The Equality, Local Government and Communities Committee at the National Assembly for Wales is currently undertaking follow-up work on its inquiry into rough sleeping.

Introduction

This paper is written from a very personal perspective and reflects on my experiences as the CEO of Kaleidoscope. I am writing about what I see the situation on the ground is but I do welcome recent initiatives by the Welsh Government such as the recent Deep Dive Exercise looking particularly at the issues of people with co-occurring issues. It is clear that there is much to do in this area and sadly up to this point little progress has been made. I do note however about recent grants been made targeted at addressing some of the issue of the group this enquiry is looking at. The targeted resource is very welcomed but as this money has only recently been determined it is impossible to say how successful it will be.

Kaleidoscope Project provides services across Wales, although its two major community drug and alcohol contracts are in Powys and Gwent. Our other services are primarily for those needing help because of their substance use involving them in the criminal justice system. Kaleidoscope provides two services in England that also have a relevance to this debate, which is a hostel for people with substance use and mental health issues in Kingston Upon Thames and a detox centre in the Wirral.

- **What services are available for rough sleepers who have co-occurring substance misuse and mental health problems across Wales?**

There are no services that I am aware of that offer integrated care that support rough sleepers in Wales. There are some services that may claim to meet the needs of people with co-occurring issues however. There are in any city services that will help with an element of a rough sleepers issues but the reason the problem continues is there is not enough joined up work that ensure people get the support they need to successfully move on in their lives.

In Newport there is accommodation that rough sleepers use, if they have a substance use issue they may be able to access the community treatment programme, and they could register for a mental health assessment. The reality of the services on offer is the vulnerable person has to meet with a variety of services. Their ability to make one appointment is often difficult but to make a range of services they need is virtually impossible.

The needs of rough sleepers are often partially met. There are interesting models where temporary accommodation is provided, be it with converted containers or night shelters. They have some value in terms of protecting people through the winter but again the critical issues a person with co-occurring problems really needs addressing is not met.

There is a lack of accommodation but in talking to rough sleepers some make a choice not to take up the hostel places that are available. It is a strange paradox that although for those of us looking at rough sleepers they seem to live chaotic lives they cannot actually cope with hostels where chaos seems to pertain because of the large

numbers of people accommodated. If you look at the large hostels there is a sense of chaos in them, because they take a large number of people with complex needs. This makes people feel unsafe both physically and mentally. Many people we help with mental health issues have autism and other conditions that make social interaction difficult and although their lives are dis-orderly they need order in their lives. It is sadly not uncommon for people we work for to look forward to a return to prison.

In terms of access to drug treatment rough sleepers are often denied access to services because they do not comply with the demands of the service provider. In Wales there has been an emphasis on recovery. In effect, what has been created is a situation where we have those deemed worthy of deserving treatment and those who do not. Those we have been told to treat are the ones committed to their recovery journey. The reality for many rough sleepers is they cannot commit to such a journey as they need their drugs to get through the day.

A commitment to your treatment is shown by the establishment of pre contemplation groups and the demand that individuals attend various sessions designed to help them on their recovery journey. Rough Sleepers are not terribly good at making appointments of these appointments are not set in relation to the rough sleepers time scale but on the restricted opening hours of the service. The other critical issue is identification, often verified by an address. This is important to ensure they are eligible for treatment and they are not been scripted elsewhere but obviously for a rough sleeper can be a significant hurdle.

Rough Sleepers with co-occurring conditions often take drugs to deal with their condition. They are not being assessed by mental health services and are thus self-medicating. The drugs or the alcohol makes them feel better in a certain moment of time in a way that a prescribed drug will not. Methadone takes away the craving for example but it does not give the high or the comfort of heroin. So if the drug is available and they have any money they will want to use this. This pattern of drug use for many prescribers is unacceptable and treatment is often withdrawn from people who consistently continue to use illegal drugs despite been prescribed. I think there is genuine concern but it is also used as a means to get difficult and demanding clients off the programme. The reality of drug treatment is often people are given lower doses than required because the prescriber can demonstrate that clients are doing well by reducing their script and the user can benefit by taking drugs on top and still get an effect,. There should be an emphasis on maximum rather than minimum prescribing. It is my view that a person taking illegal drugs alongside prescribed ones should be permitted to stay on a treatment programme because evidence shows they are still safer in treatment than out of it. That when providing a substitute medication if someone is not fit to take it when presenting there may be a delay to them receiving their medication until they are in a better state but it is not stopped entirely. I also believe that instead of penalising the person there should be a conversation about whether the dose prescribed is sufficient and look at increasing the dose rather than withdrawing treatment.

I am seeing some exciting work beginning which may however help rough sleepers with co-occurring problems.

The Housing First initiatives could be really positive and are only just emerging. Evaluating their success is extremely important. In Gwent additional funding has been made available to provide low threshold prescribing (Low threshold means less rules in place to access treatment) for 25 people who gain access to Housing through Pobl and their Housing First programme. The link between housing, drug use and mental health is really key and it is very heartening to see. There are some initiatives supported by Supporting People as well, one in North Wales which we support is an example as there is another in Torfaen. The problem with some supporting peoples contract is the issue of salary and the ability the attract workers with the right experience and training. A similar Housing First initiative is due to start in Swansea and Kaleidoscope is working with the Wallich on this initiative

In Brixton, London there is a one day prescribing service. The need for rapid access is particularly relevant to rough sleepers and the recognition of treatment access is now becoming a Welsh Government priority. The problem in Wales is the patchy nature of it, which disproportionately impacts on the furthest away from treatment which is sadly rough sleepers.I think treatment services need to be integrated with mental health services and are open at times that meet the needs of the service user rather than the needs of the staff. I think we also need to understand that consulting with rough sleepers about the service they want is critical and this may mean we have to think boldly with options such as safer places to take drugs which Scottish Government is supporting.

The continued increase in drug related deaths is a National Emergency in my view and I believe the biggest cause of death is the failure to provide even basic medical care such as substitute prescribing across Wales. I would strongly urge a National rather than a regional approach. A recent paper by the ACMD (Advisory Council on Drug Misuse) notes that rough sleepers have high levels of mental health and substance issue problems and sadly are the most likely group to have premature death. They argue for a National rather than a regional approach.

- **To what extent are integrated mental health and substance misuse services accessible and how can such services be delivered more effectively to address the specific needs of rough sleepers in particular?**

The key problem we face as an agency is that mental health services will not see people who are either drug or alcohol, dependent. I met with a worker from [redacted] who lives in [redacted] but had a serious alcohol issue. She recently had some counselling from Simplyhealth, which Kaleidoscope makes available for its entire staff, but she is still waiting for an NHS referral for counselling. She found the whole process deeply frustrating because she knew her alcohol use, was to deal with her mental health issue. So not tackling her mental health issues was extremely unhelpful. In the worst moments of her chaos she was sofa surfer which of course increased of vulnerability. It cannot be right that to get any proper help for her mental health issues, she in effect had to rely on private health care provided by her new employer. In Gwent there is close working with GSSMS (Gwent Specialist Substance Misuse Service) who try and support the most

challenging clients. The integration of services is probably the best in Wales but even GSSMS struggle to make referrals to the mental health services.

In other parts of Wales the treatment system is not properly integrated and the more providers involved in care the more gaps there are. So in Cardiff for example we provide services in Dyfodol (prescribing) for people involved in the criminal justice system. We also are now supported to provide some rapid access into prescribing but of its self this is not enough. This is because such treatment tis not integrated with the Cardiff Addictions Unit, which provides community prescribing but there is a waiting list hence the need for our rapid prescribing services, you then have around 5 or 6 voluntary agencies all with a slight variation of the service they provide.

There is little evidence of integrated services that combines mental health and substance use across Wales. On asking my managers across Wales they could not pinpoint one official support service that is specifically for rough sleepers with co-occurring mental health and substance misuse issues. There are a number of services that support rough sleepers that will also help people with mental health issues such as the Wallich but these services are not specifically focused on mental health issues. In Gwent with GDAS (Gwent Drug and Alcohol Service) there is a Co-occurring Nurse who will support rough sleepers who have mental health issues on her caseload but this is not her focus. Our Bluelight worker also supports the client group when they are referred to him and they do form a large part of his caseload. They are not however mental health or accommodation specialists.

In Gwent to be with the specialist service, GSSMS, you need to have support from the primary mental health service (CMHT) and have a Community Psychiatric Nurse. You need to engage with this services assessment process to get support. If you miss two appointments you are discharged. You will then need to provide 3 urine samples to access the service. There is a fundamental issue with giving and keeping appointments that the homeless struggle with. For those who end up in prison, which is the sad reality for many of our rough sleepers with co-occurring issues you are discharged by the mental health service, you are then discharged from GSSMS. On release, you are picked up by GDAS and the merry go round starts again. GDAS have to get them back with primary mental health services in order to receive services from GSSMS.

While they are with GDAS (a Kaleidoscope led consortium) they will receive support from our co-occurring nurse but if they do not make treatment gains (they won't as they live on the streets!) they are then discharged from us. In reality, we string this out as long as possible keeping them in IRIS (our Criminal Justice Service) way past the 24-week programme in an attempt to get them back with GSSMS, but sooner or later they are discharged and we don’t see them again until they are sent back and released from prison.

On asking about the situation in Gwent the following question was asked

How can such services be delivered more effectively to address the specific needs of rough sleepers in particular?

- Harm reduction treatment goals (nondependent on abstinence) in treatment services that encourages engagement on harm reduction basis to prevent losing people from treatment.
- Mental Health support within the substance treatment programme - Mental health Drug Nurses within treatment service and staff who are trained to provide mental health support
- A No unplanned discharge approach that does not allow mental health and substance misuse services to discharge people who fail to attend appointments. The emphasis is placed on service to see people and people can only be discharged if it can be shown that they no longer need support or are opting out of engaging.

- An assertive outreach approach for both support and treatment - supporting people from the street. Meeting people in their environment, on-street assessments, no sending appointments by letter, no discharge for failing to attend.
- Flexibility within appointment times and places. Planned exits into the main stream services
- Rapid access to alcohol detox where appropriate
- Rapid access to relapse prevention medication where appropriate
- System navigator to support engagement
- Better links with housing services
- Systems that provide housing first, that are closely entwined with mental health and substance misuse support.
- Access to tier four detox and rehab

The situation in Gwent is much better than elsewhere in Wales but it still is not good enough. The link between Criminal Justice Services, which we provide across Wales needs to be properly integrated with the NHS treatment system with rapid access into mental health services. In North Wales the co-location of services in Wrexham could be a useful start in that process. The problem of access to treatment is still an issue and the Police Crime Commissioner in his new service is placing that responsibility with the new provider. The reason for this is frustration at the slowness in meeting the need.

In Swansea and Western Bay we see increased drug related deaths but with little strategy as how to tackle this issue. The current system is not fit for purpose where access to rapid and low threshold treatment is vital.

The accommodation on offer for people with co-occurring issues is sub-standard. There is a need for specialist provision with trained workers in small cluster housing that offer long term support. The concept of big hostels, with workers barely paid above the minimum wage, with relatively poor training programmes is not acceptable.

In Kingston we provide a co-occurring hostel, where we take 16 residents. It is a relatively unique centre because of this specialism but it is supported by Kingston because the merry go round this service users face and the cost of supporting such clients in an ad hoc way is more costly. A centre that works closely with the Community Mental Health Team and the local substance use team does have

positive outcomes, in the sense this group of people do not end up in either prison or on the streets as rough sleepers. The building the service is held in however is not up to the standard needed and we are looking at providing a new build in partnership with the local authority.

Another key service needed is rapid access into detox provision. The problem faced by many rough sleepers is that they struggle to enter treatment at all, so a referral to detox is extremely unlikely. This issue is compounded by a commissioning regime that wants a plan as to their long term recovery. The rough sleeper who is only planning from day to day is going to struggle to meet these goals. I think we need to think differently about pathways to this basic health care intervention. In the Wirral they have a unique system where A&E can make a direct referral to the detox centre and it is seen as the pathway for chaotic drinkers. This takes the pressure off A&E but more importantly means the client gets the direct support they need and can be assessed by a professional team of specialist doctors, nurses and drug workers. The system fits within the treatment regime and therefore people can then be supported by the community drugs team who also will be part of the system. The barriers to accommodation become less because they have at least a brief period of treatment and a plan working with them can be agreed.

The accommodation provided for people who are rough sleepers also needs to have a wet provision, meaning they can take alcohol in a safe way. We also need to consider safe places to consume drugs as too many people are evicted for taking drugs in the hostel. The perverse issue is a drug agency will give people a needle knowing they are in emergency accommodation where drug use is forbidden and therefore either accept by taking their drugs they will be evicted from their temporary home or return to their rough sleeping friends and take those drugs back on the street. In effect we need a systems approach to tackling the issue rather than solving one problem but creating a number of further problems.