example, limiting housing choice and access
- A correlated outcome of something separate and previously unidentified
- A combination of some or all of the above

Future research might profitably investigate to what degree problematic drug use in specified locations reflects the social characteristics of the people living there and moving there – do poor drug users gravitate to poor housing in poor neighbourhoods? (compositional factors). Or could drug use be one manifestation of the social and material characteristics of the neighbourhood itself – are there housing effects that additionally impoverish and reinforce drug use as one aspect of cumulative social exclusion? (contextual factors). A related question is to what extent are any effects non-linear, so that 'threshold' effects, hypothesised as a critical mass of negative variables, may 'tip' the neighbourhood into an exclusion that is multiple, concentrated and long lasting. Both poor housing conditions and numbers of drug users have been hypothesised as such factors (Office of the Deputy Prime Minister, 2003). The methodological difficulties of tracing these pathways means that housing professionals as landlords have been reluctant to accept ownership of problems of drug use, preferring to see them as the result of individual behaviour de-contextualised from the physical environment.

1.2 Defining the problem: bringing the environment back into the frame

The research literature on drug use attracts contributions from biologists, psychologists, criminologists, sociologists, geographers and anthropologists among others. It is beset by problems of definition, not only about what the solution(s) to the problem might be at the level of treatment and prevention, but how to conceptualise the problem itself.

The nature and causes of addiction are highly contested areas of theory and there are myriad theories about the 'causes' of drug dependence. (Orford, 1985; Heather and Robertson, 1989). These theories will be discussed at greater length in the literature review. The range of theory covers the biological, psychological, social, cultural and various syntheses of these combined in various levels of complexity. The complexity of drug use and its diverse conceptual landscape (due to the large range of variables that may go to make up an individual's pathway to dependence) means that there is, as yet, no all-encompassing treatment model from which to work. Rather, today's treatment approach is largely about matching a range of treatment modalities to individuals, although many researchers and practitioners accept limited treatment effectiveness in the face of the social environment in which drug use takes place (Saunders and Allsop, 1991; Gossop, 1996).

Some researchers stress the pharmacological properties of substances and their addictive qualities that do not require a specific social context and are seen to be 'culturally innocent' (McDonald, 1994). The 'disease' view of addiction, which is dominant in the U.S. and is common in the U.K., stresses an individual psycho-biological predisposition to addiction for which there is no cure (Alcoholics Anonymous, 1939). Medical approaches which locate the cause of dependence in individual biology and/or psychology have been criticized as approaches to health care

which seek to individualise ill health and minimise the political and social structure as causal factors. They are approaches which,

> make the individual the basic unit of social analysis. It supports a politically conservative predisposition to bracket off questions about the structure of society, about distribution of wealth and power for example, and to concentrate instead on questions about the behaviour of individuals within that (apparently fixed) structure (Tesh, 1988: 161).

This de-contextualisation of dependence from the environment individualises drug users without taking account of their social networks, their class and power position, their cultural reference points or their place in a chain of drug production, distribution and consumption. Sociologists look for the causes of drug use within the social structure utilising theories of power, inequality and racism (Pearson, 1987). It is generally accepted that at an aggregate level there is strong evidence for the social and spatial distribution of drug problems with strong links to areas of deprivation (Stimson, 1995; ACMD, 1998; Lupton et al. 2002). Those from a more anthropological and ethnographic stance would conceptualise drug use in cultural and economic terms, located particularly in 'hard to reach' populations of street, youth and drug subcultures (Bourgeois, 2003).

A great deal of recent drug research uses the web of causation model (Lloyd, 1998), based on the idea of individuals 'at risk of risks', although this model has been criticised as being embedded in biomedical individualism that under-estimates social factors in the production of ill health (Krieger, 1994). In focussing on the most proximate strands of the web under the control of the medical profession and health care system, it is described as a 'prisoner of the proximate' in terms of causal identification (McMichael, 1999).

Critics of the widening of causal factors for poor health in general, and drug use in particular, out into the environment warn that it leads to a

vaguely defined list of variables characterised as 'risk factorology' (Pearce and McKinley, 1998). With a lack of specificity about what is meant by 'the environment', the number and complexity of variables runs the danger of becoming meaningless (Vandenbrouke, 1988) and only of use for 'hypothesis generating' rather than 'hypothesis testing' (Schwartz, 1994). At the other end of the scale critics warn that the huge advances being made in identifying causal factors of ill health at the genetic level runs the risk that we are entering a phase which will potentially downplay the importance of other levels, particularly public health, and that this research concentration is too narrow (Loomis and Wing, 1990; Yack, 1990).

Drugs and housing have mainly been linked, in this country and internationally, at the level of single homelessness (Johnson et al. 1997; Kennedy, Barr and Dean, 2001; Fountain and Howes, 2002), anti-social behaviour within social housing (Scott and Parkey, 1998; Papps, 1998; Dalton and Rowe, 2004), social exclusion (Gilman, 1998; Social Exclusion Unit, 1998), supported housing (Sandham, 1998; Town, 2001) and drug treatment (Gossop et al. 1990; Fiorentine, 1998; Hser et al. 1999).

Some academic studies of drug use incorporating a social and geographical element have stressed the importance of the local, the community or the neighbourhood, however defined. Within criminology, social disorganisation theorists, environmental criminologists and those utilising geographical systems have stressed the importance of place in theorizing the patterning of crime. Medical geographers and sociologists, and, in particular, social epidemiologists, have also stressed that 'place matters' and recently there has been a more sustained search for 'neighbourhood effects' focused mainly on disadvantaged communities.

New Labour's social exclusion and regeneration agenda focusing on areas of deprivation has given rise to a number of policy initiatives linking housing and drugs. These have stressed the importance of multi-agency

partnerships, including *Tackling Drugs to Build a Better Britain* (1998), *Bringing Britain Together: a National Strategy for Neighbourhood Renewal* (1998), *Tackling Drugs as Part of Neighbourhood Renewal* (2002) and the *Updated Drug Strategy* (2002). Issues regarding the misuse of drugs have entered here from a number of perspectives – health, criminal justice, community safety and community care as well as housing. A growing focus on drugs and housing was embodied in the *Anti Social Behaviour Act (*2003) which contained measures for closing down so-called 'crack houses' as a way of addressing drug use and nuisance emanating from specific locations.

1.3 Conceptualising drug use and housing

Against the background of the many and often conflicting fields in which drug use and housing are discussed, it is necessary to clarify at a conceptual level what is meant in this research by 'problematic drug use' and 'housing.'

For the purposes of this research a distinction needs to be drawn between recreational drug use and problematic use. A useful, non-scientific distinction can be made between recreational 'cocktails of celebration' and problematic 'cocktails of oblivion' (Gilman, 1998). This requires different treatment and prevention approaches,

> Prevention must encompass measures directed at multiple drugs, used in isolation, simultaneously or in sequence...drugs are used in different ways and with different patterns and intensities and with different routes by different people and with different levels of risk. Prevention is not about one, simple, monolithic entity called 'drugs' (Advisory Council on the Misuse of Drugs, 1998:3).

Problematic use may be defined as progression to dependence, risky use, intravenous use, poly drug use, criminal involvement and health and social complications of use (ACMD, 1998). Vulnerability to drug use

seems to be largely distinct from vulnerability to problematic use (Glantz and Pickens, 1992), and recreational drug users have much more in common with people who do not use drugs than they have with those addicted or who use problematically. Whilst it is arguable that there is much Class A drug use in affluent areas (Aust and Condon, 2003), nevertheless it is deprivation that is so linked with the kind of problematic behaviour that affluent people only experience when all their social and material support systems have broken down. For many deprived people these systems were never in place as a buffer against the dangerous and debilitating effects of continued drug use.

This introduction started off with a popular conception of housing as a repository and generator of aspirations in both materialistic and status terms. This research is conscious that housing can be conceptualised in many different ways. Housing may be seen not only as a physical entity but as a bundle of legal rights and responsibilities that confer differential economic and social status on the occupier. Its fixed nature means that its location cannot easily be separated from its structure so that identifying housing effects apart from both the physical and social neighbourhood offers challenges to the researcher in identifying specific housing variables. Housing is also loaded with cultural resonance in terms of the status that it confers and is important in the way in which it structures and confirms social relations between people in terms of social and economic class.

In attempting to deal with these various conceptions of housing, sometimes the research concentrates on particular aspects whilst other aspects are less emphasised. Each conception, however, needs to be seen within an overall conception of housing as having many dimensions, including the economic, legal, social, cultural and psychological.

Chapter Four deals with the spatial mapping of deprivation and poor housing associated with drugs that are related to a view of housing stressing differential legal and institutional rights governing access. It

also places these aspects of housing within an economic view of housing and drugs as commodities with negotiable value.

Chapter Five views housing more from its ability to regulate and define social arrangements, creating not just the background of the locality but its role in structuring the relationships between people based upon their movements and configurations in space. Their social interactions could be a major reason for the diffusion of drug use within certain communal housing situations. However, in dealing with physical structures in space, the research also takes account of the locational movements of drug users in time.

Chapter Six continues this theme in looking at the relationships and domestic environment of drug users and goes on to look at the effects of housing on status, in particular how being a drug user or ex drug user living in particular areas dominated by particular housing forms and a negative social environment may positively or negatively influence one's identity, and in turn how this may influence treatment outcomes.

An overall conception of housing must balance all of the different aspects of housing at different levels of analysis from the macro economic and structural through the neighbourhood and domestic to the individual human agent. It is not always possible to deal with all of these simultaneously when the focus must be on a particular aspect of housing, just as it is not always possible to simultaneously present drug use from all of its myriad interpretations. Where a particular aspect of housing is being emphasised, this will be pointed out. This does not mean that other conceptions of housing can be ignored, rather that a choice has to be made in the selection and emphasis, not only of data but of conception and interpretation.

1.4 The structure of the research

The next chapter of the thesis is a review of the literature on housing and problematic drug use and is divided into three sub-sections. It begins with an examination of macro economic and structural factors such as the operation of the housing market and the geographical distribution of poor housing, social exclusion and drug use. It then goes on to look at the influence of housing and the built environment on criminal and drug-using networks, and social and family relationships. It then looks at the relationship of housing to poor psychological health, the formation of identity and drug use.

There follows a chapter on the research design and methods used to examine the relationship between housing and problematic drug use. This includes some quantitative data but consists largely of qualitative data gained from interviews with forty problematic drug users in three areas of the North of England, as well as interviews with relevant drug and housing agency staff.

The primary research findings comprise three chapters. Chapter Four is based on an analysis of the role of housing markets in the spatial patterning of drug use at a local level. It then goes on to examine the experiences of problematic drug users in their access to housing and their movement within the housing system. It situates drug use and housing circumstances within a wider economy and examines how they might be related due to their commodity nature.

Chapter Five moves on to an examination of housing and the social environment drug users find themselves inhabiting. Specifically it examines the idea debated in the research literature of a 'hierarchy of housing and drug use'. In other words, do specific forms and locations of housing influence levels and patterns of drug use? A related question is

do drug users come to occupy progressively worse housing as their drug use intensifies?

Chapter Six examines how relationships and domestic structures and cohesion may be an influence on treatment outcomes. It goes on to examine the role of housing in treatment outcomes, particularly from a psychological perspective using Goffman's (1963) idea of a 'spoiled identity'. It looks at the conception drug users have of their housing and how important it is to their psychological well-being. It also examines the potential of housing to reinforce a stigmatized identity or, alternatively, to contribute to a new non drug-using identity.

The conclusion looks at the findings of the research and discusses its limitations. It looks at some on-going policy issues that could affect the housing of drug users in the future and highlights any implications that the research has for future policy and research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Given the broad spectrum of research traditions that have at some point been concerned with drug use issues, this literature review draws on research from a number of academic disciplines. It begins with an examination of macro economic and structural factors such as the operation of the housing market and the geographical distribution of poor housing, social exclusion and drug use. It then goes on to look at the influence of housing and the built environment on criminal and drug-using networks, and social and family relationships. It then looks at the relationship of housing to poor psychological health, the formation of identity and drug use. In this way it moves from a macro level to an increasingly individual perspective on the role of housing in problematic drug use.

2. 2 Housing Market Filtering, Areas of Deprivation and Social Exclusion

2.2 (i) Social and geographical filtering: market models

The economic literature describing the operation of the housing market, much of it from the U.S., treats it as an interrelated series of sub-markets across which change in one sector has repercussions in others. A 'filtering' process is said to operate (Galster and Rothenberg, 1991), whereby homogenous groups, (sorted and to some extent self-selected by income level, race, family life cycle or other factors), congregate within specific geographical areas. These areas exhibit typical housing features of location, design and cost, and enjoy (or do not enjoy) a certain level of services such as education, health care and physical environment.

Consequently, decline of neighbourhoods is not solely related to forces acting within those areas, but is a result of macro factors and the wider operation of housing sub-markets (Temkin and Rohe, 1996; Galster, 2001).

The filtering model postulates that as new house building takes place at the upper and middle income levels, those able to do so will take the opportunity to move up the housing 'ladder' and away from the older, poorer quality housing located particularly near the centre of towns and cities. This housing will then become attractive to, and be populated by, economically and socially disadvantaged groups. This filtering leads to a geographical concentration of decline characterised by aged buildings, landlords foregoing repairs in order to maintain income levels and abandonment of property. To cater for the changed population and family structure, landlords subdivide housing units to increase density, sometimes even at higher rental levels as they raise the rents to the maximum benefit level to provide housing to groups who nobody else will be prepared to house.

At a neighbourhood level there may also be observable 'threshold' effects or critical mass of variables which develops, such as rate of joblessness, welfare dependence, teen child-bearing, level of poor education and level of crime at which neighbourhood decline increases in a non-linear fashion (Granovetter, 1978; Crane, 1991; Quercia and Galster, 2000; Galster, 2001). Levels of drug use may be one of these threshold effects contributing to a general sense of decline and anxiety in poor areas compared with other areas (Office of The Deputy Prime Minister, 2003). In these areas there is likely to be a greater incidence of entrenched criminal networks, together with a population exhibiting a more extensive range of risk factors associated with problematic drug use as well as a greater propensity to use alcohol and legal drugs as coping mechanisms. Consequently, the government has targeted resources to these areas through a range of regeneration and drugs initiatives such as Communities Against Drugs and The National Crack Plan.

Winchester and White (1988) define marginalized groups according to three criteria – being economically marginalized, socially marginalized and legally marginalized. Drug users fulfil all three criteria, and from this perspective can be seen as one of a number of disadvantaged groups, without the social, political or economic resources to improve their position in housing terms, competing for poor quality housing at the low end of the market. Meltzer et al. (2002) showed that those who were drug dependent were over-represented in the private rented sector and were disproportionately single and lacking in social support. They also experienced problems of lack of security of accommodation due to financial problems, principally due to debts, unemployment and short-term contracts, although at little variation from other private rental tenants. According to Rothenberg et al. (1991), tenancies at the bottom of the private rented sector are characterised by high turnover, weak neighbourhood ties and increased physical neglect or abuse of property. Furstenberg and Hughes (1997) stress the way the physical arrangement of space influences social exchange patterns, with very different patterns in high-density rental housing to that of owner occupation. These patterns may facilitate negative influences, particularly regarding such things as peer influence and lack of adult supervision.

This poor-quality, high-density rented housing poses increased health and safety risks for residents as well as social psychological health risks. The lack of property investment and poverty concentrations may cause 'flight' amongst those able to leave as 'contagion' effects take hold and spread through peer influence and collective socialization as the area acquires a negative status and reputation (Crane, 1991). As areas decline more people wish to move, but living in a poor area reduces a person's ability to do so and there is a particular problem for owner occupiers unable to sell their property (Kearns and Parkes, 2003).

At its extreme it will lead to the abandonment of property that may provide locations for drug use and dealing (Rengert, 1996). In the U.S.

this has led to civil remedies to either seal up, demolish or confiscate buildings used in drug-dealing, and rigorous enforcement of building codes to clean up drug-dealing sites (Green, 1994). These buildings embody major 'incivilities' which send out signals that the neighbourhood is uncared for (Wilson, 1987). One can see these U.S. models as the basis for parts of the Anti Social Behaviour Act (2003) dealing with nuisance emanating from so-called crack houses.

2.2 (ii) Limitations of the market model

This emphasis on market 'filtering' is very evident in American research, but three other factors need to be emphasised to more accurately describe the operation of the British housing market and its relation to geographical disadvantage.

Firstly, the extent to which the state has intervened in the operation of the housing market must be considered. This was initially to correct market failure in addressing issues of social justice and ensure access to decent housing of those unable to compete successfully. But later in the century intervention took place to skew market choice in favour of a particular tenure – owner occupation. Both policies were initiated to promote different conceptions of social cohesion, but in the long run they were the agency of social polarisation as lack of public housing investment led to the residualisation of a reduced supply of council housing containing a disproportionate number of welfare claimants. As supply was cut off to some at the very bottom, the consequences were increased homelessness and recourse by those unable to qualify for council housing to the poorest parts of the private sector (Lee and Murie, 1997).

Patterns of deprivation located in specific housing areas exhibit effects such as poor physical and mental health, increased stigma and loss of self-esteem, increased crime rates and failure to attract services and investment, which persists over generations and takes on a,

> "compound reinforcing pattern of multiple deprivation, persistent over time, concentrated in particular areas and resistant to traditional policies" (Lee and Murie, 1997: 9).

However, to equate poverty with council housing (and increasingly the housing association sector), is to reinforce stereotypes that mask poverty in other tenures. Burrows (2003) found that owner occupation has become a socio-economically diverse tenure with over half of owner occupiers classed as living in poverty, a fact which makes the targeting of area-based poverty interventions problematic.

Nevertheless, in the U.K. many researchers still see housing class and social class having strong correlations, and the housing market as a means of structuring space has been theorised as an agent of social and economic inequality explaining the geographical mapping of deprivation (Atkinson and Kintrea, 2001; Forrest and Kearns, 2001; Galster, 2001). Bottoms and Wiles (1986: 16), assert, "there is a direct correlation between tenure and social class.", and "tenure has reflected and reinforced, in bricks and mortar, class divisions in Britain." (Bottom and Wiles, 1986: 113). Pahl (1970) sees the social structure and spatial and physical structure as inter related – the built environment literally acts as a constraint by fixing people geographically and socially, and, using the idea of 'housing class', he sees housing as a site of struggle between communities for resources and space with those in privately rented accommodation lacking the capacity and desire to organise as an interest group.

The situation has changed somewhat in recent years with low demand across tenures emerging as a major problem, particularly in the North. There may be no problem of housing supply in many of these areas but this has brought new problems to certain areas due to private landlords buying up former council and private stock and letting to unsupported, chaotic drug users and those involved in anti social behaviour and crime. A negative labelling operates in certain areas that become identified with

drug use. Consequently potential householders turn down offers to move there and incomers tend to have the problematic characteristics of the existing tenants. Flight from the area of those able to leave, and eventual decline has resulted. (Blackman, 2002; Office of the Deputy Prime Minister, 2004).

Secondly, an emphasis on housing market forces must acknowledge the role of various agencies involved in the supply, distribution and consumption of housing, described as the 'structures of building provision' (Ball, 1986), including the working practices of landowners, developers, estate agents and building societies whose aim is to maximise capital investment. These agencies not only shape access to housing but people's sense of possibility and what is appropriate based upon a socially conservative agenda (Knox and Pinch, 2000). Working practices include redlining areas by building societies (refusing mortgages in 'declining areas'), or steering by estate agents (agents making subjective judgements about the best 'fit' of householder to an area on racial or other social lines).

But in the social and private rented sector a drug user may have to negotiate their way around a number of housing 'gatekeepers' and may find themselves competing for housing at the low end of provision along with a number of other marginalized groups. In these cases the subjective opinions of housing officers or private landlords, whether overt or covert, may be a barrier to access.

Thirdly, from a consumption point of view, householders are not solely economic beings but are motivated by wider social factors that generate attachment or aversion to an area independently of their income level. Some 'poor' neighbourhoods may remain stable due to their dense social networks, although these networks may be inward-looking and cut off from other networks that could act as a bridge to the wider society (Forrest and Kearns, 1999). A criticism of the market model is that it gives insufficient attention to human agency and the idiosyncrasies of

people's decision-making. The market model assumes that housing consumers are rational in their behaviour, but whilst some householders have a clear, upwardly mobile life plan, others react to personal and external events in unpredictable ways on an ad hoc basis. Their choice of housing reflects a coping strategy more than a long term plan (Clapham, 2002). For certain communities the upward mobility inherent in the filtering model may be inappropriate. It is arguable that working class people see their housing in more instrumental and less in aspirational and investment terms than the middle class and that generally individuals self-select neighbourhoods that they feel comfortable in and which consequently furthers a process of homogenisation.

Drug users may see housing areas in this way, not as areas of deprivation, but as composed of social networks that are conducive to convenient drug supply and the promotion of drug careers, and composed of those sharing a similar subculture played out against a particular rundown style of the built environment that fits in with a drug-using identity.

2.2 (iii) Drug use and areas of deprivation

There are U.S. studies that conclude that economic status does not have a strong impact on drug abuse (Glantz, 1992), or that there is a risk connection only "when poverty is extreme and occurs in conjunction with childhood behaviour problems" (Hawkins, Catalano and Miller, 1992). However, whilst we must always hesitate to infer causal connections, the Advisory Council on the Misuse of Drugs has clearly stated,

> We thus assert without any of the familiar hedging with "on the one hand but on the other", that on strong balance of probability deprivation is today in Britain likely often to make a significant causal contribution to the cause, complications and intractability of damaging kinds of drug misuse. (ACMD, 1998: 113)

The literature on areas of deprivation has a long history (Engels, 1845; Mayhew, 1862), but drug and alcohol research in the U.K. and U.S. has tended to individualise substance misuse problems in line with the disease model, or to run incidence and prevalence variables against demographic variables with the environment removed from the frame (Cahalan, Cisin and Crossley, 1969). In the 1960's and 1970's when drug use became more prevalent, there was no British evidence to show that it was linked to deprivation or factors in the individual's environment. The only British study regarding drug use and environment was interestingly enough not in an area of gross deprivation, but in the new town of Crawley where dependent users predominantly lived with their parents. 74% were in regular employment and were not socially distinct from the surrounding population (de Alarcon and Rathod, 1968). Heroin use was explained by the mundane environment and lack of social cohesion amongst families who had been moved out of London into socially unstructured council estates (de Alarcon, 1969). However, in its examination of the environment this study proved the exception to the rule and research conceptualised drug use as a highly individual problem, either of a moral or medical nature.

This was despite a tradition of American research since the Chicago ecological studies in the early twentieth century that had plotted the social and geographical distribution of crime and other social problems and linked them with deprived areas (Shaw and McKay, 1942). More recent U.S. research has shown a relationship between areas of deprivation and heroin use (Hughes and Jaffe, 1971), and the over-representation of poor blacks and Hispanics in heroin-using populations has also been noted (Chein et al. 1964).

It was not until the 1980's, when a sharp growth in heroin use occurred in tandem with a sharp rise in unemployment and an influx of cheap, good quality heroin from Iran and Pakistan, that British studies began to consider a relationship between areas of social deprivation and heroin

use (Parker, Newcombe and Bakx, 1987. Parker and colleagues' study was based on the Wirral on Merseyside where the prevalence of young opiate users varied widely across communities and there were significant positive correlations between drug use and seven indicators of social deprivation. This work was corroborated in the North of England (Pearson, 1987), Nottingham (Giggs et al, 1989), and in Glasgow (Forsyth et al. 1992).

However, a note of caution should be added in assessing the prevalence of drug use in deprived areas. Forsyth's study showed that deprived neighbourhoods were a magnet for outsiders to come into to buy drugs, and counting drug users present in deprived areas is liable to exaggerate their prevalence because many live elsewhere. In the U.S. Skogan and Annan (1994) found that public housing projects associated with drug dealing contained a sizable population of undocumented residents making it difficult to affix responsibility for drug involvement to people who actually lived there. Dalton and Rowe (2004) confirm a similar situation in Melbourne.

2.2 (iv) The search for neighbourhood effects

Attempts to quantify neighbourhood effects independently of the compositional attributes of the residents are beset by methodological problems of disentangling the complex relationships between variables that exist at a macro, local and personal level and in which individuals are embedded (Galster, 2003). Galster sees housing wealth, tenure, status and levels of residential turnover as simultaneously bound up with the characteristics of a neighbourhood. These are factors that influence its collective efficacy, its behavioural norms and stability. Friedrichs et al. (2003: 802), in looking at how neighbourhood effects might operate offer the following mechanisms:

- Neighbourhood resources: reputation of place, local public services and informal organisations, accessibility to jobs, recreation and other key services
- Model learning via social ties and interrelationships, nature of interpersonal networks, peer groups etc.
- Socialisation and collective efficacy: commonality of norms, sense of control of local public space
- Resident perceptions of deviance, such as crime, drug dealing, physical decay of buildings and general state of disorder

However, they are cautious about the level of research into some of these effects and conclude,

> Urban housing policies that aim to change the neighbourhood compositions in order to gain more positive social effects, are taking the plunge into largely uncharted waters
> (Friedrichs et al. 2003:804)

Dispersed housing programmes such as the Moving to Opportunity Programme in the U.S. are hypothesised on the idea of an 'opportunity structure' (Galster, 2002) whereby quality of local resources and a person's ability to optimise those resources are heavily determined by their residential location. However, they rely little on empirical evidence (Galster and Zobel, 1998), but on the assumption that poor families, enabled to move to better-off neighbourhoods, will, through more positive peer and adult socialisation, reduction in area stigma and greater access to better services, experience greater life chances. Furstenberg and Hughes (1997), however, raise questions about the possibility of the negative labelling of poor children in more affluent neighbourhoods.

The health literature most directly makes connections between neighbourhood effects and health risk behaviours such as drug use. Duncan, Jones and Moon (1999) found that smoking behaviour was influenced independently by living in a low status, poor neighbourhood,

not simply because of the presence of more smokers acting as a reinforcing and normalising factor, but because of less individual and community resources to enable healthy choices.

Groenewegan et al. (1999) looked at whether there were neighbourhood effects on the use of benzodiazapines in a Dutch city, hypothesizing that in more socially integrated and less deprived areas their use would be less. They found that age and gender were major factors of use and exerted a compositional influence, as did the number of one-parent families whose use was higher. On the face of it, the results were against the hypothesis in that there was greater use in neighbourhoods with a lower percentage of social housing and a higher number of rooms per person. However, closer interpretation of the results, particularly the seeming contradiction in the housing variables, may be explained by the fact that the 'rooms per person' variable favours one-person households – and contrary to indicating a better standard of housing, may indicate greater social isolation of individual households.

Whilst some authors have demonstrated the existence of independent neighbourhood effects (Buck, 2001; Atkinson and Kintrea, 2001), many would agree with the statement that "the existing empirical evidence [for neighbourhood effects] is inconsistent, incomplete, and sometimes contradictory" (Ellen and Turner 1997: 854). Buck (2001), whilst finding such evidence, qualifies this, since even if they do exist, these effects are said to be far less important influences on human behaviour than such factors as education, income, employment, age and gender,

> Social scientists (and policy-makers) need to be reasonably modest about what can be known about the scale and causes of neighbourhood effects (Buck , 2001:2254).

Buck (2001) argues that housing tenure is not generally included in models identifying neighbourhood effects since "its spatial distribution is so closely related to the geography of disadvantage that it may be difficult to distinguish housing effects from area effects." (Buck, 2001: 2260).

Both Buck (2001) and Ellen and Turner (1997) have stressed the importance of qualitative methods as a means of analysing variables that may not be statistically captured by multivariate analysis. Ellen and Turner (2001) and Forrest and Kearns (2001), also stress the need to study more diverse, less disadvantaged neighbourhoods along with more analysis of what makes a 'good' neighbourhood.

2.2 (v) The 'epidemic' spread of drug use through social networks

Studies of the use of heroin in the U.S. led to observations that its pattern of spread seemed to follow the incidence and prevalence of infectious diseases (Hunt and Chambers, 1976), and epidemiology is now the basic science of public health which encompasses drug use (Giggs, 1991). Conflicting views as to whether drug and alcohol addictions should be called diseases, and a mistrust of the medicalisation of substance abuse, means that researchers are often circumspect in the use of the model, describing a 'disease-like ' spread from large to small centres of population in a hierarchical diffusion. It has been termed an "analogy" (de Alarcon, 1968: 17), and been pointed out that "there are some dangers in using this [epidemic] term" (Parker, Bury and Egginton, 1998: 4).

The drug epidemic model, whereby drug use is spread through social contact, is similar to that describing the network spread of innovations generally, and of consumer items in particular (Tarde, 1903). Imitation is said to occur by a trickle down process from 'superiors' with high cultural capital (Bourdieu, 1986), to 'inferiors' who imitate their actions. Drug use is said to spread from initiators locally in a similar process of microdiffusion. This is then replicated across wider geographical networks (utilising transport and communication infrastructure) in a process termed macrodiffusion. Diffusion models, using the language of communications rather than disease, have been found to be highly applicable to drug use (Ferrence, 2001). Knowledge about drug quality

and price, new drugs and drug administration methods are spread through social networks. These networks are largely functional rather than friendship networks, revolving around the mutual interest in the dealing, distribution and consumption of drugs. These relationships, whilst friendly on the surface, may be characterised by a high level of mistrust and can quickly turn to violence (Rhodes and Quirk, 1996).

A number of drug use studies have made use of the epidemiological model (deAlarcon, 1969; Parker et al. 1987; Parker et al. 1998). Parker and his colleagues found in their 1987 study that patterns of heroin use were in accord with the model of microdiffusion in areas of deprivation. In more middle class areas it was linked to relatively large population size in accord with hierarchical diffusion, or contiguity to areas of deprivation in accord with the model of macrodiffusion. Parker et al. (1987) used housing deprivation variables partly as indicators of general deprivation, but an important point made by Giggs (1991: 171) is the importance of residential transience,

> The high levels of residential mobility found among drug addicts have undoubtedly contributed to the rapid spread of the epidemic.

This has particular relevance to drug-using practices and the spread of HIV. Giggs illustrates a highly mobile population, to some extent internationally and nationally, but more usually locally, who have frequent changes of address within low status residential areas. The spatial patterning of housing interacts with the social networks of drug users and any dispersion of concentrations of drug users through demolition and redevelopment could have 'shotgun' effects of dispersal over a wider social and geographical area as drug users relocate and reconstitute their social networks in different geographical concentrations (Wallace, 1990).

A later study by Parker et al (1998) into the incidence of heroin outbreaks in England and Wales found that new users still fitted the earlier socially excluded paradigm from the poorest parts of cities and towns with the addition of some more middle class users from the serious end of the

recreational drug scene. However, a large scale macrodiffusion had taken place since the eighties fuelled to a large extent by supply factors such as a more efficient drug market distribution networks into parts of the country previously untouched.

Most evidence suggests that having social support is health promoting and may be a protective and moderating factor in high-risk environments. Social support can provide a sense of self-esteem, stability and control over the environment, not only when it is called upon, but in the knowledge that it is available when needed. However, for drug users an extensive social network may be a risk factor for continued use, relapse and needle sharing (Suh et al. 1997). These types of networking can be health damaging, for instance by encouraging or facilitating transmission of HIV, drug use and alcohol consumption. Individual behaviour can be heightened by group norms which encourage risk taking and take the form of health damaging behaviour such as use of psychoactive substances (Krieger, 2001; Elstad, 1998). Strong social networks of this kind can be seen as social capital of a harmful kind that are barriers to health interventions and reinforce unsafe practices (Latkin et al. 1995).

The importance of space in these networks has been highlighted by Wallace (1991), who shows that where social networks overlap at specific spatial locations, the spread of infection and health damaging behaviour will be much quicker. The arrangement of physical space within communities and, for instance, in houses of multiple occupation can influence social support because of the high resident densities and the way it influences contact between residents. The degree of proximity and the way in which encounters in communal space are regulated and promoted enable the formation either of friendships or of enforced encounters which are unwanted, possibly leading to withdrawal into private space (Fleming, Baum and Singer, 1985). For drug users in treatment, contact with user-neighbours may be an unwelcome risk, whilst a house in multiple occupation where several drug users

congregate may prove a difficult environment if a culture of drug use predominates.

One under-researched area is the degree to which the social housing allocation system could provide a medium through which drug users relocate to areas in a macrodiffusion effect. This may be from well-intentioned policies of locating them away from areas of high drug use, but may have the unintended consequence that if they do relapse they spread drug networks to previously unaffected areas.

2.2 (vi) Social exclusion, drugs and single homelessness

In Tackling Drugs to Build a Better Britain (1998), the government made explicit links between drug use and social exclusion, and highlighted problems associated with drug taking such as rough sleeping and poor housing. Narrow definitions of social exclusion associate it with lack of participation in the labour market, and it is said three out of four help-seeking drug users are unemployed, whether as a result of drug use or their drug use is related to prior unemployment (Neale, 1998). Wider definitions of social exclusion see it as bound up with social isolation and social segregation which can have a spatial expression in terms of excluded areas and 'poor spaces' which have seemed immune to successive governments' regeneration initiatives (Madanipour, 1998). Spatial patterns of exclusion are linked to debates about areas of deprivation and the existence of neighbourhood effects linked in turn to the literature on social capital (Putnam, 2000).

How housing is related to social exclusion as a process is a crucial question for theory and practice,

> Are housing policy and the housing system always and everywhere implicated as an active element in the processes of exclusion? If not, in what circumstances does it play an important role? What is the scope for housing policy to combat exclusion,

particularly when the roots of such exclusion may lie in other spheres? (Marsh and Mullins, 1998: 755)

Somerville (1998) sees this relationship as threefold: housing may reflect prevailing patterns of social exclusion, it may mitigate that exclusion or it may reinforce patterns of exclusion.

Within the literature on social exclusion, drugs have featured most prominently in discussions about single homelessness. Much of what has been written stresses single homelessness as the result of a combination of structural factors, including housing supply, and individual factors, one of which is drug use. This structure/agent dichotomy in the social sciences generally, has been addressed by Giddens, (1984) in structuration theory, but has practical policy implications in the question of whether the solution to homelessness is one of housing supply and income redistribution or one of social inclusion involving re-integration and resettlement of individuals through such things as social support, and skills training and, in the case of drug users, entry into some form of treatment.

Whilst many of the risk factors of homelessness and drug use are said to be similar – family disruption, poor attachment or communication with parents, childhood abuse, poor school performance, crime, mental illness and social deprivation (Kennedy et al, 2001), the extent to which these are causes or symptoms, and what relation these factors have to each other can only be loosely described by the 'web of causation' model (Lloyd, 1998).

Part of the problem for theory is the inability to arrive at agreed definitions of what a state of homelessness actually consists of or what its prevalence is. Similarly, there is lack of agreement in defining drug use prevalence or agreeing on what constitutes dependence or addiction. Definitions can be either too narrow or so broad that they lose all meaning in terms of practical policy response. If it cannot be agreed

what a problem is, then it is difficult to trace its causes. Neale (1997) utilises structuration theory (Giddens, 1984), in attempting to bridge the gap between the structure/individual approaches to the routes into homelessness – structures shape social action but it is also social action that shapes structures. She sees single homelessness as having no macro causes that explain all instances, but, following on from Foucault (1979), sees it better understood as stemming from a series of localised power points that constrain choice and opportunity and that must be challenged at that level.

Whilst there is much descriptive material on drugs and single homelessness there is a dearth of exploratory approaches that trace the pathways between social exclusion, poor housing and drugs as processes rather than stating that they frequently co-exist. There has been some useful analysis of the interaction between drugs and youth homelessness (Klee and Reid, 1998), but whilst there is a wealth of material on homelessness there is a dearth of material on housing situations which are a step above that condition – those in poor living conditions in the private sector or drug users in owner occupation. Research is over-concentrated on states of poverty and could usefully address the relation of drug use to such issues as mortgage indebtedness, security of tenure, housing costs, quality and location.

There is a substantial literature on single homelessness (Fitzpatrick , Kemp and Klinker, 2000; Klinker and Fitzpatrick, 2000), but several authors have criticized a lack of theoretical sophistication across the field, (Pleace, 1998; Neale, 1997). There is an awareness of the shortcomings of cross-sectional studies and a need for longitudinal data (Sosin, Piliavin and Westerfield, 1990), and longitudinal, qualitative data (May, 2000). Pleace (1998) argues that by focussing on single homelessness as a distinct category, the literature has insufficiently contextualized the processes leading to that extreme state and that a 'homelessness literature' has cordoned off debates from wider macro issues and the overall context of social exclusion.

There have been a number of 'good practice' guides regarding housing homeless drug users (Kennedy et al, 2001), in resettling them into the community with emphasis upon supported housing (Rutter, 1994; London Drug Policy Forum, 1999), and which argue for greater inclusion of those with drug and alcohol problems within Community Care assessments (Leigh, 1994). Housing practitioner guides now usually include a chapter on the implications of section 8 of the Misuse of Drugs Act 1971 and subsequent amendments which relate to those with the responsibilities of providing accommodation for drug users and who might be said to knowingly allow the use of any illegal drugs in premises under their control. This was a response to the 'Wintercomfort' case where two hostel workers were imprisoned for failing to take sufficient measures to deter drug dealing in a Cambridge hostel.

There is, however, a large amount of duplication of material on such areas as youth homelessness and health and homelessness that leaves other areas relatively unexplored, one of which is drugs. Research consists of a plethora of local studies, particularly centring on London, with limited generalisability nationally, conflation of drug use and drug dependence and widely varying prevalence estimates by location and setting.

2.2 (vii) Drug use and a hierarchy of housing

Research indicates that level of accommodation from rough sleeping through night shelters, hostels and mainstream accommodation shows a hierarchy of drug prevalence and dependency with the highest rates presenting amongst rough sleepers (Greene, Ennett and Ringwalt, 1997; Fountain and Howes, 2002). Klee (1991) found that in a survey of users living in the parental home, rented accommodation, hostels and no fixed abode, it was the latter who showed the highest usage, and highest rates of sharing equipment. An exception to this is Gill et al. (1996) who, in a

large scale survey of psychiatric morbidity amongst homeless people in night shelters, private leased accommodation, day centres and hostels, found that night shelters had the highest levels of drug and alcohol dependence, with the use of drugs even higher than amongst those living rough.

Meltzer et al (2002), in a household survey of adults with mental health disorders found that 30% of those who were drug dependent were living in the private rented sector. 23% were in social housing and 46% were in owner occupation. It is true that at 46% this is much less than the UK average for home ownership which stands around 68% (Lowe, 2004), but nevertheless represents a significant number of drug users who are homeowners. However, this sample does not include those living in institutional housing, hostels or residential treatment, or those living in temporary housing circumstances. Homeowners may also be easier to capture in a household survey, and there was also a 30% refusal rate. The survey also says nothing about the quality of housing. Owner occupation is now a much more varied tenure with many owners living in areas of deprivation (Burrows, 2003).

The idea that people's drug use increases as they occupy progressively worse housing conditions is a variation on the 'housing ladder' metaphor. But this may be simplistic – people may not have to drift down through progressively worse housing conditions before they hit the street. For some this descent can be rapid, for instance on release from prison, from care or from the parental home. U.S. studies suggest that use of crack can facilitate a particularly rapid descent (Maher et al. 1996). Using a biographical method tracing the housing histories of homeless people, May (2000) is critical of the idea of a progressive 'drift' into homelessness, finding that homeless 'careers' were much more individual and not in many cases due to 'vulnerabilities' such as mental illness or drug use, but were significantly associated with unemployment and frequent, episodic moves into and out of poor quality private rented accommodation.

Benda (1987) in general argues for a 'drift down' model of social selection whereby drug use is one route into homelessness, whilst other writers describe some drug use as a learned method of coping with the stress of homelessness which is reinforced by a homeless subculture (Klee and Reid, 1998). Drug use may also increase relative to the amount of time spent homeless (Fountain and Howes, 2002).

Some studies have focussed on the link between mental illness and homelessness (Scott, 1993), and between mental illness, drug and alcohol abuse and homelessness (O'Leary, 1997). The latter examined 'dual diagnosis' in cold weather shelters and found that 54% had mental health problems and 70% had an alcohol or drug dependency with the possibility of dual diagnosis of the whole population of 38%. This suggests that a large degree of self-medication exists. Goodman, Saxe and Harvey (1991) see the process and experience of homelessness, particularly the social disaffiliation and learned helplessness this engenders, as conducive to psychological trauma, although many homeless people had experienced traumatic events before becoming homeless.

Baker (1997:14) in a study of suicide and homelessness provides useful information on the effects of physical surroundings on states of mind, although from a necessarily small sample,

> Descriptions of rooms and bedsits in HMO's [houses in multiple occupation] where deaths had occurred indicated that these were of very poor quality, sometimes without electricity and in serious disrepair.

This study showed that the place of a person within a housing *process* was also significant in that those recently moved into inappropriate accommodation, those lacking support, those in need due to be re-housed, those with a repossession or eviction order pending and those recently returned from hospital were at high risk. Good quality, secure

housing was often seen, not as a cure-all, but as a point of stability from which to focus on other problems but there was evidence of people being located inappropriately in areas of high drug use.

The debate about the causal direction of the drugs-homelessness relationship is usually resolved by saying it is multi-causal and directional, and there is currently no overall theory to explain the many links. This would require establishing longitudinally precise time-ordered variables of such complexity that it is currently methodologically impossible. Johnson et al. (1997) argue that social selection and social adaptation (use of drugs leading to homelessness or homelessness leading to the take up of drugs) are not mutually exclusive. The relationship of homelessness to drug use over time may be so closely entwined that it is impossible to say which came first in a process in which a drift down through progressively worse housing conditions and increasing drug use may mutually reinforce one another in conjunction with other variables such as mental illness.

Some homelessness studies have turned up useful research on the theory of drug use as a coping mechanism and drug use as self-medication. Flemen (1997) found support for the hierarchical housing model of drug use and that drug use was normalised as part of a survival system of sharing resources – one that may initiate or exacerbate drug use. Klee and Reid (1998) provide one of the few explications of the pathways between drugs and youth homelessness rather than indicating in a general way that the two often co-exist. Drawing on research into concepts of self-medication and coping responses, they focus on stressors in the homeless lifestyle and the use that drugs have as coping agents. They found that three quarters of the sample said that they used drugs to self-medicate psychological symptoms such as aggression, depression and anxiety. They conclude however, that there is currently no theory which can bring together the elements that co-exist over time as the interaction of the individual and environment continues and is manifested in drug use.

2.3 Housing, Drug Use Economics and Crime Networks

2.3 (i) Drug-using sites and behaviour

A general model of drug markets starts from the basis that in the location of markets both buyer and seller need to balance access with security. Markets can be located on a continuum between open and closed (Eck, 1995). The latter is based on social contacts and is not place specific to the degree of the former that is place specific since outsiders need to know a designated point of sale. Place managers are important to open markets – these may be landlords or managers who have weak or corrupted control which enable dealing to take place.

Eck (1995) shows that in general specific drugs are sold from different kinds of addresses with distinct place management set-ups. In this way, the evolution of the crack house can be seen as a response to the short-lasting and impulsive nature of crack use, catering for the need for repeated doses to ward off the 'crash' and where repeat purchases could be catered for within a short space of time, and sometimes where sex was also available. Among crack users, shelter is a much sought after, and negotiated, commodity, particularly for those living outside the welfare system. In the U.S. many female crack addicts have three choices – to become a 'couch person' staying at a succession of temporary addresses which sometimes involves sexual payment (often with an older man who has a stable address), to use the city shelters which have a dangerous reputation, or to live on the street (Maher et al, 1996).

The effects of drug use nuisance emanating from specific dealing and using locations has been addressed in the Anti Social Behaviour Act 2003. This gives the Police powers to close and seal premises at forty-eight hours notice where drug use is causing disorder or nuisance in the neighbourhood. 'Premises' may include housing, pubs, cafes, shops, outbuildings and even common areas adjacent to buildings. The Act

recognises that the occupier is often intimidated by those dealing drugs into allowing the use of premises and makes special measures for re-housing them and other occupants who could be vulnerable such as sex workers, dependents and children.

Marketing geography has been used to predict optimal sites for drug dealing (Rengert et al. 2000). Maintenance of such areas relies upon a young, unemployed, poorly educated population – the factors closely associated with problematic drug use and a population likely to be housed within a deprived area (ACMD, 1998). Subcultural theories stress the social learning of alternative values in these areas through family, peers or neighbourhood culture where conventional values are weakly observed (Burr, 1987). An alternative response is the seeking of forms of status and economic power through drug market 'careers' which as well as financial reward brings respect based on entrepreneurship and masculine culture (Preble and Casey, 1969; Gilman and Pearson, 1991; Bourgeois, 2003).

An effective distribution system can also be historical or area specific because it is related to police policies, residential stability and demographics or the proximity of drug services (Latkin, Glass and Duncan,1998). Dalton and Rowe (2004) show that high-rise public housing in Melbourne offers four advantages to a drug market: a central location, physical design that makes police action difficult, anti-police attitudes by residents in general and a large internal demand for drugs. Drug-dealing places should ideally contain amenities, such as drug-using sites (public toilets, parks), drug treatment facilities (needle exchanges, chemists), cheap housing (hostels, transient hotels), and transport links (tube/bus station). This last point is relevant to one feature of retail markets, namely the distance people will travel to buy drugs which will depend on overall supply, quality and whether the drug itself is that of choice or an inferior substitute (Forsyth, 1992).

The nature of public and private space was examined by Dovey, Fitzgerald and Choi (2001) in a study of sites chosen by users to inject drugs. These sites were chosen by users to balance risk of disclosure with fear of remaining undiscovered if overdose occurred. For some, a derelict space fitted in with the social construction of a derelict identity, incorporating marginality, homelessness and the internalised junkie persona. Ill defined locations in terms of public/private ownership such as public toilets, car parks and the rear of commercial premises, as well as dilapidated private property without clear demarcation were examples of space where privacy was possible and yet where, if one did overdose, one might be found. They are described as liminal holes or cracks in the spatial order, "paradoxical places, spaces of desire and danger" (Dovey et al 2001: 328).

Hillier (1996) sees architecture as the medium that structures space and consequently structures the day to day movement of residents and the degree to which they come into contact with one another, either for social intercourse or simply to register one another as familiar or strangers. He found marked differences in the spatial movement and congregation of youngsters and adults on housing estates compared with traditional streets. Congregations of youngsters were associated with unease and fear of crime. He describes these youngsters as 'space explorers' occupying spaces not designed for normal use, and also includes drug users and street drinkers who use out of the way spaces to form local social solidarities.

Public policy has direct effects on the location of drug use and the environment in which it takes place. Grund et al. (1992: 384) compare the wider social context of drug use in Rotterdam and the Bronx district of New York. In Rotterdam there are high enough social benefits to support the cost of living, medical care on demand and an available supply of housing,

> The housing situation of even the lowest income groups in The Netherlands can be called decent...In Rotterdam only a small minority of addicts do not have regular housing.

They compare this inclusion of drugs within mainstream social policy and contrast it with the situation in The Bronx, an area that exhibits decades of physical and social neglect, exploitation and corruption. The area saw a massive destruction of low cost housing (60,000 units including many rooming houses and SRO's – single room occupancies) and was associated with several interacting factors – ageing buildings, overcrowding and the reduction of vital city services, such as fire, sanitation, and building safety inspection. This has contributed to a chronic homelessness problem and a physical and social environment that shapes the drug culture in terms of distribution and consumption. Whereas in Rotterdam drugs are used communally in a relaxed, social and domestic environment, using drugs in New York is a significantly different experience,

> The majority of drug sales occur in unstable and dangerous settings. Packaged drugs are sold through holes in the boarded up doors or windows of abandoned buildings from which an unseen person passes an untried quantity of pre-packaged drugs to an anonymous customer, or pre-packaged drugs are sold by small groups of people who wander a particular block, or hover in a particular doorway. (Grund et al, 1992: 385)

Quality is poor, leading to high rates of injecting ('more bang for a buck'), and because needle exchanges are thought to condone drug use, 'shooting galleries' are a feature where along with drugs one can rent a needle and syringe, with all the health implications this entails. They are frequently situated in abandoned buildings without hygiene and with the constant threat of violence and police harassment.

Latkin et al. (1994), found that location had a significant effect on drug sharing practices. People's safe injecting practices were most evident

where they were in control of their own environment – their own home, and declined in environments which were public, semi-public, friends residences and particularly shooting galleries, which could be run on a for-profit basis or as part of a social network.

2.3 (ii) Drug use economics and housing

Drug demand shows high elasticity to price, i.e. increased prices lead to less consumption and vice versa (Caulkins and Reuter, 1996; Bickel, Madden and Petry, 1998). There is a myth that the dependent addict needs a fixed amount of drug each day, but this is 'pharmacological determinism' (Grapendaal, 1992) that does not relate to the real world. The demand for drugs is also elastic depending upon available income. Resource availability is a precipitant of relapse (McKay, 1995), and users will have good days and bad days dependent upon disposable income. In bad times some will make attempts to increase income by foregoing other expenses, by committing crime, by changing to cheaper, more available substitutes or changing mode of delivery. Some will enter treatment (Bickel et al, 1998), or undergo withdrawal. But in good times the amount of drug used may expand to fit the monetary resources available, particularly when drug satiety is difficult, as with crack.

However, other factors impinge upon disposable income, most notably food and housing costs (Petry, 2000). There are indications that a small sub-group of dependent users would be willing to forego housing and chose to be homeless to maintain their drug use, especially if they have previous experience of homelessness (Petry, 2001). But generally, housing costs are inversely related to disposable income and it can be argued that reducing housing costs frees up more resources for drug use. However, Petry's (2001) experimental study may not be generalisable to the real world. Housing prices fluctuate gradually in varying relationships to incomes, drug prices and price inflation, and for those on benefit in the

U.K. the Housing Benefit system adjusts to difference in housing costs so there is no release of income when housing costs fall.

Owner occupiers could provide disposable income for drug use by utilising their housing assets. For the majority of people housing wealth represents their greatest accumulated asset and is often overlooked in assessments of income as an indicator of socio-economic status (Lynch and Kaplan, 2000). Housing equity that can be called upon by even modest home owners could act to finance drug use by providing security for loans or through release of equity.

It has been argued that the relation of drug use to employment, crime and income generation is more complex than the 'drugs causes crime' argument would support, (Faupel, 1988; Bean, 2002). Changes in employment status or level of drug use might not necessarily be accompanied by changes in criminal involvement, but depend upon the nature of employment, the type of crime and level of pre-existing involvement in criminal subcultures. So that,

> Both crime and drug use are *social* and not merely economic phenomena...In addition to providing a source of income thereby ostensibly reducing the need for criminal income, being employed exposes the addict to opportunities, demands, challenges and even obstacles which differentially affect the likelihood of various types of criminal involvement.
> Faupel, 1988: 477 – 478)

Rengert (1996) shows that residential burglary to finance drug use is most heavily concentrated in areas between the criminal's home and location of drug supply. Particularly in the U.S. drug supply locations are centres of violence, either by surrounding neighbours who feel that recourse to the police will be ineffective, or by users and dealers themselves who, by the nature of their business, have no recourse to law to regulate their trade.

2.3 (iii) Drugs, crime and the built environment

An environmental determinism that would see poor built environment as criminogenic is hard to establish given that any causal relationship would require multi-factorial analysis separating out the influences of a multitude of other variables (ACMD, 1998). The methodological difficulties of successfully achieving this are immense. According to Murie (1997b) there is nothing inherent in the tenure system that is criminogenic. Council housing was not associated with crime in the post-war years – it was generally perceived to be composed of stable, respectable, employed working class families. Rather, Murie (1997b) traces the over-representation of council housing in criminal statistics, both of offenders and victims, through the processes of residualisation, and marginalisation whereby the geography of social housing became more closely associated with the geography of deprivation and the concentration of people more associated with crime, both as victims and perpetrators.

More recently, housing researchers have come to the drugs debate through discussions of social exclusion centring on drugs and crime or in the 'decline of communities' debate centring on regeneration and tackling high crime levels and anti-social behaviour in social housing. Within the regeneration debate drugs are seen to be both a cause and a symptom of neighbourhood decline. However, the potential role of housing on the incidence of crime is still weakly defined and,

> It is possible that in this the impact of housing policy is wholly benign or that housing estates and housing neighbourhoods are merely passive receptacles for processes and activities that are determined elsewhere (Murie, 1997b: 23).

Bottoms and Wiles, (1992), seek to re-assess the importance of housing in criminological theory by utilising structuration theory (Giddens, 1984), and theorising a reflexivity between agency and structure, between individual and place,

> If we want to understand the geography of crime we have to understand how place, over time, is part of the practical consciousness of social actors who engage in behaviour, including actions we define as criminal. The structure of place is central, but it is not external to human agency and must be understood as part of an historical process. (Bottoms and Wiles, 1992: 19)

Social geographers and criminologists today are still to some extent carrying on a debate with the social disorganisation theory of Shaw and McKay (1942) who attempted to answer the question, why do the same areas experience high levels of crime despite population turnover? Stark (1987) summarises the theory, essentially of weak community control leading to increased opportunity and motivation for crime, and dependent upon contributory factors of population density, poverty, mixed land use and transience of population. This body of theory has many problems (Bursik, 1988), but it survives in discussions of the relation between the social and physical environment and deviance, particularly in discussions of social capital (Putnam, 2000; Kawachi, Kennedy and Wilkinson, 1999) and the concentrations of poverty in areas of deprivation (Wilson, 1987).

Baldwin and Bottoms (1976) question the relevance of the social disorganisation model to the British experience due to the extensive influence of the State sector on the geography of housing and consequent distribution of potential offenders. In a longitudinal study of Sheffield council housing estates (Baldwin, 1975; Baldwin and Bottoms, 1976; Bottoms and Wiles, 1986; Bottoms, Mawby and Xanthos, 1989; Bottoms, Claytor and Wiles, 1992), they found no evidence for the social disorganisation theory, as those estates with the highest crime levels were often the most stable in terms of population turnover.

Baldwin and Bottoms (1976) identify housing tenure and its market and bureaucratic operation in the public and private sectors as the key to understanding community levels of crime and its change over time. Since in council housing market price does not reflect social value of

different properties (rents are cross-subsidised and equalised for similar sized properties irrespective of location), other criteria for ranking housing have developed amongst tenants bound up with the reputation and labelling of different areas and their tenants. These are the determinants for the pattern of distribution of offenders in social housing which leads to the 'tipping' of areas towards criminality. The central question of why social housing areas with similar demographic and social class characteristics have different crime rates may be answered by differential operation of housing allocations over time that result in a labelling process of certain estates.

Labelling theories are concerned with the way in which neighbourhood reputation can become a self-fulfilling prophesy as the residents assume behaviour that fits with their pre-supposed image and which is reinforced by agencies such as police and housing departments (Baldwin and Bottoms, 1976). Dilapidated neighbourhoods confer negative status on residents and act to 'push' those with a greater stake in conformity away, and 'pull' those with no choice or who have no interest in the status or condition of the neighbourhood. These labels are often inaccurate and based on historical conditions that no longer apply. The Sheffield study found that labelling affected the composition of those moving into the estate and those moving out in a filtering process whereby some estates would be chosen by those unconcerned with their upkeep. This self-selection was far more influential on the composition of estates than any conscious policy of the housing department in 'dumping' problem tenants.

Foster and Hope (1993) illustrate how housing management practices, which led to high concentrations of the young unemployed had unintended consequences in intensifying criminality and drug use. Far from tower block living being experienced as alienating, a youth and drug subculture developed in a criminal network where the environment was perceived to be lively and full of criminal opportunity, for example by generating a market for stolen domestic items to those in unfurnished accommodation.

U.S. research in this field has particularly targeted public housing as exhibiting high concentrations of crime and drugs and where whole housing projects have been acknowledged to be beyond the control of the authorities. Many people involved in drug sales at these addresses live elsewhere but they are overcrowded with long term 'guests' and periodically may require sweeps of whole buildings to install guards, erect barriers and security doors to regain control (Skogan and Annan, 1994). However, punitive measures are often resisted since they result in increased homelessness and incarceration to a prison system that is at bursting point, and Skogan and Annan question whether environmental changes incorporating defensible space (discussed later) could be effective in the face of the economic and family structure of these tenants whose poverty is their main defining characteristic.

2.3 (iv) The built environment, space and drug use

Environmental criminology is directly concerned with geography and design (Jacobs, 1961; Newman, 1972; Coleman, 1985). The idea of 'defensible space' has been influential in the UK, though it is not without its housing critics (Murie, 1997b), some of whom charge it with environmental determinism in treating the built environment as an independent variable and human behaviour as a dependent variable, and by confusing social variables with architectural ones. It has had some influence on a 'designing out drugs' agenda which prioritises the sealing up of vacant properties, the need for quick turnover in re-lets, the installation of door entry systems, the demolition of abandoned buildings, strategic use of CCTV, better lighting and changes to the physical layout of estates as well as the introduction of wardens and concierges (Robinson and Flemen, 2002). Coleman (1985) rejects one type of determinism, the 'utopian' ideas of the demonised LeCorbusier, but proposes another kind of design determinism whereby social and moral responsibility can be fostered in particular forms of housing

arrangements, notably those based on the Garden City movement and the traditional semi-detached property.

Coleman argues that space on modern housing developments is confused as to ownership, neither private nor public, and consequently will be neglected and used by outsiders who cannot be identified as such because of the size of housing development and the number of people using entrances and corridors. Following on from Newman (1972) she correlates incidence of incivilities such as graffiti, litter and vandalism with number of dwellings per block, number of storeys, overhead walkways, corridor types, entrance types and garage types. Certain design types are demonstrated to lead to anonymity, lack of surveillance and to provide greater opportunity for crime through alternative escape routes. She argues, on the other hand, that defensible space will reduce incivilities and, using the 'broken windows' idea of Wilson and Kelling (1982), will deter more serious crime by reducing incivilities that encourage an escalation to more serious anti social behaviour and crime.

It is argued that signs of incivility in behavioural form such as public aggression, drunkenness and people 'out of it' through drug use, or in physical form such as vacant or run down houses, abandoned cars, litter and graffiti send out signals that the neighbourhood is uncared for. This creates a sense of anxiety and fear among more socially conscious residents and sends out signals to potential criminals that residents have weak control over their environment and may be vulnerable. However, the causal direction of the incivilities thesis can be questioned. Taylor and Gottfredson (1986) conclude that the effects of defensible space on crime levels range from small to moderate unless supported by other reinforcement measures. They indicate that social class and residents' behaviour patterns have more influence on offenders' images of a neighbourhood and hence their willingness to commit crime.

2.4 Housing, Psychological Health and Drugs

2.4 (i) The pathways between housing and health inequality

The positioning of drug use within a public health debate has been complicated by the emergence recently of a greater emphasis on a criminal justice agenda that prioritises coerced treatment in such responses as the Drug Treatment and Testing Order and the Drug Intervention Programme, including drug testing of arrestees and prisoners. However, the public health perspective is still one largely adhered to by drug treatment practitioners, sometimes seeing a criminal justice agenda as incompatible with their approach. There is a fairly large literature on housing and health, although little specifically relating drug use as a health issue to housing.

Research into the pathways between housing and health has largely focused on four areas: the pathological aspects of housing conditions on physical and mental health, (Halpern, 1995); the health selection of sick people into specific areas of housing (Smith, 1990; Smith, Knill-Jones and McGuckin, 1991); the health status of homeless persons, (Bines, 1994; O'Leary, 1997; Robinson, 1998), and the impact of housing processes on physical and mental health, (Nettleton and Burrows, 1998). Recently the idea of 'health capital' has entered the debate. Health capital is a resource that to some extent we are born with but which is a declining resource. We can invest in that capital or withdraw from it depending on our lifestyle, environment, life events and health risk factors (Smith et al. 2003).

Despite a long history of tracing ill health to housing conditions in epidemiology, the explicit pathways between housing and psychological health are only just beginning to be conceptualised (Dunn, 2000). The pathways between housing and drug use are even more under-researched, perhaps in part due to confusion as to whether drug use is a public health issue or a criminal justice one.

Where housing has entered debates about health inequality, housing tenure has usually been used as an indicator of other factors such as social class or income. Housing tenure is associated with differential morbidity and mortality rates, so that public and private renters suffer worse health than owner occupiers, even controlling for social class, (MacIntyre et al. 2003). However, with the growth of low-income home ownership, some owners find that they are impoverished by the demands of the tenure and using housing tenure as a proxy for wealth, income or social class is becoming increasingly problematic.

Recent research tries to disentangle housing from other social processes, for instance to show independent housing effects from social class and income (Ellaway and Macintyre, 1998), and from the more general effects of neighbourhood (Kearns et al. 2000). Ellaway and MacIntyre (1998) found that housing stressors, (overcrowding, poor heating, health hazards), helped to explain the association between tenure and depression, and that the local environment, (crime, neighbourliness, area reputation, amenities), helped explain the association between tenure and anxiety.

Another way of viewing the relationship between health and housing is to see health selection as a determinant of poor housing because those with ill health may be unable to achieve owner occupation due to lack of income, as well as finding it problematic if they do so (Easterlow, Smith and Mallinson, 2000). They may be forced to seek social housing in Britain through the medical priority system which, due to the geographical segregation of public housing, creates disproportionate concentrations of those with physical and psychological ill health in spatial areas of poor housing (Smith, 1990; Lund and Foord, 1997; Meltzer et al, 2002, 1997).

However, discretionary housing allocations systems do not always recognise drug users as a priority (O'Leary, 1997; Shaw 1998), and may lead to their concentration in parts of the private rented sector along with

other socially marginalized groups for whom this offers the only accessible form of housing. A process of social drift is said to operate whereby those with poor health, inadequate income or behaviour problems lose out in the competition for low cost housing and gravitate to the worst parts of the private housing market (Harrison and Luck, 1996). Sick people in these areas become prisoners of space since even with high levels of social capital which may be derived from the immediate neighbourhood they may have little skill or opportunity to escape their surroundings and improve their health and life chances (Granovetter, 1973; Portes and Landolt, 1996; Forrest and Kearns, 1999).

2.4 (ii) Drug use and the social environment

Research into the development and nature of problematic drug use involves some highly contested areas of theory, both within and across disciplines. The range of theory covers the biological, psychological, social and cultural as well as various syntheses of these combined in various levels of complexity (Dean, 2001). The complexity of drug use and its diverse conceptual landscape (due to the large range of variables that may go to make up an individual's pathway to dependence) means that there is, as yet, no all-encompassing explanation for the initiation into drug use or for the maintenance of use that may lead to a progression to problematic use.

Whilst many disciplines have something to say about drug use framed within their own epistemological traditions and paradigms, there has often been either an unwillingness or inability to theorise across academic boundaries, possibly due to the departmentalism of higher education and the way in which research funding operates (Hunt and Barker, 2001). Another factor is the growing, if incomplete, knowledge of the way in which the brain and nervous system are related to external stimuli. Much of this knowledge has previously been firmly rooted in the natural sciences and remained incompletely assimilated into the social sciences.

This is changing, and today the separation of mind and body and distinctions between biology, psychology and social and cultural life are less demarcated. Internal and external environments are seen to be increasingly interrelated in the development of health outcomes in general and health damaging behaviours such as problematic drug use in particular. With more acknowledgment of psychosomatic pathways and less distinction between mind and body the links between environment and health can include the effects of cultural change (McMichael, 1999), social status (Marmot, 2000; 2004), and power (Syme, 2000). Within this emerging perspective there are calls for a re-statement of the importance of the physical and built environment (MacIntyre and Ellaway, 2000), and particularly housing (Dunn, 2002), but as yet the role of the built environment remains surprisingly underdeveloped, often treated as 'background' to other social processes irrespective of the role of human agency in creating that 'background' (Ball, 1986; Berkman and Kawachi, 2000).

This review section starts with the literature relating to pharmacologically and biologically based perspectives on drug use. It then moves on to examine psychological research including theories widely used as the basis for the treatment of problematic drug use. The concept of a risk environment that includes socio-economic factors linked to the built environment and housing status is influential in identifying the initiation and progression into problematic drug use. I then look at socio-cultural and anthropological research before concluding with attempts to integrate all of these models in an overarching theory of the relation of the environment, conceived at multiple levels, to individual ill health, including problematic drug use.

(a) Genetic endowment, pharmacology and neurobiology: their relation to the social environment

Recent research has found that specific neurotransmitters in specific parts of the brain are associated with the positive reinforcement effects of drug use, particularly serotonin and dopamine. The research focus has been on the effects of the administration of particular drugs on particular parts of the brain by the stimulation of these neurotransmitters (Jaffe, 1989). Drug use has been found to be motivated by a positive reinforcement of pleasurable effects (Holman, 1994; Balfour, 1994), and a negative reinforcement to avoid unpleasant states such as withdrawal (Bozarth, 1994).

The balance of positive and negative reinforcers is complex and may be drug-specific and individual-specific. Experiments on animals suggest that reinforcing effects of self-administered opioids are biologically based and that they can be said to be unmediated by (human) culture or (human) psychology. In this sense they are "culturally innocent" (McDonald, 1994) and do not require a specific social or environmental context.

An individual's genetic endowment (genotype) can affect their physical form (phenotype) and there is evidence that certain diseases –for instance heart disease - are linked to both genes and environment. Whether substance misuse has a genetic basis is contentious and is mainly based upon the transference within families of so-called alcoholism using adoption studies (Goodwin, Schulsinger, Hermansen, Guze and Winokur, 1973) and twin studies (Goodwin, 1989; Heath, 1995) that show increased risk of inheriting such behaviour. Both these sets of studies have found links with inherited alcohol abuse, although other studies find no significant links, indeed Valliant (1983) found that children growing up in alcoholic households were as likely to have increased risks both of being teetotal or alcoholic.

This suggests that it seems to be how a person reacts to their environment and how that interacts with their biological nature that is important. This inevitably raises the old issue of how much behaviour is

due to nature and how much nurture? In order to distinguish between the degree to which the genetic component of behaviour can be measured researchers employ heritability statistics (Loehlin, 1992). To establish how genes and environment are linked Plomin, Fries and Loehlin (1977) described three types of correlation between genotype and the environment:

- 'Passive.' A correlation that arises from shared heredity and home environment
- 'Reactive.' Experiences derive from the reaction of others to a person's genetic disposition
- 'Active.' Genetic disposition leads to the selection of particular environments

In order to relate these to the environment and drug use, Dean (2001) gives the following examples,

> Passive correlation would be where problematic drug or alcohol use was facilitated in a drug or alcohol-using family environment by parents who were also predisposed genetically to such problems. A reactive correlation may be where a person genetically disposed towards problematic use developed such problems in response to opportunities provided by friends or associates. Third, active correlations would indicate the selection of problematic alcohol and drug-using circumstances by those genetically predisposed to problematic use.
>
> The analysis of such genetic-environmental links is carried out through the multivariate analysis of covariance between behavioural or psychological traits and environmental measures. (Dean, 2001: 24).

The importance of this for drug use research is that behaviours that were previously thought to be environmental may have some genetic basis. Not only may certain people inherit a predisposition for greater positive and negative responses to substances, they may also inherit a greater

predisposition to construct their environment in terms of risk-taking and engaging with drug-using groups. Plomin (1994) presents the following six hypotheses to advance the progress of research in the genetics/environment debate:

i) Specific genes will be identified that are associated with measures of the environment, for example socio-economic status and other factors thought to be non-genetic in origin. Housing and problematic drug use are strongly linked to socio-economic status (ACMD, 1998) so hypothetically could be linked, however indirectly, to biology.

ii) These genes are most likely to be found in association with 'active' experience where a degree of personal choice is more evident rather than 'passive' environments. Plomin (1994:93) quotes a greater hereditability for life events such as financial problems, marital difficulties and illness/injury. All these factors could, in turn, influence housing access and choice as well as the risk of homelessness.

iii) These genes will be in part associated with psychological traits such as cognitive abilities linking such factors as socioeconomic status and intelligence or socioeconomic status and health. It could also allow for a greater component in the development of drug use that leads in turn to the seeking out of drug-using environments.

iv) These genes will be in part independent of psychological traits. This hypothesis allows for an unmediated relation between genetic factors and drug use, or for an unregistered X factor that could change the relationship. So far the search for a drug-using gene has not materialized conclusively.

v) Genes associated with environmental measures will also be associated with outcome measures so that, for instance, genes may influence say, both depression and drug use as mutually supporting

conditions. These conditions in turn are linked with certain poor quality housing situations (Meltzer et al. 2002).

vi) Genes will be identified that are associated with passive aspects of the environment in childhood, but later in development will increasingly be associated with active experience. This hypothesis is based upon an idea of the mind as developing so that genetics differentially affect behaviour at different life stages.

These complex relationships of biology, psychology and the social environment are still ongoing in research terms but it is clear that a very large number of configurations are possible. Relevant research work would look at, for example, how a strong genetic predisposition to intoxication, a deprived living environment and a propensity for risk-taking could lead to problematic drug use whereas the same characteristics linked to a strong family structure, religious beliefs or physical disability may lead to another outcome. These relationships would be non-linear and be dependent upon both internal and external phenomena.

(b) Psychological research and the social environment

The 'disease' view of addiction, which is dominant in the U.S. and is common in the U.K., stresses an individual psychobiological predisposition to addiction for which there is no cure (Alcoholics Anonymous, 1939). Addicts are said to have a constitutional disposition that is unchangeable and if abstinence is not maintained a progressive disease process will result.

There are considerable doubts about the validity and utility of this model. That the condition is irreversible was first challenged by Davies (1962) in a study of 'alcoholics' who resumed normal drinking. Robins, Helzer, and Davis (1975) found that soldiers who returned from Vietnam dependent on heroin experienced no problems in ceasing their use when in civilian

life, a suggestion of the importance of social environment over pharmacology or biology.

Another component of the disease theory; that tolerance and withdrawal are physiological, is undercut by the demonstration of conditioned reactions of drug users to visual or auditory cues associated with drug use that induce feelings of craving (Childress, McLellan and O'Brien, 1986). This, added to cravings related to internal thoughts, emotions and moods that set up 'triggers' to use have an environmental and psychological component. The term 'craving' has been criticized by Davies (1992) for its suggestion of an autonomous force that cannot be resisted rather than as a choice people make about their behaviour, either to refrain from or indulge. Cognitive psychologists would say that there are reasons for seemingly irrational behaviour, that actions are based upon rational if not always conscious decision-making.

A perennial quest has been for an 'addictive personality.' Nathan (1988) in a review of the literature found that two variables were frequently presented as being correlated with drug abuse; antisocial behaviour in early life and depression. He found that it was antisocial behaviour and not antisocial personality that was often the precursor to alcohol abuse in later life, but that it was a poor predictor given the large number of people not conforming to this pattern. Depression was found not to be an inherent quality leading to drug use in individuals but dependent upon a drug-using lifestyle or the pharmacological effects of drug use.

These doubts about personality and the physiological basis of drug use informing a disease or medical model have led psychologists to look to the effects of the outside world on the mind as a basis for behaviour learned through experience. Several psychological theories are relevant here incorporating the influence of the environment.

(i) Classical conditioning

The idea of conditioned response used in the psychology of drug use derives from Pavlov (1927). Here, in an experimental situation dogs salivated at the presentation of food accompanied by the sound of a bell. Eventually the sound of the bell alone would make the dogs salivate without food being presented. This is the conditioned response, or in drug use terms, cue reactivity and explains why drug users' desire for drugs is stimulated by associations with the act of drug use – the sight of paraphernalia, certain places associated with use or the sight of other drug users. Areas associated with drug use are problematic in the re-housing of users not just because of easy drug supply but because of the visual and associational cues present in the environment. Desire to use can be eliminated by presenting the stimuli, inducing arousal and then terminating the presentation, for example allowing users to go through the motions of the preparation of placebo drug administration without administering the drug, or for drinkers to frequent settings associated with former problematic drinking without drinking alcohol.. This process is known as extinction and the settings and environments associated with use are a major source of cue reactivity.

(ii) Operant conditioning and social learning theory

Operant conditioning derives from the work of Skinner (1938) and explains behaviour as the outcome of rewards and punishments that affect decisions to either continue or desist from certain acts. Reinforcement of behaviour can be positive or negative. Positive reinforcement would be directly rewarding – the 'high' of drug use, or negative – the relief from withdrawal that prompts further use. Punishment can also be positive or negative. Positive in the scenario where drug use causes social disapproval that acts to curtail further use, or negative where drug use leads to social exclusion and reinforcement of use.

Social Learning Theory builds upon operant conditioning and comes from the work of Bandura (1977) as a way of explaining people's decision-

making. Not only do people react to immediate stimuli but their imagination enables them to situate themselves in future scenarios and of using their observations of the behaviour of others in terms of their own projected actions and consequences. This is done usually by a process of modelling, or of mimicking the behaviour of family, peers or cultural icons and role models. In geographical areas of deprivation and high drug use modelling of drug use behaviour takes place that is reinforced by subcultural values and alternative economies (Lupton et al. 2002). The pharmacology of substances interacts with modelling once initiation is passed, tolerance develops and dependence results so that what started as a socially reinforced from of behaviour becomes more of a chemically enforced behaviour within distinct subcultural groups.

(iii) The web of causation and the risk environment

Critics of the widening of causal factors for poor health in general, and drug use in particular, out into the environment warn that it leads to a vaguely defined list of variables characterised as 'risk factorology' (Pearce and McKinley, 1998). They argue that with a lack of specificity about what is meant by 'the environment', the number and complexity of variables runs the danger of becoming meaningless (Vandenbrouke, 1988). However, a great deal of drug treatment practice uses the web of causation model (Lloyd, 1998), incorporating a wide range of individual and social environmental risk factors based on the idea of individuals 'at risk of risks'.

The literature is divided into retrospective studies of problematic users and prospective studies of young people. Retrospective studies depend upon memory that can be faulty, subject to retrospective rationalisation and from which it is difficult to interpret causal direction. Prospective studies require very large samples to capture the rare progression to problematic use and has to start with a cohort of very young children.

These studies are resource-intensive and are mainly from the U.S. which requires added interpretation for U.K. environments.

Some of the major social environmental risk factors cited in the web of causation relevant to housing and drug use would be home and neighbourhood influences of peer and sibling influence and family influence.

(i) Peer and sibling influence

Peer influence has to distinguish between peer pressure and peer selection. Wisely, Gledhill, Cyster and Shaw (1997) found evidence of heroin using initiation through peer groups and a heroin-using partner. Glantz and Pickens (1992) found no clear evidence of the influence of peers in the transition from initiation to problematic use. Hawkins et al. (1992) point to peer rejection as a risk factor. There is little research on sibling influence or on the influence of drug using partners although recent research (Barnard, 2005) indicates a high likelihood in families of more than one sibling that if one sibling develops a drug problem then another one will. Research does not always make clear how this process operates within the domestic environment.

(ii) Family influence

Hawkins et al. (1992) see low bonding in the family as a risk factor. Baer, Garmezy, Laughlin, Pokorny and Wernick (1987) saw family conflict as a risk factor along with parental modelling and peer influence. Parental drug use is associated with initiation to use in adolescents (Kandel, Kessler and Margulies (1978). Hawkins et al. (1992) found family management style such as poor discipline, inconsistent discipline and poor monitoring of behaviour as risk factors. Velleman, Mistral and Sanderson (1997) confirmed this.

To the above can be added other risk factors such as child abuse, poor school performance, life events, criminal involvement and social deprivation. An interactive model can be formulated to place people into

high risk groups with a number of connections to the strands of this 'web' of causation. These would include care leavers, offenders and those from abusive families. Many of these factors correspond with risk factors for homelessness (Kennedy et al. 2000) although causal direction is not always clear. Newcomb, Maddahian and Bentler (1986) found that it was the number of risk factors acting together that determined the likelihood of developing problematic drug use. A key factor of the web is its interconnectedness (Glantz and Pickens, 1992).

The place of drug abuse within an overall behaviour pattern that may include delinquency, poor academic performance, early sexual initiation, drinking, smoking and other risk-taking has led to speculation that there may be a common factor underlying the entire cluster. Zuckerman (1979) suggests a disposition for sensation-seeking. Miller and Brown (1991) propose an underlying disturbance in the regulation of arousal.

(c) Socio-cultural perspectives

Medical approaches which locate the cause of drug dependence in individual physiology have been criticized as politically conservative approaches to health care which seek to individualise ill health and minimise the political and social structure as causal factors. They de-contextualise individual health from questions about the structure of society and distribution of wealth and power (Tesh, 1988).

The de-contextualisation of dependence from the social and cultural environment individualises drug users without taking account of their social networks, their class and power position, their cultural reference points or their place in a chain of drug production, distribution and consumption. Sociologists look for the causes of drug use within the social structure utilising theories of power, inequality and racism (Pearson, 1987). Those from a more anthropological and ethnographic stance would conceptualise drug use in cultural and economic terms,

located particularly in 'hard to reach' populations of street, youth and drug subcultures. Landmark cultural perspectives on drug-using cultures include Preble and Casey (1969), Agar (1973) and Bourgeois (2003). These studies locate drug users in social and economic contexts unlike many studies that view drug use as passive, isolated and de-contextualised.

Hunt and Barker (2001) argue that drug and alcohol studies have been separated institutionally, that biomedical views are paramount and have been insufficiently integrated with social and cultural research. They state that drug research is,

> dominated by two intertwined and pervasive perspectives. A combination, on the one hand, of bio-medical, epidemiologically and physiologically inspired theories of the individual, and, on the other hand, of bio-pharmacologically dominated views of substances (Hunt and Barker, 2001: 170)

They also argue that in the U.S. a politically directed anti-drugs agenda is dominating the research agenda. This research shows a preference for large quantitative studies in preference over more small scale ethnographic work often used to examine cultural and subcultural influences. This narrowing of type and scope of research is geared to drugs as a social problem and, as in the U.K., is generated by criminology.

As well as criminology, the placing of drugs research within a public health model has affected the research agenda. Hunt and Barker (2001) argue that there are many hidden assumptions behind this less authoritarian view of drug use and it contains political, social and moral assumptions (Peterson and Lupton, 1996). These include neo-liberalism that places responsibility for one's health on the individual, concern with risk factors that are viewed as self-inflicted and the regulation and body management within a 'lifestyle' perspective. Armstrong (1995) places these aspects within a categorization of 'surveillance medicine' where

health promotion and education undermine the adoption of unhealthy lifestyles that are seen to be irrational.

A basis for widening the research agenda is to argue that drug use is active, social and involves relations where drugs are an item of production, exchange and consumption. Problems of drug use are not merely inherent in substances themselves but emerge in an interaction between them, the user and the context (Heath, 1992). In common drug treatment parlance it is the relation between drug, set and setting where the ritualistic and symbolic nature of drug use provides meaning to the individual, the group and the wider society.

These meanings inform the commodity nature of drugs and as drugs are produced, exchanged and consumed they acquire different values, from crops exchanged for money to drugs exchanged for money, sex or other services such as housing, from legal to illegal transactions, from agricultural products to consumption items heavily invested with status (Appadurai, 1986). Cultural significance of drugs changes over time and the way elite groups control the perception of drug use is a question of power, whether aristocratic, religious, economic, ethnic or political. Fashion and the ultra discrimination of taste are important (Bourdieu, 1986) and as elite groups cease or change their use and the powerless increase or change their use, it is the latter who find themselves under scrutiny and sanction.

Drug use research predominantly examines lower socio-economic groups and can be said to be collaborating with notions of acceptable and unacceptable behaviour in the choice of subjects. Nader (1972) argues that drug studies need to 'study up' to professional and powerful groups as well as 'study down' to the socially excluded. Drug use research needs to examine the social meanings drug use has for users free from dominant moral or 'common sense' categorizations (Hugh-Jones, 1995).

(d) Social epidemiology: towards a conceptual synthesis

Engel (1977) argued that biological, psychological and sociological influences acted together to produce illness in the form of a 'biopsychosocial' model of disease. Other researchers in the field of the social determinants of ill health used this model and, although not usually able to specify in what proportion each of these influences operates or reacts with each other, some have gone so far as to say that it is psychosocial pathways that 'look increasingly pre-eminent in the cause of differential ill health' (Wilkinson, 1996:175). Wilkinson (1996: 185-187) speculates that the increasing use of legal and illegal drugs as stimulants, dis-inhibitors and relaxants may be a barometer of the psycho-social condition of the population in terms of stress which is differentially affected by social class.

The use of standard epidemiological models to represent patterns of drug use may be becoming inadequate since epidemiology is itself in a process of what some would claim is a paradigm shift (Kuhn, 1970; Susser and Susser, 1996; McMichael, 1999). The term 'social epidemiology' is now being used to describe the psycho-biological pathways through which the environment affects health and health-related behaviours such as drug use.

Social epidemiologists have noted the ways in which such affective states as depression and anxiety mediate the pathways between the wider environment and ill health (Carney and Freedland. 2000; Kubzansky and Kawachi, 2000). They have also looked at such protective factors as social support (Berkman and Glass, 2000) and social cohesion (Kawachi and Berkman, 2000). There has been much work on linking environmental stress to psychobiological processes, particularly involving the immune system. The positive and negative psychosocial pathways between the individual and poor health which they outline, such as low self-efficacy, poor self-esteem, ineffective coping mechanisms, leading to depression and anxiety are all risk factors which have been implicated as

triggers towards drug use. This may explain why those suffering from environmental stress leading to anxiety and depression may self-medicate with alcohol or legal or illegal drugs as a coping response

The concept of 'embodiment' is crucial to the way that the social environment affects individual health. This describes how we may literally incorporate biologically the material and social world, and, in particular, that there may be something in inequality of status and consequent differentials in control over one's life which has a psychological and pathological translation in terms of health (Marmot, 2004). This embodiment is structured by the societal arrangement of power, property, production and consumption interacting with our psycho-biology, and is conceptualised at multiple levels of scale: individual, neighbourhood, regional, national, international. Susser and Susser (1996) call this approach multilevel epidemiology that takes account of different private and public settings as well as life cycle of the individual including early life influences and the effects of cumulative disadvantage (Krieger, 2001). It would mean looking for the reasons for drug use at various levels; including the genetic and molecular, the individual biological and psychological, the social, the population and the global.

Most medical (and drug use) research is focussed at the individual level, but a basic proposition of epidemiology is that to confuse population health with individual health is an individualistic fallacy and that the health of a population is different from the sum of individual behaviours (Syme, 2000). Medical sociologists stress the role of the social environment in shaping behavioural norms because environments constrain choice about behaviour, for instance by making some acts illegal, by providing differential access to engaging in certain types of behaviour and differential means of coping with conditions (Berkman and Kawachi, 2000). In these terms social factors are the reason "poor people behave poorly" (Lynch, Kaplan and Salonen, 1997).

What remains to be fully theorised at a psycho-biological level is how environmental factors such as housing inequality could be transformed into physical and psychological ill health caused by, or resulting in, problematic drug use. One theory is that psychological effects of environmental stressors are biologically embodied through a variety of pathological mechanisms and that these socio-biological translations could go a long way to an explanation of the social gradient of health. According to Tarlov (1996), we all carry multi-gene combinations that can produce disease and these can be conceptualised as 'locks' that are only activated by the operation of environmental and behavioural 'keys'. Environmental factors such as education, housing, income and employment inequality are important components of these social 'keys' to disease in the way in which they produce identity. When identity is being formed various indicators of inequality and social rank constrain choice and opportunity, setting up an expectation-reality dissonance which triggers biological signals, the 'keys' which unlock ill health according to a social gradient,

> The gradient prevalence of chronic disease among the distinctive social strata is related to variations in the strength of the dissonance that results from the identity-expectations-reality interplay. The specific chronic disease that develops in any one individual is determined by that individual's specific polygenic inheritance. (Tarlov, 1996: 86)

Wilkinson's (1996) studies of income inequality and its relation to health show not only a health gap between the top social classes and the bottom but a social gradient of health across social class unexplained by behavioural risk factors. When housing wealth is included, the social gradient of health could be even steeper since housing wealth accounts for the greatest proportion of personal wealth in Great Britain. Whilst Wilkinson's work has generated critical debate (Fryer, 1998), attention on the social determinants of health, and particularly the concept and role of neighbourhood has become part of the debate about social capital (Putnam, 2000). Although the relation between social capital and ill

health remains to be fully conceptualised (Campbell 2000), it contains useful analysis of psycho-social pathways.

Social epidemiologists now propose more complex models to account for health-damaging behaviours at individual and population levels that depend upon multi-levelled analyses of causation. Tarlov (1996) identifies four determinants of health in affluent societies that we can relate to drug use: genes and biology, level of medical care, risk behaviour and social characteristics. He views social characteristics as the 'paramount' determinant of health, a view with which other writers have concurred, (Syme, 1994; Wilkinson 1996).

The economic, physical, commodity and legal conceptions of housing could all have some environmental interaction with the multiple factors said to be influential on the development of problematic drug use, whether biological, psychological, social or cultural. Tracing the pathways between some of these variables, including housing, would be extremely difficult. Although Plomin (1994) has sketched out a research agenda to disentangle biological, psychological and environmental effects, much of the work remains theoretical.

2.4 (iii) The place of housing in treatment

The highly ambivalent nature of drug use, of positive and negative reinforcers which make stopping and starting problematic, means that people are said to pass through a number of stages of change in their drug-using 'career', from lack of concern at their use, to contemplation of change, to motivation and action with a constant possibility of relapse (Prochaska and DiClemente, 1986). The idea of relapse prevention (Marlatt and Gordon, 1985; Saunders and Allsop, 1988), is complementary to this conceptual model. At various stages of the cycle of change housing can provide stability and a positive self-image as well

as access to support and treatment, the lack of which could threaten the recovery process.

Supported housing is central to many forms of treatment (Morris, 1995; Sandham, 1998), and its type and location requires enlightened and creative policies towards users on behalf of housing providers (Town, 2001; London Drug Forum, 1999; Allen and Spriggings, 1999). Housing may need to be situated away from the original area of use to avoid environmental triggers associated with former use, particularly for those leaving treatment facilities if they must confront the same neighbourhood factors which contributed to their using (Heather and Robertson, 1989).

The housing component of drug treatment is part of what is sometimes referred to as the 'distal needs' hypothesis. It is an area of drug research that is academically contested, although it is accepted by most treatment practitioners on a common sense basis. The distal needs hypothesis suggests that treatment aims can be furthered by meeting a range of social needs such as health, legal, housing, employment and vocational needs, which are ancillary to the main treatment regime. In a longitudinal study Fiorentine (1998) found that attending to a range of distal needs made no significant difference to treatment effectiveness, although emerging housing problems during treatment follow-up were associated with higher drug use and resolved housing problems with lower drug use. Joe and Simpson (1991), found no evidence for the distal heeds hypothesis – although they did not consider the role of housing, and Gelberg and Leacke (1993), found that adding social services to treatment made no difference to substance use with those who were either homeless or in extremely poor quality housing. This study, however, only deals with the very bottom of the housing scale, and did not extend the range to cover moderate quality housing.

Many studies do support the distal needs hypothesis. Rutter (1999), found that up to 88% of substance abusers given secure local authority tenancies reported that their abuse had stabilised, reduced, decreased or

remained nil. Several reported stopping crimes of burglary because of identification with householders. Hser et al (1999), concluded that meeting housing needs significantly improved treatment prospects. McClellan et al (1998), found that providing a range of social services including housing advice resulted in significantly less substance abuse and mental and physical health problems at six-month follow-up. Gossop et al (1990), found that what they describe as protective factors, including accommodation, were predictive of successful opiate treatment outcome.

Rehousing has been found to be an effective psychological health intervention (Elton and Packer, 1986), more so than for physical health, which is ironic since it is the latter which the medical priority system in social housing favours (Smith, Alexander and Easterlow, 1997). Rehousing may aid relapse prevention in contributing towards greater self-esteem since confidence is reported to be a predictor of positive treatment outcome (Gossop et al, 1990).

2.4 (iv) Housing, drugs and identity formation

Housing has meaning derived from the status it confers and the way it represents and symbolises the person who occupies it, and is perhaps secondary only to employment status in conferring identity. However, the outside world 'leaks' in, in the form of status aspirations which may be bound up with its style, exchange value, tenure, area and wider status determinants through culture and the mass media. The home is not only a container for our personality (Csikszentmihalyi and Rochberg-Halton, 1981), but a dialogue between ourselves and the wider community (Despres, 1991; Somerville, 1997). 'Meaning of home' studies provide an integrative model of housing use in which external factors such as the housing market, wealth, inequality and education can combine with psychological processes in the formation of identity.

Home can be seen as a psychic and physical place of control, an extension of the psyche as a symbol of one's own identity as we perceive it and as we may want others to perceive us, translated through the physical structure and internal decoration. Owning housing is associated with capital accumulation and represents most people's greatest repository of wealth, but it also provides the self-esteem that may be important to good health, (MacIntyre et al, 1998). Saunders (1990) sees owner occupation as an antidote to a hypothesised normlessness and alienation of modern life. It is said to provide 'ontological security' (Giddens, 1984), or a sense of the constancy of self-identity and the social and material environment.

Kearns et al (2000) comment that ontological security may only be detected in its absence, when people feel insecure, and Gurney (1990) argues that owner occupation is now so differentiated that many people are finding themselves either impoverished or made insecure by the tenure. He argues that those in other tenures are equally capable of deriving security from their housing and ontological security comes from other factors besides housing. The insecurity of low income owner occupation can also lead to disillusionment with the tenure through such factors as fear of repossession through sickness, relationship breakdown or unemployment, whilst the constant aspiration to move up the housing ladder is typified by a restlessness which works against the sense of stability which is said to be a defining characteristic of ontological security (Hiscock et al. 2001).

Despres (1991) reviews interpretations of home gathered from the meaning of home literature: home as security and control, as a reflection of one's own ideas and values, as permanence and continuity, as a social base for friends and family, as a refuge from the outside world, as an indicator of personal status. They are essentially territorial and psychological aspects of home which marginalization as a drug user may make problematic (Town, 2001). To be a homeowner confers status and one's centrality to the economic and social system, one's self-esteem

and identity are reinforced in a way that private renting or council renting are denied, being seen as in some way to be marginally housed. For drug users, the stigmatisation of certain housing types such as hostels, rooming houses or bed and breakfast may be socially marginalizing and exhibit a wide variety of stressors such as noise and overcrowding, added to the fact that communal living arrangements are predominantly located in stigmatised, deprived areas (Lund and Foord, 1997). A sense of shame at one's home environment may affect one's willingness to invite friends to visit, whilst institutionalised housing such as hostels may also make this difficult and affect levels of social and family support.

Stigmatisation of housing type or area can have self-fulfilling effects resulting in and reflected by neighbourhood decline (Wood and Vamplew, 1999). Dissonance may result from what a person's received image of a good home is and the reality of their actual housing, although tenure seems to be less important than neighbourhood in determining psycho-social benefits of home (Kearns et al. 2000). If the absolute quality of housing amenities is less important than their relation to what others enjoy, our positive image can only be maintained if we view our housing status (translated into value, exchange and display), positively in relation to others. Thus our housing can be seen as a major contributor to our sense of identity.

The importance of identity to drug recovery has been outlined by McIntosh and McKegany (2001; 2002). Using the concept of 'spoiled identity' (Goffman, 1963), they propose that the dissonance between one's actual behaviour and circumstances and one's future projections of how one would like to be can be a spur towards recovery. Lalander (2003) reports how a sample of heroin users protected their own identities by negatively labelling the chaotic behaviour and dilapidated appearance of a group of older amphetamine users. They saw themselves as appearing 'normal' and able to function within conventional society, and consequently they did not feel a great sense of stigma because they were able to justify their behaviour and felt that they

were not physically identifiable and did not conform to a 'junkie' stereotype. This situation as use progresses and ageing and physical degeneration takes place may change, leading to self-disgust at one's lack of control and a feeling of being 'unclean' (Lalander, 2003: 2). Recent research has looked at how users with hepatitis C perceive their condition, and finds that they viewed their lives with little self-esteem or feelings of hope. However, their condition was just one aspect amongst many of their 'problem drug user' identity (Copeland, 2004).

Lankenau (1999) describes how homeless panhandlers in Washington adopt strategies to deal with their sense of stigma deriving from the hostility of passers-by. Their stigma management involves controlling their emotions in the face of hostility, managing their appearance (either to project the role of being 'down and out' or of being 'respectable'), and making friendly contact with regular passers-by, particularly those of high status.

In extending the argument of McIntosh and McKegany (2001; 2002), one's physical housing conditions and surroundings may be an embodiment and manifestation of a degraded sense of self, whilst re-housing and a secure home may represent a commitment to new behaviour and a new identity. One's identity has drug treatment implications since an important element in much treatment is behavioural change situated within new images and identities other than those of a drug user. Litman (1986), observes that in the long-term post treatment stage some form of cognitive change needs to take place such as modified belief systems based upon self-efficacy, the belief in the possibility of change (Bandura, 1981), and the ability and confidence to make changes permanent within a repertoire of coping skills. Self-esteem is an important aspect of this. Although the role of self-esteem and drug use is beset by problems of causal direction, and lack of longitudinal research, some writers suggest a strong link from the former to the latter (Kitano, 1989), others a less strong link (Wills, 1994). The

evidence however, is mixed and high self esteem in drug use as well as low may be a complicating factor (Emler, 2001).

Downey, Rosengren and Donovan (2000) examine the role of self-concept in motivation towards abstinence and draw on literature stressing its importance in substance use initiation, the trajectory of a drug-using career, the recovery process and the transition between lapse and relapse. Three main strands of psychological theory are presented as relevant.

Firstly, cognitive dissonance theory whereby self-esteem and one's behaviour are at variance and which can only be resolved by choosing behaviour that is not in conflict with one's expressed attitude. Secondly, self-discrepancy theory postulates three domains of the self: the actual self as presented in one's behaviour, the ideal self which embodies one's aspirations, and the 'ought' self, representing responsibility and duty. Discrepancies between the actual self and the other two selves may result in depression or anxiety, and it is suggested that female users may experience greater inconsistencies between these identity scripts. Women may have gender specific factors to their drug using identities which they may internalise as spoiled in comparison with traditional views of femininity and motherhood, (Wright, 2002; Lewis, 2002). If they have children they may feel failures as mothers and be aware that their drug use may be directly or indirectly harming their children (Klee, 2002; McKeganey, Barnard and McIntosh, 2002; Advisory Council on the Misuse of Drugs, 2003). Klee (2002) found depression to be common amongst drug-using parents added to feelings of low self-esteem.

Thirdly, identity theorists see individuals having conflicts between several simultaneously desired identities – being a drug user may conflict with the identity of parent, responsible worker or citizen and the conflict may lead to the choice of one identity and the lapsing of another. Since one's housing is an expression of one's identity in its location, condition, furnishings, accumulated wealth, it seems likely that it will have an

influence over one's self-perception on a scale ranging from pride to shame. One's housing aspirations may symbolically and practically represent the desired acquisition of new identity traits. These include conformist behaviour associated with being a householder – of taking pride in one's surroundings, of paying bills, of entertaining guests, of getting on with one's neighbours and prioritising long term goals over short term gratification. Indeed, all the things many drug users visualise when they say that they 'just want to be normal'.

2.4 (v) Housing, stress control and drug use

Housing stressors affect physical and psychological health (House, Landis and Umberson, 1988; Kearns, Smith and Abbott, 1992), and exert a significant influence on psychological distress independent of economic, social, geographic and demographic characteristics (Ellaway and MacIntyre, 1998). Smith et al. (1993) found that social support moderated the effects of housing stressors in a 'buffering' effect, although at high levels of stress this was ineffective.

Studies show that those in social housing demonstrate significantly worse psychological health than those owning their homes (Meltzer et al, 2002). The effect seems to be a gradient with those owning their homes outright experiencing less psychological stress than those with mortgages (Cairney and Boyle, 2004). The relatively high morbidity (and mortality) rates in rented housing could be due to specific housing stressors such as noise, lack of privacy, enforced contact with others, overcrowding, dampness and poor heating as well as effects of the wider environment such as incivilities, crime and lack of amenities that are over-represented in this tenure, (Macintyre, MacIver and Soomans, 1993).

Housing stressors cause the body to adapt as a defence mechanism by stimulating a higher physiological arousal, metabolic rate and blood sugar level, whilst lowering the libido, depressing the immune system and

causing negative internal moods. This leads to these adaptive reserves becoming depleted leading potentially to a physiological breakdown (Halpern, 1995). Not everyone will react to stress in the same way – coping abilities and the buffering effects of social support will be important, as will cognitive interpretation of the cause and effects of the stress. Housing stressors have a cumulative impact on health combined with other major life events and daily economic and status inequalities. These may be moderated by neighbourhood effects (Elliott, 2001), and perception by the residents of their area can impact upon ill health (Sooman and Macintyre, 1995).

A key factor in psychological stress is lack of control and unpredictability of the stressor (Sapolsky, 1998). Precarious housing is a source of stress (Kearns et al, 1992), and council tenants have been perceived to have less control over their physical surroundings than owner occupiers. Renting has been perceived as a tenure of insecurity and lack of autonomy (Saunders, 1990), although Kearns et al. (2000) show that it is the context of housing which is important to feelings of psychological well-being, that is the neighbourhood and social relations. However, security of owner occupation is now much more problematic and the incidence of mortgage debt and threat of incipient homelessness, together with the stress of an unsympathetic marketplace is a form of housing insecurity leading to psychological ill health evidenced by the incidence of depression and anxiety (Nettleton and Burrows, 1998; Easterlow et al 2000).

Strain theory (Agnew, 1999) is a social psychological approach that incorporates aspects of stress research combined with subculture theory and opportunity theory. It describes certain types of social environments as being more conducive to crime since they provide more potential offenders and victims – for instance, overcrowded housing conditions lead to more time spent on the street and more opportunity for crime. High crime areas attract and retain individuals under stress, produce stress and foster criminal responses to stress as well as anger and

psychological distress. The physical environment and signs of neighbourhood incivilities are seen as examples of negative, strain-producing stimuli which are mediated by cognitive coping strategies dependent upon such things as levels of social support and status.

The relation of housing stress specifically to drug use is an under-researched area which needs to target psychological health, stress management and coping responses. The relation of psychological stress to drug use is a paradoxical one – drug use can relieve anxiety, and yet when the drug is withdrawn anxiety levels rise, contributing to a need to repeat the behaviour (Stockwell, 1989). Whilst stress management and alternative coping mechanisms constitute a major part of treatment, the role of stress and drug use as self-medication and a coping response is not straightforward and has been shown to be inconclusive.

The self-medication hypothesis is derived from psychiatry (Khantzian, 1985), and indicates that a person's 'drug of choice' is not chosen randomly, but to address particular internal conditions,

> Rather than simply seeking escape, euphoria or self-destruction, addicts are attempting to medicate themselves for a range of psychiatric problems and painful emotional states. (Khantzian, 1985: 1263)

The theory is used to explain heroin use as a calming, mellowing effect to deal with "the disorganising and fragmenting effects of rage and aggression" (Khantzian, 1985: 1259). This self-medication is applicable to affective disorders, particularly depression, and has been widened to include more overt forms of mental illness and is used in conjunction with the concept of dual diagnosis. It has more generally been widened to explain drug use as a coping mechanism in the homeless, particularly rough sleepers, where drugs are used to cope with an absence of basic facilities, stress from threatening and stigmatising situations, and absence of social support to act as a 'buffer'. But drugs (either legal or

illegal) may be used by those in other forms of sub-standard housing to cope with other stressors in a poor quality environment.

The literature on coping outlines a number of relevant factors. Firstly, the severity, controllability and chronicity of the stressor over time and the subject's perception of an event or condition as stressful (Lazarus and Folkman, 1984). Secondly, the concept of self-efficacy, or belief that one can manage a stressor, the absence of which engenders feelings of helplessness and hopelessness (Bandura, 1977). Thirdly, the utilisation of a repertoire of coping skills and strategies of decision-making such as problem-solving, positive re-appraisal and the employment of social support. When these coping resources are insufficiently operationalised drugs may be recruited to bolster strategies of survival rather than recreation. In clinical terms this is a 'neurotic' rather than a 'mature' coping response that can only address the symptoms rather than the causes of the stress (McCrae, 1992).

Hansell and White (1991), found no basis for the hypothesis that adolescents use drugs to cope with psychological distress but conclude that drug use contributes to psychological impairment over time. Hall, Wasserman and Havassy (1991) found no basis for stress in terms of life events, negative moods, physical symptoms or hassles as a predictor of drug use in cocaine treatment patients. Wasserman et al. (1998) conclude that "the role of stress in precipitating relapse remains unresolved" and point out the problem of stress reports in that relapse itself creates stress which may influence retrospective reports of stress as a justification for use. This is confirmed by O'Doherty (1991).

However, other studies do confirm the stress hypothesis as a factor in facilitating the development of drug use. Duncan (1997) found that drug dependent adolescents suffered significantly higher levels of life stress in the year preceding their first illicit drug use, supporting the idea of a stress reduction theory of drug use. Duncan views drug dependence as the result of a combination of the following: an individual with poor coping

skills, a stressful and unsupportive environment, a drug agent used to reduce stress and negative emotional conditions and drug-using peers who facilitate supply. Stockwell (1989) and Piazza and LeMoal (1998) support the stress hypothesis. The latter theorise the role of stress as an inhibitor of processes that normally operate to control the rewarding effect of a stimulus, leading to greater impulsivity, and inability to delay gratification. As there is no research evidence for a specific link between housing stressors, negative psychological states and illegal drug use, this pathway could be further investigated. An alternative view of stress is that with repeated exposure, lower socio-economic groups become de-sensitised to stress and develop better experience-based coping mechanisms (Kessler, 1979; Wheaton, 1982). This could also apply to drug users.

2.5 Conclusion

This literature review has covered the breadth of research on drug use and housing. Some of the research areas could only be explored given unlimited resources of time, labour and finance. Some of the research on the environmental causes of ill health is at a developing stage and together with studies of neighbourhood effects, they face methodological challenges in isolating environmental and social variables that affect human behaviour. Nevertheless the review provided specific avenues for investigation of the effects of housing on the situation and behaviour of the research sample and determined to some extent the focus and structure of the fieldwork and analysis.

I particularly identified a gap in the literature that I endeavoured to fill in Chapter Four. This was the literature on the commodity nature of drugs and housing and how they function together as part of a wider economy. Some research has been done on this in the US (Petry, 2000; 2001), but I think the research presented here breaks new ground in relating this to the UK situation.

Particularly important to the research was the literature on the hierarchy of housing that forms the main arguments in Chapter Five. Allied to this was the theory of a 'drift down' effect whereby drug users come to occupy progressively worse housing conditions as their drug use progresses. The research gave me an opportunity to examine whether there is a relation between particular housing forms and locations and levels of drug use and whether the drug use biographies indicated a 'drift down' amongst the sample..

Another key area of research from the literature that informed Chapter Six is the idea of a 'spoiled identity' first used by Goffman (1963) and which I have developed to include housing's ability to confer status, and the importance of this for the identity of drug users as they come to terms with the formation of a non-drug-using identity.

The structure of the research findings roughly follows the structure of the literature review. It starts from a macro level using the literature on the economics of the housing market and the operation of the social housing allocation system. It positions the research sample within these structures of housing provision and highlights the extent to which they are excluded from mainstream housing provision. It then moves to the social network and domestic level to analyse social relations and how housing impacts upon these. These investigations can also be seen against the background of the literature on crime and drug markets within a wider economy that includes housing. Having started at the macro level the research concludes with a more psychological focus on drug-using and non drug-using identities, particularly using Goffman's idea of 'spoiled identity' and the implications this has for treatment. The literature on psychological health and housing is particularly relevant here.

Having reviewed the relevant literature I now go on to present the research design and methods used to explore some of these identified links between housing and problematic drug use.

CHAPTER THREE

RESEARCH METHODS

3.1 Introduction

This chapter explains the methods used in the research from the design through to the analysis of data and presentation of the findings. It includes descriptions of the research instruments used, the sample areas chosen and the participants. It describes the processes involved in the fieldwork and in the data analysis stage. Using references to existing research literature it outlines some of the potential difficulties in conducting this type of research and the methods used to minimise them. It also points out the limitations of the research and how ethical issues were resolved.

3. 2 Research Design

The task in identifying an appropriate research design was to select one that allowed me to put housing, a factor largely neglected by previous research, at the centre of the enquiry and to examine how it might be linked with other factors such as levels of drug use. My reading had persuaded me that it was impossible to demonstrate that housing was a causal variable in the production and maintenance of drug misuse. This was because of both the methodological difficulties of quantifying and isolating housing from the numerous other variables that probably go into producing problematic drug use. But also, from a practical point of view, the small sample and limited resources I was able to muster in a PhD project would not be able to generate definitive conclusions.

I chose a mainly qualitative design because in order to address the research question I found it necessary to obtain the accounts of drug users themselves, not only concerning the complexities of their current

drug use and housing circumstances but a life history of their drug and housing biographies which is unavailable from any other source.

I proceeded on the basis that the circumstances of problematic drug users were likely to be the result both of the political and administrative structures they found themselves confronting, many of which were beyond their control, and also the agency they brought to bear on those structures. Of particular significance was how they negotiated their ways around the various sanctions and bureaucracies, and what attitudes and strategies they developed to both maintain their drug use and maintain their housing. The design I chose would therefore need to be flexible and gain sufficient depth to capture the motivations, opinions and feelings of individuals as well as a sense of the context in which their lives were framed.

I chose a cross sectional design whereby I could carry out fieldwork at a number of sites so that I would get a broader range of data to contrast and compare. This was achieved by semi-structured interviews with forty current and former problematic drug users in three contrasting areas in the North. The advantage of this design is that it allows for comparisons between groups and individuals and is relatively efficient to carry out by a single researcher. However, it has the disadvantage that since it is carried out roughly at one point in time, it fails to capture change over time. I tried to minimise this disadvantage by the construction of a retrospective housing and drug use history for each individual whereby respondents reported on their past and I plotted significant events and changes in their lifestyle along a time line from their birth to the present. This method reveals a greater complexity of housing and drug use over time (May, 2000).

I also needed to gain some insight into local structures of housing and drug service provision, and this was achieved by semi-structured interviews with staff from twenty agencies in the public, private and voluntary sector. All interviews were tape recorded and transcribed.

I introduced quantitative methods to the research in the form of a questionnaire for the users based on the Maudsley Addiction Profile (Marsden et al. 1998), which is designed to be briefly administered and to gain information on current and recent drug use, health and other social circumstances. This gave me quick access to a large amount of basic information about the interviewees and allowed me to carry out some analysis using SPSS. An analysis of the quantitative results suggested further lines of enquiry to be pursued by the qualitative methods, particularly regarding the idea of a 'hierarchy' of housing. It also provided a method of triangulation for the qualitative data. Whilst feeling that this lays me open to charges of methodological impurity and lack of nerve in not relying purely on qualitative methods, I generally agree with McKeganey (1995) that a divide between qualitative and quantitative research in the addictions arena is "an unhelpful divide", but that qualitative researchers need to carry out their fieldwork and analysis in a systematic and demonstrably rigorous way.

There were both theoretical and practical reasons why I could not rely solely on a quantitative method. On a practical level, there is very little existing information from quantitative datasets regarding the housing of drug users, and any information of an individual, longitudinal nature which may be held by drug or housing agencies, and which would be useful, would not be open to me for reasons of confidentiality.

Whilst large, relevant datasets did not exist ready-made to be analysed for my purposes, a further practical issue with rejecting a purely quantitative method was the small size of any quantitative sample I would be able to create. Whilst a relatively small qualitative sample can achieve sufficient depth so that the accounts of interviewees can resonate in terms of generalisability to other settings, a small quantitative sample would be unlikely to generate statistically meaningful data.

On a theoretical level, I rejected the option of a purely quantitative method as being less likely to capture the often complex and sometimes chaotic lives of drug users. Qualitative methods are useful for capturing and describing dynamic and complex processes, and allow for digressions at the data collection stage that often lead into areas of significance not suggested by the initial research proposal. The standard quantitative questionnaire has a tendency to initially categorise answers into a narrow field, having the effect of inhibiting disclosure rather than encouraging it, and of running counter to the process of discovery that is a feature of the qualitative method. This process of discovery and a willingness to listen to extraneous narrative can be more time consuming but elicited a richer quality of data. It can also lead to a greater rapport between interviewer and interviewee that is vital in soliciting information from those involved in illegal acts.

Assumptions about the relationship between housing and problematic drug use were forestalled so that there was no attempt to establish a hypothesis in a deductive way. My basic method was that of Grounded Theory (Glaser and Strauss, 1967: 45). This is a process of data collection for generating theory whereby the analyst cumulatively collects, codes and analyses the data, deciding in an inductive way what data to collect next and where to find it in order to develop theory as it emerges. This has obvious differences with quantitative methods,

> Unlike the sampling done in quantitative investigations, theoretical sampling cannot be planned before embarking on a grounded theory study. The specific sampling decisions evolve during the research process itself. (Strauss and Corbin, 1990: 192)

Concepts were generated in an ongoing way at the data collection stage and finalised at the data analysis stage. For instance, during the research period I became particularly interested in the living arrangements of those in houses in multiple occupation (HMO's) where large Victorian houses had been sub-divided into single units, often with shared facilities. I was interested in the way these arrangements affected

social networks and could facilitate the spread of drug use. Consequently this became a more prominent theme in my questioning and I went back and re-interviewed three people living in HMO's to gain more information about this.

However, it must be stated that it is impossible to come to data with no preconceptions and that these will be reflected in the choice of area of study and interview framework. I brought to the research my work experience and academic study and needed to be aware of not forcing the data into inappropriate categories which they could not sustain in order to suit preconceptions.

The research was financed by the Economic and Social Research Council and took place from October 2002 to September 2004. Interviews were held between March 2003 and July 2003, with some follow-up interviews in December 2003. Transcription of the tapes was completed in September 2003. Initial data analysis ran concurrently with data collection and detailed analysis and theory-building developed after all tapes had been transcribed.

3.3 Research Instruments

A number of research instruments were used:

- Qualitative interviews with local drug and housing agency staff
- Qualitative interviews with forty current and ex drug users
- The construction of a life history for each drug user concentrating on their drug, housing and social history
- A quantitative questionnaire based on the Maudsley Addiction Profile (Marsden, J. Gossop, G. Stewart, D. Best, D. Farrel, M. Lehmann, P. Edwards, C and Strang, J. 1998) concentrating on current levels of drug use and physical and psychological health

- Secondary data such as local newspapers and published material on the incidence and prevalence of drug use locally

3.3 (i) Agency interviews: the locations and sample

I chose to carry out the fieldwork in three locations across two local authority boundaries. These were the areas of Dockland and Sandport in the Northborough local authority region, and the city of Newcity. The areas were chosen because they have distinctive features that I thought it would be useful to compare and contrast in terms of their housing profiles. The structures of housing provision in these three areas are described in detail in chapter four, but suffice to say here that their different profiles as regards the private and social rented sectors made for some interesting comparisons.

I gained contacts with the respective agencies by initially arranging meetings with the Drug Action Team Coordinators for Northborough and the Newcity regions and they provided me with lists of people on the respective Drug Reference Groups who they thought might be helpful.

My reasons for interviewing agency staff were firstly to gain an insight into the local situation from an administrative context, taking in such aspects as finance, policy, service priorities, relationships between agencies, problems with service delivery and implementation of government policy, which could have a bearing on the research question. Drug users themselves were unlikely to be aware of many of the more bureaucratic processes and only articulate their effects at the level of service user, most likely when a process had not delivered a service to them as they thought it should.

Secondly, I crucially needed to gain access to a sample of users, since this would provide the bulk of my research data, and to gain access to a sample I would need the cooperation of agency staff since they acted as

gatekeepers to the drug users themselves. So, at the end of the agency interview I made my request for access to their clients after I felt the preceding conversation had established my credibility, that I had demonstrated a suitable interest in the agency's work and I had put a good case for the integrity and necessity of the research.

3.3 (ii) Agency interviews: the process

A list of participating agencies can be found in Appendix One.

Once I had identified my target sites, I sent information about the research and a covering letter requesting an interview to the Drug Action Team Coordinators for the respective areas. They provided me with lists of agency representatives who were key personnel in the fields of criminal justice, housing, health and drugs, some quite senior in management and some at the front line dealing with clients. I then wrote to these contacts and if no reply was forthcoming this was followed up with a telephone call.

Non-response was most frequent with statutory agencies, notably housing and prisons, but other agencies were able to provide information to fill in any gaps in information. The voluntary sector proved to be more responsive. It is interesting to speculate as to the reasons for non-response: local authorities were going through a period of change with the introduction and coordination of Supporting People, the new funding regime for special needs projects, and it was clearly a very busy time. Several agencies were at first quite nervous about what purpose the research would be put to – one housing association asked to see the report before anything was published, one quite bluntly asked "What's in it for us?" and one agency asked for a list of questions before agreeing to the tape being switched on. Some agencies quite simply did not reply for whatever reason.

In conducting the interviews, some senior staff were very generous with their time and provided excellent background material, as I was unfamiliar with some local conditions. All agency staff I spoke to agreed that housing was a major problem for drug users. Senior staff were generally more helpful and interested in the research than the junior staff and possibly were less concerned about openly airing their sometimes-critical opinions because their seniority gave them the security and licence to do so. Access broke down on a couple of occasions when senior staff withdrew and more junior staff were the facilitators in terms of arranging subject interviews. This highlights the idea that access is not just an initial negotiation, but has to be continually re-negotiated. There was little evidence of obstructive gatekeeping, although non-response may effectively have been used as a method of gatekeeping to avoid a perceived potential criticism of services.

In terms of 'presentation of self' which is judged to be important in gaining the consent and trust of those being studied, some agencies seemed to be impressed that 'a University' was interested in their work. Others (non-respondents?) may have seen research as irrelevant or threatening. Rather than stressing my University links I usually tried to emphasize that I had work experience in several relevant areas and displayed empathy with the work of the agency, even if in some cases their aims were not to my taste.

3.3 (iii) User interviews: the locations and sample

The sample was drawn from the locations in table one. Apart from the snowball sample I obtained these samples after interviewing the agency representatives. I was dependent on them as gatekeepers to allow access to their clients as well as to provide a convenient interview location.

Table 1. Breakdown of respondents by agency location.

Agency location	*n.*
Communities Against Drugs, Dockland	1
Supported hostel, Dockland	9
Drugs advice and treatment agency, Sandport	7
Church homeless project, Sandport	1
Night shelter, Newcity	5
Supported hostel, Newcity	1
Snowball sample, Sandport	16

The sample cannot claim to be representative of all drug users, only those at a particular location at a particular time. However, the qualitative interviewing was based on theoretical generalisability rather than the statistical generalisability of quantitative methods. Consequently, the conclusions are presented and must be replicated or not in other samples and areas depending on the robustness of the findings. This replication logic means that,

> If the experimental results hold up under different conditions and with different types of experimental participants our confidence in the generralizability of the results grows. Where the experiment is repeated with different samples and under different conditions we get more of a sense of the limits of generalizability. If an experiment only works once with a particular group of people and the results cannot be reproduced we would have little confidence in its findings or its applicability more generally (deVaus, 2001: 238).

It is only when other researchers in other areas come to similar conclusions and validate the theories generated in the current research that one could be confident of a high degree of external validity.

The sample consisted of thirty-one men (77.5%) and nine women (22.5%). Data from the Drug Misuse Database (1996 to 2000) suggests that nationally, of drug users accessing services 26% were female and 74% male, a male/female ration of 2.9:1 (Advisory Council on the Misuse of Drugs, 2003). In the area including Northborough the most recent figures show an unusually high proportion of female users entering treatment in a ratio of 1.9:1 (Beynon, McVeigh and Bellis, 2004). For the Newcity region the figures were 70% male and 30% female for both ongoing and new clients (Donmall, Millar, Jones and Morey, 2002). However, my sample contained a significant number of people not in treatment. Of the thirty-one males interviewed, fifteen were not in treatment, three because they were abstinent. Of the nine females interviewed, six were not in treatment, all of whom were currently using.

Five respondents were not included in the final sample because as the interviews proceeded it became apparent that they did not have a history of problematic use. They were 16 and 17 years olds living in a young persons' hostel in Newcity and as the interviews progressed it became apparent that their drug use was limited to occasional cannabis use. Having arranged the interviews through the hostel manager there had clearly been some confusion as to what I saw as 'problematic drug use'. He interpreted cannabis use as falling into this category and consequently arranged for five young people to be interviewed. Although it quickly became apparent that they did not fit into the profile of the type of drug user I was looking for, it would have been awkward to cancel the interviews as they had gone to so much trouble and so I conducted the interviews in the knowledge that they would probably be useless for the research.

It could be, however, that this group may go on to develop problematic use at a later point in time since some of them exhibited many of the risk factors said to be associated with the development of problematic use, such as homelessness, family breakdown and poor educational attainment leading to poor career prospects.

When I had completed my agency interviews I had twenty-four interviews. But I was confronted with three problems. Firstly, I did not have enough respondents. Secondly, all the interviewees were in treatment, and thirdly, I had only interviewed two women. An attempt to advertise for a sample of users not in treatment initially met with little success. I prepared and distributed a large number of flyers with my contact number and an offer of a £10 gift voucher. This produced only one interviewee. However, the snowball sample using other contacts eventually reached sixteen (bringing the total to forty), due to the help of three drug users who can be characterised as 'key informants' or 'contact tracers' (Power, 1995), and who proved to be useful in introducing me to users not in contact with treatment agencies.

This proved to be a substantial and significant part of the research since it avoided undue reliance on agencies as locations from which to draw a sample. I felt that there was a contrast between these users and those in treatment when I sometimes got the impression that their responses took on the particular philosophy of the treatment project. A contrasting group was necessary because users in treatment will be a reflection of the availability of treatment services in the area. These locations will also neglect those users in the community for whom treatment is under-resourced, who are waiting to go into treatment, or who are under-represented in treatment regimes generally.

The snowball sample gave me valuable insights into the social networks of drug users. Several drug users lived in flats in houses in multiple occupation (HMO's) and I interviewed two pairs of brothers, a brother and sister and two pairs of partners. Whilst these close social connections

are not desirable from a random sampling perspective, they are useful in examining the way in which particular housing forms affect the social networking and behaviour of users.

The chains in the snowball sample only extended to three stages and therefore did not give the added diversity afforded by a larger chain. This lays the research open to the charge of unrepresentativeness in that users outside this social network would not be represented. However, I think the number of users from other locations is sufficient to ensure that a reasonable cross-section of users is represented. In the end the sample either omitted or did not adequately represent some groups I tried but failed to recruit: female sex workers in Newcity, users holding down jobs, those who had left residential treatment and those who had given up drugs without treatment.

3.3 (iv) User interviews: the process

The agency interviews focused on service delivery and public policy at a macro and local level whilst the user interviews focused on the individual within a local context. The user interviews were more informal than the agency ones, and the discussions differed in that they contained slang, swearing and drug argot. Whilst some agency staff used street slang their discourse was generally couched in managerial and bureaucratic terms, although this was less the case with the voluntary sector, and less in drug agencies than housing agencies. Whilst agency staff understood the research question, some users did not really see any relationship between housing and drug use. One possible explanation for this is the powerful legacy of the medical or disease perspective, which individualises drug problems with little acknowledgement of environmental factors, so that users see their behaviour as having no relevance to where they are living. This will be discussed in more detail in the concluding chapter.

The interviews were based on an outline covering aspects of drug use and housing (See Appendix 2). They were conversational in manner, allowing for a more empathetic approach, which produced frequent digressions that sometimes revealed valuable information. Interviews were tape recorded and varied in length from about thirty to ninety minutes, with an average time of about forty-five minutes. One interview was poorly recorded and produced only a partial transcription. One tape lacked a beginning because I did not press the record button and a couple of users with strong regional accents required repeated re-playing of the tape to enable transcription. Recording quality was improved by the purchase of a tie-clip microphone, although short parts of some tapes, particularly those recorded in the open air, remained undecipherable.

There are recognised difficulties in sampling 'hidden' populations of drug users who may be suspicious of researchers and wish to keep their behaviour as anonymous as possible (Lee, 1993). Some may have erratic lifestyles, have difficulty in concentrating for long periods and may be under the influence of drugs, be lethargic or hyperactive, have little interest or insight into what they are being asked or be withdrawing from drugs and be preoccupied with their next use. Six interviewees did not turn up for the interview. I can only speculate as to the reasons. Four of these were women and there could be reluctance on the part of these users to reveal personal details to a male interviewer, added to the greater stigma women users feel about their drug use (Wright, 1996).

Because of these factors a certain flexibility was required especially since the location of the interview was rarely ideal – for instance I interviewed the majority of the snowball sample in the open air in a churchyard. Interviews in people's homes, of which there were six, were sometimes accompanied by partners or friends which could have inhibited the interviewee, although it did sometimes provoke more of a group discussion which was useful in itself. Although the interviewees showed no sign of discomfort I was aware when interviewing one woman whose

partner was present that it might be diplomatic to skate over her previous relationships. It was not generally practical for me to control the interview location. When I visited somebody's home it was largely a journey into the unknown in terms of the layout, recording conditions and how many other people would be present.

Interviews held in the offices of agencies were more straightforward although not immune to the telephone ringing, interruptions from staff who wished to use the space or to the general feeling of chaos under which many hostels operate. The co-operation of staff in getting some interviewees to record an interview was vital. The agency users were chosen by the agency staff and there was no means of ensuring a balanced sample. It was really a case of randomly interviewing those available and willing.

3.3 (v) Housing and drug use biography

Few studies of people's housing incorporate a longitudinal dimension, so that current housing can rarely give a picture of the dynamics of a person's housing 'career' or 'trajectory' and will misrepresent its complexity over time. This is particularly true of drug users whose over-representation in council housing and the poorer parts of the private sector, as well as institutional housing and hostels, may hide a past history, which does not conform to their present circumstances. This could be because of a 'drift down' effect whereby as drug use increases users come to occupy progressively worse housing conditions. This theory is discussed in chapter four.

May (2000), found that the 'drift down' theory - whereby those with limited finances, social skills and personal problems (such as drug use), are not equipped to compete for mainstream housing - needed a certain amount of qualification. He found that homeless men had much more episodic housing histories, with movement in and out of various types of

accommodation, and that periods of homelessness were often very short in between longer periods in settled accommodation. Constructing a qualitative housing biography can represent this process and it theorizes individuals as agents with motivation and a certain amount of choice, so that housing status is a dynamic process of negotiation and confrontation in which people can challenge institutions as well as be constrained by them.

Ideally, in constructing a longitudinal housing continuum for drug users, one would initiate contact and then monitor their subsequent housing moves. This would ensure a high degree of accuracy and detail in the gathering of data, avoiding problems of poor recall and missing data. However, the high degree of mobility of this group, the time needed to conduct such a project and the possibility of unacceptable attrition rates renders this method problematic. Alternatively, one is forced to use retrospective accounts, asking interviewees to outline their housing history and trace as accurately and in as much detail as possible their housing and drug careers working from the past up to the present. In using a historical framework there is an undeniable problem of recall as well as the reliability of accounts and retrospective rationalisations of drug use. There are also problems in recording levels of drug use due to variations in purity and the size of drug doses. However, in the U.K. the recording of drug levels is made somewhat easier since the purity of illicit heroin and cocaine have largely remained constant (Strang, Griffiths and Gossop, 1997).

In order to capture the complexity of housing careers I constructed a housing biography for each interviewee based upon the interviews. Interviewees were asked to recount their current housing conditions, length of stay, satisfaction and any other relevant information. They were asked about their future plans as regards accommodation as well as other factors such as employment/training and personal plans as appropriate. Then they were asked to start at their childhood home and go through their various accommodation moves, including periods of

homelessness, stays in prison, sharing accommodation, stays in hostels and night shelters as well as managing their own accommodation. From the transcripts I constructed a timeline for each person working up to the present taking into account such factors as length of stay, reasons for leaving, ability to manage, satisfaction etc.

Using their housing as a marker, as each of these housing moves was recounted I asked about their level of drug use and other factors such as employment, criminal involvement, social contacts, health etc. in order to try and establish whether certain types of housing situations were associated with variations in drug use and treatment, and what role housing played in their lives both practically and psychologically. Ideally one would desire a retrospective account of drug use to have the same degree of accuracy and detail as a current account of circumstances, but the difficulties associated with recalling drug use accurately over time means this would not be practical. So, a general indication of level of use was gained and linked to the various accommodation moves, including any relevant factors such as the perceived effect of drug use on managing accommodation, effect on health, method of drug administration and criminal justice involvement.

The rationale for using housing as a basis for a biography is that people generally can use their housing history as a framework by which they can recollect other aspects of their lives. If we can remember where we were living this might enhance our ability to remember other factors associated with that accommodation – our neighbours, where, and if, we were working, who we were living with, whether we were happy, and, for this sample group, what our drug consumption was like, so that housing can give a "shape" to our memories and our moves in and out of accommodation act as markers for retrospection.

3.3 (vi) Current and recent drug use: The Maudsley Addiction Profile

Current and recent drug use was recorded by means of the Maudsley Addiction Profile (Appendix 3). This is a research instrument developed to monitor treatment outcomes but it serves as a core research instrument that can be modified to suit the specific research question (Marsden et al. 1998). It records a number of aspects of the interviewee's life over the last 30 days, particularly levels of drug and alcohol use, risk behaviours, physical and psychological heath, personal and social functioning and criminal involvement.

I adapted the questionnaire to suit my own purposes, leaving out questions about sexual behaviour ("Number of people had sex with and not used condom") as I felt this was potentially embarrassing and likely to cause offence, especially to women who may have felt I was being unduly prurient. However, as Lee (1993) points out, difficulties in obtaining sensitive information on sexual matters may have more to do with interviewers feeling uncomfortable about asking questions than with the interviewees feeling embarrassed. In retrospect I could have been less inhibited, although this may have run the risk of giving offence.

The questionnaire has been developed to be administered briefly and in fieldwork testing of the questionnaire by Marsden et al. (1998) an average length of time for administration was twelve minutes compared with forty-five minutes for other treatment outcome instruments. The thirty-day period is a compromise between short periods, such as seven days, which could fail to capture episodic use, and longer periods, such as six months, when recall becomes a problem. Scoring is assessed by means of a number of response cards from which the interviewee chooses an appropriate answer. For instance, in measuring the experience of psychological health problems such as suicidal thoughts, the interviewee would choose an answer on a scale from "never

experienced" to "rarely experienced" to "sometimes experienced" to "always experienced". These answers then receive a score, which measures severity of health symptoms. In testing of the questionnaire by the authors to measure validity it showed high concordance with urine analysis as far as the self-reporting of drug use was concerned.

I found the questionnaire easy to administer and it provided a useful base instrument from which to digress and discuss with interviewees matters suggested by the questionnaire. It acted as a useful triangulation method for elaborating on subjects brought up in the interviews.

3.3 (vii) Secondary data

Published material relating to incidence and prevalence of drug use in the respective areas is available. Significant texts were the most recently available data on treatment in the relevant areas, as well as numerous local studies and agency annual reports. These official documents provide another dimension to the research by locating it within relevant macro factors such as demographics, crime rates, unemployment and drug and housing policy at a national and local level. Most importantly, whether drug users realise it or not, these macro factors work their way down to street level affecting the supply and price of drugs and the availability of housing.

Local newspapers were also a source of information, particularly focusing on criminal justice, although they were not without their limitations. Although their level of analysis was never theoretical they did provide easily accessible background into some local issues I would not otherwise be aware of.

3.4 Validity and Generalisability

3. 4 (i) Internal validity

(a) Truthfulness

Internal validity is problematic when the behaviour under study is socially disapproved of and illegal, and may be heavily dependent on who is asking for the information and for what purpose it will be used. For this reason studies conducted through the criminal justice system or treatment facilities may be viewed as suspect since users may feel they have something to gain or lose depending on the answers they give.

Although the evidence is variable and depends upon the sample, the context, the substance and the data collection methods, many studies find self-reports that are corroborated to a high level of concordance (over 90%), either by urine analysis, corroborating evidence from third parties or other sources. Harrison (1995) found that the accuracy of self-reported drug use depended on the social desirability of the drug, so people had no difficulty in accurately reporting their use of cannabis, but were less likely to report heroin use. However, the present study actively recruited Class A drug users, in which case their use was already confirmed through their participation. Consequently, once this was declared and accepted there was little motivation for participants to distort their level of use, as they had nothing to gain or lose through deliberate misrepresentation, notwithstanding bias may unconsciously enter the interview process.

However, there were several areas where I felt I was not being given a truthful account. Nobody, even couples in a relationship, admitted to sharing needles as this seemed to be culturally unacceptable. It also goes against the latest figures for lifetime injection practices in Northborough (Beynon et al. 2002), that show Sandport to have the highest rate of injecting for males and females in the whole region, and

the highest rates of sharing for females (47.1%), and the second highest for males (46.5%).

When questioned about how they acquired enough income to support their stated levels of drugs use, the figures sometimes did not add up, and when pressed on this shortfall of income I received only vague answers leading me to believe that they were not forthcoming about their level of criminal involvement. Subsequent to the interviews I became aware through third parties that three of the women users had worked, or were currently working, as prostitutes, but this did not come out at the initial interview (one told me this on re-interview), and, to be fair, I never asked this as a direct question. This may be a good argument for more in depth forms of interviewing.

(b) Faulty recall

Difficulties with this sort of data collection can arise because of faulty memory (Hammersley, 1994). Not surprisingly more recent events are more likely to be accurately recalled than those which took place years ago, and a further problem can arise due to retrospective rationalisations of behaviour which attribute drug use to convenient causes and which have a functional use by which the person makes sense of their behaviour. Interpretation of the past can also be affected by alteration of mood and affective states such as depression which may heighten negative responses that stress individual helplessness and lack of control. Hammersley also notes that users who have been through counselling have learned to present an almost fictionalised account of their experiences in order to make sense of the messiness and chaos that is real life,

> In this sense the processes of addiction, as described by ex addicts are largely story-telling. (Hammersley, 1994: 288)

(c) Lack of insight

There are potential problems to do with lack of insight into one's drug use and limited means of self-expression. Some respondents may never have thought about some of the issues underlying the questions being asked, or do not have an opinion or know what they think. Consequently answers may be a product of rationalisation, a spur of the moment invention or designed to please the interviewer. Giddens (1984) proposes that all human beings know a great deal about what they do and why they do it, but may only think about these things when they are posed as specific questions since much of this information may lie untapped at an unconscious or semi-conscious level. It is therefore necessary to pose the 'right' questions that pierce through received accounts of behaviour. However, what a person is conscious of in their motivations has its limits,

> The knowledgeability of human actors is always bounded on the one hand by the unconscious and on the other by unacknowledged conditions/unintended consequences of action. Some of the most important tasks of social science are to be found in the investigation of these behaviours, the significance of unintended consequences for system reproduction and the ideological connotations which such boundaries have. (Giddens,1984: 28)

Much drug treatment is based on cognitive therapy, which pre-supposes that users have poor decision-making skills and a poor grasp of their best interests. Drug users are often said to be poor planners (apart from where their drug supply is concerned), opting for short-term gratification above long-term reward. Consequently, the reasons users give for their actions may be functional in the sense of either self-justification or blaming factors such as personal weakness, peer group pressure or the norms of the neighbourhood. Whilst one accepts this functionality it is important to keep a critical perspective on the possibility that answers to questions may be rationalizations from a group with potential problems of

insight into their own behaviour. However, people behave on the basis of what they believe to be true even if to an outsider this is faulty reasoning. People may say one thing and do another; a situation which is not necessarily invalid from a research point of view since what somebody says may give a genuine indication of their intentions even if they are unable to carry it out.

Self-reports of the reasons for the behaviour of drug users are likely to favour proximate factors such as boredom, stress, family disputes, whilst non-proximate factors such as the structure of society, labour market structure and social policy are unlikely to be perceived or articulated as having a role in the production of individual drug problems. The emphasis on proximate causes is a feature of drug theory and treatment in general, so it is not surprising that individual users will emphasise these.

3. 4 (ii) External validity – generalisability

External validity is likely to be important to research funders and policy-makers who may carry with them attitudes to assessing the quality of research more applicable to quantitative methods, believing that qualitative research is not a useful basis for public policy. However, practitioners may be a more receptive audience to qualitative research and be able to imaginatively juxtapose the findings to their own experience and area of work.

I tried to get a cross-section of users from different locations and from different agencies as far as my resources would allow, but because this is a small-scale, non-randomised study it cannot be said that its conclusions could be generalized or replicated in another area or with another sample in the way that one would expect from statistical generalisability. Indeed, some qualitative researchers would argue that research is always context-dependent and cannot be duplicated in other contexts. Rather,

with theoretical generalisability it is the conclusions that can be transferable and this transferability will depend upon the reader of the research who must decide on the applicability to new contexts. It is the duty of the researcher to provide as much 'thick' description of data and research procedures as possible to aid this process and to suggest its applicability to other settings.

There is a general problem of external validity with drug use studies because its 'hidden' nature makes it difficult to specify the total number of drug users from which to draw a representative sample. It runs the risk of criticism from quantitative researchers that it is merely anecdotal and suitable for hypothesis generating but not hypothesis testing. Generalisability will also be affected by more macro factors such as housing supply, drug distribution, and availability of treatment and Police operational policy which have a specifically local context. However, this does not invalidate the depth and complexity such studies can demonstrate. Small-scale studies can be generalised at an analytical level with reference to broader theories rather than statistical populations.

This study does contain quantitative features in the form of the Maudsley Addiction Profile and at the data analysis stage its use of Grounded Theory goes some way to answering the charges that qualitative research lacks formalization. Consequently I have subjected the data to a certain amount of quantification which might not please qualitative purists, but will, I hope, make the research more credible and relevant to an audience of practitioners looking to translate the conclusions of the study to their own area. Conducting a purely quantitative study would not have resulted in the depth and complexity that was essential for addressing the research question.

3.5. Ethics

This research was approved by the Ethics Committee of Manchester University. In preparing a statement detailing the ethical issues that were potentially involved in conducting the research, a number of points were highlighted:

3.5. (i) Payment

The initial interviewees whom I accessed through agencies were given a ten-pound gift voucher. This acted as an incentive, but I felt this was also equitable and that respondents should be recompensed for their participation. The payment also served to regularise the interview relationship in terms of my taking up somebody's time and in a way gave me legitimacy in asking fairly personal questions. Some interviewees were clearly motivated by payment although the majority were motivated by the chance to tell their story, to relieve boredom and, notably, to help other drug users. Some said they found the interview process therapeutic.

However, when it came to interviewing the snowball sample, I ran into the problem that a ten pound gift voucher was not highly valued, and from my point of view it seemed to be inappropriate to offer these people, some of whom were homeless, a gift voucher. I chose therefore to pay them ten pounds in cash. Payment of interviewees has been criticised on the grounds that it makes the giving of informed consent problematic, but there are no clear guidelines to say when payment for interviews renders consent problematic and constitutes a breach of ethics. There are many research projects that give cash payment, often to enlist hard-to-reach populations (Brain, Parker and Bottomley, 1998; Lupton et al., 2002). Some researchers would never give cash since it could be used to finance an illegal activity, but gift vouchers, or other forms of payment, can easily be converted into cash and used for drugs.

Drug users, however, have been found to take part in research for a number of reasons – economic gain, expression of citizenship, altruism, personal satisfaction, drug user activism and information seeking (Fry and Dwyer, 2001). Many of these reasons go against the stereotype of drug users as motivated purely by selfish reasons. Nine of my respondents living in a supported hostel were not recompensed. Rather, at the request of the Manager a donation was made to the Residents' Fund of the hostel. Several users indicated that they would have been willing to participate irrespective of payment. However, it must be admitted that economic gain was a key motivator, particularly in attracting the snowball sample, but motivation comes from a combination of factors, not least boredom, a relief from routine and a chance to talk to somebody.

3.5 (ii) Confidentiality

All user interviewees were assured that their details would be kept confidential and that they would not be identifiable from any publication of the findings. I asked for their first name and date of birth for coding purposes. However, they were asked to sign a consent form and receipt for the gift voucher so that their surnames became known to me. I tried to make the identification of the areas and the projects, as well as the attribution of statements in the text, anonymous. This was done by using generic job titles, cutting out local place names and identifying users by their age, gender and type of housing. But a problem with small-scale surveys in narrow geographical areas is the risk that respondents are more easily identified, or, what is worse, if they are made anonymous in the text, are mis-identified as being the source of a particular statement or action.

Initially I had not decided whether or not I would identify the projects I had visited or use generic descriptions of workers not directly attributed to them by name, such as housing association manager, drugs worker etc...

I asked agency staff if they had any objection to being attributed in the text by reference to the project they worked for. None of them objected to being attributed directly, except for one Health Service worker. I had gained the impression that interviewing Health Service personnel or clients would involve a request to an ethics committee. However, whilst one Community Psychiatric Nurse would only talk off the record and did not want his statements to be attributed, a senior manager, the head of clinical nursing at the Community Drugs Service in Newcity, was quite happy to do a tape-recorded interview with no mention of ethical problems. His seniority perhaps gave him the confidence to publicise his views, a seniority which his more junior colleague did not enjoy.

It can be argued that where public agencies (and even the voluntary sector relies on public money) come in for justifiable criticism in such things as poor service delivery they should be identified and open to analysis and criticism. However, I eventually decided not to use the actual names of projects since with a small survey such as this there could be a chance of users being identified by the context of the statements of agency workers.

3.5 (iii) Informed consent

The consent form with information about the research was signed in duplicate at the beginning of the interview, one copy of which the interviewee kept, although nobody read this in any great detail before signing so I briefly recounted the main details. Users were told that if they did not wish to answer any questions they did not have to and that they could terminate the interview at any point. This option of not wishing to answer specific questions was taken up by two interviewees and the interviews proceeded onto the next question.

The issue of informed consent is a vexed one when interviewing drug users. If their use of drugs affects their cognitive abilities this may make

their actual consent problematic. However, the majority of interviewees were seen on an appointment basis so they had time to make a considered decision as to whether they wished to participate. The situation with the snowball sample is less certain. Informed consent is particularly problematic when conducting qualitative interviews since the research is emergent and iterative, raising the question - how can somebody know in advance what they are assenting to? In this case consent must be seen as something ongoing and negotiated throughout the interview in the sense that the interviewee has the right to refuse to answer and to terminate the interview.

Another problem is that the purpose of the research may be theoretical to the point where it is not understandable by the interviewee who is without specialised language and concepts. When questioned about the purpose of the research I almost automatically replied that I was seeking to establish the problems that drug users had with accommodation, so that housing and drug agencies could learn from their responses. In retrospect I am not sure if this was entirely honest and that the research was, in fact, less political or altruistic in defence of the rights of drug users.

3.5 (iv) Safety

(a) Risk to interviewer

A frequent concern about interviewing drug users is the possible dangers, particularly to a lone researcher. I must say that I never felt the slightest danger. As a rule people were friendly and open and, whether due to the effects of heroin and methadone or just by disposition were laid back and comfortable with the interviews. Most interviews were held in agency offices or in public places and where interviews were held in people's homes I either knew them personally or was initially introduced into that context by an agency worker who then left. Aggression through

intoxication was not a problem, as it is not usually with heroin users, although the effects of heroin or methadone clearly made some people's ability to concentrate on the interview difficult if the interview went on for more than half an hour. This is not to underestimate the dangers which are real with any interviewee who is not known to you.

(b) Risk to interviewee

One can only speculate as to any psychological harm that might be caused to interviewees who take part in these types of interview in terms of anxiety caused, not necessarily at the time but as they reflect upon what they may have revealed of their personal lives. This underlines the importance of an assurance of confidentiality. Two respondents refused to answer questions about their family life and some of the female respondents touched upon issues of sexual abuse that I did not feel it was appropriate or necessary to pursue from both my own and their perspectives. In general users seemed to demonstrate a willingness to talk and reveal their private lives and this could be seen as a product of their familiarity with having professionals of various sorts enquiring about their behaviour but also of their lack of power in resisting such intrusions. However, their strategies for resistance to such enquiries may lie in what they did not tell me rather than what they did.

3.6 Data Analysis

3.6 (i) The interviews

As the interviews proceeded, provisional concepts and themes emerged which I was able to pursue in more detail in subsequent interviews and which informed the data reduction and analysis stage after full transcription. This process was an iterative one and was informed by concepts which I brought to the research from previous reading and experience.

Data management was carried out by generating concepts through the process of coding, or labelling and categorising the raw data, using the principles of Grounded Theory (Glaser and Strauss, 1967). After transcribing the tapes the initial analysis was a process of data reduction by the retrieval and highlighting of text which appeared to be significant and from which concepts could be generated by grouping together patterns of data. Initially, according to Glaser and Strauss these will form the basis of 'substantive theory' that relates to the direct, empirical area of study. From this stage one may generate 'formal theory' which would relate to wider, more abstract concepts.

As I went through the text I identified groups of data which enabled me to establish a coding frame of approximately twenty categories of significance and relevance to the research question. At this stage I was conscious of the need to limit the number of categories to make the process manageable, rather than increasing the number of codes so that the data links became over-complicated with partial and insubstantial relationships. Coding has to finish somewhere although it is also important to take cognisance of deviant cases that go against preconceptions or the dominant patterns. Where these deviant cases arise I have tried to refer to them in the text.

This initial coding was further refined into a framework at a conceptual level to generate interpretations about the relationship between housing and problematic drug use. The three elements of Grounded Theory are concepts, categories and propositions which show progressive levels of analysis, all developed out of the raw data in a process of induction generating theory from the data rather than beginning with a theory and attempting to prove it.

I endeavoured to examine the interviews in terms of their representing a functional discourse that provided users with a way of explaining their drug use and housing histories. From this point of view the discourse

does not represent 'the facts' but speech is selective, motivated and functional (Davies, 1997). In other words, people have an underlying reason for saying the things they do which they may be unaware of and which serves a purpose, often unrelated to any objective idea of 'truth'. These reasons may be for self-presentation, protection of self-esteem or apportioning credit or blame. In the final analysis, answers to questions may be highly context dependent, depending on how the interviewer is perceived and what the interviewee thinks is required.

3.6 (ii) Housing and drug use histories

As I was conducting the interviews I was also constructing a rough housing and drugs use history for each interviewee on a separate sheet of paper. After I had transcribed the tapes I could elaborate this in more detail. I drew three timelines for housing history, drug use history and social history and marked off significant events in the person's life. By marking off dates along the three axes I could get a rough idea as to the concurrence of different aspects of the person's life. This method brought to light many significant events in the past lives of the sample. For instance the prevalence of periods of imprisonment that coincided shortly after with periods of homelessness on release, or periods of homelessness that coincided with periods of high drug use, or social factors such as employment or stable domestic arrangements that coincided with low drug use or abstinence. The current drug use, housing and social status of the sample could then be seen as part of a continuing process or as a marked difference in their situations and behaviour.

Whilst this retrospective method has limitations of accuracy, it nevertheless is a useful form of data reduction and gives a general overview that identifies patterns of behaviour linked to external circumstances.

3.6 (iii) The Maudsley Addiction Profile (see Appendix Three)

The Maudsley Addiction Profile questionnaires (Marsden, J. Gossop, G. Stewart, D. Best, D Farrell, M. Lehmann, P. Edwards, C. and Strang, J. (1998) were scored according to the manual which accompanies it. The data was entered on SPSS and, as well as extracting basic data for gender, age etc...was analysed in an attempt to suggest tentative relationships between variables such as housing type and psychological and physical health, housing type and level of drug and alcohol use, gender and health, and gender and level of drug use. Some of the categories proved not to be useful; for instance there was so little reporting of criminal involvement that I felt no credible conclusions could be drawn. The Maudsley data appears in the text in chapters four and six.

CHAPTER FOUR

THE SPATIAL DISTRIBUTION OF DRUG USERS WITHIN A WIDER HOUSING AND DRUG ECONOMY

4.1 Introduction

The purpose of this chapter is to examine whether problematic drug users in the sample are concentrated within specific geographical locations and within certain types of housing as regards tenure, price and quality. I was interested in the degree to which the local housing market had a 'filtering' effect referred to in the literature (Galster and Rothenberg, 1991), and whether housing acts as a constraint which can literally 'fix' drug users in some of the most deprived areas of our towns and cities. To outsiders they may be characterised as no-go areas, and for the residents as no-exit areas.

I also examine how far the local structures of housing provision operate to control access to housing and whether this is felt differentially by problematic drug users. However, in line with more recent trends in housing studies research (Clapham, 2002), I proceed on the assumption that drug users are not merely passive in the face of market forces and housing bureaucracies but bring their own knowledge and motivations to the negotiation of access with various housing 'gatekeepers'. I look at whether this process of negotiation is characterized by an imbalance of power that many poor people experience in accessing housing, but look in particular at whether this imbalance may be reinforced by problematic drug use allied to low expectations and poor knowledge of housing markets and bureaucracies.

Using housing and drug use biographies gained in the sample interviews I go on to look at how certain aspects of the lifestyles of those in the sample may lead to a housing career that includes stays in insecure housing and institutional forms of housing such as hostels and,

significantly, stays in prison. I then look at how these housing trajectories affect their degree of insecurity, reinforce their transience, and, in turn, further limit their housing choices.

The research then positions problematic drug users within a larger economy where drugs and housing each have a commodity value in terms of either money or exchange and looks at how the two are related to one another within that larger framework.

4.2 The geographical and tenurial distribution of the sample

There have always been particular locations and types of housing associated in the public consciousness and in media representations with problematic drug use. From the opium den of the nineteenth century to the crack house of the end of the millennium, through shooting galleries, squats and the fortified houses of dealers on run down social housing estates, certain drugs have largely been associated with deprivation and locations outside of the mainstream, with socially excluded people inhabiting areas of social exclusion.

I wanted to look at how these locations are spread out geographically and what structural factors shape these patterns. I endeavoured, at the same time, to look at how those in the sample negotiated these structures of housing provision. As a framework for analysis it is necessary, first of all, to outline these structures of housing provision in the three areas under study.

Dockland has a large council and social housing sector and some of the poorest wards in the country. It contains a large number of poorly maintained pre-1919 private houses, a problem of abandonment and one area is designated a Market Renewal Pathfinder, an area of low housing demand scheduled for large scale demolition and regeneration. It contains a specific area that Communities Against Drugs has targeted as

having problems with drug-related crime and anti-social behaviour. It contains a number of tower blocks of variable quality and security. Some have concierges and CCTV as a means of addressing anti-social behaviour and crime, although some still have a bad reputation for drugs and many drugs agencies said they would not recommend that somebody trying to give up drugs relocate there. There are usually vacancies in the council sector in Dockland but the dilemma drug users face is that they are usually in the most undesirable housing locations. The choice for those with no ability to wait is between bad housing or no housing.

The centre and seafront areas of Sandport typify a previously elegant seaside resort containing many large Victorian houses that no longer suit contemporary family structures. Landlords have moved in and subdivided the houses into flats to maximize the rental income. As the area has become occupied by single people and lost its family and residential feel, those who had the opportunity to do so moved out to be replaced by those who had no opportunity to access social housing, many of whom were on benefits and some of whom took drugs. Eventually certain addresses became known as places where the landlord would accept those who nobody else would accept, accelerating the exit of those who had the ability to move. This 'filtering' effect has been recognised recently and there has been some attempt at regeneration with the use of European money and housing association investment, but parts of the central area still have a bedsit-land character forming a contrast with the elegant shopping façade a hundred yards away. There is a supply of guest houses and bed and breakfasts which can be let out to local people, particularly in the winter months. Many people remark that Sandport hides a deprived population and a drug problem not reflected in its public image.

Newcity is a city that includes a mix of peripheral council estates and areas subject to central government regeneration initiatives such as the Single Regeneration Budget and Neighbourhood Renewal. It has a large

sector consisting of aged terraced housing, some of which is rented out, and includes a growing number of students competing for housing with those on benefits. House prices are well below the national average. It has a higher than the national average Asian and Asian British population: 11.6% compared with 4.6% nationally, (2001 Census). It also contains a number of private hotels that are notorious locally for drug use and regularly attract Police attention.

If we look at where the forty people questioned were living at the time of the interviews, the breakdown is as follows:

Dockland	One council tenancy Nine places in a supported hostel for homeless drug users
Sandport	Eighteen private sector tenancies, including 10 in houses in multiple occupation (HMO's) Two living in the parental home One owner occupier One person homeless Two living with friends
Newcity	Five night shelter residents One supported hostel tenancy

The current housing situation of the sample was largely a reflection of the structures of housing provision in their geographical area, so that in Sandport where social housing for single people is extremely difficult to access but where there is a large private rented sector, including HMO's, it is to the latter that drug users gravitate. The bulk of the low-cost private rented sector is situated near to the town centre and of the twenty people living in such accommodation (including the two living with friends), fifteen were situated within a half-mile of the centre of town.

In Dockland the bulk of the sample were currently residing in a supported hostel but many had in the past held council tenancies which were more easily accessible in an area where there is a problem of low demand. In Newcity the situation was more mixed as is the structure of housing provision in that area, and the situation was more complicated since the bulk of the sample were night shelter residents, some of whom came from other parts of the country. Both the supported hostel sample and the night shelter sample were situated in their respective urban centres.

The following night shelter resident was one of the older users with a long drug-use history. His housing and drug history was in many ways stereotypical of the working class council estate drug user committing crime to support a drug habit – a stereotype at the heart of current government drug policy. An interesting aspect is also the link between homelessness and an army career that has been identified in the literature (Higate, 2000).

Alan, (all names have been changed) aged 43, night shelter, Newcity

Alan was born on one of Newcity's council estates. He left home at sixteen. He is one of the older users who at the age of fifteen would burgle chemists' shops to support his drug use. This was part of a group of users who were all older than him and who taught him the techniques of crime.

He joined the army at eighteen and continued on and off to use drugs, although not usually heroin. He was in Germany for four years and after coming out he developed his heroin use and married another user.

Currently residing in the local night shelter, his housing history has consisted mainly of council tenancies. Whilst living on the estates his home was a centre for local drug activity and the Police were frequent visitors. At the times when Alan thought about giving up

drugs his motivation would falter in the face of the continued use of all those around him on the estate, and in particular his wife. Although married for twenty years he frequently, due to arguments, found himself sleeping rough or staying in the poor quality hotels in Newcity. At these times of rough sleeping he found his army survival training came in useful.
Both his own and his wife's drug use has affected the upbringing of his daughter and the home environment was so chaotic at times that she voluntarily approached Social Services to be taken into care, a fact he now much regrets.

What was particularly noticeable in the current housing of the sample was the lack of owner occupation, housing association and council tenancies, and, as we shall see, this reflects barriers of access to both private and social housing that drug users must negotiate. It is, however, important not to place too much emphasis on current housing as a guide to a person's historic housing situation (May, 2000). As we shall see the sample revealed a wide range of housing experiences to which peoples' current situation would provide no clue.

For instance, of the sample one female and five males had previously been owner occupiers, usually in a married situation which subsequently ended. The typical scenario seemed to be that the males would be the ones to leave the home, (sometimes because there was another female in the frame), leaving their previous partner in occupation. Five of the sample had previously been housing association tenants and were no longer for a variety of reasons – eviction, abandonment, going into prison. Several people had lived in what they described as squats which were usually empty council properties, sometimes with the windows boarded up and with no services. Eight of the sample had lived abroad in the past and two had lived in university accommodation. Of the sample of five living in the Newcity night shelter, three had been in the army, a link

between the services and homelessness that has been made in the literature (Higate, 2000).

4.3 Differential access to housing markets and bureaucracies

Dissatisfaction with council housing access differed between Sandport and Dockland. Sandport has acute problems with access to council housing, with waits of eight to ten years the norm. Much of the housing stock is designed for the traditional nuclear family and not for single people, who do not fall into priority groups. This deters people from registering on the waiting list and their main recourse is to an expensive, often poor quality private rented sector,

> It's a terrible housing situation in Sandport...it's an eight year waiting list, maybe longer now, maybe ten years unless you're an elderly person...it's an absolute nightmare, so I don't even bother dealing with the council, there's just no point, they [drug-using clients] are normally wanting housing pretty soon. In Sandport you get a lot of people in private accommodation who are having to pay through the roof.
> Welfare Rights Adviser, Northborough Council

In Newcity there was the added factor of a student population in competition for the existing supply of cheap housing, although there was also a lot of purpose-built accommodation being developed,

> Up by the university is taking off, a lot of people are being made homeless to make way for students, but this last eighteen months there's been lots of purpose-built student accommodation gone up.
> Clinical Nurse Manager, Newcity Community Drugs Team

In Dockland it was not lack of supply but a choice limited to the worst properties in the least desirable areas,

> If you are single, male and independent you are always going to get the bottom of the ladder...most of them [drug users] are in high-rise blocks or rundown areas, it's a recipe for disaster.
> Manager, supported hostel, Dockland

This manager criticized the council for putting recovering users "bang in the middle of smack city" and had given up referring people to the council, concentrating instead on the private sector or a local housing association,

> They're put in areas where they're known to be drug ridden and quite frankly, if you moved them out into an area like that every other drug user in the area, they all know one another, then people come knocking and people start using.
> Manager, supported hostel, Dockland

One worker in Sandport was critical of the council who have allocated a number of properties to drug users in the same locality,

> I'm a bit annoyed about how they've set that up, that estate, they've stuck drug users in, alcoholics...they've created another ghetto of new housing which is crap.
> Drug agency worker, Sandport

Indeed, during the course of the fieldwork this locality featured in the local press. (Local newspaper, 20.8.03 *"Drug Dealers Have Made our Life Hell"*)

Users confront many of the same problems in accessing private accommodation as other people on benefits: lack of a deposit, references or rent in advance. A large number of private landlords are reluctant to give tenancies to those on benefits. Bars to access in the private sector were in many cases linked to the unemployed status of the majority of users in the sample and their dependence on Housing Benefit. This is possibly a combination of dissatisfaction with delays in benefit payments as well as a perception that people on benefits may be a potential

management problem. Landlords were not always discriminatory on grounds of drug use since they usually did not know of a person's use on first meeting them, and heroin is a drug that many users may take without giving any indication that they are under its influence. However, any questions about drug use by landlords were unlikely to be met with honest disclosure as this could compromise access. One user relates coming out of prison,

> I was meant to come home to a flat being sorted out by Probation and as soon as they heard I had a drug problem that involved intravenous, it just went by the by, he asked me to be honest and frank which I was.
>
> Female drug user, aged 35, shared flat in HMO, Sandport

In the social rented sector there is no overt discrimination, although there is growing concern about covert discrimination, (*Inside Housing*, *"Vulnerable Pushed Out"*, 25.7.04). However, from a pragmatic housing officer's view, drug use only usually becomes a problem when it manifests itself in rent arrears, damage and nuisance,

> From a housing officer's point of view, to be brutally honest, I wouldn't care what problems that tenant has as long as they didn't go in arrears and they conducted the tenancy in a satisfactory way and it didn't cause any neighbour nuisance, whether they were users or not. There's probably housing officers that don't even know that some of their tenants are users because they keep themselves to themselves. We've got clients that come in here and go and live in a tenancy and don't bother with anyone because they're in a docile state anyway.
>
> Housing Officer, Communities Against Drugs, Dockland

Many users have a history of rent arrears which makes them ineligible for re-housing with the council and since the council usually has nominations with local housing associations, access is barred to them as well. This can be compounded by other problems,

> It is difficult to get housing for people with drug problems, especially when certain people have got a history with the council...they might get a Housing Benefit form through and be particularly ill or can't be bothered or don't realize. There's a literacy problem as well, there's mental health issues, they stick their head in the sand and won't open any letters.
> Welfare Rights Advisor, Northborough Council

Whilst there were many instances of failed local authority tenancies in the sample's housing histories, social housing was said to have its advantages over the private sector,

> They have low rents, they accept people on DSS and they don't discriminate because of your medical condition.
> Male, aged 35, private rented sector, Sandport

Whilst there are bureaucratic barriers to entry to social housing, additional problems of access can be the poor understanding people in the sample have of how the housing system works in the sector. This is often linked to a lifestyle which does not prioritise long term planning and such things as the monitoring of waiting lists – keeping applications up to date, attending interviews, telephoning and making contact with housing bureaucrats,

> Because drug use is the central thing in your life you can't be bothered to focus your attention, energy and resources into getting decent accommodation. You put up with that because your main aim is your drug supply and you stay at that level...it's that skill of living which is about planning ahead, saving and getting stuff together to improve the home – it just goes, it's solving the immediate problems of the drug.
> Manager, drugs agency, Sandport

There was a lot of confusion amongst users as to their status regarding their current applications for housing which often took the form of fatalism,

So, you're still on the list are you?

I'm hoping I am.

Have they ever offered you anything?

No.

Do you ever go in and ask what's happened?

No.

Have you sort of given up with the council?

Yeah, it's a waste of time.

How have you found their attitude or have you just not enquired about it?

I've not been bothered.

Female, aged 31, shared private rented flat, Sandport

Users filled in forms, usually at the prompting of advice agency staff, but then sat back with little understanding of what they had applied for,

Have you applied for housing?

Yeah, two different associations.

Do you know which ones?

No.

Male, aged 42, night shelter resident, Newcity

However, whilst access to council housing in Sandport is difficult, many areas in the North have an over-supply of housing to the extent that Market Renewal Areas include selective demolition as part of government housing policy,

> The problem in the North is not lack of housing, there's enough houses to go round. The problem is that some of the people we're talking about are not equipped to sustain a tenancy, it's setting people up to fail if they've got a substance misuse problem, just putting them in a house.
>
> Coordinator, Big Issue in the North

If securing housing is an obstacle race, drug users are severely handicapped. Constraints on access come from housing application and

allocation procedures and from restricted possibilities arising out of a drug-using lifestyle. The social housing system does not confer priority status on single people or drug users, an attitude largely derived from traditional views concerning the deserving and undeserving welfare applicant and views about drug dependence being a self-inflicted condition. Because drug users may be seen as potential management problems, social sector managers and private landlords may act in a discriminatory way, although the possibility of this is less in the social sector where more covert discrimination may be operating. Added to this is a poor understanding of the systems and an often transient lifestyle that jeopardises the continuation of their applications.

It appears that the housing situations of the sample are the result of structural constraints and human agency. In looking at their housing careers, structural factors such as housing supply, the employment situation, income distribution and the geography of poverty and health appeared significant. To these can be added personal risk factors such as a drug-using lifestyle and attitudes that do not equip them to compete successfully in housing markets and bureaucracies.

4.4 The concentration of drug users in areas of deprivation

Dockland and Sandport are located within the local authority area of Northborough. According to the English Indices of Deprivation, 2004, Northborough has high concentrations of deprivation, most notably in the Dockland area. The Drug Action Team for Northborough identified two postcode areas in Sandport as problem areas for drug misuse based on Probation re-offending statistics. (Local newspaper, 10.1.01). These areas include the town centre and seafront districts, and they are the two areas that are high in indices of deprivation, particularly for levels of crime.

On a tour of the Market Renewal Area in Dockland with a housing manager from one of the largest housing associations in the area, the deprivation was stark. Boarded up properties, some of which had been set on fire, deserted, glass-strewn streets, abandoned properties with no roofs, punctuated by the odd owner occupier holding out for a compulsory purchase compensation payment from the council before the bulldozers move in. Similar scenes could be witnessed in Newcity,

> *Are there specific areas associated with drugs?*
> Yeah
> *Do they tend to be council properties?*
> Yeah, they are all that way out of town, notoriously rough areas really, a lot of deprivation round there, boarded up houses, burnt out cars, sofas in the driveway, the streets, all that type of thing.
> Clinical Nurse Manager, Newcity Community Drugs Team

This deprivation can also be witnessed in the Community Against Drugs area of Dockland, an area where 48% of residents are classed as income deprived, and where certain roads are notorious for drugs and are locally stigmatised. One person directly linked drugs with areas of high unemployment, as well as raising the issue of drug use as a coping mechanism,

> I think it's no coincidence that drug shit in the nineteen eighties in areas like this when there was massive unemployment, particularly heroin – it's a blocker, a sedative.
> Coordinator, Big Issue in the North

The signs of a stressful environment can be seen on the street,

> There is a visibility and I've walked down the street and I've seen people swearing at each other over money and sort of been half dressed, you know, not normal behaviour during the day.
> Housing Officer, Communities Against Drugs, Dockland

Deprivation allied to a local collapse in the housing market means that areas of Dockland cannot attract in-migration. This results in frustrated

owners occupying a declining asset they are unable to sell, and housing disrepair and abandonment. Those who have the opportunity to leave do so, others are stuck in a landscape of visible decline. An agency worker in Dockland remarked on a 'filtering' effect,

> The reality is, though, that if somebody does actually get a job or a qualification or whatever, the first thing they do is move from that area and somebody just like they were moves into that area because they're the only people landlords can get, on Social Security and so on...still as bad as anywhere and nobody wants to live there though some people have to.
> Drugs project manager, Dockland

With landlords needing rental income from their properties, the area becomes attractive to marginalized groups seeking cheap accommodation. The 'push' factors which drive some people away from deprived areas are the very 'pull' factors that attract others towards them,

> I think it's that they gravitate towards areas where they feel comfortable, where there are other drug users, because they don't feel so isolated when they're in an area where they know a lot of people and the supply's on hand as well.
> Manager, supported hostel, Dockland

The problem with taking a critical view of the lower end of the private rented sector, as with hostels, is that they do provide a service for people who have no alternative. Landlords generally have a poor image in this country but there are two aspects to this. Firstly, the personality and behaviour of individual landlords were reported to be a problem. One respondent made the following statement which I cannot verify from other sources,

> Let me tell you something now. There's a lot of these landlords, right, their places are being used for drugs and the landlord's taking a percentage off whoever is dealing. There's a lot of that in Sandport, a lot. And there's also some landlords, they're not

taking the drugs, they're getting the drugs in, somebody in the house is selling them.

Male, aged 52, private rented sector, Sandport

The same respondent described a well-known arrangement of 'ghost flats' whereby landlords and tenants cheat the Housing Benefit system by setting up false tenancies,

A certain person says they're living, wherever. They're not living there, they're living with a friend and the landlord's claiming rent for that person who isn't there...they split the rent.

Male, aged 52, private rented sector, Sandport

A second problem is the structure of housing finance within which they work, particularly the operation of the Housing Benefit system. This can cause difficulties for both landlords and the tenants, and in order to show both sides of the story I interviewed tenants who had grievances but also the representative of the Residential Lettings Association which represents the interests of private landlords. They pointed to management problems familiar to this drugs worker,

Leaving syringes, arguments with drug dealers, things like that go on at all hours of the night, so it creates a little ghetto of users until they're all cleared out.

Drugs agency worker, Sandport

Other problems such as theft from meters, theft of property, damage, noise, use of property for dealing or prostitution and aggression were mentioned by the landlords' representative. This has led to the compilation by the Residential Lettings Association of a bad tenants list which members can consult when someone approaches them for accommodation. It lists tenants who have left tenancies in bad circumstances such as owing rent, causing damage or anti social behaviour and there are moves to further extend restrictions on entry to the social rented sector,

> We are arranging to share information with housing associations and the council, and we'll be setting up a Tenant Referencing Service, so it means basically that we won't get as many bad tenants coming out of local authority housing into the private sector.
> Residential Lettings Association

If this is implemented those people who have been in dispute with a landlord, (perhaps legitimately), could find themselves barred from private rented property of landlords who belong to the Association. It is worrying that this information could then be used by social housing providers and influence their decisions to give access to people on the list, especially if they do not have an opportunity to challenge claims being made against them.

As housing applicants (or supplicants) drug users fulfil a triple qualification for marginality in that they are economically, socially and legally marginalised (Winchester and White, 1988). The private rented sector may be the only recourse for drug users in certain areas. There is nothing inherently sub standard or inferior about the form of tenure since it caters for a wide cross section of people, including an affluent sub market. However, the sample were overwhelmingly concentrated at the lower end of the market in terms of quality, although not necessarily in terms of price, as landlords raised rents to meet the maximum Housing Benefit level that could be claimed.

Housing association flats were perceived as of better quality, but the areas they are frequently located in contain many of the negative factors of council estates: lack of amenities, open drug dealing and an atmosphere of violence,

> *What's the area like in [named area]? I know it's got a reputation.*
> Exactly like it, yeah, people going around selling heroin, cocaine, kids on bikes, fourteen, fifteen, go to any phone box.
> *So was that quite useful to you?*

Sometimes, sometimes not, I didn't ever score on the street, it's too dangerous.

Where did you score then?

People's houses, dealers' houses.

Male, aged 35, private rented sector, Sandport

Council estates were seen to be very insular, and some were dominated by large extended families involved in criminality. Two of the respondents had suffered from the activities of vigilantes when they were identified as drug dealers,

And who were the vigilantes, were they local neighbours?

Local heavies, you get them all over the place, you know, the general public, hard nuts...they say they're trying to protect the community but they are involved in crime, they've got their hands in the pot, people with money involved in coke.

Male, aged 26, supported hostel resident, Dockland

They smashed my house to bits, I was beaten with baseball bats and for the next couple of weeks I took my revenge on them individually.

So you had to leave the area?

Yeah, went to live in Dockland.

Were you re-housed by the council?

Well, we had an injunction against about a dozen members of the populous, they weren't allowed to be within five hundred yards of the property.

Were they young people or older?

No, no, a respectable bunch of nutters from forty to fifty...and that's what accommodation does, because I've seen it in lots of different estates where the community stays with the community.

Male, aged 30, private rented sector, Sandport

This insularity is a characteristic of the sort of social capital that can make for stable communities, but have a negative influence in its lack of

connection with external links to social inclusion such as employment. The motives of the vigilantes were also called into question by another agency worker who felt that they were little more than gangs looking for excitement rather than concerned citizens.

4.5 Dynamics of the sample: transience and locational movement

The epidemiological model of the spread of drug use (Hunt and Chambers, 1976; Parker et al. 1987; Parker et al. 1998), describes a macrodiffusion from areas of high population density to outlying areas, and a micro diffusion within areas with a high index of deprivation. However, one hostel manager described the situation in Dockland as follows,

> The main problem with drug use came in about '84/ '85 and when I read Howard's [Parker's] account it was exactly the same as what we were experiencing here in Dockland. Ironically in this area it didn't happen from the city centre and go out, it happened on the outskirts and came in.
> Supported hostel manager, Dockland

When Dockland and Sandport were joined together under local government reorganisation in 1974, this meant that under the created borough of Northborough a new housing authority came into being whereby people anywhere within the boundaries could apply for housing throughout the north and south of the borough. There are some signs that drug users in Dockland took the opportunity to relocate to Sandport using the housing allocation system as a mechanism. A policy of dispersing drug users mediated through the housing allocation system as a means of avoiding concentrating them in one area may be well intentioned but could have unintended consequences from an epidemiological perspective. In trying to escape the locations of heaviest drug use several users had relocated from Dockland to outlying areas with the consequence that if they relapsed then this had the potential to

have a diffusion effect and extend the network to previously unproblematic areas.

Several older users in the sample described how, up until the eighties, Sandport's Class A drug users were a small tightly knit network dependent on pharmaceutical drugs stolen from chemist's shops over a wide area of the North. In the eighties with the emergence of street drugs and the growth of drug use generally, Dockland became the main source of supply for users in Sandport. More people from Dockland relocated in Sandport (including three of the sample) and the links between drug users in the two locations became stronger. One agency worker remarked on the changing nature of the local drugs market,

> For a long time it was quite a marked phenomenon in Sandport, there wasn't very much dealing going on in Sandport, most people got on the train to Dockland and it was almost like they were commuting...The fact that they had to travel, it was part of the routine, it kept some control on it, it helped to keep them stable, get the money together, get my ticket, get on the train, go down to Dockland to score, back to Sandport, use, it was like there was some sort of comfortable routine. But that gradually changed. Manager, drugs agency, Sandport

There was some evidence of a more national macrodiffusion effect in Newcity where there was a traditional link with Scotland. The way that this worked was that Scottish drug users would travel to a major holiday resort in the area looking for jobs in the summer season and once that ended they would head for the next main rail link which is Newcity. Typically they would end up in the local night shelter or one of the poor quality private hotels with a reputation for drug use and enter the social networks of drug use locally.

Supporting research by Giggs (1991) and Wallace (1990) the generally transient lifestyle of many users could also be a factor in the geographical spread of drug use as they switched locations sometimes regionally but

more often locally within poor housing areas. There were several individuals who had extensive experiences of travelling around Europe, but in the main most people's frequent moves were as 'serial movers' within the local area. The average length of stay of the sample in current accommodation was three to six months.

The night shelter sample, as one might expect, came from diverse areas throughout the North and Scotland, but the Dockland and Sandport sample were largely from the vicinity of their current accommodation having moved many times locally,

> Put it this way, I'm thirty-one now, I had my first flat when I was sixteen and I've only had one Christmas in each flat, so you work that out.
> Female, aged 31, shared private rented flat, Sandport

> I couldn't count the accommodations I've had.
> *You've had a lot of moves?*
> Yeah, seventy-three accommodation moves since I was sixteen years old.
> *You've counted them have you?"*
> Yeah, I've had to write them all down for the housing.
> Female, aged 27, private rented sector, Sandport

For those with children their transience in the past was explained by a restless search for more appropriate accommodation,

> *Why were you moving around so much?*
> Just trying to get better places each time, you know, trying to get a ground floor or somewhere with a garden, better neighbours.
> Female, aged 34, private rented flat in HMO, Sandport

The transient lifestyle of many users added to their problems of keeping housing applications live since councils require periodic renewal and if people do not notify them of their change of address then their renewal form will not be received and their application will lapse. One man who

was living in an abandoned car, and had done so for the last three and a half years had recently redoubled his efforts to put pressure on the council since winter was approaching and his health was bad,

> *Are you on the council waiting list?*
> I have been for a while but they couldn't find any trace. They found something from last autumn but I actually put my name down years ago, about nine years ago.
> Male, aged 45, homeless, Sandport

Whilst many of the people interviewed, particularly in Docklands, could be said to be fairly insular in not travelling very much outside of their home areas, they nevertheless moved frequently within those areas. However, there were some notable exceptions of people with extensive experience of international travelling. Although these represent some of the more colourful interviewees they are exceptions to the general rule but nevertheless consist of a significant minority. The following two interviewees are examples:

Joey, aged 26, living in supported hostel, Dockland

Joey was born on a 'rough' council estate near Dockland and first took heroin at the age of 13. By 16 he was regularly injecting. He left home at 16 and lived in a squatted council house where his use escalated and resulted in a suicide attempt and later a prison sentence. His relationships seem to have been with non-using girlfriends from a higher social background, often students and currently with a girlfriend from a wealthy German family with whom he has travelled extensively around Europe.
Several spells in prison for acquisitive crime have gone in tandem with periods of homelessness and returns to the hostel he is currently living in. Although from an area high in deprivation he is atypical in many of his attitudes and has none of the insularity of other interviewees from Docklands. He has lived in Germany,

Spain, Morocco, France, Italy, Poland and Gibraltar, and is intending to go to Egypt and South America. He finances himself by fire eating and juggling.
He shows a high degree of transience that is largely voluntary. He also typifies the user whose'trigger' for drug use is in his home environment, of people and places associated with drugs. He does not use drugs abroad, only when he returns home.

John, aged 43, living in private rented sector, Sandport

John was born into an 'ordinary' working class environment in Sandport. He worked on oil rigs based out of Aberdeen but lost the job because of his drug use which at that time was confined to cannabis. He worked abroad in Germany and South Africa and imported cannabis on a fairly large scale, being something of an advocate for its liberating properties as opposed to 'hard' drugs. When he was charged with supplying he went on the run for three years in Holland and Spain, eventually serving four years in prison on return to the UK. He continued dealing in various locations around the North but broke his cardinal rule of not 'getting high on your own supply' when he started using heroin. Another four and a half years in prison followed a colourful series of episodes in his dealing career.

The least transient were one owner occupier (the only one in the sample), who had been in her accommodation, a flat, for twenty years, and another person who had lived at home all his life – twenty-nine years. The transience may have something to so with the relatively young age and single status of the sample, and their reliance on rented accommodation which research shows is a more transient tenure irrespective of drug use (Kemp and Keoghan, 2001; Galster, 2003).

Whilst transience could be forced on drug users through personal or tenancy problems, some people claimed to like a lifestyle of travelling around,

> I like travelling, I miss travelling.
> *So was there a kind of grapevine?*
> Of course there is, you're always bumping into people, you always meet people, it's just one big grapevine.
> Male aged 35, night shelter resident, Newcity

However, this respondent went on to say that this transience was very lonely at times and increased his use of drugs. Transience had become such a way of life for some that it was planned for in advance,

> *What are your plans for accommodation?*
> I've bought a van.
> *What, to live in?*
> Well I always keep a van in case of emergencies.
> Male, aged 30, private rented sector, Sandport

A major factor in the transience of the sample was a pattern of recurring, short prison sentences. Of the sample of forty people interviewed, twenty-three had served at least one prison sentence, usually for less than twelve months. The springboard to prison for the majority was either drug possession or a series of minor acquisitive offences in order to obtain money for drugs, principally shoplifting, credit card fraud and theft. The sample included two people who had dealt in drugs on a fairly large local scale and had been to prison for supplying, but the majority had been to prison for short periods of time after fines, Probation and community penalties had all been exhausted.

The following interviewee embodies one of the most deprived upbringings in the sample added to an adult life dominated by crime and consequent time in prison. His mental illness seems to be bound up with his drug use as drugs act as relief through self-medication. However, this creates a spiral where the need to commit crime to finance continued drug use to

ward off unpleasant withdrawal symptoms of anxiety acts as a spur to more criminal behaviour. His sense of fatalism about his condition was very apparent.

Dave, aged 34, house in multiple occupation, Sandport

Dave had a poor upbringing in a highly deprived area of Dockland. His father was abusive and a heavy alcohol user who took no interest in the children. He has had a highly transitory life, particularly punctuated by frequent stays in prison. During the research period he was charged with Class A drugs possession. He has mental health problems and his girlfriend, also a heavy drug user, is his carer. Like others in the sample, he moved to Sandport from Dockland and is a prolific criminal, having been called institutionalised by the prison authorities. He exhibits the 'revolving door' syndrome of drug users serving short prison sentences for acquisitive crime who come out with no accommodation plans and who end up homeless and committing more crime to finance drug use. He is the type of offender very much at the heart of current government drug and crime policy that seeks to target prolific criminals using acquisitive crime to finance their drug use. His housing history also very much bears out the findings of the 2002 Social Exclusion Unit's report *Reducing Re-offending by Ex Prisoners* that identifies links between drug use offending and homelessness on release from prison.

Prison is usually thought of in terms of punishment and/or rehabilitation. However, one way of looking at it is as a form of temporary accommodation, for some people preferable in some ways to life outside. According to a Social Exclusion Unit report (2002) up to a third of prisoners lose their homes during custody. One in twenty ends up sleeping rough, which leads to more re-offending since homeless ex-offenders are more likely to be reconvicted. Interviews with the sample

bore out many of these points, about lack of treatment and aftercare planning,

> When they catch you [for shoplifting] you only end up with a little jail sentence and there's no time to sort out rehab, you just come back out to the same thing.
> Male, aged 35, night shelter resident, Newcity

Losing accommodation whilst in prison can be due to landlords' anxiety about protecting their rental income or ignorance of the Housing Benefit system on the part of the claimant. Housing Benefit will pay rent on a prisoner's accommodation for thirteen weeks whilst they are in prison, so anybody who gets a six month sentence and serves three months should in theory be able to maintain their housing. (This assumes that they do not accrue extra time for breaching prison rules, including mandatory drug testing). Some respondents found the situation not as simple as that,

> *Would the Housing Benefit not pay for your flat while you were inside?*
> I don't exactly know what happened to be truthful, I had no say in the matter, you don't get told anything to do with it while you're in there, it was out of my hands.
> Male, aged 45, homeless, Sandport

It may be that other users move in to your accommodation whilst you are in prison,

> We've even had cases of other users moving in, they've come out and they've been told fuck off, it's mine now.
> Drugs agency worker, Sandport

Landlords may be unclear as to whether or when the person is going to return and, fearing loss of income, may take action,

> I was living in town but I've lost that flat now.
> *Lost it because you went into prison?*
> Yeah.

So how long were you in prison?

Three weeks

Why did you lose it for such a short time?

The Housing haven't been paying the rent and the woman that got me the flat just got someone else in while I was in prison, well I didn't know it wasn't getting paid, she sorts the forms out...I went back and she said that I had to move my stuff because she'd given my flat to someone else.

Female, aged 29, parents home, Sandport

At least this person recovered her belongings. The Social Exclusion Unit report says that many prisoners' belongings are often destroyed by landlords, including documents to prove their identity. This can cause difficulties on release when trying to claim benefits. Even if the prisoner manages to continue Housing Benefit payments whilst in prison this may not cover the full rent if they were previously paying a shortfall and topping up their rent (some in the sample by as much as twenty pounds a week). Then the landlord will be losing this shortfall whilst the person is away and may take illegal action,

I had a beautiful flat, I came out and the housing had still been getting paid but the shortfall...I would have owed him two hundred and fifty pounds, and he wasn't prepared to wait. The day I got out all my stuff was on the step, but thrown in a skip so it wasn't even useful.

Female, aged 35, shared flat in HMO, Sandport

It is difficult for prisoners to make applications for housing whilst in prison since the allocation process is geared towards point systems based on current living circumstances and facilities. Relationships with housing organisations generally were,

Awful, because basically people in custody, they wouldn't let them apply to go on the accommodation lists because your points didn't count when you were in custody because the day you got out your points were going to change.

Youth Offending Team worker, Northborough

Many of the interviewees spoke of the lack of aftercare and move-on support, despite the setting up of CARATS, (Counselling, Assessment, Referral, Advice and Throughcare), which was designed to address this. CARATS was said to be uncoordinated with the Community Drugs Team in Newcity or with the main local drug advice agency,

> They were supposed to support them for thirteen weeks post-release. I personally haven't seen much evidence for that.
> Drug agency worker, Newcity

One agency had made repeated attempts to contact CARATS workers at the local prison with no reply, and my own attempts to contact them had the same result. However, I was told that in both this prison and Newcity resettlement hostels for prisoners were in the process of being set up, although agencies seemed uncertain about the details. Several people left prison with no clear idea of where they were going, or they gravitated to hostels or hotels that were populated by others in a similar position,

> Well as soon as I got off the train I met one of the beggars down town and he says they're living at the [hotel]. So I went to the [hotel] and as soon as I walked in the room my brother was standing there with a dig, so that was me straight back at it again.
> Male, aged 26, night shelter resident, Newcity

> Every time I've got out of prison I'm always down as NFA [no fixed abode], they don't give a shite, they just kick you out of the gate, give you a grant and get on with it...they let me out of prison homeless under a psychiatrist and all that, they're the ones that are saying there's something wrong with you but they kick me out of jail homeless.
> Male, aged 34, private rented sector, Sandport

However, there were alternative minority views expressed – one found the CARATS staff "quite helpful". One even went as far as to say "prison

was my saviour" because it got her off drugs, although she was back using when interviewed.

Another problem which has been highlighted is that of drug-related deaths of newly released prisoners (ACMD, 2000), so that, "In the week following release, prisoners in the sample were about forty times more likely to die than the general population" (Singleton, Pendry, Taylor, Farrell and Marsden, 2003). This can happen when a user's tolerance goes down with a period of abstinence in prison and then on release they resume use of heroin at a dosage that they used previously,

> I've nearly overdosed a few times coming out of jail and thinking you can use the same amount.
> Male, aged 26, supported hostel, Dockland

> I ended up in detox after an overdose when I left prison.
> *Is that because you went back to using the same amount?*
> Yeah.
> Male, aged 42, night shelter resident, Newcity

Prison could be a major factor in de-stabilising the housing careers of drug users. A couple of people said that their first experience of heroin was in prison, and prison friendships could also provide a means of making drug contacts and the formation of social networks on release (Pearson and Hobbs, 2001). The lack of aftercare means that prisoners are released without any plan for stable housing, meaning in most cases a return to their old environment and making them vulnerable to a resumption of their drug career.

The preceding sections have looked at the geographical movements of the sample dictated by structural factors of the housing economy or personal factors initiating voluntary or involuntary movement. The rest of the chapter unites this viewpoint within the perspective of a housing and drug economy functioning at a local level and consisting of transactions based on the commodity nature of drugs and housing.

4.6 The commodity and exchange value of housing in the drug economy

An important perspective that emerged during the study was how drugs and housing functioned within a wider economy, both legal and illegal. There was some scant US research on this (Petry, 2000; 2001) and no British research I had come across, so it seemed a potentially fruitful area. In order to pursue this further this section looks at drug use and housing as commodities with cash and exchange values.

The person who has their own housing holds an asset which may be much in demand by others whose hold on their own housing is precarious or non-existent. It may be used, amongst other things, as a place to congregate and use drugs, to provide shelter, to hide stolen property or as a site of drug dealing. There were several instances in the sample where users had invited people to their accommodation and their stay became problematic in some way. People who visit property do not have responsibility for it and can be the cause of more nuisance than the person who is the occupier. One person saw his drug use escalate when dealers used his place for their trade,

> I had drug dealers coming in the house, I sold all my stuff, I sold all my furniture, even my cooker and fridge...there was only a mattress, I didn't even have a telly or radio. I used to let them sell drugs from the flat and it got busted in the end.
> *So do you think you were being used really?*
> Yeah, but I was getting something out of it as well, I was getting drugs.
> Male, aged 28, supported hostel, Newcity

The use of accommodation has a transaction value which can be exchanged for drugs,

> When I lived in a house in [named area], because the local drug area was only a hundred yards away where the local dealers were

the people who would score would be looking for accommodation to go and do it, so the nearest place was my house.

And they would give you some?

Yeah, that was the whole thing about it, you can come to my house but you've got to give me this, and the same thing with me if I went to someone else's house I'd give them half of what I had, like sharing the rent.

Male, aged 33, hostel warden, Dockland

But, when accommodation becomes convenient for people who have nowhere to live you might find difficulty in getting them to leave if they are intimidating you. This user had to eventually abandon his property,

I bumped into two lads, one that I knew from jail and they said they had nowhere to live and I put them up in the house and that. Drugs were getting sold from the house while I was there and they were bullying me, took my dog, a five hundred pound dog, I felt intimidated, I couldn't tell them to go or nothing, they wouldn't go anyway, and I tell you what, they sold all my furniture while I was out of the house. I come back and there was a removal van and all my stuff was gone, yeah, I couldn't believe it.

Male, aged 37, local authority flat, Dockland

However, the initial contact may be encouraged because of loneliness or because of an unwritten code that you help someone out when they are down. The favour that you are offering somebody now may be required from them in the future. The commodity nature of housing could also be a factor in propping up the relationships of drug users (as it is in conventional society). This might simply reinforce an affection bound up with mutual drug use and criminal lifestyle, or be of a more predatory and self-serving nature,

There are some people in Sandport who will take people in and ostensibly are trying to be caring towards that other person. The person is not remotely interested in the other person and will either leech off them, provide them with accommodation but really they

want something more, or that person will be intimidated by the other person and it can be either sex in either of those roles.
Client support worker, drug agency, Dockland

Because ex offenders tend not to have relationships with their female peer group, they're basically not good marriage material, so they tend to form relationships with younger women. I can think of quite a few young women who definitely solve their problems by going into relationships with men who've got access to accommodation.
And accommodation is a definite factor?
That's not being said but that would be my analysis, I see no other reason why an attractive young woman...there's two or three blokes who are really limited emotionally and are suckers for it, they're getting their needs satisfied in some capacity...the thing is where do you draw the line between what is prostitution and what is not.
Drug agency worker, Sandport

Some locations may be situated near to dealers or other places frequented by users and thus are prone to other drug users 'popping in' to use drugs, or they may be encouraged to do so by the tenant in need of drugs,

Did drug users congregate in your flat?
Sometimes, yeah, because if I didn't have any money for drugs that was the only way that I could get sorted out, off other people, score for them or whatever.
Female, aged 34, private rented flat, Sandport

These visitors could put accommodation at risk through nuisance,

Yeah, late at night shouting up, instead of knocking on the door, kicking the door in...I think everyone that's on drugs will find that it's happened to them in one way or another, it seemed to happen to me more than other people, probably because I was a single

parent on my own, a girl who was only seventeen. But I don't think you could meet a drug addict yet who'd say that they've not moved a lot and they've not had people coming round and the door's been kicked in, if you get into this it happens.
Female, aged 27, shared private rented flat, Sandport

For some people who have reached a low ebb, their accommodation may be the only way they can secure a supply of drugs,

A lot of people when they get to that stage they're either dead or they look that bad they can't shoplift, they can't rob, they're physically that bad they stay in the house and other people come round and use the house in return for drugs. They look that bad they're known in the area as a drug user and young people come to the house.
Head of drug agency, Sandport

Predatory drug users can target single men with alcohol or mental health problems,

People can be vulnerable and you see a lot of abuse of people's accommodation. We've one client and he frequently had people using his house as a [shooting] gallery and he doesn't have the capacity to get rid of these people. It really affects his drug use and his attendance here.
Client support worker, Dockland

Lone females could be particularly vulnerable to predators,

The neighbours who lived next door to me, a couple on drugs, bullied me and every Monday, because they had their money fortnightly and I had mine weekly they would demand that I buy them a bag.
Female, aged 34, private rented flat, Sandport

You would have people congregating in that house?
Yeah.

Did that cause problems with neighbours?

No, it was more they were bullying me, the neighbours were more concerned about me because they were very intimidating.

Did they used to…

Just used to come in.

To use drugs?

Yeah, just walk upstairs.

And was there nothing you could do about it?

You just don't, it's not like that down there.

Female, aged 38, shared private rented flat, Sandport

The Anti Social Behaviour Act 2003 empowers the Police to close down and seal so-called crack houses (although the act covers other Class A drug use which may be causing public disorder or nuisance) at forty-eight hours notice and recognises the above problems of predatory drug users. It recognises that the occupants of such premises are more likely to be vulnerable people with "social care and housing needs related to drug misuse, mental health, age or some other vulnerability". Whilst I did not come across anything resembling the description of a crack house in the research, the local press were beginning to report the closure of such premises in the region.

4.7 Housing, disposable income and drug use

Although drug use shows high elasticity to price (Caulkins and Reuter, 1996; Bickel, Madden and Petry, 1998), the price of heroin seemed to have been stable for some time. There was evidence of the adoption of supermarket methods by dealers – buy one get one free, and dealers now sold a range of drugs whereas in the past they would have specialised. One ex dealer who had sold large amounts of cannabis up and down the country noted a change,

> It's different from the old days, nowadays you've got to be a supermarket, that's why I no longer deal drugs, because I don't

want to be a supermarket and if I get caught with Class A drugs then I'm looking at double figures [years in prison]
Male, aged 34, private rented flat, Sandport

Levels of drug use are dependent upon the amount of disposable income a person has (Caulkins and Reuter, 1996; Bickel, Madden and Petry, 1998). Housing costs are one factor in an income and expenditure equation that will affect the amount of disposable income available to someone. People's drug use increased when they had a reasonable level of disposable income, especially since food often came free either from church or charity handouts,

I used to go in the Kentucky Fried Chicken skips, the last bag they throw out every night is just purely chicken and chips, sweetcorn, tubs of coleslaw and tortilla rolls so you can make yourself a decent butty up. Make a little barbecue area, warm the chicken up.
Male, aged 40, private rented sector, Sandport

The most often mentioned methods of raising disposable income for drugs, apart from benefits, were selling the Big Issue, begging and shoplifting. Big Issue vendors' drug use is often very high because of their extra income that is not treated as income for benefit purposes. Begging can be a quick way of generating income,

Do you get much response begging?
Yeah, I can make a tenner in twenty minutes.
Female, aged 35, private rented sector, Sandport

I used to make twenty to thirty pounds in a few hours [begging] but it's really dried up recently, yesterday I did three quarters of an hour, I got four or five quid.
Male, aged 40, private rented sector, Sandport

Begging carries the risk of arrest, although it depends upon the discretion of individual Police officers. Being taken into custody however, makes

one liable to the risk of withdrawal setting in, a condition only partly relieved by medication from the Police doctor.

Shoplifting was an extremely common form of earning drug money, although those sleeping rough might be at a disadvantage since their appearance might draw attention to themselves. A shoplifting career also had a limited life since stores were now in radio contact with one another and if you became known it was too risky or you might be barred from places. This resulted in some people travelling, sometimes long distances, out of town where they were not known. One Church worker in Sandport reckoned the cost of acquisitive drug-related crime as follows,

> Most of them need three bags a day which is thirty pounds. If they steal something they need to steal at least fifty pounds worth of goods to get a ten-pound bag, that's one hundred and fifty pounds a day per addict. We worked it out that there are a minimum of four hundred addicts in the town, that's twenty two million pounds, that's excluding how much we spend on policing or solicitors.
> Pastor, The Church, Sandport

These figures seem exaggerated – most of the users I spoke to used one or two bags per day and would probably need to steal thirty pounds worth of goods to get ten pounds cash. Nevertheless the argument about the relation of drug use to acquisitive crime is still valid and is the basis for a large part of the Government's Drug Intervention Programme.

Whilst in the legitimate economy a partner may be valued for their ability to contribute to the family resources, this was mirrored in the illegal economy where users spoke of their own or their partner's earning power with pride,

> He went from burglar to drug dealer, he saw there was a lot more money in it. We were never short of money because he was a good burglar.
> Female, aged 27, shared private rented flat, Sandport

How are you financing it [drug use]?

He finances me, he's got sticky fingers.

Shoplifting?

Yeah.

Is he good at it?

He's shit hot mate.

Female, aged 38, private rented flat, Sandport

One woman was sent out to steal to fund not just her own habit but a partner's as well,

> Well my boyfriend he was lazy and he'd let me do it all, he'd send me out at four o'clock in the morning, I had to go round looking in people's sheds and get tools and lawnmowers and things.
>
> Female, aged 26, shared private rented flat, Sandport

Prostitution was also an option for women (I never heard anybody mention male prostitution), and although I did not specifically ask the women respondents whether they had resorted to prostitution I became aware through third parties that at least three of the nine women I interviewed were selling sex for drug money. In a follow-up interview one interviewee did talk of this, saying that she had regular customers but had stopped selling sex on the street since she had been attacked.

With the easy availability and stable prices of drugs a predictable daily level of disposable income can be calculated. However, this cannot always be guaranteed and users will have good days and bad days dependent upon income. Methods of dealing with lack of supply are to forego other expenses, commit crime, borrow or earn money, rely on other available substitutes such as methadone, change the method of delivery or undergo withdrawal. In theory one method of providing income for drugs would be to forego housing and living expenditure – not to pay for rent, utility bills, food, clothing, toiletries or other items, and

users do find themselves in this position at certain times which can lead them to suffer in appearance and health.

However, when it comes to housing costs the situation is somewhat different for those on benefits. The vast majority of interviewees were economically inactive, either receiving some form of sickness benefit, Jobseekers Allowance or Income Support. (Only two people were working). Consequently, their housing costs were covered by Housing Benefit and paid direct to the landlord. This means that effectively housing costs do not impinge on disposable income and therefore potential drug money. On an individual basis Housing Benefit means that tenants do not have to take any responsibility for housing costs. This situation is likely to change however, as certain Pathfinder areas are now trailing a system whereby Housing Benefit will be paid direct to the tenant. The consequences of this for drug users will be discussed in the concluding chapter.

However, the situation can become more complicated where the cost of accommodation is greater than the maximum amount of rent Housing Benefit are willing to pay. This affects people under twenty-six particularly who are tied to the local cost of a single room – consequently they have to make up any shortfall out of their personal benefits. Even those over twenty-five can have the same problem and find themselves having to pay twenty pounds per week out of their own benefit, and given the choice between paying the top up and paying for drugs, the latter could prove more tempting. The reduction in disposable income this entails could also be an incentive to fill the gap by committing crime. Similarly, with utility bills, services may get cut off,

> All your money goes on drugs, there were some days when I'd like have a piece of toast all day. Some bills you don't have to pay, the likes of the Council Tax – no chance. Obviously you worry about your electricity because you need that, watch the telly, keep the fridge on, when it's cold. But the rent was paid by Housing Benefit so you're not really worried about that.

Male, aged 33, warden of supported hostel, Dockland

However, for some users the need for money may become desperate,

> I sold all my stuff, I sold all my furniture, even my cooker and fridge, there was only a mattress, I didn't even have a telly or radio.
>
> Male, aged 28, supported hostel, Newcity

The Residential Lettings Association, representing the views of landlords, is dissatisfied with the Housing Benefit system for a number of reasons, including levels of payment,

> If anything Housing Benefit levels haven't gone up in line with rents, they haven't increased as rents have done. Up to about two years ago rents had been going down and down and down, now there's a gradual rise because there's more demand for rented accommodation.
>
> Residential Lettings Association

This makes the point that the private rented sector has many sub-sectors, and is in fact a sub-sector of the overall housing market. What happens in one sector affects supply and demand in the others. So, as people are denied access to owner occupation because of high house prices, they are forced into rented accommodation, which means an upward pressure on rents and increased problems of access for those on benefits who landlords are already reluctant to house because they are perceived to be potentially problematic as individuals or because of benefit bureaucracy which has become synonymous with delays in payment.

One would expect that housing market forces would bring about a situation where quality and price of housing would be roughly in line – that the more one pays the better standard one would expect. However, the Housing Benefit system distorts this so that there is no effective 'shopping around' for accommodation, which would bring the sector into equilibrium. In fact some landlords in Sandport charge high rents for

poor quality accommodation because Housing Benefit will cover either the whole or most of the rent and the sort of tenants they are willing to house would not be housed by other landlords. These are a minority of landlords but they are particularly associated with the housing of problematic drug users. These landlords would not be able to attract better-off or working tenants because of the low standard of property – poorly maintained interiors and exteriors – and a vicious circle comes about whereby poorly maintained property is not treated with respect by those who live there. Where several houses in near proximity fall into this condition the locality acquires a negative reputation, the 'filtering' of tenants who are able to move out takes place and the people who move in are those who have no interest in the area, do not have any choice or have low expectations.

When people are working and not on benefits the situation is somewhat different. Several people had had a period of owner occupation in the past whilst also maintaining a drug habit. These periods, apart from the drug use, were times when to all appearances they were conventional – in steady relationships, working, paying a mortgage,

> I had a major fucking habit, I was working, I had a house, a wife, two daughters, a dog, a nice house as well. That's when my heaviest drug use was. Obviously I was registered on methadone...everyone's got this thing about a drug addict like falling around in gutters and stuff like that. I led a perfectly normal fucking life.
>
> Male, aged 48, shared private rented flat, Sandport

It is noteworthy how strong the work ethic was in some people, who had managed to combine drug use and demanding jobs for long periods (indeed couldn't function at work without drugs). But, having said that, many people had also lost their jobs because of drugs. One user said he had a "good eighties" under Thatcherism,

> [We were] a typical eighties spouse and partner running around aimlessly, constantly running after your tail, trying to get more

> money to feed the beast, the beast being the mortgage, the car, the drugs, going out socializing...it was incredibly wearing.
> Male, aged 30, shared private rented flat, Sandport

Whilst these people were owner occupiers their standard of living was higher, their disposable income was greater and their drug use increased to match. So the association of heavy drug use with areas of deprivation and poor housing becomes more complicated. Heavy drug use is associated with a high level of disposable income, but in one scenario this might result from employment and be reflected in owner occupation and conventional consumerism, the other scenario might be living on benefits with the rent covered and disposable income from other sources – crime (including dealing), selling the Big Issue, working in the black economy, and prostitution. It is notable that one of the heaviest drug-using groups were said to be prostitutes working in Newcity but, disappointingly, no further information was collected on this group.

Housing costs, to sum up, are one element in an equation which balances expenditure and income. Whilst housing has use value to the person who owns or rents it, it also has a commodity value to those who are seeking accommodation so that people who wish to use it in some way – to take drugs, for shelter - may enter the equation as income in the form of drugs or money. For those on full Housing Benefit there will be no impact on their disposable income. For those who have to pay a top up from their benefits there will be an impact that may necessitate decreasing drug consumption or increasing income by legal or illegal means.

4.8 Housing and the geography of drugs markets

In this section I will further pursue the idea of housing as a commodity in the context of social relationships and dealing networks. This will give me an opportunity to consider drugs markets in the study areas and how

they may or may not be place specific and dependent upon particular housing forms and locations (Eck, 1995; Rengert et al. 2000). Several people in the sample had dealt in drugs and one house I visited had been raided by the Police the week before my interviews

The distinction between drug user and drug dealer is never an easy line to draw. Given that most of the users in the sample are part of a social network where mutual support may be a highly valued mark of membership, it is inevitable that people will use drugs communally and share their supply, if not willingly then because of a feeling of obligation. A few of the interviewees had set themselves up in business with little long term success, although there were short term rewards of money, drugs and status,

> *So you were making money?*
> I was at first. When I first started off I was living the high life, I used to sit there with three ounces of skunk and two grand in cash, smoking the weed, buzzing with my mates, all my mates were trusted, sitting there.
> *Is this in your nan's house?*
> Yeah, we used to have a room upstairs, couches and a telly and that...I had a hydroponic, I used to grow the stuff.
> *Where, in your bedroom?*
> Yeah, in the spare room...you could make a film of it, all the faces looking in with the light shining.
> Male, aged 26, supported hostel, Dockland

This encapsulates what the drug user requires of a location – a private space, but one where access can be controlled and social contact can take place in comfort and safety. However, this scenario was short lived, the profits were used to pay for heroin and the dealer suffered at the hands of vigilantes and was made homeless. The adolescent bedroom, secure from the rest of the family was sometimes mentioned as a site of drug use, and initiation from one sibling to another,

> At first he [brother] just used to smoke weed but when he found out I was on the gear, he went into my room and started doing it like, said can I have a bit of it and he ended up on it.
> Male, aged 23, supported hostel, Dockland

Another ex-dealer dealt in cannabis from a flat with another two friends. The location afforded a certain amount of privacy and the entrance was concealed around the back of the property. Because it was above shops, any noise would not be noticeable and because the road outside was so busy users coming and going did not stand out. Communal use of drugs in the flat was common,

> There was three large shops underneath it, a chippy, a florist and a hairdresser's.
> *And did the front door lead to the street?*
> No, there was an entry that led to the back of the shops...it wasn't getting noticed because the chippy was packed all day, so was the florist, it's quite a busy area around there. There's a railway crossing so nobody really noticed.
> *And did people begin to use the flat as a kind of meeting place?*
> Yeah, I describe it as a sit-off, a place where you could sit and you knew no-one was going to bother you.
> Male, aged 18, house in multiple occupation, Sandport

Surveillance was also an important function of the location, the ability to monitor the street, and since the regulation of drug trade often depends on violence, the locations for dealing are often the locations for violence,

> He [the dealer] used to let people tick weed until next Friday, and every now and again people wouldn't pay. They lived in the area and they used to walk past the windows, and he always used to be stood in the window for people who hadn't paid him, so he used to run out and kick off, and then their mates would come over to help that lad out, and then I'd have to come out so then there was a riot in the street practically.
> Male, aged 18, house in multiple occupation, Sandport

Dealers are in something of a dilemma regarding their accommodation. Whilst a fixed location is useful to a dealer it also makes them vulnerable to Police action, and the spectacle of a constant stream of visitors at all hours may draw the attention of neighbours. On the one hand they need to be available for business, on the other they need to be discreet. Most dealers used cars which were deliberately nondescript; their aim was not to attract attention,

> My fundamentals are a decent car and anonymity.
> Male, aged 30, shared private rented flat, Sandport

> I rented a house, just on the border of Cheshire and Derbyshire, very discreet, I didn't know my neighbours, a nondescript house.
> *Did you deliberately choose it for those reasons?*
> Oh yes, because I was always seen in a nice car, so I'm just your average businessman on the road.
> Male, aged 43, living with friend, Sandport

One insight on drug using locations was gained when I re-interviewed people living in a HMO in Sandport. I was interested in the movements and interactions between the tenants, many who were drug users. I wanted to look more closely at how supportive they were as a group or whether their relationships were merely instrumental, revolving around the supply of drugs. However, these re-interviews gave me added insights on drug-using and dealing locations. There had been several changes since I conducted the first interviews. Of the five people I originally interviewed one had left, another was out, so I managed to re-interview three. Two of the people I interviewed had turned to dealing and the house had been raided by the Police the week before. Doors were smashed and boarded up. One resident had been charged with possession of Class A drugs.

This house had a long history of drug users as tenants, (somewhat in the manner of social disorganisation theory, the population had undergone a

complete turnover and yet the behaviour within the location had not changed). When the landlady had queried the number of people visiting she was told somewhat incredibly,

> We told her we were running a book club. Well if you saw the clothes they were wearing there's no way we were running any sort of clothes catalogue, the ragamuffins that used to come here. Male, aged 55, house in multiple occupation, Sandport

Both dealers' habits had "gone through the roof" to eighty to a hundred pounds a day on heroin plus one hundred pounds worth of crack in one case. Neither had made any financial profit other than to supply their own use. The house had been under surveillance and people had been constantly coming and going. Although one dealer said, "office hours were 9am to midnight" the traffic of people was heavy, ("It's not a dentist's or doctor's surgery, but it's ten times as busy, that's when it started to get out of hand.") Nevertheless, he said that to have a private location for sales was less risky in terms of the Police stopping and searching people on the street, ("I'd prefer they scored here and used here than get pulled on the streets"). His story forms the basis of the following biographical sketch:

Terry, aged 55, HMO, Sandport

At fifty-five Terry is one of the 'old school' heroin addicts whose drug use started around 1970 when the main supply was stolen from chemists' shops. Although born in Sandport his drug use was established when he started visiting clubs in Soho and using at weekends. He gravitated to dealing amphetamines and served eighteen months in Brixton prison. Returning to Sandport for four years he then spent considerable time abroad in the building trade, mainly in Saudi Arabia where he saved a large amount of his wages, married and bought a house in Sandport. When the marriage failed his wife was legally apportioned the house and he continued to

work in Bahrain and continued to use heroin – indeed pointing out that the drug promoted his ability to work, unlike alcohol.
Although 'dry' in Saudi Arabia, he has always been a heavy drinker, going on prolonged 'benders' when the opportunity arose. When the work finished he returned to Sandport and continued to drink heavily and use heroin. This resulted in severe health problems until he was given an ultimatum by his doctor to stop drinking or die. Apart from the odd lapse he has been dry for eight months, although he still uses heroin.
Currently living in a poorly maintained HMO occupied by several drug users, he nevertheless is philosophical about his position and shows no self-pity, although retains some bitterness at his wife ending up living in the house he sees himself as having paid for.
On re-interview Terry had been dealing heroin and crack from his flat and had been raided by the Police. Fortunately for him he was not in possession of drugs at the time, although another tenant was charged with heroin possession. Dealing had not resulted in any improvement in his material circumstances, merely giving him the ability to increase his own drug consumption.

The vulnerability of a fixed location can be avoided by 'going mobile' both in the sense of carrying out the trade from cars at pre-arranged destinations and by the ubiquitous use of mobile phones (which, incidentally have decreased neighbourhood nuisance since deals can be conducted at pre-arranged, anonymous public sites away from residential areas). Driving for dealers was also a means of earning money and drugs – either transporting large quantities from one region to another or dropping off ten-pound bags locally,

> I did driving for dealers and that but I was purely doing it for the heroin you see, because you get paid in heroin as well as cash, you get cash but you'd be sorted all day, get free heroin all day you see so that was the attraction.

Male, aged 29, parents' house, Sandport

In terms of the typology of drug markets (Eck, 1995), the dealers I spoke to were operating within a closed market, that is they sold drugs to people within a social network, or friends of friends who could be vouched for. Closed markets do not need to be place specific, whereas open markets need to have an identifiable location where strangers can make contact with sellers they do not know. One seller did not know his customers personally but they were vetted by the supplier who would arrange for the person to visit the flat of the seller, thus ensuring that they were one step away from a possible Police raid, the seller taking the risk of being caught in possession.

Location and design of an area also determine the extent to which non-residents can gain access to drug supplies. Self-contained peripheral social housing estates may be less accessible than central locations served by transport links (Lupton et al., 2002). It is no coincidence that both of the dealers' homes I visited were in the town centre, fulfilling the criteria necessary for the promotion of a drug market – demand from a young, unemployed population and near to other facilities such as public and semi-public places that can serve as using sites, (as well as the houses of friends), plus facilities such as treatment centres and food supplies from charitable sources. Houses and flats in the town centre could also serve as transit locations for stolen goods shoplifted in town centre shops and serve as a market for these goods,

> A lot of burglars come here, it's been raided quite a few times in the past."
>
> Male, aged 34, shared private rented flat, Sandport

> A couple of weeks ago some stupid lad run up to our flat to try and hide this bag, he had a bag with like silver foil in, so you know, it de-activates the alarms and he threw it in our flat, and I didn't even know this lad, the Police wanted to search our flat

What do you mean it de-activates the alarms?

You know, you go into a shop and there's like bars at the door and you've got like alarms on the clothes, well if you just walk past it'll go off, it must de-activate it and a lot of people have been doing that.

Female, aged 26, shared private rented flat, Sandport

One prerequisite of a drug dealing location is what past research has termed 'weak place managers' who are either unaware of what is going on, are complicit with it or unable to prevent it. These locations, with their transient populations and weak social control fulfil Stark's (1987) criteria for the increased opportunity and motivation for crime – high population density, poverty, mixed land use and transience of population. It might be said that a young, transient, unemployed population is not only a suitable market for drug dealers, but also more predisposed by virtue of motivation and opportunity towards criminal behaviour of other sorts – acquisitive crime in particular and violence associated with drug markets,

Why did you leave the flat?

Rivalry, drug dealing.

Were you being threatened?

No, he actually put a gun to another drug dealer's head, plus I had a little one so we had to move out of the flat.

Female, aged 27, shared private rented flat, Sandport

Individual addresses in these areas often exhibit some of the factors which in terms of defensible space theorists would fail to deter crime – transient populations which make the identification of legitimate tenants more difficult. Front doors to houses in multiple occupation may often be left open so that what should be a private space becomes accessible from the street,

Because we live in town you get all sorts of people coming round...you get a lot of people using drugs on the stairs because they can get in the front and back door all the time.

Female, aged 34, private rented flat, Sandport

Sites for drug using such as this – the stairs of communal buildings - fit the description of "liminal spaces" (Dovey et al, 2001), which may be confused as to ownership, where it is possible to use drugs in relative privacy but with the possibility that if overdose occurred somebody would find you. However, as with living in a hostel, living in an HMO is no guarantee that if you did not appear somebody would raise the alarm. You might even find a stranger dead,

> Say that's my flat, straight underneath my friend lived and she'd gone out for the night and this lad had just let himself in and when she got back the next morning she's screaming Robbie, Robbie (that's my boyfriend), he went down but he found the lad dead, his pants were down and he'd gone in his groin and he'd gone over. [overdosed]
>
> Female, aged 26, shared flat in house in multiple occupation, Sandport

4.9 Conclusion

We have seen in this chapter how the housing market operates in the three research areas to form local 'structures of housing provision' (Ball, 1986), an interlocked series of sub-markets that have impacts on each other. Whilst drug users may not be aware of these structural processes they nevertheless affect the choice, price and quality of accommodation that is available to them. However, they are not simply passive in the face of market and bureaucratic forces – the success they have in accessing accommodation will also depend on their knowledge of the system and ability to negotiate the bureaucracy of housing. This ability may be undermined not only by poor knowledge of the system but also by their priorities as drug users and whether they perceive housing to be of sufficient importance that they can motivate themselves towards long-term planning in the face of short term gratification which the daily need for drugs requires.

Confirming research by Giggs (1991) they are a highly transient population. Some had extensive experience of working abroad but the housing history of most was as 'serial movers' within low quality housing areas. This transience may be due to voluntary or involuntary reasons and may specifically be linked to a criminal lifestyle resulting in periodic spells in prison. This would confirm many of the points about the risks of continuing homelessness and re-offending for ex prisoners (Social Exclusion Unit, 2002).

Confirming previous research by Petry (2000; 2001), we have seen how housing and drugs are linked together in a wider economy and many of the users indicated that the biggest factor influencing the level of their drug use was their available disposable income. This research significantly extends Petry's work by providing qualitative data and by translating a conception of drugs and housing as commodities to the UK situation.

The drug economy was seen to be bound up with particular locations for both consumption and supply and confirms work by Eck (1995) on the geography of illicit retail markets.

The next chapter looks in more detail at location and housing type, and whether certain housing forms lead to increased drug consumption.

CHAPTER FIVE

NETWORKS AND NEIGHBOURHOODS: THE EFFECTS OF HOUSING TYPE AND LOCATION ON DRUG USE

5.1 Introduction

The identification of problematic drug users with poor housing and neighbourhoods is established in the literature (ACMD, 1998). Relating to this and focusing on a particular aspect of it, the central theme of this chapter is an examination of the concept of a 'hierarchy' of housing and drug use. In the research literature this refers to certain deprived housing situations being associated with differential levels of problematic drug use (Meltzer et al. 2002). A related concept is that of a 'drift down' effect whereby drug users come to occupy progressively worse housing conditions as their drug use becomes more established (Benda, 1987; Klee, 1991).

Conceptually this chapter concentrates on the social aspects of housing and the way in which social relations are facilitated by the physical nature of shared housing forms. The literature has established that drug use is diffused on an epidemiological model through social networks in a 'contagion' effect and that this can be facilitated by drug users congregating together in particular locations (Wallace, 1991; Giggs, 1991). This research study examines whether the current and past housing of the sample is or has been associated with high or low levels of drug use. If this is the case it examines what the reasons for this might be.

I proceed by quantitatively analysing the data gathered from the Maudsley Addition Profile regarding people's housing situations and their levels of drug use in the past thirty days and, using SPSS, make some comparisons between particular housing forms and different aspects of drug use behaviour such as method of drug delivery, drugs used and use of methadone. The findings from this limited quantitative data then

informs more in depth qualitative data from the interviews and biographies in examining whether a hierarchy of drug use and housing can be said to exist.

The qualitative data proceeds by seeking the opinions of the users themselves as to what they saw as the reasons for their drug use, and if it was in any way perceived by them to be related to their housing situation. It then consists of an examination of three different housing situations that many in the sample had experience of - living in houses in multiple occupation (HMO's), living in various types of hostels, and the condition of homelessness in the form of rough sleeping. In considering whether these housing forms may be associated with particularly high levels of drug use, I highlight the communal nature of this housing (or lack of it), and look at the social networks of the sample and how they may vary across different shared housing situations, I indicate possible reasons for certain housing forms being associated with high drug use. Using the interview data and the more longitudinal data afforded by the biographies, I also examine the related concept of a 'drift down' effect.

5.2 Quantitative analysis of the relationship between housing situations and problematic drug use

In order to consider whether from the limited sample there was any initial indication of support for the theory of a 'hierarchy' of housing and drug use, I analysed the data gathered from the Maudsley Addiction Profile (Appendix 3).

The respondents were asked about their current drug use levels and practices. Drugs such as amphetamines and ecstasy were used by some of the sample, although very few, so the analysis concentrated upon alcohol, heroin and crack. Using SPSS I ran several analyses to investigate the question of whether varying levels of drug and alcohol use

were associated with particular housing forms. The spread of housing forms amongst the sample was as follows:

Table 2. Numbers and proportions of the sample by housing type

Type of housing	*n.*	%
Living in supported hostel	9	22.5
Living in night shelter	5	12.5
Living in private rented flat	8	20
Living in house in multiple occupation	10	25
Living in council flat	1	2.5
Living with friends	2	5
homeless	1	2.5
Living in parental home	3	7.5
Owner occupation	1	2.5

Due to the small sample size categories of housing were collapsed in order to give larger categories and thus more robust findings. I ordered the data with the aim of looking at whether high drug use was associated with the poor quality, communal forms of housing I had identified. This resulted in two categories of analysis: poor quality communal housing forms at the bottom of the housing hierarchy, and non-communal forms of accommodation that gave more autonomy, better quality and security. The aim was to examine also if by implication a 'contagion' effect could be indicated in the more communal forms of housing as one possible reason for higher drug use.

The revised categories were as follows:

Communal, insecure housing forms = homeless, supported hostel, night shelter, house in multiple occupation, living with friends

Non-communal, more secure housing forms = private flat, council flat, parental home, owner occupation

Table 3. Revised housing types

	n.	%
Communal housing forms at lower end of hierarchy	27	67.5
Non-communal, more secure housing forms	13	32.5

I looked at these housing forms to see if there were any variations in:

- Monthly consumption in units of alcohol
- Monthly consumption of heroin by cost
- Monthly consumption of crack by cost
- Levels of methadone prescribing
- The prevalence of injecting

The results were as follows:

Monthly alcohol consumption

This was of interest since the attitudes of drug users towards alcohol can be mixed. Some users see drinkers as being sloppy in behaviour and appearance and make a point of confirming their distaste for the effects of alcohol. Others consume both drugs and alcohol in large quantities and run added risks of drug-related death due to this combination.

37.5% (*n15*) of the sample consumed no alcohol in the previous month. Of these 15 there was greater abstinence by those in non-communal housing: 53.8% (*n7).* There was less alcohol abstinence amongst those in communal, less secure, poorer housing forms: 29.6% (*n8*).

40% (*n16*) of the total sample were in the mid range of alcohol use in the previous month (from 10 to 460 units). These drinkers were composed of 44.4% (*n12*) of the sample living in communal arrangements and 30.8% (*n4*) of the sample living in non-communal arrangements.

22.5% (n9) of the total sample were in the heaviest alcohol consumption range (between 460 and 1080 units in the previous month). 25.9% (*n7*) of those living in communal housing forms were heavy drinkers and 15% (*n2*) of those living in non-communal forms were heavy drinkers. Of the sample of heavy drinkers six out of the nine were living in HMO's.

Monthly heroin consumption

Heroin had been, or currently was, the main drug of choice for the entire sample. 77.5% (*n31*) had used heroin in the past month.

The percentage of those using no heroin in the past month, 22.5% (*n9*), was higher in the non-communal housing population. 30.76% (*n4*) of those in non-communal housing were abstinent, whilst 18.5% (*n5*) of those in communal housing were abstinent.

Of those spending up to three hundred pounds a month on heroin the percentages were much the same across accommodation types. 48% (*n13*) of those in communal housing forms were in the middle range, whilst 46% (*n6*) of those in non-communal housing forms were in the middle range.

Of those using from three hundred pounds worth of heroin a month to nine hundred pounds worth the contrast was marked. 33% (*n9*) of those living in communal housing forms were heavy heroin users. Only 15.3% (*n2*) of those living in non-communal housing were heavy heroin users.

Method of heroin administration

Of the 31 people who had used heroin in the past month, 51.6% (n16) were injectors (Twelve male and four female). The percentage of those injecting was greater in communal housing than in non-communal forms. 48% (*n13*) of the communal housing population were injectors whilst 23% (*n3*) of the non-communal housing population were injectors.

Three of the six users in supported hostels were injecting, four of the five night shelter users were injecting and six of the nine HMO users were injecting. Thus the greatest proportion of injecting was in the night shelter sample, followed by the HMO sample. The heaviest users of heroin were all injectors. A history of intravenous drug use was much higher amongst the hostel and night shelter population than in the rest of the sample, although there was a general reluctance to the sharing of needles, or, more likely, a reluctance to admit to doing so,

> It just depends on the type of person, a lot of users won't [share needles], it doesn't matter how much they're rattling, they'll go and get clean pins, but there is some that will use them.
> Male, aged 26, night shelter resident, Newcity

The latest figures for lifetime injecting practices of those in treatment in the region (Beynon et al., 2002) show the highest rates of injecting in Sandport for both males and females, at 76.2% and 68.1% respectively. Females also show the highest rates of sharing injecting equipment at 47.1%, and males the second highest at 46.5%.

Monthly consumption of crack

Crack was much less used than heroin. Only 17 (42.5%) people had used crack in the last month. This is despite the fact that crack and heroin are often sold together – the crack to give a stimulant effect and the heroin to level the user out afterwards.

59% (*n16*) of the communal housing population had not used crack in the past month whilst 53% (*n7*) of the non-communal population had not consumed crack, thus going against the trend of the other findings.

In the mid range of crack users spending from ten to three hundred pounds a month, 26% (*n7*) of the communal housing group came into this category whilst 38% (*n5*) of the non-communally housed came into this group, again reversing the trend for the heroin and alcohol.

However, of the highest crack users spending from three to nine hundred pounds a month on the drug, the percentage of communal housing dwellers was 14.8% (*n4*) and the percentage of non-communal dwellers was 7.6% (*n1*).

There were no significant gender differences in levels of alcohol and heroin use or method of administration. However, amongst the small number of heavy crack users there was a higher proportion of women.

Drawing on the results there seems to be an association in the sample between living in communal housing and heavy consumption of alcohol, heroin and injecting behaviour. Results for the use of crack are not clear, although there was a concentration of heavy crack users in HMO's. Heavy users of heroin were most likely to inject and unlikely to be on a methadone programme. As a proportion, night shelter users had the highest rate of injecting followed by those living in HMO's.

Only one person (10%) in an HMO was on a methadone programme. By contrast of the nine people living in supported hostels, six were on a methadone programme, giving an indication of the staff facilitation of access to treatment and possibly the greater motivation to change amongst this group, notwithstanding that most of them continued to use heroin in small amounts. Their levels of methadone dosage were the highest in the sample, which gives an indication that before entering the hostel they must have had fairly substantial dependencies. A housing

history of these residents showed them to have had a highly transient lifestyle, often incorporating periods of homelessness. A drug use history showed them to have been some of the most chaotic users, factors that led them to present themselves as homeless at the hostel, often in very poor physical and mental health.

These findings give support for the hierarchy of housing model, although the deficiencies of the sample size make claims to any conclusions provisional upon further research. In order to provide more robust evidence the research utilises qualitative methods to examine the current and past housing of the sample and whether it cold be associated with differential levels of drug use. I start by looking at whether the sample themselves saw their housing as an influence on their drug use.

5. 3 Proximate and non-proximate reasons for drug use

In order to examine whether people saw their housing as a contributory factor in their pattern and level of drug use I asked the sample why they took drugs. In answer people concentrated on the most proximate factors or the factors most directly affecting them and perceived by them to be a cause. The main reason given was because they were addicted already and to come off was too painful. The second reason given was 'boredom' and the third reason was as a coping mechanism to deal with other emotional states or stressful events. The following statement typifies the first reason,

> We take them because we're addicted to them, it's not for fun, we just take it to stop us being ill, and that's why we were taking them to stop us being ill, nothing to do with pleasure or the situation we were in or anything, no matter where we go, we could be living on the moon, but we've got to have what we have to make us better, because we're not prescribed any medication to help us. Like a lot of people get methadone, or DF's and sleeping tablets. We don't get any of that.

Female, 34, shared private rented flat in HMO, Sandport

Here there is no acknowledgement of environmental forces, just a physical and psychological compulsion to use, a pharmacological determinism that must be satisfied. This had nothing to do with the influence of other people,

> The only thing that's stopping me [giving up] is not the circle I'm in, it's just the actual drug, because I don't have to break out of a circle, I don't hang around with anyone, all I do is come out, get my drugs, and go home, I don't take them for a buzz.
> Female, aged 29, living in family home, Sandport

Many people mentioned boredom, sometimes along with the difficulty of filling in time,

> Basically I'm bored, bored shitless, that's why I take drugs.
> Male, aged 30, shared private rented flat, Sandport

> The thing is once I'm on detox I'm just bored. I can sit and watch telly all day when I've had some drink and drugs, but I can't watch it for twenty minutes sober.
> Male, aged 40, private rented flat in HMO, Sandport

'Boredom' can be a way of describing the result of complex psychological and social processes, but could also be a rationalisation or a failure of insight or unwillingness to analyse the underlying stressors which may lay behind drug use. Agency staff were much more likely to accept a link between boredom and environmental factors,

> The crucial factor is, as well, actual boredom. I think that's a really important push factor, and certainly that's what young people report. They've been in hostels, they've been in night shelters and they start using much more because it kills time, it stops people thinking about where I am.
> Drug agency worker, Newcity

Others more specifically targeted housing and neighbourhood,

> It's widely documented that people living in poor housing stock and in areas that have a number of signs of social deprivation, there are higher concentrations of drug use, so I do think that environmental factors do contribute to drug use...there is a strong link between a poor living environment, lowered self-esteem and seeking out of substances and behaviours that's going to make people feel better.

However, this worker qualified the statement by adding,

> It's a number of factors influencing each person, it's not everyone that's using drugs to escape from the fact that they had a terrible childhood or they've been in an abusive relationship or they lived in a terrible area. Some people have just used drugs because they've enjoyed them, so it's a very difficult thing to say that there's one thing that causes it.
>
> Client support worker, drugs agency, Dockland

Another worker identified the methodological problems of isolating housing as a factor in the causes or maintenance of drug use, whether drug use is a factor which leads people into areas of poor housing, or whether people in poor housing are more prone to develop problems of drug use. Whilst to definitively answer this would require more extensive, multivariate research than this present study is capable of, it is a fundamental question for research, usually framed as the difference between 'compositional' or 'contextual' factors in neighbourhood influences (Friedrichs et al. 2003). This worker linked poor housing to poor education and consequent low income in adulthood,

> I think it would be very difficult to single out the physical environment. We deal with people who have a high incidence of being in care, of abuse, people whose lives have not been easy in a variety of ways, and there's no doubt that drug use has been a part of anaesthetising certain things. I suppose where you find

> people who have not had too much out of the education system, then they would tend to have access to some of the poorer accommodation which becomes part of it I suppose. But it would be difficult to separate out accommodation per se, I think it's just part of general kind of lifestyle chances where people have found themselves.
> Senior Probation Officer, Northborough

If some agency staff tended to see housing as part of a web of causation, as one of many factors leading to drug use, others, like the above example, saw it as both a cause and an effect.

The built environment was not mentioned by the sample of drug users when asked why they started or continued to use drugs. They mentioned environmental factors only in a general way – the home environment, the area they were brought up in, the social networks they moved around in, despite the fact that these may all be said to be mediated in some way by patterns of housing settlement. Some denied that their housing circumstances had made any difference to their use. With modern communications, particularly mobile phones, location made little difference to securing a drug supply,

> I can pick up the phone or half an hour in the car, perhaps not even that, it's only a phone call away.
> Male, aged 38, shared private flat, Sandport

If you were addicted your accommodation made no difference, and one respondent ascribed an almost mystical ability of drugs to search out the user in the most remote locations. Whilst living in Saudi Arabia he bumped into an old friend,

> But you don't go out your way, it finds you. I don't know if you remember M, he was out there and the size of Saudi Arabia, and I bumped into him, and he's got access to heroin, pharmaceutical heroin, I mean the chances of that are a billion to one.
> Male, aged 55, private rented flat, HMO, Sandport

Whilst accepting that certain places were likely to increase their use, some people specified that it was the people in these places, not the built environment or area itself,

> It was the circles I was in, not the area I was in, peer pressure and myself, just curious...and wrong choices.
> Female, aged 42, owner occupier, Sandport

> It doesn't matter where you are, if it's there, you'll find it. If you've got a habit you'll find a way of sorting it out no matter where you are...it's the people around you, I don't think you can name an area now that's clean.
> Male, aged 36, private rented flat, Sandport

People were more likely to see their drug use in terms of personal weakness and not to blame environmental factors, despite for instance, growing up in areas of high drug use, of having siblings and other family members with drug problems, of having suffered sexual and physical abuse. In individualising their problems and blaming themselves they can be said to be "prisoners of the proximate" (McMichael, 1999), accepting dominant medical perspectives and the individualising of ill health in preference to the environment,

> I think quite a lot of people are taught, and socially...they're taught to look solely in terms of themselves. It's you that has a problem with drugs, it's your problem. People are very hard on themselves, and they might not also want to see some of the things that have happened to them, pushed them into drug use.
> Drugs agency worker, Newcity

People who believe they have an 'addictive personality' or have been told they have a disease will be unlikely to see a change of environment as being important ("you take your head with you wherever you go").

5.4 Problematic drug use and a possible 'hierarchy' of housing

Following on from the last section, it was only when I posed the question directly that the sample thought about housing and drugs being, or not being, related. To get them to think about this and go into more detail I asked two questions. Firstly, where were they living when their drug use was perceived to be at its heaviest? Secondly, did they think that any of the places they had lived in over the years had affected their level of drug use?

With this added prompting, the availability of drugs in certain housing forms and locations was picked up on,

> I'd definitely say bed and breakfasts are bad places if you've got a drug problem.
> Male, aged 37, council tenant, Dockland

> *You mentioned hotels.*
> Well, since I split up with my wife and I was going to live in places like that then yeah, my drug use has gone worse in places like that because of the amount of drugs and the people that were there.

The same person identified a rise and fall in levels of use depending on the area he lived in,

> Actually when I was living with my wife in council houses most of the areas that we lived in weren't really the bad areas of Newcity for drugs, they were the better areas where there weren't many drugs. In that sense I suppose it kept mine and her drug use down. But saying that, when I lived in places like [peripheral estate], which is one of the worst places in Newcity for drugs, then my drug use would go up.
> Male, aged 43, night shelter resident, Newcity

One user who had lived within the stability of the family home throughout his drug use reflected on the possibility of a different housing and drugs trajectory,

> What you were saying, you hit the nail on the head, it [stable housing] has been a big factor in keeping me...if I'd been thrown out at the age of twenty five and gone to live with my friends I could well have ended up being what you call a jockey, which is a driver for drug dealers, so you end up driving a car round delivering drugs all day. I could quite easily have ended up doing that, I could be in prison now.
> Male, aged 29, living in family home, Sandport

Another saw her drug use fluctuate with her accommodation,

> When would you say your drug use was at its worst? Where were you living then?
>
> Nowhere
>
> *Just flitting from people's flats?*
>
> Yeah, until I got my own flat when I stopped taking it altogether.
> *Do you think having stable accommodation reduces your drug use?*
> Yeah, I tend to stable out, I like to go and do what people say...mundane things, go shopping, do this, do that, which I quite enjoy. I enjoy cooking but when I haven't got nothing life to me is fucking worthless. If I have a hit and die so be it. If I have a hit and enjoy it, wonderful.
> Female, aged 35, shared private rented flat, HMO, Sandport

> When you're in a place you just feel like you haven't got fucking anything and you've hit the bottom and that, your drug tends to go up more whereas if you're in a stable environment and you're feeling more happy then you don't use so much.
> Male, aged 26, supported hostel, Dockland

The direction of causality was picked up by one user, who saw living in certain types of accommodation being the result of his drug use,

> I'd say my drug use has put me in the accommodation that I'm in.
> Male, aged 30, shared private rented flat, Sandport

For one person his housing reflected a series of negative personal circumstances in a real and symbolic way,

> I was like in an empty fucking house, it was actually a council house but it was just...you've seen empty buildings better, it was bad like...it was horrible, I hated it.
> *Was that the worst period?*
> *That was the worst period of my life, yeah, it was scary, using a lot and my health went right down, my mum nearly had a nervous breakdown, I split with my girlfriend, it was horrible like.*
> *So these surroundings in this house, were they a mirror of how you were feeling in a way?*
> Yeah.
> *The atmosphere? Or is that a bit too fanciful?*
> No, it's not mate, it's not.
> Male, aged 26, supported hostel, Dockland

One user pointed out the relation between her depressing home environment and drug use,

> I was outside my flat today crying and begging [landlord], I said you've got to decorate my flat because I'm going to end up killing myself because it really is depressing me.
> *Because it's so depressing do you think that may have increased your drug use?*
>
> Definitely, yeah, if I had a nice place...
> *Do you think if you had better accommodation you might reduce your drug use?*
>
> Definitely, definitely, I want to stop altogether.
> Female, aged 26, shared private rented flat, HMO, Sandport

People seemed to think that their levels of drug use had increased whilst living in certain types of housing, particularly those with a large degree of communal facilities at the low end of housing provision, namely houses in multiple occupation, private hotels, large homeless hostels, Probation hostels and bed and breakfasts. To these was also added the condition of being without housing, particularly rough sleeping. I wanted to examine this idea in more detail and in analysing the housing biographies of the sample I looked at whether fluctuations in their drug use had been associated with certain housing situations. I concentrated on three housing situations many of them had experience of – living in houses in multiple occupation, living in hostels and the condition of homelessness. If there were associations I also wanted to examine possible reasons for them.

5.5 Patterns of problematic drug use in houses in multiple occupation

I want first to concentrate on a housing form, houses in multiple occupation, in a sub-sector that was occupied by the majority of the sample – the private rented sector. In previous research the sector has consistently been associated with higher morbidity and mortality rates (Cairney and Boyle, 2004) and is the tenure in which nationally thirty per cent of drug dependent users in private accommodation live (Meltzer et al., 2002). It is a very diverse form of housing with several sub-sectors, some catering to affluent groups, but in the case of drug users in the sample largely situated at the low rent end of the market and involving various degrees of sharing amenities. The data illustrates how this sector caters for those who cannot access other housing forms and who have restricted choice in location, quality and price. This section is largely based on data from Sandport where the sector, in the absence of social housing for single people, provides the main source of housing supply for drug users.

In common with many other English seaside resorts Sandport has suffered a mis-match in the supply and demand for leisure facilities (Cooper, 1997). Supply side weaknesses include a lack of investment in accommodation and poor management standards. The nature of the housing stock consisting of large Victorian and Edwardian houses without lifts or car parking has added to the difficulties. High maintenance costs of such properties allied to a declining tourist market led to an exit from holiday accommodation provision of many guest house and hotel owners and the identification of the vacant property by private sector landlords looking for investment. This was achieved by renovation, typically by sub-dividing into single units in response to the changing demand. This demand was fuelled by poor access to social housing and, more recently, as an effect of high house prices which have forced people into rented property. The current housing boom has led to two economic responses by landlords. Some are taking advantage of high prices to sell up and make a profit, and others are entering the market on a 'buy to rent' basis, seeing housing as an investment and, in view of the uncertainty in the pensions system, as an alternative pension.

The housing stock in Northborough totals 121, 777 dwellings comprising,

Owner Occupation	91,287
Local authority stock	13,210
Private rented	10,143
Registered Social Landlord stock	7,137

Northborough Council Housing Strategy 2002/03 – 2005/06: 16

The private rented sector stands at 11.9% nationally. In the postcode area which covers Sandport town centre it stands at 29.9%. There is also a concentration of houses in multiple occupation in the old tourist accommodation areas. The borough of Northborough contains approximately three thousand houses in multiple occupation. In Sandport

these are concentrated in the town centre ward or adjacent to it. This area contains a higher than average number of one-person households – 48.8% compared with 30% nationally. (2001 Census) There are, however, a large number of elderly people living in this area so one cannot assume these one-person households are necessarily a risk group for drug use.

There has been much variability in the definition of what constitutes a HMO. The (then) Department of the Environment, Transport and the Regions in 1999 described a HMO as "a house which is occupied by more than one household. This includes houses comprising bedsits, all shared houses, all houses with lodgers and houses converted into self-contained flats." (DETR, 1999: 10) I have used HMO in a qualitative sense as well as number of persons in a property. The HMO's occupied by the sample usually have more than three households, are at least three stories high and contain a number of shared facilities. In a qualitative sense they are usually poorly maintained, poorly decorated and furnished, and are either lacking in facilities or are provided with poor facilities and poor fire safety.

Whilst it is true that large amounts of money have been invested in the resort, and housing associations have moved in to undertake renovation and management of some of the worst properties, the condition and management of some of this stock continues to be a concern,

> Whilst most private sector landlords offer a high quality service, unscrupulous elements continue to create problems linked to poor quality housing, disrepair and anti-social behaviour of tenants. Northborough Council Housing Strategy 2002/03 – 2005/06: 21

There remain streets and specific addresses associated with poor management and quality, and, more specifically, are stigmatised locally as being associated with drug use. However, drug use occurs in other areas as well,

> The ones in that accommodation at the back of the town centre are the worst but they're the ones that are most noticeable, they're the ones that you would see and identify as drug users and the ones that are living quite peacefully in council houses in on the outskirts, people don't recognise them as drug users.
> Drug agency worker, Sandport

In recounting the addresses where they had lived over the years respondents named the same locations in the town centre time after time, and many people's low expectations led them to believe that this was their natural territory,

> I've just been living in bedsits in town, always in town because they're the cheapest really.
> Female, aged 34, private rented sector, Sandport

Being centrally located with a number of people using drugs may be convenient for supply but can cause problems,

> Because we live in town you get all sorts of people coming round...you get a lot of people using drugs on the stairs because they can get in the front and back door all the time.
> Female, aged 34, private rented sector, Sandport

An example of some of these issues is the following biographical sketch:

Sue, aged 35, HMO, Sandport

Sue is a 'serial mover' within the poor quality, privately rented housing market in Sandport. Although she talks about her desire for more permanent and better quality accommodation, her drug use means that she has lost her accommodation several times in the past, either because of disputes with the landlord, problems with the Housing Benefit system or through going into prison. Her

attitude to her transience is fatalistic and one of a streetwise 'survivor'.
She has had an extremely disrupted childhood and adulthood. From the age of five she was sexually abused by her brother and was not believed by anyone when she told them of this. Her mother used her to earn money as a prostitute since the age of thirteen. She has very poor mental health and takes antidepressants and sleeping tablets as well as using both heroin and crack. She supplements her benefit income by begging, selling drugs and prostitution. She has had a drug habit for twenty years and attributes this partly to the abuse she underwent as a child. She was prescribed methadone for many years but is not currently taking any.
She has been on Probation ten times and received three prison sentences for affray and possession of a large amount of heroin. When Sue attempts to quit heroin she substitutes alcohol which makes her behaviour more unpredictable and dangerous to herself and others. This resulted in her last conviction for affray.
In her Probation Officer's pre-sentence report it is said that little effective work can be done with her be cause of her "problems, accommodations and poor health." It goes on to say that "now she has found permanent accommodation her lifestyle has become more stable and she has started to address her drug use again." However, this was not borne out in my interview and subsequent conversations with Sue when her lifestyle and accommodation in a house occupied mainly by drug users seemed to be linked in a process of deterioration.

A growing source of accommodation for drug users in Sandport is a local church that has gradually expanded a portfolio of houses for rent to people who are homeless, many of whom have drug problems. Much of this housing is of a basic sort but represents the only chance of shelter

for some people. The pastor is a social entrepreneur who makes a virtue of being light on bureaucracy, which makes the organisation extremely flexible in terms of access. It now has over sixty tenancies, mainly in houses in multiple occupation, and he is critical of the council which has failed to address local homelessness,

> The local borough, who we pay our taxes to, don't meet the need, and I'm not being political, so the Church has to meet the need. So we grew organically...we are outside of all the rules and restrictions that are placed on you...we decided that we will remove ourselves from it, we have no funding except what we produce ourselves. We say this is a ministry, anything we produce goes back to the people.
> Pastor, The Church, Sandport

However, these houses were associated with a number of incidents during the time of the fieldwork. Two people were beaten to death with baseball bats, the perpetrators whose flat it was being local doormen involved in the supply of drugs. Later, another one of the tenants (an interviewee in the sample), was murdered. Later still, four addresses belonging to The Church were raided and two people arrested for supplying class A drugs. When I interviewed the Pastor, well before these raids, he was pragmatic about drug dealing,

> We have dealers that live in our houses. Now that sounds like we're going against what we're trying to do, but we've actually said to them, we don't like what you're doing – if you decide to make it mobile [dealing from cars] then we'll let you live here.
> Pastor, The Church, Sandport

Three of the sample lived in Church properties and many of the problems they identified could be applied to houses I multiple occupation and pockets of private rented housing across the borough,

> I've lived there a year and I had to rip all the carpets up because the people who lived there before me weren't very hygienic and God knows what was on those carpets. In my living room there's

also a smashed window that needs to be fixed. In my bathroom right above the toilet, like, the ceiling's collapsing, you can see the floorboards of the flat above.

Female, aged 26, shared flat in HMO, Sandport

When one has no choice of location or quality, even poorly maintained property may seem desirable, although the initial feeling of gratitude at being housed may dissipate to feelings of resentment,

They never like where they are now, they're always looking for somewhere better. I think a lot of people feel they've been forced to live where they're living.

Tenancy support worker attached to rehab, local area

There were several complaints about quality of accommodation and management of properties which the imbalance of power in the landlord/tenant relationship makes it difficult to challenge,

They don't envisage the responsibility of the landlord in maintaining it and they don't feel they have any voice or power to challenge that. You very rarely get a drug user ever getting a deposit back from the landlord, and they don't challenge it because they're vulnerable, their activities are vulnerable and criminal. What they want is a quiet life...there's a loss of belief that they've got any legitimacy – "nobody will listen to me, I haven't got a voice, I'm lumbered."

Drug agency worker, Sandport

Although access to these properties is quicker than with social housing, there can still be numerous bars to entry – references, deposits, no children, no pets, no DSS. Users frequently had to rely on word of mouth about accommodation vacancies, and a typical scenario is that whilst a person is sleeping on the floor or couch in somebody's flat a room becomes vacant in another part of the building,

We've had certain groups that have moved over the years and get cleaned out of one house. Somebody will get a flat or bedsit in

another house, word gets around...he says I've got a friend looking for a place, the landlord says fine, it saves them on advertising and they get in and the next thing you know he's got a block of drug users.
Drug agency worker, Sandport

Those interviewees who lived in houses in multiple occupation indicated that availability of drugs was a positive accommodation factor in these circumstances when using, but a negative one if trying to give up. Group living was also not without its friction,

My cousin Dawn had a flat and I used to sleep on the floor there. There was like her boyfriend and this other lad staying in this one room, but it was not nice.
Did that lead to arguments, all on top of each other?
It was drugs we used to argue over – you've had like ten mils more than me - silly little arguments, food, because like me when I get my money I go shopping straight away, buy my food. But then it was like we didn't have anything to eat, all the money was going on drugs.
Female, aged 26, shared flat, Sandport

If there seems to be a relationship between living in houses in multiple occupation and drug use, a later section (5.8) will go on to speculate and examine some of the possible reasons and the mechanisms through which this and other forms of poor quality communal accommodation might influence drug use.

5.6 Patterns of problematic drug use in hostels

Many in the sample exhibited a housing career punctuated by periodic stays in institutional and communal forms of housing: large homeless hostels situated in city centres, night shelters, Probation hostels, as well

as privately run hotels and guest houses. Many of these forms of housing have as part of their aims and objectives the resettlement of their residents into permanent housing. However, from the sample interviews it seems clear that they may have a negative effect for drug users and that their resettlement aims may be seriously compromised.

The following interviewee had an extensive hostel background that had not impacted favourably either on his housing or drug use in terms of any conception of 'resettlement'. It had, however, had negative effects on his extent of drug use in the times when he was forced to stay in some of the large privately-run hotels in Newcity.

Martin, aged 45, night shelter resident, Newcity

Although sent to borstal when fourteen, Martin had a consistent work record at a time when industrial jobs were plentiful in the Northern town he was brought up in. Recreational drugs and drinking at weekends were part of his work/leisure pattern. He was in the army for ten and a half years and left because of his drinking. He then entered an extremely transient lifestyle, one that he claims to miss. He has an extensive knowledge of the hostel system nationally and speaks of a 'grapevine' of people he would meet whilst travelling up and down the country. In Newcity he has frequently stayed at various private hotels that are known to house a number of people with drug and alcohol problems.
He has had several spells in prison for burglary. He still shoplifts to support his heroin use. Both his army training and frequent experience of rough sleeping make him sanguine about his current housing in a night shelter.

Although stays in hostels featured commonly in the housing biographies of the male sample, none of the women reported ever staying in a hostel.

Reasons for the lower representation of women generally in the hostel population could be the better access to social housing for women with children, the lack of hostel provision for women, the lower numbers of women becoming 'roofless' as opposed to staying with friends, women's willingness to put up with unsatisfactory relationships because of children, women's greater recourse to family and friendship networks and the acceptance by other agencies of the greater vulnerability of women. However, the criteria that codify homelessness priority status for council housing do not specify gender per se as an automatic qualifier for housing on grounds of vulnerability.

Hostels come in all shapes and sizes – women's refuges, ex offender hostels, homeless hostels, night shelters and those that cater for other special needs groups, all with differing levels of staff support. But I want to start by concentrating on hostels which were perceived to be problematic to drug users, according to their accounts, namely large, multi-occupancy city centre hostels catering for mainly single homeless males, a significant proportion of whom have drug or alcohol problems. As a contrast in Chapter Six I deal with the positive aspects of some hostels.

One hostel manager who has worked with drug users for many years commented on the changed composition of hostels together with a growing perception that many single homeless people also had drug problems,

> As the drug epidemic continued in the Northborough area the people who are most likely to become homeless are drug users and it just gradually evolved into a place that was dealing with drug users...most of the other hostels, you would probably find a guesstimate of about eighty per cent of the people seeking places in homeless units are drug users.
> Manager, supported hostel, Dockland

Conditions in some of the hostels justified the description 'chaotic.' Staff supervision in some of the large hostels was minimal,

> That hostel, they just left you, if they found you dead in the morning in your room, they won't check on you or anything, they wouldn't think he's not come down today, they probably wouldn't notice for a week, or how come he's not signed his Giro, they don't notice, they didn't care about you, they were always behind screens.
>
> Male, aged 24, supported hostel resident, Dockland

Lax attitudes to drug use on the premises in one hostel had led to staff themselves being involved,

> Two [of the staff] were class A drug users and one was an alcoholic...People were using drugs on the premises, they were sitting with the lads hitting off and stuff.
>
> Supported Hostel Manager, Dockland

Similar staff problems seemed to operate in some of the multi-occupancy private hotels in Newcity largely occupied by those with alcohol or drug problems. There was a consensus of those who had stayed in some hostels that there was a lack of support; the practice was "just to leave you alone, there was no structure to the thing, no help in any way."

Most former residents found their drug use escalating,

> It was like drug use all the time, doors getting kicked in...it was getting heavy, the drug use, really heavy...it was like mixing in with different people, it was just getting way out of proportion like, I would have ended up dead, it was just injecting all the time...it went through the roof, the drug use.
>
> Male, aged 35, supported hostel, Dockland

Some people chose to sleep rough rather than go into a hostel because of the threatening atmosphere,

I didn't want to stay there because of the conditions, the people that was in the place...they were very evil people I'd say...it was just horrible, they were the kind of people who'd leave you in the gutter. I had a choice to leave, so I decided to stay on the streets.

This resident overdosed in a hostel and was abandoned by his roommate,

I was with this lad and he was a bit of a bad lad, he just left me and these two lads have come in to see what's happened, and because they couldn't hear me breathing he's said to the lads just leave him, he's dead, and these lads have said no, and by the time the paramedics have come up they said if it wasn't for your mates you wouldn't be here now.

Male resident, aged 24, supported hostel resident, Dockland

On the other hand these multi occupancy hostels and hotels offer accommodation to a group nobody else will house,

I've met the managers and the clients and they provide a useful service for people who are problematic drug users, because I don't think I'd be wrong in saying that's the bulk of their residents. Quite a lot of them have a history of rent arrears so are not eligible for the council and the council acts as a clearing agency for all the housing associations, so if anyone has got arrears with any social landlord they won't be eligible for re-housing.

Coordinator, drugs agency, Newcity

The hotels in Newcity are regularly visited by the Police and seem to serve a useful function in keeping drug use within certain geographical boundaries, almost on a traditional public health model of quarantine, serving a function of social control and surveillance,

Ghettoes can be really useful in terms of policing, and useful for society to label people.

Coordinator, drugs agency, Newcity

For many in the sample these hostels and hotels represented low points and a convergence of their worst accommodation and heaviest levels of drug use.

According to the Big Issue in the North, 62% of vendors have a drug addiction problem (Daily Post, 17.10.03). During the period of research, in October 2003, two hundred Police swooped on vendors in a nearby city centre in response to complaints about aggressive begging and drug misuse. Thirty people were charged with drug supplying offences, twenty-six of whom were remanded in custody (Daily Post 17.10.03). It is clear from the accounts of users in this survey that there has always been a connection between vendors, drugs and living in large city centre hostels. This may indicate a mutually reinforcing culture of mainly male users who either beg, sell the Big Issue or both, have heavy drug use and live in hostels. When I interviewed one hostel manager back in August 2002 she told me of a Big Issue/hostel/drugs link,

> Most of the people there [a large city centre hostel] are drug users, the majority of them are out on the streets selling the Issue all day and making mega bucks from the Issue. I have a great problem with the Issue because it's giving drug users money in abundance just to spend on drugs...the majority of them do live in the likes of [hostel], so there's Housing Benefit being paid for them, a few hundred pounds, they're all drawing benefits, and yet they're allowed to be out there earning whatever on the Issue. If I thought that the money was being put to good use, fine, but it's not, it's being used to the detriment of the people. They are physically in the worst condition of any drug users. If you go and look at them in the city centre and just look at their physical health...all of them will tell you that their drug use has gone through the roof because of the amount of money they are getting.
>
> Manager, supported hostel, Dockland

An interviewee said he used to sell the Big Issue and lived in the named hostel,

> Just everyone is fucking injecting and there's no hygiene in there at all, people climbing in through windows, other people that don't live there and a lot of stuff gets stolen, not nice places to live at all.
> Male, aged 24, supported hostel resident, Dockland

Another resident commented,

> You'd sit on the chairs and there'd be needles under the cushions, a scary place.
> *Was that the worst time of your drug use, at [hostel]?*
> Yeah.
> *Was it because of the people?*
> Yeah, it was because of the environment I was in.
> Male, aged 35, supported hostel, Dockland

I interviewed the Coordinator of the Big Issue in the North one week after the arrests. He claimed that most of the people arrested were not vendors, but confirmed the link between hostels and drug use, ("anything goes in some of them"). He felt that for drug users to enter some hostels would be a "backward step."

The social networks of homeless people provide a supportive mechanism which is a response to the social exclusion from other means of support. It can be characterised as negative social capital, in that whilst it furthers the immediate needs of the individual and the group it also has self-destructive effects in increasing drug use and narrowing further the opportunities and sense of possibility of breaking out of the identity of a homeless person or of a drug user. If you are a drug user your drug use is likely to get worse moving into a hostel with other users,

> You're going into a new environment where there's new people and you want to make new friends and that. You're trying to get them to accept you, so you're looking to please them and that. It does get worse obviously, you meet new people, and you've got more opportunities to get drugs and take drugs. But it does

become worse and I think for everyone it gets worse before it gets better.

Male, aged 33, supported hostel resident, Dockland

Taking drugs gave you membership of a general culture and was the fulcrum around which social intercourse revolved, but a closer group of a few trusted friends was necessary for survival.

It's dog eat dog but if you get in with one or two of the lads you do look after each, there is a lot of bad people on the streets, you could get murdered or hurt.

Male, aged 24, supported hostel, Dockland

The multi-occupancy hotels offer dealers a ready-made market,

Some of them they like living in places like that, especially people who supply drugs because it's a place for them to get rid of their drugs.

Male, aged 43, night shelter resident Newcity

Another interviewee had also lived in the hostels,

"Yeah, it was mainly users there, alcoholics, so you get into a circle all living in the same place, you didn't have to go outside if you know what I mean, if you wanted to score."

Male, aged 45, night shelter resident, Newcity

The accounts of the sample who had been homeless indicated a connection between drug use, hostel living and homelessness. It can be described as a culture of negative social capital that has positive returns for the individual, but also negative and potentially destructive consequences.

5.7 Patterns of problematic drug use and homelessness

In this section I deal with the relationship between drugs and homelessness in the form of rough sleeping or 'rooflessness'. There were several changes in the composition of the single homeless population which became particularly apparent during the nineteen eighties. Traditionally it was perceived to be largely made up of transient middle aged or elderly men, many with alcohol problems, who might periodically stay in large dormitory-style Victorian hostels in major cities. Changes that took place in the population were, amongst others, the younger age of those becoming homeless, a changing gender composition and a greater prevalence of drug use (Fitzpatrick, Kemp and Klinker, 2000).

A considerable part of the sample had been homeless in the past, and many had literally slept rough. Some of the sample were currently living in homeless hostels or night shelters, so although not roofless, were homeless by definition of their current location. Many had slept rough for short periods in the past, but only one person was currently sleeping rough – in an abandoned car.

Some of the locations that users indicated they had been living in were extremely insecure and potentially dangerous. Examples were one couple who had lived in a container at the back of a drive-in McDonald's, two brothers who had lived under a tree in a field, and various people who had lived on the stairs in a block of flats, in bushes, in public shelters, in cars and car parks. Some of these stays in public or semi-public spaces were for long periods of time, some for short periods after arguments with partners. Some chose to stay on the street because they did not want to go into the atmosphere of a hostel.

The privations of street living were described. Keeping clean was a problem,

> I've never been a scruffy person, I'm clean and all that, but when I was on the streets you didn't have the facilities so you did go like a tramp...when I could I'd go into public toilets and get clean but basically I was just a tramp, unclean.
> Male, aged 24, supported hostel, Dockland

The life could also be dangerous,

> I was in Chester and I woke up to a knife at my throat, one lad going through my bag, another going through my pockets.
> Male, aged 40, private rented flat in HMO, Sandport

For women it can be especially frightening,

> Do you know the lake, the shelters there, I've slept in a shelter there but I swore I'd never do it again...it was quite scary, everyone congregates there, it's not just younger people, it's older people as well.
> Female, aged 26, shared flat in HMO, Sandport

It can also make them vulnerable to sexual abuse. One girl and her female cousin were offered accommodation by a man who was working with the homeless,

> My cousin said, like, there's something about him I don't like. I trust anybody, me, and I said no, we'll give it a go. Anyway I woke up one night and he was fiddling with me...and I heard - only like yesterday – that it happened to another girl and they were saying, oh she's lying, but I said no, she's not, because it happened to me and apparently he's been sacked now.
> Female, aged 26, shared flat in HMO, Sandport

However, a couple of people said that living rough even had its attractions, and demonstrated pride at being able to rough it,

> Sometimes I used to enjoy it on the streets, I'd just pick a town I'd not been to before, find somewhere to shelter and see what I could do.

So living rough doesn't fill you with any great fear then?

No, not really, I've gone a bit soft recently, I'm used to it being warm now.

Is there something you like about being outside?

Well you're not tied to anywhere, you can just take off when you want.

Male, aged 40, private rented sector, Sandport

It might sound daft, in a way it's not that bad a life...you know you can get your drugs, you meet people in the same situation, it's not a nice thing but if it's got to be done I know I can do it.

Male, aged 24, supported hostel, Dockland

Confirming research by Higate, (2000), two people who had been in the army found that their training had equipped them to cope with life on the street,

To tell you the truth, with being in the army I was used to sleeping in trenches in the middle of forests, so I was pretty much used to sleeping rough.

Male, aged 43, night shelter resident, Newcity

However, the stress suffered by those sleeping rough or in insecure housing, took various forms – physical and psychological. One of the main physical problems was keeping warm, and drugs and alcohol could be used as a coping mechanism,

Did your drug use get heavier at that time, when you were living rough?

Yeah, it did...you just wanted to be in that state all the time.

Male, aged 24, supported hostel, Dockland

For some users taking drugs apparently made them less fearful,

It calms you down a bit, you're not as frightened of somebody at night.

Male, aged 40, private flat in HMO, Sandport

However, one user illustrated the rationalisations and self-justifications that users employ to make sense of their actions,

> *Did you find that you needed to take drugs because it was cold?*
> I think I used that as a bit of an excuse to take more drugs, I don't really think taking more made any difference to...I just used it as an excuse, I'll have some more drugs to get my head down. If I took more drugs I'd get to sleep easier, you know, if it's cold and what have you but really being truthful I just used it as an excuse to take more drugs.
> Male, aged 43, night shelter resident, Newcity

Most people associated their homeless episodes with feelings of low self-esteem that drugs could temporarily rectify by blotting out stressors internalised as stigma,

> *When do you think your drug use was at its worst?*
> When I was on the street injecting...it blocked a lot of things out, pressures that the public put on you because they don't realize you're under tremendous pressure...people look at you like you're scum.
> Male, aged 26, supported hostel, Dockland

Those who were homeless reported other affective disorders such as depression and anxiety and touches on the question of to what extent homeless people take drugs as self-medication (O'Leary, 1997). As one worker stated,

> There is a strong link between a poor living environment, lowered self-esteem and a seeking out of substances and behaviours that's going to make people feel better.
> Client support worker, drugs agency, Dockland

The following biographical sketch illustrates somebody with extensive experience of sleeping rough and for whom this condition holds no terrors:

Larry, aged 40, living in HMO, Sandport

Larry is currently living in an HMO predominantly occupied by drug users. He has an alcohol and heroin problem. His main drug of choice used to be amphetamine but he has changed because his use seems to have permanently left him with bad nerves and anxiety
A large part of his housing history consists of periods of rough sleeping and he describes being the victim of violence and his use of drugs and drink to deal with the physical and psychological stresses of living on the street.
Having said that, he speaks with pride of his ability to survive these privations, although stating that he has 'gone a bit soft lately'. He professes to like being on the street and surviving by begging and getting food from skips. He has been extremely mobile, often walking long distances from town to town when he felt like a change.
It is difficult to say whether his current housing could be said to be a step up a "hierarchy' from the street since it is occupied by a frequently changing group of tenants most of whom are drug users. In many ways his drug use is the same whether he has a roof or not.

One respondent who claimed his heroin use was under control whilst at university, said that it began to cause problems,

> When I became homeless, largely due to the depression that comes on you when you become homeless.
> Male, aged 23, supported hostel, Dockland

Another, when asked if his drug use had gone up when he was on the streets replied,

Yeah, right up...that's mainly to survive the weather and the depression, to get you through.

Which was the worst part of your drug use?

The streets.

Male, aged 24, supported hostel, Dockland

The first of these respondents had a history of mental health problems that pre-dated drug use, but all the people in the sample were using drugs before becoming homeless. Their drug use was a direct or indirect factor in precipitating that homelessness, whether because of crime, rent arrears, relationship breakdown or their own unreasonable behaviour. It is true that non drug-users may become homeless for all these reasons but it seems that drug use is a major risk factor associated with becoming homeless, and that if one reaches that stage drug use may then escalate as a coping mechanism.

5.8 Mechanisms operating to increase drug use in specific housing situations

What the three housing situations I have concentrated on have in common is they all, in their different ways, involve a high degree of sociability in the sharing of space and communal resources. Drawing on epidemiological and diffusion theories (Hunt and Chambers, 1976; Ferrence, 2001), we can see that drug use is spread by social contact and demonstrates the public health idea of 'contagion'. There could be said to be a contagion effect in such housing arrangements which at certain addresses reaches a critical mass and spreads in a non-linear way so that a whole building or area becomes comprised of residents whose main daily aim is the getting and using of drugs.

This interpretation of the spread of drug use is based on social learning theory (Heather and Robertson, 1989). Practices of drug use and wider deviant values held by a large proportion in the locality become dominant

and cease to be seen as deviant, although how individuals react to these deviant values will also depend upon their social networks outside the immediate environment. (Friedrichs and Blasius, 2003).

The forms of housing highlighted, and the areas they are usually located in, thrust actual or potential drug users into enforced or voluntary contact with one another, thus facilitating, by initiation or reinforcement, the micro diffusion of drug use. When social networks come together at specific locations we can characterise this as a form of negative social capital, a mutually reinforcing subculture which may bind people to it and will draw people back if they try and leave,

> People are jealous in Dockland, if you get off drugs you tend to be offered it for nothing and stuff like that.
> *People don't want you to do well?*
> I don't think so, well every time I got off it I always had people knocking on the door, here you are, getting it for nothing and all that.
> Female, aged 38, shared private rented flat, Sandport

> I think my basic plan is to move out of Sandport, getting away from all the little rats that are in this town. Because the one thing about this town is that you can be going down and down and people will kick you down, but you start going up and up and up and people will drag you back down. They don't like to see people doing well. The one thing about this town is it doesn't matter how hard you try to get off drugs you can't, because the town itself, it's so small, it's only a square.
> Female, aged 27, shared private rented flat, Sandport

However, because of the ambivalence that characterises their dependence users are often complicit in forming social contacts which in the long term can be detrimental to them. Whilst the social networks they belong to can be negative, they also provide positive features of group belonging,

Because when people were coming round to my flat and I seen them doing it I wanted to be like them...I thought it was like cool.

So why were they congregating in your flat?

I think I wanted to fit in because I'd not been well and I was just getting well again and I wanted to have friends, I didn't want to be lonely, but they wasn't proper friends.

Male, aged 28, supported hostel, Newcity

One person started using cocaine after moving into a house in multiple occupation,

I moved into this house, nine bedsits, and other people were doing it, I was introduced to it.

Is that house particularly known as a drug house?

I think the Police know about it, people come out completely wrecked, either like that or half asleep, the dole don't let Giros be sent there.

Male, aged 18, house in multiple occupation, Sandport

The physical arrangement of rooms in these houses and hostels means that people are thrust into contact with one another, either in communal spaces such as shared kitchens, lounges, hallways, gardens or by traffic in and out of each others rooms,

So how do you think the place you are living in now is continuing your cycle of drug taking?

Someone knocks on my door – Karl I've got £7.50, do you want to go halves on two rocks? So you do that, then you're high and you've got £50 in your pocket and you think right, another two, another two, until it's gone, and then everyone does this in the house.

Male, aged 18, house in multiple occupation, Sandport

Places cannot be separated from associations with people and it is useful to examine the social networks of users in terms of positive and negative influences on drug use and also on treatment. We might say that when

negative social networks coincide with specific locations that have high drug use associations, then the prognosis for recovery is not good. Alternatively, when positive social networks coincide with locations of low drug use associations, the prognosis is much improved.

We have seen that in hostels the use of drugs can be a bonding mechanism, a means of conferring insider status and of meeting new people in lonely, difficult circumstances. But we have also seen how under these circumstances drug use can escalate as a culture of drug use and hostel living or street living becomes reinforced. There was in these places where you had to be out all day a problem of filling the time. Drugs and crime had the function of providing a structure,

> The hostel opens from nine o'clock at night to nine o'clock in the morning, so you're out for the rest of the day, so I never had anything to do or that so I was just shoplifting, getting a bag and then straight out shoplifting, getting a bag and it was just the same pattern over and over again.
>
> Male, aged 26, night shelter resident, Newcity

Quite a few users stated that they made a deliberate attempt to keep themselves to themselves (eleven of the sample reported not seeing a friend in the last thirty days), and the idea that they knew a lot of people but had very few friends was commonly held,

> I'm not a runner with the pack, I like to shadow the pack and see what's going on and then hopefully just pop up to collect something off the plate.
>
> Male, aged 30, private rented flat, Sandport

This comparison to a pack (of dogs? of hyenas?) was repeated about life on the street (that it was "dog eat dog"), and in a different context to describe a small, mutually supportive social network,

> *Do you see friends most days?*
>
> Yeah, we survive in packs.

How does that work? I mean if someone hasn't got any heroin do you help each other out?

Yeah, well say one day I can make money, so I look after us and when someone else can make money they look after us.

And how many people does that involve?

Four.

Female, aged 31, shared flat, Sandport

The story of this interviewee is expanded below:

Rita, aged 31, HMO, Sandport

Rita is one of the heaviest heroin and crack users in the sample, as is her boyfriend. She is currently part of a small mutually supportive group of four people living communally in an HMO who steal to support their drug habits and "survive in packs".

Their housing biographies are characterised by transience and a fatalism about their housing circumstances and prospects. She is currently living in a flat where two people were recently beaten to death with baseball bats by doormen involved in the supply of drugs.

Her early life was spent in South Africa until the age of seven. When her parents returned to the UK she started to show signs of unhappiness such as running away from school and home. She was in care from the age of fourteen to sixteen when she started a pattern of heavy drinking.

She was married at sixteen and had three children. Her partner was abusive and the marriage broke up. He currently has the children as Rita admits that he is in a better position to look after them financially and from the point of view of her drug use.

She met her current boyfriend when she was twenty-seven and he introduced her to heroin. Rita has a lot of experience of living rough

but her mother remains a strong source of emotional and practical support, although she cannot deal with having Rita living with her.

Postscript: by the time the research was finished, Rita had been murdered and a man living rough in Sandport was convicted of her murder.

Some had old friends who were dead from drug use, particularly the older ones who looked back to before the nineteen eighties and the introduction of street drugs, (which one user dated to 1976 to 1978), to a time when Class A drug use consisted of pharmaceuticals stolen from chemists. The social networks then were much smaller and tight knit.

> That was how you got drugs in those days, there was no street sellers as such, if you wanted gear you screwed a chemist.
> Male, aged 55, house in multiple occupation, Sandport

> At that time it was a very tight knit group. There weren't a lot of people who used hard drugs and the ones who did tended to keep in a group.
> *Was that how you met your wife, in this network, you were both using?*
> Yeah, my wife lived in a flat just across the road from my brother and his girlfriend who were both using drugs... she'd come over to my brother's house.
> Male, aged 43, night shelter, Newcity

What we have here is the convergence of a small tight knit social network, including siblings, using drugs communally within a narrow locality.

As social networks became less tightly knit, street dealers appeared, the age range extended and the number of users increased, it became increasingly important to have a small number of friends one could rely

on. Alternatively, one could cut oneself off from the scene, only making contact briefly with a dealer once a day. This could be a conscious way of managing one's drug use, but could also be forced upon you by your pattern of drug consumption which had the effect of narrowing your social contacts,

> I don't have much of a social life anyway because of the drugs...I socialize with other drug users but not the general public and that. It's gradually getting better because I'm mixing with a different class of people.
> Male, aged 33, supported hostel, Dockland

> You start off as a social thing and as you're going along like you find that everyone who was your mate is no longer your mate, it's not like that any more...when you first get together you do share and that but you find out later on people only want you for your money or whatever, so you go your own way then, you start using on your own, it's like that.
> Male, aged 33, supported hostel, Dockland

One person felt this isolating effect acutely since her partner had recently died,

> I'm not used to being on my own, I just can't handle it, plus in the past I'd always worked...and now I've just got me and no job and all day. It's like the last couple of years I cut myself off I suppose from a lot of people...my worst thing is to be alone with me. You know I was thinking the other day I'd rather be in a hostel, at least I'd be with people, you know people say you're going to lose your home, I don't care, at least maybe then I wouldn't be on my own. It's got to that point at the moment.
> Female, aged 42, owner occupier, Sandport

However, whilst one can extend one's social network by more communal housing arrangements, the research has pointed out the possibility of the

dangers of this in terms of immersion in drug culture as drug use becomes more easily facilitated.

5.9 Problematic drug use and a possible 'drift down' effect

Current levels of drug use and current accommodation may not give an adequate impression of patterns of drug use or housing over a longer time period. To address these issues the research uses retrospective life histories concentrating on housing, drug use and social history of the sample. To gain some impression of the relationship of levels of drug use to their housing situations dynamically and on a within-case basis, I wanted to look at the idea of a 'drift down' theory of drug use whereby drug use is said to intensify and be correlated with the occupation of progressively worse housing conditions.

There is an undeniable association between areas of deprivation and problematic drug use, (ACMD, 1998). However, I would characterise the majority of the sample as coming from working class homes of a fairly traditional, respectable kind, neither deprived nor affluent. The sample from Dockland largely came from parental homes on council estates and reflected the overall tenure balance in the area. One does not wish to stigmatise council housing, and its relation to deprivation is mixed with many people classed as poor living in other tenures, but several of the Dockland sample described some of the negative factors of the areas they were brought up in and where their initiation to drugs took place,

> See, where my mum moved to, where I was brought up was a very rough area, a very hard upbringing, there'd always be fighting.
> Male, aged 24, supported hostel resident, Dockland

> I started smoking pot when I was twelve, I was on heroin by the time I was thirteen.
> *Was that an area fairly rife with drugs?*

> Yeah, it was pretty bad, yeah, it was a pretty bad area, especially for heroin
>
> Male, aged 26, living in supported hostel, Dockland

Whilst identifying areas of deprivation with drug use, agency workers usually qualified this by saying that they had middle class users on their caseload who did not conform to a deprived stereotype. This would confirm findings by Aust and Condon (2003), showing high levels of Class A drug use in some affluent urban areas. Middle class users may not be said to be problematic in the sense used in this research and be able to support their habit for longer and hide some of its visible effects, at least temporarily,

> I don't think it's just deprived people that do it, it seems to be deprived people who get more permanently captured by it really, people who've got better lives seem to be able to dip in and out of drug use. People in deprived areas seem to dip into it and more seem to get captured. There seems to be more people who've been in poverty, more people who've been abused, more people who've been in institutions and so on than the general population...just in my experience most of my clients seem to be from relative deprivation.
>
> Manager, drugs agency, Dockland

However, some people from middle class backgrounds do end up in these areas using drugs, and one hostel manager described how once a certain stage of drug dependence is reached, those who started off in middle class homes become indistinguishable in appearance and housing circumstances from those who came from a deprived background,

> Those middle class kids who get into drugs end up in the rundown areas simply because that's where the drugs are available, they don't necessarily come from that area. I'm still seeing people now, nice homes, two parents, good schools, had all the advantages in life but get caught up in the drug scene. Now those same people

are living on the sink estates it's not good enough to say that it comes from sink estates because they didn't start there, they've ended up there and you'll find that they will come down in life because of their drug addiction and end up living in squats and in totally inappropriate housing conditions.
Manager, supported hostel, Dockland

A 'drift down' effect may be illustrated by the following biographical sketches:

Andy, aged 35, private rented flat, Sandport

Andy was born into a wealthy family in North Wales and followed his father's work to Scotland, Cumbria and Manchester. He has previously lived at one of the most expensive addresses in Sandport. At 17 he left home and developed an alcohol and drugs problem. As a musician in a band he lived in squats in London and moved frequently up and down the country. He was sacked from the band for his drug use.
He is unusual in the sample in not having been to prison.
He had a housing association flat in an area of Liverpool known for heavy drug use and has been in rehab units for his addictions. His drug use resulted in a health crisis that made him return home but he had to leave after an argument with his sister. His transience was largely voluntary and part of a rock band lifestyle but his health problems make it necessary that he secures stable housing. His current housing is beset by problems of disrepair and anti social behaviour by neighbourhood children. His heavy drug use has been related to his poor quality accommodation both in the past and currently, but one gets the impression that in the past the poor accommodation of squats was bound up with a rock music lifestyle, whereas at present Andy has no choice and his situation is far from 'cool' or glamorous.

Geoff, aged 40, private rented flat, Sandport

Geoff was born into a wealthy family who owned large amounts of property in Scotland. He went to university where he started taking heroin, he says at the instigation of a lecturer, and became the 'black sheep' of the family. He has travelled extensively around Europe and is a qualified chef. His peak of Class A drug use (cocaine mainly) was when he was employed at an upmarket restaurant and had extensive social contacts in the sports and entertainment world locally. Having had his own house whilst married he left for another woman who is also a heroin user and who he now shares accommodation with. Now working in a series of temporary jobs, he retains a strong work ethic. He has affectations to being above other drug users in terms of his education and background but his drug use in the past has found him homeless, living on council estates and mixing in a criminal underworld. He finds it difficult to compare his current social circle and circumstances with what might have been.

The condition of homelessness did not always seem to be an end point of a slow descent through ever-worsening housing conditions, but could be precipitated suddenly in the sample by such factors as loss of accommodation that was tied to a job, leaving a university course and student housing or arguing with parents and leaving the paternal home. The process of becoming homeless due directly or indirectly to use of drugs can vary between tenures. In hostels it might be as a result of breaking the drugs policy, behaviour due to intoxication or arguments over drugs. In owner occupation it might be the inability to meet mortgage payments whilst sustaining a drug habit, or the breakdown of a relationship because of drug use. In private sector accommodation and

social housing it might be a breach of tenancy rules regarding such things as neighbour nuisance, rent arrears, damage to property or drug dealing.

5.10 Conclusion

This chapter has taken both a quantitative and qualitative analysis of the relation of housing to levels of drug use. The quantitative analysis augments the qualitative results although the method used to obtain the sample and the size of the sample limits generalisability.

We saw that three housing forms – HMO's, hostels and homelessness were significant in the biographies of the sample in being associated with their heaviest drug use. The data seemed to indicate that it was in part the diffusion of drug use in these communal housing forms through social networks that was operating to spread drug use in a 'contagion' effect, thus confirming previous research into drug epidemiology and the social networks of drug users (Giggs, 1991: Wallace, 1990). This qualitative data was confirmed by the limited quantitative data, although it was not true for incidence of crack use.

Whether there is a 'hierarchy' of housing associated with varying levels of drug use would require more extensive research of a greater variety of housing forms, but we might tentatively suggest that communal housing forms at the bottom of the housing market such as large city centre hostels, HMO's and the condition of homelessness are the housing conditions associated with the heaviest alcohol and heroin use. The research thus confirmed work by Klee (1991), Greene, Ennett and Ringwalt (1997), and Fountain and Howes 2002).

We might also add that the quantitative data suggest that these might be the settings most associated with injecting practices and, apart from

hostels that offer intensive support, are least associated with methadone maintenance treatment. This requires more qualitative research.

Whilst the large hostels probably constitute the highest risk of escalating one's drug use, the smaller hostels with good staff support and access to treatment probably constitute the best option for the promotion of a drug-free life or managed drug consumption. However the high rates of methadone prescribing in these hostels are perceived by many users as being an alternative dependency problem.

Use in the private sector presented a more diverse picture that matches the diversity of the tenure itself. The distinction between what constitutes an HMO and a private tenancy was sometimes arbitrary and of a qualitative nature as much as anything. Some private tenants registered no drug use at all whilst others registered some of the heaviest use. The qualitative data indicated that the private sector is the easiest housing to access for many users but carries with it many problems of disrepair and insecurity.

There was some evidence in the biographies of a 'drift sown' effect of middle class users who had come to occupy poor housing and become indistinguishable from other users as their drug use progressed. But evidence from the sample for the 'drift down' theory can be contradictory. There are examples of people who in some cases started out as fairly affluent home owners who were now living in basic rented accommodation. This could be related to the progressive effects of drug dependence whereby chaotic behaviour, criminal involvement and inability to prioritise housing over drug use in terms of finance means that users come to occupy accommodation that nobody else wants to live in. But this picture is complicated by other factors such as relationship breakdown that can precipitate movement from good stable housing into the cheapest quality accommodation or into a hostel. It has to be said also that if there is a process of 'drift down' there are also examples of 'drift up' whereby people who had been literally homeless had improved

their housing situations. In some cases a 'drift up' from street to being housed in very poor circumstances could not be said to offer the circumstances for a significant improvement in drug use.

Chapters Four and Five have described the way in which being housed has been a process of constraint, limiting and confining literally, socially, economically and geographically. I now wish to extend this but also to look at housing as an opportunity in terms of identity-change and as a means of improving material and psychological well-being. The following chapter will stress structure less and agency more, specifically from the perspective of recovery from drug use and the way in which a change of housing may materially and symbolically stand for a new beginning.

CHAPTER SIX

POSSIBILITIES AND BARRIERS TO RECOVERY: THE ROLE OF HOUSING AND PERSONAL RELATIONSHIPS IN THE CONSTRUCTION OF NEW IDENTITIES

6.1 Introduction

We have seen that poor housing is very often associated with many other negative social factors, one of which may be increased drug use in poor areas and at the bottom of a hierarchy of housing. The role of housing in positive and negative treatment outcomes is the subject of this chapter. Can housing really make a difference to recovery from problematic drug use when there seem to be so many powerful social and psychological factors acting to either reinforce or change drug-using behaviour? In this chapter I will examine whether housing type and location can promote physical and mental health that furthers treatment goals and acts to reduce the need for drug use.

I look at how drug treatment and housing situation affect one another and go on to look at how poor housing inter-reacts with people's sense of self, of their identity. For drug users their poor housing may reflect and confirm not only their poor status in other people's eyes, but also in their own eyes, particularly regarding their lack of power and self-esteem. In developing this latter point I extend arguments from McIntosh and McKeganey, (2001; 2002), who drew on their reading of Waldorf, (1983), and Burnacki, (1986). These authors examined change from drug-using to non drug-using behaviour and the strategies people adopt to make the transition by effecting necessary shifts in their perceptions of themselves and their actions. These authors, in turn, used the concept of 'spoiled identity' taken from Goffman, (1963).

I use the same concept but adapt it by focusing on how a change in housing situation might be a means of re-constituting a spoiled identity.

Previous chapters have looked at housing largely as an agent of constraint, limiting people's horizons and fixing them geographically and socially. This chapter moves to a perception of housing as a potential agent of opportunity, extending horizons and people's sense of possibility. I examine people's strategies of recovery and the role good housing might play in building self-esteem, status and a sense of empowerment and inclusion.

The conception of housing in this chapter stresses the social nature of housing and the way in particular that relationships and housing situation are so closely entwined that a conception of 'the domestic' must include both. I draw on a growing 'meaning of home' literature to examine users' expressions of what the idea of a home means to them and what sort of housing they would like for themselves. Their conceptions of housing are very much bound up with its status and how this relates to the condition of its built form and the status and condition of the neighbourhood in which it is located.

In relating this to drug treatment outcomes, the perception of their housing situation, both in material and status terms, by drug users can be seen as either a positive or negative reinforcement of their image of themselves and represent either a negative reinforcement of a drug-using identity or a reflection of the possibility of a new pattern of behaviour and lifestyle in which drugs represent the past.

6.2 Housing and treatment outcomes

Drug dependence might be characterised as a condition of ambivalence (Orford, 1985; Heather and Robertson, 1989). The user often simultaneously wishes to continue taking drugs because of the positive mental and physical states they induce, but also wishes to cease that use because of its associated problems – health, legal, financial and social. Dependence has also been described as a chronic relapsing condition

without any cure in the conventional medical sense. People may oscillate between treatment, abstinence or variations in levels of use for years, indeed for all their lives. The assertion that 'treatment works' is undercut by the high proportion of negative individual treatment outcomes in terms of relapse (Gossop et al. 1990).

Housing can be the location for treatment but can itself be seen as a variable in treatment outcome. Sometimes treatment and housing are very obviously entwined, for instance in residential rehab or supported hostels for recovering drug users. Some research claims secure housing to be a distal need (Hser et al. 1999), or a need the fulfilment of which is associated with a greater success rate of treatment outcome for those whose needs are considered in a holistic way.

But housing and drug treatment services sit uneasily together as a result of differing professional cultures and priorities. Housing managers cannot afford to prioritise the health of their drug using tenants above the effect that any anti-social behaviour might be having on their neighbourhoods. This can lead to a defensive attitude on the part of housing workers whenever a drug user is referred to them, and may lead to informal strategies of denying them access, (Inside Housing, 25.6.04, *Vulnerable Pushed Out*). Treatment workers are often frustrated because, as they see it, one of the most important pieces of the recovery jigsaw – housing – is beyond their control. They may be able to put a lot of other pieces together in terms of medication, social activities, education, counselling, but without stable housing they may see the most carefully worked out support package unravel,

> [I think we have managed to] establish very good working relationships with a whole range of services – mental health, social services, Police, Probation, the prescribing services, GP's...we've got access now to medical treatment, crisis intervention, arrest referral. The worst resource we have access to is housing.
> Drug agency head, Sandport

The recognition of the degree to which housing has an influence on treatment outcomes was sometimes dependent on what sort of treatment was being proposed and how much the treatment modality incorporated environmental influences on drug-using behaviour. Social learning theory stresses the 'trigger' effects within the social environment, including locational factors, which can be the impetus to relapse,

> The environment has got a lot to do with people relapsing. Partly it's the trigger when you get back. I think partly what brings them back is a feeling "this is where I use."
> Drug agency head, Sandport

The temptation to use may be stimulated by the cues which the environment provides - the associations of past use in particular locations acting as triggers to repeat the addictive behaviour,

> Every time I come back home, that's where the main problem is.
> *Is that because of people or is it the place?*
> I don't know, I think it's the type of life I'm living here.
> *Is it associations with the past?*
> Yeah, that's what I do when I'm here.
> Male, aged 26, supported hostel, Dockland

These reflexes might be considered evidence for a conditioned response to external stimuli. Relapse prevention teaches users to avoid risky places, situations and people that might lead to use (Marlatt and Gordon, 1985). However, as we saw in Chapter Four, these risky situations and people are all found in the places where councils in the past have relocated drug users, where the housing market filters people with drug problems into specific geographical locations and into forms of housing where the triggers are all around. On the other hand, some psychological approaches to dependence might downplay the environment,

> Because nothing changes, it's not where you go, what you do, where you live, it's what's going on in your head, you take your head with you everywhere you go.
> Project leader, rehab unit, local region

Agency staff universally recognised the importance of housing, even if they did not always elaborate why it was important or how it operated to further recovery outcomes. The importance of housing became more apparent when it wasn't there, was in danger of being taken away or was perceived to be having negative effects. When things were ticking along housing became background to other social processes. When it became foregrounded it was usually a sign that something was going wrong.

Despite the condition of dependence being characterised by ambivalence and a drug user's life geared to short term rather than long term goals, treatment aims may require the user to exhibit certain personal traits, motivation being one. Along with these personal attributes the user may be required to demonstrate certain approved characteristics, primarily that they are stable and not 'chaotic'. The latter condition is rarely elaborated, but it may mean a condition where drug use has become so all consuming (of energy, of time, of physical and mental resources, of social relationships), that the user cannot focus on anything else but the getting and using of drugs. Not having settled housing may be one factor that indicates to professionals that one is 'chaotic.' Caught in a condition of short-term gratification, housing may not assume its full importance,

> Consequently, it's [drug use] more important in the end than sustaining the rent or sustaining the home or sustaining relationships, but they do end up alone and do end up without homes, or in less than wonderful homes because they're not maintaining them either, maintaining the cleanliness and maintaining the fabric of a home either, so it goes down the pan a bit. They end up with a rag at the window instead of proper curtains, the most important thing is to close it out.
> Drug Agency Coordinator, Dockland

To some treatment practitioners a stable housing scenario may be either a desirable or, in some treatment modalities, an essential prerequisite for being accepted for treatment. Housing may be required as a location for

treatment, as in home detox programmes where it may be assumed that if somebody is living in housing where there are other drug users, or a partner who is using, then this location may not be appropriate. Users themselves perceived that where they were living currently was not conducive to giving up drugs,

> You can do home detox but it wouldn't work here because most of them are users, you have to go into a new environment.
> Male, aged 40, house in multiple occupation, Sandport

Homeless drug users have found access to health services in general to be a problem, and it may be that a chicken and egg situation arises – can one access drug treatment if one does not have housing, and can one address one's housing problems if one is using drugs? There was though, a realisation amongst agency staff that housing without treatment and support was not itself an answer to homelessness,

> The problem is that some people we're talking about are not equipped to sustain a tenancy, it's setting people up to fail, if they've got substance misuse problems, just putting them in a house.
> Big Issue in the North Coordinator

If housing can be said to be a distal need and the provision of good quality, secure housing a positive influence on treatment outcomes, this must relate to its physical structure and its location within high or low drug-using neighbourhood environments. What goes on outside the housing is important but so also is what happens inside it and the next section goes on to look at a conception of the domestic to include the built form and its connection with the day to day relationships of drug users. It looks at how housing stability and relationship stability are linked but also at how housing affects treatment outcomes within the context of human relationships.

6.3 Housing, treatment and the domestic relations of drug users

We have seen how belonging to a social network of drug users can be seen in terms of positive and negative effects. Drug using networks provide a sense of shared values, comradeship and mutual support in opposition to a society from which drug users are marginalized and stigmatised. They can, however, encourage greater drug consumption, criminality and unsafe practices such as needle sharing. The proximity of social contacts can also be a factor in relapse, so that many users say that in order to give up drugs they must give up old friends. This raises the question of drug-using partners living together and the way this may mutually reinforce their drug use, and in particular the way in which this is likely to impede treatment goals if one or both wishes to change their drug-using behaviour. How difficult will it be trying to give up drugs whilst occupying the same accommodation with a partner using drugs?

Of the thirty-one males in the sample, ten were currently in a relationship whilst six of the nine females were currently in a relationship. Whilst these numbers are small I think the qualitative data may provide indications of a relationship between male and female drug use and relationship patterns, and also on the initiation of female drug users into the use of Class A drugs that has been the subject of earlier research (Maher et al., 1996; Wright, 2002). The findings that women drug users were much more likely to be in relationships and that their partners were likely to be drug users is borne out by previous research (Klee et al. 1990; Klee, 1996; Wright, 2002). Men are more likely to be single or to have a non drug-using partner, although initiation of non drug-using partners by males was spoken of in the study.

Of the sample of thirty-one males, fifteen were not in treatment, three because they were abstinent. Of the nine females interviewed, six were not in treatment, all of whom were currently using. Unfortunately conclusions from this small sample are not statistically valid as regards the question of male/female entry to treatment but using a

capture/recapture analysis Beynon et al. (2001) calculated that in the region containing Sandport and Dockland 47.1% of female drug users were in contact with treatment services compared to 27.3% of males. The authors conclude,

> Contrary to some concerns this would suggest that treatment services are not more difficult to access by females. (Beynon et al., 2001:12).

One of the main positive factors in recovery is the support of a partner and especially a partner who is a non-user. Men are more likely to live with non-users than females, but in general they respond to treatment less well. Where both partners are using and one tries to give up, the other person may have an interest in sabotaging their recovery. It may be seen as a judgement on their own behaviour, which they feel unable to change, and represent a threat to the existence of the relationship itself and the security that it brings. It can also lead to arguments based on mistrust,

> *So do you feel you have to keep quite a close eye on her?*
> I have to, yeah.
> *Does that cause arguments with her?*
> It does sometimes. She says she's going somewhere and I say I'll come with you.
> *You don't trust her if you don't know where she is?*
> No.
> And is that liable to start you drinking if she's off somewhere and you don't know where she is?
> Well it's not the drink, it's the drugs. I'm thinking I'm going back down that road, like if she starts again, I'll start again.
> Male, aged 52, shared private rented flat, Sandport

This sort of behaviour is more often associated with women drug users acting as 'caretakers' of their partner's use, attempting to limit that use or trying to match that use themselves. One solution may be to go away for residential treatment, but what happens when one returns?

> I stayed there [rehab] for three months but as soon as I came out I started using again within two days.
> *Is that because you knew you were going to use when you were in there?*
> It's because I went back to my wife and she was still using so the drugs were there, I mean I was stupid but that's how it turned out...I think it will be easier now because I won't be going back to the same environment.
> Male, aged 43, night shelter resident, Newcity

Housing could be an important factor in the formation of relationships. One agency worker had noticed a number of these relationships being formed based on older male users and young females, sometimes for predatory reasons that were not just sexual but related to the commodity nature of housing as outlined in Chapter Four. Younger females were probably more able to earn money, mostly through shoplifting as they had not yet come to the notice of shop security staff. To most women a drug user with a criminal record would not be an attractive option, although this was not true of all women, some of whom might be attracted to the 'outlaw' aspects of drug use and crime or who were themselves engaged in drug use and criminal activities. One worker saw a possible link with the criminal justice system,

> I think I've always found that people who've been through the criminal justice system and have used drugs have almost an arrested development and like young women. Young women are attracted to older men and see them as a bit worldly, they don't see the lifestyle they're getting involved in.
> Youth Offending Team worker, Northborough

Of the sixteen people in relationships, all were in relationships with other drug users and for some their housing was situated within a social network dependent upon surrounding drug markets and neighbourhood drug use. This was sometimes how they met their partner,

My wife lived in a flat just across the road from my brother and his girlfriend who were both using drugs and I met my wife over at my brother's house, I met her there and we sort of got together that way, she was already using drugs.
Male, aged 43, night shelter, Newcity

Only one of the female users were introduced to drugs by their current partner but five of the female users also had one or more family members who had problems with drugs,

This is how I met my boyfriend, him and my uncle Colin used to sell drugs and I used to go out and drop off for him. [My brother] got into the crack cocaine, that was from my uncle as well – he's such a loving uncle! – he offered to give it him for nothing.
So, your uncle sounds like he's quite heavily involved in the drug scene.
He is, quite a few members of my family are into it, cousins, nephews.

Another female user mainly had a drink problem but lived with a partner who had both a drink and heroin problem. Living together had eventually led to her developing her own heroin problem,

Mind you he did try to keep it very much separate from me, but I always had to find out, curiosity killed the cat type of thing. I wouldn't take it – don't do it because it's bad – I had to find out for myself.
Female, aged 42, owner occupier, Sandport

Relationships with a drug user could result in a non-user taking up drug use, but mutual drug use could itself be a major reason that the relationship was formed initially and provided the glue that ensured its survival. When that bond was threatened by one partner wishing to cease their drug use the relationship could be put under threat and in some cases could bring about the sabotage of recovery plans. This could be either deliberately due to one partner's insecurity over the

current basis of the relationship disappearing or because it is too difficult to maintain abstinence within daily sight of another person using drugs. The next section develops this domestic theme and goes on to look at the wider family situations of the sample and focuses on those with children.

6.4 Housing, domestic cohesion and drug use

A major factor in prevention of relapse and drug treatment success is the strength of social support that can act as a 'buffer' or protective effect against environmental and psychological stress. For many in the sample this support was not present. According to some interviewees the attitude of many parents to discovering their children's' drug use was to throw them out of the home. However, it appeared that parents were often unable to decide which was worse, housing their children at home or not housing them and not knowing where they were and what was happening to them. In some instances this led to the family home being used as a temporary base with very uneasy relations until an incident was the trigger to the user being thrown out again. As already indicated, many of the users came from disrupted families where siblings had drug problems or parents had alcohol problems, although no user mentioned having a parent with a drug problem.

However, for some, families could be a source of support. The family home and mothers particularly, were mentioned as a source of refuge and support, even when it was not possible for them to stay there,

> I was at my mum's and my mum's boyfriend was with her and he's very poorly and she couldn't cope with me being a heroin addict...I'd spend a couple of months at my mum's and then I'd go back on the street for a bit and then I'd spend another few months at my mum's, then on the street again.
>
> Female, aged 33, shared house in multiple occupation, Sandport

This person visited her mum every day to get cleaned up whilst she was living rough. Another depended on her mother for financial and emotional support,

> I'd be out on the street if it wasn't for my mum, basically she's helped me a lot you know, financially...she got that worried a few months ago, I'd lost so much weight I had to tell her about the drug problem. She won't see me starve but she's elderly and it's a lot of pressure, she's worried all the time...I was leaning a lot on my mum, I still am, that's playing on my mind as well.
> Female, aged 42, owner occupier, Sandport

Several told of disrupted childhoods when the family home was the location of bad memories,

> My mum was never at home, she'd go out to work and then when she came home she'd go out clubbing it. My mum and dad got divorced and my mum took off and my dad went to live with my nan, and she didn't want me, she couldn't have me so I went into care.
> Female, aged 33, shared flat in house in multiple occupation, Sandport"

Their own homes were sometimes characterised by domestic violence, which for people living in multi occupancy accommodation can take on a more visible and public character than is the case in traditional housing. It may also be that where couples are involved in the drug market, even if only as consumers, they are witnesses to acts of violence, which becomes a more accepted and ordinary way of resolving disputes,

> He went to prison. He was violent and I was scared to leave him and then when he went to prison I actually left him, I thought, well he can't get me no more.
> Female, aged 26, shared flat in house in multiple occupation, Sandport

Did you manage to keep the house together and everything?
Yeah, I had to, otherwise I'd get my head kicked in. When I left him, I left him with what I stood up in, took the kids and left and got my own house.
Female, aged 38, shared private rented flat, Sandport

Sexual abuse was not a question I directly asked about but it was mentioned by no fewer than four of the sample of nine women who stated that they had been sexually abused within the family, one by a brother in law and three by brothers (one by brothers and the father). Three of them stated they had been raped, one whilst working as a prostitute. This same person had been working as a prostitute at the instigation of her mother to go out and earn money. Sexual abuse may be linked to drug use in terms of self-medication to deal with trauma and bad memories, but as one agency worker put it, a lot of claims are unprovable,

When you get somebody to come out the other end and start to recover, the reasons why they got into substance misuse in the first place come to the fore because they've been suppressing it with drugs. It's also a strategy people use to say I was abused, one of the reasons I'm a victim of all this is because somebody victimised me in the first place. So I'm a secondary victim...Now I don't know how many people believe they were abused...a lot of this is unprovable.
Head of drug agency, Dockland

Break-up of relationships could result in housing crises for one or both partners, or the fragile nature of housing circumstances of users could be a factor in the transitory nature of those relationships. It can lead to social isolation trying to care for young children alone in poor quality accommodation, which can lead to relapse or the use of drugs as a coping mechanism,

I ended up on it myself because he ended up going to jail, I was in the house on my own with a child.

Female, aged 29, living with father, Sandport

Threats to the stability of relationships could be the ubiquity of prison sentences amongst the sample and the transitory nature of their housing as a result. Also there is the prevalence of domestic violence and relationships formed for predatory reasons, which might be more likely to result in relationship breakdown. Four of the sample had experienced the death of a partner – two murdered and two drug-related. Of the drug-related deaths, one was of a partner who had recently left prison,

> I waited eight or nine years for a council house and got one, and I'd only had the house for six weeks, he'd only been out of prison for six weeks and I found him dead in the house, he'd been there for days."
>
> Female, aged 34, private rented flat, Sandport

Another user whose partner had died did not like being alone in the flat they once shared together,

> *So how do you feel about being in the flat now on your own?*
> I hate it...I'm just not used to being on my own. It's like the last couple of years I cut myself off I suppose from a lot of people. I was just happy being with him, he was poorly and I felt I just wanted to be there.
>
> My worst thing is to be alone with me. You know I was thinking the other day I'd rather be in a hostel; at least I'd be with people. You know people say you're going to lose your home, I don't care, at least maybe then I wouldn't be on my own, it's got to that point at the moment.
>
> Female, aged 42, owner occupier, Sandport

The stability of the domestic environment could depend upon the presence or absence of children in the home. This could be a factor that was associated in various ways with a parent's use of drugs. The domestic settings in which drug consumption took place could be a factor

in the involvement of Social Services and whether children were taken into care or were living with relatives. Clearly in some drug-using environments there are real dangers – children neglected, witnessing violence, domestic violence, dealing with unpredictable behaviour and moods, the possibility of ingesting drugs or playing with needles, as well as general disruption to things like bedtimes, mealtimes and schooling. A single parent within a confined space and in poor quality accommodation may find stress levels a trigger for self medication and domestic arguments may be more likely in confined, poor quality accommodation if there is no space to cool off.

Some children witnessing drug use may, through social learning, come to accept drug use as normal and end up with drug problems themselves. It can, however, work the other way,

> *You know you said your daughter's in care, was that for any reason other than you and your wife were using drugs?*
> No, she asked to go into care herself, she went to the authorities and asked could she go into care because like I say she didn't like me and her mum taking drugs because we were always stoned. I mean I realize it now but at the time I was so stoned all the time I just didn't care. But I can understand why she did that now and how bad it must have been for her, it can't have been very nice at all, she was thirteen.
> Male, aged 43, night shelter resident, Newcity

The Advisory Council on the Misuse of Drugs (2003) created a risk profile and included a number of factors that increased the probability that any children of drug users would not be living at home. Drug use risk factors were,

(a) daily heroin use
(b) daily alcohol use with use of illicit drugs
(c) regular stimulant use
(d) sharing injecting equipment

Social risk factors were,

(a) unstable accommodation
(b) living alone or with strangers
(c) living with another drug user
(d) criminal justice involvement
(ACMD, 2003: 27)

Meier et al., (2004) in a comparison of a sample of drug-using parents living with their children and a sample whose children lived elsewhere confirmed that the greater number of risk factors the less likely were children to be living with the parents.

Of the nine women interviewed, six had one or more children, only one of whom was currently living with their mother. The others were either living with the father, the grandparents or in care. Three of them were fairly philosophical about this,

> I left him and he was financially better off to look after the children. It's not a thing you do, dragging your kids round the street looking for drugs.
> Female, aged 38, shared private rented flat, Sandport

This woman still saw her children every day and the other two whose children were with the father and grandparents realized that their current drug-using lifestyle was incompatible with care of the children. For the other three, one had just got her child back from the care of Social Services. It seemed this was proving to be a positive development in that it coerced her into abiding by treatment goals, as a kind of blackmail,

> The baby got took into care because we were homeless...I've just got my daughter out of care but I'm still up against the authorities at the moment so I've got to sort of run with what they say and play their game or they'll just take my baby off me, I thought "I'll be a good girl and keep my mouth shut."

But it was difficult for her to make long term plans such as going into rehab,

> There's no funding for rehabs with babies and partners, they won't fund it nowadays.
> Female, aged 27, shared private rented flat, Sandport

Another woman was more anxious and illustrated the dilemma of wanting to continue to take drugs and wanting to maintain her children with her. But once Social Services were involved these two goals could not be reconciled if drug use was of a chaotic nature and the home environment was not deemed to be suitable. She had recently had her two children back from care for ten weeks but they had again been taken from her because of the nature of her drug use,

> In the first place the reason they was took was my drug use, my chaotic drug taking they said. So as a result of that I did the detox, did the Subutex which they were happy with, and since December I've had them back and they've been taken again.
> *Why was that?*
> They just said I shouldn't have been taking drugs while I had my children, that I had the wrong sort of people in my flat.

She blamed one factor of her accommodation, common in HMO's, for missing appointments with Social Services,

> The mail boxes where I live, you go in the front door and you're in a little hall and everybody's mail is just thrown all over the place, everything goes missing all the time, I wasn't notified of these appointments.
> Female, aged 34, private rented flat, Sandport

There were added accommodation problems for this mother as well. Since her children were in care and she was in a two bedroom property on her own, Housing Benefit would not continue to pay the full rent, despite her plans to have the children back at some stage. In contrast one father had secured a two-bedroom council flat with a spare bedroom

for access for his child who could stay at weekends. However his new identity and lifestyle was being put at risk by his ex partner,

> She's bounced down in a taxi, she's gone – you're out of order, you're not seeing her, shouting all over the block, I'd only just moved in, she's shouting – "you're a bad smackhead" for everyone to hear, she attacked me.

He claimed the stress of this had led him to use drugs again,

> When something happens like my ex saying you're not seeing the kid it's upset me and the first thing I think which will sort me out is gear, just numb me sort of thing and I won't be thinking much. Male, aged 37, council tenant, Dockland

Clearly many of the sample had experienced unstable domestic settings and upbringings and had a lack of social support in their own family lives. But whether the instability of their family lives resulted in increased drug use, or their heavy drug use led to instability remains unresolved. As the ACMD report points out,

> Whether the children of the higher risk users were living elsewhere because of their parents' uncontrolled drug use or adverse living conditions, or whether having children elsewhere has an effect of encouraging riskier behaviour and worse living conditions, are important questions that require further detailed research. (ACMD, 2003: 25).

The following interviewee was experiencing problems in trying to balance the role of a dependent drug user and that of a mother:

Tanya, aged 34, private flat, Sandport

Tanya left home at fifteen because she did not get on with her stepfather. Her housing history is as a 'serial mover' within the town centre area of Sandport and its low quality private rented

sector. She says that the reasons for her high degree of transience are to seek out better conditions for her children although it is clear that her drug use has caused many problems, particularly as a result of inviting friends around for communal drug use.
Social Services are very much involved with the family and currently the children are in care because of Tanya's accommodation being used as a centre of drug use. This is usually at her instigation so that she can get free drugs, but also because she is centrally located and accessible.
She is still grieving for her husband who died from a heroin overdose shortly after release from prison. This resulted in her losing her council accommodation that she had occupied for six weeks after being on the waiting list for eight years.
Housing Benefit have now told her that if she does not get her children back soon then she must move from her current two bedroom flat into single accommodation, thus adding to the difficulties of her ever getting access.
Her predicament brings to mind the comments in the Advisory Council on the Misuse of Drugs report on the needs of children of problem drug users (2003) when they say more research needs to be done into parents' increased drug use after their children are taken away from them. For some mothers in the sample the removal of their children had acted to coerce them into treatment, for others it had made their drug use worse because of increased anxiety.

It is possible that women suffer a greater sense of stigma because of transgression of traditional gender roles (Friedman and Alicia, 1995). For some of the women whose children were not at present with them, life was on hold until they could be reunited,

We can't make any plans for our future because we've got to see where we go with the baby with Social Services. But that's what we want, we just want a normal life off drugs.
Female, aged 27, shared private rented flat, Sandport

What are your plans for the future?
Get on Subutex, get a job, work on getting my daughter back and lead a normal life.
Female, aged 29, living at family home, Sandport

So how do you feel about the future? Are you optimistic or...?
I will be if I know there's a chance I can get my kids back, then everything will be all right, but if I don't get my kids back I don't even want to live, I haven't got a life without them.
Female, aged 34, private rented flat in HMO, Sandport

The desire for 'normality' was one often expressed and for women a stable housing situation was a condition for having their children returned to them by Social Services. The idea of normality was often bound up with the idea of being a householder and being employed, but most people accepted that these things were not achievable until they had made changes to their drug use.

6.5 Housing as a contributor to a spoiled identity

For the vast majority of people in the sample, even the first rung of a housing 'ladder' remains unobtainable since the idea is constructed in terms of owner occupation, a tenure unaffordable to those on low incomes, and certainly out of reach to those on benefits who make up all but two of the sample. Restricted economic and geographical horizons characterise their housing choices, with the aspirational housing featured in lifestyle terms on TV representing a no-go area to them, and the

accommodation they find themselves in embodying a no-exit area in terms of location, price and quality.

I wanted to look at whether the negative housing situations of many in the sample could contribute to a sense of stigma that might be bound up with their identities as drug users - whether their housing reinforced or reflected a negative perception others had of them and they had of themselves. In this I was extending the work of McIntosh and McKeganey (2001; 2002) who adapted the ideas of Goffman (1963) and the use of the description 'spoiled identity' to explain a sense of stigma internalised by drug users in reaction to the negative opinions of others.

.Goffman states that the central feature of stigma is,

> A question of what is often, if vaguely, called 'acceptance'. Those who have dealings with him fail to accord him [sic] the respect and regard which the un-contaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding that some of his own attributes warrant it
> Goffman, 1963:19)

So, the negative opinions of others about one's condition or behaviour will not be felt as stigmatising unless we internalise the justification for those opinions. We may, alternatively, reject them, reject them in attitudes of defiance and self-justification, or be ambivalent about them so that we continue with a given behaviour knowing that it is perceived negatively by others and yet unable or unwilling to change it.

Behaviour that leads to change may arise from a single stigmatising incident that assumes symbolic importance, a "rock bottom" where the accumulation of past shame is consolidated in a point of no return. Alternatively, it may be a slow undramatic realization that a choice has to be made between a life one is tired of and one which one aspires to. Examples of the former abound in the confessional literature of addiction.

From the sample, people, now abstinent, gave examples of how they internalised the opinion of others and themselves in terms of stigma. One stated,

> I was a lot thinner, I wasn't eating, I wasn't washing properly, but I used to look at people who looked worse than me and say I'm not as bad as that, but some people tell me that you looked like you were dying...Yeah, and going begging, shoplifting and eating out of soup kitchens because you haven't bought no food, asking people for fags, picking dockers off the road and going up town wearing scruffy clothes, asking people for money, begging and shoplifting during the day and manipulating people and asking my mum for money and stuff like that.
> Male, aged 28, supported hostel, Newcity

A revulsion with one's physical and behavioural identity may run parallel with an over-riding need for drugs that sets up a psychological dissonance between what one perceives oneself to be and what one aspires to be,

> *How did that make you feel about yourself, did you feel pretty awful about yourself when you were going round town begging, or were you not capable of analysing yourself at that point?*
> That's a good question. I knew it wasn't right deep down, but I needed the drugs more, I was more obsessed with drugs.
> *That covered up your shame?*
> Yeah.
> Male, aged 28, supported hostel, Newcity

This stigma was most keenly felt in periods of exclusion such as rough sleeping when one's condition took on a more public character. Lankenau (1999) describes how those begging adopt strategies to deal with public hostility and manage their stigma. This may be by controlling emotions, managing one's appearance and making friendly contact with regular passers-by. One person said "people look at you like you're scum." Another related,

I phoned my mum up and seen her and she seen the state I was in, it broke her heart and she let me back home.

She didn't see you begging?

No, I'd be ashamed if she did...I got caught begging in my own town once by my uncle and he told my mum.

How did you feel about that?

It was so embarrassing, but if you haven't got anything you've got to.

Male, aged 24, supported hostel, Dockland

For users who had come from more middle class backgrounds, the dissonance in their current lifestyle could be felt of as deeply shameful,

You talked about not having contact with your friends through choice, is that because you don't want them to know your circumstances?

I'm embarrassed about my circumstances and I'd like to keep away until I'm more presentable.

Male, aged 23, supported hostel, Dockland

The ostracism in middle class areas could also be much greater,

Do you feel stigmatised at all?

Oh yeah, especially where I come from [affluent area] ...they shun and ignore me purely because of my heroin use.

How do they know?

Word just gets around. When I told you I got arrested for possession, it was considered such a big deal it was in the [local paper] when I was in court. Because it was in the paper it just went round like wildfire and I did notice a big change in people's attitudes then, but they are hypocrites because they'll go out and do ecstasy and cocaine at weekends.

Male, aged 29, living at family home, Sandport

In contact with medical staff, users were sometimes made to feel a sense of stigma and being labelled,

Do you feel you've been stigmatised through your drug use?

Very much so, yes.

By who?

By the whole system, right down to doctors' receptionists.

Have you had some run-ins with doctor' receptionists?

Many, it's almost like; we don't want your type here.

Male, aged 30, private rented flat, Sandport

Like nurses in hospital because they know you're on gear, just the way they speak to you.

Have you found that with doctors at all?

I have done with certain doctors...because they think you're after just one thing.

Male, aged 26, night shelter resident, Newcity

One user had difficulty in accessing drug services because of the location of the drug clinic,

Why is it a problem?

Social stigma mate. If I went down there people would get to know, there's people around who still don't know I'm into hard drugs...my mum.

How would she find out?

Well, it's jungle drums in this town, it's not in the best of situations on a main bus route, they're all looking out the window – look, look, pointing. I won't even go there with anybody, it really is a bad corner that.

Male, aged 55, private rented flat in HMO, Sandport

Shame at one's degraded physical state may mean that you rarely venture outside,

A lot of people when they get to that stage they're either dead or they look that bad, they can't shoplift, they can't rob, they're physically that bad so they stay in the house and other people come round and use the house in return for drugs. They look that

bad they're known in the area as a drug user and young people come to the house.

Youth Offending Team worker, Northborough

Whilst all users had some regrets about their use, this often took the form of a sense of waste and could be internalised as low self-esteem,

I think it was a big waste, I've always hated it because I couldn't get off it. I look back now and I've wasted the last eight years of my life.

So do you not think there were good times?

No, nothing at all.

Male, aged 26, night shelter resident, Newcity

Some users salvaged their good memories of drug use and saw the experience as a learning one,

It's modelled me into who I am now I suppose, but I do feel I've wasted a big part of my life through heroin use, I've got to be honest there. But it's been, I'd say, an eighty per cent waste of time and twenty per cent useful. It's made me not judge people as easily as I might have done, it's made me not be snobby towards people, I think I'm more understanding, more compassionate. I think I've found out a lot about myself by talking about my heroin problems, not just about my heroin, but about me as a person which I think is going to be useful to me in the future, so it's not been a complete waste of time.

Male, aged 29, living in family home, Sandport

It's been an experience, there has been good times, most of it's been a bit bad like, the stick you get off people and that, they class you as the lowest of the low and that and no-one respects you and you don't respect no-one. You're in your own little world sort of thing and you don't want to be bothered and you don't want to bother other people.

Male, aged 37, council tenant, Dockland

There was good times, I don't regret being a drug addict, I mean I wouldn't be a member of AA if I weren't a drug addict and it's good.
Male, aged 28, supported hostel, Newcity

When a drug-using lifestyle and one's sense of identity were not in conflict there was no sense of dissonance,

I don't intend to stop using drugs.
No, I got that impression.
Is it that obvious?
Well, I mean some people say it's all doom and gloom, the other thing I suppose is age, some people reach a certain age and they feel they can't keep doing it.
I'll try my best but my lungs aren't as good as they used to be. I won't give up drugs until the day I die.
Male, aged 45, night shelter resident, Newcity

A stigmatised identity was the internalisation of a labelling process that in part operated externally through stigmatised housing in stigmatised locations. This can take the form of certain addresses becoming part of the folklore and office culture of agencies such as the Police, Social Services etc. as well as the wider community. It may lead to potential tenants avoiding these properties.

I wanted to look specifically at how housing and neighbourhood was bound up with a sense of stigma, in the sense of internal states reflecting the physical environment. One worker describes how the physical environment and mental states of users are in an almost symbiotic relationship in a cycle of parallel deterioration. Almost as if an embodiment of the physical environment is taking place, or the physical environment becomes a reflection of interior moods,

It is sad because people end up cutting themselves off from everybody ultimately because it becomes all-consuming...they do

end up alone and do end up without homes, or in less than wonderful homes because they're not maintaining them either, maintaining their cleanliness and maintaining the fabric of a home either. So it goes down the pan a bit, they end up with a rag at the window instead of a proper curtain, the most important thing is to close it out. They don't take it down in the day, it stays up all the time so the place is always in gloom because it's a mess and they don't want anyone to see it, so there's a downward cycle there about hiding it, hiding yourself.
Manager, drugs agency, Dockland

The degree to which people's accommodation – the depressing environment, the feeling of being trapped, staring at four walls or at the never switched off television – can contribute to negative internal states, and whether these negative mental states could provide the motivation to use drugs as a coping mechanism, is an interesting one, yet difficult to demonstrate. According to past research psychological distress is linked to lack of control or powerlessness (Mirowsky and Ross, 1989). At its extreme it can result in a state of learned helplessness or passivity to external stimuli, a feeling that one is at the mercy of environmental forces and leading to a generalised sense of demoralisation. These feelings may be reinforced by social isolation, lack of social support and a sense of meaninglessness and normlessness.

We have seen how those who are homeless may use drugs as a coping mechanism, to deal with the physical hardships and anxiety that goes along with that condition. But there were many other situations that people related where it seemed they had used drugs as a coping mechanism to deal with negative psychological states. Some users related thoughts of suicide and suicide attempts,

I had a nervous breakdown, this is how my mental heath problems came about, and I tried to kill myself, I jumped off a motorway bridge.
Was that drug-related?

Yeah, through amphetamines and ecstasy.

Coming down?

Yeah, this is before I got into heroin and I ended up spending seven months in the psychiatric hospital.

Male, aged 28, supported hostel, Newcity

Have you ever attempted suicide?

I've gone walking about bridges where trains are.

Female, aged 29, living at family home, Sandport

Do you have suicidal thoughts?

Yeah, the rope from my dressing gown is still hanging from my skylight where I was going to hang myself, honestly, it's still hanging there now.

So would you say you're constantly thinking about that?

Yeah, I've had it planned out and everything.

Female, aged 27, shared private rented flat, Sandport

Many of the interviewees appeared to exhibit poor levels of psychological health, of anxiety, stress and depression, and it was unclear whether these symptoms were present before their drug use, were an outcome related to it, or were related to stopping using,

They said I had serious depression, they said you're thinking too much all at once and you're not letting yourself sleep. He reckoned the voices were, like, due to coming off the drugs, the drugs I'd abused in the past.

Male, aged 23, supported hostel, Dockland

They said I was bi-polar. Now they're saying I've got a lot of symptoms of schizophrenia, but I haven't been diagnosed schizophrenic.

So you're getting mixed messages off people?

Yeah, but it could all purely be down to drug use, I don't know.

Did you have these symptoms before you started taking drugs?

No, it could be brought on or aggravated by drugs, it's very complicated.
Male, aged 23, supported hostel, Dockland

Do drugs take away these feelings, [depression] is that why you take them?
Yeah.
Do the symptoms come back when you stop taking them?
Yeah, so then I change it for alcohol and I don't go better, I go worse, there's no happy medium with me at all.
Female, aged 35, shared private rented flat in HMO, Sandport

Drugs calm me down, I've got insomnia and I'm hyperactive.
Male, aged 34, shared private rented flat in HMO, Sandport

Several mentioned emotional pain on the death of a parent or partner, and three specifically mentioned drug use as a response to unpleasant feelings related to poor mental health. The combination of circumstances and reasons for use are notoriously difficult to unravel and left people sometimes bemused. One described the progression from occasional use to dependence linked to negative internal states,

I had friends outside heroin use but they moved away, going to university or through moving away with their girlfriends or whatever. In a way I was sort of left behind. I didn't have a very good view of life and myself at the time. I was quite depressed, it really happened after I had the anxiety problem and I was left a bit sort of in limbo and I suppose it was just, not a natural progression, but an unnatural progression, but it was a progression just the same. At the time I didn't consciously say to myself, right I'm going to start using heroin now, it just happened...You know it's a very hard thing for me to tell you why I got into heroin use.
Male, aged 29, living in parental home, Sandport

Agnew's strain theory (1999) brings together social psychological and criminological theories centring on place, indicating for instance how poor housing conditions may lead to individuals viewing their housing negatively and spending more time on the street. Negative stimuli visible in a deprived area can impact on behaviour and mood,

> I ended up in a one bedroom flat which was really bad, all drug deals going on round the back of there, drug dealers living next door to me...It was terrible for the kids and the metal fire escape was all shaky, it was a horrible place, all dirty needles down in the yard, it was a right mess.
> Female, aged 34, private rented flat, Sandport

Incivilities such as litter, graffiti and neglected spaces may create psychological responses of stress and anger which can be exaggerated or modified by the presence or absence of social support or personal coping strategies. Dilapidated neighbourhoods confer a negative status on their residents; a labelling effect reinforced by agencies such as the Police, housing authorities, Social Services that can lead to self-fulfilling behaviour and a subculture of deviance.

Users may come to internalise these labels and take on attitudes and behaviours of those around them according to social learning theory. However, whilst to an outsider these living environments may seem deeply unattractive, they may be more comfortable to a user who has a social network of like-minded people in the vicinity and a ready supply of drugs. Social capital may be high although of a negative character. Drug use has taken hold in some communities where it offers alternative values,

> Yeah, it's kudos, esteem, it's what you do, it's how they see themselves living their lives, there might be the odd job here and there but they're doing more stealing than they are odd jobbing, and as their use escalates their problems escalate.
> Clinical Nurse Manager, Newcity Community Drugs Team

To the extent that one's identity was bound up with a sense of place then for an active drug user, to be located in a run-down location could be seen as natural, one could be 'at home' in such an environment. Yet when one's feelings about drug use became more ambivalent, that location and its wider social environment could be a permanent reminder of one's condition. Being forced to associate with people who were not of your choosing and whose negative attributes were a daily reminder of one's own perceived moral and physical degeneration reinforced the feeling of having let oneself go. The poor physical environment around you - the lack of space, the lack of privacy, poor quality furnishings and decoration, lack of facilities for yourself and your children – these physical factors might contribute to poor mental health in the form of affective disorders such as anxiety and depression.

Hostel accommodation could also be felt of as stigmatising,

> I don't want to go into a hostel and have my dignity taken away from me. I want a private room, somewhere I cannot be stigmatised because they say, oh, they're down at that hostel.
> Male, aged 30, private rented flat, Sandport

To be a hostel resident in an area you were brought up in was uncomfortable,

> There's only two hostels which would be suitable for anyone in their right mind. I wouldn't want to go to. hostel because I grew up round there and it would be embarrassing for me.
> Male, aged 23, supported hostel, Dockland

A sense of stigma may be reinforced by a sense of fatalism about being trapped in addiction and also being trapped physically in the environment, of there being 'no way out', of one's future horizons being restricted socially and literally in a geographical sense of being 'fixed',

> *And when you came out of jail where did you head for?*
> Straight to score.
> *Where to live?*

Same again, just crashing at my sister's or just wherever

[partner interrupts] *The last time you came out you tried to kill yourself didn't you? Because he thought there was no hope for him and he was just going to end up doing the same again, back to jail.*

So have you not much confidence that you could give up? Or do you want to give up?

Well, I always think about giving up but I am weak when it comes to all that.

Male, aged 34, female aged 35, shared flat, HMO, Sandport

Low expectations of housing were common. Even living in a container at the back of a McDonald's was "all right",

When you were living in the container, was it not very cold?

No, it was all right.

You found it OK?

Yeah, it was all right, we had a carpet down and we put our sleeping bags down, it was all right.

So did you just go there late at nights?

No, we'd spend the day there, we were living there, it was all right, no one bothered you.

Female, aged 34, shared flat in HMO, Sandport

This person had previously abandoned a rented house and all her belongings,

You just kind of left the keys and walked out?

Yeah.

Did you have many personal possessions at the time?

Yeah, we had a full house.

What did you do with it?

Just left, I just walked away, I always walk away.

Female, aged 34, shared flat in HMO, Sandport

This relationship to accommodation, this feeling of it only being temporary because sooner or later I always move, was common.

In a national survey into the social and economic circumstances of adults with mental disorders the authors include those with alcohol and drug dependence in their sample (Meltzer et al, 2002). They found that the drug dependent group included the highest proportion in privately rented housing at 30% and they were the group least likely to own their own homes. Along with the other mentally disordered groups there was a high degree of dissatisfaction with their accommodation with 15% of drug users expressing concern about the long-term security of their housing, mainly due to financial problems and short leases. Ten per cent felt that their health had been made worse by their accommodation.

Whilst the qualitative data seemed to indicate a high degree of psychological ill health amongst the sample, I used the Maudsley Addiction Profile to tentatively examine whether poor psychological health in specific housing situations could be confirmed quantitatively. Using SPSS I looked at whether there was any association between poor psychological health and type of housing based on the collapsed housing categories used in Chapter Five. I also ran some analyses of the quantitative data to consider the relationship between gender, housing and anxiety, and gender, housing and depression.

Housing and levels of anxiety

The anxiety score is made up of the following elements:

- Feeling tense
- Suddenly scared for no reason
- Feeling fearful
- Nervousness or shakiness inside
- Spells of terror

Those in poor quality communal housing had a similar proportion of people with low anxiety scores (0-5 points) as those in non-communal housing forms, 29.6% (*n8*) and 30.8% (*n4*) respectively.

Those in communal housing forms had a similar proportion of people with medium anxiety scores (6-15 points), 52% (*n14*) and 54% (*n7*) respectively.

Those in communal housing forms had significantly more people with high anxiety scores (16-20 points), 22.2% (*n6*) compared with 7.6% (*n1*) in the non-communal sample, although the inadequacies of the data are here particularly apparent.

Five of the seven people with the highest anxiety scores (from 16 to 20 points) were living in HMO's. One of these featured in the highest scores for consumption of alcohol, heroin and crack, and another in an HMO in the highest scores for heroin and crack consumption. They were both female.

Housing and levels of depression

The depression score is made up of the following elements:

- Feeling hopeless about the future
- Feelings of worthlessness
- Feeling no interest in things
- Feeling lonely
- Thoughts of ending your life

Those in communal housing forms and non-communal forms showed no marked differences in their levels of depression, except at the low depression index score (0-5 points) due to the low non-communal sample size where 55.5% (*n15*) of the communal sample had low depression

scores compared to 7.7% (*n1*) who had low depression scores. Again, the data does not allow for generalisations to be made.

29.6% (*n8*) of the communal sample had medium depression scores of 5 to 11 points whilst 46.1% (*n6*) of the non-communal sample had medium depression scores.

11.1% (*n3*) of the communal sample had high depression scores of 16 to 20 points, whilst 15.3% (n2) of the non-communal sample had high depression scores. Three of the five were women. Three of the five with the highest anxiety scores also featured in the five highest scores for depression. One of these was one of the highest crack users, and one was one of the highest alcohol, crack and heroin users. However, not much of statistical validity can be gained from these figures unless one looks in more detail at the life histories.

Considering that the sample of women was quite small (9) their representation in the high anxiety and depression scores was disproportionate. Of the three women in the top five anxiety and depression scores, the qualitative data showed that two had been in psychiatric units in the past and all three had been sexually abused by one or more family members which might indicate self-medication to deal with traumatic experiences. Interestingly, all three presented a very confident manner that must have hidden their insecurities. Whether this indicates a use of drugs to alleviate unpleasant internal states as a coping strategy or as self-medication remains conjectural, as does the question of causal direction of drug use and depression and anxiety.

Ken, aged 34, HMO, Sandport

Ken has used heroin since the age of fourteen when he was in care. His mental health is poor and he scored highly on the anxiety and depression scores in the Maudsley Addiction Profile. He has been

diagnosed as a paranoid schizophrenic and takes Largactol to deal with the symptoms, although he sometimes forgets to take it. He feels that people are wary of him because of his sometimes aggressive and impulsive behaviour.
He is heavily dependent on his partner who is also a heavy drug user. She says "I took him under my wing because he's got no social skills."
His medical condition, allied to a long criminal record, means his chances of employment are poor although he has done many courses in prison. He is fatalistic about his situation and the likelihood of returning to prison. His housing history illustrates the 'revolving door' syndrome of poor housing/prison/homelessness. He frequently has suicidal thoughts.

Physical health affects one's mental health, and worries about future prognoses or pain of current symptoms may be alleviated by drug use. Consequently, the relationship of accommodation, physical ill health and drug use was one I also considered. In the interviews three people said they started to use heroin to cope with physical illness, one when he broke his back, another who had arthritis, and another who had Crone's Disease. However, physical ill health was more likely to be the result of drug use rather than a pre-existing state. Several users reported contracting Hepatitis C, these were mainly the hostel sample who were encouraged to get tested, although two others also stated being positive,

> Even today we've got a very small minority of people, intravenous drug users, who are HIV positive. I mean, quite the opposite with Hepatitis C because it's rampant and that is a major problem here because we've got...I would say at least seventy per cent of ours have got Hepatitis C.
>
> Manager, supported hostel, Dockland

Using SPSS I used the quantitative data to consider the possible relationship between physical health and type of housing, but could find

no relationships between them. Neither was there any apparent pattern between high drug use and reported physical health, or gender and physical health. However, three people featured in the top six for anxiety, depression and poor physical health that could point to some crossover between physical and mental health, although the evidence from this small sample is not sufficient to be generalisable.

The quantitative data was generally inconclusive for both psychological and physical health. Perhaps the questionnaire does not specifically cover some of the physical symptoms of intravenous drug use such as abscesses, collapsed veins, blood poisoning, and muscle wasting that some of the sample might possibly report. Or it could be that life as a drug user has hardened people to bodily discomfort and ailments that might cause unease in other people are unremarkable to some of the sample. Also, given the 'time bomb' effect of Hepatitis C, it could be that many intravenous users in the sample could have problems in the future regarding their physical health.

6.6 Forms of housing as agents of change

If, as we saw in Chapter Five, users themselves were divided as to whether their housing had affected their drug use, nevertheless, policies which many agencies operate relating to the housing of drug users are based on the assumption that there is a link and that the provision of stable, good quality housing is a vital contribution towards positive treatment outcomes and resettlement into the community. Hostels that offer staff support operate on the basis that those with drug problems are unlikely to successfully maintain a tenancy without being equipped with practical living skills such as budgeting, health and hygiene and cooking, ideas usually based on a middle class good housekeeping model, that form part of a resettlement programme.

As well as these aspects, other areas of the person's life are examined in a holistic way. Here the assumption is that to address only one aspect of a person's situation is to ignore the inter-connectedness of social factors that have formed the background to their drug use. So, the provision of housing, or employment, or training, or education, or social skills and activities, or advocacy and legal advice make up part of the programme, sometimes referred to as distal needs, or matters ancillary to treatment, but by attending to which successful treatment outcomes can be maximised.

A drug-using lifestyle may be one where housekeeping standards or skills have not been seen as a priority,

> I think the actual drug use itself de-skills people because it's immediate gratification. People wake up in the morning and the first thing they think about is where am I going to get my ten pounds to get my gear today...everything else pales in significance so all the thinking ahead and new strategies, that skill of living which is about planning ahead, saving and getting stuff together to improve the home, it just goes.
> Manager, drugs agency, Sandport

Respect for one's property and the housekeeping standards of users generally was mixed. Many users were very house proud and it was remarked that people who had been in prison or the services were usually quite tidy,

> I would say that the vast majority of people's houses that I go to are very well kept, not especially great housing stock but it's definitely been cared for. When someone's using chaotically that's when you see places that aren't as clean as they could be, inadequate furniture, if furniture at all, lack of electricity and gas.
> Client support worker, Dockland

If they were stable then their accommodation would be no worse or better than anybody else living on benefits. Crack users were singled out for their chaotic living arrangements,

> I've been to people's houses who are using crack and the mirrors are smashed, a lot of stuff has been sold off and they lost it for a bit. Their offending rate goes up. Coming back to accommodation, the crack user very often has to be out more to raise money, they'll have a real binge, the chaotic stuff, accommodation goes mad, they go mad and get arrested a lot. Drugs agency worker, Sandport

The aim is to motivate change towards a new non drug-using identity by reinforcing self-esteem and self-efficacy, or the belief that change is achievable. This is encouraged through the acquisition of social and practical skills which validate a person's worth in their own eyes and by addressing any consequences of drug use such as outstanding legal, health, housing and financial problems. Some drug users' confidence and levels of social skills may be low. Some may just want a quiet life. Their experience of dealing with authority may be negative, their social and assertive skills undeveloped along with an awareness of their lack of power,

> There's a loss of belief that they've got a legitimacy – "nobody will listen to me, I haven't got a voice". This is one of the problems we have with people, they won't make a complaint because of their self-perceptions. It could be a civic duty to themselves or society, that there's a genuine complaint about something, they will not make a complaint, their self-perception is that I will not be believed. If someone has been known to the Police, been in and out of prison, known as a drug user, the percentage of belief about what they say is going to be very low - those are the rules of the life I'm living - they have quite a low opinion of themselves. Drugs agency worker, Sandport

We have seen that users very often exhibit guilt and shame, conscious of their spoiled identity, and the aim of much treatment is to instill confidence and turn recovery from something that is desirable into something that is achievable,

> Our aim is to help people create a new identity for themselves, to stop thinking of themselves as an ex user, to think of themselves as a student, or a volunteer or an employee because people have very strongly held beliefs that are attached to their identity by virtue of being a drug user.
> Client support worker, drugs agency, Dockland

Change for some may involve a physical move, often referred to as the 'geographical cure', away from associational triggers to use drugs. The difficulty of this will depend upon the strength of ties binding the user to former locations and associates. A minority can maintain their abstinence in the neighbourhood they came from, but this requires great mental strength, cognitive skills and relapse prevention strategies. Change for drug users is complicated since it is not only cognitive and behavioural change that must be made in order to leave dependence behind, but there must be a confrontation with the physical and pharmacological symptoms of dependence.

Whether this motivation to change comes about as a result of a 'rock bottom' experience or a gradual maturing out of the drug use lifestyle, users may be faced with some difficult decisions about their social contacts and housing situation,

> People who want to change and want to stop using drugs will find that very difficult whilst they are living with drug users, either their partners or their friends, or they're kipping down on somebody's floor, or they don't have their own accommodation, they have a very tenuous grasp on any accommodation. There's a significant number of people, really they have to change their accommodation before they are likely to change very much else really.
> Senior Probation Officer, Northborough

This change is very difficult to bring about when you are living amongst other users and caught in a repetitive cycle of drug consumption and activities to raise money to get drugs,

> The way of life that people live really doesn't give them any time or energy, emotional energy, to decide to change. They are on a treadmill by and large of offending, grafting [stealing], scoring and out again a few hours later.
> Senior Probation Officer, Northborough

> Because drug use is the central thing in your life you can't be bothered to focus your attention, energy and resources into getting decent accommodation. You put up with that because your main aim is your drug supply, and you stay on that level.
> Manager, drugs agency, Sandport

In a process of change something like a complete locational and psychological makeover may be required,

> It's a difficult world for these people and unless they can get right out of it they are exposed to the triggers wherever they go. One thing people need is a new identity, about like the CIA gives people in the Witness Protection Programme, they really need to go away and have a new life and a job, and they can go off and be somebody else. It's not realistic but some people have to break with an awful lot of the structure of their lives in order to have this other life that they want. Some people don't have to do that, some people can stay in their house and resist the dealer, they make new friends and they can put the thing in the past.
> Manager, drugs agency, Dockland

These people, however, are generally held to be a minority and the negotiation of previous social networks is fraught with difficulty since they have had both a positive and negative influence on peoples' lives,

> It's important to break down that link with the peer group, but it's important to see it in a realistic sense, that it's not all black and white, some people are being very much cared for by other users, others are very much manipulated by other users. It's about slowly addressing an individual's links with a peer group, giving them other options that give them the same level of security and satisfaction.
> Client support worker, drugs agency, Dockland

Where housing circumstances are poor and social networks are thought to be a negative influence on treatment prospects, some form of community treatment may not be appropriate. An alternative form of accommodation may be required as a base for treatment, either in a hostel that offers structured support and where treatment can be accessed, or in a rehab unit whose main aim is a programme of treatment within a residential setting. The Manager of one supported hostel I visited reflected on a change that has taken place in many hostels over the last twenty years, a change from the old night shelter provision, where food and shelter were offered on a nightly basis, to a system involving a greater professionalisation of provision in terms of resettlement.

Some of the smaller hostels were found to be a contrast to the larger hostels we came across earlier. They employed more specialised, qualified staff and a more structured approach to working with drug users,

> Agencies are actually phoning us up and saying we've identified this person who wants to make changes in their life, so now people are beginning to select us as the answer, rather than it's somewhere where a homeless drug user can go and just doss basically. I've got to explain what we do before they make a commitment to come, because it's not like any other hostel where they can come and go as they like.
> Manager, supported hostel, Dockland

Along with receiving food and shelter residents carry out a work programme each day. At the time of my visit they were constructing a training centre at the back of the project for which they received payment. Not only did this ease them into work habits but it also filled the time, and people were not out of the building where they might be tempted into crime,

> When I first came here it was madness, they were all going out grafting and I had to say to staff – what's he just walked in with? They were coming in with stolen goods and it was just madness. But now we don't have to think about things like that because people are here during the day, they're not out. That's the first break with the lifestyle, staying in, taking part in the training, getting good food down them and somewhere safe. Because I do think they are safe here, we've got security locks on the door and that's more to keep people out than in, when they're in here they know that nobody can burst in and beat them up.
> Manager, supported hostel, Dockland

The refuge aspect of this accommodation was borne out by residents who were in fear of former drug-using associates, but the enforced training programme was not to everybody's taste and a couple of residents were hoping to leave because of this. Clearly when people are in desperate need of accommodation they will sign up to the aims and objectives of a project, only to resent this later on.

A greater professionalisation, (increasingly demanded by funders who want to see results in terms of outputs), means that those drug users perceived to be more chaotic and unable to fit in with structured resettlement programmes will have access to a decreasing number of hostel providers. Another service manager made the point in relation to the above hostel,

> This hostel was set up by the church and it was the bottom of the ladder, it would take anybody and it was a great resource because people who got kicked out of everywhere else would be accepted

by them. But because of that it could be a pretty shitty place and I think because of that it got badly judged. But people doing that bad judgement were missing the point because now they've responded to the criticism, become much more structured, less tolerant, but by doing that they're excluding people who used to be able to get in there. So those people have nowhere to go.
Manager, drugs agency, Sandport

For those who respond to the regime the hostel can provide access to health care, training, treatment and leisure opportunities within a drug-free environment. But whilst residents were extremely respectful towards the hostel and its rules, which forbade drugs on the premises, most residents, nevertheless, continued to use drugs outside. This appeared to be at a much-reduced level and in a more managed way, in some cases once a week as a 'treat' and in all cases in a crime-free way. However, it seems they did not all abide by the rules,

Quite a lot in here have got hepatitis and what they do they do, that's fair enough but some people do it in places where it shouldn't be done. You find the odd spike buried in the garden where someone else could pick it up. That's one of my sore points in here.
Male, aged 35, supported hostel resident, Dockland

One problem such hostels face is that two of the central things that may be required in reconstituting an identity – permanent housing and a job – may be two things that it is beyond the power of the hostel to directly provide, being under the control of other agencies. One project leader saw a job as central to recovery,

What people want is a job because that defines what you are. I think it's no coincidence that drugs hit in the nineteen eighties in areas like this when there was massive unemployment.

He stressed work as particularly important to the male identity,

> It's what a man's about...what you do, what you earn, defines you.
> Big Issue in the North Coordinator

Other workers put more stress on re-training and leisure, seeing getting a job which might be low paid and lacking in status as demoralizing and a trigger for a return to drug use. Also, many ex-users might be too "knackered" and physically or mentally unable to take up work according to one rehab manager. The approach many agencies followed was to keep peoples' aims realistic,

> Some people get incredible hopes up because they think if I can beat that I can beat anything. Those are the people I feel are most at risk because they're not thinking about the reality of their situation. Everybody has bad days and the people who are over-confident are those who are going to drop the furthest.
> Client support worker, drugs agency, Dockland

For drug users, conscious of time that they consider wasted, there may be an urge to run before they can walk,

> I lost seventeen years of my life but I feel positive really, it's just that it takes time, it's like I'm trying to catch up too quick.
> Male, aged 33. supported hostel, Dockland

Many hostels have move-on units which act as a halfway house that act almost to cushion re-entry into the mainstream and where ex residents continue to visit the hostel for support. Whilst this support continues people have the freedom to manage their accommodation plus a resource to call on if problems arise. But when it comes time for them to take up their own tenancies with a private landlord, housing association or local council, relapse prevention strategies must be planned ahead,

> What you have to prepare them for is reality...people are quite frightened and don't know if they can keep off drugs and worry about the long term.
> Manager, rehab unit, local area

This, however, may be a realism which is positive,

> They are usually the people who tend to be quite successful because they're thinking about the pitfalls. If they over-think about them, sometimes they go back on drugs on an insecurity basis, but people who have some worries, some doubts, are concerned about going back into the neighbourhood with users about, those people tend to do better, they start connections in their heads that will help them deal with those situations when they do eventually arise.
>
> Client support worker, drugs agency, Dockland

Moving into new housing stimulates great hopes and great fears. The responsibility of cooking, cleaning, paying bills; of furnishing and decorating may seem like a new freedom to many, whilst for others it may take on the character of constructing a prison for oneself,

> This is it, brand new flat, brand new start, brand new life – and then in a month the bubble bursts. They're very energised, very motivated and then after a while, Oh my God, prison cell! ...and then it's keeping that contact, keeping them motivated. It's very lonely coming from rehab, a house with seventeen people to going into your own flat with the idiot box on in the corner as your only company twenty-four seven. It's quite soul destroying, the honeymoon's over.
>
> Manager, rehab unit, local area

One of the main differences between hostels and rehabs as locations is that often the rehab residents come from areas outside the immediate location. This reflects the aim of getting the drug user away from triggers associated with former drug use to a space free from contagion, sometimes out in the countryside, physically and psychologically separated from that past life.

Access to rehab may be difficult to plan and depend upon available funding for which there is much competition. New criminal justice interventions may provide an added means of access, but there was some difference of opinion amongst the agencies interviewed as to whether criminals were leapfrogging other users for places in rehab, even to the extent of deliberately increasing offending with the aim of being fast-tracked for treatment,

> I think lots of drugs workers felt the drugs agenda had been hijacked by the criminal justice agenda, and there are some issues with regard to access to services. People on DTTO's (Drug Treatment and Testing Orders) are fast-tracked, so I've had reports that people have escalated their crime in order to get on a DTTO and that waiting times have gone up to a year.
> Drugs agency worker, Newcity

Whether or not this was actually happening one worker said, "it's perceived by other drug users as queue jumping", but it was vehemently denied by the Senior Probation Officer responsible for administering the DTTO in Northborough,

> I've actually yet to come across anybody who's committed an offence to get treatment, which is a notion that's bandied about. Most of the drug users we work with have been users for ten, fifteen, twenty years, so it's hardly a short cut to treatment.
> Senior Probation Officer, Northborough

When access to a rehab unit is achieved, communal living often becomes part of the treatment with users forced to share the preparation and consumption of meals, the cleaning and the upkeep of the house and grounds. The claustrophobic nature of group living, allied to a temperamental resentment of a strictly enforced regime, may lead to a much anticipated and hard-won place at a rehab unit being terminated either by the user or the staff. The inherent selfishness of a dependent drug user may be difficult to adapt to an environment where people are expected not only to share daily tasks, but their feelings, their failings and

their fears. However, their fears of reverting to their past life may be an incentive to complete treatment, and if completion is a condition of a DTTO, there is the added coercion factor, something which some drugs workers dislike, believing that motivation to change must come voluntarily.

Several of the sample had been in residential treatment, only one of whom was currently drug-free. Problems could arise during a stay but one of the main problem areas was leaving and securing a place to live,

> It tends to be the people coming out of rehab who have the biggest problem with housing...I've found a lot of people coming to the end of their stay in these places are not having anywhere to go. They've made massive changes in respect of their outlook and then don't have any accommodation to stay in to optimise these things and that often triggers lapses.
> Client support worker, drugs agency, Dockland

One problem may be that if the person is not from the unit's area then they have no local connection necessary for housing in that area, and local housing departments may be unsympathetic to provide housing to recovering drug users, perceiving them as unwanted competition with local people and a possible source of management problems,

> You couldn't get with a housing association because you have to be resident in Norfolk for six months and rehab didn't class as being resident.
> *What was the attitude of the housing department in Norfolk to people from rehab coming into the area?*
> They wasn't quite happy, they didn't have an agreement with the rehab, they had their own drug problems, they didn't want more.
> Male, aged 28, supported hostel, Northborough

It is also very difficult to coordinate fixed term funding for residential treatment and the availability of a housing vacancy at the end of it.

Consequently users may be forced to leave rehab at the end of their funding with only their area of origin to return to, with no planned housing,

> If my brother didn't have that room I'd have been at my mum's. My mum lives where they'd all be using. I had a flat on the same landing which I gave up when I was in treatment because obviously there were bad things going on there. I wasn't happy having six months of therapy, and I'm vulnerable, coming back to Newcity and ending back where I'd come from.
> Male, aged 28, supported hostel, Newcity

Another problem can arise when residents develop links with the area and the unit has arrangements with a local provider to provide a certain amount of re-housing,

> They do a great job with residential rehab, and they are working in groups and they're bonding, bonding, bonding, they're like a family after a while, they're really close and they've got a housing association that re-houses them all in [nearby area]. It's one of the more deprived areas which means that there's not such a demand for the housing, and they're all together in [named area] and when somebody relapses they take several other people with them because they're so bonded they come round late at night banging on the door saying – please, you've got to help me! The ongoing bit is where it's going wrong because housing isn't what they do. They're desperately trying to help all of them by giving them somewhere to live, but because they're working with one housing association they all end up within a street, or within a house with each other some of them.
> Manager, drugs agency, Dockland

Supported housing and residential treatment units can act as agents of change, but that process must be continued out in the community in mainstream housing where the negotiation of 'normality' may be one of the hardest tricks to pull off. Avoiding relapse in locations dangerous for relapse will necessitate the building and maintenance of interior

resources in the form of self-esteem and self-efficacy, as well as the strengthening of cognitive processes such as decision-making and relapse prevention. It also requires a changed attitude to housing as more than just bricks and mortar and a temporary stopping-off place. The next section examines what the idea of home means to drug users in the sample and how a changed attitude to the home could aid the recovery process and be bound up with the construction of a new identity.

6.7 Motivation to change and the meaning of home

The process of change from a drug-using lifestyle to a non drug-using one is often seen as a number of 'push' and 'pull' factors, or circumstances which are either antipathetic to the individual and which they seek escape from, and circumstances which are desired in preference to the current ones. I investigated what housing meant in terms of the construction of a new identity by attempting to establish what users felt about their current housing and the sort of housing they would like, in other words what the push factors were in their current housing and what the pull factors were in their desired housing.

The characteristics of housing which people were looking for when they were using drugs were different from those they saw as positive to a drug-free lifestyle, although some aspects were the same. Whereas when they were using, a location convenient for drug supply and regular contact with other users might be a plus, these were the very things people wanted to escape from in constructing a new life.

Possibly due to past experience, security was important ("high up, a good lock on it"), as was the ability to monitor visitors,

> *What about the block as a whole, do you think it's risky as far as drug use goes?*

> Not really, there's security twenty-four seven, there's video cameras, like, to actually answer the door, and you've got to have a fob to get in, and if you was knocking for someone you'd have to explain to the concierge who you were seeing, stuff like that.
> Male, aged 37, council tenant, Dockland

One user who said, "I won't give up drugs until the day I die", still wanted to stay in the city centre,

> I'd like a place in the city centre. I don't want to be fobbed off with shit accommodation that's far out from the city because I don't want to be shoved so far out of town that I can't get to meet people. If I'm in the city centre at least I can get some contact.
> Male, aged 45, night shelter resident, Newcity

Several people felt that if they were re-housed to a new area they would have to keep their address secret from former acquaintances. However, one danger of avoiding old friends was that if new social networks were not created this could result in isolation, boredom and loneliness,

> *Do you get stressed out?*
> Yeah, depressed and what have you.
> *Is that related to anything in particular or just your general situation?*
> I'd say I've got no one now that I bother with.
> *Are most of your friends still on the drug scene?*
> A good few of them are, yeah.
> *And have you cut that part out now?*
> Yeah, I don't see no one.
> *So you're a bit isolated?*
> Yeah.
> Male, aged 37, council tenant, Dockland

Without the getting and using of drugs to supply a structure to the day, time can be a big problem and a new flat may take on the contours of a prison cell.

To maintain the change process strategies had to be put in place to strengthen self-efficacy and self-esteem. Many people, despite their experiences remained optimistic about the future, although this often depended upon the thought of accessing and successfully completing a programme of treatment at some time in the future. Several looked forward to educational courses, and the work ethic was strongly expressed in some people who regretted that their drug use had led to them losing jobs. The desire sometimes expressed was to,

> Start living a normal life again, whatever normal is.
> Female, aged 42, owner occupier, Sandport

For those who had felt themselves to be socially excluded and stigmatised, conventional aims, including stable housing, could be very attractive,

> I want to get like a nice flat or house, have a baby, just be normal after I'm off the methadone and that.
> Female, aged 26, shared private rented flat in HMO, Sandport

> I'm starting college now to get some qualifications, I want a nice job, my own house and a car.
> Male, aged 24, supported hostel, Dockland

The house is seen as part of an identity package which bridges the gap between social exclusion and inclusion. Home ownership for the majority of people in this country is said to confer,

> "status...success...permanence...security...refuge...control...free dom...autonomy"
> (Saunders, 1990: 270)

These myths inherent in the image of home ownership can be disputed and illustrated by examples of the downside of owner occupation: the insecurity of those unable to meet mortgage commitments, the home as a private place of danger and abuse or the transience and restless

dissatisfaction of those caught in a repeated search for a higher rung on the housing ladder. Although rented housing might not provide the status and conspicuous signs of success quoted by Saunders, it could provide the other things associated with 'ontological security' such as permanence, refuge, control and autonomy. Most of those interviewed had a very loose attachment to the accommodation they had lived in. This is not surprising since it was not usually accommodation that they had freely chosen. One agency worker commented,

> I see my home as a home, they see it as a house, just bricks and mortar. I think it's because it's not theirs, rented accommodation. Tenancy support worker, local area

However, there is nothing inherent in rented housing which makes it of less status, (as evidenced by the rich living in rented apartments), it is more to do with particularly British popular associations attached to certain types of rented housing, underlined by successive government policies that have made owner occupation the tenure of choice. But it is not surprising given the national obsession with home ownership that some users should share this. If some were in search of normality or conformity as an antidote to their previous, often chaotic, lifestyles, then home ownership was one way of achieving that normality.

The transience of their former housing careers was for some people an aspect of their lives which they wanted to change. That transience had not been a transience of choice, but a series of situations forced upon them directly or indirectly by their drug use. For others, however, transience represented a kind of freedom which they enjoyed and wanted to continue,

> *Do you intend to get your own place?*
> No.
> *What are your plans?*
> We'd like to live back in Spain...just travelling, squatting in houses, wherever we are. We don't travel with any money, the only thing we have for money when we're travelling is what we make

ourselves on the street. We have like someone playing bongos, someone with like chains that go on fire, swinging them and then I'll be doing the fire eating or juggling fire or whatever.

So where did you learn to be a fire-eater?

We were hitchhiking and a circus picked us up and we stayed with them for a few months, I learned the basics there.

Male, aged 26, supported hostel, Dockland

This is a far cry from the bruised and repentant user in search of conformity. What it does illustrate is a considerable degree of self-reliance and also self-esteem, and little sense of a spoiled identity. This kind of freewheeling transience is very different from the enforced homelessness some users experienced on the streets, and was more attractive in another country in a warmer climate.

People tended to see their accommodation in instrumental terms, as shelter, as a refuge from the outside world, sometimes conscious of the very tenuous hold that this accommodation gave them over homelessness. Thus, it was the supported hostel residents who spoke most warmly about their current accommodation because their homelessness was recent and their memories of it very vivid. They spoke of their gaining a place in the hostel as literally a life-saving event. Unlike those in private accommodation, their treatment needs were being addressed on a daily basis, their self-worth was continually validated by staff and the structured programme reinforced that they were no longer just drifting, that they could access services, gain skills and eventually gain permanent housing and a drug-free life,

I just look at it this way, that I've landed here and since I've been in here I've got to get up every day, not take drugs every day and, as I said before, I actually feel I'm worth something now.

Male, aged 35, supported hostel, Dockland

Those in private accommodation were often grateful for the most sub-standard accommodation, feeling that this was somehow their natural

habitat and that other options were closed to them. Their low housing aspirations accompanied them through recovery, re-packaged as 'realism'. Their housing ambitions were modest,

> I had a lovely place before I went to jail and I really want to get back to that, my own kitchen, my own bathroom. I can't bathe where lots of people have used...and the toilet...
> Female, aged 35, shared private rented flat in HMO, Sandport

For some with experience of living on the streets, even a bed in a night shelter can seem like a re-entry point,

> *You're reasonably happy here are you?*
> To be truthful I am because let's face it, there's nowhere else for me to go because the next step from here is the streets, so I'm quite happy here. If you think about it there's only a window between me and the outside, so I'd rather be inside.
> Male, aged 45, night shelter resident, Newcity

Their housing aspirations were not couched in middle class terms, of housing as an expression of status, of lifestyle, of conspicuous consumption. They knew that owner occupation was not a realistic option for them in the near future, but nevertheless they aspired to the security and personal control of a private space and autonomy which might be termed a state of 'ontological security',

> I'm taking one step at a time, it's early days. I want to find a flat first, find a job, then I'll think about college. I want to get my flat sorted.
> *So you obviously think getting a flat is important then?*
> Oh, aye, obviously, it's your life isn't it? It's your base, you go back there and sort your life out in the flat you need. You can't live in other peoples' accommodation. Doing that, it's not on, you're lost, you need your own place to go back to. It's no good, it keeps you unsettled doesn't it? If you start staying at your mates' houses you're going to get unsettled yourself aren't you? Whatever you're like, you'll end up on your arse, if you don't mind me saying.

Male, aged 28, staying with friend, Sandport

Having a base was important, although that base might not be thought of with feelings of great attachment, more a private space for re-charging the batteries, even merely a place to sleep and use drugs away from the public gaze or risk of police interference,

Do you look on it as a home?

A base.

You don't feel attached to it, you'd like to decorate or put down roots?

"No."

This person, living with a partner who had mental health problems, felt a regular need to get out of the house,

Is it important for you to get out of the house?

Yeah, I've got to have a break from [partner], because his illness is permanent and I have to get out to clear my head. I have to go out a few times a day.

Female, aged 35, shared private rented flat, HMO, Sandport

For many people the home could be a place that held negative connotations – one person could not go back to his flat and was staying with a friend after a burglary which had given him the sense of personal violation common to many burglary victims. For two women their accommodation was associated with the death of a partner in drug-related circumstances, a situation which resulted in guilt, loneliness and the physical surroundings taking on the characteristics of imprisonment. The parental home for some had also been associated with negative events; of physical and sexual abuse, parental drinking and domestic violence, the latter a situation which at least three of the women had experience of themselves in their own home.

With these negative associations there were also positive reflections by some on their childhood homes. Several were anxious to say that they

had happy childhoods with nothing in their family background to indicate their future drug use. For several people the family home was still a source of material and emotional support, particularly from mothers.

For those used to sub-standard rented accommodation – with its smell of damp, its unfashionable carpets and furnishings, the evidence of previous tenants in the cigarette burns on the furniture, the stains on the walls and its air of neglect which seems to permeate from the physical surroundings to the occupant – the move to a newly refurbished local authority tenancy could represent a major symbolic step,

> Yeah, it's nice, it's all new stuff as well when I went in, two seater couch, chair, the curtains actually match and you've got these tables and chairs in the living room, nice ones like, and the material on the chairs actually match the couch and the curtains. It's great, washing machine, fridge, everything.
> Male, aged 37, council tenancy, Dockland

To realise these modest aspirations may be an important boost to one's self-esteem and a concrete representation of the foundations of a new identity, as illustrated by the following two examples:

Ged, aged 37, council flat, Dockland

Ged has been a prolific offender since childhood. He was referred to the Communities Against Drugs project in Dockland because he was the type of offender they wished to target causing community damage by his acquisitive crime to pay for drugs. The team of workers includes a community psychiatric nurse, a Probation Officer, a Housing Officer and a Community Safety Officer who is a Police Officer.
Ged has a structured programme of day centres, college and social activities that occupies his time as, since he has given up drugs, he has felt himself to be socially isolated. He has regular random drug

tests and through the project he has moved into a refurbished tower block flat that is fully furnished, has a concierge and is in sharp contrast to the previous low quality privately rented accommodation that has been his usual housing experience. It is also in contrast to the tower block flat of his brother who, in return for drugs, allows other people to use his accommodation as a location for drug use, in other words as a shooting gallery.

Because Ged had rent arrears with the council the Housing Officer brokered an arrangement for him to pay these off at two pounds a week and cleared the way for him to gain access with the housing officer's influence.

Because he has a two bed flat this means that his daughter can visit him at weekends, and he speaks with great pride of his new surroundings and feels that they, along with the other activities he is involved in, have given his self confidence a boost.

Mick, aged 33, private flat, Dockland

Mick is a 'graduate' of a supported hostel in Dockland. He has been drug free for eight months and is now working as the warden of the move-on accommodation into which people move after leaving the main house. He describes a housing career that includes three housing association tenancies, one of which he held for ten years. This housing career has been interrupted by several prison sentences that have resulted in him being housed in hostels on release.

He has taken heroin since the age of sixteen and stopped seventeen years later. He has stayed in several rehab facilities in various parts of the country – Southampton, Coventry and Scarborough - but feels that he has 'matured out' of the revolving door syndrome of acquisitive crime and prison. He now feels that the future is an

attempt to make up for lost time but feels that a sense of waste means he is often trying to do too much too quickly.
He is appreciative of the support he has had from the hostel and shows pride in his current position of warden. His own background gives him the status and credibility to work with the current residents and gain their respect.

6.8 Conclusion

This chapter has looked at the role of housing in positive and negative treatment outcomes. It started by looking at the domestic arrangements of drug users and how sharing space with another user could seriously undermine one's treatment prognosis. Difficulties will arise for the person contemplating change if their domestic arrangements are not conducive to recovery. This may be the case where their housing is populated by other people using drugs, particularly if they are in a relationship and sharing space with another drug user. People with children face added difficulties in the way in which their housing situation may be viewed negatively by Social Services. In this the research supported the Advisory Council on the Misuse of Drugs report (2003) into the needs of children of problem drug users, but also highlighted the possibility of increased drug use by parents after having their children taken from them which the report also highlights and states needs more research.

The chapter proceeded by developing the work of McIntosh and McKeganey (2001; 2002) in looking at the change from drug-using to non-drug-identities, but it is new in that it extends that work to identify housing as a key factor in identity formation, either as a positive or negative influence in the way in which it configures status in terms of how drug users perceive themselves and are perceived by other people.

We saw that prognosis for recovery from drug dependence may involve a change of identity and that housing may be one element that is bound up with the conception we have of ourselves and that symbolises our status in other people's eyes. In the difficult move from a stigmatised identity (Goffman, 1963), housing can represent, reflect and confirm a transformation of internal perception necessary for recovery.

Quantitative analysis was largely inconclusive in an analysis of psychological and physical health and requires more sophisticated and larger studies, so this research is based mainly upon biographical data which shows high levels of psychological distress, sometimes exhibited by psychiatrically diagnosed disorders, sometimes by anxiety and depression to the extent of suicidal thoughts. However, these negative affections are usually framed within the ambivalent attitudes of many users to their drug use – that they both want to continue to use and to stop using.

CHAPTER SEVEN

CONCLUSIONS AND DISCUSSION

7.1 Introduction

The starting point for this research was an awareness that although there were extensive research traditions in the drugs and housing fields there was insufficient cross-disciplinary research whereby the two had been brought together to investigate any relationships between them. I sought to extend his cross-disciplinary approach and demonstrate the degree to which the two were indeed related.

In order to utilise the two research traditions it was necessary to combine structural analysis of housing institutions and processes with analysis that focussed on human agency. Qualitative research methods provided a detailed analysis whereby the testimony of drug users themselves provided the data that expanded upon a more limited set of quantitative data gathered through questionnaires. Their accounts could explain the meaning housing had for them and how it affected their lives as well as incorporating some longitudinal, biographical analysis of individual cases.

The research was designed to move in scale from the economic structuring of the housing market and the positioning of the sample within it, down in scale through their social and domestic situations within a housing context, and then down to the scale of individual identity bound up with housing choice, or lack of it. Housing was conceptualised as a physical resource of varying quality and one that has a commodity value in terms of exchange within a wider drugs economy. It was also seen as a resource that confers legal and social status and has implications for social and personal identity.

The following section examines the main findings of the research, its limitations and the implications for future research and policy.

7.2 Findings

7.2 (i) Drug users in space and time

The research began by examining the spatial, temporal and economic patterning of the sample. This began with a fairly traditional analysis of housing as an inter-related system of sub-markets that filters socio-economic groups geographically into housing appropriate to their ability to pay (Ball, 1986; Knox and Pinch, 2000). The housing experiences of the problematic drug users were considered in terms of their geographical location and movement in and out of a variety of housing forms. The locations of the sample tended to follow the structures of housing provision at the bottom end of the housing market in each of the areas. In this the research confirmed the findings of other research that sees problematic drug users as one of a number of marginalized groups, without the social, political or economic resources to improve their position in housing terms (Winchester and White, 1988).

In Sandport, with limited access to social housing, it was to the poorer parts of the private rented sector that they gravitated, spatially situated in two central postcode districts around the town centre and seafront area. This confirms an over-representation of those who are drug dependent in the private rented sector (Meltzer et al, 2002) and the degree to which drug users were located in the poorest areas is confirmed in this largely affluent area by the English Indices of Deprivation (2004) showing that the highest level of multiple deprivation (particularly crime) is in the same postcode areas as a Probation survey located the highest proportion of drug users. This area also contains an unusual number of HMO's.

In Dockland a majority of the sample were currently living at a homeless hostel, but their housing histories indicated they had previously resided in social housing. This was an area of low demand, where access to council housing was comparatively easy and a stock of high-rise flats was available for single people. Although social housing was more accessible

the quality was poor and available housing was situated in areas known to be problematic for recovering drug users.

Dockland is an area of high multiple deprivation and its status as such, linked to its high rates of drug use prevalence, confirms the link between high deprivation and high rates of problematic drug use (ACMD, 1998). The Communities Against Drugs area where the study was carried out covers one ward where 48% of residents are income deprived (English Indices of Deprivation, 2004), an area of low housing demand where the housing market has virtually collapsed since the only in-migration is from renters denied access to other forms of housing. For this reason many of the sample in planning out their recovery strategies would be looking to the private rented sector when they moved on in the future and would be actively avoiding social housing estates.

In Newcity the evidence for spatial concentration was not clear because the sample consisted of several night shelter residents who had moved there from other parts of the country. However, the two people who were local had lived previously on peripheral housing estates that were stigmatised as being associated with drugs. These estates exhibited high rates of deprivation, and included a stock of high-rise flats, some of which had been demolished partly as a result of their association with drug use. Agency workers and drug users identified drug use as being endemic on some council estates and in the town centre hotels.

The different structures of housing in the three areas affected people's access to accommodation. Structural constraints were possibly reinforced by overt or covert discrimination by landlords, although this was usually a result of their unemployed status and reliance on Housing Benefit rather than their status as drug users. However there were not just structural constraints on access arising out of lack of ability to pay in the case of private housing or the demonstration of need in the case of social housing. Negative influences on prospects for access were associated with their poor knowledge of the housing system, fatalism in

dealings with housing officers and expectations that access would be denied. Many respondents exhibited a feeling that sub-standard accommodation was somehow their natural territory.

In general the sample showed a high degree of transience in their housing histories. The average length of stay in current accommodation was two to six months. This could possibly be influenced to some extent by the relatively young age and the single status of many of the sample, as well as the fact that rented accommodation is heavily populated by 'serial movers.' However, a significant factor was found to be that the crime associated with their drug-using lifestyle resulted periodically in short prison sentences which led in turn to the ending of their tenancies. This was often unnecessary and was a result of ignorance of the Housing Benefit rules. The research revealed poor operation of the resettlement process for newly released prisoners who were often relocated into unsuitable areas in terms of treatment outcome or were released with no accommodation to go to at all. In this it supported many of the findings of the Social Exclusion Unit report, *Reducing Re-Offending by ex Prisoners* (2002).

The geographical relocation of people in general was a way in which drug use could be spread in a diffusion effect through social networks. This confirms previous research by Wallace (1990) and Giggs (1991) showing diffusion within local social networks and between regional areas. The joining together of Dockland and Sandport into one local authority may have encouraged the relocation of some of the sample from an area of traditionally high drug use in the Dockland area to a previously low area of drug use in Sandport. The degree to which this enhanced contiguity had affected levels of drug use in Sandport cannot be answered by this research, although three of the sample had made the move from Dockland to Sandport. It is possible that the housing allocation system could be used as a structural mechanism whereby drug users could relocate and spread drug-using networks in a macrodiffusion effect. Therefore, policies of dispersing drug users to outlying areas via the

housing allocation system in order to remove them from areas of high risk could have the unintended consequence of extending drug use networks to previously unaffected areas.

7.2 (ii) The commodity nature of housing and drugs

In this research housing was conceptualised as a commodity embedded in a wider economy where, as a commodity in demand, it had a transaction value in the drug economy. Although there is some limited US research this area, (Petry, 2000; 2001), this research provides an innovative approach to the study of the transaction values of drugs and housing in the UK. Drug consumption was found to be highly elastic dependent upon disposable income. Disposable income could be maximised in legal or illegal ways. The two respondents who reported that their heaviest drug consumption was when they were at their most conformist on the surface, seemed to contrast with the other group with the heaviest drug consumption who had a tenuous grasp on accommodation – living in hostels or homeless. However, what united them was their level of disposable income – mainstream employment for one group and the maximisation of their income by unconventional or illegal means such as begging, crime, prostitution or selling the Big Issue by the other. This could point to a pattern of the heaviest levels of drug use occurring in the most stable housing and the most fragile with the key factor being level of disposable income.

One reason that people in hostels and in poor housing circumstances could maximise their disposable income was because Housing Benefit was paid direct to their landlord and so did not enter their income and expenditure calculations. Unless their accommodation costs exceed the amount of rent Housing Benefit will pay locally, in which case they will have to eat into their disposable income to make up the shortfall, housing costs can be disregarded and any extra income earned in the black economy or by illegal or unconventional means is potentially a source of

drug expenditure. Changes to this system are currently being piloted and are discussed below.

Housing was seen to be a negotiable commodity that was an attractive asset to those whose grasp on housing was tenuous or non-existent. The research showed that it could be bartered as a drug-using site in return for drugs, and there was some evidence that it was a contributory factor in the formation and breaking up of relationships. Some of these relationships were predatory involving a sexual element as well as a material one of shelter. Some of these relationships were part of a mutually supportive network whereby local drug users provided each other with accommodation on a temporary basis in times of need, sometimes endangering the housing stability of the provider.

7.2 (iii) The hierarchy of housing and drug use

Initial quantitative analysis of data gained from the Maudsley Addiction Profile was undertaken. I analysed the results to see if there was anything approaching a hierarchy of housing as described in the literature (Greene et al, 1997; Klee, 1991) whereby certain forms of housing could be positively correlated with high levels of drug use. A related question was whether there was any evidence for a 'drift down' phenomenon (Benda, 1987; Flemen, 1997) whereby people come to occupy progressively worse housing circumstances as their drug use intensifies in a spiral of decline.

This analysis indicated that when the different housing situations of the sample were conflated into two categories there seemed to be an indication of a link between levels of high drug use and certain poor quality, communal housing forms. There was some evidence for a hierarchy of housing when current consumption of alcohol, heroin and crack was examined. There was also some difference in levels of methadone prescribed and in methods of drug administration. HMO's

stood out as containing the greatest proportions of very heavy alcohol, heroin and crack users and the least proportion of those on a methadone programme. However, the greatest proportion of injectors was the night shelter sample, followed by those in HMO's. The sample did not include anyone currently staying in one of the large hostels but the housing and drug use histories demonstrated that for those who had been residents this represented their heaviest period of drug use.

In contrast those who were currently living in supported hostels with high levels of staff support and a structured programme of activities, although demonstrating some of the heaviest drug use in the past, were now stable. A large proportion were on a methadone programme, although they still used small quantities of heroin. It could be said that the structure and high staff support acted as a protective mechanism in keeping drug use manageable.

The limited extent of this quantitative data made conclusions unreliable but it was felt that a qualitative analysis could look further at any relationship and reveal the underlying processes.

The qualitative examination of the private rented sector was largely based upon the Sandport sample. Although the sector is a diverse one the sample tended towards the lower quality end with those in HMO's experiencing the worst physical standards in terms of space, amenities and physical standards. Landlords in this sub sector were more likely to grant access and be less discriminating about their choice of tenants. Whilst this was positive in terms of access it nevertheless confined people to a network of properties that were not in demand by others because of their poor standards and sometimes stigmatised reputation. Accusations were made that landlords colluded with their tenants' drug use to the extent of supplying drugs but I was unable to verify this. However, it seemed that landlords colluded with tenants to defraud the Housing Benefit system by setting up false tenancies.

An analysis of many of the housing biographies showed that stays in large multi-occupancy hostels had been a feature. Respondents had an overwhelmingly negative opinion of the living environments that these places offered and described how the negative effects had increased their levels of drug use. Some people chose to sleep rough rather than to enter a hostel and as well as drug use it was felt that they encouraged criminal behaviour as part of a homelessness subculture. There seemed to be a relationship between living in the large hostels, selling the Big Issue and heavy drug use. This was underlined by arrests at the time of the research of a number of residents of the hostels who sold the Big Issue and who were charged with supplying Class A drugs. The social networks that evolve in these hostels can be seen as a form of negative social capital that provided a sense of community and support to a group of socially excluded people, but which nevertheless was destructive in its personal effects and further accentuated their exclusion from any positive links back into the mainstream.

Those who had slept rough described a number of locations they had used and also the dangers it presented, particularly for women. A minority claimed to like certain aspects of being outside and those with an armed forces background told of how their training had hardened them to the physical privations they experienced. Confirming previous research (Klee and Reid, 1998) there was some evidence of self-medication as a coping mechanism to deal with the psychological and physical effects of living rough, but no firm conclusions could be gained as to the causal direction between drugs and homelessness other than to say that those who had been homeless had already embarked upon a drug-using career. Most likely drug use and homelessness reflexively interact so that they mutually reinforce one another.

The research seems to confirm the findings of the limited quantitative data and show that poor quality, communal forms of housing such as HMO's and large hostels may be linked with levels of high drug consumption. More autonomous forms of housing such as having one's

independent accommodation or living within a support structure within a family or in a small hostel seemed to act as a protective factor against increased drug use although the causal direction of this relationship is unclear ie: whether living in erratic housing conditions leads to greater drug use, or whether one's erratic drug use leads to one living in unstable accommodation.

The mechanism for the relationship appears to be the social networks that exist in these forms of communal housing. It seems that when drug-using social networks form at specific locations then the microdiffusion of drug use is likely to intensify in a pattern of daily use. This diffusion model is based on a 'contagion' effect operating through friendship and social networks that is magnified into a subculture revolving around the daily acquisition and consumption of drugs. The social networks of those in other forms of accommodation were different, so that whilst they were part of a loose social network this was largely instrumental and dependent on the supply of drugs, they typically depended upon a much smaller network of two or three people for day-to-day contact and support. It is also of note that a quarter of the sample reported not seeing a friend in the last thirty days, whether through choice or because their drug use had cut them off from social contacts.

However, the association of poor housing as a final point in a drift down through progressively worse conditions and increasing drug use produced some contradictory indications. Whilst there were examples of formerly middle class people who had become homeless, this was not always a gradual process linked to drug use. Homelessness could be a sudden and unexpected experience brought about by losing a job or having an argument with one's partner or parents. Having said that, drug use seemed to be a risk factor due to the criminal lifestyle of many of the sample that meant periodic stays in prison and the consequent loss of accommodation. The drug-using lifestyle also prioritised short-term gratification over long term planning and crack users were felt to be at

particular risk of homelessness due to the impulsive nature of the drug and the overriding need for money it demanded.

Middle class users were felt by agency staff to be able to maintain and manage their drug use for a longer period due to financial and family support, but once their drug use became problematic and had reached a certain point they effectively became indistinguishable from other users in terms of appearance, housing situation and lifestyle. It was interesting that two of the sample reported their heaviest drug use as occurring when they were financially, and in housing terms, at their most secure. Their use escalated with their amount of disposable income and indicates the existence of a sample of Class A drug users within mainstream employment, as indicated by research by Aust and Condon (2003).

7.2 (iv) Relationships and the domestic environment: implications for drug treatment and care of children

Those individuals in the sample who were in relationships were all with partners who were also drug users. If one's treatment outcome could be compromised by the location and type of housing one lived in, then those living with drug-using partners would find it particularly difficult to successfully complete treatment whilst their partners continued to use. A possible indication of this is that very few of those in relationships and living with their partners were on a methadone programme and some of the heaviest heroin and crack use was reported by those who were in relationships. It could also indicate that the relationships revolved around drug use or that these users did not even attempt to enter treatment because they realised that to do so whilst living with a drug using partner was not feasible or that it would mean an end to the relationship.

Several female interviewees told of a history of sexual abuse and domestic violence, and they were particularly vulnerable to predators who wished to use their accommodation for drug use or in times of

homelessness. Of the six women users who had children, only one had her children living with her. They could be said to be in a high-risk group for mothers separated from their children in accordance with the criteria outlined in the Advisory Council on the Misuse of Drugs report (2003). Some of them were philosophical about this, accepting that their drug using lifestyle was not compatible with bringing up children. Others appeared to be desperate to be reunited with their children.

7.2 (v) Housing and identity

In moving from the economic and structural level of analysis of housing provision through the social networks and domestic arrangements of the sample the research narrowed down to the individual level and a more psychological approach to investigate the way in which housing is bound up with identity and psychological health. It went on to look at the role of good, secure housing in treatment and recovery.

The relegation of the sample to poor areas of housing illustrated how housing acts as a mediator of social exclusion that was generated by other processes, specifically low income. But it also acted as a generator and magnifier of social exclusion in its ability to construct and define social identity. The identification of certain housing forms with negative personal characteristics affects self-image. Some of the sample described their drug use in terms of a 'spoiled identity' (Goffman, 1963; McIntosh and McKegany, 2001: 2002), and regretted their involvement. Others salvaged the positive aspects and saw it as in part a learning experience. Still others had no intention of giving up drugs. Several users saw their dependence in terms of personal weakness. Low expectations and fatalism were common in approaching both housing opportunities and addressing drug dependence.

Many exhibited poor psychological health but the specific relationship with housing could not be established by this research. It could be that

certain people had underlying psychological symptoms exacerbated by drug use and possibly modified by a depressing, constricted environment. Other stress-inducing factors such as low status, low income, powerlessness and social exclusion could also play a part. There was some indication of drug use being used as a coping mechanism to deal with emotional pain or bereavement, and those who had been homeless clearly indicated that they had used drugs as self-medication to deal with physical and psychological stressors.

The perception by people when asked whether their drug use was linked to their housing situation drew out an interesting division in the responses. Some thought that their location and accommodation had increased their drug use, others said that it had made no difference. It is not surprising if people did not see any connection between the wider environment and the nature of their drug use. In this they would be reproducing the dominant medical view of drug dependence that individualises ill health and downplays environmental influences.

It must also be said that the concept of a housing influence on patterns of drug use is not a concept that is readily understood or easily demonstrated. Consequently it is not surprising if people may not see housing as an influence when much more readily understood influences on their drug use are more apparent. Also, because the motivations for drug use may be complex and not easily understood or articulated, drug users may be inclined to provide convenient rationalisations for themselves or for an interviewer. These are not wilfully dishonest, but may have a functional role for the individual in terms of self-justification or the protection of self-esteem. This is understandable but means that self-reports always need to be treated with care.

7.2 (vi) Housing and change

The sample from small, staff-intensive hostels with clear resettlement and treatment programmes exhibited a more optimistic and focussed attitude to their drug use than the snowball sample who had no contact with treatment agencies. Part of this was a self-efficacy that involved a vision of leaving their drug-using identities behind. These hostels, and also the residential rehabs I visited, operate as refuges on the basis that drug use has a 'contagion' effect that requires a protective environment, almost a quarantine, from potentially negative contact with other drug users. There was, however, some indication that the greater professionalisation in hostels was leaving the most chaotic users literally out in the cold. The main problem with residential treatment seemed to be the re-entry point after the completion of the programme. Since housing provision was not under the control of the facility and was not always coordinated, people often returned to the areas associated with their previous drug use where the risk of relapse was high.

7.2 (vii) Summing up

From this research it appears that housing touches the lives of problematic drug users at many points, from their location, their social networks, their domestic arrangements and their identities. Because of its fixed nature in terms of location, design, tenure and quality it is associated with our social identity. It is only by literally moving that many people attempt to change their identity and behaviour along with their housing position. To be unable to move from poor accommodation and be denied access to other housing forms is to risk being labelled negatively by one's housing. Certain housing forms seem to be identified with high drug use and If that housing is located within areas of multiple deprivation then these areas are more likely to contain high levels of problematic drug use and social networks that revolve around the consumption of drugs.

7.3 Implications of the findings for future research and policy

During the course of the research it became apparent that there were areas of policy that were in the process of change and that in the future could have an impact on the housing situation of drug users. The first of these is a possible change to Housing Benefit payments. Nine councils are currently piloting a Local Housing Allowance which, if successful, could be rolled out nationally. Under the scheme tenants receive a flat rate of benefit to cover their housing costs based upon local rent levels. This amount is the same for all tenants irrespective of the actual rent they pay. So, if a tenant moves to a cheaper property they can keep the difference in benefit. The idea is to encourage people to shop around and take more responsibility for their accommodation. In order to stress this last point tenants receive their Allowance directly and will only be paid to the landlord if the tenant is eligible for reasons of 'vulnerability.'

Housing associations and private landlords have voiced concerns about this system and have predicted increased rent arrears and evictions as tenants may spend their rent money on other items of expenditure. This has particular relevance to drug users because firstly, as the research shows, many are dependent on benefit for their rent payment. Added to this is their constant need for ready money to finance their drug use as well as their prevalent attitude of short-term gratification that takes precedence over long term planning. Most of the sample preferred their Housing Benefit to be paid direct to the landlord since it avoided the temptation to spend the money. It remains to be seen whether the definition of vulnerability will include drug dependence or what discretion there will be in the system to enable people to have their rent paid to the landlord directly.

Whilst there could be increased evictions and rent arrears, there could also be a narrowing still further of access to rented accommodation as landlords either quit the market or refuse to take tenants on Housing Allowance. The new system would also impact on the disposable income

of drug users which we have seen is a major influence on their level of drug use. It is possible drug users will take advantage of the new system by choosing to occupy the very worst and cheapest housing in order to release disposable income for drug use. This will concentrate users even more in areas of deprivation.

The second policy area that may undergo change in the future is the licensing of HMO's, a situation that already exists in Scotland. The research shows that those drug users living in HMO's are living in the worst conditions in the private rented sector. The exact form this licensing will take is not yet clarified but, predictably, small landlords are resisting what they see as interference in their business and predicting that the increased costs necessary to meet improved standards will force many out of the market. The problem with a licensing system is that whilst it is well intentioned and justified on grounds of safety standards and quality generally, it could remove a source of accommodation from those at the bottom end of the market. Often those with no prospect of access to good accommodation are grateful for a roof over their heads and do not share a middle class idea of good housekeeping standards.

One worrying finding to come out of the research was the operation of a bad tenants register by the Residential Lettings Association, the organisation that represents the views of small private landlords, and their proposal to share this information with social housing providers. This system seems open to abuse and discrimination against tenants who have been in dispute with their landlords, possibly for good reason. On the face of it landlords would be free to put forward the names of any tenants they wished and this information, which could be no more than gossip or the result of malice, could affect the housing applications of those applying to social landlords. It is hoped that social housing providers reject this proposal.

The research highlighted the negative impact of short prison sentences on the housing careers of drug users. It confirmed many of the points

made in the Social Exclusion Unit's report (2002), namely a high level of drug-related deaths following release, lack of suitable aftercare in terms of housing after release and the high rates of re-offending relating to homelessness after release. The research revealed that the CARATS system was not integrated with drug and housing services in the community and that no resettlement plans existed for many of the sample when they had left prison. It also showed how prisoners often lost their accommodation unnecessarily since landlords and tenants were often ignorant of the Housing Benefit rules. This situation could be improved by a greater effort by Probation and prison staff to ensure that prisoners serving short sentence have their accommodation kept open for them by liaison with landlords. This would prevent homelessness, reduce the resumption of drug use on release and rates of re-offending. There is also an indication that social housing providers could be more proactive in accepting applications from people in prison.

The research highlighted some good practice in the smaller supportive hostels but there was a worrying consequence that in the push for greater professionalism in their management there was a group of drug users who could not fit the criteria of a structured programme necessary to be accepted in such hostels. These users were left with recourse to the larger hostels where their drug use was likely to be reinforced or intensified. This issue brings into focus the whole idea of 'resettlement' and how much it is an acceptable term for the social control of deviance. The idea of fitting people back into a society that has excluded them in the first place is rather ironic, although a sentiment echoed by several users in the sample was that they just wanted to be 'normal.'

The recognition of housing as an important factor in treatment means that social landlords need to be sensitive to the vulnerability to relapse of drug users in areas of existing high drug use prevalence. A dilemma here is that since drug dependence is characterised as a chronic relapsing condition, to move users to outlying areas deemed to be 'clean' housing authorities run the risk of diffusing drug users over a wider area should

they relapse. Nevertheless, this is an argument for greater support in the community rather than the present situation of the creation of ghettoes of users housed within small geographic areas.

7.4 Limitations of the research

There are several limitations to this study, some of which are due to the limited resources available to a PhD student working alone, some of which are seen as limitations inherent in small-scale qualitative studies, some of which are due to the nature of researching 'hidden' populations.

The choice of the research design and methods was complementary to the research question which, in examining the relationship of problematic drug use to housing, needed to capture the dynamic and transitory lifestyles of the respondents and to register their opinions both about their housing situations and about their drug use. The choice of research instruments best suited to achieving this was to use a semi-structured interview that gave the opportunity to respond to the individual nature of their lives. It is doubtful if quantitative methods could achieve the same depth or sensitivity to the complexities of their situations.

With the gains achieved by these qualitative methods there is a sacrifice to some of the quantitative researcher's main approaches. The study does not pretend to deal with a representative sample of problematic users. Indeed, any study, whether quantitative or qualitative that purported to demonstrate such a sample would be highly suspect due to the sampling difficulties inherent in 'hidden' populations. I did attempt to get a roughly representative sample as regards gender and when it became plain that I was only getting a sample from treatment settings I switched the research towards a snowball sample of users who were mainly outside treatment.

Inevitably certain groups of people were not represented. Some groups in particular I sought to gain access to but could not – one of these was sex workers in the city sample. I made enquiries of an agency that deals with them but nothing came of it. I was told that they were heavy crack users and their housing arrangements would have been a useful addition to the study. The sample could also have been more weighted towards the city area. The problem here was that I had to exclude five respondents because they did not fulfil the criteria of 'problematic' drug use. Consequently only six respondents made up this sub sample. I would also have liked to interview more people who were living drug-free. Nearly all the respondents were either dependent or in an ambivalent stage of indecision about the costs and benefits of stopping or continuing with their drug use. Many of the users had experience of the circularity of stopping/starting their drug use many times and so could compare the quality of life of those different stages, but their accounts of being 'straight' were largely retrospective.

Another group noticeable by their absence are middle class users and those managing their drug use within the bounds of a conventional identity, in full time employment and owner occupation. The emphasis in the sample was on those who were either in contact with treatment agencies, living in hostels or not in contact with treatment but living in the poorest areas. Social science is often accused of concentrating on deprived groups – for one thing their lack of power makes them 'vulnerable' to research – and criticism has been levelled at studies which only focus on *known* drug users leading to a questionable association between drug use and the poor whose use may be more visible – either literally on the street or in statistics. Because affluence acts as a cushion against negative aspects of drug use, at least in the short term, this acts to keep it hidden and better managed.

Meltzer et al. (2002) show a significant number of drug users living in owner occupation and whilst this tenure is now varied and potentially problematic for some people who are classed as living in poverty (Lee

and Murie, 1997), nevertheless there must be a substantial number of dependent drug users who are affluent and employed. Aust and Condon (2003) show high rates of Class A drug use in affluent urban areas, although these users may not be 'problematic' in the sense used in this research. They may not experience the legal and social problems of the sample and may be shielded by the protective factors of their income and social status.

There is a limited representativeness and generalisabillity due to the small scale of the sample and due to the limited number of areas covered. The first of these points arises out of the limited resources available, but as to the second, within the constraints of the resources and in the selection of the three areas for study I attempted to get a varied picture of housing provision. One area was high in multiple deprivation, one was a seaside resort with a large private rented sector and the other a city that exhibited a full range of provision from tower blocks to leafy suburbs.

The generalisablity of small scale studies lies at a theoretical level, rather than a statistical or representative one. Any conclusions that arise out this research can be transferred to other settings and compared. Its transferability to other settings will depend upon the reader who must decide upon its applicability and whether its theoretical conclusions are relevant to new contexts and populations.

The research proceeded against a background of methodological difficulties that all research trying to link the built environment with human behaviour has had to deal with. Most notable is the question as to whether the identification of housing variables is possible within a multitude of other variables that could have an influence on drug use. How much drug use behaviour is the result of the compositional factors of the people who live in certain types of housing, and how much is a result of the environmental context in which they find themselves is also a question that a project of this nature is not qualified to answer definitively,

only to propose suggestions. There currently exists no reliable method for quantitatively measuring a pathway between drugs and housing. However, the usefulness of qualitative research is that it captures processes that can be missed by a concentration on correlating a fixed set of variables. An experimental method can narrow the frame of research to the number of variables one is comparing, whilst a qualitative method can uncover unforeseen variables and present a more all-encompassing view of social phenomena.

7.5 Possibilities for future research

Research is being refined to measure the effects of housing on other areas of social life, in particular poor health, a link that has a long research history, although one much more established with physical than psychological health. The literature surrounding the social gradient of health (Wilkinson 1996; Marmot 2004) offers useful evidence linking social factors with illness but it has had little to say so far specifically about drug use as a response to social and environmental stressors. There is also much work being done on neighbourhood effects that could produce specific assessments of contextual housing effects on behaviour.

Perhaps the most fruitful area for future research into the pathways between drug use and housing could lie in the field of social epidemiology. These writers (Berkman and Kawachi, 2000) would assert that the social environment is the paramount determinant of health, and, although they have only touched upon housing and drug use specifically, many of their conclusions are relevant to the argument that the physical environment could bring about psychobiological responses through a process of 'embodiment' (Tarlov, 1996). Work by such writers as Wilkinson (1996) and Marmot (2004) demonstrate the importance of the social and economic environment to the gradient of health, taking into

account such factors as relative power and status that may be embodied in ill health.

What remains to be fully theorised at a psychobiological level is how housing inequality could be transformed into physical and psychological ill health caused by, or resulting in, problematic drug use. Using social epidemiological theories we could suggest that psychological effects of physical and social environmental stressors are biologically embodied through a variety of pathological mechanisms and that these sociobiological translations could be a factor in drug use. Unfortunately, whilst there is some empirical evidence to support the idea of psychobiological translations from the environment to health-damaging behaviours, much of this work is in a developing stage, and a social epidemiological approach to the relation between housing and drug use would certainly be beyond the resources of the present research. I do, however, think that this approach will become more important and respected in the future as the links between environment and health-damaging behaviours such as drug use become more fully developed.

A related field to social epidemiology is research into neighbourhood effects that is confronting the methodological problems of isolating and measuring environmental variables (Galster, 2003). Again, this is a developing area but one that is more specifically focused on housing effects, behaviour and health. Although drug use has not come within its orbit of research so far, as techniques for isolating environmental variables become more sophisticated, it could be that this would be a fruitful research route into the study of housing and problematic drug use.

As regards this present piece of research, it would be interesting to conduct a follow-up study and re-interview the participants. I did a certain amount of re-interviewing of a sub-sample of people living in a house in multiple occupation and this confirmed my earlier statement that this sample lead a dynamic and transient lifestyle that is most effectively captured by qualitative methods.

7.6 Afterword

This piece of research started from the premise that the two research traditions of drug use and housing studies needed to be brought closer together. It has gone some way to link drugs and housing across several areas where a link might not previously have been apparent. It was conducted with limited resources but it is hoped that it points the way to future research possibilities.

Appendix one

The agencies interviewed were:

Dockland:

Communities Against Drugs – Housing Officer and Community Psychiatric Nurse. A multi agency initiative to address problems linking drugs with crime and anti-social behaviour in an area identified as having a high degree of deprivation and drug use. The staff team includes a community psychiatric nurse, a Probation Officer, a housing officer, a youth liaison officer and is headed by a Police Officer

Supported hostel – Manager. A voluntary sector hostel which houses homeless drug users and provides training, counselling and move-on accommodation

Housing Association – Housing Officer. A large housing provider involved in the Market Renewal Area.

Northborough (includes Sandport and Dockland):

Training and support agency – Chief Executive. Provides individual counselling, training, advice and advocacy for drug users

Youth Offending Team – Substance Misuse Worker. Works with young people involved in the criminal justice system

Probation Service – Senior Probation Officer. Works with older offenders and supervises the Drug Treatment and Testing Orders

Housing and Welfare Rights Advice Service – Welfare Rights Advisor. Operated by Northborough Council. It gives housing advice and provides a particular service for drug users in Sandport and Dockland based at two drugs advice and treatment centres.

Residential Lettings Association – Members Representative. Provides advice to private sector landlords

Community Safety Section – Police Officer. Audits crime and anti-social behaviour, in particular it is linked to the Drug Action Team

Sandport:

Drugs Council – Manager. Provides counselling and support to drug users as well as a needle and syringe exchange scheme. It can also refer users to the Community Drugs Team for methadone prescribing

Church – Pastor. Has acquired a substantial number of properties in the area which are let to those unable to access mainstream accommodation

Housing Advice Centre – Manager. Deals with many homeless enquiries and operates a bond scheme for those unable to access private sector accommodation

Newcity:

Night shelter – Manager. Provides meals and accommodation of a basic kind to those outside mainstream housing provision

Supported hostel – Manager. Houses those homeless and under 26, not specifically drug users

Supported hostel – Project Workers. A general homeless hostel run by a large national housing association

Drugs advice agency – Young Person's Project Worker. A drop-in and counselling and advice centre which also operates an outreach facility and works with street sex workers

Community Drugs Team – Clinical Nurse Manager. Provides clinical and other support to dependent drug users. Linked to homeless health project and street sex workers project

Other areas:

The Big Issue in the North – Manager. Provides homeless people with a source of legitimate income, undertakes resettlement work, campaigns for the homeless

Residential treatment unit – Manager and Resettlement Worker. 17-bed rehab for drugs and alcohol, plus tenancy support and resettlement project

Residential treatment unit – Project Worker. 8-bed rehab for drugs and alcohol

Appendix two

Interview Schedule

PERSONAL DETAILS

Name, D.O.B., gender, ethnic origin
Area of origin, education, employment
Family structure/children

BRIEF CURRENT DRUG, SOCIAL AND HEALTH STATUS (last 30 days)

Administer Maudsley Addiction Profile

CURRENT HOUSING STATUS

- Location
- Getting access, problems moving in
- Length of time there
- Tenure
- Who living with
- Quality/number of rooms/privacy/ability to have guests
- Cost
- Level of security/insecurity/noise
- Quality of area and amenities
- Neighbours/drug users in area
- Social, emotional support/friends/family/boredom/isolation
- Satisfaction
- Reason for leaving – planned/unplanned
- Perceived relationship to drug use/non-use

HOUSING HISTORY *[As above. Write this down as a framework for later comparison with health/treatment/social history]*

Types of Housing

- Care system

- Family
- Friends
- Private sector
- Social housing
- Owner occupier
- Homeless
- Institution

FACTORS LINKED TO PREVIOUS HOUSING SITUATION:
[Use housing history as a framework. Take each housing move in turn]

1) *DRUG USE*

- Frequency and level of use
- Types of substance used
- Supply, social networks
- Problems associated with use – social, criminal, emotional, financial
- Alcohol
- Perceived relationship to housing situation

2) *TREATMENT AND EFFECTIVENESS*

- Counselling
- Detox – inpatient/home
- Day programme
- Prescribing
- Residential
- Other
- Effectiveness/reasons for discontinuation – planned/relapse
- Perceived relationship to housing situation

3) *SOCIAL SITUATION*

- Employment/training
- Leisure/interests/time management
- Finances/benefits/debt
- Relationships/friends/family/social contacts – users/non-users
- Perceived relationship to housing situation and drug use

4) *PHYSICAL HEALTH*

- Accidents/illness
- Hospital admission
- Medication
- Poor sleep
- Poor appetite
- Failure to care for self
- Perceived relationship to housing and drug use

5) *PSYCHOLOGICAL HEALTH*

- Stress/Anxiety – panic attacks/feeling fearful/bad nerves
- Depression – feeling hopeless/suicidal/loneliness/lack of interest
- Paranoia
- Anger/aggression
- Poor memory
- Self-harm
- Other
- Medication
- Perceived relationship to housing, social situation and drug use

6) *CRIMINAL JUSTICE INVOLVEMENT*

- Victim of crime
- Prison, Probation
- Perceived relationship to housing, social situation and drug use

FEELINGS ABOUT THE FUTURE

- Housing
- Drug use
- Treatment
- Social situation
- Physical health
- Psychological health
- Criminal justice involvement
- Employment/training
- Education

- Family/relationships
- Other

SELF-ESTEEM

Feelings about current/past drug use – loss, guilt, shame, regret, self-justification, waste, pride

Optimism/desire for change, hopelessness/lack of control

Feelings of stigma/discrimination/spoiled identity

Do you think where you have lived has made any difference to your level of drug use, your treatment or your ability to stay of drugs?

Appendix three

The Maudsley Addiction Profile

MAUDSLEY ADDICTION PROFILE (MAP)

SECTION A: MANAGEMENT INFORMATION

Include the study specific information as required (e.g. participant identification, programme codes; interview point)

SECTION B: SUBSTANCE USE

CARD 1

None	1 day only	2 days only	3 days only	1 day a week	2 days a week	3 days a week	4 days a week	5 days a week	6 days a week	Every day	Some other number
0	1	2	3	4	9	13	17	21	26	30	

CARD 2

Oral	Snort/sniff	Smoke/chase	Intravenous	Intramuscular
1	2	3	4	9

a. Enter number of days used in past 30 days [Card 1] – enter "0" for no use;
b. Enter amount used on a typical day in the past 30 days [verbatim]
c. Record route(s) of administration [Card 2]

SUBSTANCE	DAYS USED	AMOUNT USED ON TYPICAL DAY	ROUTE(S)
B1. Alcohol			
B2. Heroin			
B3. Illicit methadone			
B4. Illicit benzodiazepine		Drug:	
B4. Cocaine powder			
B5. Crack cocaine			
B6. Amphetamine			
B7. Cannabis			
B8. Other:			

SECTION C: HEALTH RISK BEHAVIOUR

If no illicit drugs injected in the past 30 days, skip to sexual behaviour questions

C1. Days injected drugs in the past 30 days **[card 1]** Days

C2. Times injected on a typical day in the past 30 days Times

C3. Times injected with a needle/syringe already used by someone else Times

If no penetrative sex in the past 30 days, skip to Section D

C4. Number of people had sex with and not used condom People

C5. Total number of times had sex with and not used condom Times

---

SECTION D: HEALTH SYMPTOMS

CARD 3

Never	Rarely	Sometimes	Often	Always
0	1	2	3	4

D1. How often experienced the following physical health symptoms

	Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Always (4)
a. Poor appetite	☐	☐	☐	☐	☐
b. Tiredness/fatigue	☐	☐	☐	☐	☐
c. Nausea (feeling sick)	☐	☐	☐	☐	☐
d. Stomach pains	☐	☐	☐	☐	☐
e. Difficulty breathing	☐	☐	☐	☐	☐
f. Chest pains	☐	☐	☐	☐	☐
g. Joint/bone pains	☐	☐	☐	☐	☐
h. Muscle pains	☐	☐	☐	☐	☐
i. Numbness/tingling	☐	☐	☐	☐	☐
j. Tremors/shakes	☐	☐	☐	☐	☐

D2. How often experienced the following emotional or psychological symptoms **[card 3]**

	Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Always (4)
a. Feeling tense	☐	☐	☐	☐	☐
b. Suddenly scared for no reason	☐	☐	☐	☐	☐
c. Feeling fearful	☐	☐	☐	☐	☐
d. Nervousness of shakiness inside	☐	☐	☐	☐	☐
e. Spells of terror or panic	☐	☐	☐	☐	☐
f. Feeling hopeless about the future	☐	☐	☐	☐	☐
g. Feelings of worthlessness	☐	☐	☐	☐	☐
h. Feeling no interest in things	☐	☐	☐	☐	☐
i. Feeling lonely	☐	☐	☐	☐	☐
j. Thoughts of ending your life	☐	☐	☐	☐	☐

SECTION E: PERSONAL/SOCIAL FUNCTIONING

If not in a relationship in the past 30 days, skip to relatives questions

E1. Days had contact with partner in the past 30 days **[card 1]** Days
(ie. say them or talked on the telephone)

E2. Number of these days were there was conflict with partner Days
(ie. had major arguments)

If not relatives or any contact with relatives in past 30 days, skip to friends questions

E3. Days had contact with relatives in the past 30 days **[card 1]** Days
(ie. say them or talked on the telephone)

E4. Number of these days were there was conflict with relatives Days
(ie. had major arguments)

If not friends or any contact with friends in past 30 days, skip to Section E7

E5. Days had contact with friends in the past 30 days **[card 1]** Days
(ie. say them or talked on the telephone)

E6. Number of these days were there was conflict with friends Days
(ie. had major arguments)

E7. Number of days of paid work in past 30 days **[card 1]** Days

E8. Days missed from work because of sickness or unauthorised absence in the past 30 days Days

E9. Days formally unemployed in the past 30 days Days

CARD 4

Selling drugs	Fraud/forgery	Shoplifting	Theft from a property	Theft from a vehicle	Theft of a vehicle	Other crimes

E10. Crimes committed in the past 30 days **[card 4 and card 1]**

	Days committed **[card 1]**	Number of times committed on a typical day **[card 2]**
a. Selling drugs		
b. Fraud/forgery		
c. Shoplifting		
d. Theft from a property		
e. Theft from a vehicle		
f. Theft of a vehicle		

Other crimes:

END OF INTERVIEW

BIBLIOGRAPHY:

Advisory Council on the Misuse of Drugs, 2000. *Reducing Drug Related Deaths.* London: The Stationery Office

Advisory Council on the Misuse of Drugs. 1998. *Drug Misuse and the Environment.* London: Home Office

Advisory Council on the Misuse of Drugs. 2003. *Hidden Harm: Responding to the Needs of Children of Problem Drug Users.* London: Home Office

Agar, M. 1984. *Ripping and Running: A Formal Ethnography of Urban Heroin Addicts.* New York: Seminar Press

Agnew, Robert. 1999. A General StrainTheory of Community Difference in Crime Rates. *Journal of Research in Crime and Delinquency* 36 (2): 123 – 155

Allen, Chris and Nigel Sprigings. 1999. *Managing Risk Together.* Salford University of Salford Housing and Urban Studies Unit

Anonymous. 1976. (3rd Edition). *Alcoholics Anonymous.* New York: A.A. World Services

Appadurai, A. 1986. Introduction: Commodities and the Politics of Value. In A. Appadurai (ed) *The Social Life of Things: Commodities in Cultural Perspective.* Cambridge: Cambridge University Press

Armstrong, D. 1995. The rise of surveillance medicine. *Sociology of Health and Illness* 17: 393 – 404

Atkinson, Rowland and Keith Kintrea. 2001. Disentangling Area Effects: Evidence From Deprived and Non-Deprived Neighbourhoods. *Urban Studies* 38 (12): 2277 – 2298

Aust, Rebecca and Joanne Condon. 2003. *Geographical Variations in Drug Use: Key Findings from the 2001/02 British Crime Survey England and Wales. Home Office Statistical Bulletin.* London: Home Office

Baer, P.E., L.B. Garmelzy, R.J. McLaughlin, A.D. Pokorny and M.J. Wernick. 1987. Stress, coping, family conflict and adolescent alcohol use. *Journal of Behavioral Medicine* 10: 449 – 466

Baker, Leila. 1997. *Homelessness and Suicide.* London: Shelter

Baldwin, John and Anthony E. Bottoms. 1976. *The Urban Criminal.* London: Tavistock

Baldwin, John. 1975. Urban Criminality and the 'Problem' Estate. *Local Government Studies* 1 (4): 12 – 20
Balfour, D.J.K. 1994. Neural mechanisms underlying nicotine dependence. *Addiction* 89 (11): 1419 – 23

Ball, Michael. 1986. The Built Environment and the Urban Question. *Environment and Planning D: Society and Space* 4: 447 – 464

Bandura, Albert. 1977. Self-efficacy: Towards a Unifying Theory of Behavioral Change. *Psychological Review* 84 (2): 191 – 215

Barnard, Marina. 2005. *Drugs In the Family: The Impact on Parents and Siblings*. York. Joseph Rowntree Foundation

Bean, Philip. 2002. *Drugs and Crime*. Devon: Willan

Benda, Brent B. 1987. Crime, Drug Abuse, Mental Illness and Homelessness. *Deviant Behavior* 8: 361 – 375

Berkman, Lisa and Ichiro Kawachi (eds). 2000. *Social Epidemiology*. Oxford: Oxford University Press

Berkman, Lisa and Thomas Glass. 2000. Social Integration, Social Networks, Social Support, and Health. pp 137 – 173, in *Social Epidemiology,* edited by L. Berkman and I. Kawachi, Oxford: Oxford University Press

Beynon, Caryl, Jim McVeigh and Mark A. Bellis. 2004. *Drug Treatment in Cheshire and Merseyside 2001/02*. Liverpool: Centre for Public Health, Liverpool John Moores University

Bickel, Warren K., Gregory Madden and Nancy M. Petry. 1998. The Price of Change: The Behavioural Economics of Drug Dependence. *Behavior Therapy* 29: 545 – 565

Biernacki, P. 1986. *Pathways from Heroin Addiction: Recovery Without Treatment*. Philadelphia: Temple University Press

Bines, Wendy. 1994. *The Health of Single Homeless People*. York. Centre for Housing Policy, University of York

Blackman, David. 2002. 'The Decent People All Moved Out'. *Roof* Sept/Oct: 18 – 20

Bottoms, Anthony E. and Paul Wiles. 1986. Housing Tenure and Residential Cime Careers in Britain. pp 101 – 162 in *Crime and Justice: A Review of Research 8* edited by A.J. Reiss and M. Tonry. Chicago: University of Chicago

Bottoms, Anthony E. and Paul Wiles. 1992. Explanations of Crime and Place. pp 11 – 35 in *Crime, Policing and Place* edited by D.J. Evans, N.R. Fyfe and N.R. Herbert. London: Routledge

Bottoms, Anthony E., Ann Claytor and Paul Wiles. 1992. Housing Markets and Residential Community Crime Careers: A Case Study from Sheffield. pp 118 – 144 in *Crime, Policing and Place* edited by D.J. Evans, N.R.Fyfe and D.T. Herbert. London: Routledge

Bottoms, Anthony E., R.I. Mawby and P. Xanthos. 1989. A Tale of Two Estates in *Crime and the City* edited by D. Downes. London: MacMillan

Bourdieu, Pierre. 1986. *Distinction: A Social Critique of the Judgement of Taste*. London: Routledge

Bourgeois, Philippe. 2003. (2nd Edition) *In Search of Respect: Selling Crack in El Barrio.* Cambridge:Cambridge University Press

Bozarth, M.A. 1994. Opiate reinforcement processes: re-assembling multiple mechanisms. *Addiction* 89 (11): 1425 – 34

Brain, Kevin, Howard Parker and Tim Bottomley. 1998. *Evolving Crack Cocaine Careers: New Users, Quitters and Long-term Drug Users in North West England.* London. Home Office

Buck, Nick. 2001. Identifying Neighbourhood Effects on Social Exclusion. *Urban Studies* 38 (12): 2251 – 2275

Burgess, Robin. 2002. *Tackling Drugs as Part of Neighbourhood Renewal.* London: Home Office

Burr, Angela. 1987. Chasing the Dragon: Heroin Misuse, Delinquency and Crime in the Context of South London Culture. *British Journal of Criminology* 27 (4): 333 – 357

Burrows, Roger. 2003. How the Other Half Lives: An Exploratory Analysis of the Relationship Between Poverty and Home-ownership in Britain. *Urban Studies* 40 (7): 1223 – 1242

Bursik, Robert J. 1988. Social Disorganization and Theories of Crime and Delinquency: Problems and Prospects. *Criminology* 26 (4): 519 – 551

Cahalan, D., I. Cisin, I. and H. Crossley. (1969) *American Drinking Practices: A National Study of Drinking Behaviour and Attitudes.* New Brunswick: Rutgers Center for Alcohol Studies

Cairney, John and Michael H. Boyle. 2004 Home Ownership, Mortgages and Psychological Distress. *Housing Studies*. 19 (2): 161 – 174
Campbell, Catherine. 2000. Social Capital and Health: Contextualizing Health Promotion within Local Community Networks. pp 182 – 196 in

Social Capital: Critical Perspectives edited by S. Baron, J. Field and T. Schuller. Oxford: Oxford University Press

Carney, Robert M. and Kenneth E. Freedland. Depression and Medical Illness. pp 191 – 212 in *Social Epidemiology* edited by L. Berkman and I. Kawachi. Oxford: Oxford University Press

Caulkins, Jonathan and Peter Reutter. 1996. The Meaning and Utility of Drug Prices. *Addiction* 91 (9): 1261 – 1264

Chein, I., D.L. Gerard, R.S. Lee and E. Rosenfield. 1964. *Narcotics, Delinquency and Social Policy: The Road to H.* London: Tavistock

Childress, A.R., A.T. McLellan and C.P. O'Brien. 1986. Abstinent opiate abusers exhibit conditioned craving, conditioned withdrawal and reductions in both through extinction. *British Journal of Addiction* 81: 655 – 60

Clapham, David. 2002. Housing Pathways: A Post Modern Analytical Framework. *Housing, Theory and Society* 19: 57 – 68

Coleman, Alice. 1985. *Utopia On Trial.* London: Hilary Shipman

Cooper, Chris. 1997. Parameters and Indicators of the Decline of the British Seaside Resort. pp 79 – 101 in *The Rise and Fall of British Coastal Resorts* edited by G. Shaw and A. Williams. London: Pinter

Copeland, Lorraine. 2004. The Drug User's Identity and How it Relates to Being Hepatitis C Antibody Positive: A Qualitative Study. *Drugs: education, prevention and policy* 11 (2): 129 – 147

Crane, Jonathan. 1991. The Epidemic Theory of Ghettos and Neighbourhood Effects on Dropping Out and Teenage Childbearing. *American Journal of Sociology* 96 (5): 1226 – 1259

Csikszentmihalyi, M. and E. Rochberg-Halton. 1981. *The Meaning of Things: Domestic Symbols and The Self.* Cambridge: Cambridge University Press

Dalton, Tony and James Rowe. 2004. A Wasting Resource: Public Housing and Drug Use in Inner-city Melbourne. *Housing Studies* 19 (2) pp 229 – 244

Davies, D.L. 1962. Normal drinking in recovered alcohol addicts. *Quarterly Journal of Studies on Alcohol* 23: 94 – 104

Davies, John Booth. 1997. Conversations with Drug Users: A Functional Discourse Model. *Addiction Research* 5 (1): 53 – 70

DeAlarcon, R. 1969. The Spread of Heroin Abuse in a Community. *Bulletin on Narcotics* 21 (3): 17 – 22

DeAlarcon, R. and N.H. Rathod. 1968. Prevalence and Early Detection of Heroin Abuse. *British Medical Journal* 2: 549 – 553

Dean, Alan. 1997. *Chaos and Intoxication*. London: Routledge

Department of the Environment, Transport and the Regions. 1999. *Licensing of Houses in Multiple Occupation: England. Consultation Paper*. London: DETR

Despres, Carole. 1991. The Meaning of Home: Literature Review and Directions for Future Research and Theoretical Development. *The Journal of Architectural and Planning Research* 8 (2): 96 – 114

DeVaus, David. 2001. *Research Design in Social Research*. London: Sage

Donmall, Michael, Tim Millar, Andrew Jones and Helen Morey. 2002. *Treating Drug Misuse: Report for Cumbria and Lancashire Drug Action Teams 2001/02*. Manchester: Drug Misuse Research Unit, University of Manchester School of Epidemiology and Health Sciences

Dovey, Kim, John Fitzgerald and Youngju Choi. 2001. Safety Becomes Danger: Dilemmas of Drug Use in Public Space. *Health and Place* 7: 319 – 331

Dovey, Kim. 1999. *Framing Places: Mediating Power in Built Form*. London: Routledge

Downey, Lois, David B. Rosengren and Dennis M. Donovan. 2000. To Thine Own Self Be True: Self-concept and Motivation for Abstinence Among Substance Abusers. *Addictive Behaviors* 25 (5): 743 – 757

Duncan, Craig, Kelvyn Jones and Graham Moon. 1999. Smoking and Deprivation: Are there Neighbourhood Effects? *Social Science and Medicine* 48: 497 – 505

Duncan, David F. 1977. Life Stress as a Precursor to Adolescent Drug Dependence. *The International Journal of the Addictions* 12 (8): 1047 – 1056

Dunn, J. R. 2000. Housing and Health Inequalities: Review and Prospects for Research. *Housing Studies* 15 (3): 341 – 366

Dunn, J.R. 2002. Housing and Inequalities in Health A Study of Socioeconomic Dimensions of Housing and Self Reported Health from a Survey of Vancouver Residents. *Journal of Epidemiology and Community Health* 56: 671 – 681

Easterlow, Donna, Susan J. Smith and Sara Mallinson. Housing for Health: The Role of Owner Occupation. *Housing Studies* 15 (3): 367 – 386

Eck, John E. 1995. A General Model of the Geography of Illicit Retail Marketplaces. pp 67 – 93 in *Crime and Place: Crime Prevention Studies 4* edited by J.E. Eck and D. Weisburd. New York: Criminal Justice Press

Ellaway, Anne and Sally Macintyre. 1998. Does Housing Tenure Predict Health in the UK Because it Exposes People to Different Levels of Housing Related Hazards in the Home or its Surroundings? *Health and Place* 4 (2): 141 - 150

Ellen, Ingrid G. and Margery Turner. 1997. Does Neighbourhood Matter? Assessing Recent Evidence. *Housing Policy Debate* 8 (4): 833 – 866

Elliot, M. 2000. The Stress Process in Neighbourhood Context. *Health and Place* 6: 287 – 299

Elstad, J.I. 1998. The Psycho-social Perspective on Social Inequalities in Health. pp 39 – 58 in *The Sociology of Health Inequalities* edited by M.Bartley, D. Blane and G. Davey-Smith. Oxford: Blackwell

Elton, P.J. and J.M. Packer. 1986. A Prospective Randomised Trial of the value of Rehousing on the Grounds of Mental Ill-Health. *Journal of Chronic Disease* 39 (3): 221 – 227

Emler, Nicholas. 2001. *Self-esteem: The Costs and Causes of Low Self-worth.* York: York Publishing Services

Engels, Friedrich. [1865] 1987. *The Condition of the Working Class in London.* Harmondsworth: Penguin

Faupel, Charles E. 1988. Heroin Use, Crime and Employment Status. *The Journal of Drug Issues* 18 (3): 467 - 479

Ferrence, Roberta. 2001. Diffusion theory and Drug Use. *Addiction* 96: 165 – 173

Fiorentine, Robert. 1998. Effective Drug Treatment: Testing the Distal Needs Hypothesis. *Journal of Substance Misuse Treatment* 15 (4): 281 – 289

Fitzpatrick, Suzanne, Peter Kemp and Susanne Klinker. 2000. *Single Homelessness: An Overview of Research in Britain.* Bristol: Policy Press

Flemen, Kevin. 1997. Homelessness Is Habit Forming. *Inside Housing* Feb 14: 14 – 15

Fleming, Raymond, Andrew Baum and Jerome E. Singer. 1985. Social Support and the Physical Enviroment. Pp 327 – 345 in *Social Support and Health* edited by S. Cohen and S.C. Syme. London: Academic Press

Forrest, Ray and Ade Kearns. 1999. *Joined-Up Places? Social Cohesion and Neighbourhood Regeneration.* York: York Publishing Servies

Forrest, Ray and Ade Kearns. 2001. Social Cohesion, Social Capital and the Neighbourhood. *Urban Studies* 38 (12): 2125 – 2143

Forsyth, Alasdair J.M., Richard H. Hammersley, Tara L. Lavelle ad Keith J. Murray. 1992. *British Journal of Criminology* 32 (3): 292 – 309

Foster, Janet and Timothy Hope. 1993. *Housing, Community and Crime: The Impact of the Priority Estates Project.* Home Office Research Study 131. London. Home Office

Foucault, Michel. 1979. *Discipline and Punish.* Harmondsworth. Penguin

Fountain, Jane and Samantha Howes. 2002. *Home and Dry? Homelessness and Substance Use.* London: Crisis

Friedman, Jennifer and Marisa Alicea. 1995. Women and Heroin: The Path of Resistance and Its Consequences. *Gender and Society* 9 (4) 432 – 449

Friedrichs, Jurgen and Jorg Blasius. 2003. Social Norms in Distressed Neighbourhoods: Testing the Wilson Hypothesis. *Housing Studies* 18 (6): 807 – 826

Friedrichs, Jurgen, George Galster and Sako Mustero. 2003. Neighbourhood Effects on Social Opportunities: The European and American Research and Policy Context. *Housing Studies* 18 (6): 797 - 806

Fry, Craig and Robyn Dwyer. 2001. For Love or Money? An Exploratory Study of Why Injecting Drug Users Participate in Research. *Addiction* 96: 1319 – 1325

Fryer, David. (ed) 1998. Book Review Special. *Journal of Community and Applied Social Psychology* 163 – 180

Furstenberg, Frank F. Jr. and Mary Elizabeth Hughes. 1997. The Influence of Neighbourhoods in Children's Development: A Theoretical Perspective and a Research Agenda. pp 23 – 47 in *Neighbourhood Poverty vol 2: Policy Implications in Studying Neighbourhoods* edited by J.. Brooks-Gunn, G. Duncan and J.L. Aber. New York: Sage

Galster, George and Anne Zobel. 1998. Will Dispersed Housing Programmes Reduce Social Problems in the U.S.? *Housing Studies* 13 (5): 605 – 622

Galster, George and Jerome Rothenberg. 1991. Filtering in Urban Housing: A Graphical Analysis of a Quality-Segmented Market. *Journal of Planning Education and Research* 11: 37 – 50

Galster, George. 2001. On the Nature of Neighbourhood. *Urban Studies* 38 (12): 2111 – 2124

Galster, George. 2002. Transatlantic Perspectives on Opportunity, Deprivation and the Housing Nexus. *Housing Studies* 17 (1): 5 – 10

Galster, George. 2003. Investigating Behavioural Impacts of Poor Neighbourhoods: Towards New Data and Analytic Strategies. *Housing Studies* 18 (6): 893 – 914

Gelberg, Lillian and Barbara D. Leake. 1993. Substance Use Among Impoverished Medical Patients: The Effect of Housing Status and Other Factors. *Medical Care* 31 (9): 757 – 766

Giddens, Anthony. 1984. *The Constitution of Society*. Cambridge: Polity Press

Giggs, John, Philip Bean, David Whynes and Christine Wilkinson. 1989. Class A Drug Users: Prevalence and Characteristics in Greater Nottingham. *British Journal of Addiction* 84: 1473 - 1480

Giggs, John. 1991. Epidemiology of Contemporary Drug Abuse. pp 145 – 175 in *Policing and Prescribing* edited by D.K. Whynes and P.T. Bean. London: MacMillan

Gill, Baljitt, Howard Meltzer, Kerstin Hinds and Mark Petticrew. 1996. *Psychiatric Morbidity Among Homeless People*. London. HMSO

Gilman, Mark and Geoffrey Pearson. 1991. Lifestyles and Law Enforcement. pp 95 – 123 in *Policing and Prescribing* edited by D.K.

Gilman, Mark. 1998. Onion Rings To Go: Social Exclusion and Addiction. *Druglink*. May/June: 15 - 18

Glantz, M.D. and R.W. Pickens. 1992. Vulnerability to Drug Abuse: Introduction and Overview, in *Vulnerability to Drug Abuse*, edited by M.D.

Glantz and R.W. Pickens. Washington D.C: American Psychological Association

Glaser, B.G. and A.L. Strauss. 1967. *The Discovery of Grounded Theory*. Chicago: Aldine

Goffman, Erving. [1963] 1990. Stigma: Notes on The Management of Spoiled Identity. Harmondworth. Penguin

Goodman, Lisa, Leonard Saxe and Mary Harvey. 1991. Homelessness as Psychological Trauma: Broadening Perspectives. *American Psychologist* 46 (11): 1219 – 1225

Goodwin, D.W. 1989. Biological factors in alcohol use and abuse: implications for recognizing and preventing alcohol problems in adolescence. *International Review of Psychiatry* 1: 41 – 49

Goodwin, D.W., F. Schulsinger, L. Hermansen, S.B. Guze and G. Winokur. 1973. Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry* 28: 238 – 43

Gossop, Michael, Lyn Green, Grania Phillips and Brendan Bradley. 1990. Factors Predicting Outcome Among Opiate Addicts After Treatment. *British Journal of Clinical Psychology* 29: 209 – 216

Gossop, Michael. 1996. (4th Edition) *Living with Drugs*, Aldershot: Arena

Granovetter, Mark S. 1973. The Strength of Weak Ties. *American Journal of Sociology* 78 (6): 1360 – 1380

Granovetter, Mark. 1978. Threshold Models of Collective Behaviour. *American Journal of Sociology* 83 (6): 1420 – 1443

Grapendaal, Martin. 1992. Cutting Their Coat According to Their Cloth: Economic Behavior of Amsterdam Opiate Users. *The International Journal of the Addictions* 27 (4): 487 – 501

Green, Lorraine. 1994. *Policing Places with Drug Problems*. California: Sage

Greene, Jody M., Susan T. Ennett and Christopher L. Ringwalt. 1997. Substance Use Among Runaway and Homeless Youth in Three National Samples. *American Journal of Public Health* 87 (2): 229 – 235

Groenewegen, Peter P., Hubert G. Leufkens, Peter Spreeuwenberg and Wilmar Worm. 1999. Neighbourhood Characteristics and Use of Benzodiazepines in The Netherlands. *Social Science and Medicine* 48: 1701 – 1711

Grund, Jean-Paul, L. Synn Stern, Charles D. Kaplan, Nico F.P. Adriaans and Ernest Drucker. 1992. Drug Use Contexts and HIV Consequences: the Effect of Drug Policy on Patterns of Everyday Drug Use in Rotterdam and The Bronx. *British Journal of Addiction* 87: 381 – 392

Gurney, Craig. 1990. *The Meaning of Home in the Decade of Owner Occupation: Towards an Experiential Research Agenda. Working Paper 88,* School for Advanced Urban Studies, University of Bristol

Hall, Sharon M., David A. Wasserman and Barbara Havassy. 1991. Effects of Commitment to Abstinence, Positive Moods, Stress and Coping on Relapse to Cocaine Use. *Journal of Consulting and Clinical Psychology* 59 (4): 526 – 532

Halpern, David. 1995. *More Than Bricks and Mortar: Mental Health and the Built Environment.* London: Taylor and Francis

Hammersley, Richard. 1994. A Digest of Memory Phenomena for Addiction Research. *Addiction* 89: 283 – 293

Hansell, Stephen and Helene Raskin White. 1991. Adolescent Drug Use, Psychological Distress and Physical Symptoms. *Journal of Health and Social Behavior* 32: 288 – 301

Harrison, Lana D. 1995. The Validity of Self-Reported Data on Drug Use. *The Journal of Drug Issues* 25 (1): 91 – 111

Harrison, Larry and Hugo Luck. 1996. Drinking and Homelessness in the U.K. pp 115 – 140 in Alcohol Problems in the Community edited by L. Harrison. Routledge: London

Hawkins, J.D., R.F. Catalano and J.Y. Miller. 1992. Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescent and Early Adulthood: Implications for Substance Abuse Prevention. *Psychological Bulletin* 112: 64 – 105

Heath, A.C. 1995. Genetic influences on alcoholism risk. *Alcohol Health and Research World* 19 (3): 166 – 171

Heath, D.B. 1992. U.S. drug control policy: a cultural perspective. *Daedalus* 121 (3): 269 – 291

Heather, Nick and Ian Robertson. 1989 (2nd ed.). *Problem Drinking. Oxford:* Oxford University Press

Higate, Paul R. 2000. Tough Bodies and Rough Sleeping: Embodying Homelessness Amongst Ex-servicemen. *Housing, Theory and Society* 17: 97 – 108

Hillier, Bill. 1996. *Space Is The Machine.* Cambridge: Cambridge University Press

Hiscock, Rosemary, Ade Kearns, Sally Macintyre and Anne Ellaway. 2001. Ontological Security and Psycho-Social Benefits from the Home:

Qualitative Evidence on Issues of Tenure. *Housing, Theory and Society* 18: 50 – 66

Holman, R. B. 1994. Biological effects of central nervous system stimulants. *Addiction* 89 (11): 1435 – 42

Home Office. 2002. *Updated Drug Strategy 2002.* London: Home Office

Home Office. 2003. *Anti Social Behaviour Act 2003: Notes of Guidance Part One.* London: Home Office

House, J.S., K.R. Landis and D. Umberson. 1988. Social Relationships and Health. *Science* 241: 540 – 545

Hser, Yih-Ing, Margaret L. Polinsky, Margaret Maglione and M. Douglas Anglin. 1999. Matching Clients' Needs with Drug Treatment Services. *Journal of Substance Abuse Treatment* 16 (4): 299 – 305

Hughes, P.H. and J.H. Jaffe. 1971. The Heroin Copping Area: A Location for Epidemiological Study and Intervention Activity. *Archives of General Psychiatry* 24: 394 – 401

Hugh-Jones, S. 1995. Coca, beer, cigars and yage: meals and anti-meals in an Amerindian community. In: J. Goodman, P.E. Lovejoy and A. Sherratt (eds) *Consuming Habits: Drugs in History and Anthropology.* New York: Routledge

Hunt, Geoffrey and Judith C. Barker. 2001. Socio-cultural anthropology and alcohol and drug research: towards a unified theory. *Social Science and Medicine* 53: 165 – 188

Hunt, Leon Gibson and Carl D. Chambers. 1976. *The Heroin Epidemics: A Study of Heroin Use in the United States 1965 – 75.* New York: Spectrum

Inside Housing. 2004. *Vulnerable Pushed Out.* 25 May: 1

Jacobs, Jane. 1961. *The Death and Life of Great American Cities.* New York: Random House

Jaffe, J.H. 1989 Addictions: what does biology have to tell? *International Review of Psychiatry* 1: 51 – 61

Joe, George W. and D. Dwayne Simpson. 1991. Unmet Service Needs in Methadone Maintenance. *The International Journal of the Addictions* 26 (1): 1 – 22

Johnson, Timothy P., Sally A. Freels, Jennifer A. Parsons and Jonathan B. Vangeest. 1997. Substance Abuse and Homelessness: Social Selection or Social Adaptation? *Addiction* 92 (4): 437 – 445

Kandel, D.B., R.C. Kessler and R.Z. Margulies. 1978. Antecedents of adolescent initiation into stages of drug use: a developmental analysis. *Journal of Youth and Adolescence* 7:13 – 40

Kawachi, Ichiro and Lisa Berkman. 2000. Social Cohesion, Social Capital and Health. pp 174 – 190, in *Social Epidemiology* edited by L. Berkman and I. Kawachi. Oxford: Oxford University Press

Kawachi, Ichiro, Bruce P. Kennedy and Richard G. Wilkinson. 1999. Crime: Social Disorganization and Relative Deprivation. *Social Science and Medicine* 48: 719 – 731

Kearns, Ade and Alison Parkes. 2003. Living In and Leaving Poor Neighbourhood Conditions in England. *Housing Studies* 18 (6): 827 – 851

Kearns, Ade, Rosemary Hiscock, Anne Ellaway and Sally Macintyre. 2000. 'Beyond Four Walls'. The Psycho-social Benefits of Home: Evidence From West Central Scotland. *Housing Studies* 15 (3): 387 – 410

Kearns, Robin A., Christopher J. Smith and Max W. Abbott. 1992. The Stress of Incipient Homelessness. *Housing Studies* 7 (4): 280 – 298

Kemp, Peter A. and Margaret Keogan. 2001. Movement Into and Out of the Private Rented Sector in England. *Housing Studies* 16 (1): 21 – 37

Kennedy, Catherine, Kieran Barr, Jo Dean and Joanne Neale. 2001. *Good Practice Towards Homeless Drug Users: Service Provision and Practice in Scotland.* Edinburgh: Research Department, Scottish Homes

Kessler, R. 1979. Stress, Social Status and Psychologicl Distress. *Journal of Health and Social Behaviour* 20: 259 – 272

Khantzian, Edward J. 1985. The Self-medication Hypothesis of Addictive Disorders: Focus on Heroin and Cocaine Dependence. *The American Journal of Psychiatry* 142 (11): 1259 – 1264

Kitano, H. 1989. Alcohol and Drug Use and Self-esteem: A Socio-cultural Perspective, in *The Social Importance of Self-esteem* edited by A.M. Mecca, N. Smelser and J. Vasconcellos. Berkley Ca. University of California Press

Klee, Hilary and Paul Reid. 1998. Drug Use Among the Young Homeless: Coping Through Self-Medication. *Health* 2 (2): 115 – 134

Klee, Hilary. 1991. Homelessness Among Injecting Drug Users: Implications for the Spread of Aids. *Journal of Community and Applied Social Psychology* 1: 143 – 154

Klee, Hilary. 2002. Drugs and Parenting. pp 145 – 164 in *Drug Misuse and Motherhood* edited by H. Klee, M. Jackson and S. Lewis. London: Routledge

Klinker, Susanne and Suzanne Fitzpatrick. 2000. *A Bibilography of Single Homelessness Research.* Bristol: Policy Press

Knox, Paul and Steven Pinch. 2000 (4th Edition). *Urban Social Geography: An Introduction.* Harlow: Prentice Hall

Krieger, Nancy. 1994. Epidemiology and the Web of Causation: Has Anyone Seen the Spider? *Social Science and Medicine* 39 (7): 887 – 903
Krieger, Nancy. 2001. A Glossary for Social Epidemiology. *Journal of Epidemiology and Community Health* 55: 693 - 700

Kubzansky, Laura D. and Ichiro Kawachi. 2000. Affective States and Health. pp 213 – 241 in *Social Epidemiology* edited by L. Beckman and I. Kawachi. Oxford: Oxford University Press

Kuhn, T.S. 1970 (2nd ed.). *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press

Lalander, P. 2003. *Hooked on Heroin: Drugs and Drifters in a Globalised World.* Oxford: Berg

Latkin, C., W. Mandell, M. Ozsiemkowska, D. Celentano, D. Vlahov, M. Ensminger and A. Knowlton. 1995. Using Social Network Analysis to Study Patterns of Drug Use Among Urban Drug Users at High Risk For HIV/Aids. *Drug and Alcohol Dependence* 38: 1 – 9

Latkin, Carl, Gregory E. Glass and Terry Duncan. 1998. Using Geographic Information Systems to Assess Spatial Patterns of Drug Use: Selection Bias and Attrition Among A Sample of Injection Drug Users. *Drug and Alcohol Dependence* 50: 167 – 175

Latkin, Carl, Wallace Mandell, David Vlahov, Maria Oziemkowska, Amy Knowlton and David Centano. 1994. *American Journal of Community Psychology* 22 (3): 415 – 430

Lazarus, R.S. and Folkman, S. 1984. *Stress, Appraisal and Coping.* New York: Springer

Lee, Peter and Alan Murie. 1997. *Poverty, Housing Tenure and Social Exclusion.* Bristol: Polity Press

Lee, Raymond, M. 1993. *Doing Research on Sensitive* Topics. London: Sage

Leigh, Chris. 1994. *Everybody's Baby: Implementing Community Care for Single Homeless People.* London: CHAR

Lewis, Suzan. 2002. Concepts of Motherhood. pp 32 – 44 in *Drug Misuse and Motherhood* edited by H. Klee, M. Jackson and S. Lewis. London: Routledge

Litman, G. 1986. Alcoholism Survival: The Prevention of Relapse in *Treating Addictive Behaviours* edited by W. Miller and N. Heather. New York: Plenum

Lloyd, Charlie. 1998. Risk Factors for Problem Drug Use: Identifying Vulnerable Groups. *Drugs: education, prevention and policy*, 5 (3): 217 – 232

Loehlin, J.C. 1992. *Latent Variable Models: An Introduction to Factor, Path and Structural Analysis*, 2nd ed. Hillsdale, NJ: Lawrence Erlbaum

London Drug Policy Forum. 1997. *Housing Drug Users: Balancing Needs and Risks*. London: London Drug Policy Forum

Loomis, D and S. Wing. 1990. Is Molecular Epidemiology a Germ Theory for the End of the Twentieth Century? *International Journal of Epidemiology* 19: 1 – 3

Lowe, Stuart. 2004. *Housing Policy Analysis: British Housing in Cultural and Comparative Context*. Basingstoke: Palgrave

Lund, Brian and Mark Foord. 1997. *Towards Integrated Living? Housing Strategies and Community Care*. Bristol: Polity Press

Lupton, Ruth, Andrew Wilson, Tiggey May, Hamish Warburton and Paul J. Turnbull. 2002. *A Rock and a Hard Place: Drug Markets in Deprived Neighbourhoods*. London: Home Office

Lynch, J.W., G.A. Kaplan and J.T. Salonen. 1997. Why Do Poor People Behave Poorly? Variation in Adult Health Behaviours And Psychosocial Characteristics by Stages Of the Socioeconomic Lifecourse. *Social Science and Medicine* 44 (6): 809 – 819

Lynch, John and George Kaplan. 2000. Socioeconomic Position. pp 13 – 35 in *Social Epidemiology* edited by L. Berkman and I. Kawachi. Oxford: Oxford University Press

Macintyre, Sally and Anne Ellaway. 2000. Ecological Approaches: Rediscovering the Role of the Physical and Social Environment. pp 332 – 348 in *Social Epidemiology* edited by L. Berkman and I. Kawachi. Oxford: Oxford University Press

Macintyre, Sally, Anne Ellaway, Rosemary Hiscock, Ade Kearns, Geoff Der and Laura McKay. 2003. What Features of the Home and the Area Might Help to Explain Observed Relationships Between Housing Tenure

and Health? Evidence from The West of Scotland. *Health and Place* 9: 207 – 218

Macintyre, Sally, Sheila MacIver and Anne Soomans. 1993. Area, Class and Health: Should We Be Focusing on Places or People? *Journal of Social Policy* 22 (2): 213 – 234

Madanipour, Ali. 1998. Social Exclusion and Space. pp 75 – 89 in *Social Exclusion in European Cities: Processes, Experiences and Responses* edited by A. Mandanipour, G. Cars and J. Allen. London: Jessica Kingsley

Maher, Lisa, Eloise Dunlap, Bruce D. Johnson and Ansley Hamid. 1996. Gender, Power, and Alternative Living Arrangements in the Inner-City Crack Culture. *Journal of Research in Crime and Delinquency* 33 (2): 181 – 205

Marlatt, G. and J. Gordon.1985. *Relapse Prevention*. New York: Guilford Press

Marmot, Michael. 2000. Multilevel Approaches to Understanding Social Determinants. pp 349 – 367 in *Social Epidemiology* edited by L. Beckman and I. Kawachi. Oxford University Press

Marmot, Michael. 2004. *Status Syndrome: How Your Social Standing Directly Affects Your Health and Life Expectancy*. London: Bloomsbury

Marsden, John, Michael Gossop, Duncan Stewart, David Best, Michael Farrel, Petra Lehmann, Carolyn Edwards and John Strang. 1998. The Maudsley Addiction Profile (MAP): A Brief Instrument for Assessing Treatment Outcome. *Addiction* 93 (2): 1857 – 1868

Marsh, Alex and David Mullins. 1998. The Social Exclusion Perspective and Housing Studies: Origins, Applications and Limitations. *Housing Studies* 13 (6): 749 – 759

May, John. 2000. Housing Histories and Homeless Careers: A Biographical Approach. *Housing Studies* 15 (4): 613 – 638

Mayhew, H. 1862. *London Labour and the London Poor*. Griffin-Bohn. London

McCrae, Robert D. 1992. Situational Determinants of Coping. pp 65 – 76 in *Personal Coping: Theory, Research and Application* edited by B.N. Carpenter. Westport, Conn: Praeger

McDonald, M. (ed). 1994. *Gender, Drink and Drugs*. Oxford: Berg

McIntosh, James and McKeganey, Neil. 2002. *Beating the Dragon: The Recovery From Dependent Drug Use*. Harlow: Prentice Hall

McIntosh, James and Neil McKeganey. 2001. Identity and Recovery from Dependent Drug Use: The Addict's Perspective. *Drugs: education, prevention and policy* 8 (1): 47 – 59

McKay, J.R. 1995. An Examination of the Cocaine Relapse Process. *Drug and Alcohol Dependence* 38: 35 – 43

McKeganey, Neil, Marina Barnard and James McIntosh. 2002. Paying the Price for Their Parent's Addiction: Meeting the Needs of the Children of Drug-using Parents. *Drugs: education, prevention and policy* 9 (3): 233 – 247

McKeganey, Neil. 1995. Quantitative and Qualitative Research in the Addictions: An Unhelpful Divide. *Addiction* 90: 749 – 751

McMichael, A.J. 1999. Prisoners of the Proximate: Loosening the Constraints on Epidemiology in an Age of Change. *American Journal of Epidemiology* 149 (10): 887 – 897

Meier, Petra S., Michael C. Donmall and Patrick McElduff. 2004. Characteristics of Drug Users Who Do or Do not Have Care of Their Chidren. *Addiction* 99: 955 – 961

Meltzer, Howard, Nicola Singleton, Alison Lee, Paul Bebbington, Traolach Brugha and Rachel Jenkins. 2002. *The Social and Economic Circumstances of Adults with Mental Disorders*. London. HMSO

Miller, W.R. and J.M. Brown. 1991. Self-regulation as a conceptual basis for the prevention and treatment of addictive behaviours. In N. Heather, W.R. Miller and J. Greeley. (eds) *Self-control and the Addictive Behaviours*. Botany New South Wales: Maxwell Macmillan Publishing Australia

Mirowsky, John and Catherine E. Ross. 1989. *Social Causes of Psychological Distress*. New York: Aldine de Gruyter

Morris, Jenny. 1995. *Housing and Floating Support: A Review*. York: York Publishing Services

Murie, Alan. 1997a. The Social Rented Sector, Housing and the Welfare State in the UK. *Housing Studies* 12 (4): 437 – 461

Murie, Alan. 1997b. Linking Housing changes to Crime. *Social Policy and Administration* 31 (5): 22 - 36

Nader, L. 1972. Up the anthropologist: perspectives gained from studying up. In: D. Hymes (ed) *Reinventing Anthropology.* New York: Random House

Nathan, P.E. 1988. The addictive personality is the behavior of the addict. *Journal of Consulting and Clinical Psychology* 56: 183 – 188

Neale, Joanne. 1997. Homelessness and Theory Reconsidered. *Housing Studies* 12 (2): 47 – 61

Neale, Joanne. 1998. Drug Users Aren't Working. *Druglink* March/April: 21 – 22

Nettleton, Sarah and Roger Burrows. 1998. Mortgage Debt, Insecure Home Ownership and Health: An Exploratory Analysis. *Sociology of Health and Illness* 20 (5): 731 – 758

Newcomb, M.D., E. Maddahian, R. Skager and P.M. Bentler. 1986. Risk factors for drug use among adolescents: concurrent and longitudinal analysis. *American Journal of Public Health* 76: 525 – 530
Newman, Oscar. 1972. *Defensible Space*. New York: MacMillan

O'Doherty, Fiona. 1991. Is Drug Use a Response to Stress? *Drug and Alcohol Dependence* 29: 97 – 106

O'Leary, Jenny. 1997. *Beyond Help? Improving Service Provision for Street Homeless People with Mental Health and Alcohol or Drug Dependency Problems*. London: National Homeless Alliance
Office of The Deputy Prime Minister. 2003. *English House Condition Survey 2001*. London. ODPM

Office of the Deputy Prime Minister. 2004. *Making It Happen: The Northern Way*. London. ODPM

Orford, Jim. 1985. *Excessive Appetites: A Psychological View of Addictions*. Chichester: John Wiley

Pahl, R.E. 1970. *Patterns of Urban Life*. London: Longmans

Papps, Pauline. 1998. Anti-social Behaviour Strategies – Individualistic or Holistic? *Housing Studies* 13 (5): 639 – 656

Parker, Howard, Catherine Bury and Roy Egginton. 1998. *New Heroin Outbreaks Amongst Young People in England and Wales*. London: Home Office Police Research Group

Parker, Howard, Russell Newcombe and Keith Bakx. 1987. The New Heroin Users: Prevalence and Characteristics in Wirral, Merseyside. *British Journal of Addiction* 82: 147 – 157

Pavlov, P. 1927. *Conditioned Reflexes*. Oxford: Oxford University Press

Pearce, N and J. McKinlay. 1998. Back to the Future in Epidemiology and Public Health. *Journal of Clinical Epidemiology* 51: 643 – 646

Pearson, Geoffrey and Dick Hobbs. 2001. *Middle Market Drug Distribution*, *Home Office Research Study* 227, London: Home Office

Pearson, Geoffrey. 1987. Social Deprivation, Unemployment and Patterns of Heroin Use, pp 62 – 94 in *A Land Fit for Heroin? Drugs Policies, Prevention and Practice*, edited by N. Dorn and N. South. Basingstoke: MacMillan

Peterson, A. and D. Lupton. 1996. *The New Public Health: Health and the Self in the Age of Risk*. Thousand Oaks: Sage

Petry, Nancy M. 2001. The Effects of Housing Costs on Polydrug Abuse Patterns: A Comparison of Heroin, Cocaine and Alcohol Abusers. *Experimental and Clinical Psychopharmacology* 9 (1): 47 – 58

Petry, Nancy. M. 2000. Effects of Increasing Income on Polydrug Use: A Comparison of Heroin, Cocaine and Alcohol Abusers. *Addiction* 95 (5): 705 – 717

Piazza, Pier, Vincenzo and Michel LeMoal. 1998. The Role of Stress in Drug Self-administration. *Trends in Pharmacological Sciences* 19: 67 – 74

Pleace, Nicholas. 1998. Single Homelessness as Social Exclusion: The Unique and the Extreme. *Social Policy and Administration* 32 (1): 46 – 59

Plomin, R. 1994. *Genetics and Experience: The Interplay between Nature and Nurture*. London: Sage

Plomin, R., J.C. De Fries and J.C. Loehlin. 1977. Genotype-environment interaction and correlation in the analysis of human behaviour. *Psychological Bulletin* 84: 302 – 322

Portes, Alejandro and Patricia Landolt. 1996. The Downside of Social Capital. *The American Prospect* 7 (26): 18 – 21

Power, Robert. 1995. A Model for Qualitative Action Research Amongst Illicit Drug Users. *Addiction Research* 3 (3): 165 – 181
Preble, E. and J.J. Casey. 1969. Taking Care of Business. *International Journal of the Addictions* 4 (1): 1 – 24

President of the Council. 1998. *Tackling Drugs to Build A Better Britain.* London: HMSO

Prochaska, J.O. and C.C. DiClimente. 1986. Towards A Comprehensive Model of Change in *Treating Addictive Behaviours: A Process of Change* edited by W.R. Miller and N. Heather. New York: Plenum Press

Putnam, Robert D. 2000. *Bowling Alone: The Collapse and Revival of American Community.* New York: Simon and Schuster

Quercia, Roberto, G. and George C. Galster. 2000. Threshold Effects and Neighbourhood Change. *Journal of Planning Education and Research* 20: 146 – 162

Rengert, G. 1996. *The Geography of Illegal Drugs*. Oxford: Westview Press

Rengert, George, Sanjoy Chakravorty, Tom Bole and Kristin Henderson. 2000. A Geographical Analysis of Illegal Drug Markets. pp 219 – 239 in *Crime Prevention Studies 11* edited by M. Natarajan and M. Hough. New York: Criminal Justice Press

Rhodes, Tim and Alan Quirk. 1996. Heroin, Risk and Sexual Safety: Some Problems for Intervention Encouraging Community Change. pp 161 – 185 in *Aids, Dugs and Prevention: Perspectives on Community Action,* edited by T. Rhodes and R. Hartnoll. London: Routledge

Robins, L.N., J.E Helzer and D.H. Davis. 1975. Narcotic use in South East Asia and afterward. *Archives of General Psychiatry* 32: 955 – 961

Robinson, David. 1998. Health Selection in the Housing System: Access to Council Housing for Homeless People with Health Problems. *Housing Studies* 13 (1): 23 – 41

Robinson, Ian and Kevin Flemen. 2002. *Tackling Drug Use in Rented Housing.* London: Home Office

Rothenberg, J., G.L. Galster, R.V. Butler and J. Pitkin. 1991. *The Maze of Uban Housing Markets.* Chicago: University of Chicago

Rutter, Deborah. 1994. *Keys to Change: A Study of the Role of Local Authority Housing in the Care and Rehabilittion of Drug and Alcohol Users in the London Borough of Lambeth.* London: Home Office

Sandham, James. 1998. *An Evaluation of the Housing Support Project.* Warwick: Coventry Warwickshire Substance Misuse Initiative

Sapolsky, R. 1998. *Why Zebras Don't Get Ulcers: A Guide to Stress, Stress-related Diseases and Coping.* New York, W.H. Freeman

Saunders, Bill and S. Allsop. 1988. Relapse: A Critique. pp 249 – 277 in *Relapse and Addictive Behaviour* edited by M. Gossop. London: Routledge

Saunders, Bill and Steve Allsop. 1991. Alcohol Problems and Relapse: Can the Clinic Combat the Community? *Journal of Community and Applied Social Psychology* 1: 213 – 221

Saunders, Peter. 1990. *A Nation of Home Owners.* London: Unwin Hyman

Schwartz, S. 1994. The Fallacy of the Ecological Fallacy: the Potential Misuse of a Concept and the Consequences. *American Journal of Public Health* 84: 819 – 824

Scott, Jan. 1993. Homelessness and Mental Health. *British Journal of Psychiatry* 162: 314 – 324

Scott, Suzy and Hilary Parkey. 1998. Myths and Reality: Anti-social Behaviour in Scotland. *Housing Studies* 13 (3): 325 – 345

Shapiro, Harry. 1998. From Clinic to Community: The Changing Face of Treatment. *Druglink* Nov/Dec: 8 - 11

Shaw, Clifford S. and Henry D. McKay. 1942. *Juvenile Delinquency and Urban Areas.* University of Chicago

Shaw, Ian, 1998. Practice and Research for Housing the Socially Excluded. pp 27 – 45 in *Social Care and Housing* edited by I. Shaw, S. Lambert and D. Clapham. London: Jessica Kingsley

Singleton, Nicola, Elizabeth Pendry, Colin Taylor, Michael Farrel and John Marsden. 2003. *Drug-related Mortality Among Newly-released Offenders.* London: Home Office

Skinner, B.F. 1938. The *Behavior of Organisms.* New York: Appleton-Century Crofts

Skogan, Wesley G. and Sampson O. Annan. 1994. Drugs and Public Housing: Towards an Effective Police Response. pp 129 – 148 in *Drugs and Crime: Evaluating Policy Initiatives* edited by D.L. Mackenzie and C.D. Uchida. London: Sage

Smith, Carolyn A., Christopher J. Smith, Robin A. Kearns and Max W. Abbott. 1993. Housing Stressors, Social support and Psychological Distress. *Social Science and Medicine* 37 (5): 603 – 612

Smith, Susan J. 1990. Health Status and the Housing System. *Social Science and Medicine* 7: 753 – 762

Smith, Susan J., Alan Alexander and Donna Easterlow. 1997. Rehousing as a Health Intervention: Miracle or Mirage? *Health and Place* 3 (4): 203 – 216

Smith, Susan J., Donna Easterlow, Moira Munro and Katrina M. Turner. 2003. Housing as Health Capital: How Health Trajectories and Housing Paths are Linked. *Journal of Social Issues* 59 (3): 501 – 525

Smith, Susan J., Robin Knill-Jones and Ann McGuckin (eds). 1991. *Housing for Health.* London: Longman

Social Exclusion Unit. 1998. *Bringing Britain Together: A National Strategy for Neighbourhood Renewal*. London: HMSO

Social Exclusion Unit. 2002. *Reducing Re-Offending by Ex-Prisoners*. London: Social Exclusion Unit

Somerville, Peter. 1997. The Social Construction of Home. *Journal of Architectural and Planning Research* 14 (3): 226 – 245

Somerville, Peter. 1998. Explanations of Social Exclusion: Where Does Housing Fit In? *Housing Studies* 13 (6): 761 – 780

Sooman, Anne and Sally Macintyre. 1995. Health Perceptions of the Local Environment in Socially Contrasting Neighbourhoods in Glasgow. *Health and Place* 1 (1): 15 – 26

Sosin, Michael, Irving Piliavin and Herb Westerfelt. 1990. *Journal of Social Issues* 46 (4): 157 – 174

Stark, Rodney. 1987. Deviant Places: A Theory of the Ecology of Crime. *Criminology* 25 (4): 893 – 909

Stauss, A. and J. Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. London: Sage

Stimson, Gerry. 1995. Foreword in J.W.T. Dickerson and G.V. Stimson (eds) *Drugs in the City*. London: Royal Society of Health

Stockwell, Tim. 1989 (2nd ed.). Anxiety and Stress Management. pp 242 – 250 in *Handbook of Alcoholism Treatment Approaches: Effective Alternatives* edited by R.K. Hester and W. R. Miller. Needham Heights Mass. Simon and Schuster

Strang, J., Griffiths, P. and Gossop, M. 1997. Heroin in the United Kingdom: Different Forms, Different Origins and the Relationship to Different Routes of Administration. *Drug and Alcohol Review* 16: 329 – 337

Suh, Tongwoo, Wallace Mandell, Carl Latkin and Joohyung Kim. 1997. Social Network Characteristics and Injecting HIV-risk Behaviours Among Street Injection Drug Users. *Drug and Alcohol Dependence* 47: 137 – 143

Susser, Mervyn and Ezra Susser. 1996 Choosing a Future for Epidemiology. 1. Eras and Paradigms, 2. From Black Box to Chinese Boxes and Eco-Epdemiology. *American Journal of Public Health* 86 (5): 668 – 677

Syme, S. Leonard. 1994. The Social Environment and Health. *Daedalus* 123 (4): 79 - 86

Syme, S. Leonard. 2000. Foreword. pp ix – xii in *Social Epidemiology* edited by L. Berkman and I. Kawachi. Oxford: Oxford University Press

Tarde, G. 1903. *The Laws of Imitation*. New York: Holt and Co.

Tarlov,Alvin R. 1996. Social Determinants of Health: The Sociobiological Translation. pp 71 – 93 in *Health and Social Organization: Towards a Health Policy for the Twentieth Century* edited by D. Blane, E. Brunner and R. Wilkinson. London: Routledge

Taylor, Ralph B. and Stephen Gottfredson. 1986. Environmental Design, Crime, and Prevention: An Examination of Community Dynamics. pp 387 – 416 in *Crime and Justice: A Review of Research 8: Communities and Crime* edited by A.J. Reiss and M. Tondry. Chicago: University of Chicago

Temkin, Kenneth and William Rohe. 1996. Neighbourhood Change and Urban Policy. *Journal of Planning Education and Research* 15: 159 – 170

Tesh, S.N. 1988. *Hidden Arguments: Political Ideology and Disease Prevention Policy.* New Brunswick: Rutgers University

Town, Helen. 2001. *Brand New Day: Working With Tenants With Drug Problems – A Good Practice Guide*. Northampton: CAN Homeless Action Team

Valliant, G.E. 1983. *The Natural History of Alcoholism*. Cambridge MA: Harvard University Press

Vandenbroucke, J.P. 1988. Is 'The Causes of Cancer' a Miasma Theory for the End of the Twentieth Century? *International Journal of Epidemiology* 7 (4): 708 – 709

Velleman, R., W. Mistral and L. Sanderling. 1997. *Involving Parents in Drugs Prevention.* Paper presented at the Drugs Prevention Initiative Research Conference, Liverpool quoted in Lloyd 1998: 221

Waldorf, Dan. 1983. Natural Recovery From Opiate Addiction: Some Social-Psychological Processes of Untreated Recovery. *Journal of Drug Issues.* Spring: 237 – 281

Wallace, Roderick. 1990. Urban Desertification, Public Health and Public Order: 'Planned Shrinkage', Violent Death, Substance Abuse and Aids in The Bronx. *Social Science and Medicine* 31 (7): 801 – 813

Wallace, Roderick. 1991. Travelling Waves of HIV Infection on a Low Dimensional 'Socio-Geographic' Network. *Social Science and Medicine* 32 (7): 847 – 852

Wasserman, David A., Meryle G. Weinstein, Barbara E. Havassy and Sharon M. Hall. 1998. Factors Associated with Lapses to Heroin Use During Methadone Maintenance. *Drug and Alcohol Dependence* 52: 183 – 192

Wheaton, B. 1982. A comparison of the Moderating Effects of Personal Coping Resources on the Impact of Exposure to Stress in Two Groups. *Journal of Community Psychology* 10: 293 – 311

Whynes and P.T. Bean. London: MacMillan
Wilkinson, R. 1996. *Unhealthy Societies: The Afflictions of Inequality.* London: Routledge

Wills, T.A. 1994. Self-esteem and Perceived Control in Adolescent Substance Abuse. *Psychology of Addictive Behaviours* 8: 223 - 234

Wilson, J.Q. and G. Kelling. 1982. Broken Windows. *The Atlantic Monthly* March: 29 – 38

Wilson, William, Julius. 1987. *The Truly Disadvantaged: The Inner City, The Underclass and Public Policy.* University of Chicago Press

Winchester, H.P.M. and White, P.E. 1988. The Location of Marginalised Groups in the City. *Environment and Planning D: Society and Space* 6: 37 – 54

Wisely, C., N. Gledhill, R. Cyster and H. Shaw. 1997. *The New Young Heroin Users.* Unpublished report quoted in Lloyd 1998: 222

Wood, Martin and Clive Vamplew. 1999. *Neighbourhood Images in Teesside.* York: York Publishing

Wright, Samantha. 2002. Women's Use of Drugs: Gender Specific Factors. pp 15 – 31 in *Drug Misuse and Motherhood* edited by H. Klee, M. Jackson and S. Lewis. London: Routledge

Yack, D. 1990. Biological Markers: Broadening or Narrowing the Scope of Epidemiology? *Journal of Clinical Epidemiology* 43: 309 – 310

Zuckerman, M. 1979. *Sensation Seeking: Beyond the Optimal Level of Arousal.* Hillsdale, NJ: Erlbaum