# Pan London Substance Misuse In-Patient Detoxification and Stabilisation Unit and Intermediate Rehabilitation Beds

## Pathways Report: September 2023

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pathway
Healthcare for homeless people

CITY OF LONDON

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# Executive summary

## Purpose of the report

This evaluation was commissioned by the Pan London Substance Misuse Programme Commissioners and undertaken by Pathway. It aims to:

- Identify any barriers and/or facilitators to access and engagement for people who are rough sleeping or at risk of rough sleeping, within the Pan London Substance Misuse Programme, with particular focus on the In-Patient Detoxification and stabilisation beds (IPD1) at Guys and St Thomas' NHS Trust (GSTT), also known as ACCS1.
- Provide evidence of the effectiveness of the In-Patient Detoxification and stabilisation unit at GSTT and the abstinence based intermediate rehabilitation provision at Mildmay Mission Hospital by using anonymised discharge data to follow client journeys across the programme and identify outcomes.

## Background to the units

The Pan London Substance Misuse Programme commissioned the In-Patient Detoxification and stabilisation (IPD1) beds at Guys and St Thomas' NHS Foundation Trust (GSTT) and the intermediate rehabilitation beds at Mildmay Mission Hospital (Mildmay) to address the needs of people who are rough sleeping or at risk of rough sleeping. This population experiences some of the starkest health inequalities in London, with high rates of complex co-morbidities (including substance use often in combination with mental health and physical health problems) and early mortality. Due to this high level of co-morbidity, specialist services are needed, as detoxification and stabilisation cannot safely occur in the community and move-on options following detoxification / stabilisation are often complicated.

A high proportion of this population are severely and multiply disadvantaged and have experienced significant and complex trauma, often starting in childhood[1,2]. Substance use is often used to self-medicate or block out this trauma[1]. Trauma in early life can also impact how people develop relationships and interact with services, often resulting in non-engagement or exclusion from services due to non-attendance. A lack of stable, appropriate support and accommodation is a further barrier to engagement with treatment and healthcare, creating a revolving door of homelessness, addiction, ill health, and early death.

[1]Chase, L., 2015. Hard Edges: Mapping severe and multiple disadvantage: Summary Report: England. http://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

[2] Liu, M., Luong, L., Lachaud, J., Edalati, H., Reeves, A. and Hwang, S.W., 2021. Adverse childhood experiences and related outcomes among adults experiencing homelessness: a systematic review and meta-analysis. *The Lancet Public Health*, *6*(11), pp.836-e847. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00189-4/fulltext#seccestitle120

Recognition of the need for improved integrated pathways for vulnerable excluded populations, is highlighted in Dame Carol Black's two-part Independent review of drugs, with a 'whole system' approach based on accountability, collaboration and partnership.

The IPD1 beds at GSTT and the intermediate rehabilitation beds at the Mildmay Mission Hospital have multidisciplinary teams which aim to support people with complex needs in a person-centred way. They include specialist clinicians, nursing staff, drug and alcohol specialists, clinical psychologists, and psychiatrists.

## Methods

Discussions were held with service users, a range of stakeholders and people working in the GSTT IPD1 unit and the Mildmay Mission Hospital. These discussions enabled us to identify outcomes for 79 out of 135 of the service users who had been through the IPD1 beds from when they opened in July 2021 until December 2022 and of the 18 people who have been admitted to Mildmay between March and December 2022. These discussions have also contributed to the overall understanding of facilitators, barriers, and gaps of the substance misuse pathway.

## Findings

### Who was being admitted?

Admissions to both units appeared appropriate, with 94% having a history of rough sleeping or being at risk of rough sleeping and the majority having very complex needs (co-morbidities / high level of clinical complexity / significant mental ill health) alongside high alcohol and/or polydrug use. This suggests that the population admitted through the IPD1 unit could not have safely undergone detoxification or stabilisation in the community and needed a specialist MDT to provide adequate and appropriate support.

### Detoxification and stabilisation completion rates

Detoxification and stabilisation completion for the 135 people admitted to the IPD1 beds at GSTT between July 2021 until December 2022 were 84%.

GSTT IPD1 admissions: Tracking the service users' journeys.

## Overall outcomes

The subset of 79 admissions for whom we have follow-up data had very similar admission / discharge information and completion rates as the whole cohort of 135 admissions, suggesting that this subset is likely to be a good representation of the whole cohort.

Out of these 79 individuals, 56 (71%) had appeared to benefit from their stay within the IPD1 beds by either having achieved a 'good' outcome or by at least being 'further along their journey'. The following shows further breakdown and explanation:

- 32 (41%) were identified as having what we classified as a 'good outcome' at the time of follow-up. This included 26 people who were now abstinent, a further five who were controlled on Opiate Substitute Therapy (OST) alone and one person who was now in a care home with controlled support.
- 24 (30%) were still using substances but were 'further along their journey'. Though not abstinent or controlled on OST alone, these individuals were in a better position than before their admission to the unit. This included people who had, for example, been rough sleeping and polydrug using prior to admission, but who had changed their pattern of substance use to less harmful ones, maintaining engagement with their substance misuse support team and were in accommodation. Other examples included people who had been threatened with eviction from their hostel due to behaviour and who were now maintaining their accommodation.
- For 20 people (25%), there was no apparent improvement in their situation. This included people who were unable to 'sit with their trauma' when sober or not intoxicated.
- At the time of follow-up, two people had sadly died.

What was clear from stakeholders was that many people need repeated opportunities to have a detoxification and rehabilitation journey as *"few people make it first time - going around the cycle more than once is part of their journey. Failed placement isn't necessarily a failure in the longer term"* (Service provider). Having a positive experience within the GSTT unit, even if they do not complete their detoxification, can help people recognise that they could try again.

## Discharge destinations

There was a range of discharge destinations from the GSTT IPD1 beds.

Out of the 79, 51 (65%) were discharged to 'stable' accommodation, the majority of these being to residential rehabilitation (51%) or the Mildmay Mission Hospital (24%). Out of those discharged

to residential rehabilitation, 19 (73%) had good outcomes. However, out of those discharged to the Mildmay Mission Hospital, only 3 (25%) had good outcomes.

24 (30%) were discharged to accommodation that we identified as 'less stable', such as a hostel or temporary accommodation. There was a range of reasons for discharge to a hostel, which included lack of other options, service user choice, aftercare plan not acceptable to the service user or early discharge from the unit following relapse. Though there was only one person discharged to less stable accommodation with a good outcome, 58% were, nevertheless 'further along in their journey'.

Though the complexity of a number of the service users who were discharged to less stable accommodation is clear, it is likely that had there been more choices of appropriate move-on options and aftercare support, particularly for people who have experienced significant trauma, outcomes could have been better. A few commissioners/providers said it can feel like you are *"setting people up to fail,"* with another acknowledging that *"detox doesn't make you independent and able to obtain and sustain your own tenancy" there is "no real infrastructure for afterwards."*

### Who is not getting referred into the unit

Speaking to people from T1000 and RhEST teams who work with some of the most complex and entrenched rough sleepers, getting their clients referred into the IPD1 beds was difficult. These frontline staff are often left supporting people they consider very high risk of dying, with their concerns and recommendations often not listened to by community health or addiction teams, even when they believe there is a window of opportunity for their client to benefit from admission for detoxification or stabilisation.

However, it was also clear from a clinical psychologist working with this population that there often needs to be significant work to support someone who has experienced trauma before they can be in a position to undertake a detoxification programme.

There are currently clearly gaps within services for people sleeping rough with substance use disorder, and though the IPD1 unit is reaching people with extremely complex needs, there are still some of the most entrenched rough sleepers and people with very complex needs whose needs are not being met by community substance misuse services.

## Mildmay Mission Hospital admissions

We also looked separately at the 18 admissions to Mildmay Mission Hospital's intermediate rehabilitation beds between March 2022 and December 2022.

Of these admissions, 14 were admitted from the GSTT unit, and four were admitted following an acute hospital stay, where they underwent detoxification or stabilisation. The Mildmay Mission Hospital intermediate rehabilitation beds were used to support people to transition and prepare for rehabilitation or other move-on options. Admissions provided opportunity for further assessments / referrals, stabilisation, clinical and therapeutic interventions, and psychosocial work.

This often includes people where other rehabilitation units would not be appropriate often as a result of their multiple and complex needs. 16 of the 18 admissions had serious medical co-morbidities in addition to their substance use needs including neurological disorders, gastrointestinal and liver disease, trauma related injuries, malignancies, and mental ill-health.

There were a number of people who relapsed while in the Mildmay, despite individualised and group support. It was clear to the Mildmay's specialists that some of them had extremely complex needs with a history of significant trauma, and they were unable to 'sit' with their trauma while sober. Service User journey outcomes from Mildmay may not be as good compared to those who went to residential rehabilitation; however, this is most likely due to the lack of alternative options or places of support for people carrying high levels of trauma.

## Risk of relapse

Service users and providers highlighted a number of reasons for relapse. These included a lack of a range of trauma informed options post detoxification (such as specialist rehabilitation) or post rehabilitation, such as supported accommodation where people could retain abstinence or harm minimisation while receiving psychosocial support. People in recovery felt at risk of relapse due to isolation and a lack of long-term psychosocial support to enable them to maintain their journey of recovery and achieve or maintain a sense of purpose.

## Conclusions

- Both the GSTT IPD1 beds and Mildmay Mission Hospital are working with some of the most complex people who are or at risk of rough sleeping providing much needed medical interventions and management for people who do not normally receive it.
- There are excellent completion rates of detoxification and, considering the complexity of the population, a high rate of favourable outcomes at follow up.
- Many people need more than one attempt at detoxification and success should not be simply considered as to whether someone achieves abstinence.
- There are, however, insufficient detoxification and stabilisation beds, rehabilitation, and move-on options across London, with these gaps contributing to long wait times, lack of referral and relapse.
    - Wait times to get into the unit can result in loss of a window of opportunity for change.
    - There are significant gaps in the range of rehabilitation options available.
    - There are significant gaps in supported accommodation for people who are abstinent and people who are controlled on OST.
- There are people, often those who have experienced extreme trauma, who the community health and substance misuse services are not reaching due to difficulties around engagement.
- Frontline outreach homelessness staff are often left carrying the burden of some of the most high-risk individuals.
- In order to prevent relapse, many people, including those who achieve abstinence, need ongoing person centred, trauma informed support to help get a purpose back in their lives and maintain a journey of recovery.

## Key recommendations for Pan London substance misuse pathway

In order to tackle the stark health inequities facing this multiply excluded population there is a need for:

- **Long-term, person-centred, trauma informed / psychosocial support,** provided throughout all stages of the journey, with particular attention during transitioning periods. This could include:
    - Individuals or a specialist team (e.g., from Inclusion health, homelessness support workers, outreach workers, care navigators and peers with lived experience), working alongside substance misuse teams to provide wrap around support and help prepare clients for admission and support them following detoxification or stabilisation.
    - Sustained recovery team to support ongoing psychosocial support following discharge from local substance misuse services.
    - Support provided by connecting peers who are in a similar situation, such as those who have been through detoxification/rehabilitation.

- Homeless substance misuse engagement service **that includes a clinical prescribing element**

- **Practical and emotional support for staff** working directly with people with substance misuse who are sleeping rough.

- **Appropriate targets and measures of success that consider and reflect the complexity of this population.**
    - Recognising value of harm reduction or being further along their journey and that achieving abstinence is not necessarily appropriate or achievable for everyone.

- **A greater number of in-patient detoxification and stabilisation and intermediate rehabilitation beds** to support this population across London.
    - There is a need for more medically managed beds such as the GSTT IPD1, but also some less clinical, medically monitored units for people with less complexity.

- **A wider range of services** to support planning, person centred care and choice including:
    - more flexibility from community substance misuse teams around non-attendance with support to encourage engagement.
        - E.g., Consider whether use of long-acting buprenorphine (Buvidal) can be expanded into areas not currently using it.

    - a place where people who are rough sleeping can be stabilised and prepared for detoxification prior to admission.
    - a choice of types of rehabilitation, including
        - community rehabilitation
        - specialised rehabilitation units (including trauma informed and gender specific, unit for people with learning difficulties / cognitive impairment / alcohol related brain injury, for people not fluent in English, for people with mobility problems, for people not ready to come completely off opiate substitution therapy)

    - a range of trauma informed support and accommodation options following detoxification or rehabilitation including:
        - abstinence based supported accommodation.
        - supported accommodation for people controlled on OST / less harmful substance use.
        - Independent accommodation with wrap around / floating support

- **Using opportunities to capitalise on windows of opportunities**, such as:
    - Establish effective communications between community substance misuse teams and specialist homelessness support workers that truly listen to each other's insights and suggestions about appropriateness of referrals for people to be considered by panel.
        - Consideration should be given to such specialists completing assessments to be taken to panel in the relevant borough.
    - Develop a pathway for a direct referral to intermediate rehabilitation beds or rehabilitation from an unplanned hospital admission - particularly if there is a long hospital stay and someone is medically detoxed and wants support to remain abstinent.
    - Improved access to MDT/clinical support for service users that are being supported by Pan London front line workers (T1000 and RhEST).

- **Effective utilisation of the waiting time between referral and detox**
    - Substance misuse team and/or key workers to facilitate continued engagement by being compassionate, acknowledging the wait time, and providing support during this difficult period. This wait time can also be an opportunity for
        - addressing physical health and dental health needs, particularly as detoxification from substances can result in emergence of pain that had hitherto been masked by substances.
        - engaging with counselling to address other underlying issues.
    - Provide support groups by peer mentors to discuss the journey, help with expectations, offer encouragement, and potentially look to the future, past detoxification, and rehabilitation.

- **Integrated working between substance misuse, health, homelessness, housing, and adult social care to support appropriate move-on options, in or out of borough as appropriate.**
    - Relationships need to be further developed / strengthened between community substance misuse teams, housing / homelessness teams and adult social care.

- **Recognition of the need to support people to maintain and develop a sense of purpose** at all stages of their journey.

# Introduction

This is a report about the substance misuse detoxification and stabilisation pathway in London for people experiencing homelessness who are sleeping rough or at risk of sleeping rough. It explores the outcomes of people who have been through the Pan London Substance Misuse In-patient Detoxification and stabilisation (IPD1) beds at Guys and St Thomas' NHS Trust (GSTT), also known as ACCS1; intermediate rehabilitation beds at Mildmay Mission Hospital (Mildmay), along with insights and reflections on the pathway that is in place for this population.

The findings are divided into 4 main sections:

PART 1: stakeholder's perspectives of IPD1 detoxification and stabilisation beds and pathway.
PART 2: stakeholder perspectives of the intermediate rehabilitation beds at the Mildmay Mission Hospital.
PART 3: perspectives of how the whole pathway is working and
PART 4: follow-up information of service users who have been through the GSTT IPD1 beds (4a) and Mildmay beds (4b).

## Aims and objectives.

The aims of this project were to:

- Identify any barriers and/or facilitators to access and engagement for people who are rough sleeping or at risk of rough sleeping, within the Pan London Substance Misuse Programme, with particular focus on the In-patient Detoxification and stabilisation beds at (GSTT).
- Provide evidence of the effectiveness of the In-patient Detoxification and stabilisation unit at GSTT and the abstinence based intermediate rehabilitation provision at Mildmay Mission Hospital (as appropriate) by auditing anonymised discharge data which is held by the Pan London Substance Misuse Programme to follow client journeys across the programme.

  The objectives were to work with substance misuse, homelessness, and rough sleeping lead.
  Contacts and service users to:
- Review entry pathways into Pan London services and identification of any potential/actual barriers to commencing a treatment journey.
- Explore causes/motivation for early discharges from IPD1 and intermediate rehabilitation beds by speaking with relevant staff and service users.

- Undertake an audit of the 135 service users (or the number of service users who community services are able to provide information for) discharged from the In-Patient Detoxification and stabilisation unit between July 2021 and December 2022, and 18 cases discharged from Mildmay Mission Hospital between March 2022 and December 2022, to learn more about individual journeys in and out of these services.
- Highlight areas of good practice and provide recommendations on what is needed to address gaps and barriers to enhance an integrated pathway for this population.
- Commissioners of the Pan London Substance Misuse Programme can take forward the recommendations to the implementation stage / development of an action plan.

## About the IPD1 unit at GSTT

The service at GSTT provides a hospital-based, medically managed inpatient detoxification and stabilisation service for people who are rough sleeping or who are at risk of rough sleeping as part of a Pan London response to supporting this group. The six inpatient detoxification and stabilisation elective admissions STT are for people who are dependent on drugs and/or alcohol who also have high levels of co-occurring, complex physical/mental health medical needs. It addresses the needs of service users with significant physical co-morbidities who have not been able to access community detoxification due to the risks of acute clinical deterioration and the shortfalls in clinical expertise and available facilities.

With specialist care, including medical, psychiatry and psychology, the unit offers a holistic and supportive programme to help people withdraw safely from drugs and alcohol. The intention is to meet immediate needs while providing opportunities for long term change, contributing to ending rough sleeping and tackling entrenched health inequalities.

The aims of the service at IPD GSTT, as in the services specification, are to:

- To deliver an integrated IPD care pathway underpinned by a shared understanding of the recovery principles applicable to all commissioned drug and alcohol treatment services across London boroughs.
- To provide a multi-disciplinary partnership between pan-London local authorities, community substance misuse teams, housing and social care, and tertiary care in order to provide a holistic inpatient detoxification service.
- To collaborate with the provision of local authority services aligning with presenting needs aiming to maximise positive treatment outcomes.
- To place the needs of those who are rough sleepers who have complex needs at the centre of delivering holistic care, promoting health, well-being, and life chances.
- To raise the aspirations of service users and lower barriers to care to strengthen engagement with treatment by building trust and understanding in the service provided

## About the intermediate rehabilitation beds at Mildmay Mission Hospital:

The six stabilisation-based intermediate rehabilitation beds based at the Mildmay Mission Hospital were commissioned for people moving on from an In-Patient Detoxification or stabilisation (IPD1) stay, who have been sleeping rough or are in hostel accommodation or are at risk of returning to the street. They are intended to provide support to those who need more time in a setting that will support their stabilisation, improve sustained recovery, and prepare them for either further residential/community rehabilitation or step-down housing in the community. Some people will require additional support to manage co-existing physical and mental health needs. Most of Mildmay intermediate rehabilitation referrals were received in conjunction with a referral to the GSTT unit.

Aims of the intermediate rehab beds from service specification:

- Build on the outcomes from IPD and support sustained treatment, engagement, and recovery.
- Deliver a safe and supportive intermediate rehabilitation residential setting, which supports stabilisation.
- Provide sufficient varied and skilled clinical and psychological assessment and intervention to maximise positive treatment and recovery outcomes.
- To manage different aspects of care for alcohol and/or drug stabilisation, associated medical pathology and improving physical and psychological health and wellbeing.
- Participate in a multi-disciplinary partnership with London LAs, IPDs, community substance misuse teams, pan London Homeless Substance Misuse Engagement Team, rough sleeping teams, housing, specialist general health services, mental health services, social care services, safeguarding, domestic abuse services and tertiary care to provide a holistic service for people who sleep rough/in hostel accommodation/risk of return to the street.
- Place service users at the centre of delivering holistic care, promoting health, well-being, and life chances.
- Raise the aspirations of service users and lower barriers to care to strengthen engagement with treatment by building trust and understanding in the service provided

## Background to the units

The Pan London Substance Misuse Programme commissioned the In-patient Detoxification and stabilisation (IPD1) beds at Guys and St Thomas' NHS Trust (GSTT) and the intermediate rehabilitation beds at Mildmay Mission Hospital to address the needs of people who are rough sleeping or at risk of rough sleeping. This population experiences some of the starkest health inequalities in London, with high rates of complex co-morbidities (including substance use often in combination with mental health and physical health problems) and early mortality.

Due to this high level of co-morbidity, specialist services are needed, as detoxification cannot safely occur in the community and move-on options following detoxification are often complicated.

A high proportion of this population are severely and multiply disadvantaged and have experienced significant and complex trauma, often starting in childhood. Substance use is often used to self-medicate or block out this trauma[1]. Trauma in early life can also impact how people develop relationships and interact with services, often resulting in non-engagement or exclusion from services due to non-attendance. A lack of stable, appropriate support and accommodation is a further barrier to engagement with treatment and healthcare, creating a revolving door of homelessness, addiction, ill health, and early death.

Recognition of the need for improved integrated pathways for vulnerable excluded populations, is highlighted in Dame Carol Black's two-part Independent review of drugs, with a 'whole system' approach based on accountability, collaboration and partnership.

The IPD1 beds at GSTT and the intermediate rehabilitation beds at the Mildmay Mission Hospital have multidisciplinary teams which aim to support people with complex needs in a person-centred way. They include specialist clinicians, nursing staff, drug and alcohol specialists, clinical psychologists, and psychiatrists.

## Methodology

Using both quantitative and qualitative data, we sought to answer the following questions:

- What are the barriers and/or facilitators to access and engagement of people who are rough sleeping or at risk of rough sleeping within the Pan London Substance Misuse Programme, with particular focus on the In-Patient Detoxification and stabilisation beds at GSTT?
- What is the evidence regarding the effectiveness of the In-Patient Detoxification and stabilisation unit at GSTT and intermediate rehabilitation provision at Mildmay Mission Hospital?

Discussions were held with a range of stakeholders to gain their insight and experience of working with individuals needing detoxification or stabilisation, of referring them to the GSTT IPD1 unit, and to share anonymised service user journey information. Visits to GSTT and Mildmay Mission Hospital also took place. In addition, service users of the GSTT IPD1 and Mildmay who gave consent were interviewed.

Stakeholders included:

- Borough substance misuse commissioners and providers.
- People working within the Regional Homeless Engagement Substance Use Team (RhEST), who are commissioned as part of a Pan London Substance Misuse pathway to work with people who sleep rough with complex needs to improve access to drug and alcohol treatment, and in particular, inpatient treatment or stabilisation.
- People's Recovery Project, a newly formed charity that is piloting 'alternative routes into detoxification and rehabilitation without conditions or delays,' for people experiencing street homelessness and addiction.
- T1000 Care Navigators, outreach workers who work with the most high-risk people who are experiencing long term or repeated episodes of street homelessness.
- Transformation Partners Health and Care Co-occurring conditions team, who focus on improving coordination between substance use and mental health services for people experiencing homelessness in London.
- Psychologist working in hostels from South London & Maudsley (SLAM), an NHS Foundation Trust specialising in mental health.
- Nurse from a hospital Drug and Alcohol team.
- Doctor from an inclusion health hospital team.

Semi-structured interviews and focus groups were conducted with stakeholders between May 2023 and July 2023. Most took place over video conferencing via Microsoft Teams. Face-to-face interviews were conducted at GSTT, Mildmay Mission Hospital, and with the RhEST team and T1000 navigators. Service user interviews took place over the phone. At least two of the evaluation team members were present, with one facilitating and the other taking notes, except for service user interviews where there was usually one team member. All data captured was anonymised.

At the start of the project, the evaluation team were given the following information on each admission by the commissioners: local authority from where the person was referred, date of admission and date of discharge from the unit, whether there was successful completion of detox, whether the discharge was planned, type of accommodation from which the person was admitted (e.g. street, hostel, temporary accommodation etc.) and type of accommodation to where the person was discharged (such as hostel, rehab, temporary accommodation, street).

In advance of meetings with borough commissioners and providers, in order to help them be prepared to discuss their clients' journeys, participants were emailed this anonymised information regarding service users who had been through the service from their borough, along with specific questions. Information received by email or during an interview with the service providers and/or commissioners informed our analysis and helped to determine the journey outcome of each service user.

Additional data from a focus group with people with lived experience was collected outside of this project by members of the Drug and Alcohol team at Transformation Partners Health and Care in June 2023. This was used in understanding some of the barriers and facilitators in supporting recovery, across the entire substance misuse and homelessness pathways. The notes from this focus group were themed and used to inform the section on services users' perspectives of what's needed to support recovery.

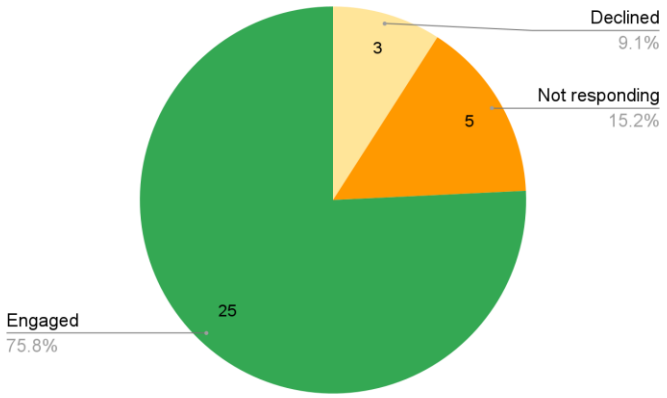
After the initial data analysis, the evaluation team members met with a group of six people with lived experience to share and sense-check the findings, listen to their feedback and ask them about their recommendations. Their input was incorporated, and members of the evaluation team had a follow-up meeting with one of the individuals with lived experience before finalising the recommendations.

# Findings

## Stakeholder engagement

Most stakeholders were responsive and well engaged with this evaluation. Out of the 33 boroughs in London, 25 engaged in this project. Amongst these 25 boroughs, 57 providers and commissioners were interviewed. See Figure 1.

Figure 1 London boroughs engaged with the project.




Twenty-two other stakeholder participants were: care navigators from the T1000 programme (7), senior practitioners and service managers from RhEST (4), directors of the People's Recovery Project (2), UCLH substance misuse nurse and Homeless Health consultant (2), TPHC Co-Occurring Conditions team (5), SLAM clinical psychologist working in hostels (1).

In addition, eight service users who had been through the IPD1 at GSTT were interviewed, the findings of which are captured within 'service user perspectives' sections.

# PART 1: GSTT IPD1 beds

Most people we interviewed recognised that detoxification and stabilisation forms only one part of a pathway for people with substance misuse issues - preparation before and move-on afterwards are essential parts of someone's journey.

However, it was also recognised that this population has very high rates of complex trauma, with often a range of complex needs, meaning flexibility and alternative options are needed within the pathway. This is explored further in this report.

## Who gets referred into the IPD1 unit: how are decisions made?

There were variations in how decision making occurred regarding who would be referred into the In-patient Detoxification and stabilisation beds. These varied according to the population's needs, the team, and the decision makers. Some examples of these variations are explored in the following sections, but one example of the overall steps involved in the decision-making process of a borough with a high level of people sleeping rough that used both the GSTT IPD1 and Mildmay beds, is outlined below:

- Reasons for referral are related to 'professional concern' or 'patient wants detox.' Need for admission would normally be discussed initially at an MDT with internal and external partners, including housing/supported housing, outreach providers/navigators and other relevant agencies. Examples of decisions made by the MDT would be, for example, if a person only wants detox, they may discuss and go back to say "*no, it needs to be detox + rehab*." Or the MDT may decide that a person needs a period of stabilisation first (such as in a hostel) if they are an entrenched rough sleeper.

- Following the MDT, the application goes to a panel unless there are exceptional circumstances, or for example, a person is detoxed in hospital, in which case they would refer to Mildmay Mission Hospital initially, and then discuss funding. At the panel, plans are discussed to tailor needs, such as the need for translation services, rehabilitation, or move-on accommodation. Once a pathway has been established, a referral will be sent to GSTT (and where appropriate to Mildmay), copying in housing, support workers, etc.

## Requirements for aftercare / move-on plans

One of the requirements for admission to the IPD1 unit is an aftercare plan (such as rehab) to be in place. Though the majority of people accepted that this was important in principle, the difficulty in securing appropriate aftercare arrangements, such as appropriate accommodation or

residential rehab, was seen as a barrier to referral and delays to detox. This caused frustration for some, with a provider saying, *"some then end up self-detoxing, safely or unsafely."* Another said it can lead to staff not making the referral – *"...no time to prepare a post detox plan or address homelessness."* However, the GSTT unit does try to be more flexible around this than when the unit first opened. For example, they used to not accept people with the plan to return to a hostel, but now they do allow it (see below under GSTT perspectives). The Mildmay Mission Hospital was also considered as a move-on option for people where it was not clear what the appropriate discharge destination would be (explored further within the Mildmay sections). However, due to a low number of beds at the Mildmay Mission Hospital, and the need to coordinate an admission to GSTT for detoxification and stabilisation around when there would be a bed available at Mildmay, wait times were often much longer.

## Preparation for referral into the IPD1 beds

Pre detoxification stabilisation and/or preparation requirements (and terminology) varied between boroughs with a range of approaches. These were explored in the discussions with providers and commissioners as well as people working in T1000, RhEST and People's Recovery Project.

### Provider and commissioner perspectives

Some providers/commissioners said they felt it was important to have a quicker turnaround from panel for the rough sleeping pathway than for the non-rough sleeping pathway whereas others did not 'fast track' clients from the street to detoxification/rehabilitation except for urgent cases.

This meant that in some boroughs, there were reduced thresholds for people within the rough sleeping pathway in terms of what was required in advance, regarding workup or preparation for detox. For example, one provider spoke about the difficulty making plans with clients who are intoxicated and said, "*we believe referral to the unit is best for 'fast track' clients. We do not ask these clients to stabilise or engage in group work first as this will set them up to fail."* As one provider said, *"getting their engagement when they're not detoxed, many of whom are entrenched rough sleepers and say they don't want treatment or a house, it's difficult."* Some acknowledged that many people are unprepared to engage with groups and that most of their referrals were based on 'medical needs' and 'homelessness.' They wanted to get away from the traditional view which required clients to attend groups and do group work. Instead, they offer more informal groups such as coffee drop-in mornings and have "*diverse plans*" discussed at panel, tailoring steps, and housing. Despite the recognition that it was "*difficult to find the balance in getting the client to engage with the preparation*" most agreed that being prepared for an admission to the IPD, and making some plans for afterwards, were important.

For other boroughs, there was an expectation of stabilisation and a structured process to decision making with MDTs.

Comments regarding preparation included: it's *"important for clients to demonstrate a degree of readiness, stability"*; *"People who are rough sleeping need time to build relationships with the team"*; *"it's 'important ...to help people cope with it and get into the right mindset"*. One provider said there can be pressure from some professionals *"to push clients into the unit"* which then can *"prevent time for adequate preparation, setting them up to fail."* One borough group said that within their borough, they required people to be stabilised onto OST before they would refer for admission to the unit. This required a move off the street, into accommodation and onto a script before being *"potentially referred onto detox if appropriate."*

For a number of boroughs, people were not referred into the In-patient Detoxification and stabilisation beds from the street. Pre referral 'stabilisation' was felt to be essential and included moving someone into accommodation, such as a hostel, to help get clients accustomed to living off the streets before considering referral to the unit.

Some borough groups also acknowledged that *"some people need to go in more than once and initial non completion should not be seen as a failure when working with someone who is complex."* One of those groups also said, *"intention is not always abstinence, but the intervention can modify behaviour."*

Other borough groups have no or low numbers of specialist homelessness services and said that as they do not have outreach support, they are unable to work with people experiencing rough sleeping. They felt limited as to how much they could do or offer. Some said that is why they do not use the rough sleeping pathway. *"We don't have rough sleeper staff who are trained with knowledge and experience for this population …to bridge the gap."*

### Clinical psychologist perspective

A psychologist who works with people who have experienced significant trauma and who are in hostels described the difficulty of recognising and untangling clients' needs that may need addressing before they can consider detox: *"When I'm listening to cases, I can see why people* [hostel staff] *want detox for their client"*. She felt that referrals can be driven by support workers' anxieties rather than clients' psychological readiness. *"I understand the frustration. Staff are holding a lot of risk and chaos."*

Regarding one particular person that she worked with who went through the IPD1 unit, she described the importance of her client's initial motivation to stop using. There was a lot of intensive preparation work needed, which included the client needing to look at her trauma history, consider her triggers and understand how she was using substances to escape difficult feelings. Thinking about the aftercare plan was also *"really important, but also really tricky with our clients'*. The initial plan was to go to rehabilitation, but the client changed her mind while in the detox unit. *"This*

*happens a lot, thinking about rehab is really, really scary. Many people think they want to go to rehab... but they still want to avoid the painful work."* The psychologist did however feel that for recovery, people *"don't necessarily [need] to go into their trauma but do need an awareness of how they* [substance use and trauma] *are linked."*

### Frontline / outreach navigators and support workers perspective

The experience of stakeholders from T1000 and RhEST, who work with some of the most high-risk and complex rough sleepers, was that it was extremely difficult for their clients to engage with community substance misuse teams, making it difficult for their clients to get to a stage where their community substance misuse team refers them to panel for consideration of detoxification and stabilisation. Though the IPD1 unit was originally set up to support people who were rough sleeping who had high levels of co-morbidities, T1000 care navigators felt that *"referrals into the GSTT unit are not now just for the most complex as was intended"*. This was not a result of referrals being rejected by the IPD1 but that referrals were not reaching the unit.

They were also concerned that in some boroughs the referral process is long, and clients end up *having multiple assessments, which they may refuse to engage with, may be unnecessarily traumatising and results in losing people on the way*. They felt this lack of flexibility left the *"most marginalised"* in society, i.e., complex, street homeless, "*having to jump through hoops."* T1000 outreach workers voiced frustration that, though they know their clients extremely well, they are often not listened to by community substance misuse teams who may not have the skills and resources to work flexibly and engage people with this degree of complexity and trauma.

However, this wasn't the same everywhere, as the pathway and thresholds for referral into IPD1 vary across London *"it's a "roll of the dice"*. Some boroughs were flexible but for a number there was a requirement of being *"scripted and stabilised for 6 months or attending groups before being referred - which for some people is completely unrealistic"*. Examples of flexibility in some boroughs can be seen regarding prescription of Buvidal [an injectable treatment for opiate addiction that can be given weekly or monthly rather than most OST which needs to be taken daily]. As a care navigator from T1000 remarked

> "*Buvidal would have made it easier but there are significant hoops to getting it prescribed. Some areas use Buvidal more easily than others… Often, instead of looking for reasons why someone is not engaging, services will close cases… for example, they may only try phoning clients once, or send appointments via text message to a person who can't read. This approach is not client focused yet common across the system with the 'three strikes and you're out' policy… A formulaic engagement process feels an ironic way to deal with such complex addiction issues and unfortunately results in the most complex cases being discharged from services for non-attendance."*

As a result, those working within T1000 and RhEST teams described that their clients with complex needs often end up at crisis point, accessing emergency medical detoxification through a hospital admission ("*detox by stealth"*) following which they are discharged and *'frequently relapse'*. A care navigator from T1000 said, *"Because I rely on the NHS to provide emergency detoxes, 80% of my clients relapse constantly"*. Or worse, *"die before they get to be successful."* He added, "*in addition, clients with cognitive impairments, such as with Korsakoff's, do not meet the referral criteria as they're not able to engage with the commitment required."* Following is a case example from T1000 Care Navigators where an opportunity for recovery was nearly lost:

> *"One of our team had a client who had been requesting an alcohol detox for a year but was refused referral for detox as he had difficulty engaging with groups online. His care navigator had later taken him to GSTT at crisis point for another reason. Here the hospital Pathway team fought to keep his bed until a safe discharge could be located, as a return to his hostel posed a substantial risk to his health and even life. A lot of work went into getting him into rehab and he has since remained abstinent and is looking into becoming a social worker." (*T1000 care navigator manager).

T1000 and RhEST described how they felt quite frustrated trying to get their clients to be considered for detoxification and stabilisation due to the lack of success with supporting them to jump through the required hoops in order to get considered for referral. One worker said:

> "*I have a client who has to go to weekly pre-detox groups, before he is allowed to go to detox, he is sleeping in a tent in a park. To make an appointment at 10am on the other side of the borough is very difficult. We can meet them and take them to the appointment. We are lucky that we can do that." (*RhEST senior practitioner)

The RhEST practitioner's role is to support engagement of the most entrenched people, but they recognised how hard it was for people who were marginalised and homeless to engage with current services.

For clients who were high risk and who could not engage with community substance misuse services, both RhEST and T1000 workers described referring clients to social services due to safeguarding concerns. However, this could also be really challenging because their concerns were often disregarded by social services. Though they are not a statutory body, they were often left holding the risk for clients who are not accepted into appropriate services.

These outreach workers described how they are currently watching clients deteriorate with addictions and co-morbidities. With no access to detoxification or stabilisation, or adequate health support, they are left case managing clients who they believe are at high risk of sudden death.

*"We are managing risk..we are knocking on the doors of the local authority to basically prevent a sudden death."*

### Acute hospital: perspectives

For people working in an acute hospital setting, there is frustration that people who have been detoxed in the hospital cannot move directly into rehabilitation- even if they are in the hospital for some time. A homeless health doctor working in an acute setting said, *"One of the biggest things I'd like to be able to do when seeing patients in hospital is refer directly from hospital to inpatient drug and/or alcohol rehab*."

Another person working in substance misuse services within a hospital said:

> *"In-patient detox should be available for all those who need it. I've been working a long while in this and we used to have detox units within hospitals, like a complete ward. We didn't have difficulty getting people in… People are progressively becoming unwell because the pathway isn't there for them. Or the hoops they have to go through… Acutes are picking up the slack and are not funded to do it."*

For some people admitted to non-detox, medical beds following an acute hospital admission, some providers/commissioners managed to secure a bed at the Mildmay Mission Hospital. However, due to capacity, this is not always possible, resulting in some people having to return from hospital admission to less stable living circumstances, increasing their risk of relapse.

### Waiting for a bed

The waiting list for the unit has increased over the time it has been open, due to increased demand. Commissioners and providers said the wait time changed to six weeks but is now eight to 12 weeks, with a couple saying it can be up to 16 weeks. One provider said, there was a "*massive benefit, where the waiting list was so short and the intervention on hand, you could get someone really unwell in for treatment fast…the waiting time now, I worry those complex ones, will die waiting*." One described ringing weekly to ask where their clients are on their list. Others acknowledged that there was flexibility and that urgent cases were prioritised by the IPD unit.

Referrers described how long wait times can be a problem as people's circumstances change; they may lose motivation, and the window of opportunity can be lost. This was thought to be especially the case for those with polysubstance detoxification needs where *"the window of opportunity for the client is often narrow for these high-risk clients"* (Service provider).

However, one borough group said that the wait time can be used as preparation time, which can be helpful to maximise success in some cases. One person who had been through detoxification and rehabilitation made a number of suggestions as to how this waiting time could be used productively, to support continued engagement and increased success of detoxification (captured in Part 3 Service users' perspectives).

### Service user perspectives of the unit

All eight of the service users we interviewed were very positive about their experiences within the detoxification and stabilisation unit. One service user who had an extended stay due to health complications said the unit was *"fantastic - unbelievable."* A couple of service users said they felt scared or nervous when they first went. One said he felt fortunate to be on a ward with others who supported each other. However, another service user said he witnessed other people struggling, particularly those detoxing from methadone, who were rude to nurses and very demanding. One service user said he liked that they *"do whole MOT"* while there. A couple of service providers singled out the nurses saying they were *"lovely," "empathetic"* and *"great,"* "brilliant" and one said the "*staff were all very understanding, doctors really good*." Some other comments about the unit were: *"they were very helpful," "I can't say enough how good they were at St Thomas. They were all brilliant. Very tolerant."*

One service user described:

> *"We were taken to the gym before breakfast and would be allowed a smoke break then. Then after every meal. The night staff would take you down for a cigarette before the end of the night. I can't say enough how good they were at St Thomas'. They were all brilliant. Very tolerant."*

There were some negatives, however. A couple of people struggled with the smoking restrictions. One service user commented on the wait time to get into the unit, saying, "*there were times I felt frustrated about the wait, not sure when it will be – waiting – not knowing is difficult*"*"*. He also commented that once in the unit, he found it "*weird*" because it was a hospital. He also had a negative experience where he was stigmatised, when initially in a bay with people who were there for other medical reasons and not for detoxification or stabilisation, who he heard talking about him. However, the unit responded and moved him into a different bay, so he felt they were "*quite accommodating*"*"*. However, he did not think the health care assistants were helpful, stating they had *"no manners"* and did not give service users "*privacy or dignity*." This contrasted with the rest of the team, who he said were excellent.

It must be recognised that the eight service users interviewed were introduced to us by the substance misuse service providers. There is likely to be significant selection bias in that the service users whom providers approached and who were happy to talk to us were more likely to have good outcomes and feel more positive.

### Providers and commissioner's perspectives of the unit overall

For the most part, providers and commissioners had very positive things to say about the GSTT IPD1 unit and their staff with comments such as: *"brilliant to have this resource"*; *"amazing resource and essential for this cohort"*; *"excellent care"*, *"it's a great service"*; *"Has made such a difference to rough sleepers"*; *"lucky to have this facility in London"*; *"safe place to detox"*; *"good outcomes, working well"*; *"a complete wrap around service for rough sleepers"*; *"very well organised unit in terms of referral process"; "clients have generally had a really good experience there and have gone onto rehab quickly afterwards"*; *"clients understand what it's like to go there and work well with the team there"*; *"client success story: they enjoyed attending groups on the ward, enjoyed the view"*. Other feedback included that the unit provides an individualised approach and has responded to feedback from service users.

Providers and commissioners described the staff as supportive and skilled, willing to negotiate with clients to make them more comfortable: *"Staff there are excellent;" "team very flexible and accommodating;" "helpful trauma informed staff."*

There were many comments about the good working relationship between themselves and the unit and the clients and the unit contributing to a *"positive impact on clients' outcome."* The staff were applauded for the way they manage challenging behaviour: *"they are able to contain clients in a way that they haven't been contained before."*

In addition, they showed compassion, sensitivity, and flexibility: *"If clients are struggling on the unit, they* [the IPD1 staff] *will call* [the person supporting them in the community] *to say, "the client is having a wobble" – can they come in and settle them."*

## The referral form and referral process

### Providers and commissioners' perspective

For some, the referral process was considered *"simple…paperwork useful and straightforward."* However, others commented that the referral form was too lengthy, and key workers / care coordinators struggled to complete it. One highlighted that it requires a lot of medical information with the requirement to have clinical input, which was seen as a barrier. Some also expressed confusion about what workup was required prior to admission.

Overall, the unit was commended for being very hands-on and communicating well by phone or email in the run-up to clients being admitted. Also, where needed, *"consultants will arrange meetings with the client's community team to explain the plan, outline roles of the care workers and what is expected of them, discuss any considerations of changes in tack."*

One borough has monthly MDT meetings with the unit to discuss updates and considerations around clients' admission / discharge plans, provide feedback on any challenges and highlight safeguarding issues. They also help plan how best to manage medication issues, such as discharge plans around OST where relevant.

Several commissioners and providers felt that the unit was originally presented (and some believe it is advertised currently) as an 'open-door' system where anyone could get detoxed; however, this is not the case. "*When it was explained to me, I thought we would be providing for the marginalised of society, to save lives, and to motivate people, as another gateway*." This presentation of the unit has created expectations within the community that providers are having to manage, even though many would like to have a more open referral pathway. Others have said they were confused and asked: If the pathway is for people sleeping rough / homeless, then why is there a requirement for a discharge destination prior to admission?

### Staff from the GSTT unit perspective

The unit highlighted the importance of quality referrals that have medical oversight saying, *"detox is such a risky process, doing a detox, we are trusting that the clinical lead or consultant has assessed the client. It often doesn't feel like this has happened"*. If they are unable to assess the medical situation, the referral is returned and there is often a delay due to information needing to go back and forth. GSTT staff reported that it is rare for them to reject a referral. They will, however, send back referrals for further information as they are strict on the quality of the referral to prevent delayed admissions.

Referrals come to a shared mailbox and the clinical coordinators send them to a panel who then meet weekly. The panel involves the MDT (consultant nurse, psychiatrist, consultant physician and toxicologist). Each case is "*rag rated"* in terms of priority, based on medical vulnerability and then they offer a visit and a date for admission. However, there is some flexibility to fast track someone, i.e., to *"jump the queue*", for someone who is very unwell, but that relies on a good referral.

As part of the referral process, the GSTT panel does require an aftercare plan in place, but they also *"look deeply at back up primary and secondary plans."* They try to be flexible. For example, before they used to not accept people with the plan to return to a hostel, but now they do allow it, recognising they are in a *"privileged position in the system"* and they *"don't want to gate-keep*

*community teams"*. If clients are complex, then they will suggest a visit. The first service user walked out of the unit as he was not aware that he was going to a hospital. They learned from that and said that visits are an important part of preparation, as service users may have bad connotations with hospitals, they may have lost friends there or have been unwell.

### Complexity and Medical management

For many, the overall impression of the unit is that it is needed and valuable because it provides excellent access to clinical expertise within a multidisciplinary team, incorporates preventative and curative interventions (such as investigations for physical health problems, maternity care, hepatitis management). It was described as providing holistic care with robust care plans and was like a *"one stop shop"* for those with multiple co-morbidities (Borough group).

Commissioners and providers said the unit worked flexibly with very complex clients, some of whom were felt to maybe need more than one attempt at detox. *"GSTT is best for those with complex needs"* such as those who use party drugs / chemsex, high methadone dose alongside medical vulnerabilities. For some people, additional preparatory work included home visits, outreach or working with family. This flexibility was seen as very useful.

It was also recognised that the unit was really helpful in approving admissions urgently where necessary. However, some commissioners and providers thought that the unit staggered admissions of the most complex cases so as not to have too many people with very complex needs at the same time. This was felt to cause a longer wait for some clients who may need it the most.

### Hospital environment

Providers and commissioners recognised that having a detoxification and stabilisation unit in a hospital was very valuable for the reasons outlined above. Also, the GSTT unit does encourage visits prior to admission in order to help prepare service users and manage expectations. However, not all service users managed this, and the hospital environment did not suit everyone; some felt uncomfortable on a *"bustling"* ward which may have contributed to some service users absconding / self-discharging.

Additional comments were that, as the detoxification and stabilisation beds are on a ward alongside other medical patients, some service users felt judged by others in the hospital. Service users could also feel stuck on wards and struggle with regulations around smoking being only at set times with the need to be accompanied. Interviewees recognised that the unit did try and accommodate service users with the facilitated breaks *"Some have managed to keep to this and have done really well, but others struggle"* (Service provider).

In contrast, some stakeholders were concerned that the unit was not structured like a traditional rehabilitation service with clear rules and boundaries in place and that it was not necessarily dry as service users can access drugs/alcohol through other patients in the hospital.

Some were concerned about a lack of activities with daily structure to reduce boredom and cravings, encourage change and prepare for rehab. One borough group said, *"The recovery journey and experience is extremely important. Otherwise, you are just in a hospital bed. You need to keep these clients engaged, give them hope, give them activities, so people don't get bored, get cravings, and drop out"*.

A few stakeholders were concerned that as the unit was not single gender, it could not accommodate people who had experienced gender-based trauma. It was also raised that there needs to be consideration around pets while someone is admitted. This is a wider problem and can be very relevant for this population, and a barrier for people to agree to an admission. However, there is a charity Dogs on the Street that will look after dogs when their owners need hospital admission.

## PART 2: Mildmay Mission Hospital intermediate rehabilitation beds

Mildmay staff reported that referrals were "*always appropriate,"* in terms of level of need and complexity. Planning in advance for an admission and an aftercare plan was considered an important part of the referral process, and likely to be associated with more successful outcomes. Nonetheless, the unit undertakes reviews during an admission in case adjustments need to be made. Though the majority of admissions were planned ones from the GST IPD1, in exceptional cases there were admissions straight from hospital.

Coordinating a smooth transfer from GSTT directly to the Mildmay Mission Hospital could be complex, as it necessitates bed availability at the Mildmay coinciding with discharge from GSTT. Although solutions to streamline this have been implemented, including weekly meetings between the units' bed managers, difficulties can arise if discharge from GSTT becomes delayed. Given the clinical complexity of the clientele, these circumstances can be difficult to predict and may result in the temporary block of a bed at Mildmay.

On admission to the Mildmay Mission Hospital, there is an initial risk assessment that incorporates, among other things, mental health, and nutritional health. During admission there is access to multi-disciplinary teams including a medical team, psychiatry, clinical psychology, substance misuse support worker, physiotherapy dietetics and move-on coordinator.

As well as a place for treatment, Mildmay staff viewed their unit as a place for preparation where service users have the rare opportunity to plan for rehabilitation and life beyond it. A Mildmay staff member said, *"We have realised that quick discharge from GSTT does not always work."* At the Mildmay they offer 1-2-1 work and group work with service users *"to try to think about rehab and what that may be like"* (Mildmay Mission Hospital staff member). This was reported to be particularly beneficial to those who remain unstable and vulnerable following detoxification or those who were fast-tracked into detoxification and "*can't do planning due to intoxication"* (Mildmay Mission Hospital staff member). Discharge planning for those not going to rehabilitation may also include linking service users into community-based services such as housing support.

Whilst Mildmay Mission Hospital staff felt that they provide service users with the opportunity to optimise their circumstances for rehabilitation and life afterwards, they also recognise that, as extremely vulnerable people, the possibility for relapse is high. With this in mind, staff perceive the Mildmay as an important place where this cohort can try abstinence, a chance to give service users "*a good experience of being sober…[and] make sure their experience is good so they can try again"* if things don't continue (Mildmay Mission Hospital staff member). This attitude is also reflected in their tolerant approach to lapses where they will give service users two warnings before discharging them from the site.

### Provider and commissioner perspectives on Mildmay Mission Hospital

Eleven London boroughs had used the Mildmay intermediate rehabilitation beds, though the admissions between March 2022 - December 2022 came from just eight boroughs. There were 22 boroughs that had not used the Mildmay beds. The most commonly cited reasons for this were a lack of clarity around eligibility criteria, clients' geographical preference and funding. A number of boroughs were unclear as to who should be accessing the Mildmay beds and how, whilst another had unsuccessfully tried to refer to the unit and had not received feedback as to why it had been rejected. One borough was under the misapprehension that the Mildmay is a place for "*people who are less complex*" and those who are "*more stable."* Four boroughs reported that they were either not familiar with the Mildmay or had little understanding of what they offered.

Among the borough commissioners and providers that had used or thought about using the Mildmay beds, there was general consensus that the Mildmay was "*very valuable resource as a step down*" and "*very suitable for substance misuse and stabilisation wor*k", "*a good place to stabilise people".* Providers also said, "*Mildmay seems to be fantastic, with access to physios and a gym" "Mildmay are flexible and compassionate,*" it is "*another great service*" and "*a bonus having it,*." This was felt to be especially the case if aftercare was not fully planned or delayed, or if further assessments needed completing, including for those with no recourse to public funds.

It was reported that Mildmay Mission Hospital is able to do more person-centred care than other rehabilitation centres, is more open and has flexibility and diversity around what they offer. Some providers also shared that their clients had fed-back positively about the physical space.

There were however some challenges with referrals, the main ones being a long waiting list due to lack of beds. Early on, one service provider had to return to less stable living circumstances following detoxification at GSTT, due to lack of a bed at the Mildmay Mission Hospital. This person relapsed before an admission to Mildmay could be facilitated. This has since been ironed out so that where the discharge plan includes a bed at the Mildmay, admission to the GSTT IPD1 will not happen until it is clear there will be a bed available at the Mildmay at the time of expected discharge.

Some providers and commissioners felt there could be improved communication from the Mildmay Mission Hospital around initial referrals, their management of admissions and around discharge dates. There was also some lack of clarity around how referrals were managed, One referrer believed that, despite a referral being made to Mildmay Mission Hospital along with the initial referral to GSTT, an admission to GSTT was delayed due to lack of a move on plan, as it was not clear whether Mildmay had accepted the referral.

Initially at the start of the service, due to limited staff, service users were able to leave the premises unescorted. However, following some people relapsing while leaving unescorted, within the first days after admission, the process has been changed and service users must now sign a contract on admission stating that they will not leave the premises unaccompanied for the first two weeks.

### Service user perspective of the Mildmay Mission Hospital

Two service users were interviewed whilst in Mildmay Mission Hospital. They both had very positive comments about the staff and facilities. The following highlights their impressions and some of the activities that were available:

> *"The staff were blinding* [brilliant]*. Groups every afternoon. They will let you have a fag afterwards. I would engage with all the groups to get an extra fag break… I like it here. First 2 weeks we were not allowed out due to temptation. Now I go out every morning and buy my paper. I sit in the church yard and do the crossword. I do the drink and alcohol group on a Monday, Mindfulness on Tuesday. I find the mindfulness too zen. I do it - don't get me wrong - since I have been here I do them all. I do Gym three times a week. I couldn't even do one press up, but I can knock a few out now. I can see the drug and alcohol support worker whenever I need to see her. She does the rounds every morning. Tomorrow we are having a backgammon competition. Thursday, I do my laundry*."

The Mildmay Mission Hospital were also very understanding when someone had a brief lapse:

> *"I had a slip when I got here. Someone in my life who was negative. He was in touch as he thought that I would need a friend. I got rid of them. The staff here called it 'a positive from a negative.' He was visiting me, but he wasn't a friend. He was a manipulator*."

## PART 3: How is the entire substance misuse pathway working to support recovery? Reflections on person centred care and options

### Service user's perspectives of the pathway: What's needed, important or helpful to support recovery.

> "*First, being given food and shelter. Then, being believed, heard, and seen. Then, recognising the assets you have… Then, the things that are holding you back*" (Service user).

### Trust

It was also clear from most service users how all stages of this journey required trust - both being able to trust others and for others to trust them. For example, one service user explained how previously he had a GP who would not listen to him about his auditory hallucinations, but now, with a different GP who 'believes' him, he is receiving treatment. As another service user said, *"trust was key"* to feel seen and heard and enable them to start seeing their own self-worth.

Living with shame and stigma does not help in recovery, and service users spoke of the importance of developing self-worth and self-esteem to help find one's own voice. Moving away from their unhelpful networks can be hard, as one service user explained:

> *"The most non-judgemental people are other users or drug dealers."*

It takes time and work to build up the confidence to use that voice and service users reported wanting to be treated without being patronised and where they are not "*stereotyped as a homeless addict"* so they can "*move away from the 'homeless addict' identity*." A number of service users also emphasised the importance of therapeutic support throughout the pathway.

### Compassionate response from substance misuse teams when service users wanted to address their addiction:

Another service user was surprised that there was not more support for people when they had their *"light bulb"* moment and decided they wanted to undergo detox.

He reflected that the community substance misuse teams did not acknowledge the importance and difficulty of making that decision. *"In most people's heads who are suffering or going through this, they think that the minute they decide it's too much, and time to change, if they turn up and say, 'I'm ready,'"* professionals will respond positively, and help will be available, particularly as most previous contacts with professionals had emphasised how important it was to address their addiction. However, instead, "*there is a whole world of bureaucracy to go through*'" which can result in a loss of trust and disengagement. He commented on how important it was when someone has a light bulb moment for services to *"be compassionate... and build a continual relationship to keep you engaged"* considering the inevitable delays in accessing detox.

### Using the waiting time effectively

A service user felt it was important for providers to acknowledge the potential length of waiting time and be upfront about it with their clients. For one service user the waiting period was the "*biggest shock*" with the need to "*fill the void*." He said, "*you miss your friends, you miss your social connections. That's when your demons start flaring up*". He suggested how important it is to explore how to use this time and support people to remain engaged, such as accessing counselling, linking with other social support, or linking them with other people on the waiting list.

As well as the importance of the development of trust and support to continue engagement, he also suggested that the time while waiting to be admitted into the IPD1 beds could be used for sorting out visits to the GP and dentist, in order to begin addressing sources of the pain that often emerge once detoxed. He shared an example where a toothache that was "*just a bother"* can turn into full on *"excruciating pain"* once the drugs and alcohol are gone.

## Choice

Having a choice and being involved in decisions help to build self-confidence and self-esteem. However, choice is often lacking as the following service user (who had been through the GSTT IPD and is in recovery), shared:

> "*The whole journey, you have no choice. They go on about being person centred, but there is nothing person centred about it. You are just not included...* [however,] *...My support worker sat with me to talk through it, [what to expect for the journey]. People need to be told what they can achieve in 2 years, not 2 weeks".*

### Longer term support

Safe supported accommodation where retaining abstinence is realistic.

A service user explained:

> *"When you are hospitalised, your freedom is limited, takes away your control. People say they are acting on behalf of your best interest, but staff can get busy, delayed. This causes negative behaviours in you. Defensive. You get discharged into a certain environment with so many restrictions* [in residential rehab]*. Then, after rehab, you are being housed with people living with drugs and alcohol, from prison, etc. How did you go between these extreme environments?' The [homeless] pathway 'doesn't take this into consideration."*

Just as commissioners and providers said that there is a lack of safe, dry accommodation, here the service user explained what this means in reality: *"Some people see you as people to take advantage of. People will approach you and befriend you, and then that person preys on you and other vulnerable people around you…"*

Hostel environments were often not seen as safe, with one service user describing his experience as "*not protective from harassment."* This was a particular concern of someone who identifies as LGBTQ and felt very unsafe.

There were several other concerns about accommodation following detoxification / rehabilitation.

When thinking about the future after leaving Mildmay Mission Hospital, one service user said, "*...I want supported accommodation as I don't want to be with lots of other addicts. I want a monitored place with a warden. I want it to feel safe and for it to be my house*."

Other concerns included being housed in areas with other vulnerable people or having to sort out private rented accommodation, which is often hard to get for people on benefits. Others who had wanted to relocate out of London said this was impossible.

### Long term wrap around support

Many service users who had been through the pan London service expressed the need for long term support in one form or another. One service user said, *"it's also important to note that sobriety and avoidance of a relapse is extremely anxiety ridden, especially with the system limitations, such as hostels, housing, etc*."

Another service user who had been through the GSTT IPD and rehabilitation and is now abstinent remarked *"now it's all finished and wrapped up and 'see you later' but there's still a lot on my mind – I've been on benefits for 3 years and I need a purpose back in my life".*

Another service user, also now abstinent following GSTT IPD and rehabilitation, who was living independently in a different borough from his original substance misuse service, was not getting any support around maintaining his abstinence. He feared he was at risk of relapsing, as he described his feelings of isolation. He was trying to get purpose back in his life but felt there was a clear need for longer-term support for people at all stages, including post rehabilitation.

### Value of support network and peers with lived experience

Peer support from other people with lived experience who have been through something similar was found to be very valuable in helping build a sense of belonging and trust: *"having someone to go to an appointment with you – sometimes it can be the only thing that encourages you to attend"* (Service user).

Others suggested that it would be very helpful to have a support network of people following detoxification of people who were in the same situation.

### Personal development

When planning for the future, one service user reported, *"for me I had to have a stable recovery from alcohol and drug dependency before I could even think about my future".*

Others spoke about the importance of being active, setting goals and objectives, the need for direction, and the *"development of a skill that will either further personal development or enable employment."* Along the journey, *"consistent and gentle encouragement"* was recognised as important.

> *"We all need encouragement, sometimes you need someone to celebrate and recognise your achievements, especially when you can't do it yourself."*

## Providers and commissioner's perspectives of the pathway

### Person centred decision making

Stakeholders recognised the importance of service users' involvement in the decision making around detox, move-on following the detoxification and stabilisation unit and/or move-on from rehab. The GSTT unit emphasised *"it's important for us to talk to the person first* [before they're

admitted] *and see what they want."* Several said that, where it could be arranged, having a client visit the unit before admission was helpful for them to get a sense of what it would be like, and it helped the unit to set expectations.

However, some acknowledged that involving service users in decision making around move-on whilst intoxicated, in advance of being detoxed, can be complex, as people's needs and decisions change throughout the process.

One provider suggested a need to be able to rapidly explore and review their clients' decisions and expectations around onward referral while on the ward. However, GSTT unit staff felt that assessments for rehab/move-on are not appropriate once someone has been admitted to the unit as this process can be very unsettling. One GSTT staff member said: *"People can find it really unsettling, and this spills out elsewhere – more boundary pushing, more unsociable behaviour because they feel threatened or unsafe."*

In order to support appropriate rehabilitation or move-on options, some boroughs used a specialist social worker knowledgeable about the range of different rehabilitation units available nationally to work with their service users and determine the most fitting move-on placement available to match the service user's needs. This was seen as very important as some people had very complex and specific needs, such as women who had experienced sexual trauma. Others expressed a need-to-know what rehabilitation units there were around the country.

### Options for move-on following detox

Providers and commissioners acknowledged the importance of avoiding service users returning to a hostel. For example, one said, *"If the person doesn't have housing, it defeats the purpose. We need all the stakeholders working together."* One service user shared her previous experience of going through detoxification with no aftercare in place. She said, *"I was sent back to the hostel, which set me up to fail"* because she was surrounded by others who were using.

Another key concern raised was that if service users cannot complete detoxification or rehab, they can end up losing their accommodation, including hostel accommodation, due to their bed space being closed, precipitating them into homelessness.

People interviewed also said there is a need for more rehabilitation units and more abstinence-based supported accommodation, with a need for a *"range of different types"* (Borough group). There are different approaches and philosophies used in rehabs, and stakeholders said it is important to have staff who can assess and match the service user to the most suitable/preferable rehabilitation and model to their individual client needs. For example, *"some need regimented regimes while others need therapeutic ones"* (Service provider).

There are particularly gaps for gender specific accommodation, particularly rehabilitation for women with significant trauma. In addition, there are other barriers for some people accessing residential rehabilitation including a lack of beds for people with brain injury / cognitive impairment, learning disabilities or for service users with dual diagnosis or functional support needs. There are additional gaps for people with no recourse to public funds (NRPF) or where there are language barriers. Ongoing care and support for people with alcohol related brain injury *"is a real missing part, maybe even for all of England"* (Service provider).
It was also clear from stakeholders that residential rehabilitation is not appropriate for everyone who completes detoxification, and some people change their minds about going to rehabilitation during or following their detox.

For some, community rehabilitation could be more appropriate, where previous support can be continued (see Service User D). However, there is a lack of community rehabilitation available.

In addition, most rehabilitation units require service users to be completely abstinent and not on OST, which many *"may not be ready for"* (Service provider), though some allow service users to remain on stable, low doses of methadone (such as 30mls or less).

Some stakeholders noted that rehabilitation generally focuses on the past / root cause, but for many within this service user population, this can be too traumatic and inappropriate. It is not clear how trauma informed rehabilitation units are, and the requirement of group work participation, which is common, can be particularly challenging.

Step down to Mildmay intermediate rehabilitation beds was acknowledged by a number of providers to be a good steppingstone for some service users, who may not be ready for rehabilitation or the group-work this often involves. Mildmay is somewhere where more one-to-one work can be undertaken.

### Supported accommodation / Wrap-around support.

Additionally, there are expectations for service users who go into rehabilitation to have a move-on plan for afterwards and *"a degree of readiness, stability,"* which often requires additional work with people who are rough sleeping (Borough group). Some rehabs are connected with move-on accommodation, but often, this is not the case. There were cases where people completed detoxification and residential rehabilitation but were let down by Local Authority housing and did not know where they would be housed until the day of discharge from rehab. Continuity of care can be disrupted by relocation / rehousing. This can be important and detrimental when a service user has built a relationship with their team.

A referrer shared his frustration about the lack of decision making he or his clients have when being found accommodation by the local authority following rehabilitation. He described two people who successfully completed detoxification and residential rehabilitation being placed out of the borough, away from all of their support networks and who subsequently relapsed.

The need for more abstinence-based supported accommodation or accommodation with more wrap-around support was apparent for people coming out of both detoxification and residential rehabilitation. This includes a need for women's only provision. Sometimes, service users return to wet hostels or unsupported temporary accommodation following residential rehab. There is a need for *"somewhere where people can come out of rehab and go into a safe place, whatever that looks like, where they are not being set up to fail"* (Borough group).

In addition, for those leaving detoxification for whom residential rehabilitation was not appropriate and for those having community rehab, service users are usually returned to a hostel or temporary accommodation, because, as one provider suggested, *"accommodation is the bigger problem... and unfortunately, there are no dry hostels or abstinence-based provision… sometimes there is no other option".*

## PART 4: Admissions to the IPD1 at GSTT and the Mildmay Mission Hospital

There were 135 people admitted to the IPD1 unit at GSTT from when it opened in July 2021 until December 2022. The Mildmay intermediate care beds were opened in March 2022, and during the period until December 2022 there were 18 admissions.

The following sections provide the analysis of admissions to both units. Though the majority of cases admitted to the Mildmay Mission Hospital came through the IPD1 beds at GSTT, we have divided detailed analysis of admissions to the IPD1 at GSTT (Part 4a) from those admitted to the Mildmay Mission Hospital (Part 4b).

### PART 4a: GSTT IPD1 admissions: Tracking the service users' journeys.

#### Original data

Out of the 135 admissions, completion rates were high with 112/135 (83%) completing their detox. We have some follow-on information on 79 admissions. To note, without service user identifiable information, matching and tracing service users was extremely challenging and involved huge commitment from the providers and commissioners.

A comparison of the whole cohort of service user data (135) to the subset (79) regarding admission address, discharge destination, and completion of detox, found the subset percentages

to be very similar (Table 1). This is encouraging as it suggests that our subset data is likely to be reasonably representative of the entire caseload.

Table 1 service user data received in advance: comparison of whole cohort to the subset of 79 service users.

| | Whole cohort: **n=135** | Subset for whom we have further information **n=79** |
|---|---|---|
| **Admission address** | | |
| NFA | 10 (7%) | 5 (6%) |
| Hostel | 71 (53%) | 43 (54%) |
| Temporary accommodation / temporary address | 46 (34%) | 28 (35%) |
| Other | 8 (6%) | 3 (4%) |
| **Discharge address** | | |
| Hostel | 35 (26%) | 18 (23%) |
| Temporary Accommodation | 23 (17%) | 14 (18%) |
| Residential rehabilitation | 61 (45%) | 33 (42%) |
| Intermediate / community rehab | 9 (7%) | 9 (11%) |
| Other or unknown | 7 (5%) | 5 (6%) |
| **Completion of detox** | **112 (83%)** | **66 (84%)** |

The rest of the information in this section refers to the 79 admissions (accounting for 78 service users) for whom we have further information. We are aware that at least one was a service user who was admitted twice during the evaluation time period (i.e., up to December 2022).

### Appropriateness of admissions to the IPD1 unit

From the information we have about the 79 admissions, almost all 74 (94%) were appropriate admissions to the unit in that they had a history of rough sleeping and/or were at risk of rough sleeping or were considered a complex case. The majority had very complex needs (co-morbidities / significant mental ill health) and high alcohol and/ or polydrug use.

Though not many people were admitted directly from the street, many had a recent history of sleeping rough and were placed in temporary accommodation or a hostel prior to being referred to the GSTT unit.

Only four individuals did not have a history of rough sleeping and/or were not at risk of rough sleeping and/or were not considered a complex case. Three of the four came in from temporary accommodation, and one came in from his own tenancy (the provider stated this person was not at risk of rough sleeping and believed it must have been an error listing him as such). There was a further individual out of the 79 for whom we had insufficient information about their likely current situation.

### Substance uses on admission.

Table 2 shows a breakdown of substance use upon admission. As can be seen, the majority of people, 63 (88%), were using alcohol on admission. 27 (43%) of these were using alcohol alongside other substances (14 of whom were using multiple substances). Eight (10%) people who were not using alcohol were admitted with polydrug use.

Table 2 Break down of substance use upon admission of the 79 service users.

| | |
|---|---|
| Alcohol alone | 36 |
| Opiates alone | 4 |
| OST alone | 1 |
| Alcohol + OST script* | 4 |
| Alcohol + 1 other substance (e.g., cannabis, benzodiazepine, crack/cocaine/ opiate) | 9 |
| Alcohol + more than 1 other substance (Polysubstance) | 14 |
| Polydrug (not alcohol) | 8 |
| Missing data | 3 |

* 1 for detoxification from OST, 3 for alcohol detoxification only

MDT support: clinical need and co-morbidities

We do not have comprehensive information on the co-morbidities and clinical complexity of all people admitted to the IPD1 at GSTT. However, for those we have additional information, many had physical multimorbidity's often combined with significant mental ill health in addition to their substance use. Some conditions included heart failure, chronic obstructive pulmonary disease (COPD), infections including communicable diseases and skin/soft tissue infections, neurological disorders including seizures (with some requiring acute seizure terminating treatment), surgical problems and a high number with chronic liver disease. These medical issues demonstrate the significant risks in detoxing a cohort whose health needs often go unmet.

Whilst in the unit, service users also had access to health promotion services, including flu immunisations and screening programmes for blood-borne viruses. There were new diagnoses of Hepatitis C and at least one of HIV, with instigation of treatment.

For some service users, it is clear that the multidisciplinary team enabled the admission for detoxification to have a wide health impact, addressing multiple needs and providing holistic care.

**Service User A:**

*A service user who was rough sleeping was admitted for alcohol detoxification. As a result of the service user's cognitive impairment, GSTT staff experienced challenges managing the lack of impulse control and difficult behaviour that arose from the alcohol-related brain injury. This service user was reported to have been given significant support, and although successfully detoxed, they relapsed multiple times within a few days at the Mildmay, resulting in an early discharge. Nonetheless, the substance misuse providers remarked that the unit was amazing at managing their behaviour. Following a period of living in less stable accommodation, they are now more suitably housed and are awaiting a Care Act Assessment.*

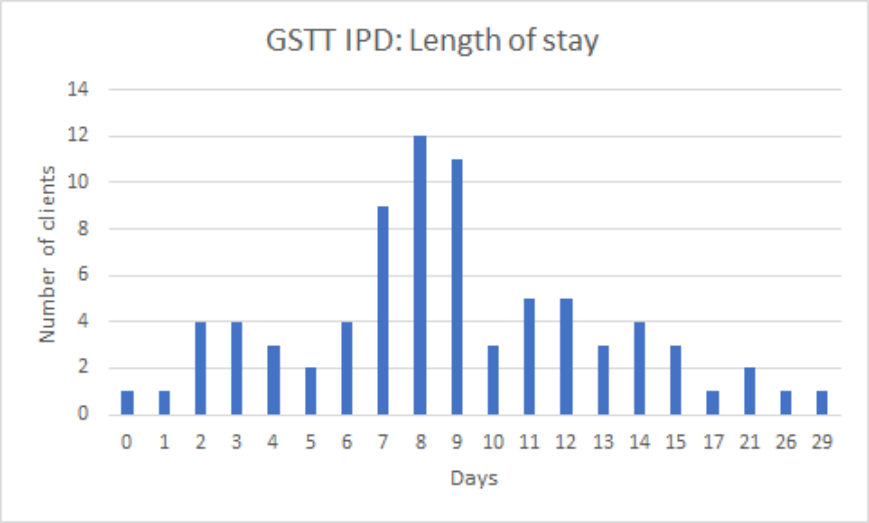
**Service User B:**

*A service user with alcohol and crack use who was in a hostel prior to admission to the IPD1 at GSTT had been engaging with the community drug and alcohol team and had undergone some preparation work. He had complex co-morbidities with mental health issues, epilepsy, and a past major head injury. Following his IPD1 stay, he was discharged to residential rehab, supported throughout by a social worker. He was abstinent when discharged from the local addiction service.*

## GSTT length of stay

The length of stay at the IPD1 was analysed for the subset of 79 service users (see Figure 2). The average length of stay was nine days and ranged from 0 - 29 days. Service users with length of stay greater than 12 days tended to be those who were admitted for detoxification of polysubstance use, and/or those with medical requirements arising from physical and mental health co-morbidities.

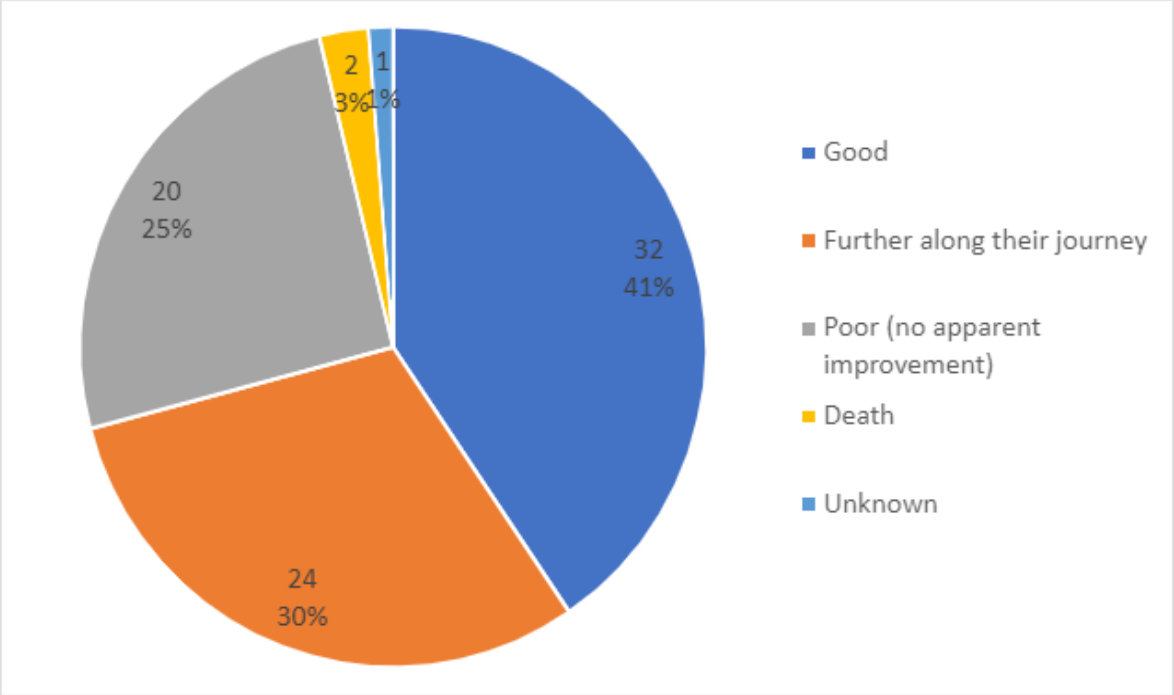
Figure 2 GSTT length of stay




## Outcome of the 79 service users for whom we have follow on data.

Although each service user's journey is unique, we were able to categorise overall outcomes regarding their recovery from their substance use. Outcomes have been broadly categorised into Good (abstinent or controlled on OST alone), Further along their journey or Poor (no apparent improvement) - see Figure 3. People with no apparent improvement in their substance misuse may have still had an opportunity for wider clinical improvement due to their inpatient stay.

Figure 3 Overall outcomes for 79 service users




Good outcome:

Overall, 32 (41%) had good outcomes. This included 26 (33%) who were abstinent when last in contact and 5 (6%) who were abstinent other than being stabilised onto OST plus one person who was now in a neurological care home with controlled support.

**Service User C:**

**Good outcome - now abstinent-** *A person with mental and physical health issues, including Hepatitis B, was using opiates with a history of injecting. History of sex working and had no fixed address on admission. Completed detox, was referred to residential rehab and is now in housing through Housing First. Remains abstinent, attends Narcotics Anonymous and is supported in the community-by-Community Psychiatric Nurse.*

**Service User D:**

**Good outcome - stabilised on OST-** *A person with significant mental health issues, history of trauma and self-harm. Used opiates, crack, and cocaine. Left halfway through the initial detox; however, with additional preparation (work with a psychologist, conversations with the unit, etc.) she went back into the unit for stabilisation. Her second admission discharge was initially planned for residential rehab following detox. However, she chose to return to a women's mental health hostel and continued with community rehab and support there. Currently, she is stabilised on buprenorphine, has regular engagement with her recovery worker and psychologist and is currently volunteering.*

### Further along in their journey

A further 24 (30%) still had substance misuse problems but were 'further along their journey'. Though not abstinent or controlled on OST alone, these individuals were in a better position than prior to their admission to the unit. This included people who were, for example, rough sleeping and polydrug using who had changed their pattern of substance use to less harmful ones, maintained engagement with their substance misuse support team and/or were in more stable accommodation. What was clear from the providers was that many people need repeated opportunities to have a detoxification and rehabilitation *"few people make it first time - going around the cycle more than once is part of their journey. Failed placement isn't necessarily a failure in the longer term*". Having a positive experience within the GSTT unit, even if they do not complete their detox, can help people recognise that they could try again.

**Service User E:**

**Further along their journey-** *A person with a very complex history of extensive trauma, challenging behaviour, and very high risk. Previously lived in crack houses, the street and was evicted from unsupported temporary accommodation. The initial plan was for her to go to rehab following detox, but she self-discharged from detox after three days. However, she has remained in her supported accommodation, is engaged with her substance misuse team, and wants to go to another placement. The plan is for her to have another detox followed by rehab in a specialised women's sexual trauma unit (further detox is being delayed until rehab available). Without this her chances of poor outcomes, including death, are considered very high.*

### Poor outcome (no apparent improvement regarding substance use)

For 22 (28%) individuals it seemed unlikely that they were in a better situation than prior to their referral into the unit regarding their substance use. However, all people admitted to the IPD1 unit had a full clinical review, so some people within this category had benefited from clinical interventions.

**Service User F:**

**Poor outcome (no apparent improvement)-** *A person with alcohol dependence and a history of antisocial behaviour, who had been excluded from a number of services due to aggressive behaviour. Prior to referral into the GSTT unit, preparation and stabilisation work was undertaken with his recovery worker and he was supported from the street into accommodation. He had a pre-planned visit to GSTT to see the environment and meet staff to be familiar with the unit pre-admission. The plan was to discharge to Mildmay for further follow-on support; however, he self-discharged and relapsed. He was provided with alternative accommodation which he left. He is no longer engaged with the substance misuse services.*

**Service User G:**

**Poor Outcome (no apparent improvement)-** *A person who was rough sleeping, engaged with services and was placed into accommodation prior to detox. Successful completion of detox from alcohol and was discharged back to his accommodation. Although the plan was for enrolment in community counselling, the person relapsed and stopped engaging.*

### Deaths

There were two people who had been through the GSTT unit who sadly died a number of months following discharge from the unit. Their cases are outlined below.

**Service User H:**

*A person with a history of alcohol dependence and heroin use, mental health issues and a heart condition (no further details are available) who was of no fixed abode (NFA). He completed detox, then went to Mildmay. From Mildmay he was to go to a residential rehab, but self-discharged. He was placed into temporary accommodation by his local authority. He attempted suicide, was sectioned, and admitted to hospital. He was due to go into supported housing. We have no other details surrounding his death, the cause of which is pending a coroner's report - though his death is believed to be suicide.*

**Service User I:**

*A person with alcohol dependency who had no recourse to public funds (NRPF) was placed into a homeless health NRPF bed prior to admission to GSST. Completed his detox, but despite not being eligible for benefits, he was placed into the borough's hostels pathway. He continued to use alcohol, but had ongoing support, including immigration support, and was referred to the Blue Light Project. The* service user *died nine months following his admission to the GSTT unit.*

### Completion of detoxification by outcomes

Completion rates within the unit were high with 66/79 (84%) having completed their detoxification and 13 (16%) who did not. A breakdown of outcomes is shown for those who completed detoxification (figure 4) and those who did not (figure 5). It can be seen that 45% of those who completed detoxification had a *'good outcome'* compared with 15% of those who did not complete their detox, and 22% of those who completed had a *'poor outcome (no apparent improvement)'* compared with 26% who did not complete.

There was a range of reasons for non-completion of detox, but at least 10 people had very complex problems with significant trauma and mental health problems often compounded by significant physical health problems. Some had been admitted with the aim of stabilisation, rather than abstinence, due to their complexity. One of the 13 had been an admission directly from hospital due to very complex multimorbidity, so presumably had not had any preparation work prior to admission. Another struggled with the smoking restrictions. One had been evicted from a number of hostels and the borough was considering exclusion from the borough.

Figure 4 shows outcomes for people who completed their detoxification and figure 5 shows outcomes for people who did not complete their detoxification. As can be seen from figure 5, despite non-completion, some people had still gained from the experience within the unit.

Out of the 79 service users, at least eight service users have since returned for a further detoxification or are working towards going for a further detoxification and/or rehabilitation.

Figure 4 Completed detoxification - out of the total number of service user data captured.

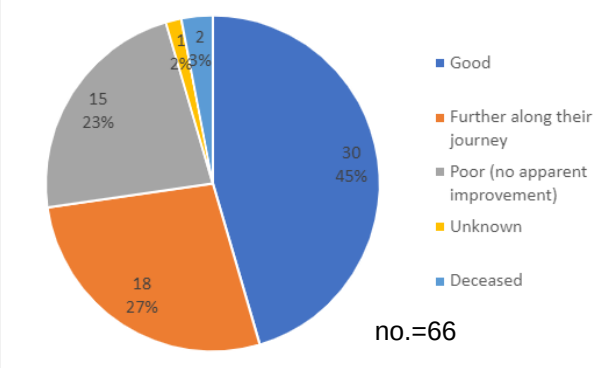
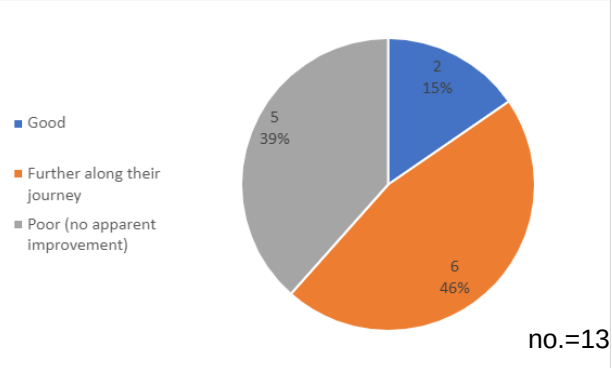



Figure 5 Did not complete detoxification - out of the total number of service user data captured




## Onward destinations

This section reviews the onward destinations of the 79 admissions following discharge from the unit. This includes the location and nature of the discharge along with their outcomes.

The onward destinations have been broadly categorised into 'stable,' 'less stable' and 'uncertain.' Stable accommodation describes those that provide the service user with a secure place to stay where their needs are likely to be met. These include residential rehabilitation centres, Mildmay intermediate rehabilitation beds, secure accommodation (including own tenancy or permanent housing), specialist supported housing such as care homes, mental health supported accommodation and faith-based accommodation. Less stable accommodation describes those that do not provide long-term accommodation and includes hostels, temporary accommodation including bed and breakfast accommodation (B&Bs).

Of these 79 admissions, 51 (65%) were discharged to stable accommodation, 24 (30%) were discharged to a less stable destination and four (5%) were discharged to an unclear place - see Table 4 for more detail.

Outcomes for these discharge categories are described below and also summarised in Table 4.

### *1. Stable discharges*

Out of the 51 people who were discharged to stable accommodation, the majority were discharged to rehabilitation (51%) or to Mildmay Mission Hospital (24%). The remaining 13 were discharged to a range of accommodations such as their own tenancy, specialist support housing or faith-based accommodation.

Overall, 59% of stable discharges had a good outcome as defined above. A further 18% of stable discharges, though not abstinent or controlled use, had still benefited from their admission and were *further along in their journey*.

Out of those discharged to a 'stable' environment, 10 (20%) went on to have poor outcomes (no apparent improvement). These include seven service users who self-discharged or were asked to leave rehabilitation or Mildmay, two who lost their secure accommodation and one who had been discharged to residential rehab, who had died (Service User H). Table 4 shows a further breakdown of outcomes by accommodation.

**Service User J:**

**Stable discharge with good outcome-** *A person with a history of seizures, depression and rough sleeping was referred to the IPD1 unit for alcohol and benzodiazepine detox. Engagement with the rough sleeping in reach team took place to help provide one-to-one support, support with housing, psycho-social intervention, and harm reduction prior to referral. The person went on a pre-planned visit to GSTT to see the environment and meet staff to be able to be familiar prior to admission. The provider noted that the team at GSTT were integral to the care planning for admission. At one point during his admission, he wanted to leave the unit and said that the staff were 'horrible;' however, it transpired this was in response to him being challenged when he wanted to leave the ward. However, he was persuaded to stay and completed detox and entered residential rehab for 12 weeks. After completing rehab, he moved to semi-supported accommodation with further community support. He remains abstinent.*

**Service User K:**

**Stable discharge that relapsed-** *A person with mental health issues and history of seizures had multi-agency support prior to entering the GSTT unit. Completed detox at GSTT of alcohol and drugs and was discharged to residential rehab. On-going support was provided throughout the two weeks in rehab by the substance misuse social worker, and drug and alcohol worker. However, they self-discharged from rehab and returned to stay with friends. Was able to maintain recovery for 6 months, but then relapsed and was placed in a hostel to avoid street homelessness. Still engaging with support services. Further along their journey as they maintained contact with their support services and helped back into a hostel to avoid street homelessness.*

*2. Less stable discharges*

Of the 24 less stable discharges, 71% were discharged to a hostel and 29% were discharged to other temporary accommodation. Reasons for less stable discharges included: service user self-discharged 4 (17%), the proposed discharge and aftercare plan was declined by service user 7 (29%), early discharge due to relapse during detoxification 2 (8%), planned discharges to a hostel in agreement with service users' preferences 5 (21%) with a further 6 (25%) being unclear. An example of a planned discharge to a hostel was where the aim of the intervention was not realistically aiming for abstinence. One case involved a service user whose current hostel was planning to evict him, and no other hostel would take him back. He went through medical detoxification to help modify his behaviour. He is still drinking but, at the time of evaluation, had managed to remain in his hostel for 6 months.

Although the frequency of cases associated with poor outcomes (no apparent improvement) were slightly greater amongst less stable discharges (33%) compared to stable discharges (20%), the majority of less stable discharges were found to have still gained from their admission to the detox. One service user had a 'good' outcome' following her second admission to the unit and a further 58% of people were 'further along their journey'. This included a number of service users who were now engaged with their substance misuse worker, with some having reduced substance use, some scripted-on OST and some considering a further admission for detoxification or stabilisation. The benefit of the admission was apparent for some people where discharge was even the result of a relapse as well as those with a planned discharge to a hostel.

**Service User L:**

**Service user with planned discharge back to hostel, further along their journey-** *A male service user was admitted to GSTT for alcohol detoxification. He had a complex background of alcoholic liver disease, Hepatitis B, and a high fatality risk. Prior to this referral, he had failed to engage with local alcohol services and expressed ambivalence towards recovery. The service user underwent preparation for detoxification and was supported into temporary accommodation by street outreach teams. After completing detox, he was discharged back to his hostel. Although he returned to drinking, he has reduced his pattern of use and continued to engage with his substance misuse support team whilst maintaining his accommodation.*

*3. Uncertain place of discharge*

Four cases (5% of total) were discharged to unclear destinations. Two service users were non-English-speaking and, as a result, were not eligible for residential rehab, but were referred for community-based support. Another service user self-discharged. It is unclear where these service users were discharged to.

**Table 4. Discharge destinations and their associated outcomes (n=79)**

| | **Outcomes** (% of those discharged to this destination) | | | | | ***total*** |
|---|---|---|---|---|---|---|
| | **Good** | **Further along their journey** | **Poor (no apparent improvement)** | **Death** | **Unknown** | |
| **Discharge destination** | | | | | | |
| *Rehabilitation* | 19 (73%) | 5 (19%) | 2 (8%) | 0 (0%) | 0 (0%) | ***26 (33%)*** |
| *Mildmay Mission Hospital* | 3 (25%) | 2 (17%) | 5 (42%) | 1 (8%) | 1 (8%) | ***12 (15%)*** |
| *Secure accommodation, supported housing, care home, faith-based* | 8 (62%) | 2 (15%) | 3 (23%) | 0 (0%) | 0 (0%) | ***13 (16%)*** |
| *Hostel* | 1 (6%) | 11 (65%) | 4 (24%) | 1 (6%) | 0 (0%) | ***17 (22%)*** |
| *Temporary accommodation* | 0 (0%) | 3 (43%) | 4 (57%) | 0 (0%) | 0 (0%) | ***7 (9%)*** |
| *Uncertain discharge* | 1 (25%) | 1 (25%) | 2 (50%) | 0 (0%) | 0 (0%) | ***4 (5%)*** |
| ***total*** | ***32*** | ***24*** | ***20*** | ***2*** | ***1*** | ***79 (100%)*** |

PART 4b: Mildmay Mission Hospital admissions: Tracking the service user journeys.

## Referrals into the Mildmay Mission Hospital

There were 18 admissions into the Mildmay intermediate rehabilitation beds, between March 2022 - December 2022: 14 were admitted directly from the GSTT detoxification and stabilisation unit, of which 13 were matched to the GSTT IPD1 data, and 4 were admitted directly from a range of hospitals, following acute admissions. 16 of the 18 people admitted to the Mildmay Mission Hospital had serious medical co-morbidities in addition to their substance use needs including neurological disorders, gastrointestinal and liver disease, trauma related injuries, malignancies, and mental ill-health.

## Reasons for admission to the Mildmay Mission Hospital

A number of admissions were for intermediate / step-down following detoxification or stabilisation at GSTT or hospital, to optimise health and wellbeing to support people with transitioning and preparation for rehabilitation or other move-on options. Admissions provided an opportunity for further assessments/referrals, stabilisation, clinical and nutritional interventions, physiotherapy, and psychosocial work.

Examples of interventions included someone who had successfully undergone alcohol detoxification but was dangerously underweight, so needed nutritional support and weight optimisation before they could be safely discharged to residential rehab. Another included someone with poor mobility where a stay at the Mildmay Mission Hospital, with access to intensive therapy, could potentially remove the need for carer or nursing support.

Further examples were people who had undergone detoxification who also had complex medical multimorbidity. This was the situation for the four people that were admitted to the Mildmay Mission Hospital after receiving emergency hospital treatment where they were simultaneously detoxed.

**Service User M:**

*One service user who was rough sleeping prior to an emergency hospital admission, where they needed treatment in a high-dependency unit whilst in a coma. They subsequently had a long stay at the Mildmay due to ongoing complications which required intensive wound care and work up for further surgery. Whilst at the Mildmay they were able to access psychological support and work towards rehabilitation at a suitable place. They went on to successfully complete rehab and transitioned into supported accommodation with ongoing care from their substance misuse team.*

There were a number of service users referred to Mildmay Mission Hospital with very complex needs for whom rehabilitation was not an option and it was also unclear, until they had received more support from the MDT, what type of move-on would be appropriate (see service user N).

Despite the overall lack of improvement relating to alcohol use, service user N's case demonstrates the value of the stay at GSTT and Mildmay in supporting him with physiotherapy and regaining his mobility.

**Service User N:**

*A man in his 50's, with alcohol addiction, who had been rough sleeping, had an emergency admission to GSTT due to episodes of collapse and sustained a significant fracture affecting his mobility. He was successfully detoxed at GSTT and had physiotherapy which enabled him to regain mobility. He was discharged to the Mildmay and had continued physiotherapy and support from a specialist drug and alcohol worker and clinical psychologist, to begin to work with his significant childhood trauma. Though the service user liked the environment at Mildmay and felt safe and understood, he was unable to maintain abstinence. His addiction support worker said, "he found it too difficult to sit with his trauma while sober."*

The Mildmay Mission Hospital was also used on occasion to help stabilise service users who were undergoing multi-staged detoxification at GSTT. This included a service user who was on a very high dose of methadone that could not be detoxed in one go, so went from GSTT to Mildmay and back to GSTT.

For others, admission to the Mildmay Mission Hospital was needed where there was a delay between completion of detoxification and the availability of rehab, appropriate housing, or accommodation (see service user O).

**Service User O:**

*A person who experienced domestic violence and whose partner was also using, had a short stay at the Mildmay following detox. She had detoxed more quickly than expected and was awaiting her place in rehab. The service user went on to complete rehab and continues to be abstinent with plans to start volunteering for their substance misuse service.*

There were a couple of service users with complex needs who had no recourse to public funds While in the Mildmay Mission Hospital they were able to have further assessments and support around regularising their immigration status (see service user P).

**Service User P:**

*A person with no recourse to public funds was referred for alcohol detox. Prior to admission, he was supported by street outreach and substance misuse teams. Grant money was secured to fund emergency accommodation. Following successful detoxification, he was admitted to the Mildmay as a step down. During this time, he received intensive support to resolve his immigration status. Eventually he was granted settled status but with no rights to claim housing benefit. This meant he had to start working quickly in order to fund accommodation. This was facilitated by an employment service. However, the pressure of rapidly transitioning to employment alongside underlying mental health issues was believed to have led him to start drinking again and ultimately return to the streets. He has since had multiple admissions to hospital.*

## Mildmay Mission Hospital: length of stay

The average length of stay at the Mildmay was 49 days with a range of 0 - 175 days.

Eight service users had lengths of stays less than 30 days. This included those awaiting rehab, either because they needed a period of stabilisation, e.g., optimisation of physical health, or because their rehabilitation placement was not yet ready. Three service users in this group absconded or were discharged following multiple relapses.

Five service users had stays ranging between 1 - 3 months. Some of these service users were awaiting housing whilst others were undergoing medical investigations. Two of these service users had complex detoxification/rehabilitation journeys in that they both struggled with multiple lapses that were triggered by their experiences of significant, complex trauma. They were eventually discharged following a number of warnings.

Five service users had stays of over three months. Aside from one service user for whom we have limited information, all other service users had extremely complicated backgrounds ranging from advanced multimorbidity that required ongoing medical input to those with precarious social circumstances including no recourse to public funds.

## Mildmay Mission Hospital: overall outcomes and discharge destinations

It was clear from the 18 cases admitted, that a number of people had no clear discharge destination when they arrived at the Mildmay. Prior to detoxification and stabilisation, many were high risk users, with long histories of addiction, street homelessness and psychological trauma.

Relapse and self-discharge were frequent, explaining some of the discharges to hostels or the street.

**Service User Q:**

*A service user was referred into the unit following an acute hospital admission. She had bought cans on her way into the unit and needed an extra detox on arrival. She did ok for the first few weeks, and displayed insight when given a warning when sober, but was very difficult with the nurses while intoxicated. She was finally asked to leave due to repeated intoxication, so was discharged back to the hostel. A few months following her Mildmay admission, she was admitted to intensive care following an overdose. She underwent a further detox and remained abstinent for 1 month but then relapsed and is drinking again - though apparently less than previously.*

Out of the 18 people admitted to the Mildmay, at the time of our evaluation, there were five with good outcomes, four people who were further along their journey, seven whose outcomes were poor (including one person who subsequently has died) and two whose outcomes we were unable to ascertain.

For nine of the 18 admissions, discharge was to stable accommodation: five to their own tenancy and four to rehab. However, four were discharged to a hostel or temporary accommodation, three ended up back on the street, one transferred to hospital and one we were unable to ascertain.

## PART 4c Overall reflection on outcomes

### What is associated with good outcomes?

The preparation required before detoxification was captured for several service users who had a 'good' outcome. This ranged from facilitating those who had been rough sleeping to have some time living in a hostel, to a structured programme encompassing the biopsychosocial model of care.

Integrated multi-agency working has been pivotal in the care of many service users. Cross-sector partnership collaboration across housing, adult social care, health, and addiction teams, were highly beneficial when dealing with the most vulnerable service users. Other feedback applauded good communication and flexibility around discharge, such as delaying discharge to resolve a medical issue.

Completion of long stay residential rehabilitation was also associated with good outcomes.

Examples of particularly helpful practice included the rehabilitation unit picking a service user up from detox, and rehabilitation services that provide a comprehensive service including a full relocation program for all over the country.

Although service users with no recourse to public funds were unable to access residential rehab, some maintained their recovery by accessing charitable, religious based aftercare facilities whilst others were provided with dry, supported accommodation by their local authority. Another sustained abstinence while engaging with community rehabilitation counselling (though success from this was frequently not the case).

Being placed in secure stable housing post-detoxification or rehabilitation was associated with good outcomes. This included people who were supported to maintain their own tenancy, provided housing through schemes such a Housing First or moved into abstinence-based supported accommodation. The provision of a home that provides security and appropriate support, appeared to help many achieve their goals.

There were also some people where the detoxification and stabilisation gave them an opportunity to be assessed and placed into high level supported environments, including specialist care homes.

One service user had a temporary relapse, but despite this was supported and encouraged to continue with rehabilitation. This demonstrates the importance of supporting service users through recurrence of substance use, and motivating them back to recovery, whilst maintaining their accommodation.

Some service users reconnected with family and returned to relationships that had been damaged through substance use, with a couple of people returning to the family home after completion of rehabilitation.

The benefits of a multistage approach to detoxification and rehabilitation, particularly for higher risk service users with polysubstance use, was also seen with an initial admission for stabilisation, followed up by a stay in the Mildmay for a period of stabilisation, then detoxification in the unit, before returning for stabilisation and further detox.

### What is associated with poor outcomes (no apparent improvement)?

Clearly, when working with a population with such complex needs, detoxification and rehabilitation are not going to always be successful in achieving abstinence or stabilisation, and it was clear from a number of discussions that some people need a number of opportunities for detoxification and stabilisation as part of their journey.

For many people, their relapse was a result of their early trauma, making it too hard not to self-medicate. A significant amount of long-term support from clinical psychologists and other professionals may be necessary to enable people to get to a place where they can become more stable or sustain abstinence whilst sitting with their trauma.

However, there were also a range of systemic factors that were associated with poor outcomes. Some people, who would have benefitted from rehab, were not able to access it. This included people who had no recourse to public funds as well as people with recourse, who did not have good English language skills. Another service user was unable to enter rehabilitation due to being on a methadone prescription, as most rehabilitation units require abstinence even if the service user is stable on opiate substitution therapy.

There were at least two other people who successfully completed detoxification and rehabilitation but relapsed after being housed out of the area where their support systems were. This was despite the local authority knowing what their needs would be well in advance of them leaving rehab. This highlighted the risk in lacking ongoing support for people, which is often needed on a long-term basis.

There were also service users who, stakeholders believed, experienced social isolation and a sense of a lack of purpose which contributed as risk factors for their relapse.

## Summary and Discussion

This report has demonstrated that there is a huge need and value in the IPD1 beds at GSTT and the intermediate care beds at Mildmay Mission Hospital.

94% of people admitted to IPD1 beds at GSTT and all people admitted to the Mildmay Mission Hospital had a history of or were at risk of rough sleeping. The majority had very complex needs (co-morbidities / significant mental ill health) and high alcohol and/ or polydrug use.

Though a small number were admitted directly from the street (10 out of 135 admissions to the IPD), some boroughs had placed people who were sleeping rough, into temporary accommodation or a hostel prior to being referred into the GSTT unit.

There are differences between how boroughs make decisions about who should be funded for detoxification and rehabilitation, with a range of views regarding preparation and stabilisation requirements prior to referral into the unit. This issue is complex with some suggesting that people who are rough sleeping should have automatic admission for detoxification and others suggesting stabilisation needs to first occur.

Those working with some of the most entrenched people who are sleeping rough report that they are often not listened to by professionals and services, including the community substance misuse teams, about concerns they have regarding their clients. This results in some of the most vulnerable, high-risk individuals not being assessed for suitability for a referral into the IPD, resulting in missed opportunities.

These teams suggested that for the pathway to work effectively and equitably, there needed to be further considerations regarding who has the right to refer into the unit. They also suggested that different boroughs responded differently to their clients, with some being more flexible regarding threshold for referral and alternative treatment options (such as using long-acting buprenorphine) whereas others were more likely to discharge people from their service for non-engagement.

The clinical psychologist highlighted the importance of preparation work for people who have experienced significant trauma. She recognised though, that frontline staff are often the only people supporting service users who they fear are at high risk of dying. Frontline staff frequently feel abandoned by health and social care services and are often left alone to manage this risk. They may therefore see the only safe option being detoxification, whether or not the service users have had specific preparation or not. There is currently an apparent lack of accountability by health, social care, and addiction services for these high-risk individuals. There is a clear need for much more support for frontline staff when working with people with this degree of risk and complexity whether they are appropriate for detoxification or not.

The GSTT unit is able to take people who could not be safely detoxed outside of a hospital environment due to the high levels of complexity and risk. Although this environment does not suit everyone, the multidisciplinary team at the IPD1 were very successful at supporting people with this complexity through the process. Service users and providers applauded the unit for its flexibility and holistic approach, addressing a range of complex medical issues which had often been previously undiagnosed or untreated.

It was clear that some people need more than one chance for detoxification and that this should not be considered a failure. Given the obstacles that this population experiences, service users may require a number of opportunities for detoxification or rehabilitation. What was clear from this evaluation, was that success should not only be seen as whether or not someone has achieved and sustained abstinence but also whether they were further along their journey. A good experience with detoxification, even if followed by relapse, can support their journey towards greater stabilisation or recovery in the long term.

From follow-up data of people who had been through the GSTT IPD, when taking into consideration the complexity of the service users admitted, a high percentage of outcomes at follow-up were good, though this depended, among other things, on an individuals' needs and what after-care support was provided. There were examples of where flexibility shown by the unit, alongside integrated multi-agency working between housing, adult social care, health, and addiction teams, supported good outcomes. However, there were challenges due to a lack of a range of aftercare options. This prevented some people from entering the unit for detoxification or if they did, some returned back to their previous accommodation such as a wet hostel, where they were surrounded by peers who were using, making it extremely challenging not to relapse.

Out of the 79 individuals for whom we had follow-on information, 84% had completed detox. 41% had a good outcome at the time of follow-up (meaning they were abstinent, or if not abstinent controlled on OST alone); 30% though not abstinent or controlled on OST were further along their journey whereas 28% had poor outcomes (no apparent improvement), meaning that their situation regarding their substance use had not significantly improved following their referral into the unit. However, all people admitted to the IPD1 unit had a full clinical review, so some people within the 'poor outcome' category had benefited from clinical interventions.

There was a range of discharge destinations from the GSTT IPD. 51 out of the 79 (65%) were discharged to stable accommodation, the majority of these being to residential rehabilitation (51%) or the Mildmay (24%). Out of those discharged to stable accommodation, 59% had a good outcome. However, on further analysis, only 25% of those discharged to the Mildmay achieved this good outcome, in contrast to the 73% of those discharged to residential rehab. This disparity highlights the complexity of service users referred to the Mildmay and the lack of appropriate alternative places of support. 24 out of the 79 (30%) of people were discharged to a less stable accommodation, such as a hostel or temporary accommodation for reasons such as a lack of other options, service user choice, aftercare plan not acceptable to the service user or early discharge from the unit following relapse. Only one person was discharged to a less stable accommodation that had a good outcome; however, 58% were further along in their journey.

An additional concern for people on this pathway is that their hostel or temporary accommodation bed may be closed if the plan is for them to go from detoxification to rehab. If they are then unable to complete detox, they are at risk of street homelessness.

Out of the 18 admissions to the Mildmay Mission Hospital between March 2022 to December 2022 14 people were admitted from the GSTT unit, and four admitted directly from an acute hospital admission. Mildmay beds were used for a range of reasons including intermediate / step-down following detoxification at GSTT or hospital, to optimise health and wellbeing to support people with transitioning and preparation for rehabilitation or other move-on options.

They were felt to be extremely valuable by the boroughs that used the beds, but a number of boroughs did not refer to them. There was often a lack of clarity about how admissions and discharges were managed, as well as inconsistent communication around the admissions, service users progress and discharges, which was reported at times to have impacted the coordination of smooth transfers in and out of Mildmay.

Out of the 18 admissions, five were discharged to their own tenancy or supported accommodation, four were discharged onto rehabilitation and 1 transferred to hospital. Out of the remaining eight people, three were discharged to a hostel, three ended up back on the street and two we were unable to ascertain. Outcomes for people who had been referred into the Mildmay were not as good as for those who went elsewhere from the IPD1 unit, with only four out of the 18 having a good outcome, and with nine having poor outcomes (no apparent improvement). What was clear when looking through these cases, was that people being referred into the Mildmay beds were often some of the most complex - often with high levels of trauma, emotional and behavioural issues.

Though the complexity of a number of the service users who were discharged to less stable accommodation and to the Mildmay is clear, it is likely that had there been more choices of appropriate move-on options and aftercare support, particularly for people who have experienced significant trauma, outcomes could have been better.

## What's needed for the pathway to work smoothly.

### Long term flexible trauma-informed support

Considering the complexity of this population and the high levels of trauma, there was a range of needs and gaps that were highlighted, including more options for detox, rehabilitation, and aftercare support.

As it can take considerable time to develop trust, it is clear that there is a need for support to be provided by people who are trusted by the service users, at all stages of their journey. For many people who are entrenched rough sleepers or have complex trauma, this trust has been developed with outreach workers or other support workers or peers or inclusion health professionals. Where possible, their relationship with their client's needs to be acknowledged and they need to be enabled to continue to provide support pre, during and post detoxification. Wraparound psychosocial support often needs to continue for some time following detoxification and or rehabilitation, helping people to maintain harm reduction or sustain recovery and get a purpose back in life.

### Stabilisation pre detox

For those who are rough sleeping, most people interviewed agreed there is a need for a safe place where people who are at very high risk, including vulnerable women who have experienced gender-based violence can go prior to detoxification for 'in between help'. This included a place to receive intensive clinical and psychological help where people can get accustomed to living off the streets and/or reducing substance use and women-only accommodation. In addition, stabilisation accommodation prior to detoxification can facilitate other preparations to occur in the planning for detoxification and move-on, such as housing application paperwork. Currently some people are being accommodated in hostels or temporary accommodation prior to referral but this was not always possible due to lack of appropriate accommodation.

### Increase number and range of detoxification and stabilisation beds.

There are currently insufficient detoxification and stabilisation beds in London for this population, as evidenced by the often-cited long waiting times (2-4 months according to providers). An increased range and number of detoxification and stabilisation units are needed, in order to offer admissions quicker whilst offering service user focused care that is matched to individualised needs and circumstances. This includes flexible/bespoke options for people not ready for full detoxification or rehabilitation but who want to make changes, nonetheless. A particular gap that was identified was for women who have experienced sexual trauma, who may feel unable to go to a mixed setting for detoxification or stabilisation.

Some commissioners and providers suggested every hospital should have a detoxification unit. Whereas others suggested that in addition to the specialist medically managed beds, there was a need for a less clinical, more homely environment for clientele who are "*apprehensive about approaching services*."

One said, *"it feels that the amount of resources that go into caring for these people when they are dying outweighs the costs that we put into these units*."

### Support during detoxification and stabilisation

It was also suggested that additional support such as in-reach into the units, by people who are trusted by their clients, can help *"maximise an admission ...and prevent misunderstandings during an admission"* (Borough group).

What was also seen was the need for people to be able to safely go through detoxification in stages. This was felt to be particularly helpful for service users using high amounts of substances

who were wanting abstinence. However, multi-stage detoxification necessitates somewhere safe for people to be between admissions, such as at Mildmay, where it has worked well.

### Post detoxification move-on

#### Post detoxification transitional support

Service users need to be involved in the decision making with individualised plans. However, for some, this can be challenging prior to detoxification as *"people need to be in the right headspace to make decisions, and they are not when they are intoxicated"* (Borough group). This means that post detox, prior to rehabilitation there may need to be a period of transition for decision making, once people have had an opportunity to reflect on what they need or can manage.

Several commissioners/providers said it would be good if the client could stay in the same facility for rehabilitation and one suggested a couple of weeks post detoxification to help with transitioning, before moving on to rehab. Mildmay beds have been used for this if people need longer prior to moving into rehabilitation or their onward accommodation.

Mildmay beds were not used by all boroughs, but where they were used, they were found to be extremely valuable in optimising health and wellbeing. This was particularly the case for service users who, following detox, were not suitable or ready for residential rehab, often due to need for further nutritional, clinical, nursing or physio intervention. In addition, the beds were found to be valuable where aftercare was delayed, not fully planned or for those with no recourse to public funds. They were also occasionally used as a step-down following an acute hospital admission for people who had undertaken detoxification as part of an acute admission and who had needs for further physical recovery.

#### Choice of post detoxification/rehabilitation options

Some boroughs were able to identify a range of different types of units, particularly where they had a dedicated Social Worker who spent time assessing clients and working out what type of rehabilitation/ move-on would work. However overall, it was felt that it was very difficult to find rehabilitation options appropriate for people with the degree of complexity and trauma that this population has experienced. This was particularly the case for women who had experienced sexual trauma. In addition, there were gaps following detoxification and stabilisation for people whose English was not good enough to engage with a programme of work and for others who had cognitive impairment or brain injury or learning difficulty.

There was also a need identified for post detoxification options with psychosocial and addiction support for people needing harm reduction rather than abstinence. This includes people who want to remain on opiate substitution such as methadone or buprenorphine, despite detoxing from alcohol and/or other substances. Currently people are not able to access rehabilitation if on OST, which excludes them from the equivalent support offered in residential rehab.

In addition, there was a need identified for appropriate places of care and support for people following detoxification who would like to remain abstinent but due to their significant trauma, do not want to go to rehabilitation where they would likely need to revisit / address their trauma.

Community / day-based rehabilitation options were suggested as an important option for some people, who did not feel they could undertake residential rehabilitation, but many providers no longer provide this.

### Accommodation post detoxification and or rehabilitation:

There were concerns about the lack of appropriate move-on options for people both from detoxification or from rehabilitation, which could increase risk of relapse. It was acknowledged that people often need significant ongoing psychosocial support following detoxification or rehab, and yet the systems are often not in place to provide this. There are a range of different post detoxification and/or post rehabilitation options that are needed:

#### Supported accommodation:

An area of need that most stakeholders recognised was for safe dry/abstinence, gender specific, supported accommodation, for people leaving both detoxification and rehab. There appear to be major gaps across London, where currently most ‘supported’ accommodation for people experiencing homelessness with complex needs, is in hostels. An example included a suggestion of an abstinence hostel with monitoring plans such as regular testing to prevent relapse. Ealing had an example of this in Charrington Road.

#### Housing

Even where it is felt that people do not need specific supported accommodation, and could manage in independent accommodation, ongoing psychosocial support is often essential. There was often a problem transitioning between rehabilitation and housing, with delayed decision making by housing colleagues in identifying suitable accommodation in advance of discharge from rehab. This was found to result in service users being moved into unfurnished accommodation, out of borough and, a long way from support networks. These experiences have contributed to at least two of this cohort relapsing. This raised the need for more integrated working between local authority housing and substance misuse services.

An alternative that worked for some people who were happy to move out of area, was where some rehabilitation providers offered relocation support.

### Long term flexible solutions

There is clearly a need for long term flexible person-centred solutions with a range of aftercare / rehabilitation options. It was acknowledged this often needs more flexibility in budgets to source support appropriate for people's individual needs, including funding appropriate options which are out-of-area where necessary.

What was also clear was the need for support for people who have experienced significant trauma, and for whom abstinence may not be an option, as they are unable to sit with their trauma while abstinent.

Service users and other stakeholders also highlighted how important it is to support people to have a purpose and structure, as an important bridge into therapeutic interventions and also to sustain recovery. From service users interviews there remained anxiety among people who were now abstinent, that they were at risk of relapse due to isolation and lack support to enable them to maintain their journey of recovery and achieve or maintain a sense of purpose.

Some commissioners/providers raised examples of some innovative projects in parts of the country working in different ways with people with complex needs that could be explored and considered alongside people with lived experience. There were examples given, such as the Amber project which provides help and support to young people who have experience of self-harm through fun activities. Also, social prescribing activities such as photography, drum workshops, football, gym, and cooking, which as one commissioner said, *'can help engage with people you'd never engage with before.'*

## Recommendations

The following are recommendations based on the findings from this evaluation of the substance misuse detoxification pathway in London for people experiencing homelessness. They include stakeholder's insights into what works well and what's needed as well as practical suggestions regarding the IPD1 unit and the Mildmay.

If we are to address the considerable health inequalities experienced by this population, there is a need for more resourcing of specialist services. *"Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need"* Sir Michael Marmot.

## Key recommendations for Pan London substance misuse pathway

To tackle the stark health inequities facing this multiply excluded population there is a need for:

- **Long-term, person-centred, trauma informed / psychosocial support,** provided throughout all stages of the journey, with particular attention during transitioning periods. This could include:
    - Individuals or a specialist team (e.g., from Inclusion health, homelessness support workers, outreach workers, care navigators and peers with lived experience), working alongside substance misuse teams to provide wrap around support and help prepare clients for admission and support them following detoxification or stabilisation.
    - Sustained recovery team to support ongoing psychosocial support following discharge from local substance misuse services.
    - Support provided by connecting peers who are in a similar situation, such as those who have been through detoxification/rehabilitation.

- **Homeless substance misuse engagement service** that includes clinical prescribing

- **Practical and emotional support for staff** working directly with people with substance misuse who are sleeping rough.

- **Appropriate targets and measures of success that consider and reflect the complexity of this population.**
    - Recognising value of harm reduction or being further along their journey and that achieving abstinence is not necessarily appropriate or achievable for everyone.

- **A greater number of in-patient detoxification and stabilisation and intermediate rehabilitation beds** to support this population across London.
    - There is a need for more medically managed beds such as the GSTT IPD, but also some less clinical, medically monitored units for people with less complexity.
- **A wider range of services** to support planning, person centred care and choice including:
    - more flexibility from community substance misuse teams around non-attendance with support to encourage engagement.
        - E.g., Consider whether use of long-acting buprenorphine (Buvidal) can be expanded into areas not currently using it.
    - a place where people who are rough sleeping can be stabilised and prepared for detoxification prior to admission.

- a choice of types of rehabilitation, including **community** and **residential** considering a range of needs. These include:
  - specialised trauma informed, gender specific, rehabilitation.
  - rehabilitation supporting people.
    - with learning difficulties / cognitive impairment / alcohol related brain injury,
    - not fluent in English
    - with mobility problems
    - not ready to come completely off opiate substitution therapy.

- a range of trauma informed support and accommodation options following detoxification or rehabilitation including:
  - abstinence based supported accommodation.
  - supported accommodation for people controlled on OST / less harmful substance use.
  - Independent accommodation with wrap around / floating support

- **Using opportunities to capitalise on windows of opportunities**, such as:
  - Establish effective communication between community substance misuse teams and specialist homelessness support workers that truly listen to each other's insights and suggestions about appropriateness of referrals for people to be considered by panel.
    - Consideration should be given to such specialists supporting the completion of assessments to be taken to panel in the relevant borough.
  - Develop a pathway for a direct referral to intermediate rehabilitation beds or rehabilitation from an unplanned hospital admission - particularly if there is a long hospital stay and someone is medically detoxed and wants support to remain abstinent.
  - Improved access to MDT/clinical support for service users that are being supported by Pan London front line workers (T1000 and RhEST).

- **Effective utilisation of the waiting time between referral and detox**
  - Substance misuse team and/or key workers to facilitate continued engagement by being compassionate, acknowledging the wait time, and providing support during this difficult period. This wait time can also be an opportunity for:
    - addressing physical health and dental health needs, particularly as detoxification from substances can result in emergence of pain that had hitherto been masked by substances.
    - engaging with counselling to address other underlying issues.
  -

- Provide support groups by peer mentors to discuss the journey, help with expectations, offer encouragement, and potentially look to the future, past detoxification, and rehab.

- **Integrated working between substance misuse, health, homelessness, housing, and adult social care to support appropriate move-on options, in or out of borough as appropriate.**
  - Relationships need to be further developed / strengthened between community substance misuse teams, housing / homelessness teams and adult social care.

- **Recognition of the need to support people to maintain and develop a sense of purpose** at all stages of their journey.

## Sharing good practice and mapping services

Providers and commissioners requested an opportunity to share knowledge and learn from what other boroughs were doing such as:

- A forum to support cross borough learning where good practice and lessons learned could be explored and shared. Examples included:
  - Sharing case examples of where an entrenched rough sleeper has been supported to access services and been able to stay away from substances. What has enabled the cycle to be broken?
  - What has been the impact and what learning can be shared about borough specific initiatives and projects including those which have received additional funding through rough sleeping initiatives?
  - What can other boroughs share from their knowledge and experience of using different rehabilitation units and other recovery-based community services and what they offer.
  - Forum to hear directly and learn from service users who have been through the units.

- Mapping of different services inside and outside of London including range of rehabilitation units, recovery-based community services and other services that can be shared across London.

## Specific practical suggestions from borough providers and commissioners

### Communication

- Greater transparency around bed availability to support planning.
    - Though there is a fast-track system for people who need urgent admission, such as for someone the referrers are concerned might die, if there is no bed available, referrers need to be informed so they know they need to look elsewhere. Updating providers if anything affects admissions (e.g., strikes) so everyone is aware of the changes and knock-on effect.
- For joint referrals to GSTT and Mildmay, referrers need clarity about acceptance from both organisations in order to plan move-on.
- Increased communication from Mildmay
    - Give feedback on non-accepted referrals with reasons for the decision.
    - Update referrers and other relevant professionals, such as GP, on progress of admission and plans for discharge.
- Messaging and promotions about the units:
    - More clarity on admission criteria to help manage expectations.
    - Use pictures and descriptions for potential service users to help with preparation, engagement, and expectation.
    - Re-engage with providers in boroughs not using the Mildmay Mission Hospital to provide a better understanding of how to use the beds.
- Ensure discharge reports to referrers and GPs are provided following an admission to IPD1 at GSTT and Mildmay Mission Hospital.

### Service offer

- Increase / maintain expertise in domestic violence against women.
- Offer of some preparation work around smoking cessation for service users before they arrive in the IPD1 unit.
- Provision of liaison role, especially for Mildmay Mission Hospital where issues often arise, to support in the coordination of discharge.

### For monitoring, evaluation, and shared learning:

- Consider future data capture to facilitate communication, follow up and evaluation of outcomes.

Referrals

- Improve links and enhanced pathways to residential rehabilitation and aftercare services to support the discharge process.
- There should be more opportunistic working and referral into the unit when a service user has an unplanned emergency admission to hospital.

## Suggested next steps.

- Dissemination of the findings to steering group and stakeholders and other pan London and national fora, where appropriate
- Pan London substance misuse commissioners to consider how the above recommendations can be acted on in the short, medium, and long term.
- Consider using current networks of providers, commissioners, and other stakeholders across London to form a community of practice to:
    - Share good practice, resources, and learning.
    - Consider how to promote equity of approach around provision of a flexible, compassionate, and welcoming response to support engagement with people experiencing homelessness (e.g., around use of Buvidal)
    - Consider what preparation / stabilisation (if any) is needed in advance of detox.
- Co-produce multidisciplinary workshops alongside people with lived experience to explore.
    - What, from their initial contact and ongoing support with addiction services, would help them prepare for their journey to recovery
        - Disseminate a recovery handbook and recommendations, for multidisciplinary support workers and their clients, to explore what is needed to support a personalised individual journey towards recovery (which Pathway are currently working on).
    - How peer support networks could be set up.
- Implementation of the specific practical suggestions regarding GSTT and Mildmay Mission Hospital, particular with regards to clarifying referral pathways.
- Mapping of specialist detoxification and rehabilitation services nationally.

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