Written evidence from St Mungo’s
March 2019

About St Mungo’s

St Mungo’s vision is that everyone has a place to call home and can fulfil their hopes and ambitions. As a homelessness charity and housing association our clients are at the heart of what we do.

We provide a bed and support to more than 2,800 people a night who are either homeless or at risk, and work to prevent homelessness.

We support men and women through more than 300 projects including emergency, hostel and supportive housing projects, advice services and specialist physical health, mental health, skills and work services.

We work across London and the south of England, as well as managing major homelessness sector partnership projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN).

We influence and campaign nationally to help people to rebuild their lives.
For any questions about this submission, please contact rory.weal@mungos.org.

1. Summary of response

1.1. There are strong links between homelessness and drug use, particularly pronounced for individuals sleeping rough. Any response to drug use must take into account housing and homelessness as both a determinant and compounding factor, which exposes individuals to increased harm and makes accessing services more challenging.

1.2. Need is increasing, with more people sleeping rough and a higher proportion of those sleeping rough using drugs. Rough sleeping has increased by 165% since 2010. At the same time, figures show that the proportion of people sleeping rough with a recorded drug support need in London rose from 31% in 2015/16 to 40% in 2017/18.¹ These needs are often bound up with mental health problems and complex trauma.

1.3. People sleeping rough are particularly exposed to harms relating to drug use, with fatalities from overdose rising dramatically in recent years. Data from the Office of National Statistics shows 597 people died sleeping rough or in emergency accommodation in 2017, 190 (32%) of whom died due to drug poisoning.² The number

¹ Data from the Combined Homelessness and Information Network, https://data.london.gov.uk/dataset/chain-reports
of people who died while homeless from drug poisoning has increased by 52% over five years.

1.4. **Ensuring rapid access to treatment, combined with holistic support for complex needs and access to housing, is the most effective way to tackle drug use.** Tried and tested interventions such as Opioid Substitution Treatment and Needle and Syringe Exchange are highly effective in reducing harm. Data shows that for opiate users there is a sharp reduction in the overall proportion of people with a housing problem between starting drug treatment and the six-month review.³

1.5. **However, drug and alcohol treatment services are often not accessible to people sleeping rough, and there is significant unmet need as a result.** Financial pressure on services has led to a shift away from targeted outreach and interventions for pre-contemplative and contemplative service users. Gatekeeping is common, with clients frequently having to jump through multiple hoops before starting treatment.

1.6. St Mungo’s is calling for the following:

- **Rapid access to harm minimisation and treatment** – people sleeping rough or at immediate risk should be able to rapidly access treatment for their drug use, regardless of local connection. This will require a new funding package and an end to restrictive practices.

- **Increased efforts to effectively join-up and integrate support services** – homelessness services and drug services should be jointly commissioned to provide integrated holistic services, addressing support needs in combination and providing personalised support in a psychologically-informed way.

- **Improved commissioning for marginalised groups** – there should be a greater emphasis on providing services for so-called ‘hard to reach’ groups, and developing a wider range of outcomes measures to more accurately reflect need and personal priorities.

- **Wider efforts to end rough sleeping should be supported as a drug prevention intervention** – future national rough sleeping strategies should be developed with Public Health England and relevant agencies to address the underlying drivers of drug use and provide effective interventions.

2. **Health and harms: what is the extent of health harms resulting from drug use?**

³ Change in the proportion of individuals (aged 18 and over) reporting a housing problem at six monthly time periods during treatment (2014-15): among opiate users it is 20% at baseline; 13% at 6 months, below 10% at 18 months; Data from the National Drug Treatment Monitoring System, available at https://www.ndtms.net/.
2.1. Drug use and addiction is associated with a wide range of health and other social harms, including but not limited to physical and mental health problems, unemployment, family breakdown, and offending. Drug use can be a causal factor in someone’s homelessness, as well as entrenching homelessness once experienced. Drug use compounds other needs such as mental and physical health problems, and makes it more challenging for individuals to access support for these needs.

2.2. In 2017/18, 63% of people sleeping rough with a drug support need in London also had a mental health support need. 55% of those with a drug need also had an alcohol need recorded. This demonstrates substantial overlaps in need among this population, and the importance of designing services to support co-morbidities of drug use with alcohol use and mental health problems. We also know there are frequent experiences of personality disorder, complex trauma, and chronic physical health problems among this group, which must be addressed.

2.3. One of the major health harms directly resulting from drug use is overdose. 263 overdose incidents were reported by St Mungo’s services in 2018. Of these incidents, 100 were deemed intentional (including suicide attempt, self-harm) – 38% of the total. In 2018, St Mungo’s services reported 22 fatalities known or strongly suspected to be as a result of overdose.

2.4. These figures represent an increase in overdose incidents, including overdose related fatalities, compared to previous years. However, this appears to have been driven by an increase in reporting of such incidents by our street outreach services working with people sleeping rough. This is a positive move and helps provide a more accurate picture of the support needs of people sleeping rough. Even so, keeping our clients safe is our first priority and we continuously seek to improve the ability of our services to respond to safety concerns related to drug use. This includes a major increase in the number of St Mungo’s services which have access to Naloxone.

2.5. Our data also suggests that overdoses on the streets may more often result in fatality than overdoses in accommodation-based services, including hostels – in 2018 of the 24 overdoses reported by street outreach services 7 were fatal. A number of factors can affect this data, as outreach services are less likely than hostel staff to learn of less serious overdose incidents. However, it does suggest an increased vulnerability to the most severe health harms associated with drug use for those sleeping rough – which reflects evidence elsewhere in the literature.

2.6. National data also shows rising numbers of drug related deaths among people sleeping rough. The Office of National Statistics has shown that 597 people died sleeping rough or in emergency accommodation in 2017, 190 (32%) of whom died due to drug poisoning. Of the total drug poisoning deaths, 57 (38%) also mentioned alcohol on the death certificate. Homeless people accounted for 5.0% of all drug poisoning deaths in England and Wales in 2017.

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5 Internal St Mungo’s Overdose and Naloxone Report 2018
6 Ibid.
2.7. There has been a substantial increase over time in drug poisoning deaths of people who are homeless, from 125 (26% of the total) in 2013, to 190 (32% of the total) in 2017.\(^8\) This constitutes a rise by 52 per cent over five years, and is the primary driver for the overall increase in deaths among the homeless population.

3. How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

3.1. The most effective means of prevention is to address the underlying drivers of use. There is compelling evidence that high-risk drug use is closely associated with a variety of social factors including housing, employment, deprivation and poverty. These factors also impact on the outcomes individuals have from treatment.

3.2. On an individual level, prevention should involve a strong focus on housing. This means preventing individuals from becoming homeless, and rapidly relieving their homelessness if they are forced to sleep rough. We know that the longer people spend sleeping rough, the more likely they are to develop drug use support needs. Rapid relief from rough sleeping delivered along the principles of No Second Night Out is an essential response to this.\(^9\) However, these interventions are often not adequately integrated with drug services, with delays in accessing harm minimisation and getting people on substitute prescriptions.

3.3. On a systems level, prevention should also focus on addressing social drivers upstream. Homelessness, and in particular rough sleeping, has risen dramatically in recent years. Rough sleeping has risen by 165% since 2010.\(^{10}\) The Government’s Rough Sleeping Strategy 2018 outlined a variety of interventions to meet the Government’s commitment to end rough sleeping by 2027 and halve it by 2022. Some Government funding has gone to projects with particular specialisms in substance use, but drug and alcohol services are not being integrated with new homelessness services as a matter of course.

3.4. An approach to ending rough sleeping should be seen as an important driver of drug use prevention, and recognised accordingly by national agencies with close co-operation in local and national strategic plans.

3.5. The moving of drug and alcohol treatment provision to local authorities presents a significant opportunity to address these drivers of drug use. Local authorities should be able to plan and integrate substance use services with homelessness services, including street outreach teams, hostels and emergency accommodation. However, in practice moving these services to local authorities has exposed them to significant reductions in funding, which has acted as a barrier to effective integration and partnership working at a local level.

3.6. Local approaches to reducing drug use and rough sleeping should go hand in hand, with Health and Wellbeing Boards stepping up to their roles in strategically planning

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8 Ibid.
9 More information on NSNO can be found at http://www.nosecondnightout.org.uk/about-nsno/
interventions to support this group. These forums exist, but specific joined-up strategies for this cohort are lacking. Using HWBs to carry out Joint Strategic Needs Assessments of the homeless and substance using population should be undertaken far more widely.

4. Treatment and harm reduction: how effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

Effectiveness of treatment

4.1. In some senses the efficacy of drug treatment provision in the UK presents a positive picture. The LGA report *Improving the public’s health: local government delivers* argues that ‘treatment services are performing highly’ despite cuts, with 98% of individuals in treatment in 2016/17 waiting less than three weeks to be offered an appointment to start an intervention, with 82% of first interventions having zero days waiting time.\(^{11}\)

4.2. The interventions on offer have a robust evidence base, particularly Opioid Substitution Treatment. Other interventions such as opioid detoxification and psychosocial keyworking show positive outcomes. Residential rehabilitation is recommended by NICE for people seeking abstinence with significant comorbid physical, mental health or social problems – complex needs frequently associated with people who sleep rough.

4.3. Being in drug treatment has a significant impact on the housing status of individuals. Data from NDTMS show that for opioid users there is a sharp reduction in the overall proportion of people with a housing problem between starting treatment and the six-month review\(^{12}\). A similar fall is seen in the non-opiate treatment population, although housing problems are generally less prevalent within this group. These figures should be approached with caution, but could suggest an important role being played by drug treatment in helping people find and maintain accommodation.

Barriers to accessing treatment

4.4. However, despite the benefits of drug treatment, in practice these services are too rarely available for individuals with the most complex needs, and in particular those sleeping rough. A survey of 71 street outreach services across England carried out by St Mungo’s in 2018, found that a majority of areas do not provide substance use services which outreach workers deemed accessible to people sleeping rough.\(^{13}\) Only 48% of respondents said community detoxification services were available to people sleeping rough in their area, 41% for residential detox and 43% for dual diagnosis services. This is


\(^{12}\) Change in the proportion of individuals (aged 18 and over) reporting a housing problem at six monthly time periods during treatment (2014-15): among opioid users it is 20% at baseline; 13% at 6 months, below 10% at 18 months; Data from the National Drug Treatment Monitoring System, available at https://www.ndtms.net/.

compounded for people with No Recourse to Public Funds – only 48% of respondents said substance use services were available for individuals with NRPF in their area.

4.5. Data from the National Drug Treatment Monitoring System shows significant levels of need among people who are homeless accessing treatment. The number of people registered homeless entering treatment for drug or alcohol problems is high – In 2017/18 some 9,767 people presented with an ‘urgent housing problem (usually no fixed abode), 8% of all those in treatment.14 A further 14,037 had a wider housing problem (such as staying with friends, or in a hostel) – 11% of all those in treatment.

4.6. However, NDTMS data also suggest significant unmet need among people who are homeless. Data shows the number of people entering drug treatment with an ‘urgent housing problem’ has increased from 8,338 people in 2010/11 to 9,767 in 2017/18 – an increase of 17%.15 This demonstrates a rising level of need among this group, but this figure is significantly lower than the increase in rough sleeping, which has risen by 165% since 2010. At the same time we know that drug use has increased among people sleeping rough. This suggests that, while more people who are homeless are entering treatment, barriers to treatment exist for some of the most vulnerable.

4.7. Many homeless clients find it difficult to engage with the mainstream offer provided by treatment services. Financial pressures have led to a shift away from targeted outreach and interventions for pre-contemplative and contemplative service users. Gatekeeping is common, with clients seeking treatment frequently having to jump through multiple hoops. This results in these individuals being excluded from treatment and not showing up in statistics.

**Joined-up services and partnership working**

4.8. It is important to recognise that people who sleep rough often experience complex and interdependent issues which cannot easily be resolved, or even fully understood, by the intervention of a single agency. Homeless people must navigate multiple services, all of which have their own priorities and strategies, and people are often deterred by an accumulation of negative past experiences.

4.9. For this reason, the inadequate provision of joined-up and integrated services is a key feature prohibiting effective interventions for vulnerable groups, including people who are homeless. Homelessness services are frequently not aligned with local treatment services, nor do they have a specific focus on treatment themselves.

4.10. Reductions to drug and alcohol service budgets has led to reductions in outreach functions, and a reduction in drugs workers providing on-site support, scripting and referral in homelessness projects – such as day centres and hostels. In our survey of street outreach services, only 41% reported having staff with a specialism in drugs and alcohol support needs in their team, with just 14% of respondents reporting that their service received funding from local authority public health budgets, and 5% said the same for local authority substance use budgets.16

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14 Data from the National Drug Treatment Monitoring System, available at https://www.ndtms.net/.
15 Ibid.
4.11. Reductions in outreach functions is often motivated by a greater focus on individuals in structured treatment, with outcomes based on successful treatment completions. This has resulted in cuts falling hardest on those individuals at the pre-contemplative stage of drug use, with little assertive outreach or support available to this group.

4.12. There are multiple other examples of silo working, which disproportionally impact people sleeping rough with complex needs. Service provision for individuals with ‘dual diagnosis’ – comorbid substance use and serious mental health problems – is severely lacking. It is a common occurrence for individuals to be turned away both from substance use treatment and from mental health services because of disagreement over their primary presenting need. Given that 69% of people sleeping rough in London with a mental health problem also have a co-morbid substance use need, this failing requires urgent attention.

5. Recommendations

5.1. **Rapid access to harm minimisation and treatment** – people sleeping rough or at immediate risk should be able to rapidly access treatment for their drug use. This should include immediate access to harm minimisation including needle exchange and substitute prescriptions to stabilise individuals, with referral for psychosocial therapy, detox or residential rehabilitation where appropriate. Central government should establish a fund to cover the cost of the first four weeks of treatment, available across local authority boundaries to anyone (including people with NRPF).

5.2. **Increased efforts to effectively join-up and integrate support services** – homelessness services and drug services should be jointly commissioned to provide holistic services, addressing support needs in combination and providing personalised support in a psychologically-informed way. Specialist drugs workers should be integrated in street outreach teams, day centres, and accommodation settings. Co-commissioning with clinical commissioning groups to ensure that the physical and mental health needs of people using drugs are met could deliver significant improvements in outcomes.

5.3. **Improving commissioning for marginalised groups** – greater emphasis on providing services for so-called ‘hard to reach’ groups in local commissioning plans would drive forward systemic improvements for people sleeping rough. Changes to monitoring should be made to better incentivise commissioning more services for ‘pre-contemplative’ and ‘contemplative’ individuals. This should include developing a wider range of outcomes measures to more accurately reflect need and personal priorities, including national and local monitoring of: good treatment access, the proportion of people in need who are in treatment, and incident rates of blood-borne viral infections.\(^{17}\)

There should be separate drug treatment outcome indicators for people registered as homeless, to ensure services work more effectively for this group.

5.4. **Wider efforts to end rough sleeping supported as a drug prevention intervention** – in order to achieve its target of ending rough sleeping for good, the Government needs to build at least 90,000 homes for social rent every year, improve stability and affordability in the private rented sector and provide guaranteed, long-term funding for homelessness services. Targeted initiatives must be developed in close collaboration with Public Health England and the Department of Health and Social Care as a matter of urgency to support people sleeping rough with drug support needs and prevent further deaths.