The Kerslake Commission on Homelessness and Rough Sleeping

Kerslake Commission evidence submission

Homeless Hotel Drug and Alcohol Service (HDAS-London)

1. Thinking about the response to rough sleeping during the pandemic, which measures, policies, practices or joint working do you think worked well and why?	The Pan-London Homeless Hotel Drug and Alcohol Service (HDAS) was commissioned by the Mayor of London and City of London at the end of March 2020, in the context of the “Everyone In” initiative. There was concern that a significant proportion of London’s rough sleeping population would have support needs in relation to substance misuse (SM) and HDAS was commissioned to address this need, helping people and the professionals supporting them to navigate the complex SM treatment landscape in London and support with harm reduction in the hotels. London SM providers collaborated and agreed that the best model would be to provide an operational and strategic overview and a Single Point of Contact (SPOC) model of phone and email support for staff working in the hotels, to help manage SM need and refer residents into local treatment support, operating within existing and updated government and PHE guidance - Early development by HDAS of Pan-London “cross-provider principles”, clinical protocols for substance withdrawal, and a central point of coordination was valued by all stakeholders. - The combination of readily available recovery workers and clinicians, via a dedicated telephone and email system, worked well throughout the reported period. - HDAS was able to provide rapid bespoke virtual training on substance misuse, within the context of the specific needs of the temporarily housed homeless population, to over 40 homeless sector staff during the reporting period. This received excellent feedback. - HDAS supported 75 new referrals into between April and September 2020; Alcohol was the most common substance for treatment referral (57% of all new treatment referrals) and was the main subject of contacts from hotel staff seeking advice and support. - HDAS distributed harm reduction guidance and leaflets to all hotels as well as workbooks for residents to support harm reduction. HDAS distributed naloxone, lockboxes, and Needle Exchange (NX) packs in addition to over 3,000 electronic-cigarette starter kits, over 20,000 electronic-cigarette refill pods, and nicotine replacement products.

2. In contrast, which measures, policies, practices or joint working do you think have not worked well and why?	The lack of early and consistent assessment of substance use need made it difficult to have an overall understanding of need in each hotel and for HDAS to be anything but responsive to specific queries and referrals from hotel staff. Formal screening on entry to the hotel may have allowed for earlier identification, and a better response to substance misuse needs. Prompt sharing of information could have helped inform harm reduction and other interventions offered as well as supporting continuity of care for those ultimately evicted or entering hospital. Often HDAS was informed anecdotally of hotel evictions after the event. HDAS support was almost entirely remote. Whilst face to face in-reach may have been more helpful, HDAS would have had to recruit dedicated staff for this purpose on short contracts across different parts of London with significant resource/contract management implications.
3. Please describe the specific challenges, and opportunities, in the next phase of the Everyone In programme and helping people to move on from hotel accommodation.	Information sharing presented challenges throughout. Despite putting in place arrangements to support move on of residents, HDAS has, to date, not been informed of or involved in supporting any moves into longer-term accommodation. Local treatment services have reported anecdotally that they generally learnt about moves when service users themselves informed them.
4. And finally, what do you think needs to be put in place to embed the good work that developed during the pandemic, or improve upon it?	I enclose by email our 'Lessons Learned' report which highlights our recommendations. Some of which are described here below: 1.Maintain the important principle that people experiencing rough sleeping do not need a local connection to a borough to receive treatment from substance misuse services, given the fact that many have no recourse to public funds and that there is regular movement across borough boundaries to access accommodation. 2. In areas with high numbers of people experiencing rough sleeping, ensure resources are available for specialist support and pathways within treatment services, including for outreach, fast-track/low threshold treatment, ongoing recovery support to sustain tenancies. 3. Promote multi-disciplinary models, integrating substance use support within local/London regional/Pan London strategies to improve health (e.g.

ICS-level, hospital discharge) and housing (e.g. No Second Night Out, Housing First, prison release) pathways and outcomes for London's homeless population based on a shared purpose.

4. SM treatment services should where resources allow and where there are high numbers of rough sleepers in the borough, designate a lead to engage with partner services (and HDAS) to oversee pathways into treatment, integration with homeless health, harm reduction support etc. for people experiencing rough sleeping.

5. Consideration should be given to piloting some outreach approaches in London (could be mobile across London) to engage with pre-contemplative drinkers who are rough sleeping, including with both language and alcohol harm reduction skills.

6. To support tracking of treatment journeys and outcomes for rough sleepers engaging with treatment services and to inform continuous improvement in how this population is served, consideration should be given to including a "rough sleeper identifier" (possibly linked to CHAIN) within treatment provider case management systems.