

Pan-London Homeless Hotel Drug & Alcohol Support Service (HDAS)

Lessons Learned

Experience of delivering substance misuse support to people experiencing rough sleeping in emergency accommodation during the COVID-19 pandemic in London and resulting Guidance for future provision of substance misuse support for people experiencing rough sleeping

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Context

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” policy. This policy placed rough sleeping populations in emergency hotel accommodation across the country to protect them from COVID-19, enabling them to self-isolate. There was concern that a significant proportion of London’s rough sleeping population would have support needs in relation to substance misuse (SM). 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.¹ Initially commissioned for a period of three months, with subsequent contract extensions for a further six months (to date),² this model has continued, with minor modifications.

Two overarching observations:

- This has been a unique project, bringing the majority of London’s SM providers who normally compete (reflecting the nature of commissioning) together to deliver a multi-agency, multi-disciplinary service;³
- The “Everyone In” policy and the work of frontline homeless and healthcare staff to support people in hotels has been unprecedented and a unique opportunity to engage a population that suffers significant vulnerabilities, inequity in access to health and social care services (including substance misuse treatment) and adverse health outcomes as a result.⁴

¹ Including PHE: *Operational advice for alcohol, drugs and nicotine in emergency accommodation for people experiencing rough sleeping* at <https://www.local.gov.uk/sites/default/files/documents/Alcohol%20drugs%20and%20nicotine%20in%20emergency%20accommodation.pdf>.

² Current funding to 1st January 2021.

³ All providers of SM services in London boroughs (NHS and third sector) were invited to collaborate in HDAS. While not all chose to actively participate, organisations delivering part or all elements of services in 30 of London’s 33 boroughs did so. The central delivery team was made up of staff from Change Grow Live (Service Coordination), Turning Point (Coordination and Recovery Lead) and South London and the Maudsley NHS Foundation Trust (SLaM – Clinical Lead) with additional clinicians and recovery workers from these organisations and Westminster Drug Project (WDP), Phoenix Futures, We Are With You, and Central and North West London NHS Foundation Trust (CNWL). Staff from other providers did contribute by responding to HDAS questionnaires and attending forums during this period.

⁴ See St Mungo’s (2020), *Knocked back: Failing to support people sleeping rough with drug and alcohol problems is costing lives*.

This Lessons Learned document aims to:

1. Review the SM and tobacco harm reduction and SM treatment need within the hotel system and evaluate the support provided by HDAS and local treatment services;
2. Provide practical guidance (based on those conclusions) for how rough sleepers can best be supported with SM and tobacco harm reduction both when immediately off the streets in temporary accommodation and when moving into more permanent accommodation.

Methodology

This report was compiled during September and October 2020 and covers the period 1st April to 31st October. It has drawn on:

- Data and feedback gathered in the course of delivering HDAS, including:
 - Data on HDAS contacts and resources distributed
 - Feedback questionnaires completed by SM services in June and September 2020
 - SM service forums held in July 2020
- Feedback sessions focused on “Lessons Learned” with:
 - Partners within the HDAS Cross-Provider Network
 - HDAS staff team
 - Homelessness Service Providers responsible for day-to-day operational management in Greater London Authority (GLA) hotels
 - Homeless healthcare professionals directly involved in delivering healthcare to GLA and Local Authority (LA) hotels
- Data analysis from COVID-19 Homeless Rapid Integrated Screening Protocol (CHRISP) assessments compiled by University College London Hospital’s (UCLH) Find & Treat Team
- Published research regarding the “Everyone In” policy in London to date.

Drafts of this report and guidance were widely circulated to stakeholders involved in the project before finalising and any corrections or additional information incorporated.

Executive Summary

HDAS support to substance misuse treatment providers and hotels

- 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.
- Minimal numbers of out of hour (OOH) contacts were recorded, leading to an ability to scale back HDAS to a 9-5 operating model within three months of the service being established.
- In the few instances where substance misuse services pushed back on referrals into treatment, these were able to be quickly escalated and resolved by HDAS due to links with senior members of staff from partner organisations.
- 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.

Substance misuse need within the hotel population

- Previous work has indicated that of people experiencing rough sleeping in London 42% are estimated to have alcohol misuse needs and 41% have drug misuse needs.
- 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.
- 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.

Harm reduction Interventions

- 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.

- Tobacco harm reduction resources were universally well received and contributed to an anecdotal reduction in residents breaking lockdown to buy cigarettes, residents sharing cigarettes or picking up stubs off the street (with an associated risk of COVID-19 infection), and residents being evicted for smoking in their rooms.

Missed opportunities?

- The characteristics of the population and the context presented several challenges to providing support to residents of the hotels during lockdown.
- 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.
- 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.

Conclusions

- The nature of emergency hotel provision, with people experiencing rough sleeping placed in and moved into hotels city wide across boroughs, necessitated a Pan-London response to substance use need, given the fragmented commissioning of London treatment services (28 separate services across 33 boroughs with different models of delivery).
- The cross-provider nature of HDAS helped:
 - Rapid escalation to find solutions to any barriers to engagement and treatment;
 - Identify, create and distribute resources e.g. workbooks and "distraction packs";
 - Cross-check information about residents in treatment e.g. clients raised at MDTs;
 - Quickly share information about hotels opening, closing, plans for move-on etc.
- HDAS ensured the visibility of substance misuse harm reduction and treatment among the range of needs within London's rough sleeping population and promoted the availability of support via local and national platforms.

Based on these findings, a number of recommendations have been made as guidance for Commissioners of services, treatment services and partner health and homelessness services for future good practice.

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Direct HDAS support to substance misuse treatment providers and hotels

This section gives a brief overview of some of the key elements of HDAS delivery during this period to provide context to the findings that follow.

Coordination

HDAS responded to the need to coordinate approaches to substance misuse treatment for rough sleepers and provided a coordinated response to needs in the hotels. HDAS quickly agreed a set of principles for continuity of care across London treatment providers which clarified:

- Except in exceptional circumstances, where an individual was currently under the care of/or scripted by an SM service, they were to remain under the care of and/or scripted by that service, even if the individual was resident in one of the homeless hotels in another borough;
- If a person was new to treatment or not currently under the care of an SM service, they should be assessed by the service local to the hotel in which they were currently resident.

Feedback from treatment providers indicates that these principles (updated in April to address movement in and out of hotels) supported a clear understanding of the role of local treatment services in a complex and chaotic situation during lockdown, with rough sleepers moved across borough boundaries.

In addition to client-related queries to the SPOC, HDAS responded to numerous phone and email queries from a range of stakeholders during this period (100+ 'General information' Contacts logged). These included queries about how to get people identified as rough sleeping into hotel accommodation in the early weeks of lockdown and contact details for substance misuse services. HDAS also coordinated responses to requests for information, advice and resources (including harm reduction – see below) from the GLA, LAs, hotels themselves and treatment services.

The central HDAS team attended multi-disciplinary team (MDT) meetings in hotels and coordinated information-sharing, where possible, between hotels and SM treatment services. Feedback for this report indicated that this central SM coordination role was appreciated by all stakeholders.

Clinical response

A key part of HDAS's work was to coordinate a safe, evidence-based, and clinically appropriate response to the spectrum of alcohol and drug misuse in the hotels. The rapid development of Clinical Protocols⁵ by South London and the Maudsley NHS Foundation Trust (SLaM) clinicians on behalf of HDAS (first drafts available 20th March) were given to hotel and healthcare staff (and subsequently permanently available via Healthy London Partnership website⁶ and FutureNHS online

⁵ *A Protocol for the Management of Alcohol Withdrawal in Temporary Homeless Hotels during the COVID-19 Outbreak, A Protocol for the Management of Nicotine Withdrawal in Temporary Homeless Hotels during the COVID-19 Outbreak, A Protocol for the Management of Opiate Withdrawal in Temporary Homeless Hotels during the COVID-19 Outbreak*

⁶ <https://www.healthylondon.org/resource/homeless-health-during-covid-19/>.

Collaboration Platform), may have contributed to the resulting relatively low number of calls relating to clinical queries to the HDAS SPOC. In providing feedback for this report, healthcare staff (largely GPs and nurses) working in the GLA hotels particularly valued access to clinician support and the protocols from Day-1, most notably in relation to alcohol use disorders. HDAS's Clinical Lead Emmert Roberts attended weekly Covid-19 Homeless Health Clinical Leads Group meetings and drew on his NHS/Homeless Health links to ensure that HDAS was well integrated within homeless health response to COVID-19 throughout.

24/7 clinical on-call was provided initially (as required in the specification) but out-of-hours support was rarely needed: In the first week of operation, 3 out-of-hours calls were logged. After a month, clinical on-call was reduced to weekdays 9am-5pm and weekends 9am-5pm for medical emergencies only. Weekend provision was also utilised rarely (averaging two calls per month), although healthcare staff were appreciative when they did call, as such weekend clinical emergency cover was stopped at the end of August. Recovery Workers regularly consulted with clinicians about advice given to hotel professionals (see below) and clinicians found it very useful to have access to all SM providers via HDAS e.g. to check current prescribing regimes for individuals etc.

SPOC (support from experienced recovery workers)

The SPOC (available 9am-5pm weekdays throughout) was used by hotel staff to seek advice from recovery workers as to how to support residents, as well as to ask for help in making treatment referrals into local SM services. Feedback from hotel staff was that this was appreciated and that accompanying resources emailed by SPOC workers were helpful (e.g. substance misuse workbooks, leaflets). The combination of recovery workers and clinicians - therapeutic approach reinforced by clinical support where needed – worked well.

Case study: A call was received to the SPOC worker to discuss a resident drinking 4-5 bottles of Vodka per day, spending most of the day in bed, with concerns about self-neglect. He was a frequent hospital attendee and did not want to be referred into local SM treatment.

Actions Taken by HDAS:

- Checked hotel team were aware of how to safely minimise alcohol-related harm;
- Recommended linking in with his GP, particularly around safeguarding;
- Contacted on-call HDAS clinician resulting in referral information given for the SLaM alcohol assertive outreach (AOT) service (frequent flyer team)

Case Study: A resident was referred to HDAS by a Nurse working in a south London GLA hotel, concerned about his drinking. He was unable to purchase his own alcohol and was showing signs of alcohol withdrawal. Nurse contacted HDAS SPOC, who with on-call clinical support provided guidance around purchasing and providing alcohol to the resident under observation. Facilitated contact with local treatment service to provide further support and prioritised assessment.

Training

HDAS (consultant Kevin Flemen) provided SM harm reduction training to 42 staff working in GLA hotels and outreach teams from St Mungo's (22), LookAhead (10), Thamesreach (9, mainly from London Street Rescue) and DePaul (1) over 5 sessions during May. The feedback received was excellent. Participants referenced a low level of knowledge of SM issues and how to address

residents presenting with SM needs. Many participants were sessional staff, new to the role or had limited experience of identifying and referring people for SM needs. Access to the training (delivered via Zoom) for staff on shift patterns proved problematic and despite reminders and re-scheduling, there was a relatively high drop-out rate (44%). Training was not continued into June and July because of the expectation that hotel staff would not have capacity while focusing on moving people on to more permanent accommodation.

Identification and assessment of substance use need within the hotel population

Evidence of the level of substance use and treatment need in hotels

2018/19 Combined Homelessness and Information Network (CHAIN) data for London⁷ indicated that 42% of people seen sleeping rough had alcohol misuse needs and 41% had drug misuse needs. The table shows the potential need within the GLA hotel population based on these percentages, actual self-reported problematic use identified by UCLH's Find & Treat Teams via CHRISP assessments, and HDAS treatment referral data, noting limitations to that data:

	Potential need in GLA hotels based on an estimated maximum GLA hotel population of 1,500	Self-identified problematic use (CHRISP assessments)	HDAS-supported treatment referrals (8th April to 8th September 2020)
Alcohol need (n)	630	166	43
Drug need (n)	615	223	32 (20 opioids)
<i>Limitations to data</i>		<i>CHRISP assessments undertaken with c.40% of GLA hotel residents. Required residents to be compliant with a lengthy telephone assessment in English</i>	<i>Some referrals were made directly into local treatment services (not via HDAS), many residents were already in treatment (see below)</i>

In early May 2020, HDAS was able to obtain (under data sharing agreements) "raw" and incomplete NHS data on GLA hotel residents. Change Grow Live (who deliver 10 out of 28 treatment services across London) analysed the records where data were sufficient to cross-check against its local treatment data and found:

- 35 residents currently in treatment with a Change Grow Live treatment service;
- Of those primary problematic substance: 19 alcohol; 12 heroin (of whom 8 on prescriptions for Opiate Substitution Therapy); 2 cocaine/crack; 1 amphetamines.

We can expect that not all residents with problematic alcohol or drug use sought support while staying in the hotels, and indeed some refused referral into local treatment services. We know for example that many were supported to maintain alcohol use as a harm reduction intervention (see below). We also know of significant numbers of "pre-contemplative" alcohol users resistant to treatment. There are also concerns that entrenched drug or alcohol users may have resisted entering the hotels or have left the hotels early on, either voluntarily

⁷ CHAIN is a multi-agency database recording information about rough sleepers and the wider street population in London, commissioned and funded by the GLA.

(particularly once lockdown eased) or through eviction because of their drug or alcohol use: this warrants further research.⁸

Recently published research from Kings College London (KCL) in a GLA hotel, based on interviews with 33 residents, found that “there seemed to be little demand for addiction-related treatment in the hotel... few residents identified addiction-related needs and many reported total abstinence.”⁹

There was no systematic process for identifying and assessing substance misuse need on entry into the hotels during March/April: the primary focus was on COVID-19 risk (physical health and age-based vulnerabilities). Feedback from professionals for this report indicated that those residents who accessed harm reduction support or were referred into treatment largely self-identified, or their behaviour (heavy drinking etc) led to staff intervening and offering support for referral into treatment.

In the course of discussions for this Lessons Learned report, St Mungo’s (responsible for managing 8 of the original 13 GLA hotels) clarified that residents who they felt weren’t coping in the hotel environment because of higher support needs (including intravenous (IV)/“chaotic” drug use, or at risk of eviction), were moved to St Mungo’s “Staging Posts” (existing accommodation for rough sleepers) at the height of the lockdown and referred into local treatment services where necessary. This would correspond with feedback gathered for the KCL study that people with addiction-related problems were sometimes moved out to other hotels. It has not been possible to check whether there was an increase in Staging Post referrals for treatment or harm reduction support to local services for this report. HDAS support was promoted to the Staging Posts, with some harm reduction resources provided, and some staff trained.

More systematic assessment of SM in the hotels was provided via:

- **CHRISP Assessments.** HDAS Lead Clinician (SLaM) provided input into this assessment questionnaire to ensure that key information regarding SM and tobacco needs were identified. The team started undertaking assessments in May, and HDAS began to receive referrals from the assessment team in early June, continuing into mid-end July.¹⁰ HDAS received over 30 new referrals from the CHRISP assessment team, almost all of which were referred on into local treatment services (with a few exceptions where consent had not been gained);
- **Housing needs assessments** to support move-on in which basic information about current SM treatment was captured. This was at least two months after many people first entered the hotels (June).

⁸ For example, CHAIN data for the period April-June 2020 shows 61% of the 11 rough sleepers identified on the streets (i.e. not in emergency accommodation) in Tower Hamlets had a drug need (compared to 68% of 32 in the same period in 2019). This underlines the continued importance of assertive outreach resource to engage rough sleepers in harm reduction and support accessible pathways into treatment.

⁹ Neale, J et al. (2020) “Experiences of being housed in a London hotel as part of the ‘Everyone In’ initiative. Part 1: Life in the Hotel.” National Addiction Centre, King’s College London: London. DOI 10.17605/OSF.IO/RT7J9.

¹⁰ As of end September, the team had undertaken a total of 1,178 assessments across GLA hotels. Assessments were done via phone, relying on self-identification of SM need, and translation services where required. In addition to identifying SM needs, these assessments also identified acute and chronic mental and physical health problems, cognitive issues, and social care needs, that had previously been unidentified.

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.

Observations about substance use in the GLA hotels

Drug use: Of 1,177 residents who undertook a CHRISP assessment, 223 self-identified with problematic drug use (19%). 97/223 (43%) reported that their drug use since moving into the hotel had remained about the same; 99 (44%) that it had reduced and only 24 (11%) that it had increased. UCLH Blood Borne Virus testing teams also identified a reduction in drug use across residents in GLA and LA hotels: of 12% who had "ever injected", 4.6% were currently injecting; of 21.8% who had "ever smoked crack/heroin", 13.3% were currently smoking. KCL research found that the main reasons given for a reduction in drinking or drug use were: not having money; less social interaction; feeling stable and more relaxed in the hotel; trying to be healthier; and receiving treatment (including prescribed alcohol) in the hotel.

IV drug use: Of 1,177 residents who undertook a CHRISP assessment, 35 self-identified as being IV drug users (3%); HDAS supported 20 opiate referrals but did not collect data on whether residents were injecting or smoking; HDAS Clinical Lead responded to two queries from hotels about amphetamine and steroid injecting but no calls about IV heroin/crack use. Low take-up of HDAS needle exchange packs and feedback from homelessness providers managing hotels seem to indicate low IV drug use in the hotels. There are a number of possible reasons for this, including: a reduction in IV drug use on entry into hotels (correlating with an increase in those accessing treatment and evidenced by CHRISP data which recorded 8% of GLA hotel residents assessed as "ever used IV drugs" against 3% "current"); "hidden" injecting practices (with needles obtained from pharmacies/other sources); injecting drug users refusing to be placed in emergency accommodation, leaving voluntarily or being evicted early on; injecting drug users being accommodated in more "specialist" accommodation such as Staging Posts (see above).

Cannabis: HDAS supported 3 referrals to treatment services for cannabis use.

Cocaine: HDAS received 4 contacts where crack cocaine use was specifically mentioned (mainly in association with other drugs) and referrals into treatment were made.

"Spice": HDAS received 5 contacts where spice use was mentioned (mainly in association with other drugs or alcohol). Healthcare staff working in North West London interviewed for this report expressed surprise that higher rates of spice use were not reported within CHRISP assessments given its prevalence in some sections of London's homeless population pre-lockdown. There are concerns that spice use may be being under-reported due to shame associated with its use and that this may increase the risks people are exposed to.

Alcohol: High levels of alcohol misuse were identified. It was the most common substance for treatment referral via HDAS (57% of all treatment referrals), and the subject of many contacts from hotel staff seeking advice and support. CHRISP assessments identified 166 people self-declaring problematic alcohol use. While 213 residents said that they were consuming less alcohol while in the hotel, 72 indicated that they had been drinking more. More recently, HDAS was made aware of

concerns about pre-contemplative alcohol users refusing engagement with local treatment services and presenting with challenging behaviour in some hotels. In October/November, HDAS was working with St Mungo's, the GLA and the local treatment service to develop a joint solution to this problem in one of the remaining GLA hotels.

Case Study: A male Polish-speaking resident was discussed at an MDT at one of the GLA hotels due to close within the month (July 2020). He was said to be intoxicated a lot of the time which was impacting on his ability to care for (attend appointments etc) a leg wound. He had refused to talk to staff about his drinking. HDAS staff member present at the MDT was able to identify a Polish-speaking worker within the outreach team of the local treatment provider. A telephone conversation was arranged, and he spoke to the worker at length about his history of alcoholism and previous poor experience of accessing mental health support which had made him wary of engagement. By the end of the call he was open to the idea of speaking to someone further about getting help for his alcohol use.

Information on **incidents** (including acute alcohol withdrawal necessitating hospitalisation, overdose) and **evictions** (including for substance misuse, and tobacco smoking) was not shared systematically with HDAS. The service is not aware of any incidents of drug overdose, which if true would be a significant achievement, given typically high rates of drug-related deaths within homeless populations.¹¹ The service is also not aware of the number of times that ambulances were called in relation to drug or alcohol-related incidents. On occasion HDAS was contacted for advice about how to support someone at risk of eviction because of substance misuse, but often HDAS was informed anecdotally of evictions after the event. Prompt sharing of this 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.

Note on “Dual Diagnosis”¹² prevalence

CHRISP data indicated high prevalence of mental health needs within the hotels, consistent with an understanding of mental health conditions as a driver for and result of homelessness. HDAS did not consistently record co-existing conditions within client referrals but anecdotally many referring hotel staff mentioned co-existing mental health issues, including substance misuse as a “medication” for those conditions. The Enabling Assessment Service London (EASL) was commissioned by the GLA to support residents with mental health needs in the majority of GLA hotels.

¹¹ 99 drug poisoning deaths of homeless people related to heroin and 75 related to alcohol in 2018 (see Office for National Statistics, Deaths of homeless people in England and Wales: 2018 at <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018#drug-related-deaths-of-homeless-people-have-more-than-doubled-over-six-years>).

¹² Dual Diagnosis is a term used to denote co-existing SM and mental health conditions. While prevalent within rough sleeping populations, it is also important to note that rough sleepers often present with multiple healthcare needs in addition to addictions and mental health. Barriers to accessing support for those with dual diagnosis (exclusion for challenging behaviours, failure to meet treatment “thresholds” or being passed between services) are particularly acute for rough sleepers.

Harm Reduction interventions

Most of the hotels were able to put in place harm reduction approaches based on Clinical Protocols (opiate, alcohol, tobacco) compiled and shared by HDAS. In addition, HDAS distributed harm reduction guidance and leaflets to all hotels as well as workbooks for residents to support harm reduction.¹³

Case Study: Shortly after it opened, HDAS heard worrying reports from one of the GLA hotels in south London, of residents being evicted with a few minutes notice for being seen with alcohol on the premises. Hotel management was also refusing to allow Naloxone on site for fear it would 'encourage' drug use or allowing vaping devices, leading to smoking in rooms, the associated fire risks and an increased risk of contracting COVID-19, by congregating outside. HDAS escalated this to the GLA immediately, and the local treatment service escalated it via their local authority commissioners. This situation was ultimately resolved between the GLA and the hotel provider and harm reduction approaches were introduced, as in other hotels.

Drug Harm Reduction

HDAS distributed Naloxone (81 kits), lockboxes (24) and Needle Exchange (NX) packs (80) to the GLA hotels between April and October. Most of these resources were given out as "starter packs" when hotels began operating. Minimal additional NX resources were requested by hotels between April and October. We are aware that some local SM services provided these resources directly to GLA hotels (see **Appendix A**) which might account for the relatively low take-up of these resources (see also discussion of IV drug use above).

Alcohol Harm Reduction

There were significant concerns about the potential for high rates of acute unplanned alcohol withdrawal when the hotels began operating. HDAS distributed a Clinical Protocol immediately, with guidance that staff should, where appropriate, purchase alcohol for alcohol dependent residents in order to prevent them from going into unplanned withdrawal (particularly during the lockdown period while residents were restricted from leaving the hotel). HDAS clinicians were on call to support this approach and had several conversations with staff uncomfortable about encouraging residents to keep drinking or purchasing alcohol about why this was necessary. HDAS training for staff also addressed this issue. As reported in a recent commentary on this approach, "professionals commented that once hoteliers were 'on-board' with alcohol being consumed on site as a means of harm reduction, evictions due to drinking or resultant behaviour reduced."¹⁴ The first priority was to reduce harm, and for those residents interested in reducing their alcohol consumption, support was given to them (via workbooks) and staff (via SPOC, guidance) to manage reductions.

¹³ Workbooks for hotel residents to complete on their own or with help from hotel staff were developed (from resources provided and adapted by Phoenix Futures with input from HDAS Clinical Lead and CGL National Service User representative) and distributed to all hotels in May. Workbooks were produced for Alcohol, Heroin, Crack, Spice, Cannabis and Cocaine. Alcohol workbooks were translated into Polish, Romanian and Punjabi. Harm reduction leaflets were also widely distributed.

¹⁴ For further details of this approach, see *Prescription of alcohol in emergency homeless hotel accommodation during the COVID-19 lockdown*, Dr Emmert Roberts, and Dr Emily Finch, 9/10/20, <https://www.addiction-ssa.org/prescription-of-alcohol-in-emergency-homeless-hotel-accommodation-during-the-covid-19-lockdown/>

Tobacco Harm Reduction

HDAS distributed over 3,000 units of e-cigarette starter kits, 20,000 e-cigarette refill pods, nicotine replacement mouth gum and oral spray to GLA hotels from early April with all hotels regularly requesting additional supplies. Nicotine mouth spray and gum were also distributed to LA hotels via Great Chapel Street Medical Practice and to Enfield LA hotels via the Enable substance use treatment service/LA. Feedback from hotel and healthcare staff is that these resources have been very helpful, contributing to an apparent reduction in:

- Residents breaking lockdown to buy cigarettes;
- Residents picking up stubs off the street (with associated risk of COVID-19 infection);
- Residents being evicted for smoking in their rooms.¹⁵

CHRISP data from GLA hotels indicates that 61 residents (only 5% of the total number assessed) said they had accessed vaping devices since entering the hotel; 297 residents said their smoking had reduced; 280 said their smoking was "about the same"; 96 said their smoking had increased. Provision of e-cigarettes was accompanied by a nicotine withdrawal policy (for healthcare staff) and leaflets and a training video on how to use the e-cigarettes for hotel staff. In mid-June, HDAS produced a leaflet "*Want to stop or reduce your smoking*" (English, Punjabi, Polish, Romanian), designed for those moving out of the hotels, but available to all residents. This provided advice and guidance on support available, including the free Stop Smoking London helpline: 0300 1231044 and website: <https://stopsmokinglondon.com>. Interestingly, in Manchester, in addition to e-cigarettes, hotel residents were given access to an app offering access to on-call stop smoking advisers, allowing them to log their cravings, get tips on dealing with them and see how their health were improving.¹⁶

¹⁵ For a study of smoking in one GLA hotel that concluded that the distribution of free nicotine replacement therapy (particularly e-cigarettes) helped to reduce some tobacco consumption, see Neale, J., Brobbin, E., Bowen, A., Craft, S., Drummond, C., Dwyer, G.-J., Finch, E., Henderson, J., Hermann, L., Kelleher, M., Kuester, L., McDonald, R., Parkin, S., Radcliffe, P., Roberts, E., Robson, D., Strang, J., Turner, R., & Metrebian, N. (2020) "Experiences of being housed in a London hotel as part of the 'Everyone In' initiative. Part 1: Life in the Hotel." National Addiction Centre, King's College London: London. DOI 10.17605/OSF.IO/RT7J9.

¹⁶ NHS Addictions Provider Alliance: <https://www.nhsapa.org/post/gm-smoking-cessation>.

New treatment referrals

Evidence of new treatment referrals for London's homeless population

In addition to HDAS data on new treatment referrals supported by the service (75 treatment referrals April to September 2020), data* provided to HDAS from Change Grow Live, Turning Point and SLaM services shows:

Change Grow Live (data drawn from 10 London services):

- No increase or reduction in new alcohol and alcohol & non-opiate treatment starts for service users (SUs) recorded as NFA pre-COVID and during the COVID period (stable at 25 and 19 respectively);¹
- A reduction (half) the number of new non-opiate treatment referrals from 11 to 5;
- More than doubling of opiate treatment referrals (this reflects a general population-wide increase in opiate treatment during this period) from 79 to 158.

SLaM (data drawn from 2 London services):

- **Lambeth** didn't see any difference in alcohol/opiate treatment starts for SUs recorded as NFA in the same periods pre and during COVID. 7 residents from GLA hotels started treatment (3 opiate, 2 alcohol, 1 crack, 1 spice);
- **Wandsworth** service had 8 new treatment starts from GLA hotels during the COVID period.

Turning Point (data provided for Westminster, Kensington & Chelsea, Hammersmith & Fulham combined drug treatment service (DAWS)):

April to July 2020, the following numbers of rough sleepers supported into treatment (alongside support to access emergency accommodation):

- Westminster: 40 new treatment starts (all drugs)
- Kensington & Chelsea: 6 new treatment starts (all drugs)
- Hammersmith & Fulham: 12 new treatment starts (all drugs)

**Note on data: Treatment services do not identify SUs within case management systems as "people experiencing rough sleeping". Generally, those sleeping rough are identified as NFA. However, because people experiencing rough sleeping were accommodated in hotels during this time, there appears to have been inconsistency across and within services as to how residents were recorded, with some recorded as NFA, and others inputting hotel postcodes. Work is still being done at a service level to identify and analyse treatment numbers and outcomes within the population accommodated in hotels.*

For hotel residents with identified SM needs (not currently in treatment) who consented to referral, healthcare staff and homelessness workers referred them into the local treatment services. HDAS played a role in supporting staff who were unclear who the treatment provider was, or where they needed specific help (completing and emailing referral forms, chasing responses to referrals etc). There was some feedback about HDAS representing "another layer" in the referral process, but overall it was felt that the benefit of one service to support staff to navigate the complex landscape of SM treatment providers outweighed the drawbacks.

A few issues relating to treatment referrals arose:

- Some waits for assessments in Tower Hamlets where the service was impacted by having two large GLA hotels in the borough and a significant increase in referrals (around 20 from GLA hotels) in the first few weeks of lockdown;

- In some cases, access to treatment and support was delayed or prevented by the inability of the SM treatment service staff to contact residents to undertake phone assessments;¹⁷ on a number of occasions, HDAS was asked to help liaise with hotel staff when an appointment was missed and we are aware of several cases where assessments were pending for many weeks because of missed appointments, in some cases residents refused to engage when final contact was made;
- In a very small number of cases services pushed back on referrals saying there was no local connection: these were escalated quickly by HDAS with SM senior managers and dealt with swiftly, referring to the agreed Cross-Provider principle that anyone new to treatment should be referred to the service local to where they are placed in emergency accommodation. This worked well.

Anecdotally, healthcare staff said they felt that rough sleepers were able to access treatment quicker than in “normal” times, and HDAS SPOC workers reported that they felt that HDAS had facilitated prompt access to treatment. It is impossible to evidence this, although certainly HDAS was able to pursue referrals if healthcare or hotel staff raised concerns about delays.

Case Study: In September 2020, the BBC profiled a person experiencing rough sleeping who had successfully received treatment for heroin use while in a GLA-commissioned hotel in London after many years of sleeping rough and drug use. HDAS had supported his referral into the local treatment service in late April and were happy to hear of his continued engagement with treatment and successful reduction in heroin use. His recovery is ongoing.

¹⁷ For example, 15% of referrals (16 residents) from GLA and LA hotels to Change Grow Live’s Tri-Borough Alcohol Service (1st April to 31st August) covering Westminster, Kensington & Chelsea, Hammersmith & Fulham, were recorded by staff as “not contactable” after several attempts, and so were ultimately unable to access support.

Local treatment service support into hotels

Local treatment services developed different models of support for rough sleepers accommodated in emergency hotels (including GLA) in their borough (see **Appendix A** for boroughs where GLA hotels were sited). This was largely dependent on the availability of resource within their services (noting also that face to face contact was largely suspended during lockdown, with most staff in treatment services working remotely).

Case study: In Westminster, Kensington & Chelsea and Hammersmith & Fulham (combined drug service), Turning Point (DAWS Service) developed an in-reach model (working closely with the CCG and LA) which provided support to GLA and LA hotels. A full treatment service was offered to each hotel (harm reduction, assessment, rapid prescribing, key working, staff training), with a designated drug worker (on-site as part of the health and social care team in larger/more “high need” hotels) and 24/7 SPOC 7 days a week.

Where treatment services did have dedicated outreach teams, many of them focused support on LA-commissioned accommodation where there was minimal on-site support. Feedback to HDAS from treatment services in July¹⁸ indicated that these outreach teams had built on existing joint working with homeless teams to deliver joined up care to residents in LA hotels. This included treatment service representation within regular multi-disciplinary meetings (MDTs) to identify and support appropriate accommodation solutions for complex clients. Generally, all those services with positive stories to tell had dedicated assertive outreach teams as part of their commissioned delivery models.

HDAS played an important role in monitoring (as far as possible) treatment service support to GLA and LA hotels across London and sharing information and best practice across services (individually, as part of treatment service forums and via fortnightly Cross-Provider meetings).

Case studies: Remote interventions by treatment services

HDAS is aware that some residents in emergency accommodation were supported to reduce alcohol or drug consumption while there, using the hotels as a “safe space” to reduce either with or without medication. We have been unable to obtain definitive numbers and success rates for these interventions, however, the following is one example:

Tri-borough alcohol service (covering Westminster, Kensington & Chelsea, Hammersmith & Fulham) supported GLA and LA hotel residents (beginning of April to end of August 2020) to reduce alcohol consumption safely through “virtual” supported reduction programmes with clinical oversight, providing advice and support to staff in the hotels.

¹⁸ Online Forums held, 14th and 28th July 2020.

Missed opportunities?

The limitations of remote support

Engagement with residents around their substance use did happen in hotels (see case studies), but very little intensive engagement was possible. Key working by hotel staff (once they had the capacity to do this) was focused on accommodation move-on plans and not on wider needs. There is no evidence that hotel staff supported residents with HDAS substance misuse workbooks for example.

The characteristics of the population and the context presented several challenges to providing remote support to residents of the hotels during lockdown. Many of the residents were non-English speakers, so undertaking assessments required language support. Many didn't have mobile phones or ran out of credit so there were difficulties contacting them. Although many could be accessed via hotel room phones, once lockdown had eased many were less contactable. Feedback from St Mungo's managers was that remote engagement with residents was extremely difficult and that face to face in-reach would have been more helpful.

As indicated in Appendix A, local treatment service in-reach to GLA hotels was limited throughout the period. Although restrictions on face to face contact were reduced over the summer,¹⁹ drug and alcohol harm reduction and treatment support (including assessments) largely continued remotely, impacted both by service capacity and organisational approaches to risk management for staff. HDAS support was almost entirely remote (apart from deliveries to hotels and attendance at MDTs), with support provided to hotel staff rather than directly to residents. HDAS SPOC Workers were drawn from existing SM treatment services who were continuing to work in their own services alongside HDAS (achievable while working remotely). In order to conduct in-reach into hotels, 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.

The remote nature of most support certainly impacted on HDAS and treatment services' ability to use this unique opportunity to engage with London's rough sleeping population. This will be particularly true for residents with significant barriers to engagement including mental capacity/mental health conditions. There is scope for considering how this might be better addressed in future, including joined up support with mental health provision. Enhanced remote support options were discussed by HDAS (including online/phone peer support, appointments for psychosocial interventions with recovery workers), but not pursued because of the ongoing uncertainty about the nature of HDAS, and hotel provision (month-on-month contract extensions).

Continuity of care

It has not been possible to determine with any certainty whether those people experiencing rough sleeping who were already in treatment for SM when placed in emergency accommodation received adequate continuity of care throughout this process. Despite requests, HDAS was unable to obtain comprehensive information on rough sleepers accommodated who were already in treatment to

¹⁹ E.g. updated DHSC Guidance (last updated 16th October) permits face to face contact when necessary for vulnerable service users, healthcare interventions, people newly starting treatment and community alcohol detoxification services (at <https://www.gov.uk/government/publications/covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol/covid-19-guidance-for-commissioners-and-providers-of-services-for-people-who-use-drugs-or-alcohol>).

share with services (with the exception of early incomplete data referenced earlier), so it was left to services and their service users to maintain contact with each other.

In mid-July,²⁰ HDAS recorded concerns and reports from treatment services (notably Hounslow and Tower Hamlets) about rough sleepers known to services “dropping out” of hotels where they were previously known to be staying (many returning to begging once lockdown restrictions had eased). No information was provided to these treatment services about them leaving (including those returning to the street voluntarily or evicted) and where they might have gone to.

In June 2020, HDAS undertook a significant piece of work to prepare for the “move-on” of residents out of hotels and into accommodation. This was in response to a specification change request by the GLA and PHE-London. In fact, much of the movement during July and August was between hotels as hotels closed before residents were found accommodation.²¹ HDAS circulated guidance to hotels about information to share with treatment services (including via HDAS) for “move-ons” to ensure continuity of care, seeking to reduce a range of significant risks including safeguarding, dual prescribing and overdose as a result of disengagement/drop-out.

HDAS didn’t receive information on move-ons from hotels (either into accommodation or other hotels) until the closure of the GLA hotels in Tower Hamlets at the beginning of August. By then, according to GLA data 207 residents had moved out of the hotels, and hundreds had been transferred between hotels. St Mungo’s have fed back to HDAS that the majority of those residents moved out of hotels in July/August were relatively “low need” residents who moved into private rented accommodation and would therefore are unlikely to have needed treatment continuity support.

In early August, prior to the closure of the hotels in Tower Hamlets, HDAS organised a meeting between hotel staff and the Tower Hamlets treatment service to discuss the c.20 residents either already in treatment or awaiting assessment. A significant number were moved to a new GLA hotel in Waltham Forest and HDAS was able to support by:

- Ensuring that residents referred but still awaiting assessment were referred into the Waltham Forest SM service;
- Liaising between the Tower Hamlets and Waltham Forest services regarding transfer of care (underlining the principle of continuity of treatment provider until an accommodation solution had been found, unless in exceptional circumstances);
- Reassuring the Tower Hamlets service about concerns of double prescribing when residents moved to new areas, circulating guidance to GPs and SM services about the importance of checks before prescribing to people experiencing rough sleeping.

Subsequently, HDAS was given a list of residents in treatment when further GLA hotels were closed at the end of September and were able to liaise with local SM services to ensure they were informed of moves to other hotels and able to support residents.

²⁰ Via Cross-Provider SMS Forum, 14th July 2020, attended by representatives from 17 boroughs.

²¹ 6 GLA hotel closures June-July.

Despite these more recent actions to support moves **between hotels**, HDAS has not been involved in supporting any **moves into longer-term accommodation**.²² Homelessness provider managers said that they had instructed staff to keep treatment providers informed of moves in response to HDAS requests, but local treatment services have reported anecdotally that they generally learnt about moves when SUs themselves informed them.

²² According to latest MHCLG data, 556 people had been moved into settled accommodation or a rough sleeping pathway outside of temporary accommodation from GLA hotels as of 25th September (see:

Support for rough sleepers in Local Authority emergency accommodation

An estimated 3,500 rough sleepers were placed in hotels, B&Bs and other accommodation across London's 33 boroughs by local authorities (LA). HDAS was commissioned to support GLA hotels as a priority but where there was capacity, to support LA accommodation. There were several barriers to this which limited HDAS support to LA hotels.

In mid-May, the GLA asked LAs directly if they were interested in support from HDAS, identifying only 5 (Camden, City of London, Ealing, Hammersmith & Fulham, Islington, Kingston). All were contacted by HDAS in mid-May to offer support, but only two expressed an interest in staff training. It is assumed that the rest felt that support provided by local SMS was sufficient.

Direct links made between HDAS and the Great Chapel Street GP Practice generated referrals from across LA hotels in **NW London**. These enabled a number of LA hotel residents to access treatment services and alerted local services to the presence of these hotels (there was a lot of confusion between Hounslow, Hillingdon and Ealing services about which services served which hotels as some were on borough boundaries, which HDAS helped to iron out, escalating any problems to SM provider senior management). HDAS Workbooks and tobacco harm reduction resources were also distributed in NW London through this link. HDAS were not able to replicate this provision across other areas of London because of lack of centralised information on LA accommodation arrangements.²³

HDAS is aware that SM needs amongst the rough sleeping population in some LA-commissioned hotels were still being identified several months after people were placed in accommodation because of the lack of consistent on-site support and in-reach healthcare support provided at many of these venues. In some areas, treatment services were not aware of where people experiencing rough sleeping had been accommodated until several weeks after lockdown (see case study).

At the same time, HDAS is also aware of very positive best-practice multi-disciplinary approaches to addressing support needs of people within local authorities during the pandemic that actively incorporated SM services (e.g. Kingston, Haringey, Hackney).²⁴

Case Study: In Southwark, the treatment service learned that most of Southwark's rough sleeping population had been housed by the local authority, many in two large hotels outside the borough. However, information on these arrangements and a list of residents was not obtained until late May. Once this was understood, the Southwark service took steps to identify and respond to SM needs (providing Naloxone and other harm reduction resources, offering assessments etc), but this did not get underway until early June, two months after people had first been placed in hotels.

²³ HDAS put together its own spreadsheet of LA accommodation, drawing intelligence from local treatment services and other contacts, but this was not comprehensive.

²⁴ See Healthy London Partnership Webinar, 6 August 2020, *Homeless health next steps for London: health needs assessments and the importance of an MDT approach*
<https://www.youtube.com/watch?v=SLOGllhDXus&feature=youtu.be>

Conclusions about Pan-London cross-provider provision

The nature of GLA homeless hotel provision, with people experiencing rough sleeping picked up and moved into hotels across boroughs, necessitated a Pan-London response to substance use need, given the fragmented commissioning of treatment services (28 separate services across 33 boroughs with different models of delivery).

As a cross-provider partnership, HDAS incorporated CGL, Turning Point and SLaM staff as part of the central HDAS team and Westminster Drug Project (WDP), Phoenix Futures, We Are With You, and Central and North West London NHS Foundation Trust (CNWL) within the SPOC team (representing organisations delivering part or all elements of treatment services in 30 of the 33 boroughs). In particular, the cross-provider nature of the service helped:

- Escalate and find solutions to barriers to engagement and treatment;
- Identify and quickly adapt appropriate resources e.g. workbooks and “distraction packs”;
- Cross-check information about residents in treatment e.g. clients raised at MDTs;
- Quickly share information about hotels opening, closing, plans for move-on etc.

Case Study: A female resident of a GLA hotel was referred to HDAS SPOC by the CHRISP Team. She was already in treatment on a methadone script for opiate use with Turning Point in a London service but wanted a change to her dose. Turning Point SPOC Worker was able to check client records and ensured that her key worker was made aware. Her case was raised shortly afterwards at an MDT with the CHRISP Team, healthcare colleagues and St Mungo’s. CHRISP team had concerns about her cognitive abilities. HDAS staff member present at MDT was able to provide information on her current treatment and history, notably safeguarding concerns about her relationship with her partner (with potential impact on her move-on accommodation options) and put the St Mungo’s worker directly in touch with her key worker, sharing concerns about cognitive ability.

Agility and flexibility of HDAS (and its component providers) and Commissioners was vital in the context of the pandemic and worked well, with the service moving through several phases with different focuses of attention. Effective cross-partnership collaboration helped the service to achieve successful go-live within a few days, negotiating technical/logistical teething difficulties. HDAS has provided a model of providers working together that could be stood up quickly in response to emerging need in the future.

HDAS ensured the visibility of substance misuse harm reduction and treatment among the range of needs within London’s rough sleeping population and promoted the availability of support via local and national platforms. This included:

- Active communications via email, phonecalls, deliveries to hotels, attending multi-disciplinary meetings;

- Presentations by the Clinical Lead to the *Pathway* Experts by Experience Panel, *Pathway* Faculty Meeting presentation,²⁵ NHS Addictions Provider Alliance conference presentation,²⁶ and the London Network of Nurses and Midwives (LNNM);
- Drink and Drugs News double-page article;²⁷
- NHS Substance Misuse Providers Alliance (now Addictions Provider Alliance) blog;²⁸
- Article on the Society for the Study of Addiction website;²⁹
- Speakers in two Healthy London Partnership Webinars attended by professionals working across the health and social care sector;
- All Party Parliamentary Group on Dual Diagnosis presentation on Homelessness and Substance Misuse during the COVID-19 Pandemic.

HDAS representation at weekly **GLA operational “Next Steps” meetings** with hotel managers, physical and mental healthcare providers provided a very useful understanding of the hotel context and an opportunity to offer additional support where required. Similarly, HDAS representation at the **Covid-19 Homeless Health Clinical Leads Group meeting** enabled integration of SM issues within healthcare considerations.

Pan-London representation and perspective has proved vital to ensuring ongoing joined up responses to improving the health of London’s homeless and ensuring that SM engagement opportunities are maximised during this period. Positive feedback from stakeholders for this report testifies to this, as does ongoing HDAS input (ensuring cross-provider representation) into:

- Pan-London processes for people experiencing rough sleeping (e.g. Homeless Health “second surge” preparedness planning and development);
- Roll-out of “mini” CHRISP assessments across homeless outreach teams and for use in newly established No Second Night Out (NSNO) Triage Hubs;
- Proposals for additional Pan-London substance misuse initiatives (Clinical Lead presence on PHE- London Task and Finish Group) including for inpatient unit resources and support for prison releases;

²⁵ <https://www.pathway.org.uk/events/faculty-meetings/>

²⁶ <https://www.nhsapa.org/post/bos-1-2020conf>

²⁷ <https://www.drinkanddrugsnews.com/ddn-september-2020/>

²⁸ *Homeless Hotel Drug & Alcohol Support Service (HDAS-London) during COVID-19*

<https://nhssmpa.org/blog/hdas-london-during-covid-19>

²⁹ *Prescription of alcohol in emergency homeless hotel accommodation during the COVID-19 lockdown*, Dr Emmert Roberts, and Dr Emily Finch, 9/10/20,

<https://www.addiction-ssa.org/prescription-of-alcohol-in-emergency-homeless-hotel-accommodation-during-the-covid-19-lockdown/>

- Ongoing learning opportunities e.g. Change Grow Live Clinical Conference, City Health Conference and invitation to HDAS Clinical Lead to take part in the stakeholder group supporting the development of NICE guidelines on integrated healthcare for homeless people.

With the imminent mobilisation of additional resources to address substance use within London's homeless population via Public Health England/Ministry for Housing, Communities & Local Government (MHCLG) funding to 21 of London's 33 boroughs,³⁰ there is a clear potential role for HDAS to support treatment services and Pan-London homeless, healthcare and other stakeholders to work together effectively, including across borough boundaries.

³⁰ Rough Sleepers Drug & Alcohol Treatment Grant targeted at MHCLG Taskforce Areas.

Guidance for provision of substance use support to people experiencing rough sleeping

This guidance is based on the above findings.

A. Commissioning of services to people experiencing rough sleeping

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.³¹
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.
7. Triage systems used by homeless outreach services and homeless pathways (e.g. NSNO and including any emergency accommodation processes similar to the recent "Everyone In") should ensure that basic information on substance use is promptly recorded, with information-sharing agreements in place to ensure this information is shared with healthcare services and treatment providers (whether NHS or third sector), where consent is given. Basic information should include:

³¹ As substance misuse services are legally designated 'primary medical services' overseas visitors can use these services, irrespective of immigration status. Proof of ID, lack of proof of address and lack of immigration documentation should not be reasons people are prevented accessing services – as per national guidance: Primary Medical Care Policy and Guidance Manual (PGM) <https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/>.

- Substances used (drugs, alcohol)
 - Whether they are interested in getting help
 - Whether they are aware of harm reduction approaches
 - Whether someone is already in treatment and if so, which service/GP.
8. Based on an understanding that SM treatment providers play a key role in wraparound, multi-disciplinary care for people experiencing rough sleeping with substance use needs, they should be included in MDT discussions about accommodation solutions and informed of any moves so that care is not interrupted (particularly for those who are prescribed and have medication pickup arrangements with local pharmacies).
 9. Information from hostels or other accommodation for people experiencing rough sleeping, including from Tenancy Sustainment Teams about alcohol or drug related incidents should be shared with local treatment services so that they can support with harm reduction approaches where resources allow.

B. Should emergency homeless hotel accommodation be established in future:

1. Ensure treatment provider representation (HDAS and SM outreach teams/treatment providers local to hotels) from the start in all operational discussions (particularly with hotel providers/senior management) to ensure rapid response and escalation.
2. Prompt assessment of substance use and tobacco harm reduction need as people enter hotels and sharing of this information with HDAS/SM treatment providers.
3. Review and re-circulate HDAS Clinical Protocols and harm reduction information to all staff.
4. Ensure clinical and recovery worker on-call response available for substance use concerns (with the flexibility to scale up/down in response to need).
5. Ensure prompt access to drug/alcohol/tobacco harm reduction resources with targeted support provided based on intelligence from hotel staff.
6. Offer additional harm reduction/substance use awareness training to hotel staff.
7. Ensure joined-up working with mental health providers for those with co-existing needs.
8. Consider incorporating stop smoking support (online/phone) alongside e-cigarette/nicotine replacement provision.
9. Ask treatment providers to give people experiencing rough sleeping referred for support a unique identifier so their progress can be tracked.
10. Consider providing HDAS and/or treatment providers access to CHAIN (if up to date) under data sharing agreements in order to cross-check information on SUs in treatment and ensure continuity of care; failing that, homelessness services should quickly identify and share

information on the whereabouts of people in treatment as part of early assessment processes.

11. Prompt sharing of information on drug or alcohol-related incidents/evictions to inform responsiveness and risk mitigation
12. HDAS/local treatment service involvement in MDTs to discuss "complex" residents.
13. Consider seeking cross-provider agreement for fast-track referrals for people experiencing rough sleeping with dedicated staff (where resources allow) to conduct assessments (in person and remotely) with capacity for follow-up and multi-agency working to increase chances of sustained engagement; where resources are not available, this could be flagged to HDAS to seek temporary additional funding.

C. Recommendations for future Pan-London treatment provider partnership (HDAS or equivalent)

1. Ensure visibility and involvement of substance misuse and tobacco harm reduction support within homeless health (including mental health) and housing pathways across London to ensure integration, identification of gaps in resources, consistency in response, shared purpose.
2. Ensure substance misuse provider involvement in any second wave pandemic response or future rough sleeping initiatives
3. Provide a consistent response to emerging or complex issues that would benefit from Pan-London collaboration e.g. NFA prison releases, hospital discharge pathways, response to people experiencing rough sleeping with dual diagnosis
4. Ensure pathways are clear for escalation of issues to GLA/PHE as commissioners of Pan-London provision e.g. impact of rise in rough sleeping, placement of staging posts etc. on treatment services
5. Maintain and update/agree cross-provider principles for treatment and care of people experiencing rough sleeping (continuity of care etc) to reflect latest need and a common standard of care
6. Share resources and learning across provision of treatment for people experiencing rough sleeping
7. Ongoing mapping and sharing information on the substance use, dual diagnosis/specialist complex needs and tobacco harm reduction support available across London, including additional PHE/MHCLG-funded resources, to help people experiencing rough sleeping and partner services navigate the system and quickly access help.

8. HDAS Clinical Protocols for addressing drug, alcohol and nicotine withdrawal should remain live, updated and widely available to services supporting homeless populations.
9. Build in funding for a formal evaluation component of any new projects.
10. Support additional research to inform learning and future guidance, including into:
 - Successful completions, unplanned exits/disengagement, assisted alcohol withdrawal within hotel or hostel accommodation etc following referral into treatment for people experiencing rough sleeping during this period;
 - Support for people with dual diagnosis during this period;
 - Use of hospital protocols for treating/prescribing for substance use for people experiencing rough sleeping with a view to assessing whether they reflect developments in prescribing that are more suited to this population and that support continued engagement and stabilisation;
 - Prevalence of IV drug use amongst the homeless population;
 - Patterns of Ambulance call-outs and A&E attendance for people experiencing rough sleeping for alcohol/drug-related incidents during the COVID pandemic;
 - Evidence of drug/alcohol-related incidents in the hotels and how these were addressed;
 - Evidence of drug/alcohol users remaining on the streets or returning to the streets early and an evaluation of the support they received on the streets during the COVID pandemic.

Appendix A: Overview of support provided by local SM Services to GLA hotels

	Wandsworth	Hammersmith & Fulham, Kensington & Chelsea, Westminster	Croydon	Tower Hamlets	Newham	Ealing	Southwark	Lambeth	Barking	Redbridge
No special arrangements	X			X	X	X			X	
In-reach		X (drug service on-site clinics)					X			
SPOC for hotel staff		X (alcohol service)	X					X		X
Training		X (drug and alcohol services)					X			
Harm Reduction resources			X				X			X

Abbreviations:

CHAIN	Combined Homelessness and Information Network
CHRISP	Covid-19 Homeless Rapid Integrated Healthcare Screening Protocol
GLA	Greater London Authority
HDAS	Pan-London Homeless Hotels Drug and Alcohol Support Service
LA	Local Authority
MDT	Multi-disciplinary Team
PHE	Public Health England
SM	Substance Misuse
SPOC	Single Point of Contact