Making connections to build recovery

London Drug and Alcohol Network Homelessness Project Report

July 2013

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1 Background to the project

About LDAN and DrugScope

The London Drug and Alcohol Network (LDAN) was launched in 2001 and acts as the voice of the drug and alcohol sector in London as well as providing representation to central, local and regional government. The London-wide membership network reflects the interests of treatment providers across the capital, and aims to influence both policy and practice.

In 2009, LDAN merged with DrugScope, the national membership organisation for the drug and alcohol sector and the UK's leading centre of expertise on drugs and drug use, combining resources whilst retaining LDAN's distinct identity and role within London. DrugScope represents around 450 membership organisations involved in drug and alcohol treatment, young people's services, drug education and criminal justice, as well as related services including mental health and homelessness/rough sleeping.

DrugScope is also a member of the Making Every Adult Matter (MEAM) coalition. This is a coalition of four national charities – Clinks, DrugScope, Homeless Link and Mind – formed to influence policy and services for adults facing multiple needs and exclusions. Together the four charities represent over 1600 frontline organisations working in the criminal justice, substance misuse, homelessness and mental health sectors. The coalition is supported by the Calouste Gulbenkian Foundation and the Garfield Weston Foundation. We have been able to develop our work for London Councils in a way that is both informed by and informing of our MEAM work.

The LDAN Homelessness project

This project was delivered in partnership with Shelter and Homeless Link and funded by London Councils. It ran from 2009 to March 2013 with the aim of promoting closer working between agencies from the drug and alcohol sector and homelessness and rough sleeping services, and supporting them to develop more effective interventions and pathways to recovery.

The link between rough sleeping and substance use is clear, but complex. The Combined Homeless and Information Network (CHAIN)[1], a database used to record information about rough sleepers in London suggests that, historically, problems relating to drugs, alcohol and mental health (or a combination of the three) are common amongst rough sleepers in central London, with only around a quarter of rough sleepers having none of the three support needs mentioned.[2]

This has meant that homelessness agencies have developed considerable expertise in supporting people with histories of drug and alcohol use, just as drug and alcohol treatment providers provide effective support to people in housing need. With homelessness often accompanied by complicating factors such as poor physical and mental health, the challenges have been and remain significant. Housing support services and treatment providers often have to invest considerable time in engaging clients who can initially be suspicious, withdrawn or occasionally hostile towards services. To repeat the process of engagement again across multiple agencies can be counter-productive: the LDAN Homelessness project aimed to address this by both promoting closer working and collaboration between sectors, and also through enabling both sectors to develop a thorough understanding of one another's capacities, activities and aims. The project has also contributed to the emerging agenda around 'multiple need' driven by

1 http://www.broadwaylondon.org/CHAIN/WhatisCHAIN.html
2 http://www.broadwaylondon.org/CHAIN/Reports/S2H%20bulletin_201112.pdf

the increasing recognition that the most marginalised typically require support from a range of services, including substance misuse, homelessness, mental health and criminal justice.

Whilst LDAN had the role of delivering the element of the joint project with a particular focus on drug and alcohol use, the delivery was carried out collaboratively, enabling expert organisations from both sectors to take the lead in highlighting and sharing good practice.

This report is intended as a resource for both sectors in London, providing an overview and update of key issues for policy and practice, and summarising some of the topics explored at the LDAN forums, as well as highlighting innovations in meeting the needs of rough sleepers and homeless individuals with histories of dependency and complex needs. It also provides directions to the resources accrued over the lifetime of the project, which will remain on the LDAN website for the continued benefit of project participants and others.

This report also includes an overview of policy and service developments up to April 2013: the preceding years have been transformative for homelessness and rough sleeping, with changes including the ending of the Supporting People ring fence, the widespread adoption of the Places of Change model[3] and the introduction of new models of services including No Second Night Out[4] and No-one Living on the Streets (NLOS)[5] as well as the first large-scale use of a Social Impact Bond to address rough sleeping.[6]

From 2013, this period of change is being reflected in the drug and alcohol treatment sector: the National Treatment Agency (NTA) has been subsumed into Public Health England (PHE) with the former London NTA regional team now subsumed into the new London PHE team - funding and commissioning is in flux, all set against the intense financial pressures currently faced by the broader voluntary, community and social enterprise sector. A renewed focus on recovery and integrated, holistic support will shape the sector in the coming years, with access to appropriate housing increasingly recognised as a foundation stone for sustained recovery and effective re-integration.

Project partners

In addition to LDAN's partner agencies Homeless Link and Shelter, we would like to thank the agencies from a range of sectors who have supported and contributed to this project, alongside London Councils who funded the project and provided on-going support. In particular, these include Alcohol Concern, the City of London Corporation, Crisis, East London NHS Foundation Trust, Foundation 66, the London Drug and Alcohol Policy Forum (LDAPF), the London Pathway, Making Every Adult Matter (MEAM), Nacro, New Horizon Youth Centre, No Second Night Out, Phoenix Futures, Release, St Mungo's, Thames Reach, Solace Women's Aid, and the Three Boroughs Health Inclusion Team. We would also like to express our gratitude to the wide range of organisations and hundreds of individuals who participated in the project network meetings, and who contributed their experiences, knowledge and insights.

The work continues through a new London Council's funded project, LC Homelessness Plus, which brings together DrugScope/LDAN, Homeless Link and Shelter to build on the

3 http://homeless.org.uk/london-placesofchange#.UZX0zLWcdyx
4 http://www.nosecondnightout.org.uk/about-nsno/
5 http://www.selondonhousing.org/download/138/nlos-no_one_living_on_the_streets
6 http://www.london.gov.uk/priorities/housing-land/tackling-homelessness-overcrowding/homelessness-rough-sleeping/social-impact-bond-for-rough-sleepers

second tier support for services that we've developed with London Councils in 2013-15. Further details of this project are provided in the conclusion to this report, including details of how your service can get involved.

2 Homelessness & substance use: key facts and figures

Rough sleeping

The Autumn 2012 street counts found 557 rough sleepers in the capital, an increase of 25% on the previous year, and continuing the upwards trend established since 2008. Nationally, there was a total of 2,309 rough sleepers, up 6% on the previous year but 31% higher than 2010.[7] CHAIN, the database used to record every contact with rough sleepers in London, has a figure of 5,678 individuals in 2011-12[8].

This continues the trend of increasing numbers of people sleeping rough, the number having fallen continuously over much of the decade preceding the 2008 financial crash and economic downturn. Drug and/or alcohol use continues to be prominent among identified support needs, along with mental health problems – figures for the first two months of 2013 suggest that of rough sleepers contacted by outreach teams, 71% had some combination of support needs relating to alcohol, drugs and/or mental health.

The proportion of rough sleepers in England located in London has remained relatively stable at between 20 and 25%. Whilst much rough sleeping continues to be concentrated in the capital, there are pockets of high levels and increasing numbers across all of England.

More than 60 areas have now adopted the No Second Night Out approach aiming to respond quickly to new rough sleepers and to protect them from the risks and harms associated with prolonged and entrenched rough sleeping.

Homelessness Applications

The number of statutory homelessness applications in England has continued its upwards trend, with 113,260 decisions made in 2012-13, up 4% from the previous year.[9] Acceptances have increased by 6%, although the number of households placed in a different local authority increased in the final quarter of 2012 by 32% to 9,670; this could be related to both welfare reform and restricted access to alternative accommodation in high cost areas. Use of comparatively expensive B&B accommodation is also up by 26%,[10] with many London local authorities unable to meet the recommended 6 month time limit for use of this sort of accommodation.

Drug use and access to treatment

Many indicators about drug use, treatment and recovery are moving in the right direction. Problematic drug use (i.e. people who use opiates and/or crack cocaine) has recently fallen in England from 332,000 in 2005-06 to 299,000 in 2010-11.[11] The average time spent waiting for access to treatment has declined from 9 weeks in 2001, to just 5 days in 2012. Fewer young people are using drugs, and the number of under-30s dying from drug misuse declined from 677 to 277 between 2001 and 2011.

Nationally, just over 197,000 adults were recorded as having been in treatment in 2011-12, down from over 204,000 in the preceding year.[12] Ninety seven per cent were seen

7 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/73200/Rough_Sleeping_Statistics_England_-_Autumn_2012.pdf
8 http://www.broadwaylondon.org/CHAIN/Reports/S2H%20bulletin_201112.pdf
9 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf
10 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/157996/Statutory_Homelessness_4th_Quarter__Oct_-_Dec__2012_England_revised.pdf
11 For key statistics on treatment see http://www.nta.nhs.uk/uploads/prevalence-commentary.pdf
12 For key trends see http://www.nta.nhs.uk/uploads/commentaryfinal%5B0%5D.pdf

within three weeks of referral. The numbers of heroin or crack users starting or returning to treatment in England fell from 64,288 in 2005-06 to 47,210 in 2011-12, and the number of heroin users starting treatment for the first time fell from 47,709 in 2005-06 to 9,249 in 2011-12. In addition, the number of people successfully completing and not returning to treatment increased from 2,637 in 2005-06 to 13,589 in 2011-12.[13] This means that fewer clients were entering treatment for the first time or returning to treatment in 2011-12, more were successfully completing and the average age of the client group in treatment was edging upwards; for example, more people over 40 are dying of drug misuse – up from 504 in 2001 to 802 in 2011.[14] Services are often working with older 'problem drug users', who may have more entrenched needs (including homelessness). In addition, they are increasingly working with other forms of substance misuse – for example, the creation of a 'club drugs clinic' in Kensington and Chelsea – and alcohol issues.

Whilst the trend in London reflects the nationwide direction with the number of opiate and crack cocaine users declining from 62,000 to 51,000 between 2008 and 2010, drug use remains a significant problem for the capital. Whilst the number of users per 1,000 population in London is, for most age groups, unexceptional, the overall number of drug users in London represents around a sixth of the total number in England.[15]

The impact of drug treatment

There has been significant on-going monitoring of the impact of drug treatment, much of which was summarised and discussed in a report from the National Audit Commission on 'Tackling Problem Drug Use' (2010), and has more recently been included in a resource pack for local commissioners produced by the NTA shortly before its abolition, and entitled 'Why Invest'. The figures include:

- Every year drug addiction costs society £15.4 billion in England
- Every £1 invested in evidence-based drug treatment saves £2.50, which would have been spent later on picking up the costs of a failure to intervene
- Drug treatment in England prevents an estimated 4.9 million crimes each year, with an estimated cash saving to society of £960 million
- The National Institute for Clinical Excellence says that drug treatment is cost effective, saving the NHS around £230 million annually and preventing over 300 deaths with a 'value of life' of over £500 million.[17]

Alcohol issues and treatment

The Homeless Link website explains that 'alcohol misuse is one of the most prominent causes and effects of homelessness' and that 'a high percentage of homeless individuals have some form of support need relating to alcohol misuse'. The Alcohol Concern website states that:

- There are an estimated 1.6 million people dependent on alcohol in England
- 108,906 adults were in structured alcohol treatment in England in 2011/12 (64% male, 36% female)
- In 2011-12, 13,299 children and young people under the age of 18 in England accessed specialist services for problems with alcohol
- Only 5.6% of dependent or harmful drinkers access treatment
- For every £1 invested in specialist alcohol

13 See NTA 'Falling drug use: the impact of treatment' at http://www.nta.nhs.uk/uploads/prevalence-commentary.pdf
14 http://www.nta.nhs.uk/uploads/infographicdownload[0].pdf
15 http://www.nta.nhs.uk/uploads/prevalencestats2009-10.pdf
16 The 'Why invest' resource at www.nta.nhs.uk/uploads/whyinvest2final.pdf
17 These and a range of other facts and statistics are on available on the Alcohol Concern website at http://www.alcoholconcern.org.uk/campaign/statistics-on-alcohol further information from the NTA is also available at http://www.nta.nhs.uk/uploads/alcoholcommentary2013final.pdf

treatment, £5 is saved on health, welfare and crime costs.[18]

The Drug Strategy 2010 reports that:

- Alcohol misuse costs between £18 and £25 billion annually
- The estimated financial burden of harmful alcohol use for the NHS is £2.7 billion[15a]

It has been estimated that half of all violent crime is alcohol related.

Homelessness and substance misuse – Homeless Link SNAP survey

Homeless Link's 2011 Survey of Needs and Provision (SNAP)[19] highlighted the comparative difficulty homelessness services in London have in accessing specialist drug and alcohol services, along with a tendency to deliver more in-house provision in the face of a challenging funding environment.

Key findings include the following:

- Almost all projects in SNAP 2010 or 2011 had clients with drug or alcohol issues.
- Data from SNAP 2010 and 2011 shows that many clients have drug or alcohol problems, but day centres and hostels commonly have higher proportions of clients with these problems than the more settled second stage projects.
- In 2011 around half of day centres and hostels in the sample reported that more than 50% of their clients had a drug or alcohol problem, while between 35% and 39% of second stage projects reported the same.
- In 2011 higher proportions of day centres than accommodation projects reported that more than half of their clients had a drug or alcohol problem, but in 2010 higher proportions of hostels than other project types reported this.
- Between 2010 and 2011 the proportions of day centres and second stage projects reporting that more than half of their clients had a substance misuse problem increased, while the proportion of hostels doing so decreased.
- Seven London projects reported substance misuse services as a gap in provision in their area.
- 1 in 5 London projects refuse access to people if they are intoxicated.

A summary of the key points can be found here: http://www.ldan.org.uk/powerpoints/H8SNAP11%20substance%20misuse%20pptx.ppt

3 Homelessness & substance misuse: policy and services

Rough sleeping in London – a brief history

Rough sleeping has ebbed and flowed in London for decades, before reaching crisis point in the late 1980s and early 1990s, when "cardboard cities" sprang up near Waterloo station, Embankment and elsewhere. Homelessness and rough sleeping became highly visible across much of Central London. In 1990, the Rough Sleepers Initiative was implemented, which ran until 1999. This introduced not only much needed funding to the sector, but also a more co-ordinated and strategic approach to rough sleeping, that arguably reached its apogee in the Places of Change model, which promoted (and funded) holistic services aiming to address the entirety of an individual's needs, from accommodation to employability, health and, where relevant, substance use.[20] Partnership working with specialist services from the drug and alcohol sectors, along with mental health and employability and skills has long been

18 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf
19 SNAP reports from 2008 to 2013 are available at http://homeless.org.uk/snap#.UcAfhbVwaUl
20 More information on Places of Change is available on the Homeless Link website at http://homeless.org.uk/places-of-change#.Ubg0x_mcde8

identified as a contributor to sustained success. Rough sleeping in London has been affected by the post-2008 economic downturn: after falling consistently for many years, numbers on the streets have started to rise. Whilst the number of UK nationals sleeping rough has increased gradually, the overall number has grown significantly due to rough sleepers from overseas, particularly from the 10 countries that joined the European Union in 2004 and 2007[21](often referred to as the A10 countries), some of whom were in precarious employment and accommodation, and experienced disproportionately the impact of the recession and subsequent prolonged period of economic stagnation. These rough sleepers added new layers of complexity arising from language barriers, often unclear eligibility for public funds, cultural norms relating in particular to alcohol and sometimes a reluctance to engage with services or, in some cases, to return to their original home and be seen to have "failed".[22]

Service provision

Around a quarter of all rough sleepers in the UK are in London. The range of services aimed at meeting the needs of homeless people is consequently large and diverse. It includes:

- **Outreach services.** These work with rough sleepers on the street to support them to access services.
- **Day services.** These now almost universally offer a full range of interventions aimed at addressing not only housing need but also access to substance services, medical treatment, employability and social inclusion. Access is usually but not always by self-referral or walk-up.
- **Hostels.** These generally provide relatively short-term accommodation where immediate needs will be assessed and met prior to onward referral. Access to hostels is largely via outreach teams or other referral agencies.
- **Supported housing,** often with a particular focus on substance use, mental health or complex needs. Previously, this type of accommodation was often permanent or at least long-term; many London boroughs now work towards a model where supported housing is an intermediate stage on a pathway to greater independence. Access is generally by referral from another service only.
- **Floating or community support.** This support aims to help resettled former rough sleepers to maintain their accommodation and tenancy, and crucially, supports people at risk of homelessness before they ever get to the point of rough sleeping. Referral can be from another service, from a third party such as a GP or local authority, or in some cases, self-referral.
- **No Second Night Out.** Since 2010, this project has provided a rapid response to those new to rough sleeping as part of the Mayor's commitment to end rough sleeping in London by 2012.
- **Cold weather provision** often provided by voluntary organisations and faith groups. This provision is invaluable in cold weather and offers opportunities to engage clients with services. The **Severe Weather Emergency Protocol** takes effect when the temperature is expected to be below zero for three nights – this comprises emergency accommodation aimed at ensuring all rough sleepers have access to shelter when at risk due to severe weather.
- **Specialist services for A10 rough sleepers** who may have limited recourse to public funds, depending on their precise circumstances.
- **Local authority Housing.** These services are responsible for dealing with homelessness applications and assessing eligibility for statutory provision.

21 http://www.broadwaylondon.org/CHAIN/Reports/S2H%20bulletin_201112.pdf

22 http://www.migrantsrights.org.uk/files/news/CRONEM_report.pdf

Homelessness and related services, including some services for people with histories of drug and/or alcohol use were previously commissioned by local authorities via a ring-fenced funding stream – Supporting People. Whilst the overall funding from central government has been largely protected since 2010, the ring-fence was removed in 2009 meaning that discretionary services for adults no longer have a dedicated and protected funding stream.[23] The majority of homelessness services in London are commissioned by local authorities, although the Greater London Authority commissions or supports a number of services as well as providing strategic oversight of rough sleeping and homelessness in London.

Recent developments: The Mayor's London Delivery Board replaced by the Mayor's Rough Sleeping Group

The London Delivery Board (LDB), established in 2009 to drive the commitment to end rough sleeping in the capital by 2012, was disbanded in early 2013. Whilst progress was made through initiatives including No Second Night Out and projects such as St Mungo's The Lodge and Broadway's The Old Theatre, aimed at the most entrenched, long-term rough sleepers, the primary target of 'ending rough sleeping' was not achieved. The LDB, comprised of representatives from local authorities, homelessness agencies, central government and public services, including the police and the UK Border Agency, has been replaced with the Mayor's Rough Sleeping Group. This group consists of the Mayor, representatives from the Department for Communities and Local Government and seven London boroughs: Westminster, City of London, Camden, Ealing, Tower Hamlets, Southwark and Lambeth. The voluntary sector is not included in its core membership, but will be permitted to attend two of the quarterly meetings per year.

https://www.london.gov.uk/priorities/housing-land/tackling-homelessness-overcrowding/homelessness-rough-sleeping

No One Living on the Streets (NLOS) – an improved service for those not new to rough sleeping

Rough sleeping is damaging to health and wellbeing, and the longer a rough sleeper is on the streets, the higher those risks become – the average age at death of a rough sleeper is barely above 40. Substance use, physical health problems, mental health issues, exploitation, violence and crime are key risks, as is the rapid erosion of social capital. Recovery capital – the assets and attributes that enable an individual to enter and sustain recovery - is almost impossible to accrue whilst sleeping rough. Aimed at ensuring no new rough sleeper spends more than one night on the streets, No Second Night Out has, since April 2011, provided a rapid response service, delivered by Broadway and (since 2013) St Mungo's. Since its introduction, 8 out of 10 rough sleepers new to the London streets have avoided spending a second night on them.

The same principles have now been extended to those who are not new to the streets, via No-one Living On the Streets (NLOS) , which provides a 24/7 rapid assessment hub for those who are not new to the streets, linked to short term accommodation. The emphasis will be to reconnect individuals into appropriate services as rapidly as possibly, with short term accommodation being used where circumstances are more complex or an interim stay is agreed.

This broadening of the availability of rapid access to short-stay accommodation marks a step change for rough sleepers in

23 http://homeless.org.uk/supporting-people#.UcAkorVwaUk

the capital, and will enable more thorough assessments to be made of support needs including alcohol and drugs: failure to identify and, where possible, meet these needs can have a detrimental impact on an individual's ability to engage constructively in services and work towards both recovery from substances and a fulfilling life away from the streets.

The role of the drug and alcohol sector

"Underlying physical, mental and psychological health problems, as well as substance abuse and addiction are key underlying cause of rough sleeping which can be compounded during time on the street. Primary care and providers of drug and alcohol treatment will have a crucial role to play in meeting the immediate health needs of those brought in and during the length of the SIB (Social Impact Bond) intervention. The key to this will be to make sure that clients are getting the appropriate care and treatment to which they are entitled, when they need it."
http://www.selondonhousing.org/download/138/nlos-no_one_living_on_the_streets

Drug and alcohol services in London – a brief history

Drug and alcohol policy since the 1980s has to some extent been focussed on risk – the harm reduction agenda driven by concern about HIV and other blood-borne viruses in the 1980s, joined later by an emphasis on drug-related offending and crime reduction under the Labour governments from 1997 to 2010, exemplified by closer integration between the criminal justice sector and treatment providers (for example, Drug Rehabilitation Requirements for offenders, the development of the Drug Interventions Programme to identify and assess offenders with drug problems and route them to treatment, and investment in an Integrated Drug Treatment System in prisons). Particularly from 2007, there was an increased emphasis on social inclusion and reintegation. The Labour government's 2008 drug strategy, *Drugs: Protecting Families and Communities*,[24] promised 'a radical new focus on services to help drug users to re-establish their lives', recognising, for example, the relationship between poor housing and higher drug use.

The 2010 Drug Strategy was subtitled *Supporting people to live a drug free life*,[25] and this goal was placed at 'the heart of our recovery ambition'. The definition of recovery in the strategy as 'an individual person-centred journey' resting on the three principles of 'wellbeing, citizenship and freedom from dependence' was widely welcomed in the sector. The Strategy makes explicit reference to the role of substitute prescribing in treatment of heroin dependency and the possibility of what is described as 'medically assisted recovery'.

Of particular significance, the Drug Strategy 2010 developed the theme of social inclusion and reintegration – with 'a safe place to live' identified as a vital component of what it calls 'recovery capital' and 'the ability to access and sustain suitable accommodation' identified as one of eight 'best practice outcomes' for a 'recovery-orientated system'. It includes a section on 'Tackling Housing Need', which explains that 'evidence suggests that housing, along with the appropriate support, can contribute to improved outcomes for drug users in a number of areas, such as increasing engagement and retention in drug treatment, improving health and social wellbeing, improving employment outcomes and reducing re-offending'.

24 http://webarchive.nationalarchives.gov.uk/20100419081707/http:/drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008
25 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

The Drug Strategy 2010 also covers treatment for severe alcohol dependency, recognising that the issues are broadly the same as for addiction to illegal drugs (see below). Further evidence of the increasing focus on homelessness in the drug and alcohol sector is provided by the inclusion of 'resolved housing problems' among clients who were homeless at the start of their treatment journey as one of the outcomes for eight 'payment by results' drug and alcohol recovery pilots launched in April 2012. One of the pilot areas is the London Borough of Enfield.

Recent reforms

Between 2001 and April 2013, the development of drug treatment in England was overseen by the National Treatment Agency for Substance Misuse (NTA), which was a special health authority within the NHS, and operated both nationally and through its regional teams – including the NTA London Regional Team. Drug treatment was largely funded by a 'pooled treatment budget' of around £460 million in 2012-13, which was nominally 'ring fenced'. At local level, Drug Action Teams and Drug and Alcohol Action Teams within local authorities have had responsibility for delivering the drug strategy.

In April 2013 the National Treatment Agency was abolished with its functions absorbed into a new body, Public Health England, and the former pooled treatment budget, along with other drug and alcohol spend, absorbed into a new public health budget.[26] These budgets are now held by Directors of Public Health employed by local authorities, including in the London Boroughs. This is a fundamental change for the drug and alcohol sector and has raised concerns about the risk of deprioritisation and disinvestment (see below).

The London region NTA was also abolished in April 2013, with its staff and functions absorbed into the London PHE team. London is unique in the way PHE is structured, with a single, integrated regional structure. The London PHE region is working closely with the Greater London Authority, as well as the London Boroughs, and other key stakeholders, including the Mayor's Office for Police and Crime (MOPAC).[27]

Some criminal justice interventions are being commissioned at local authority level, supported, in London, by funding from the Mayor's Office for Policing and Crime (MOPAC). Offender health – and specifically treatment in prisons - is now the responsibility of NHS England (formerly referred to as the NHS Commissioning Board). The new commissioning arrangements may offer scope for joined-up commissioning that might better address cross-cutting themes including substance use, homelessness and housing need, health, employment and offending.

Public health reform – risks and opportunities

The funding for community drug and alcohol treatment is included in the public health budgets that are now the responsibility of Directors of Public Health in the 33 London Boroughs. Each London Borough has a Health and Wellbeing Board, which is responsible for producing a Joint Strategic Needs Assessment (JSNA) and a joint Health and Wellbeing Strategy (JHWS) that will set out the Borough's plans and priorities for health and public health, including substance misuse. The 2013-15 Public Health Budget for England was announced in January 2013. This provides a sum of £5.45bn over two years, ring-fenced for public health purposes.[28]

Whilst the budget is ring-fenced for public health, there is concern about a lack of meaningful protection for funding for drug and alcohol services, which was previously partly ring fenced. A version of the incentive structure used under the Pooled Treatment Budget remains in theory, but has been diluted

26 https://www.gov.uk/government/organisations/public-health-england
27 http://www.london.gov.uk/priorities/policing-crime/about-mopac
28 https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15

by its incorporation into a larger pot that has a much broader range of outcomes to deliver against. Out of the 66 public health outcome indicators[29], only 3 relate directly to drugs and alcohol (although there are additional related indicators), whilst around a third of the public health budget comprises money that was previously invested in drug and alcohol services, including the former Pooled Treatment Budget.

Furthermore, whilst in March, the Department of Health published final Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies for Health and Wellbeing Boards, which contained a number of positive elements, including promoting integration between different services, drugs and alcohol were not mentioned at all in the main body of the text.[30] Inequalities are mentioned, but only in the general sense and there is no explicit commitment to address the "deep" inequalities experienced by the most marginalised in society.

In correspondence with DrugScope (April 2013), the Public Health Minister, Anna Soubry MP, gave reassurances that local authorities will be required to report spending on an annual basis, with categories for adult drugs, adult alcohol and young people's drug and alcohol services. She stated that the government is 'expecting to keep the provision and funding of substance misuse treatment under close review in the first year, it is being seen as a critical litmus test of the effectiveness of the devolution of these responsibilities to local authorities'. Clearly, there remains genuine interest from Government, at the same time anxieties about disinvestment persist in the sector.

While there are risks of disinvestment, it is important to acknowledge some opportunities too. The increased role of local authorities in planning and commissioning drug and alcohol services creates opportunities for more effective 'joining up' of services at local level with a focus on local need and priority. The development of community budgets and other forms of innovative local commissioning could support the development of stronger, more integrated services able to work across a broader spectrum, including homelessness, substance use, employability and physical and mental health. There is also the option of rebalancing investment in forms of substance misuse other than so-called 'problem drug use' (heroin and crack cocaine), including alcohol services. The relatively recent arrival of New Psychoactive Substances (NPS, sometimes called "legal highs" or club drugs) poses a new challenge for treatment providers and related services, including for young people and sections of the LGBT community, a challenge increasingly being met by new and innovative services in London.

Service provision – a beginners guide

Whilst the tier system previously described under now superseded guidance on 'Models of Care' for drug treatment provision no longer formally exists, it still provides a useful template for understanding how service provision works in practice and the variety of specialist interventions that are available, which includes:

- Tier 1: Non-specific (general) Service: this can include (for example) General Practitioners, probation, housing and homelessness services. Access is primarily aimed at people who are already engaged with these non-specialist services.
- Tier 2: Open Access Service: including advice & information, drop-in services, harm reduction services (including needle exchange). Many of these services are specifically targeted at people who are not yet ready to engage with more structured

29 http://www.phoutcomes.info/
30 The Department of Health guidance on Joint Strategic Needs Assessments and joint Health and Wellbeing Strategies is accessible at http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

and intensive provision, and are designed to be low threshold with limited conditions for access.

- Tier 3: Community Services: community drug teams provided by the NHS or voluntary sector, structured day treatment, GP prescribing and aftercare. Access to these services is generally by self-referral or referral from another agency.
- Tier 4a: Specialist Services: hospital inpatient, residential rehabilitation. Referral is almost always required, although special arrangements may be in place for emergency access to services in some locations.
- Tier 4b: Highly Specialist Services, including liver units, forensic services.
- Criminal justice interventions, including the Drug Interventions Programme (DIP), which serves as a link between the criminal justice sector and drug treatment. (DIP was discontinued as a nationally managed programme with its own budget from April 2013, although many London Boroughs continue to run services that are based on DIP provision, and which are now sometimes referred to as Offender Access to Treatment Services. DIP-style interventions are also integrated into the work of Integrated Offender Management teams.)

The focus now is increasingly on 'building recovery in communities' and therefore linking treatment services with services providing housing and employment support, for example. There are also a range of services working with particular groups affected in different ways by drug and alcohol problems – for example, families, club drugs, the LGBT community, domestic violence and sex workers. In addition, of course, there are young people's drug and alcohol services, where the issues are primarily with alcohol and/or cannabis, and entrenched dependency is relatively rare.

Alcohol policy

Broadly speaking, the developments discussed above apply equally to alcohol and drug treatment – for example, both drugs and alcohol are included within the responsibilities of PHE and the 2010 Drug Strategy 'recognises that severe alcohol dependence raises similar issues and that treatment providers are often one and the same', concluding 'therefore, where appropriate, this strategy will also consider severe alcohol dependence'

In 2012 the Government published an Alcohol Strategy.[31] This strategy has a particular (but not exclusive) focus on 'binge drinking' and its impact on town and city centres and the pressures that the misuse of alcohol places on hospitals, particularly on Accident and Emergency (A&E) departments. (The Public Health Outcomes Framework includes an outcome for the reduction of alcohol related admissions to hospital - alongside other indicators for which alcohol policy and services are critical, such as a reduction in mortality from liver diseases and reductions in violent crime.)

The Alcohol Strategy has little to say about the treatment of alcohol dependency, which is covered to some degree by the Drug Strategy 2010. It does refer to the issue of 'dual diagnosis' and the links between alcohol misuse and mental health problems, as well as the challenge of improving support and services for offenders with alcohol problems, including prisoners.

It also considers other health interventions. Identification and Brief Advice (IBA) will focus on individuals who are 'at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem'. Local authorities are encouraged to examine the evidence for local investment in IBA by primary care staff. The strategy also commits the Department of

31 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98121/alcohol-strategy.pdf
DrugScope has produced a briefing on the Alcohol Strategy and other recent developments in alcohol policy, which is available at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSBriefingAlcoholStrategy.pdf

Health to include IBA in the NHS Health Check for adults age 40 to 75 from April 2013. In addition, the strategy 'encourages' hospitals to employ 'Alcohol Liaison Nurses', with responsibility for:

- Medical management of patients with alcohol problems in the hospital;
- Liaison with community alcohol and other specialist services;
- Education and support for other healthcare workers in the hospital; and
- Delivery of IBA in hospital with a focus on key groups, including pregnant women.

Hospitals are dependent on Clinical Commissioning Groups (potentially in partnership with public health) to provide the necessary funding for Alcohol Liaison Nurses.

In reality, most substance misuse services are already working across illegal drugs and alcohol in response to the needs of their service users. This is also becoming the norm at policy level, as shown, for example, by the inclusion of alcohol dependency as a key issue within the Drug Strategy 2010 and in the eight Drug and Alcohol Recovery Payment by Results pilots. Recent changes to commissioning arrangements could rebalance local investment in illegal drug and alcohol services in favour of the latter.

StreetLink - New National Rough Sleeper Reporting Line

Launched before Christmas 2012, StreetLink aims to improve services to the public and rough sleepers by "hiding the wiring" when making a referral or self-referral. The process of accessing help and support for rough sleepers has often been complex and confusing, with no single route of access or referral, and different measures put in place by local authorities to meet their own priorities. Through a national phone line, a website and a mobile phone app, StreetLink provides a single referral route for concerned members of the public, or for rough sleepers themselves.

Managed by Homeless Link and delivered by London homelessness agency Broadway, StreetLink should make a substantial contribution to reducing rough sleeping and helping the areas that have adopted the No Second Night Out Standard to meet their objectives. StreetLink does not provide accommodation itself, but acts as a conduit for referrals to outreach teams and building based services.

If working with a homeless client, drug or alcohol agencies should wherever possible direct clients to day services; if they have no option but to sleep rough, a referral to StreetLink would be appropriate.

StreetLink: http://www.streetlink.org.uk/

London advice and service directory: http://www.homelesslondon.org/portalhl/UserAction.do?method=welcome

How does criminal justice sector reform apply to London?

Police and Crime Commissioners (PCCs) will have an interest in the provision of drug and alcohol services, given the impact on crime and community safety. In London, uniquely, the Mayor holds the PCC function, which in practice is delegated to the Deputy Mayor for Policing and Crime, with the support of MOPAC (the Mayor's Office for Policing and Crime). MOPAC's budget includes former Drug Interventions Programme money, and it is now helping to fund Offender Access to Treatment activity across London through a 'London Crime Prevention Fund'.

The London Police and Crime Plan 2013-16

In March 2013, MOPAC published the Police and Crime Plan 2013-2016 for London, following a consultation to which DrugScope/LDAN contributed.

It is based on five key pledges that were reflected in the Mayor's 2012 manifesto, including 'develop smarter solutions to alcohol and drug crime'.

It includes commitments to:
- 'develop an alcohol related crime strategy for London focused on prevention, enforcement and diversion', including developing 'compulsory sobriety schemes' and 'promoting the use of controlled drinking zones'; and
- a drugs strategy for London which will 'put more responsibility on offenders to overcome dependency, learning from the HOPE programme in the USA, which requires offenders to report daily and participate in random drugs tests'. Those placed on the HOPE probation programme 'must subscribe to an intensive drug-testing regime to ensure they remain abstinent, whilst other treatment is provided to help them remain drug free'.

The MOPAC plan suggests a HOPE programme could be commissioned on a payment by results basis using a Social Impact Bond to fund it.

Another key component of this strategy is the piloting of a new Alcohol Abstinence Monitoring Requirement (AAMR) to test 'how widely magistrates use AAMR; the technical processes within the criminal justice system; the effectiveness of electronic monitoring and breath tests; compliance with and breaches of the order; offending and behaviour costs'. Depending on the outcome of the pilot, there will be consideration of roll out across London. The pilot sites are the London Boroughs of Sutton and Croydon.

It also confirms the importance of Drug Interventions Programme (DIP) style interventions in areas where drug related acquisitive crime is still important, but says that London boroughs have the freedom to identify their own priorities, including alcohol related crime and illegal substances other than opiates/ crack cocaine. We understand that all London Boroughs that applied for funding for DIP-style interventions (or Offender Access to Treatment Services) received the funding they applied to as part of the bidding process for funding from a London Crime Prevention Fund allocated through MOPAC.

Find out more:
The MOPAC website is at http://www.london.gov.uk/priorities/policing-crime

The MOPAC Police and Crime Plan is at http://www.london.gov.uk/priorities/policing-crime/mission-priorities/police-and-crime-plan

Contacts for the drug and alcohol team within London PHE are at http://www.nta.nhs.uk/contacts-lon.aspx

4 Homelessness & substance misuse: welfare and employment support

One of the key issues that is currently affecting organisations that participated in the LDAN homelessness network is welfare reform. Homeless men and women, particularly those with histories of substance use or complex needs, face an exceptional array of barriers to employment, and in many cases lack the support and facilities needed to demonstrate job seeking or other required activity. For services, the challenge is to keep up to date with and on top of a raft of fundamental reforms to the welfare system and provide guidance for their clients. The LDAN homelessness project has provided support for services, and a 'voice' for their issues and concerns in policy processes. We have had the opportunity to develop this strand of work in parallel with another LDAN project, 'Pathways to Employment', funded by Trust for London. We have worked closely with our London Councils project partners on welfare issues, making joint submissions to policy consultations with Homeless Link, including the Work and Pensions Select Committee inquiry on the Work Programme.

Benefit changes[32] A rolling programme of welfare reform has since 2010 posed significant issues both for homeless men and women themselves, and also for services aiming to support them. Reforms, including the replacement of Incapacity Benefit with Employment and Support Allowance (ESA), have meant that many claimants have had to complete a new process of assessment and in some cases have had to be supported through appeals processes. One of the consequences of cut-backs in public spending has been to reduce the external resources available to support benefit appeals, meaning that homelessness organisations and treatment providers have often had to develop expertise and good practice in unfamiliar areas of work. For claimants on Job Seekers Allowance (JSA) there has been a renewed focus on conditionality – the tasks that claimants have to undertake to remain eligible for their benefit. The intention behind Universal Credit is to simplify working-age benefits and provide a stronger incentive to take paid employment – this is welcome, but the challenges for homeless people and homeless services are significant. From a service provider perspective, concerns around the impact of the overall benefit cap (OBC) and Universal Credit have not been fully addressed, with continuing uncertainty around the status of "supported exempt accommodation" posing a risk to accommodation services.

At the time of writing, welfare reform continues apace, with several new elements coming into effect from April 2013 onwards. Of the changes that will affect large numbers, one of the first to be implemented is the replacement of Council Tax Benefit with local support schemes. The overall benefit cap is being piloted in parts of London prior to national roll-out by September 2013, whilst Personal Independence Payment (PIP) will be phased in from April, followed by Universal Credit, expected to be introduced nationwide from October onwards.

Universal Credit: this new benefit replaces several existing benefits, including housing benefit, income-based Jobseeker's Allowance (JSA), income-based Employment and Support Allowance (ESA), income support, child tax credit and working tax credit. By default, payments will be made monthly and to one member of the household, although alternative arrangements should be made available for people who may need it. Groups that the Department of Work and Pensions (DWP) has indicated are likely to need budgeting support include homeless people, people with histories of drug and alcohol dependency, people in

32 http://www.dwp.gov.uk/docs/dwp-reform-story-overview.pdf

temporary and supported accommodation and people with mental ill health. The DWP has the aim of establishing local support services to assist with the transition to Universal Credit, delivered by local authorities in partnership with housing providers and other voluntary sector agencies.

Whilst the expectations of working age and job-ready claimants are likely to be more demanding under Universal Credit, there are significant and positive developments for people entering treatment for drug or alcohol dependency. This is expected to take the form of 'tailored conditionality', in which all availability and job search requirements will be lifted for a period of six months or the duration of treatment, whichever is shorter. Whilst the precise details have yet to be confirmed, the indications are that anyone entering structured treatment, if recorded by the NDTMS data collection system, will qualify, although the Universal Credit Regulations stipulate that the treatment has to be "recovery orientated", which may be open to interpretation.

The Social Security Advisory Committee (SSAC)[33] has been gathering evidence for an inquiry into "at-risk" claimants and the introduction of Universal Credit; DrugScope has provided information via submissions both in writing and in person. The SSAC report makes a number of recommendations aimed at protecting vulnerable claimants in the transition to the new regime.

Council Tax Benefit: Council Tax Benefit has historically been administered locally (with Housing Benefit) but funded by central government. This has now changed: local authorities have been given funding based on the cost of council tax benefit in 2012-13, but reduced by 10%, and have been given complete discretion over implementing this saving, other than the requirement that pensioners are protected. As pensioners make up a significant proportion of council tax claimants, that means that non-pensioners face a substantially higher increase, in some cases of 20% or more, although some local authorities have chosen to take money from elsewhere to lessen the impact. One of the biggest potential risks is that people who may have become accustomed to not having to pay or actively manage council tax may be unaware of the changes, and may consequently fall into arrears. The New Policy Institute has collated information for council tax local support schemes: http://counciltaxsupport.org/the-story-so-far/

Overall Benefit Cap (OBC):[34] this is being piloted in Bromley, Croydon, Enfield and Haringey, with the expectation that it will be rolled out to all London boroughs by the end of September 2013. The cap is set at £26,000 for households with children or £18,000 for single claimants. Households where someone is in receipt of Working Tax Credit, Disability Living Allowance, PIP, the support component of ESA or some other benefits will be exempted from the OBC – households that may be affected should have been contacted by their local authority and/or the Department for Work and Pensions by now. Shelter has warned that the OBC risks increasing homelessness, particularly in London and the South East of England, whilst the four local authority pilot areas, who have to support households through the transition and meet short-term costs incurred have indicated that funds from central government to meet these support needs are inadequate. London Councils, the umbrella body for local authorities in London have expressed concern that the pilots are not being evaluated and thus will not inform wider roll out, expected to start on 15th July 2013 and to be complete by September.

33 http://ssac.independent.gov.uk/pdf/occasional/implementation-uc-claimants.pdf
34 http://www.dwp.gov.uk/adviser/updates/benefit-cap/
https://www.gov.uk/government/news/benefit-cap-implementation
http://england.shelter.org.uk/get_advice/housing_benefit_and_local_housing_allowance/changes_to_local_housing_allowance/benefit_cap_from_2013

Personal Independence Payment (PIP): this benefit is the replacement for Disability Living Allowance (DLA). PIP was introduced for new claimants from April 2013, existing claimants have a degree of protection in that their eligibility will not be reduced as long as their circumstances do not change. However, as many people's circumstances change from time to time – for example by moving house or an improvement or deterioration in health, the number of people with that protection will be eroded over time. Concerns have been expressed by disability and welfare rights organisations that changes to criteria, particularly around mobility, will mean that many people who need financial support will no longer receive it.

Welfare reform and employment support

The Work Programme was introduced in June 2011 and is the cornerstone of the coalition government's "Get Britain Working" measures. Delivered by a mix of private companies and voluntary, community and social enterprise organisations and local authorities agencies, it is possibly the largest single payment by results (PbR) initiative in Europe. The Programme utilises a "black box" model in which providers are free to experiment and innovate, and utilises differential payments, where the harder to help – including people with histories of homelessness and drug and alcohol use – attract higher payments for success. However, the first 18 months of the Programme have been challenging. Results are lower than expected, subcontractors from the homelessness and substance use sectors have generally had fewer referrals than anticipated, and in some cases have left the Programme.

In late 2012, DrugScope and Homeless link submitted written evidence to the Work and Pensions Select Committee as part of its inquiry into the performance of the DWP Work Programme for customer groups with particular support needs and barriers to employment. In January 2013, DrugScope/ LDAN gave evidence to the Committee about the performance of the DWP Work Programme for people who have histories of drug and/ or alcohol use. Alongside other specialist and representative groups including Crisis and Mind, LDAN gave evidence drawing on work carried out with member agencies, and our London Councils funded work.

The Work and Pensions Select Committee heard that many treatment providers involved in the Work Programme as sub-contractors had been receiving few referrals, whilst clients on the Work Programme had reported a lack of access to specialist services, infrequent meetings with Work Programme providers, and a high number of sanctions reported.

In May, the Work and Pension's Select Committee (WPSC) published its report, Can the Work Programme work for all customer groups?[35] The report reflected many aspects of the submission DrugScope made jointly with Homeless Link in December 2012, and made some of the same recommendations we called for. Of particular interest:

- The WPSC recommended that the Department for Work and Pensions should use the underspend in the Work Programme to date – caused by lower than expected payments for job outcomes and sustainment – to fund specialist, pre-Work Programme support to those furthest from the job market, with claimants with severe drug and alcohol issues mentioned.
- It also recommended that 'milestone' payments should be introduced for those with the most significant barriers to employment.
- The report drew attention to the deficiencies of the use of benefit type as a proxy for need, and the contribution to this problem made by a Work Capability Assessment. The Committee recommended a shift to needs-based assessments and more specialist provision.

35 http://www.publications.parliament.uk/pa/cm201314/cmselect/cmworpen/162/162.pdf

- It notes the challenge of engaging employers to provide opportunities for marginalised groups.
- The report recommends more detailed information about the use of 'supply chains', expressing concern that specialist organisations are not playing a role (one large provider from the drug and alcohol sector received 5 out of an anticipated 1,000 referrals in its first year), and observes that many charities are effectively subsidising their Work Programme activities from other sources.

Vulnerability is also considered. DrugScope's own research before submitting evidence suggested that a number of people using treatment services had had their benefits suspended, or sanctioned. The Committee draws attention to the poor communications received and lack of understanding and awareness of the Programme that may be behind many non-attendances at initial appointments. The Committee recommends that DWP carries out a review of sanctions. Regulations brought in in October 2012 introduced a much tougher regime, so it is crucial that there is transparency around this and reassurance that sanctions are not being used disproportionately to the detriment of vulnerable claimants.

Work Programme drug and alcohol pilots

Starting in April 2013, drug and alcohol pilots will run within the Work Programme – these involve (i) closer working between prime contractors and supply chains and (ii) an additional payment at job outcome stage to strengthen the incentive to providers. Both of these pilots include measures that DrugScope/LDAN has called for, although neither address the full set of recommendations made to the Select Committee. Neither pilot is running in London, but they could pave the way for similar measures to be applied more widely, both geographically and for other client groups, including people with histories of rough sleeping and homelessness.

LDAN Employment Pathways Project

Many drug and alcohol services in London are delivering education, training and employment services, or working with external support services to create positive pathways to employment for their service users. However, to date this work has not been significantly highlighted or promoted within London. With funding from Trust for London, LDAN launched an employment project in 2009 to start building an evidence base on what works in employment support for people with drug and alcohol problems, and influence pan-London and national policy in this area. The first phase ran for two years.

The second phase of the project, funded from 2011 to 2013, is focussed directly on engaging and influencing London employers and educational establishments. The pan-London employment expert group draws from the business, public and charity sectors, service user representatives, and key service providers, and includes Job Centre Plus, the National Treatment Agency (Public Health England from April 2013), BeOnsite, the Centre for Economic and Social Inclusion, St Mungos, the London Drug and Alcohol Policy Forum, and A4e. The project is helping to open up opportunities for clients, and provide guidance and support to drug workers and service users through targeted events and information resources.

Further details and resources are at http://www.ldan.org.uk/employment.html

5 Homelessness & substance use: other issues

Many homeless people have problems with drugs and alcohol, and many users of drug and alcohol services will develop problems with housing – it is therefore important that anyone involved in delivering or commissioning services considers a number of other issues that have been explored by this project. Some of the key issues are highlighted below, with links to further information and resources.

Legal concerns

A particular concern for homelessness services involved with the LDAN network was to be clear about their legal responsibilities with respect to illegal drugs. This issue was brought into focus by the case of "the Cambridge Two", Ruth Wyner and John Brock, who were convicted in December 1999 under section 8 of the Misuse of Drugs Act 1970[36] for 'knowingly allowing the distribution of a Class A drug' (heroin) on the premises of the Wintercomfort day centre for homeless people in Cambridge, and sentenced to 5 and 4 years imprisonment respectively (R v. Brock and Wyner [2000][37] EWCA Crim 85 – 'The Cambridge Two'). While this was an exceptional case, and was widely regarded as a miscarriage of justice, it is certainly important for managers and staff of homelessness services to be aware of the law in this area.

Misuse of Drugs Act 1971 (MDA)

Section 8 of the MDA is the primary legislation governing the production, supply and use of illicit drugs on premises, including in homelessness services. Under section 8:

'a person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits or suffers any of the following activities to take place on those premises:

- The production (or attempted production) of any controlled drug
- The supply (or attempted supply) of any controlled drug
- The preparing of opium for smoking
- The smoking of cannabis or prepared opium.'

The maximum legal penalty is 14 years. A curiosity of this legislation is the provisions on preparation and use apply only to smoking of cannabis and opium. An implication of this is that whilst cannabis use on managed premises is problematic, services may work with heroin and crack cocaine users with a greater degree of legal safety, although knowingly permitting or suffering any drug to be produced or supplied is absolutely prohibited.

It is important that all homeless services should have an effective drug policy, which should state: (1) the organisations approach to drugs and a clear set of rules, and (2) what staff and management should do in the event of a breach.

Those working with homeless people with drug problems should also be aware of section 9A of the MDA. This makes it a criminal offence to supply or offer to supply articles for administering or preparing controlled drugs – for example, foil, spoons, safe inhalation pipes and tourniquets could fall within this prohibition, although prosecutions are rare. Section 9A also identifies exceptions which can be provided. These are needles and syringes, citric acid, filters, swabs, water ampoules, utensils for preparation of controlled drugs and ascorbic acid.[38]

Storage of drugs

It is illegal to handle controlled drugs without legal authority (Misuse of Drugs (Safe Custody) Regulations 1973 and Misuse of Drugs Regulations 2001). Neither drug workers or people working in homelessness services

36 http://www.legislation.gov.uk/ukpga/1971/38/contents
37 http://www.bailii.org/ew/cases/EWCA/Crim/2000/85.html
38 Foil now exempt following the Home Secretary accepting the recommendation of the ACMD https://www.gov.uk/government/publications/acmd-further-advice-on-foil-2013

have the legal authority to handle controlled drugs under the relevant statutory provisions. If handing drugs to the police, it is always advisable to inform them beforehand that you intend to do so.

Part 1 of the Anti-Social Behaviour Act 2003 (ASBA)[39]

This enables the police to close residential premises where there is

- use, production or supply of Class A drugs; and
- this is associated with serious nuisance or disorder to members of the public in the preceding three months.

The Magistrates' Court must consider the application within 48 hours of a notice being served, and can make a closure order. Court cases can only be adjourned in exceptional circumstances and, if so, must be heard within 14 days.

Once a notice is served it is an arrestable offence for anyone other than the occupier to enter the premises. If the court issues a closure order the premises will be sealed for a period of three to six months and no one may enter during this period.

These provisions will be of particular interest to services providing community or floating support. Services will want to protect clients from action under Part 1 of the ASBA given the impact on homelessness, and help to ensure legal representation.

Further information

Niamh Eastwood, Director of Release, delivered a presentation to the LDAN Homelessness Forum that addresses this issue, and forms the basis of this summary: http://www.ldan.org.uk/powerpoints/H2Legal%20issues%20affecting%20those%20working%20with%20drug%20users%20(2).ppt

A specimen drug policy for homelessness services has been produced by Kevin Flemen and Homeless Link: http://www.kfx.org.uk/resources/htdp2011.pdf

Release is the national centre of expertise on drug law (it also deals with other issues where drugs are involved, including benefit issues such as Work Capability Assessment appeals). The Release website is at www.release.org.uk
Release runs a helpline on 0845 4500 215

Dual diagnosis

A high proportion of people with drug or alcohol problems will have mental health problems and vice versa, which can create challenges in providing care and support, with a tendency for service users to be 'bounced between services'. Homelessness and rough sleeping is often associated with "tri-morbidity" – a situation where poor physical health is compounded by mental illness and substance use.

According to a study conducted in 2002 (The Co-morbidity of Substance Misuse and Mental Illness Collaborative study)[40] :

- 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems;
- 30 per cent of the drug treatment population and over 50 per cent of those in treatment for alcohol problems had 'multiple morbidity';
- 38 per cent of drug users with a psychiatric disorder were receiving no treatment for their mental health problem; and
- 44 per cent of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year.

39 http://www.legislation.gov.uk/ukpga/2003/38/contents
40 http://dmri.lshtm.ac.uk/docs/weaver_es.pdf

While dual diagnosis has historically challenged mainstream services there has been some significant progress. In 2002, the Department of Health published a 'Dual Diagnosis Good Practice Guide',[41] that stipulates that secondary mental health services are responsible for the care of anyone with a severe mental health problem and substance misuse problem. Other guidance documents have since been published including "A Guide for the Management of Dual Diagnosis in Prisons in 2009."[42]

This guidance has focussed on support for people with severe mental health problems, and there has been less attention to services for the high proportion of people with drug and alcohol dependency who also experience 'common' mental health problems, including depression and anxiety. DrugScope/LDAN has raised concerns about the barriers to people with substance misuse issues accessing psychological therapies, such as Cognitive Behaviour Therapy, including through the Improving Access to Psychological Therapies (IAPT) programme. In January 2012 - in part as a response to issues raised by the homelessness forum - an 'IAPT positive practice guide for working with people who use drugs and alcohol' was produced by IAPT, DrugScope and the NTA.[43]

Changes to the commissioning and provision of drug and alcohol treatment and other health services from April 2013 onwards offer genuine opportunities for the commissioning of effective integrated services, although there is also a risk that services for a relatively small and entrenched population may be de-prioritised.

Homelessness and health

In May 2013, Anna Soubry MP, Parliamentary Under Secretary of State for Public Health, announced £10 million funding to enable the expansion of support for homeless people on discharge from hospital.

Rough sleeping is associated with "tri-morbidity" – poor physical and mental health combined with substance use. This poses multiple problems – cost, use of scarce hospital places, but primarily the serious harms experienced by those experiencing multiple disadvantages. By working with rough sleepers prior to discharge, there will be opportunities to link people into services and ultimately to break the cycle of harm caused by repeated discharge to the street or poor accommodation.

The Department of Health recently announced a £10m Homeless Hospital Discharge Fund – more information can be found here: https://www.gov.uk/government/publications/homeless-hospital-discharge-fund-2013-to-2014

You can read more about Liverpool Primary Care Trust, one of the pioneers of this approach here: http://homeless.org.uk/sites/default/files/Liverpool-Hospital-Admission-and-Discharge-Protocol-RLH.pdf

Presentation from Dr Nigel Hewett and Alex Bax of the London Pathway, which provides integrated medical care to homeless patients: http://www.ldan.org.uk/powerpoints/H5London_Pathway_Update_2010.ppt

41 http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4009058
42 http://www.nta.nhs.uk/uploads/prisons_dual_diagnosis_final_2009.pdf
43 http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf

Further information on dual diagnosis
Dr Nikki Wood, Dual Diagnosis Service Lead at East London NHS Foundation Trust and David Campbell, Service Manager at St Mungo's Brent Dual Diagnosis Project delivered presentations on dual diagnosis, which can be found here: http://www.ldan.org.uk/Homelessforum7.html

Turning Point produced a Dual Diagnosis Good Practice Handbook in 2007, which is at http://www.nmhdu.org.uk/silo/files/dual-diagnosis-good-practice-handbook.pdf

A recent discussion paper on dual diagnosis from the Centre for Mental Health, DrugScope and the UK Drug Policy Commission can be found here: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DSDualDiagnosisDiscussionPaper.pdf

'The IAPT positive practice guide for working with people who use drugs and alcohol' is at http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf

Multiple needs, multiple exclusions and multiple disadvantage

It is increasingly recognised that inter-related conditions of substance misuse and mental health are in turn complicated by additional societal difficulties faced by homeless people – offending (or being the victim of crime), social exclusion, difficulties in accessing services, and difficulty in complying with treatment, particularly for mental health problems. This has resulted in a number of policy initiatives on 'multiple needs', 'multiple disadvantage' and 'multiple exclusions', as well as new funding for work in this area. In 2009, the Making Every Adult Matter coalition was launched with funding from the Calouste Gulbenkian Foundation. The partners included DrugScope and Homeless Link, alongside Clinks and Mind, enabling us to 'cross-fertilise' our homelessness project and MEAM work, including regular presentations and updates on the multiple needs agenda at LDAN homelessness network meetings.

In September 2011, MEAM published the *Turning the Tide* vision paper[44]. This set out a joint MEAM vision that in every local area people experiencing multiple needs (including homelessness, mental health problems and substance misuse) will be:

- supported by effective, co-ordinated services; and
- empowered to tackle their problems, reach their potential and contribute to their communities.

In 2012, MEAM produced a progress report on the Vision Paper proposals in collaboration with Revolving Doors Agency.

In June 2012, MEAM published an evaluation of three service pilots looking at co-ordinated local approaches to people experiencing multiple needs and exclusions in Cambridge, Somerset and Derby, which followed 39 clients with multiple needs. The evaluation demonstrated increases in individual well-being in all the pilot areas and reductions in costs to the criminal justice system in two areas (in one this gain was sufficient to offset the costs of getting people the help they needed). This work has informed the development of a 'MEAM approach' to multiple needs which is described as 'a non-prescriptive framework for developing a coordinated approach in your local area'.

The LankellyChase Foundation now works exclusively in the area of 'severe and multiple disadvantage', with a 'focus on the persistent clustering of social harms such as homelessness, substance misuse, mental and physical illness, extreme poverty, and violence and abuse'. This work includes grant making, special initiatives and commissioned policy and research.

44 http://www.meam.org.uk/wp-content/uploads/2011/09/turning-the-tide.pdf

The Big Lottery Fund is making an investment of £100 million in 'Fulfilling Lives', a programme to support people with multiple problems like homelessness, mental ill-health, addiction and re-offending. The ten areas that will benefit from this funding in England include the London Boroughs of Camden and Islington, where the lead organisation is the Single Homelessness Project, and the London Boroughs of Lambeth, Southwark and Lewisham, where the work will be led by Resolving Chaos.

Further information
The Making Every Adult Matter website is at www.meam.org.uk The MEAM approach has a separate site at www.themeamapproach.org.uk

The LankellyChase Foundation site is at www.lankellychase.org.uk/

The BLF 'Fulfilling Lives' is at www.biglotteryfund.org.uk/prog_complex_needs

Women's homelessness

DrugScope/LDAN developed this project at the same time we were delivering another London Council's funded project on domestic violence, and there was considerable cross-over between these two projects. Domestic violence often co-exists with housing need, both as a consequence of that need and often also as a cause. We have produced a companion report on the domestic violence project, *Making the connection: developing integrated approaches to domestic violence and substance misuse*, which is available on the DrugScope and LDAN websites.
In 2012, St Mungo's launched the 'Rebuilding Shattered Lives' campaign[45] to address women's homelessness. St Mungo's notes that one in 10 rough sleepers in London are women, as well as over half of those living in temporary accommodation. In addition, 'many homeless women are "hidden" – trapped in abusive relationships, living in crack houses or squats, or sofa-surfing with friends and family'. Research with St Mungo's female clients has found that:

- 66% have a mental health problem
- 55% have a drug and/or alcohol problem
- 54% of those who have slept rough have also been involved in prostitution.

It also notes that female homelessness is increasing and that existing homelessness provision is not always appropriate for women. Hostels and day centres are often male dominated, which can be a particular issue for women with a history of domestic victimisation and abuse. Homeless women frequently face particular issues relating to prejudice and stereotypes, pregnancy, complex trauma and prostitution or sex worker. A particular issue is the potential role of services in helping to reconnect and rebuild relationships – it is noted that over 45% of St Mungo's female clients are mothers.

Research carried out by Homeless Link[46] indicates a decline of 40% in women-only accommodation between 2011 and 2012. Research by St Mungo's as part of the Rebuilding Shattered Lives campaign highlighted a shortage of specialist and holistic services, as well as the additional stigma encountered by homeless women who use substances.

Offenders and resettlement

Both homelessness and substance misuse workers work extensively with offenders and ex-offenders, including prison leavers. The majority of people accessing drug treatment services will have an offending history, and many are entering services directly through the criminal justice system – including the Drug

45 http://rebuildingshatteredlives.org/
46 http://homeless.org.uk/sites/default/files/Womens%20Spotlight%202012%20-%20Report%20v2%20-160812%20FINAL_0.pdf

Further information

More information and resources about the Rebuilding Shattered Lives project here: http://rebuildingshatteredlives.org/ There are also interactive areas of the site where you can feed in views and experiences.

Marketa Swaby and Rita Martin from St Mungo's spoke about the work of Rebuilding Shattered Lives; their presentation can be found here: http://www.ldan.org.uk/powerpoints/HSept12Rebuilding%20Shattered%20Lives%20Drugscope%20Presentation%20Sep12.ppt

Esther Sample, Women's Strategy Coordinator for St Mungo's updated the forum on the needs faced of homeless women: http://www.ldan.org.uk/powerpoints/H8Esther%20SAmple%20PP%20Presentation.ppt

Amy Hall, Clinical Nurse Specialist at the Three Boroughs Health Inclusion Team can be found outlines work in the Borough at http://www.ldan.org.uk/powerpoints/HSept12Women%20Accessing%20Services%20–%20A%20Statutory%20Perspective%20with%20pics.ppt

Interventions Programme (now discontinued as a nationally managed programme), receiving a Drug Rehabilitation Requirement as part of a community order or following release from prison, including through local Integrated Offender Management services.

It has been estimated that around 1 in 5 clients in an average homelessness project are prison leavers. The Homeless Link SNAP[47] survey 2012 comments that across all project types prisoners most commonly made up between 1 and 25% of clients and this is unchanged since 2010. It found that prison leavers were the majority of clients in a significant minority of day services, with 29% of day centres reporting prison leavers made up more than 50% of clients compared with 14% of hostels.

The 2012 Bromley Briefing[48] produced by the Prison Reform Trust gathers together official data and research information. It notes that:

- 15% of prisoners were homeless before entering custody and 9% were sleeping rough
- 37% of newly sentenced prisoners said they would need help finding a place to live when released
- 71% reported using drugs in the year before custody and 64% in the four weeks before custody
- between a third and a half of new receptions into prisons are estimated to be "problem drug users".

Failing to address these issues significantly increases the risks of reoffending. It has been calculated that evidence based drug treatment can prevent nearly five million crimes a year in England, with a cost-benefit of around £9.5 billion annually. Similarly, the Bromley Briefing reports that 79% of offenders who were homeless before custody were re convicted within a year compared to 47% of those who had accommodation.

It is also important to remember that many homeless men and women have been the victims of crime and to provide appropriate support. A 2004 survey published by the London School of Economics and Crisis[49] found, for example, that 52% of their homeless sample had experienced violence in the past year, compared to 4% of the general population, and 8% of the homeless sample had been sexually assaulted. A high proportion of homeless women have experienced domestic abuse.

Criminal records can sometimes be a barrier to resettlement, although specialist homelessness agencies have generally adopted a progressive risk-management approach rather than blanket rules. As noted, prison leavers make up a significant proportion of

47 http://homeless.org.uk/sites/default/files/Criminal%20justice%20SNAP%202012.pdf
48 http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileNov2012small.pdf
49 http://www.crisis.org.uk/data/files/document_library/research/livinginfear_full.pdf

the clients of both homelessness and drug and alcohol services. A lack of tailored advice, support and guidance given to prison leavers is problematic: prisoners often lose contact with their family and friends, lose their job, have limited financial resources and substance use and mental health needs. Addressing substance use and providing treatment within prisons that is subsequently picked up on release into the community also continues to be challenging, but new commissioning arrangements for offender substance services offer opportunities to address this, as does the provision of "through the gates" services from organisations like the St Giles Trust and NACRO and support to claim welfare benefits and engage with the DWP Work Programme before being released.

The development of Integrated Offender Manager (IOM) teams who bring together all relevant agencies to work with offenders and ex-prisoners, sharing information and adopting a holistic approach, is also positive. The Drug Interventions Programme has often been embedded within IOM provision, with drug and alcohol treatment services recognised as partners in the delivery of IOM. The Homeless Link guide 'Better together: preventing re-offending and homelessness' (2011)[50] highlights the role of voluntary sector homelessness organisations, stating 'we must play our part and ensure we are seen as a critical partner in the roll out of IOM in every local area'.

The Ministry of Justice is developing proposals for 'Transforming Rehabilitation' with a strong focus on 'through the gates' support for prisoners, including mentoring, and which will be commissioned nationally on a 'payment by results' basis. The 'Transforming Rehabilitation – strategy for reform' (2012)[51] recognises that 'nothing we do will work unless it is rooted in local partnerships and brings together the full range of support, be it on housing, employment advice, drug treatment or mental health services'.

Further information

The Bromley Briefing 2012 is a comprehensive source of information data on offenders, particularly prisoners, and is available at http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileJune2012.pdf

The UK Drug Policy Commission briefing 'Reducing drug use, reducing reoffending' (2008) is a useful overview of the issues, although there have been policy reforms since its publication.
It is at http://www.ukdpc.org.uk/publication/reducing-druguse-reducing reoffending/

You can find the presentation from Mervyn Barrett, Head of Resettlement at Nacro here: http://www.ldan.org.uk/Homelessforum6.html

50 http://homeless.org.uk/criminal-justice-project#.UelHtbVwaUk
51 http://www.justice.gov.uk/transforming-rehabilitation

Residential rehabilitation

Residential rehabilitation services have a particular relevance for agencies working with homeless clients. These services deliver programmes of treatment within a 'residential' environment and tend to work with clients with entrenched and long-standing substance misuse and other problems. However, they can be difficult to access, with long waiting times, and many are based on an abstinence model, which may not be suitable for all clients. Some residential services require clients to be drug-free prior to entry. This can be difficult for substance users in housing need to achieve; rough sleeping, or hostels where chaotic drug use may be relatively common, are difficult environments in which to manage abstinence and to demonstrate the stability and commitment often required to obtain funding for rehabilitation.

A 2012 NTA review[52] of the role of residential rehabilitation in integrated treatment systems noted that these services are changing and adapting. There has been a recent growth in services 'offering alternative arrangements' to the traditional 'out-of-town' residential services. There are sometimes called 'quasi-residential' services and are ''based around housing support … combining local accommodation and an off-site treatment programme'. It concludes that 'although the residential setting is shifting, the traditional commitment to abstinence remains a fundamental tenet for most rehab providers. This puts the onus on individuals to be motivated to be drug-free before they undertake the programme.' It is common for individuals to undergo 'detox' before entering residential programmes. Detox may be provided by the service or require referral to NHS in-patient provision before entry to the rehab programme. The NTA review also notes that people accessing residential rehabs usually have longer and more entrenched drug and alcohol misusing careers, poorer physical and psychological health and more significant housing problems compared to the drug treatment population as a whole

People entering residential rehabilitation will also require support with housing and accommodation issues. This will include practical help with issues like housing benefit and maintaining council (and other) tenancies. In addition, many have housing problems when they enter a residential programme, and require support with re-entry and/or supported housing. Phoenix Futures[53] – one of the largest providers of residential treatment services – reports that nearly a quarter of its clients are homeless or living in temporary accommodation before coming into its services, which are able to provide supported housing after someone leaves the residential programme, bridging the gap between residential and independent living.

Further information

The NTA's The role of residential rehabilitation in an integrated treatment system (2012) is available at http://www.nta.nhs.uk/uploads/roleofresi-rehab.pdf

Homeless Link's Clean Break toolkit for commissioners is here: http://toolkits.homeless.org.uk/cleanbreak

"Celebrating Places of Change" provides detailed information about the Places of Change model: http://issuu.com/homelesslink/docs/celebratingplacesofchange/2

52 http://www.nta.nhs.uk/uploads/roleofresi-rehab.pdf
53 http://www.phoenix-futures.org.uk/home/

6 Taking it forward: Next steps for LDAN/DrugScope

DrugScope/LDAN will be taking forward the learning from, and issues highlighted by, this project in a number of ways. We are, for example, working with partner organisations from the homelessness sector on all aspects of welfare reform (for example, we provided evidence to the Work and Pensions Select Committee inquiries on the work programme and on the role of Job Centre Plus[54] jointly with Homeless Link and will continue to build on this activity going forward). We will also be closely monitoring and reporting on changing commissioning structures and service configurations in the London Boroughs, and highlighting both issues of concern and good practice, with a particular focus on the development of innovative and holistic approaches that work across sectors, including homelessness and substance misuse. We will continue to contribute as partners in the Making Every Adult Matter (MEAM) coalition, feeding in the learning from this project and helping to develop and disseminate **The MEAM approach**[55] to multiple need.

We are also delighted to have received further funding from London Councils to work with Homeless Link and Shelter to build on this project through a new programme of work in London called **London Councils Homelessness PLUS – 2013-2015** (or **LC Homelessness Plus**). The project is providing support, specialist advice, training, capacity building opportunities and a full-range of other infrastructure support to front-line agencies providing support to equalities groups around homelessness.

LC Homelessness PLUS consists of:

- Forums – focussing on recent policy changes, innovations in service delivery and to network with colleagues. The forums will be facilitated alternately by LDAN/DrugScope and Homeless Link.
- Good practice events – focussing on topics such as health, substance use, welfare reform, homeless women, young homeless people and black, Asian and minority ethnic homelessness, delivered by DrugScope and Homeless Link.
- Training – face to face as well as webinars, podcasts and e-learning courses, for example homelessness law, allocations, funding and equalities, led by Shelter.
- A mentoring programme - including mentoring skills training and matching schemes led by DrugScope and Shelter.
- Briefings - including homelessness policy, welfare reform and homelessness statistics from DrugScope, Homeless Link and Shelter.
- A monthly e-bulletin – including details of homelessness related events, news, funding and partnership working opportunities and agency news, from Homeless Link.
- Bi-monthly LDAN News – looking at drug and alcohol issues in London in detail, from DrugScope.
- Information and support - around diversifying funding, partnership opportunities and improving services to protected equalities groups
- Information on trends – for example drug trends, young homeless people and homeless migrants.
- Opportunities to work collaboratively on policy responses and submissions affecting London agencies.

LC Homelessness PLUS aims to provide support and advice to over 250 agencies, and more personalised support to at least 2 agencies from every London borough.

54 http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScope%20Homeless%20Link%20Role%20of%20JCP%20final.pdf
55 http://www.themeamapproach.org.uk/

Further information

Find out more about London Councils Homelessness PLUS at http://www.ldan.org.uk/homelessness.html

Find out more about The MEAM Approach to multiple need, and register interest in supporting the approach, at http://www.themeamapproach.org.uk/

Why not also sign up for DrugScope's free daily e-bulletin DS Daily, which provides a summary of all the key developments on drugs and alcohol (and to follow us on twitter). You can sign up at http://www.dsdaily.org.uk/

Some useful links

DrugScope
http://www.drugscope.org.uk/

London Drug and Alcohol Network
http://www.ldan.org.uk

Alcohol Concern
http://www.alcoholconcern.org.uk/

Homeless Link
http://homeless.org.uk/

London Councils
http://www.londoncouncils.gov.uk/

London Drug and Alcohol Policy Forum
http://www.cityoflondon.gov.uk/services/adult-health-wellbeing-and-social-care/drugs-and-alcohol/Pages/london-drug-and-alcohol-policy-forum.aspx

Making Every Adult Matter
http://www.meam.org.uk/

Mayor's Office for Police and Crime
http://www.london.gov.uk/priorities/policing-crime/about-mopac

No Second Night Out
http://www.nosecondnightout.org.uk/

Release
http://www.release.org.uk/

Shelter
http://www.shelter.org.uk/

UK Drug Policy Commission
http://www.ukdpc.org.uk

Other organisations who have contributed to the LDAN project

East London NHS Foundation Trust
http://www.eastlondon.nhs.uk/

Foundation 66
http://www.foundation66.org.uk/

Nacro
http://www.nacro.org.uk/

New Horizon Youth Centre
http://www.nhyouthcentre.org.uk/

nia
http://www.niaendingviolence.org.uk/

Pathway – Healthcare for Homeless People
http://www.pathway.org.uk/

Phoenix Futures
http://www.phoenix-futures.org.uk/home/

Thames Reach
http://www.thamesreach.org.uk/

Solace Women's Aid
http://www.solacewomensaid.org/

St Mungo's
http://www.mungos.org/

Three Boroughs Health Inclusion Team
http://www.threeboroughs.nhs.uk/index.php?PID=0000000199

About LDAN

The London Drug and Alcohol Network (LDAN) was launched in 2001 and provides voice and representation for the drug and alcohol sector. As a London-wide network representing the interests of treatment providers, LDAN is uniquely placed to influence policy and practice across the capital.

LDAN merged with DrugScope in 2009, combining expertise and resources while retaining LDAN's distinct identity and position within London.

Further information about LDAN, including how to become a member and membership benefits, is available on the LDAN site at www.ldan.org.uk

About DrugScope

DrugScope is the national membership organisation for the drug and alcohol field and the UK's leading independent centre of expertise on drugs and drug use. We represent around 450 member organisations involved in drug and alcohol treatment, young people's services, drug education, criminal justice and related services, such as mental health and homelessness.

DrugScope is a registered charity (number: 255030).

Further information about DrugScope – including becoming a DrugScope member and member benefits – is available at http://www.drugscope.org.uk/

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Appendix – Summary of LDAN Forum meetings

Presentations and other materials are available online via the footnotes for each individual forum. Please note that the first forum was in 2009, and DrugScope cannot vouch for the currency of third party presentations. Speaker job titles and employers were correct at the time of each forum, but may no longer be accurate.

October 2009[25] saw the launch of the project. Harry Shapiro, DrugScope's Director of Communications provided an overview of drugs and drug treatment, including an early overview of new psychoactive substances, or NPS. Laura Barker. South East Service Manager from Foundation 66 provided an overview of their work with individuals with complex needs, whilst Ollie Hilbery, Programme Director from the Making Every Adult Matter coalition (MEAM), a partnership between DrugScope, Clinks, Homeless Link and Mind, established in 2008 spoke about the need to improve support for people with multiple needs who experience a combination of issues that impact adversely on their lives, are routinely excluded from effective contact with the services they need and who tend to lead chaotic lives that are costly to society.

In January 2010,[26] the forum heard from Niamh Eastwood, Deputy Director of Release, who provided expert advice on legal issues of concern to service providers, focussing on both the Misuse of Drugs Act 1971 and also the more recent Anti Social Behaviour Act 2003, the legislation often used in connection with crack houses and of interest to agencies providing community or floating support. Niamh went on to cover issues relevant to accommodation providers in particular, including issues around finding controlled drugs, storage of prescribed drugs and paraphernalia.

At the same forum, Jodie Woodward from nia - a Hackney-based organisation that provides a range of support services for women & children experiencing physical, sexual and emotional abuse spoke about the particular challenges faced by organisations serving that client group and also the often complex and multi-faceted role played by substance use within an abusive relationship.

The March 2010[27] forum looked at older homeless people with alcohol problems. Don Shenker, Chief Executive of Alcohol Concern provided an overview of alcohol use, with a particular focus on the impact on crime, health and the family, alongside information about brief advice and treatment options. Bekim Bërlajolli from Thames Reach's Robertson Street project gave an introduction to the Robertson Street project, which offers a highly specialist service to older ex-rough sleepers with prolonged histories of alcohol use, whilst Helen Mathie, Policy Manager at Homeless Link introduced their Survey of Needs and Provision (SNAP) and Health Needs Audit tool.

In June 2010,[28] attention turned to the quickly emerging "legal highs" market, with Andrew McNicoll, Communications Officer from DrugScope, looking both at trends and also some of the associated risks. Peter Middleton from New Horizon Youth Centre introduced Open Space, which provides support to young female sex workers in the Kings Cross area.

The fifth LDAN Homelessness Drug and Alcohol Forum was held in September 2010:[29] Sim Mandair, Senior Substance Worker at Solace Women's Aid spoke about their vulnerable families project. This was followed by group work on providing support for people with support needs related to homelessness, domestic violence and substance misuse. Chief Executive Alex Bax and Clinical Director Dr Nigel Hewett then spoke about the innovative London Pathways, working in University College Hospital to improve outcomes for homeless hospital patients as well as readmissions as a result of integrated healthcare.

25 http://www.ldan.org.uk/Homelessforum1.html
26http://www.ldan.org.uk/Homelessforum2.html
27 http://www.ldan.org.uk/Homelessforum3.html
28 http://www.ldan.org.uk/Homelessforum4.html

The final forum of 2010 was held in December[30] and included a training presentation on the criminal justice system and resettlement by Mervyn Barrett, Head of Resettlement from Nacro. There was also a presentation about St Mungo's Assertive Offender Resettlement Project by Project Manager Sam Cowie, and group work on coordination with the criminal justice system in providing support for people with issues related to homelessness and substance misuse.

The first forum of the new year was held at the Guildhall in March 2011[31] and included a training presentation on Dual Diagnosis by Dr Nikki Wood, Dual Diagnosis Service Lead, East London NHS Foundation Trust, an example of practice by David Campbell, Service Manager, St Mungos Dual Diagnosis Project, Brent and group discussion on supporting homeless clients with dual diagnosis issues.

September 2011[32] again featured an instructive presentation and update from Niamh Eastwood, Deputy Director of the drug law charity Release, on the legal issues around housing and drugs. Joe Whittaker, Policy and Research Officer from Homeless link presented findings from the updated annual Survey of Needs and Provision (SNAP), while Esther Sample, Women's Strategy Coordinator at St. Mungos, discussed the issues around working with homeless women with substance misuse problems.

The final forum of 2011 was held in December,[33] and featured Harry Shapiro (Drugscope) discussing the findings of the 2011 Druglink street drug survey. Peter Cockersell, Director Health and Recovery from St Mungos on psychologically informed environments (PIE), which utilise hostels and day centres to respond to the psychological needs of clients with complex trauma, and Rachel Smith of Crisis talked about the Crisis at Christmas programme, and the provision made for people with substance dependency.

The March 2012[34] forum looked in depth at residential treatment services and nursing in the community. Dianne Hilton, Head of Operations Residential Services from Phoenix Futures, presented on housing issues for people in and leaving residential treatment, and in particular the experience of their housing 'fast track' programme for people with drug dependency problems leaving prison. Michael Simpson, Policy Officer from DrugScope/ LDAN provided an update on welfare reform.

Outreach was the focus on the June 2012 forum.[35] It included presentations on outreach work in the capital, an overview of the London policy context following the re-election of Boris Johnson as Mayor, and a look at the latest statistics from the CHAIN database. Jack Edgecombe of Thames Reach and Paula Bennett, Team Manager of No Second Night Out gave a joint presentation on outreach services, while Sarah MacFadyen, Policy and Parliamentary Officer at Crisis, delivered the policy overview and Homeless Link's Research Manager Rachel Coffey looked at the findings of SNAP 2012.

The final LDAN forum of 2012 was held at the Guildhall in September.[36] Paul Anders, Senior Policy Officer at DrugScope, provided a brief policy round-up, before Marketa Swaby, Deputy Manager for St Mungo's Complex Needs Team (North and East) and Rita Martin, a St Mungo's Complex Needs Worker at the Mare Street Hostel, spoke on the meeting's theme of services for women. Amy Hall, a Clinical Nurse Specialist at the Three Boroughs Health Inclusion team, presented from a statutory perspective.

29 http://www.ldan.org.uk/Homelessforum5.html
30 http://www.ldan.org.uk/Homelessforum6.html
31 http://www.ldan.org.uk/Homelessforum7.html
32 http://www.ldan.org.uk/Homelessforum8.html
33 http://www.ldan.org.uk/Homelessforum9.html
34 http://www.ldan.org.uk/Homelessforum10.html
35 http://www.ldan.org.uk/homelessness.html#
36 http://www.ldan.org.uk/homelessness.html#