Complex Needs & Dual Diagnosis
ALL PARTY PARLIAMENTARY GROUP

Minutes from the 43rd All Party Parliamentary Group on Complex Needs and Dual Diagnosis meeting on 'Homelessness and Substance Misuse in the COVID-19 Pandemic'
Tuesday 21st July, 1:30pm-2:30pm
Virtual Meeting

Chair – Jane Stevenson

Jane Stevenson (JS) opened by welcoming everyone to the first virtual meeting of the APPG. She mentioned that APPG has been running for 13 years now and that this was her first chairing given her new position in parliament. She apologised that the co-chair Lord Victor Adebowale couldn't be in attendance but expressed his desire to return for the next meeting.

'Homelessness and Substance Misuse in the COVID-19 Pandemic'

JS provided some background for the upcoming discussion which was going to be had:

- Recent studies suggest two thirds of homeless people cite drug or alcohol use as a reason for first becoming homeless and those who use drugs are seven times more likely to be homeless.
- Since the lockdown began, more than 14,500 people who were on the streets or at risk of sleeping rough have been given emergency accommodation.
- This has necessitated huge efforts from local authorities who were given £3.2m from the government to address this.
- JS mentioned the deprivation in her constituency in Wolverhampton where rough sleeping is an increasingly prevalent issue
- JS spoke of the Homeless Hotel Drug and Alcohol Support Service (HDAS-London), the first pan-London commissioned drug and alcohol service providing alcohol, tobacco and drug support to those individuals experiencing rough sleeping temporarily housed in hotel accommodation across the capital.

JS then introduced the guest speaker:

- **Dr Emmert Roberts (ER)** - An MRC Clinical Research Fellow in the National Addiction Centre, Institute of Psychiatry, Psychology & Neuroscience (IoPPN) and Honorary Specialist Registrar in Substance Misuse Psychiatry at the South London and the Maudsley (SLaM) NHS

Foundation Trust. He has a strong interest in substance misuse, co-morbidity and the overlap of physical and mental health conditions.

- JS said that Dr Roberts will present on the crucial work that HDAS are currently doing, amongst other issues. It will be a chance to reflect on the opportunities presented by the pandemic to take action on rough sleeping and support people with complex needs to get off the streets and the possibility for solutions in the longer term.

ER said that he would tell us a story of how HDAS came into existence and what work they had been doing in recent months.

When COVID-19 struck the Ministry for Housing Communities and Local Government (MHCLG) began an umbrella policy entitled 'Everyone In' this mandated that every rough sleeper in England must be brought off the streets to protect them from the virus. In London this meant over 4500 rough sleepers were helped and these were separated into 3 groups:

- COVID Care – For those who had COVID-19 symptoms or tested positive
- COVID Protect – For anyone with medical vulnerabilities to COVID-19
- COVID Prevent – For everyone else

ER explained that rough sleepers have high co-morbidities. 50% of rough sleepers have alcohol issues, 20% have opioid or other drugs issues and 80% have tobacco addiction.

ER went onto describe the changes introduced by the Health and Social Care Act which shifted responsibility for the commissioning of drug and alcohol services from the NHS solely to local authorises (LA). Each LA commissions a local drug and alcohol service which means in London there are 33 different services. There is little incentive for service providers to work together.

HDAS was born, initially commissioned for 3 months with all providers coming together. This includes SLaM, the Central North West London (CNWL) NHS Foundation Trust, Turning Point, CGL, WDP, We Are With You and Phoenix Futures. Due to its success, the contract was recently extended until September 2020. HDAS works on 4 different areas:

1. Support telephone line and email for professionals in the hotels, providing specialist substance misuse support. This is because many residents supported in the hotels may have behavioural problems as they adapt to their change in environment, and may have reduced access to substances while they are housed. This support line gives advice and support for those running the hotels. There have been positive steps as many of those in support have never previously accessed local substance misuse services. As of last week, the 100th new person who'd never been in touch with services was helped.
2. Providing 'material stuff to hotels'. For example harm reduction materials, naloxone, individual lock boxes (for OST), and electronic cigarettes. HDAS also created workbooks for people in recovery. This is because of the pandemic face to face psychosocial support services were difficult to access so these were useful.
3. Training for professionals working within hotels – Most hotels have an in-house homeless specialist team. 60% of them run by St Mungos. This involved basic overdose training and how to provide the best support for residents with substance misuse issues.

4. Strategic work – liaison with stakeholders. Engaging clinical leadership groups, GLA, homelessness providers to make working together easier.

ER said that some great work had been done but also admitted that there'd been ups and downs along the way. And that there is still much more to be done.

JS thanked **ER** for his presentation. Highlights the importance of him shining a light on such pressing issues.

Robert Walker (RW) asked what considerations were being made for rural areas where there are pockets of deprivation and homelessness.

ER – The policy of 'Everyone In' is a national MHCLG policy which means there is provision across the country but states he can only speak to London's experience. It's down to LAs for what they do. Though he mentions that typically LAs have relied on their existing rough sleeping pathways and have bolstered those with extra funding.

Julie Bass (JB) asks where HDAS are monitoring outcomes and are they helping build the economic case as well as the health and wellbeing case to enable continuity of funding on an ongoing basis?

ER - UCL are conducting health needs assessment by phone across the hotel network, so far they have completed 1000. They aim to get up to 70% of all people housed to ensure its comprehensive. This data is invaluable for local health systems. Also each charity is doing evaluations of their own services.

ER also mentioned the work of Kings College London who are doing qualitative work. This includes doing interviews to try and capture people's experiences and show what the stories of the people in the hotels are.

JS asks how do we share best practice and make sure learning is spread?

ER - At the very beginning of the pandemic this sharing of information was hit or miss. Now there is a forum every 2 weeks where people from services can raise issues but also share learning. He admits that there have been periods of chaos but as time has gone on things have become more settled.

Matt Steinberg (MS) asks apart from clinical, are there any peer support or art based interventions being done at this time?

ER – Due to the pandemic and social distancing it's hard to facilitate this sort of stuff. As social distancing has eased he hopes this will become more common again. **ER** says that support is being delivered by telephone to people in the hotels and that a great advantage of having people in hotels is a direct line of contact for support services. People were initially sceptical about having telephone support but it is becoming normalised.

RW - Do you provide general mental health awareness training i.e. Mental Health First Aid Matters?

ER – Mental health work is going on and must go in conjunction with substance misuse treatment, largely provided by local mental health trusts and the Enabling Assessment Service London (EASL). **ER** stressed the importance of working together to ensure the best possible treatment.

Samantha Dorney-Smith (SDS) – Stresses the need to hear peoples voices on this, we need to show why this way of operating is better than others.

ER completely agrees. Most of this is being done by researchers at the moment although there is a press release next week going about HDAS which will have case studies. They're cautious about asking people to place themselves into the public eye about their experience as it can be overwhelming for them.

Mark Dronfield (MD) posits what an amazing opportunity the sector has been provided. This is the first time ever that quality beds have been availability to service users and there is the chance to align treatment with housing which is at the heart of solving this issue. He states that the key has been partnership. He cites the example of the central London drug and alcohol service having Fulham FC's club doctor helping them. This partnership must be embedded in future work.

ER agrees that this has been positive for providers and broken down barriers. The encouragement of cooperation not competition is key. He says that channels are open now that weren't before. Virtual communications have helped this. There is no need to drive across London for a 20 min meeting.

Dan Ware (DW) states that he is the co-founder founder of DDA (Dual Diagnosis Anonymous). They were granted some funding to run social activities for our peer members. As a result they have run Weekend Retreats, Bowling Nights and Meals Out - organised by and for members. This has proved really popular and helped them strengthen themselves as a supportive community for people with a Dual Diagnosis. States the importance of this sort of activity.

Lee Wilson (LW) Says up in Leeds Humankind's work on this has been very successful where everybody has engaged. Their analysing this time around why people are coming into treatment who never have before. Also regarding the importance of arts he mentioned their arts based interventions in Leeds, Guitar lessons, salsa dancing and they've linked with West Yorkshire playhouse and delivered Macbeth. **LW** acknowledges that having a single LA in Leeds as opposed to 33 in London, makes things simpler.

Paul Heritage (PH) described his experiences in Rio de Janeiro where the work he has been doing has been influenced by the UK in terms of using arts based therapies. In Rio, they had to close their 5 choirs, but used their infrastructure to provide food/health/hygiene support on daily basis for last 4 months. Last week they added story-telling, photography, music workshop - using social distancing.

Lynn Emslie (LE) Described her work in Somerset. It is similar to London's work but college accommodation was used instead of hotels. She warned of the disparity between people who have been recently housed in the 'everybody in 'scheme and people already accessing services. It must be assured that everybody receives the same high quality support

ER highlighted the £250 Million disinvested from substance misuse since 2012, the highest of all the public health services that have been cut. He agreed that **LE** was she is right in pointing out that Somerset and London have huge differences. This is because London has a large homeless population who can't access benefits and have no recourse to public funds.

Positively though MHLCG have released extension funding for hotels while accommodation options are sorted out and he hopes that everyone will be given an offer of more permanent accommodation.

Samantha Dorney-Smith (SDS) stated that there were about 4200 people in hotel accommodation in London; approx. 1400 supported in directly GLA funded hotels (for people not already known to a specific LA). As many people as possible are being moved out into the private rented sector with floating support if necessary but the move on for people needing support, but particularly those with No Recourse to Public Funds is obviously challenging. However there does seem to be a commitment to hold them as long as possible, in order to do everything possible to deliver a good outcome. But some people will not get the ideal solution. They also currently have a problem with newly homeless people having nowhere to go.

Andy Meakin (AM) – Flexibility which has been created between providers has made the impossible possible. There is a need to continue this collaboration; he also called into question the effectiveness of competitive procurement.

ER agreed that procurement practice is flawed and the pandemic shows it can work in a different way. More pan London commissioning is possible.

LE agrees but states that what's been funded is above and beyond what is typically available and questions how we sustain this level of service. Higher levels of funding won't last forever.

ER admits that London is lucky that MHLCG has given them greater funding. He states HDAS is a temporary fix, there needs to be more done. Substance misuse funding is not enough and that will need changing but the noises that are coming from central government are more positive, seems more receptive E.g. the Dame Louise Casey Taskforce.

To finish his remarks **ER** says that COVID-19 has shone a light on homelessness. It's shown we can end it if we want to and have the will. He said that if you'd have asked him 4 months ago if we could have housed every rough sleeper across the country, he'd have said no. This is a major step forward.

JS thanks **ER** for speaking. She states what an enlightening discussion it has been and how it's been shown what we can do to end homelessness.

JS thanks everybody for attending and closes the meeting.

Attendees

Name	**Organisation**
Alan Butler	Dual Diagnosis Anonymous
Andrea Crosby Joseph	CQC
Andy Meakin	Voices of Stoke
Baroness Armstrong	House of Lords
Cassie Newman	Social Interest Group
Christine Norman	Imperial College Health Partners.

Claudia Knowles	Imperial College Health Partners
Daniel Ware	Dual Diagnosis Anonymous
Daniela A. Collins	Middlesex University
Elsa Corry-Roake	Revolving Doors Agency
Emily Batchelor	Crisis
Emmert Roberts	HDAS London
Emma Cookson	St Mungos
Gemma Bruce	Turning Point
James Walker	Changes Plus Ltd
Jane Stevenson	House of Commons
John Graham	Streetscene
John Trolan	The Nelson Trust
Judith Ralphs	Integrated Commissioning RBKC and WCC
Julie Bass	Turning Point
Lee Wilson	Humankind
Louis Bezants	Public Health England
Lynn Emslie	NHS South West
Mark Dronfield	Turning Point
Matt Steinberg	Outside Edge Theatre Company
Paul Heritage	Peoples Palace
Raffael Milani	University of West London
Robert Walker	Changes Plus Ltd
Samantha Dorney-Smith	Queen's Nursing Institute
Sarah Kennedy	Turning Point
Sarah Pearson	Humankind
Seamus Manley	Hopkinson House, Complex Needs Hostel
Steve Chevis	Medway Council
Tim Kendall	Consultant in Mental Health and Criminal Justice