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MAYOR OF LONDON

Research into drug and alcohol support needs of non-UK nationals that were rough sleeping: final report

IFF Research on behalf of the Greater London Authority

April 2025

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Executive summary

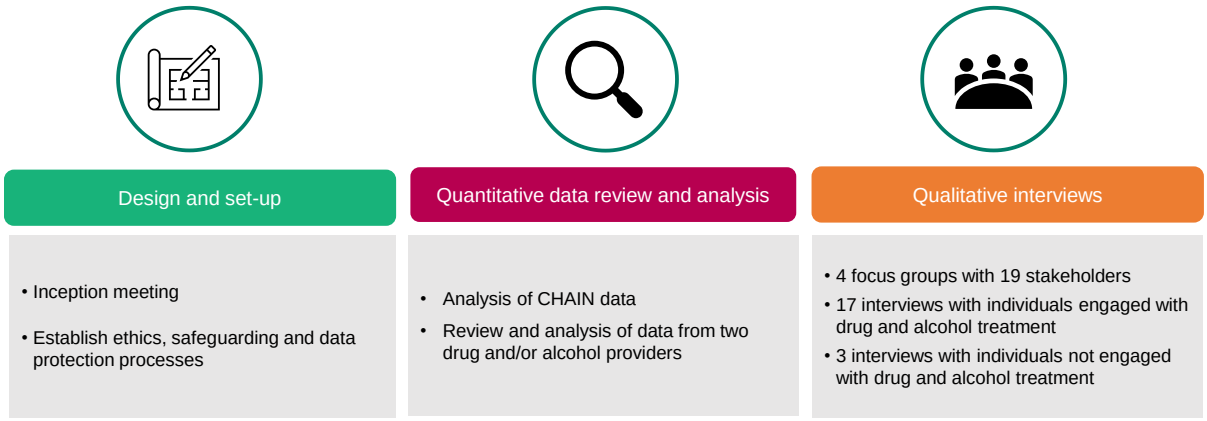
About this research

The Greater London Authority (GLA) commissioned IFF Research, in January 2025, to explore the drug and alcohol support needs of non-UK nationals who have experience of rough sleeping across London. The research aimed to:

- Improve understanding of the number of non-UK nationals who are rough sleeping and also have a drug and alcohol need;
- Identify barriers and facilitators to accessing services; and
- Collate good practice and examples of what tailored, culturally informed support looks like.

The research used a mixed-methods approach (as shown in Figure 1.1 below). Four London boroughs were engaged by GLA in the research.

Figure 1.1 Research approach



How many rough sleeping non-UK nationals also have a drug and/or alcohol need?

- In 2024, nearly half of those recorded on Combined Homelessness and Information Network (CHAIN) as rough sleeping in London were non-UK nationals (48%).
- Amongst all rough sleeping UK nationals, half (50%) were found to have a drug and/or alcohol support need, compared to just under a third (31%) of non-UK nationals that were rough sleeping.
- In total, 1,820 non-UK nationals rough sleeping in London in 2024 were recorded as having an alcohol and/or drug need.
- Over half (52%) of rough sleeping non-UK nationals with a support need had a support need for alcohol only, compared to under a third (29%) having a support

need for drugs only. One in five (19%) had a support need for both drugs and alcohol.

- Across the ten most prevalent non-UK nationalities, there were considerable differences in the proportions assessed as having a drug and/or alcohol support need. Irish individuals rough sleeping were the most likely to have been assessed as having a drug and/or alcohol support need, at around two thirds (65%) of those assessed. Indian (60%) and Polish (59%) individuals rough sleeping were also more likely to be assessed as having a drug and/or alcohol support need.

What are the main barriers to engaging with drug and/or alcohol support?

- **Having limited understanding of English**, which impacted people's ability and willingness to engage with support at each stage of the journey. Service users and stakeholders agreed that it was key that support was delivered in their native language.
- **Lack of awareness of drug and alcohol support services**. Several service users also expressed uncertainty about what accessing support services would actually involve, which had dissuaded them from seeking support at an earlier point.
- **Service users feeling that they have been let down by support services in the past**. This in turn created a sense of distrust towards people in positions of authority, a feeling that was particularly prevalent among specific groups such as sex workers.
- **Barriers relating to having restricted eligibility due to their immigration status**. This included lengthly delays to immigration applications meaning people were waiting and in 'limbo'; concerns about sharing personal data; and concerns around the impact of immigration status (and particularly having No Recourse to Public Funds[1]) on eligibility for free support and treatment options.
- **Speed and timing of support once someone has decided to engage**. Quick access to support was seen as crucial, particularly given the risk that they might move on from the area, or that the nature of addiction means they may change their mind quickly.

What is working well to support engagement with services?

- **Strong relationships with support staff**. This included the effectiveness of outreach teams, and importance of key attributes and ways of working amongst staff delivering support (e.g. being non-judgemental, showing and genuine interest, and being accountable and reliable). Stakeholders and service users also shared positive views about the role of peer support workers.

[1] The "no recourse to public funds" condition is imposed on grants of limited leave to enter or remain with the effect of prohibiting the person holding that leave from accessing certain defined public funds, set out at paragraph 6 of the immigration rules. Further information about this can be found here: Who has no recourse to public funds (NRPF) | NRPF Network

- **Offer of non-treatment-related activities**, such as social clubs and free meals. These groups offer an initial incentive for individuals to connect with services, even if they are not actively considering treatment at that time.
- **Multi-disciplinary working** was important to discuss individual's needs and put in place holistic support plans.
- **The opening times and format of support** was also important to enabling service users to engage. Good practice examples included opening on a weekend and offering walk-in options to increase flexibility and availability.

2 Introduction

The Greater London Authority (GLA) commissioned IFF Research, in January 2025, to explore the drug and alcohol support needs of non-UK nationals who have experience of rough sleeping across London.

IFF Research would like to express our appreciation to staff across the four London boroughs who contributed to this research and in particular CGL, Turning Point and St Mungo's for their support in arranging the qualitative fieldwork. We are also especially grateful to the rough sleeping, non-UK nationals who took part in this research and generously shared their valuable experiences with us.

Background and context

The Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) 2022-2025 supports 23 London boroughs and 5 pan-London projects to provide evidence-based drug and alcohol treatment and wraparound support for people sleeping rough or at risk of sleeping rough, including those with co-occurring mental health needs.

Whilst drug and alcohol treatment services have improved in recent years in many areas of London, feedback from the voluntary sector suggests that rough sleeping non-UK nationals who have a drug or alcohol need are less likely to be engaged with treatment services and that there are few services and resources specifically designed for this group. Of those that do engage in support, there is little evidence of the outcomes of treatment they received.

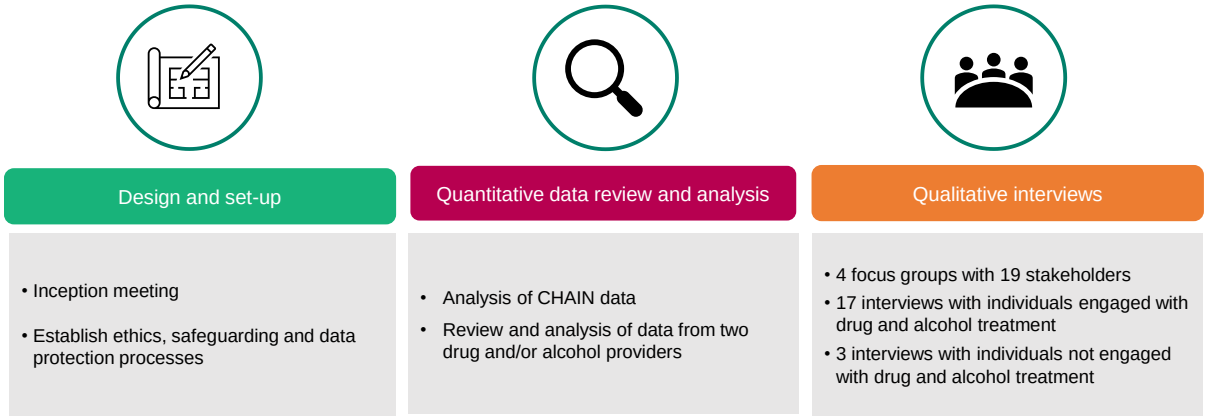
Aims and approach

This research aimed to:

- Improve understanding of the number of non-UK nationals who are rough sleeping and also have a drug and alcohol need**;**
- Identify barriers and facilitators to accessing services**;** and
- Collate good practice and examples of what tailored, culturally informed support looks like.

The research used a mixed-methods approach (as shown in Figure 1.1 below). Four London boroughs were engaged by GLA in the research. See Appendix for more detail on the approach.

Figure 2.1 Approach diagram



Quantitative data review and analysis

The quantitative strand of the research involved two separate pieces of analysis. The first part was analysis of CHAIN (Combined Homelessness and Information Network) data. CHAIN aims to be the UK's most detailed and comprehensive source of information about rough sleeping in London. The aim of this analysis was to understand the profile of people who were rough sleeping in terms of their nationality and drug and/or alcohol needs and compare UK and non-UK nationals to identify any differences which could inform the design of support. Homeless Link[2] provided IFF with 22 aggregated data tables, including number of individuals rough sleeping by nationality in each borough, demographics of individuals rough sleeping (including age and gender), and drug and/or alcohol support needs. These were produced for each year 2022-2024.

The second part of the quantitative analysis involved working with a support provider delivering drug and/or alcohol services across the four boroughs to access data relating to rough sleeping non-UK nationals. Aggregated data tables were provided and included 24 tables, relating to the demographic information, as well as anonymised, aggregated data for 716 individuals that were rough sleeping, including 272 individuals who had a non-UK country of birth. Data related to the calendar year 2024 only.

[2] The organisation responsible for the management of CHAIN: CHAIN | Homeless Link. It is funded by the GLA.

Qualitative research

The qualitative research focused on four boroughs: Westminster, Southwark, Newham, and Ealing. Table 1.1 below shows the engagement across the four boroughs. We held one focus group in each London borough with key stakeholders who provide support to people who are rough sleeping, non-UK nationals and have a drug and/or alcohol need. In total, 20 participants contributed to the focus groups.

In addition to speaking with stakeholders, 17 people with lived experience of accessing drug and/or alcohol support (known as 'service users' throughout the remainder of this report) were interviewed. Three people who had a drug and/or alcohol need but have not engaged in support also took part in an interview. These individuals are referred to as 'non-service users' in this report. Drug and/or alcohol treatment providers and other support providers in the four boroughs identified individuals for interview, after being briefed on the research objectives and criteria by IFF Research. Interviews took place face-to-face at treatment and/or community centres.

Table 2.1 Qualitative research across the four London boroughs

	No. of stakeholders in focus groups	Interviews with service users	Interviews with non service users
Ealing	4	7	0
Newham	6	1	0
Southwark	6	2	3
Westminster	4	7	0
TOTAL	**20**	**17**	**3**

Research considerations

As the research has involved a relatively small sample (20 stakeholders, 17 service users and 3 non-service users), the findings may not be generalisable to other individuals and/or areas of London. Qualitative evidence is not intended to imply prevalence but rather to illustrate the range of experiences and provide depth of understanding.

When interpreting data from the CHAIN database, it is important to note how individuals are recorded. A record tends to be made for a new individual when they are seen rough sleeping for the first time, usually by outreach workers. Any subsequent sightings or engagement with other service providers should then been entered to update the database, about their location, circumstances, needs etc. It is understood by IFF that the information held on CHAIN is a mixture of details confirmed with the individual by sector workers, and

estimates made during engagement with them. Due to the homeless population being relatively transitory, people that are sleeping rough may have been recorded as rough sleeping in multiple boroughs on CHAIN. This means that, in some of the tables in this report, one person may have been counted more than once. This is indicated in footnotes where relevant.

Regarding the provider data, the data analysed here is from one provider, so any findings may not be representative of other services. IFF Research also intended to use provider data to gain insights into what support outcomes look like, and the goals that are set for individuals upon starting an intervention. However, the provider data on treatment goals was limited.

Definitions of terms used in this report

Individuals rough sleeping on CHAIN are those individuals who are seen by a commissioned outreach worker bedded down on the street, or in other open spaces or locations not designed for habitation, such as doorways, stairwells, parks or derelict buildings at least once in the period between January 2024 and December 2024. . Within the qualitative interviews, a more flexible definition was undertaken to include those who have had some experience of rough sleeping in the past. Nevertheless, all the individuals who provided information on their accommodation situation in the qualitative interviews were either currently rough sleeping or in temporary accommodation. In the provider data, an individual was defined as ‘rough sleeping’ if they self-identified as such when coming into contact with the service. This can later be verified by case workers (e.g., in situations where it is required for onward referral), but is not included as a field in case management data.

The term ‘non-UK national’ has been used in this report to describe those who are not a British citizen.

In the provider data, nationality and immigration status were not recorded, and it was therefore not possible to definitively identify non-UK nationals or any immigration status-based definitions. Therefore, Country of Birth was used to identify those that were rough sleeping and were not born in the UK, as the closest approximation to this. When discussing the provider data, we have referred to these individuals as individuals not born in the UK that were rough sleeping.

Throughout this report, the terms ‘service users’ and ‘non-service users’ have been used to refer to non-UK national individuals with past or current experience of rough sleeping. Additionally, ‘service users’ are those currently receiving drug and/or alcohol support.

3 Profile of need

Prevalence of non-UK nationals rough sleeping

In 2024, nearly half of those recorded on CHAIN as rough sleeping in London were non-UK nationals (48%). Four-in-ten (41%) were UK nationals, and the remaining tenth (11%) were recorded with their nationality as 'not known'. The split between UK and non-UK nationals has not changed notably since 2022 (when non-UK nationals accounted for 46% of individuals rough sleeping), despite the overall number of individuals rough sleeping in London increasing by 34%.

The most common nationality aside from British was Romanian, at over one in twenty (6.5%) of London's rough sleeping population recorded in 2024 (Table 2.1). The number of Romanian nationals has decreased by 18% from 1,027 in 2022 to 843 in 2024. Other common nationalities include Polish (4.5%), Eritrean (4.4%), Sudanese (3.8%) and Indian (3.0%). Afghani, Iranian, Irish, Lithuanian and Nigerian were also amongst the 10 most prevalent non-UK nationalities. There has been a particularly significant increase in the number of Sudanese nationals (432% rise from 92 to 489) followed by Eritrean nationals (151% increase from 230 to 578) since 2022.

Table 2.1: Ten most prevalent non-UK nationalities of individuals rough sleeping, as a proportion of all those rough sleeping in London (2024)

Nationality	Count	% of all
Romanian	843	6.5%
Polish	585	4.5%
Eritrean	578	4.4%
Sudanese	489	3.8%
Indian	395	3.0%
Afghan	256	2.0%
Iranian	185	1.4%
Lithuanian	149	1.1%

Irish (Republic)		
Nigerian	135	1.0%
Total individuals rough sleeping in London	13,031	100%

At borough level in 2024, Newham (66% - 369 individuals) and Ealing (66% - 470 individuals), had the highest proportion of non-UK nationals among the people recorded as rough sleeping there across all London boroughs. This was followed by Haringey (65% - 280 individuals), Redbridge (63% - 183 individuals), Hounslow (59% -178 individuals) and Hillingdon (58% - 258 individuals). That said, Westminster had the highest numbers of non-UK nationals recorded as rough sleeping (1,145, 46% of all people recorded as rough sleeping in that Borough). In contrast, a strong majority of individuals rough sleeping in Bexley (78% - 101 individuals), Sutton (76% - 34 individuals) and Richmond (69% - 61 individuals) were UK nationals. Hammersmith & Fulham (33% - 147 individuals), City of London (29% - 256 individuals) and Westminster (19% - 483 individuals) had the highest proportion of individuals rough sleeping where nationality was not known.[3]

The drug and alcohol support needs of rough sleeping non-UK nationals[4]

Overall, 75% (10,588/14,154) of individuals rough sleeping recorded in London in 2024 were assessed for drug and/or alcohol related support needs.[5] Non-UK nationals were more likely to have been assessed for drug and/or alcohol support needs than people found rough sleeping from the UK (12% of non-UK nationals were not assessed, versus 21% of UK nationals).

Amongst all rough sleeping UK nationals, half (50%) were found to have a drug and/or alcohol support need, compared to just under a third (31%) of non-UK nationals that were rough sleeping. Looking only at those who were assessed, 35% of non-UK nationals had a drug and/or alcohol support need identified compared to 63% of UK nationals.

In total, 1,820 unique non-UK nationals rough sleeping in London in 2024 were recorded across boroughs as having an alcohol and/or drug need. The boroughs where these individuals were most likely to be found largely reflected the boroughs where non-UK

[3] Please note, de-duplicated data at borough level was not available, and therefore this analysis is based on a higher total number of rough sleepers (14,154 records versus 13,031 unique individuals rough sleeping recorded in 2024).
[4] As above, the higher total number of rough sleepers (14,145) used as the total for all those rough sleeping in London in this sub-section.
[5] The Support Needs & Lifestyle form (also commonly referred to as Support Needs Assessment) is used to record client support needs on CHAIN. This includes substance dependency, mental and physical health, immigration situation, and experience of domestic abuse, among other factors.

nationals were also most prevalent, with around one in ten recorded in Ealing (12%) or Westminster (10%). It was also relatively common for them to have been recorded in Newham (7%) and Haringey (6%). .[6]

Across the ten most prevalent non-UK nationalities, there were considerable differences in the proportions assessed as having a drug and/or alcohol support need, as shown in table 2.2. Irish individuals rough sleeping were the most likely to have been assessed as having a drug and/or alcohol support need, at around two thirds (65%) of those assessed. Indian (60%) and Polish (59%) individuals rough sleeping were also highly likely to have been recorded as having alcohol and/or drug support needs, at around six in ten of all individuals rough sleeping from these countries.

In contrast, Sudanese nationals were the least likely to be recorded as having a drug and/or alcohol support need, at fewer than one in ten (8%) of those assessed. Eritrean (9%) and Afghan (10%) nationals were also unlikely to be assessed as having a drug and/or alcohol support need.

Table 2.2: Top 10 non-UK nationalities assessed as having an alcohol and/or drug support need

	Substance support need		
	Count	% of all those with a support need	% of all individuals (assessed and not assessed) of this nationality with support need
Poland	348	8.0%	59%
India	236	5.4%	60%
Romania	205	4.7%	24%
Ireland (Republic of)	95	2.2%	65%
Lithuania	76	1.7%	51%
Portugal	62	1.4%	48%
Italy	54	1.2%	45%
Eritrea	53	1.2%	9%
Bulgaria	48	1.1%	44%
Sudan	39	0.9%	8%
Sum of top ten combined	1,216	28%	34%

[6] De-duplicated data was not available at borough level, and so the percentages quoted here are based on 2,051 rough sleepers being assessed as having a drug and/or alcohol need in 2024 (with some individuals being recorded in multiple boroughs).

Total individuals rough sleeping in London who have been assessed to have a drug and/or alcohol support need (de duplicated)	4,363	100%	33%

Feedback from the focus groups with support providers largely confirms this picture. Stakeholders confirmed that Eastern European nationalities (particularly Polish) were most prevalent among non-UK nationals that were rough sleeping with drug and alcohol support needs. Additionally, several stakeholders in Ealing highlighted the prevalence of South Asian groups, including individuals from India. Other regions of origin mentioned include South America and West Africa, both of which were highlighted in Southwark. This was broadly reflected in the in-depth interviews conducted with service users and non-service users (though this was not intended to be representative). Likewise, this profile of nationalities was similar in the data shared by a support provider, with Eastern European nationalities alongside Indian being listed as the most common.

In terms of other characteristics, CHAIN data indicates that the vast majority of those non-UK nationals with a support need were men (94%), and they were mainly spread across the 26-35 (24%), 36-45 (35%), and 46-55 (27%) age groups. Stakeholders also identified men aged between 30 and 60 as a key group. This age profile was reflected in the interviews with non-UK nationals with experience of rough sleeping and a drug or alcohol need, where the most common age group was 35-44, and the vast majority were male.

The CHAIN data indicates that non-UK nationals with a drug and/or alcohol need appeared to be more likely to have been rough sleeping for longer than UK nationals (29% were seen sleeping rough in four separate months or more in 2024, compared to 23% of UK nationals).

The amount of time the engaged individuals we interviewed had been rough sleeping varied noticeably, ranging from three weeks to 25 years. Nevertheless, and in alignment with CHAIN data and feedback from stakeholders, many had been rough sleeping on and off for multiple years. All the engaged individuals who were interviewed had been in the UK for at least three years.

Support service needs

Across the whole London rough sleeping population, needing support only for drugs was most common (40% of those with any drug or alcohol support need), followed by needing support only for alcohol (33%), but still over a quarter of those with a need for support (27%) needed it for both alcohol and drugs.

There were marked differences in the types of support needed by UK and non-UK nationals. Non-UK nationals were far more likely to only need support for alcohol (52% of those with support needs versus 19% of UK nationals), and less likely to only need support for drugs

(29% versus 48% of UK nationals) or for both (19% versus 33% of UK nationals). This was also reflected by the provider data received, where 28% service users born abroad that were rough sleeping needed support for Alcohol, compared to 8% of UK-born service users.

Overall, 45% of all individuals rough sleeping who had a drug and/or alcohol support need in 2024 had high support needs, 32% had medium and 23% low support needs.[7] Those with only alcohol support needs were distributed evenly across the levels of support needed (around a third needed each of high, medium and low support). Whilst those with drug support needs only, and especially those with both alcohol and drug needs, were more likely to have high support needs (48% and 57% respectively) than low (21% and 12% respectively).

Non-UK nationals with high support needs were most likely to be of Polish nationality (22%), followed by Indian (14%), Romanian (9%) and Irish (8%), and the same pattern is seen amongst those with a medium level of need.[8]

Stakeholders highlighted that support service needs were highly complex, and influenced by a number of overlapping factors, such as mental health issues, having no recourse to public funds, and, in some cases, modern slavery and/or sex work.

Stakeholders highlighted the prevalence of mental health issues, emphasising the common presence of trauma resulting from experiencing extreme situations, including in their country of origin. Indeed, in interviews, individuals often spoke about the influence of traumatic life events, e.g. bereavement, illness, relationship breakdown.

Additionally, drugs or alcohol were frequently relied on to deal with the trauma of sleeping rough itself. Both service users and non-service users also described using alcohol and/or drugs to cope with daily survival.

"I just hang around. I waste my time. When we have a drink, we don't feel the cold."

Service user – South Asian

Engagement with drug and alcohol support

Individuals who have a bedded down contact on CHAIN and are recorded as having a drug and/or alcohol support need may include people who are currently accessing treatment (e.g., those with a low need include those who are proactively accessing recovery services). However, CHAIN data does not include whether individuals are engaging in drug and alcohol treatment or not and so it's not possible to analyse the proportion of non-UK

[7] According to the CHAIN user guidance, drug and/or alcohol support needs are classified as follows:

- Low need: Low risk to the individual's mental and physical health (e.g., they are actively working to reduce use, engaged in support services)
- Medium need: Moderate risk to the individual's mental and physical health (e.g., regular or problematic use, demonstrable impact on their health and self-care)
- High need: Serious risk to the individual's mental and physical health (e.g., not accessing support, at risk of overdose)

[8] Nationality-level data on level of need contains duplicate observations

nationals that are seen rough sleeping and whether they are engaged in treatment, a key gap in the data.

Provider data showed that just under three fifths (58%) of all non-UK born service users who were rough sleeping were self-referred into support. After this, the most common referral sources were via the criminal justice system (14%), health and social care services (12%), or from outreach (10%). This is reflected in the findings from the qualitative research, as self-referral and referrals from outreach teams were frequently mentioned as the common referral sources for non-UK nationals that were rough sleeping.

Table 2.3 Referral source for support for those rough sleeping

	Non UK national		UK national	
	Count	% of those	Count	% of those
Self	**159**	58%	**245**	55%
Summary: Criminal Justice System[9]	**37**	14%	**122**	27%
Summary: Health and Social Care[10]	**33**	12%	**41**	9%
Outreach	**28**	10%	**16**	4%
Housing/homelessness service	**5**	2%	**10**	2%
Peer led initiatives	**1**	0%	**0**	0%
Relative/peer/ concerned other	**1**	0%	**0**	0%
Children and family services	**0**	0%	**1**	0%
Other	**8**	3%	**9**	2%
Base	**272**	-	**444**	-

Amongst service users engaged in the research, they had experience of accessing a range of support options. This included taking alcohol and/or drug-related information and advice and engaging with formal support options including structured interventions.

Participation in peer support groups was common. One-to-one meetings with support workers, usually on a weekly basis, were also very common. Many individuals also

[9] A summary code made up of: Arrest referral, ATR, DRR, Prison and Probation Services
[10] A summary code made up of: Adult mental health services, Adult social care services, Adult treatment provider, GP, Hospital, Hospital alcohol care team/liaison nurse and Liaison and Diversion

mentioned receiving health support, such as staff serving as a point of contact for doctors and in some cases attending GP appointments alongside service users. Many individuals received prescribing-based interventions for drug use. Additionally, a couple of individuals were on waiting lists for detox.

This is supported by the provider data, which stated that the vast majority (99%) of those non-UK individuals rough sleeping were placed on a psychosocial intervention, which focuses on addressing the behavioural, emotional and social factors that may be influencing the individual. These interventions could include support like counselling, psychotherapy, group therapy or peer support groups. The other most common interventions were classed as recovery support (83%)[11], and a pharmacological intervention (50%)[12]. Approaching three in five (57%) interventions were classed as engagement via the RSDATG (Rough Sleeping Drug and Alcohol Treatment Grant).

Table 2.4 Intervention Type for those that were rough sleeping

	Non UK national		UK national	
	Count	% of those	Count	% of those
Psychosocial intervention	**269**	99%	**427**	96%
Recovery support	**227**	83%	**354**	80%
RSDATG Engagement	**155**	57%	**186**	42%
Pharmacological intervention	**135**	50%	**292**	66%
Housing Support Grant Casework	**12**	4%	**24**	5%
IPS (Individual Placement & Support)	**7**	3%	**4**	1%
Housing Support Grant Financial intervention	**0**	0%	**2**	0%
Base	**272**	-	**444**	-

[11] Interventions like this tend to focus on long-term recovery and social reintegration. Examples can include helping individuals into supported accommodation, peer mentoring and lived-experienced programmes, or schemes helping the individual into education or employment.
[12] A pharmacological intervention involves the use of medication to help support individuals that are rough sleeping with their mental and/or physical health.

4 Barriers and enablers to engaging with treatment

Five key facilitators and ten barriers were identified through the qualitative research. Figure 3.1 below shows the key facilitators and barriers at each stage in the support journey. This illustrates the breadth of difficulties individuals face, particularly even to consider seeking support. Few barriers and enablers were unique to being a non-UK national (only immigration status and language), though may be heightened by this fact. Each facilitator and barrier is explored in detail in this section.

Figure 3.1 Barriers and enablers to engaging with drug and/or alcohol support

Barriers to engaging with drug and/or alcohol support

Awareness of support

Findings from interviews with service users and non-service users suggested a general lack of awareness of drug and alcohol support services, beyond Alcoholics Anonymous (AA) and Cocaine Anonymous (CA). Many service users had not accessed any other support for their drug and/or alcohol use prior to being in contact with their current support provider, and had learnt about the service through word of mouth from other people on the street; a few also went to a treatment centre with a friend the first time they visited.

“It helped being with a buddy.”

Service user - Polish

Several service users expressed uncertainty about what accessing support services would actually involve, which had dissuaded them from seeking support at an earlier point. Service users would have welcomed clearer information on key aspects such as the format of the session, expected outcomes, who else attends the sessions, and expectations of them as a participant. Stakeholders also highlighted the importance of how information about support is communicated. One stakeholder suggested that an emphasis on long-term recovery goals can be overwhelming for service users and instead, information should focus on informing service users of possible short-term outcomes to encourage engagement. This could encourage people to engage with the service initially and work towards longer-term outcomes as time goes on.

“The end goal hasn't then got to be wanting to stop using, so I think that can sometimes put people off because they don't want to make that change currently.”

Stakeholder – drug and alcohol support provider

Negative perceptions of support

Several stakeholders said it was common for service users to feel they have been let down by support services in the past. This in turn created a sense of distrust towards people in positions of authority, a feeling that was particularly prevalent among specific groups such as sex workers. This distrust was felt to have prevented people from engaging with services when they first needed support in an effort to avoid further disappointment.

"Where they've had a bad experience with one particular service and it might not be homelessness, it might not even be, you know, drug and alcohol services, but that then taints their image of professionals."

Stakeholder – drug and alcohol support provider

This was confirmed in interviews by several service users, who reflected on negative past experiences which had made them wary of support. This included one person who described a time that a charity told them they would be in touch again to help them, but never returned, while another said they initial did not want to have to retell their story to a

new service and revisit the trauma they had experienced in the process. Some non-service users had similarly negative expectations of support.

"Every time I go to get support, I have to tell my story all over again."

Service user – Lithuanian

"No one will help me to quit alcohol for long term, only short term. I've been drinking now for 50 yrs. There is no way that anyone can stop me from drinking."

Non-service user – Romanian

Immigration status

There were five main barriers to people who have unclear or limited entitlements due to their immigration status deciding to seek drug and/or alcohol support:

- Concerns about sharing personal details and engaging with support services in fear that their information could be passed on to immigration authorities, potentially increasing their risk of deportation. Despite reassurances from staff about confidentiality policies, this remained a significant concern for many service users.

"I think the barriers are that they believe they're going to be sent back home if they engage."

Stakeholder – local council

"I feel paranoid...maybe Home Office looking for me to deport me."

Non-service user - Romanian

- General distrust of the 'system' and people in positions of authority, based on previous negative experiences of immigration applications or support services. Stakeholders also mentioned that rumours tended to circulate amongst service users about what is involved in engaging with support. These can reinforce existing misconceptions, further contributing to the distrust of professionals and putting people off seeking help and accessing services.

"Talk within the Polish community that [support provider] will then deport people and I've went through that miscommunication and…people talking and not being aware of actually what's on offer can then sort of make people not want to access treatment because of that."

Stakeholder – drug and alcohol support provider

- Asylum seekers and refugees frequently move to different areas of the UK, which can result in individuals choosing not to access support or delaying the start until they are more 'settled'.

- Lengthy delays in immigration applications meaning people were waiting and in 'limbo'. Stakeholders also felt that immigration status was often perceived as a top priority for non-UK nationals, and they wanted this resolved before accessing other support.

"Speed up the immigration process so that the people aren't sort of living in limbo for so long. It's a long, convoluted process that people give up on, so they go underground."

Stakeholder – local council

- Immigration status (and particularly having No Recourse to Public Funds[1]) can sometimes mean that the drug and/or alcohol support options that service users can access without paying are limited to those classed as primary care. This means not being able to access inpatient detox or residential rehabilitation. More generally, it was felt by stakeholders there is a lack of clarity about what support would be available for free and what would need to be paid for. Some service users also assumed that they would have to pay for all of the support, which would not be possible. Where they do access support they are not entitled to receive for free, this can result in large bills.

"Someone's status will affect their ability to access benefits and their ability to access treatment. So, their status is not only something that they will worry about, but something that has a very practical implication on their ability to access services."

Stakeholder – drug and alcohol support provider

Eligibility criteria

Beyond immigration status, there are other eligibility criteria attached to some forms of support which were seen to disproportionately impact people who are rough sleeping. For example, stakeholders mentioned it is common for services to require individuals to have resided in a single borough for a minimum of 6 months in order to be eligible for support. Given the transient nature of individuals rough sleeping, stakeholders felt that meeting this requirement often posed a significant issue. That said, this kind of eligibility criteria was not commonly mentioned in interviews, suggesting service users may have either been unaware of these restrictions or had not personally experienced any issues due to this.

[1] The "no recourse to public funds" condition is imposed on grants of limited leave to enter or remain with the effect of prohibiting the person holding that leave from accessing certain defined public funds, set out at paragraph 6 of the immigration rules. Further information about this can be found here: Who has no recourse to public funds (NRPF) | NRPF Network

"If someone's not been within Westminster for a minimum of six months, that also limits what they can actually access which also is a bit sort of disheartening to the client because they actively want support, and we are limited with what we can offer."

Stakeholder – drug and alcohol support provider

Feelings of shame

Some service users said they felt a sense of shame and stigma due to their rough sleeping (e.g. poor hygiene) and this made them less confident about seeking support.

"I was worried about stinking."

Service user – South Asian

There were also some specific cultural barriers associated with some non-UK nationals that added to feelings of shame, which differed depending on home country or religion. Examples of this included:

- **Eastern Europeans:** alcohol was described as a key part of cultural life and therefore people did not feel they had a 'drinking problem'. It was also felt that it was a 'taboo', and particularly amongst Eastern European men, to admit you needed help and be seen as not being able to 'control yourself'.

- **Muslims:** as alcohol is prohibited within the Quran, those practicing Islam can be concerned about the cultural repercussions, such as bringing shame on family members or friends through admitting alcohol dependency or even being seen at a support centre. This impacted service users' decisions to start receiving support, but also continue engagement.

"It is a taboo in Poland and my friends would mock me for a lack of self-control if I admitted I had a problem."

Service users – Polish

"For those of Muslim faith, alcohol predominantly isn't permitted. Therefore, if people are seen going into a drug and alcohol service, it can create a barrier because it comes with cultural repercussions, potentially shame from family members or friends."

Stakeholder – local council

Language

One of the main barriers to non-UK nationals engaging with drug and/or alcohol support was having limited understanding of English, which impacted people's ability and willingness to engage with support at each stage of the recovery journey.

In terms of deciding to seek support, service users said they were concerned about whether or not they would be able to speak their own language on arrival to the service and therefore

communicate their needs easily. Seeing promotional materials (e.g. leaflets and posters) in English only was also felt to heighten this concern. Stakeholders agreed that having reception staff who speak a range of languages worked well to engage non-UK nationals.

"Do the people only speak English on the reception? I wouldn't know what to do then and would probably leave."

Service user – Polish

Service users were also initially concerned that support itself would be offered in English only. One non-service user gave an example of being given a drinking diary that was written in English and, even though a support worker offered to translate the diary for him, he lost motivation to engage with this particular activity. This reinforced his language concern and discouraged him from finding out more about what support was available.

Although some service users do have a functioning level of English, several felt that knowing they could receive support in their own language was a key factor in them choosing to access support. Without this they may not have felt confident enough to communicate deeper feelings which is essential for treatment.

"How am I going to share my feelings with you if I can't speak the language easily?"

Service user – South Asian

Once accessing support, service users and stakeholders agreed that it was key that support was delivered in their native language. Ideally, this would be through support staff being able to speak the language required, as this supported the building of strong relationships. In Ealing, stakeholders noted examples of utilising the skills of Polish and Punjabi staff to deliver support, and the treatment provider runs weekly group support sessions for people who speak each of these languages.

"When we hire workers who specifically have language skills for the cohorts that we're looking at, that can be really helpful."

Stakeholder – drug and alcohol support provider

Where services did not have support staff who spoke a particular language, the need to use interpreters (often on the phone or online) was a barrier to engagement. One key challenge was not being able to match interpreters to the specific needs or preferences of service users, such as requests for gender matched interpreters (where someone may feel embarrassed or uncomfortable discussing their experiences with a person of the opposite gender). However, stakeholders said it can be difficult to accommodate these preferences due to limited access to interpreters.

"The obstacle was the gender of the interpreter…whereas a male Romanian would ideally prefer to deal with someone that is male."

Stakeholder – drug and alcohol support provider

The impersonal nature of interpreters, particularly where they were remote, was also seen as problematic. For example, it can make it uncomfortable to have difficult or sensitive conversations when an interpreter is on the phone and cannot be seen.

"Language...most people don't want to speak with a machine. That's why they prefer live people."

Service user - Polish

Stakeholders also noted that some support sessions (e.g. where an assessment is being done) that can already take a while, can take even longer with interpretation. This has created challenges for service users to maintain concentration and engagement.

"We are limited to using [phone interpretation services] to do very lengthy assessments. It's not very personable and to have to rely on that every time you engage with someone… can also be a bit of a barrier as well."

Stakeholder – drug and alcohol support provider

Slow and/or infrequent access to support

A common issue around accessibility that was raised in interviews with service users was the speed and timing of support once someone has decided to engage. Quick access to support was seen as crucial, particularly given the risk that they might move on from the area, or that the nature of addiction means they may change their mind quickly. However, long waiting lists mean it can be a number of weeks before they get help, increasing the risk they will disengage.

Service users also suggested that support sessions, whether this be one-to-one key working or group sessions, were as infrequent as once a week or even once a month which was insufficient for managing the daily triggers and setbacks that this group experience. Quick and regular contact was crucial to build trusting relationships and support service users to overcome these complex issues.

Location of support services

Service users reported that groups often take place in churches which can be unappealing for those from non-Christian backgrounds. One service user even expressed concern over being met with racism due to support being delivered in a church.

"I'm a Hindu or Sikh and it's going to be a little bit strange. It's a Church!"

Service user – South Asian

Service users also said that support if often held at a variety of different locations and noted that it is not always easy to navigate unfamiliar environments. It can also be difficult to fund travel between the different locations.

Limited tailoring of support

While service users were generally very positive about the support they received, many suggested a need for more tailored support based on specific alcohol and/or drug needs. Currently, many services combine drug and alcohol support and a common improvement suggested by service users was having support that is more directly relevant to their specific substance use. For example, one service user struggling with an opiate addiction described attending a support group and feeling that the content was more directed at those struggling with alcohol addiction, so it did not feel as relevant for him.

Another concern raised by service users was the variation in recovery stages among attendees within support groups. While some service users found it encouraging to see others further along in their journey, others – typically those further into their recovery journey - expressed concerns about the presence of individuals who were continuing to use drugs and/or alcohol while attending the sessions. They felt this negatively impacted their own recovery, as it reminded them of behaviours they were trying to leave behind. For example, one service user noted that some attendees would visit the pub following the session which made it more difficult for people to remain committed to reducing their alcohol consumption.

"If there are some people that are bad for you, you want to separate from them but then you come [to the support group] and they are still there so that's why I stopped going because it's very easy to go back again. If you want to continue being sober you can't be with the same people."

Service user – Lithuanian

To address these challenges, service users suggested it would be beneficial to have greater separation between people at different stages of their journey, emphasising the need to have space away from those who are still actively using substances. This could create a more positive and supportive environment and reduce the risk of relapse.

"To talk with the others who are trying to do exactly the same thing that I'm trying to do is very helpful. To share the stories, because maybe they gonna give me advice on how they stopped, which support they use…Even a normal conversation is very helpful"

Service user - Polish

Lack of support for other issues

Another common theme across the stakeholder and interviews with service and non-service users was that engaging with support for their drug and/or alcohol problems was not generally perceived as a priority. Rough sleeping non-UK nationals are often navigating complex challenges, including housing instability and concerns over their immigration status which often took precedence over starting their support journey.

"It's just incredibly difficult to manage and stay engaged with services when you're rough sleeping because you have so much other stuff going on at that time."

Stakeholder – drug and alcohol support provider

"Their biggest concern is not, 'I need to stop drinking so much,' it's, 'I need to know what I'm going to eat today. I need to know where I'm going to sleep tonight."

Stakeholder - drug and alcohol support provider

More broadly, stakeholders commented that some service users may be experiencing a sense of hopelessness and lack of purpose which reduces their motivation to explore services that could help them. They may feel they have been 'abandoned by society' or that they are not deserving of help.

"They just feel like they're lost, in a way, and I think that's a barrier for them to keep going."

Stakeholder – local council

Enablers of engagement with drug and/or alcohol support

Relationships with support staff

One of the key facilitators in services users accessing and continuing to engage with drug and/or alcohol support was a strong relationship with support staff.

Firstly, outreach teams were seen as an effective way of engaging rough sleeping non-UK nationals. Being engaged by an outreach team was the second most common referral route according to the qualitative research. The effectiveness of outreach teams was felt to be closely linked to their ability to reach and quickly build a rapport with those who were not actively seeking support. This then opened up the possibility for conversations about accessing support further down the line. Outreach teams also assisted individuals with navigating the process of accessing support, for example through a "handholding" service for taking individuals to support hubs.

Once engaged in support, key attributes and ways of working amongst staff delivering support that encouraged strong relationships included:

- Being non-judgemental;
- Listening and making people feel like they have been heard;
- Showing a genuine interest in people's lives, including beyond their drug and/or alcohol needs;
- Being accountable and reliable, taking action when they said they would;
- Taking a proactive approach to engagement, for example going on outreach shifts to find people who had missed an appointment.

“They need to feel that you care and also that you do what you say you are going to do, when you say you will do it. Basically, don’t let people down.”

Stakeholder – drug and alcohol support provider

“Knowing [the support worker] cared made me not want to mess up – I couldn’t let them down.”

Service user – Polish

Stakeholders and service users shared positive views about the role of peer support workers or mentors who were involved in running peer support groups. Service users were positive about this type of support, as the peer mentors’ lived experience meant they felt able to relate to them easily. Seeing the success of the peer support worker also gave service users more confidence in the ability of the service to help, contributing to their decision to access support for themselves. The peer support worker also spoke the same language as many of the people in this lived experience group which helped service users to feel more comfortable and confident to access support.

"The most important thing is [I] can write to [the peer support worker] even at night and [he] can support [me]"

Service user - Polish

"It's not like a peer mentor, [he's] just like a friend...we've known each other so long"

Service user - Polish

A safe, social environment

A key factor that encourages individuals to engage with services is the non-treatment-related activities that services often provide, such as social clubs and free meals. These groups offer an initial incentive for individuals to connect with services and people with similar experiences, even if they are not actively considering treatment at that time. Additionally, these spaces provided a safe and supportive environment as well as an opportunity to build a social network. Many service users had heard about drug and/or alcohol support services via word of mouth and often attended support the first time with a friend, highlighting the importance of building these networks.

"[I] know that the people in the group are same like [me] with the same problems...but it's a sweet escape.”

Service user - Polish

For example, one peer mentor was supported by Barka – a charity dedicated to assisting homeless central and eastern European migrants in the UK – to set up a group for Polish service users. Beyond discussing alcohol and drug needs, this group has created a sense of

belonging and community, for example via sharing Polish food bought using a grant from the Big Ideas Fund. Stakeholders were very positive about the impact its holistic approach as had so far.

"[Barka is] creative…looking for different solutions… that has been such a winner for us that I hope there's a way to invest in that. Yeah, because what they are offering is a holistic solution, not only access to treatment, detox, but rehab and communities and work and new skills. The whole thing and belonging and connection and meaning."

Stakeholder – local council

Flexible opening and appointment times, covering the whole week

The opening times and format of support was also important to enabling service users to engage. Examples were provided of services that worked well to support rough sleeping, non-UK nationals:

- Build on Belief (BOB) specialise in offering weekend services for people who are experiencing or recovering from substance dependency. Both stakeholders and service users felt it provided important support through offering safe space to go outside of their regular meetings with their support worker, and also on a weekend when there is less support available.

- Stakeholders also commented on the benefits of services such as Newham Rise, which offers a walk-in assessment appointments with flexible open times. Individuals who are rough sleeping and are struggling with addiction can find it challenging to keep firm appointments so walk-ins could be the only opportunity for engagement. Stakeholders also commented on the benefit this flexibility has for certain groups such as sex workers who may have limited availability at certain times of day.

"For the hardest to engage, Newham Rise is really crucial because it allows them to access service when they're kind of in a good place...before they start to feel sick [from withdrawal]"

Stakeholder – drug and alcohol support provider

"There's early outreach to meet people or spot people earlier on in the day. And weekend services...Build on Belief service to...get people in those more unsociable hours"

Stakeholder – drug and alcohol support provider

Delivering support face-to-face

Both service users and stakeholders acknowledged that support can be delivered in a variety of formats, but face-to-face meetings were the most common and preferred method among service users. This was felt to be better for rapport building. Service users also valued the warm, welcoming atmosphere of these spaces which often include the offer of

free food and a comfortable environment to spend time in. It also provides them with a physical space away from alcohol or drugs.

"If I'm here, I'm not drinking. It feels like home!"

Service user - Polish

Multi-agency working

Given the varied and complex needs of individuals, stakeholders felt that working together with other professionals in the sector was especially important. This included using professionals already known to service users to introduce additional support offers, and working together to ensure holistic support is provided that covers multiple areas of need. For example, in Newham, the outreach workers from the Rough Sleeping Team provided a handholding service to support service users into treatment services for their initial assessment.

In addition, multi-disciplinary team meetings were used to discuss individual's needs and put in place holistic support plans. This included access to employment or training, housing and accommodation support, and additional health support (e.g. dentist and GP).

"The forums that have been arranged by [Council] [have] been really helpful in terms of making sure that we do collaborate, and all teams know what each other is doing. But also, there's the opportunity for us to discuss complex clients to try and support them as a multi-agency approach which I think is a great example of best practice."

Stakeholder – drug and alcohol support provider

Conversely, limited support for other needs beyond drugs and/or alcohol, especially mental health issues, impacted on the ability of drug and/or alcohol providers to secure engagement and positive outcomes from service users. This was often because mental health support was needed before service users could effectively engage with drug and/or alcohol support. Stakeholders shared some examples of good practice where services are attempting to link up providers and supply a 'one-stop-shop' where service users can access multiple services in one place, reducing the need to travel to multiple locations. An example of this is the Change Please bus in Newham, where individuals rough sleeping can access GP services, dental care, hairdressing and advice among a variety of other services.

"Non-UK nationals access services aboard that bus so they can get things like hairdressing, dental..."

Stakeholder – drug and alcohol support provider

5 Support outcomes

Stakeholders emphasised the difficulty of achieving positive outcomes for non-UK nationals who are rough sleeping and are drug and/or alcohol dependent. In their view, a successful outcome might consist of taking first steps of engaging in support, or of taking harm reduction advice, with a goal of improving health or maintaining general survival.

"Every intervention is a success for this cohort because they are so hard to reach and so hard to engage."

Stakeholder – drug and alcohol support provider

Over three fifths (63%) of rough sleeping non-UK nationals had their discharge reason reported as "incomplete" treatment, most commonly because of individuals dropping out (58%). This was higher than UK nationals, of who 52% were listed as incomplete due to dropping out. Only one in ten (10%) rough sleeping non-UK nationals were reported as being discharged because of their treatment being completed, which included being drug or alcohol free, or being only an occasional user (excluding heroin or crack cocaine). Beyond completing treatment, positive outcomes discussed in the qualitative research typically related to:

- Improved health, e.g. reduced damage to their liver from misuse of alcohol;
- Reduced contact with health care services, e.g. fewer hospital admissions;
- Reduced usage of or complete abstinence from drugs and/or alcohol;
- Feeling a renewed sense of hope and/or optimism about the future;
- Supporting the repairing of relationships, e.g. with friends and family members;
- Greater understanding about the availability of support services, including potentially accessing support to address other needs, for example housing, employment, training, immigration;
- Supporting repatriation to an individual's country of origin, where this was the expressed preference of service users. This involved helping to re-engage individuals with their family members, alongside working with them to detox.

The remaining non-UK nationals were recorded as being transferred on to another organisation (27%), including being taken into custody (15%), which was significantly lower than those born in the UK (29%).

Table 5.1 Discharge reason for those that were rough sleeping, excluding those who were still in treatment

	Non UK national		UK national	
	Count	%	Count	%
Incomplete client died	**5**	3%	**2**	1%
Incomplete dropped out	**90**	58%	**145**	52%
Incomplete onward referral offered and refused	**0**	0%	**1**	0%
Incomplete retained in custody	**0**	0%	**4**	1%
Incomplete treatment commencement declined by client	**1**	1%	**2**	1%
Incomplete treatment withdrawn by provider	**2**	1%	**1**	0%
Transferred in custody	**23**	15%	**82**	29%
Transferred not in custody	**19**	12%	**27**	10%
Treatment completed Alcohol free	**7**	5%	**7**	3%
Treatment completed Drug free	**5**	3%	**5**	2%
Treatment completed occasional user (not heroin or crack cocaine)	**3**	2%	**4**	1%
Summary: Incomplete	**98**	63%	**155**	55%
Summary: Transferred on	**42**	27%	**109**	39%
Summary: Treatment Complete	**15**	10%	**16**	6%
BASE	**155**	-	**280**	-

Of those that were not born in the UK and were transferred or referred onto another organisation (including prisons), the vast majority attended the onward referral (79%). This was notably lower than those that were born in the UK, where 88% attended their onward referral.

6 Conclusions and future considerations

The Greater London Authority (GLA) commissioned IFF Research, in January 2025, to explore the drug and alcohol support needs of non-UK nationals who have experience of rough sleeping across London. The conclusions and future considerations are structured around the two objectives of this research, with examples of good practice included where relevant.

Improve understanding of the number of non-UK nationals who are rough sleeping and also have a drug and/or alcohol need

The CHAIN analysis has shown a high prevalence of rough sleeping non-UK nationals, who have a drug and/or alcohol support need, and for alcohol specifically, this need is more prevalent when compared to the UK rough sleeping population.. The numbers of rough sleeping non-UK nationals recorded on CHAIN as having an alcohol and/or drug need has also increased since 2022, reaching 1,820 in 2024. This indicates the ever-increasing importance of providing support for this group.

It is a positive sign that most of those rough sleeping non-UK nationals identified in the CHAIN data have been assessed for a drug and/or alcohol support need. This is an important first stage, not only in recording the scale of need, but also in identifying individuals to share support information with.

There are a number of findings from the CHAIN analysis that could be considered when commissioning future support for rough sleeping non-UK nationals. Firstly, cultural factors seem to play a key role in drug and/or alcohol support needs. There were substantial differences in the CHAIN analysis across non-UK nationalities in proportions assessed as having a drug and/or alcohol support need. Stakeholders also confirmed this and highlighted particular groups where support could be usefully focussed. For example, Eastern European nationalities (particularly Polish) were particularly prevalent among non-UK nationals that were rough sleeping with drug and alcohol support needs.

Secondly, rough sleeping non-UK nationals were far more likely to only need support for alcohol and less likely to only need support for drugs, compared with rough sleeping UK nationals. The qualitative research also showed that service users would welcome more tailored support based on specific alcohol and/or drug needs. Currently, many services were felt to be generic across different substance issues and levels of need, meaning support sometimes did not feel directly relevant to service users' needs.

Identify barriers and facilitators to accessing services

There were ten main barriers and five enablers identified to rough sleeping non-UK nationals engaging with drug and/or alcohol support. Most of these continued across services users' engagement with support and were identified at the points of deciding to seek support, accessing support and continuing the engage with support.

The research highlighted three key themes, relating to barriers and facilitators. The first was around awareness and perceptions of support. Typically, service users and non-service users did not have awareness of the range of support services available and relied on word-of-mouth. Many service users also had negative perceptions of support services, having had previously bad experiences.

Future considerations:

- Raise awareness of available support. This should include clear information on what the support would involve, including format, location, timings and accessibility (e.g. language). Information should also focus on informing service users of the range of positive' support outcomes that could be achieved, rather than on those that can be overwhelming (e.g. abstinence). Information available in a range of languages would also support engagement.
- Build on the sharing of information via word of mouth. Service users seemed less reluctant to engage where a peer had recommended the support, as it helped to overcome negative perceptions. Consideration could be given to utilising the role of champions' in the community to share positive messages and experiences of support.
- Continue outreach work, as this was identified as an effective way of engaging rough sleeping non UK nationals. The effectiveness of outreach teams was felt to be closely linked to their ability to reach and quickly build a rapport with those who were not actively seeking support.

The second theme related to eligibility and accessibility. This was in terms of immigration status (and particularly No Recourse to Public Funds), language barriers, and interlinked feelings of shame and cultural factors. This was the theme that related strongly to individuals being from non-UK nationalities. Much of this is beyond the remit of individual services to resolve (e.g. length delays in immigration applications), but there were suggestions to improve engagement.

Future considerations:

- Ensure all information and early engagement with service users allays any concerns around sharing personal information, and the impact of immigration status on access to treatment. Although information is currently shared about this, service users would welcome clearer information on this (and in their own language).
- Providing information to address specific cultural barriers; for example, Eastern European men feeling alcohol misuse was a taboo and not wanting to admit to needing help to control themselves'. Examples of culturally informed good practice that worked well to address this included:
    - Having support or peer workers with similar lived experience. This helped service users to feel better able to build strong relationships and receive support from them.

    - Providing social environments, where the focus was not on drug and/or alcohol support. This supported service users to become familiar with support staff and receive support for other issues (which they likely consider a priority), before feeling comfortable to begin addressing their drug and/or alcohol need.
- Having support staff who speak the same language as service users will always be the preference and ideal approach. Where this is not possible, service providers reviewing approaches to interpretation would be beneficial, as this was frequently highlighted by stakeholders and service users as a challenge. Consideration should be given to how gender matching and face to face interpretation could be more commonplace.

The final theme was around the support provided. This included the format, location, and tailoring of support to individuals' specific needs. Many services users were positive about the support received and in particular the attributes and ways of working amongst support staff.

Future considerations:

- Where possible, consider providing the location of support services in culturally and religiously neutral places. Rough sleeping non UK nationals felt that support locations, e.g. in churches, could discourage them from engaging and sustaining engagement in support.
- Examples of good practice in the format of support included:
    - Offering support at the weekends. This was particularly welcomed, as often other public buildings (e.g. libraries) are closed or have shorter opening times.
    - Having flexible support options, e.g. walk in appointments, was welcomed and supported those who are not able to keep to fixed timings to engage in support.
- Consider having greater separation between people at different stages of their journey, to create distance from those who are still actively using drugs and/or alcohol. This could include different groups (or sub groups) for those at different stages of their support journey. Service users felt that this could create a more positive and supportive environment and reduce the risk of relapse.

Opportunities for improving data on non-UK nationals who are rough sleeping

Through the combination of CHAIN data and provider data, we can begin to analyse the support journey for non-UK nationals that are rough sleeping in a quantitative manner. This is beneficial because comprehensive datasets allow for more thorough understanding of issues that can help inform potential solutions. However, at present, there are still some key limitations with how this data can be used:

- **Definition of 'non-UK nationals':** CHAIN records nationality and immigration status, whereas the provider data analysed in this report does not, and instead only records Country of Birth. While we know from qualitative interviews that concerns around immigration status was a barrier to engaging in support, it is currently not possible to use provider data to analyse engagement according to immigration status. That said, service user fear of repercussions due to immigration status may mean support providers are not well-placed to include this in their data collection.

Engagement in treatment: Individuals recorded on CHAIN as having a drug and/or alcohol support need may include people who are currently accessing treatment (e.g., those with a low need include those who a proactively accessing recovery services). However, the data does not include whether individuals are engaging in drug and alcohol treatment or not and so it's not possible to analyse the proportion of non-UK nationals that are seen rough sleeping and whether they are engaged in treatment.Each of these limitations could be mitigated to some extent through linking provider data with CHAIN to provide a more complete picture of people who are seen bedded down on the streets by outreach teams and their engagement with drug and alcohol treatment services.

The volume and type of data available from providers is relatively comprehensive, and is also likely to be well-aligned across different providers as they are required to report their data monthly to the National Drug Treatment Monitoring System (NDTMS).[2] Given this data set is already well-established, it may be most beneficial to explore options of linking NDTMS and CHAIN data. .

In addition, there may be opportunity to improve or enhance the data recorded by providers, most notably improving the recording of treatment outcomes to improve the ability to measure the effectiveness of services (for example, measuring a broader range of positive outcomes). Support providers could also consider where additional data fields may support them to respond to the barriers to engagement identified in this report (e.g., recording preferred language, separate from nationality).

[2] Further information on the type of information recorded in NDTMS can be found here: DAPB0107: National Drug and Alcohol Treatment Monitoring System - NHS England Digital.

Appendix

About CHAIN

The CHAIN (Combined Homelessness and Information Network) database is used by multiple agencies to record information about people sleeping rough across London, and about others in the wider street population. It is managed by Homeless Link, and is funded by the GLA.

CHAIN aims to be the UK's most detailed and comprehensive source of information about rough sleeping in London. The system allows users to share information about work done with people sleeping rough and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated.

It is updated by services who work directly with individuals rough sleeping, including outreach teams and hostel staff. It does not include information about the 'hidden homeless', that is people who may be squatting, sofa surfing or else otherwise inaccessible to outreach workers.

A variety of data points are recorded on CHAIN, including but not limited to:

- Basic identifying and demographic information.
- Information about people's support needs (for example mental health problems or drug and/or alcohol use).
- Information about people's circumstances prior to rough sleeping.
- Contacts made with outreach workers on the street (i.e. instances of people being seen rough sleeping).
- Key outcomes, actions and events (including arrivals at and move on from accommodation).

Data tables from CHAIN are published on a quarterly basis, and annual reports are also produced and made publicly available with aggregated information for each full, calendar year.

How individuals are recorded on CHAIN

A record tends to be made for a new individual when they are seen rough sleeping for the first time, usually by outreach workers. Any subsequent sightings or engagement with other service providers should then been entered to update the database, about their location, circumstances, needs etc. It is understood by IFF that the information held on CHAIN is a mixture of details confirmed with the individual by sector workers, and estimates made during engagement with them.

Reporting conventions

Treatment of duplications

Due to the homeless population being relatively transitory, and the illusionary nature of the borders between London Boroughs, people that are sleeping rough may be recorded as rough sleeping in multiple boroughs on CHAIN. This means that, in some of the tables in this report, one person may have been counted more than once. It is not easy to 'de-dupe' the data so that people are counted only once, since it is difficult to understand which field should be used to do this. For example, if we chose to present them in only one Borough, on what basis would that be done: where they were seen most, where they were last seen, where they were referred for a particular service, etc.

Additionally, it is perhaps useful to see the demand on resource, represented by individuals presenting across multiple Boroughs.

Reliability of data

The reliability of the data relies on the consistent and timely recording by frontline service providers in each Borough. The CHAIN data show that some Boroughs are more consistent in their recording than others: Westminster, for example, was less likely to ask or estimate an individual's nationality than other Boroughs. This creates a higher proportion than is probably desirable in the 'Nationality Not Known' category, and has the potential to reduce meaningful analysis of the other categories.

Weighting

It has not been possible, and is not desirable, to weight the data used in this report. Due to this, and the issues outlined above, the findings should therefore be taken as indicative and not as conclusive evidence about the non-UK national rough sleeping population in London.

Definitions of terms used in the CHAIN analysis

Individuals rough sleeping and 'length of rough sleeping'

Individuals rough sleeping on CHAIN are those individuals who are seen by a commissioned outreach worker bedded down on the street, or in other open spaces or locations not designed for habitation, such as doorways, stairwells, parks or derelict buildings at least once in the period between January 2024 and December 2024.

IFF were advised to use a metric that records the number of separate months someone was seen rough sleeping in the preceding 12 as the most reliable metric of longer term rough sleeping. This means, for example, that if someone was recorded as rough sleeping in four months, it may not have been four consecutive months but four different months in 2024. Figures have been grouped in the section of this report which discusses this due to low base numbers, and to ensure meaningful analysis, and longer-term rough sleeping is defined as being seen rough sleeping in four separate months or more.

'Non-UK nationals'

The term 'Non-UK nationals' has been used in this report to describe those who are not a British citizen.

To ensure the report focuses on the most meaningful analyses, country-level findings are provided for the 10 most prevalent countries of origin at a London-wide level. Once analysis begins to be undertaken for other countries, the base sizes become too low (risking identification), especially when trying to present these at a Borough-level.

Key data tables in addition to those in the main report are provided below.

Table 1: Rough sleepers by nationality, 2022-2024

This table shows the number of rough sleepers in London per year, split by whether they were UK nationals, non-UK nationals, or whether their nationality was unknown. It also shows the change in the number of rough sleepers between 2022 and 2024.

	2022		2023		2024		Difference 2024 vs 2022	
	Count	% of all	Count	% of all	Count	% of all	Count	% change
UK nationals	4,225	44%	4,711	42%	5,300	41%	+1,075	+25%
Non UK nationals	4,480	46%	5,445	48%	6,258	48%	+1,778	+40%
Nationality unknown	992	10%	1,098	10%	1,473	11%	+481	+48%
TOTAL / BASE: ALL ROUGH SLEEPERS	9,697	100%	11,254	100%	13,031	100%	+3,334	+34%

Table 2: Ten most common nationalities of rough sleepers in 2024, with change compared to 2022 and 2023 (excluding UK nationals)

This table displays the top ten most common non-UK nationalities amongst rough sleepers in London. It shows the number recorded per year, and what proportion of the total number of rough sleepers this represented. It also displays the change between 2022 and 2024.

	2022		2023		2024		Difference 2024 vs 2022	
	Count	% of all	Count	% of all	Count	% of all	Count	% change

Romanian								
Polish	522	5.4%	537	4.8%	585	4.5%	63	+12%
Eritrean	230	2.4%	547	4.9%	578	4.4%	348	+151%
Sudanese	92	0.9%	278	2.5%	489	3.8%	397	+432%
Indian	232	2.4%	362	3.2%	395	3.0%	163	+70%
Afghan	94	1.0%	129	1.1%	256	2.0%	162	+172%
Iranian	83	0.9%	117	1.0%	185	1.4%	102	+123%
Lithuanian	149	1.5%	140	1.2%	149	1.1%	0	0%
Irish (Republic)	117	1.2%	133	1.2%	146	1.1%	29	+25%
Nigerian	79	0.8%	106	0.9%	135	1.0%	56	+71%
TOTAL / BASE: ALL ROUGH SLEEPERS	9,697	100%	11,254	100%	13,031	100%	+3,334	+34%

Table 3: Rough sleepers with drug and/or alcohol support needs by nationality, excluding those without assessment

This table shows the number of rough sleepers in London with drug and/or alcohol support needs, per year, split by whether they were UK or non-UK nationals. It also displays these figures as a percentage of the relevant total, as well as a column showing change between 2022 and 2024. Rough sleepers who had not had their support needs assessed are excluded from these figures.

	2022		2023		2024		Difference 2024 vs 2022	
	Count	% of all	Count	% of all	Count	% of all	Count	% change
UK nationals	2,044	58%	2,220	57%	2,527	58%	+483	+24%
Non UK nationals^	1,432	41%	1,620	42%	1,820	42%	+388	+27%
TOTAL / BASE: ROUGH SLEEPERS WITH	3,497	100%	3,866	100%	4,363	100%	+866	+25%

SUPPORT NEEDS

^ note that these figures include those whose nationality was listed as 'unknown – outside of UK'. In most other tables provided, this category was not split out within those classed as 'unknown', and these individuals will have been excluded from the figures elsewhere.

Table 4: Proportion of all rough sleepers with drug and/or alcohol support needs, 2024, by level of support need

This table shows the number and proportion of rough sleepers with high, medium or low level of support needs, split by whether these needs related to alcohol only, drugs only, or both. A summary column shows the number and proportion for rough sleepers with any of these needs.

	Alcohol (only) need		Drugs (only) need		Alcohol and drugs need		Total (Any type of need)	
	Count	%	Count	%	Count	%	Count	%
High need	466	33%	833	48%	675	57%	1,974	45%
Medium need	489	34%	532	31%	370	31%	1,391	32%
Low need	475	33%	366	21%	149	12%	990	23%
Total (Any level of need)^	1,433	100%	1,736	100%	1,194	100%	4,363	100%

Level of need unknown not shown (accounts for 8 / 0.2% of those with support needs).

Table 5: Level of support needed amongst rough sleepers, 10 most prevalent non-UK nationalities with a drug and/or alcohol support need, 2024

This table displays the top ten most common non-UK nationalities with substance support needs amongst rough sleepers in London in 2024. It splits them by need level, and shows them as a proportion of non-UK national with support needs.

	Non UK nationals with drug and/or alcohol support needs					
	High needs		Medium		Low	
	Count	%	Count	%	Count	%
Poland	160	22%	141	20%	90	15%
India	101	14%	100	14%	59	10%
Romania	70	9%	89	12%	80	14%
Ireland (Republic of)	62	8%	40	6%	16	3%
Lithuania	44	6%	36	5%	9	2%
Portugal	30	4%	23	3%	12	2%
Italy	18	2%	19	3%	27	5%
Eritrea	11	1%	14	2%	37	6%
Bulgaria	29	4%	12	2%	17	3%
Sudan	4	1%	16	2%	24	4%
Top ten combined	529	71%	490	69%	371	63%

Total all non UK nationalities^						

^Individuals reported in multiple boroughs counted multiple times. Percentages are of all non-UK nationals (excluding those with unknown nationality) with drug and/or alcohol support needs with level of support needed in the column header.

Table 6: Proportion of rough sleepers in each London borough with UK or non-UK nationality, 2024

This table shows the number and proportion of rough sleepers in each London borough, by whether they were UK or non-UK nationals, or nationality unknown.

	UK		Non UK		Nationality unknown		Total
	Count	% of borough	Count	% of borough	Count	% of borough	Count
Barking & Dagenham	57	43%	70	53%	6	5%	133
Barnet	82	38%	117	55%	14	7%	213
Bexley	101	78%	26	20%	2	2%	129
Brent	171	32%	271	51%	88	17%	530
Bromley	77	53%	63	43%	5	3%	145
Camden	429	44%	515	53%	33	3%	977
City of London	424	48%	199	23%	256	29%	879
Croydon	211	45%	221	47%	35	7%	467
Ealing	221	31%	470	66%	22	3%	713
Enfield	107	43%	132	54%	7	3%	246
Greenwich	207	53%	133	34%	51	13%	391
Hackney	145	50%	105	36%	39	13%	289
Hammersmith & Fulham	153	34%	147	33%	147	33%	447
Haringey	126	29%	280	65%	27	6%	433
Harrow	49	48%	42	41%	12	12%	103
Havering	46	64%	19	26%	7	10%	72
Heathrow	137	46%	152	52%	6	2%	295
Hillingdon	174	39%	258	58%	16	4%	448
Hounslow	110	36%	178	59%	14	5%	302
Islington	239	44%	205	38%	98	18%	542
Kensington & Chelsea	114	54%	95	45%	3	1%	212
Kingston upon Thames	58	44%	72	55%	1	1%	131

	UK		Non UK		Nationality unknown		Total
	Count	% of borough	Count	% of borough	Count	% of borough	Count
Lambeth	253	50%	210	41%	44	9%	507
Lewisham	197	58%	129	38%	14	4%	340
Merton	38	45%	41	49%	5	6%	84
Newham	154	28%	369	66%	32	6%	555
Redbridge	102	35%	183	63%	5	2%	290
Richmond	61	69%	25	28%	3	3%	89
Southwark	254	42%	302	50%	48	8%	604
Sutton	34	76%	11	24%	0	0%	45
Tower Hamlets	248	46%	228	43%	59	11%	535
Waltham Forest	99	44%	111	50%	14	6%	224
Wandsworth	75	42%	92	51%	12	7%	179
Westminster	882	35%	1,145	46%	483	19%	2,510
Bus route	32	36%	56	62%	2	2%	90
Tube line	3	60%	1	20%	1	20%	5
TOTAL: SUM OF ROUGH SLEEPERS RECORDED IN EACH BOROUGH	**5,870**	**41%**	**6,673**	**47%**	**1,611**	**11%**	**14,154**

Table 7: Distribution of rough sleepers with drug and/or alcohol support needs 2024, by borough

This table shows the number and proportion of rough sleepers in each London borough with drug and/or alcohol support needs, by whether they were UK or non-UK nationals.

	UK		Non UK		Total	
	Count	% of all	Count	% of all	Count	% of all
Barking & Dagenham	32	1%	28	1%	60	1%
Barnet	26	1%	27	1%	53	1%
Bexley	67	2%	8	0%	75	2%
Brent	90	3%	97	5%	187	4%
Bromley	35	1%	10	0%	45	1%
Camden	211	7%	114	6%	327	7%
City of London	173	6%	66	3%	242	5%

	UK		Non UK		Total	
	Count	% of all	Count	% of all	Count	% of all
Croydon	116	4%	64	3%	181	4%
Ealing	142	5%	239	12%	383	8%
Enfield	47	2%	28	1%	75	2%
Greenwich	116	4%	47	2%	164	3%
Hackney	70	2%	40	2%	111	2%
Hammersmith & Fulham	69	2%	31	2%	102	2%
Haringey	64	2%	125	6%	191	4%
Harrow	15	1%	7	0%	22	0%
Havering	17	1%	6	0%	23	0%
Heathrow	35	1%	31	2%	67	1%
Hillingdon	87	3%	71	3%	158	3%
Hounslow	50	2%	59	3%	109	2%
Islington	124	4%	58	3%	184	4%
Kensington & Chelsea	49	2%	32	2%	81	2%
Kingston upon Thames	35	1%	19	1%	55	1%
Lambeth	125	4%	73	4%	198	4%
Lewisham	106	4%	47	2%	153	3%
Merton	17	1%	13	1%	30	1%
Newham	82	3%	144	7%	226	5%
Redbridge	59	2%	87	4%	146	3%
Richmond	41	1%	10	0%	52	1%
Southwark	139	5%	97	5%	237	5%
Sutton	19	1%	4	0%	23	0%
Tower Hamlets	155	5%	69	3%	224	4%
Waltham Forest	46	2%	38	2%	84	2%
Wandsworth	43	1%	37	2%	83	2%
Westminster	405	14%	215	10%	621	12%
Bus route	10	0%	10	0%	20	0%
Tube line	2	0%	0	0%	2	0%
TOTAL: SUM OF ROUGH SLEEPERS	2919	100%	2051	100%	4994	100%

	UK		Non UK		Total	
	Count	% of all	Count	% of all	Count	% of all
RECORDED IN EACH BOROUGH^						

^Please note, those with nationality unknown are excluded from this table due to low base of 24. Individual rough sleepers may be reported in multiple boroughs, so the total number of rough sleepers shown in tables with data by borough is higher than the total number of rough sleepers in London-wide data (where duplicates have been suppressed in the CHAIN data).

Table 8: Long-term rough sleeping amongst those with alcohol and/or drug support needs by nationality, 2024

This table shows the number of times individuals with alcohol and/or drug support needs were recorded sleeping rough in London in 2024, split by whether they were a UK or non-UK national, or nationality unknown.

Number of separate times seen rough sleeping in 2024	UK		Non UK		Not known		Total	
	Count	%	Count	%	Count		Count	%
Once	1,197	47%	756	42%	13	54%	1,966	45%
Twice	485							
Three times	275							
Between 4 6 times	394							
Between 7 12 times	176							
TOTAL: SUM OF ROUGH SLEEPERS RECORDED IN EACH BOROUGH	2,527							

Table 9: Gender of non-UK national rough sleepers with drug and/or alcohol support needs

This table shows the number and proportion of female and male rough sleepers with support needs, split by whether these needs related to alcohol only, drugs only, or both. A summary column shows the number and proportion for rough sleepers with any of these needs.

	Alcohol (only) support need		Drugs (only) support need		Both alcohol and drugs support need		Total Any support need	
	Count	%	Count	%	Count	%	Count	%

Female								
Male	905	96%	480	91%	318	90%	1,703	94%
Total	942	100%	525	100%	353	100%	1,820	100%

^Non-binary and gender not known data not shown here. Non-binary accounts for 0.3% (6) of all with any drug and/or alcohol support need and not known for 0.1% (1). Note that these figures do not include those whose nationality was recorded as 'not known'.

Table 10: Age of non-UK national rough sleepers' with drug and/or alcohol support needs

This table shows the number and proportion of rough sleepers with support needs by age band, split by whether these needs related to alcohol only, drugs only, or both. A summary column shows the number and proportion for rough sleepers with any of these needs.

	Alcohol (only) support need		Drugs (only) support need		Both alcohol and drugs support need		Total Any support need	
	Count	%	Count	%	Count	%	Count	%
18 25	26	3%	35	7%	22	6%	83	5%
26 35	179	19%	162	31%	92	26%	433	24%
36 45	281	30%	200	38%	153	43%	634	35%
46 55	312	33%	104	20%	69	20%	485	27%
Over 55	144	15%	24	5%	17	5%	185	10%
Total^	942	100%	525	100%	353	100%	1,820	100%

^Note that these figures do not include those whose nationality was recorded as 'not known'.

Provider data

IFF research was able to secure data from one provider, providing services across multiple London boroughs, in the format of data tables. Data covers all rough sleeping service users supported in London in 2024, split by country of origin (UK vs. non-UK). The key findings from this analysis was used in the report.

In the provider data, an individual was defined as 'rough sleeping' if they self-identified as such when coming into contact with the service. This can later be verified by case workers (e.g., in situations where it is required for onward referral), but is not included as a field in case management data.

Qualitative research

Borough selection

The GLA engaged four London boroughs in the research (Westminster, Ealing, Newham and Southwark). When selecting which boroughs to approach to participate in the research,

GLA identified boroughs with higher numbers of rough sleeping non-UK nationals and consideration was given to ensuring a geographic spread They all received the RSDATG.

Interview structure

The focus groups lasted for up to 90 minutes and took place over video calls on Teams.

Individual interviews lasted for up to 45 minutes and took place face-to-face in treatment centres or supporting locations. Interpreters, comprising a mixture of support staff and a remote translation service, were used for some of the interviews.

Interviewed population by strand

Table 6.1 Stakeholder focus groups participation

	No. of focus group participants	Roles
Westminster	4	- Borough rough sleeping commissioner - Housing support advisor - Drug and/or alcohol support provider staff
Ealing	4	- Borough drug and alcohol program manager - Staff at homelessness charities - Staff at drug and/or alcohol support provider
Newham	6	- Drug and/or alcohol support provider staff - Police officer - Member of borough Council - Staff at rough sleeping service
Southwark	6	- Borough rough sleeping coordinator - Borough community wardens - Staff at drug and/or alcohol support provider
TOTAL	20	N/A

Table 6.2 Service user and non-service user interview participation

	Service users	Non service users
Borough		
Westminster	7	0

Ealing		
Newham	1	0
Southwark	2	3
Gender		
Male	16	3
Female	1	0
Another gender	0	0
Age		
18 34	3	0
35 54	13	3
55+	1	0
Nationality		
Europe	11	3
Middle East	1	0
Africa	0	0
Asia	3	0
Americas	0	0
Australasia	0	0
Multiple nationalities	2	0
Substance group		
Opiate	6	0
Non opiate only	1	0

Alcohol only		
Non opiate and alcohol	4	0
TOTAL	17	3

Qualitative data management and analysis

All discussions were recorded with consent, stored on IFF's secure drive in a folder to which only designated team members had access, and written up thematically by the researcher using a bespoke analysis framework.

IFF's qualitative analytical approach is informed by grounded theory and structured by the research questions but builds upwards from the views of participants. It is continuous (during and after fieldwork periods, and between phases) and iterative, moving between the data, research objectives and emerging themes.

The analysis framework was structured by key research questions and data entered into relevant cells including direct quotes and examples. It included columns for the researchers' own interpretation and key conclusions. Data was then coded, looking for patterns by theme within and across interviews.

The analysis process consisted of two key elements. Firstly, recordings of discussions were coded and systematically summarised into an analytical framework organised by issue and theme. Secondly, an interpretative element focussed on identifying patterns within the data and undertaking sub-group analysis. Researcher analysis sessions, led by the director, during which the team came together to discuss and test emerging themes and insights, were conducted after each phase and used to support interpretation of the data.

All evidence sources were analysed in their own right; the analysis process then went on to compare and contrast the findings across evidence sources. During this, the quality of evidence was weighed up. Any inconsistencies between different data sources were explored and explained. Where there were competing findings by evidence source, stronger evidence was considered over evidence with gaps.

“

IFF Research illuminates the world for organisations businesses and individuals helping them to make better-informed decisions.”

Our Values:

1. Being human first:

Whether employer or employee, client or collaborator, we are all humans first and foremost. Recognising this essential humanity is central to how we conduct our business, and how we lead our lives. We respect and accommodate each individual’s way of thinking, working and communicating, mindful of the fact that each has their own story and means of telling it.

2. Impartiality and independence:

IFF is a research-led organisation which believes in letting the evidence do the talking. We don’t undertake projects with a preconception of what “the answer” is, and we don’t hide from the truths that research reveals. We are independent, in the research we conduct, of political flavour or dogma. We are open-minded, imaginative and intellectually rigorous.

3. Making a difference:

At IFF, we want to make a difference to the clients we work with, and we work with clients who share our ambition for positive change. We expect all IFF staff to take personal responsibility for everything they do at work, which should always be the best they can deliver.

IFF Research

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