

# **Wet Day Centres in the United Kingdom: A Research Report and Manual**

Commissioned by  
The King's Fund and Homelessness Directorate

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## **The research team**

Maureen Crane and Tony Warnes of the Sheffield Institute for Studies on Ageing (SISA), University of Sheffield, were responsible for the study and the research report and guidance manual. They also undertook some of the interviews. Aggie Crawford, Ruby Fu and Jayne England carried out many of the interviews with clients, staff, police officers, and local business proprietors. The research team has been supported by the clerical staff at SISA, and we particularly thank Kate Smith.

## **Acknowledgements**

We are most appreciative and grateful to the clients, staff, session workers and others who participated in the study and agreed to be interviewed. Without their help, support and willingness to share their experiences and opinions, this study would not have been possible. We received exceptional co-operation from the staff and clients at the four wet centres that were studied in detail – the Anchor Centre in Leicester, the Booth Centre in Manchester, the Handel Street Centre in Nottingham, and Tollington Way (formerly the Finsbury Park Street Drinkers’ Initiative) in north London. We are also extremely grateful to the many wet centre managers and other staff who gave up their valuable time to comment on the early draft of the report, and attend the workshop in London (see below). This event generated very useful feedback which has helped to structure this final report.

We also express our appreciation of the advice, practical help and guidance given by David Jones of the King’s Fund, and Kate Noble and Helen Jones of the Homelessness Directorate. We lastly thank the King’s Fund for hosting the study workshop.

Attendees at the workshop on the draft report:

John Chalmers, Anchor Centre, Leicester; Paddy Chandler, Handel Street Centre, Nottingham; Amanda Croome, Booth Centre, Manchester; Toby Blake, Oxford Day Shelter, Oxford; Gary Harvey, Housing Department, Nottingham City Council; Lisa Barker, Housing Department, Leicester City Council; Richard Phillips, Alcohol Concern; Nancy Rotem, NORCAS, Great Yarmouth; David Jones, King’s Fund; Helen Jones, Homelessness Directorate.

## Summary

This document reports a short study of the work of ‘wet’ day centres in England for street drinkers – in other words, centres where drinking is allowed. It has two parts, an account of the research undertaken and its findings (Chapters R1-R5), and a ‘development manual’ in the form of guidance notes for those who are considering both the need for and how to establish similar facilities (Chapters M1-M4).

### The Research Section

- The background to the study and its methods are described in the first chapter. The aims were to produce a directory of wet day centres across England, and to collect detailed information about the operations of four.
- Over the years, both punitive and supportive measures have been used to tackle the problem of street drinking. More recently, drinking bans have been introduced in many town and city centres. At the same time, services for homeless people with alcohol problems have expanded, with the development of wet hostels and supported housing projects for heavy drinkers. Chapter R2 reviews these various approaches, and comments on the paucity of information about effective ways to tackle long-standing alcohol problems.
- Chapter R3 is a directory of wet centres and drop-in centres for street drinkers in the UK. The first wet centre was established in Dundee in 1978, and in 1991 the first in England was set up in Nottingham. Others have subsequently been developed in London, Brighton, Oxford, Leicester and Manchester. The chapter overviews the development and work of these centres, and demonstrates their diverse organisational structures, funding, staffing arrangements and service profiles.
- The fourth chapter provides summary information about four wet centres that were studied in detail: Tollington Way in north London, Booth Centre in Manchester, Handel Street Centre in Nottingham, and the Anchor Centre in Leicester. The services that they provide and their ways of working with clients differ, although most have crucial input from street outreach teams and specialist primary health, mental health and substance misuse agencies.
- Interviews were conducted with 101 wet centre clients, and Chapter R5 summarises their characteristics and problems, the help that they have received, and their opinions of wet centres. It describes the vulnerabilities of this client group, many of whom have dual or triple mental health, alcohol and drug problems. Most are or have been homeless. Even among those who have tenancies, many are struggling to manage at home, have rent arrears and debts, and require tenancy support.

### The Guidance Manual

- Wet day centres have two over-arching aims: (i) to provide support, help and treatment for severely disadvantaged and chaotic people, including street drinkers, who are excluded from other services; and (ii) to tackle an anti-social behaviour problem in a constructive, non-criminalising way. The first chapter in this section (M1) reviews these two aims and provides guidance on the factors that should be taken into account when making a detailed

specification. The precise aims will be a function of the groups of clients to be served, and the extent to which the key roles are or can be undertaken by other facilities.

- Chapter M2 describes many issues that need to be considered and the steps that should be taken when planning and setting up a wet centre. It discusses the kind of organisation that should run the centre, the optimum location, finding premises, overcoming local opposition, gaining planning permission, funding sources, and the role of various specialist service providers including the police. Many of the existing wet centres experienced problems with finding premises and local opposition, and for some several years elapsed from the recognition of a need to the establishment of the centre.
- The third chapter (M3) describes the work that needs to be undertaken with wet centre users who have alcohol problems. It describes ways of engaging with the clients, assessing their needs, meeting their basic needs, individual case-work, addressing alcohol problems, and the role of activities. The wet centres have different rules about drinking alcohol on the premises, and the merits of different policies are discussed.
- Managing a wet centre is not easy and several difficulties and stresses are discussed in Chapter M4. There is particular attention to the specification of the roles, training, supervision and support of staff. The problem of the rarity of apparent success and its effect on job satisfaction is addressed. The work involves helping clients who have been drinking heavily for years, and very often progress is slow. Moreover, it is usual for the clients who stop drinking to stop attending, and the staff may be unaware of the positive outcomes of their work.
- The final chapter (M4) also describes the ways of maintaining control in the centre so that neither bullying, intimidation nor immoderate drinking occurs. Examples are presented of the procedures used by existing centres to manage the local environment and to minimise the centre's impact on the neighbourhood. The importance of setting standards, targets, and efficient performance recording and monitoring systems is made clear, not least so that wet centres can demonstrate their achievements and secure continuation funding.
- Low threshold, point-of-contact wet day centres play an important and successful role in working with street drinkers, rough sleepers and other groups of street people who are excluded from or have difficulty in accessing existing services. They link them into specialist or mainstream agencies, and help them not only to desist from anti-social behaviour but also in many cases to make constructive changes in their lives.
- The functions should therefore be established in any town or area with street drinkers and other marginalised and vulnerable 'street people'. The precise form of the facilities that provide the functions should however be decided locally, following widespread and multi-agency consultation, and in the light of the capacities and development potential of the area's existing facilities and organisations.

## R1

### Background to the study and its methodology

This study of wet day centre provision in England was commissioned by the King's Fund and the Homelessness Directorate. Following the King's Fund award of a grant to the Finsbury Park Street Drinkers Initiative in north London (now known as Tollington Way), its Grant Committee were interested to find out more about the different ways in which wet centres worked. Discussions were held with the Homelessness Directorate and the organisations agreed to commission jointly a short study of the different approaches adopted by wet centres and to disseminate the findings. The study commenced in May 2003 and data collection was completed in September 2003.

#### Aims and objectives

The aims and objectives of the research were:

- To produce a directory of wet and wet /dry day centres across England.
- To collect detailed information about the operations of four wet centres.
- To assess the main factors that encourage or inhibit the development of wet centres, and their effect on the local area in terms of street drinking.
- To review how the development of wet centres and other projects for street drinkers might inform future national initiatives, *e.g.* the *National Alcohol Harm Reduction Strategy*, and the work of *The Homelessness Directorate*.
- To produce a research report and manual about the setting up and running of wet day centres.

#### Methodology

The research has elements of a review, a synthesis of basic facts, and an exploration of the roles of the wet centre services and of their effectiveness for both the clients and localities (whether city-centres or suburban neighbourhoods).

##### **i. Directory of wet centres and drop-in centres for street drinkers**

A directory has been compiled of all 'wet' centres known to be operating in the UK, *i.e.* centres that target street drinkers and permit drinking on the premises either in designated rooms or in the garden. Details have also been included about day centres that either target street drinkers but do not allow drinking on the premises, and generalist homeless people's day centres that have a designated 'wet area' for drinkers. The centres were identified by contacting the managers of known wet day centres, by contacting homeless people's services in different locations and enquiring about local provision for drinkers, and by online searches.

Eight wet day centres in England and one in Dundee were identified. Visits were made to all the centres in England, and information gathered from the managers about: (i) development,

objectives, services provided, and funding; (ii) staffing arrangements, including recruitment and retention; (iii) client characteristics, including whether housed or homeless, and their problems and needs; (vi) ways of working with the clients and help given; and (v) the centre's relations with the neighbourhood, local authority, police and other agencies, especially health, alcohol, housing and social services staff. Brief information was collected on the other centres through visits to Ben's Place in Sheffield, the Cornerstone Day Centre in Manchester, and the Homeless Alcohol Recovery Project in Birmingham, and through telephone interviews and documentation. Contact was also made with service-providers in other towns and cities where searches had identified that day centre facilities for street drinkers were planned.

## ii. Detailed study of four wet day centres

A detailed study of four wet centres was undertaken: Tollington Way in north London; Booth Centre in Manchester; Handel Street Centre in Nottingham; and the Anchor Centre in Leicester. These were selected as they were believed to work in different ways with street drinkers. Tollington Way allows drinking on the premises, while the Booth Centre permits drinking in the garden and provides a service to drinkers alongside an activities-based day centre. The Anchor Centre works with street drinkers together with drug misusers, while the Handel Street Centre, which is managed by Framework Housing Association, has been in operation for a decade and also provides a tenancy support service. Table R1.1 enumerates the interviews undertaken at each of the four centres.

### a. Review of documents and reports

Documents on the genesis, history, external relations and performance of each centre were reviewed, with particular attention to recent usage and evaluation reports.

**Table R1.1 Interviews conducted at the wet centres**

People interviewed	Handel Street	Tollington Way	Booth Centre	Anchor Centre	Total
<b>Clients</b>	<b>25</b>	<b>25</b>	<b>25</b>	<b>26</b>	<b>101</b>
<b>Centre managers and core staff<sup>1</sup></b>	<b>9</b>	<b>7</b>	<b>6</b>	<b>6</b>	<b>28</b>
<b>Outreach workers</b>	<b>1</b>	<b>n.a.</b>	<b>1</b>	<b>2</b>	<b>4</b>
<b>Health and social service workers</b>	<b>5</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>11</b>
<b>Police</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>5</b>
<b>Stakeholders</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>1</b>	<b>5</b>
<b>Local businesses and residents</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>3</b>
<b>Total number</b>	<b>44</b>	<b>35</b>	<b>37</b>	<b>41</b>	<b>157</b>

*Notes:* 1. Includes two interviews with volunteers and an interview with the art tutor at the Booth Centre, Manchester. n.a. not applicable.

*b. Interviews with the centre manager and core staff*

Interviews were conducted with the centre managers and core staff, and details gathered on: (i) the origins and development of the centre, including the acquisition of premises and negotiations for funding; (ii) the centre's objectives, changes over time, and services provided; (iii) the recruitment, experience, training and retention of staff; (iv) funding arrangements; (v) the role of staff, assessments of client needs, case-work, and help given at the centre; (vi) performance measures and outcome monitoring; (vii) inputs from health, alcohol, social services and housing workers; (viii) the centre's relationship with the local community, local authority, police and other key statutory agencies; and (ix) their views of wet centres, lessons learned, and the potential and limitations of the centre. Two volunteers at the Booth Centre were also interviewed. Check-lists guided all interviews.

*c. Interviews with session workers*

Interviews were conducted with session workers at the centres, including health and substance misuse workers, street outreach teams, and social workers. Information was gathered about: (i) their input at the centre; (ii) the help that they give to the clients; and (iii) their views of the wet centre, and its potential and limitations for street drinkers. Check-lists guided all interviews.

*d. Interviews with clients*

Interviews were conducted with 25 clients at each centre (26 at the Anchor Centre). Using a questionnaire of closed and open-ended questions, information was gathered on: (i) personal characteristics; (ii) recent housing history and experience of homelessness; (iii) physical and mental health problems, and treatment; (iv) alcohol and drug problems, and treatment; (v) history of drinking, street drinking patterns, and recent problems with the police; (vi) financial situation, daily living and household skills, and help at home; (vii) use of the wet centre, reasons why they use it, help received, and changes in their housing and drinking since attendance; (viii) use of other centres; and (ix) opinions of the wet centre, and help that they would like but are not receiving.

Information from the clients' interviews has been coded and entered into an SPSS database. Their characteristics, problems and needs, help given, and their opinions of the wet centres have been examined. Comparisons have been made by age, housing situation, and the centre that they attend.

*e. Interviews with stakeholders and other agencies*

Interviews were conducted with stakeholders and other agencies with an interest in the day centre, to gather their opinions about the benefits and potential of the centre. Included were the police in all four locations, the Head of Hostels and Housing Community Care Service in Leicester Housing Department, and the Homelessness Co-ordinators in Nottingham and Manchester local authority housing departments.



#### *f. Assessment of local situation*

An assessment of the environs and regulatory context of each centre was undertaken to gauge the centre's influence on street drinking and impact on the local community. There was: (i) a review of local policies, procedures and reports relating to street drinking in the locality; (ii) interviews with the manager of a neighbouring housing complex in Leicester and business proprietors in London and Leicester who had concerns about the wet centres; (iii) interviews with the local community police officers; and (vi) street outreach work was carried out twice in London and once in Manchester with outreach workers to meet street drinkers who did not use the wet centres and to find out the reasons.

The centres in London and Nottingham were studied first, and then those in Leicester and Manchester. It was not possible to interview all session workers, stakeholders and local businesses. This was partly due to time constraints, and partly because the study was conducted over the summer when staff were on holiday or unable to spare the time to be interviewed.

#### **iii. Review of literature and policy documents**

A literature search was conducted of research and evaluation studies of day centre and related interventions with heavy drinkers and street drinkers. Standard scientific abstract databases were used, as well as the catalogues and resources of *The King's Fund*, *Alcohol Concern*, and the *Institute of Alcohol Studies*. Policy documents were also reviewed, and interviews were conducted with the Director of Policy and Services at *Alcohol Concern*, and the Senior Policy Officer for Alcohol and Drugs at the Greater London Authority.

#### **iv. Workshop to discuss draft report**

A draft report of the study was prepared and circulated in early September 2003, and a workshop held at the King's Fund on 11th September 2003 to discuss the report and the study's findings. It was attended by: four wet centre managers (Booth Centre in Manchester, Handel Street Centre in Nottingham, Anchor Centre in Leicester, and Oxford Day Shelter in Oxford); the Homelessness Co-ordinator in Nottingham City's Housing Department; the Head of Hostels and Housing Community Care Service in Leicester City's Housing Department; the Director of Policy and Services at *Alcohol Concern*; a worker who is involved in developing a local wet centre from NORCAS, an outreach team in Great Yarmouth; and the study commissioners and researchers.

#### **The report**

This report has two sections. The first concentrates on the findings of the research and has four chapters on: a review of punitive and supportive measures to tackle street drinking; an overview of wet centres and drop-in centres in the UK for street drinkers; a description of the performance of the four wet centres that have been studied in detail; and an account of wet centre clients and their views of the centres. The second section of the report is a manual and guide to the design, planning and running of a wet centre for street drinkers and other indigent and exceptionally vulnerable people. It is based on the findings of the research.

## R2

### **Punitive and supportive measures to tackle street drinking**

Alcohol consumption in England and Wales has received increasing attention in recent years, partly because deaths directly attributable to alcohol increased from 2,500 in 1979 to almost 6,000 in 2001 (Alcohol Concern, 2003). A 'National Alcohol Harm Reduction Strategy' is currently being prepared. Street drinkers are one of the most vulnerable groups in society. There are no official figures of their number, but in 1995 a *Mental Health Foundation Working Group* estimated that there were between 5,000 and 20,000 persistent street drinkers in England and Wales (Mental Health Foundation, 1996). Over the years, both punitive and supportive measures have been used to tackle the problem of street drinking. These are reviewed in this chapter.

Many street drinkers have chronic alcohol and physical and mental health problems, and most are homeless or have housing-related problems. They drink on the streets for company, because the prices in public houses are high, and because some live in hostels with alcohol bans. Many have been drinking on the streets for a long time. Among 43 street drinkers in the London Boroughs of Camden and Islington, 68% had been drinking outside for more than five years. Two-thirds drank on the streets every day, and nearly half spent less than five hours each day indoors (Vision Twentyone, 2000). They have high risks of assault and of arrest for drunkenness, shoplifting and other public order offences (Alcohol Concern, 2001). Many receive little or no help from mainstream health and social services. Their chaotic behaviour means that many have been barred from or cannot cope with the rules and procedures of generic services.

#### **Punitive measures to tackle street drinking**

Recent governments have been concerned about several forms of street homelessness behaviour, namely rough sleeping, street drinking, begging, and drug dealing and taking, which are regarded as anti-social and damaging to the quality of public spaces and residential areas. Attention has been given to the impacts on residents, shoppers, tourists and local businesses. According to *Shelter* (2001, p. 4), 'street homelessness is one of the most acute symbols of the failure of social policy'. Street drinkers, particularly in groups that commandeer prominent spaces in town centres and parks, are perceived by the public as intimidating, and businesses are aggrieved by the damage they cause to their trade (Shimwell, 1999; Vision Twentyone, 2000).

Attempts to control street drinking date back years. 'As soon as the Hastings police force was formed in 1836, it had to deal with street drinkers, whose main crime (then as today) was to make the place look untidy'.<sup>1</sup> Over the years, habitual drunken offenders have been detained by the police until they were sober. Since the late 1980s, local measures to curb street drinking have gradually spread. In 1988 seven local authorities, including Coventry, took part in a two year pilot to test the effectiveness of a byelaw making it an offence to drink alcohol in designated

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<sup>1</sup>. See <http://www.victorianweb.org/gender/wojtczak/under.htm>.

places after being warned not to do so by a police officer (St John-Brooks and Winstanley, 1998). An evaluation concluded that the byelaw should be made more widely available. In 1990, the Home Office issued a model byelaw entitled, *Consumption of Intoxicating Liquor in Designated Places*, which was subsequently revised. Before passing such byelaws, local councils had to review the problem of street drinking in their area for six months, and then apply to the Home Office for permission. Byelaws could not ban drinking throughout a town or city, only on specified streets or in areas such as parks. By 2001, 100 local authorities had drinking byelaws (Alcohol Concern, 2001). Similar byelaws in Scotland date back to 1989, when they were piloted in areas of Motherwell, Dundee and Galashiels.

The *Crime and Disorder Act 1998* (Sec. 1a) introduced anti-social behaviour orders against an individual acting in ‘a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as himself’. Either the police or the local authority can apply for an order, and an individual is expected to desist from a particular activity for a minimum of two years. Persistent problematic behaviour associated with alcohol misuse is liable to an anti-social behaviour order. The Act also requires each local authority to produce a ‘Community Safety Strategy’, with the involvement of the police, probation service, health trusts, and the voluntary sector. Some councils, e.g. Wigan, Lewisham and Hammersmith & Fulham, have introduced wardens and outreach workers to work with street drinkers as part of their community safety strategies.

The *Criminal Justice and Police Act 2001* (Ch 16, Secs. 12-16) clarifies the powers of the police to stop drinking in public places. Local authorities can create alcohol-free zones in designated places, and police officers can confiscate alcohol from people in these places if there is reasonable belief that the person is drinking or intends to drink. Failure to hand over drink can result in arrest and a maximum fine of £500. The police have discretion over when to act. The local authority has to consult various people before an order can be made to designate a place an alcohol-free zone, including the Chief Officer of Police for the proposed area, the local authority and the Chief Officer of Police in neighbouring areas, local licensees, and a notice of intent has to be put in a local newspaper and representations invited.

### **Supportive measures to tackle street drinking**

Since the 1970s, reports have identified the vulnerability and unmet needs of single homeless people who are socially inadequate and chronic alcoholics. Recommendations were made that help and treatment should be provided by psychiatric and social services rather than through the criminal justice system (Archard, 1979; Home Office, 1971; 1974). In 1973 the responsibility for dealing with habitual drunken offenders was transferred from the Home Office to the then Department of Health and Social Security (DHSS). The DHSS offered funds to voluntary bodies to provide services for people with alcohol problems, and specialist hostels, detoxification centres and rehabilitation programmes were established. The DHSS supported two detoxification centres where drunken offenders could be taken by the police (rather than police cells). These were the

Leeds Detoxification Centre which opened in 1976 and is managed by St Anne's Shelter and Housing Action, and a unit at the Withington Hospital in Manchester which opened two years later. In 1981, the Home Office funded a centre in Birmingham that was open overnight for alcoholics. The Leeds centre is the only one still operating.

By the mid-1980s, services began to recognise that some heavy drinkers were reluctant or unable to abstain, as required of their clients by many alcohol services. One response has been the creation of 'wet' and 'damp' projects for homeless people who are heavy drinkers. 'Wet' projects allow drinking on the premises, while 'damp' schemes target heavy drinkers but disallow alcohol consumption in the project. Their aim is 'harm minimisation' – they encourage controlled drinking and less dangerous substitutes, and promote healthier and more stable lifestyles. Wet hostels and supported housing projects began in the mid-1980s, with the establishment in 1985 of the Heavy Drinkers Project in Manchester by Peterloo Housing Association (now run by Manchester Methodist Housing Association), and of Wernham House in Aberdeen in 1986 by the Aberdeen Cyernians. The first UK wet day centre opened in Dundee in 1978, and the first in England was established in Nottingham in 1991 (described in Chapter R3).

Services for homeless people with alcohol problems have expanded since the mid-1990s with funding from the former Rough Sleepers Initiative, the former Rough Sleepers Unit, the extant Homelessness Directorate, and from the Department of Health's *Drug and Alcohol Specific Grant*. Compared to drug services, however, funding for alcohol services is poor. Some towns and cities now have wet hostels and housing projects for heavy drinkers, but demand outstrips supply and there are still only a handful of wet day centres. According to homeless sector staff, accessing alcohol services for their clients is often difficult: services are few and there is often a long wait (Bevan and Van Doorn, 2002; Crane and Warnes, 2001). This is particularly true for those clients who have dual problems of alcohol abuse and mental illness or drug misuse.

The 1998 Green Paper, *Our Healthier Nation*, announced a national strategic approach to the treatment of alcohol abuse. A Strategy Unit in the Cabinet Office was formed in July 2002 which with the Department of Health aimed to implement a *National Alcohol Harm Reduction Strategy* for England by 2004. A consultation paper on the strategy was circulated in October 2002 (Strategy Unit and Department of Health, 2002), and an *Interim Analytical Report* in September 2003 (Strategy Unit, 2003).

### **The effectiveness of the various approaches**

A few local studies of street drinkers have been conducted (*e.g.* Morrish, 1993; Holman, 1994; Vision Twentyone, 2000), but there has been little rigorous research into effective ways of tackling long-standing alcohol problems. The UK *Alcohol Research Forum* recently noted the paucity of research into alcohol problems (Alcohol Concern, 2002). For several years, detoxification has been promoted as an initial step in helping a person to abstain from alcohol, and as a respite measure for some who wish to temporarily withdraw. Many street drinkers have participated in numerous detoxification programmes. There is now evidence to suggest, however,

that multiple episodes of alcohol withdrawal may increase the incidence and severity of seizures during detoxification, render a person more vulnerable to brain damage, and contribute to alcohol-related neuropathology and increased cognitive dysfunction (Becker, 1998; Littleton, 1998). It is alleged that for the most part, ‘treatment advances [detoxification] have evolved independently from developments in neurochemical understanding’ (Littleton, 1998, p. 13).

The use of drinking bans has spread widely in the last few years, but little is known of their implications. They may benefit local people and businesses, but their impact on street drinkers and the wider community is less clear. Where local authorities have introduced a drinking byelaw, the result has sometimes been a displacement of street drinkers from town centres to residential areas (St John-Brooks and Winstanley, 1998, p. 9). This could lead to street drinkers becoming more marginalised if they are unable to access services in central locations, and if outreach workers have difficulty finding and working with them. In its response to the *National Alcohol Harm Reduction Strategy Consultation*, Homeless Link recommended the commissioning of research to understand better the needs of street drinkers and the effects of controlled drinking area policies upon them.

There is little evidence of the most effective ways to tackle the complex health and alcohol problems, poor motivation, and chaotic lifestyles of many street drinkers. Many move in and out of hostels and tenancies, and return to the streets when rehousing fails or they are barred from services. Interventions that help control drinking and stabilise chaotic patterns of behaviour are at an early stage of development. Some wet hostels and day centres have been operating for a few years, yet there has been little evaluation of their services to assess the short and long-term outcomes of various ways of working. This study is short and does not have the capacity to carry out a thorough and full systematic evaluation.

## R3

### **An overview of wet centres and drop-in centres for street drinkers**

This chapter overviews the work of wet centres and drop-in centres for street drinkers in the UK. The early sections describe their origins and the difficulties of finding premises and establishing a centre, and there is an inventory of their locations, funding, staffing and services. It includes all ‘wet’ centres known to be operating in the United Kingdom, *i.e.* those that target street drinkers and permit drinking on the premises in either a designated room or garden. The last section provides details of the few day centres that either target street drinkers but do not allow drinking on the premises, or are generalist homeless people’s centres but have a designated ‘wet area’ for drinkers. Three tables provide basic profiles of the centres’ services and funding, and contact details are given at the end of each centre’s description.

#### **Wet centres developed up to 2000**

##### *The Wishart Centre, Dundee*

The first wet day centre in the UK was established by Dundee Cyrenians Wishart Centre Ltd in 1978 in the Wishart Memorial Church for local night-shelter residents. For its first ten years, the service users were mainly middle-aged and elderly men who were heavy drinkers. In 1986 a temporary Drug Problem Centre was opened on the premises and it was frequented by young drug users. For a time the two groups co-existed, but in 1996 the Dundee Cyrenians opened a new purpose-built centre providing 24-hour accommodation and support for drug users, and the day centre re-registered as The Wishart Centre.

Contact details: The Wishart Centre, 61 King Street, Dundee DD1 2LD. Tel: 01382 2296671.

##### *Handel Street Centre, Nottingham*

The first wet day centre in England was established on the eastern edge of Nottingham city-centre in January 1991 by Nottingham Help the Homeless Association (NHHA)<sup>1</sup>. Known as the Handel Street Centre, it came about because of an increase in the number of street drinkers in the city during the previous few years, which had led to public and political complaints and concerns. The City Council and the police proposed a wet centre in Nottingham which would permit drinking on the premises. The Council first approached The Salvation Army and then NHHA about managing such a facility. The purpose of the centre was: (i) to provide shelter, food and beverages during the day to heavy drinkers, where there would be no pressure on them to move on; (ii) to provide primary health care to heavy drinkers who did not access health services; and (iii) to reduce the nuisance of street drinking.

NHHA expressed concerns that: (i) there would be little chance of carrying out effective rehabilitation work with heavy drinkers in a day centre; and (ii) having around 25 heavy drinkers

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<sup>1</sup> In July 2001 NHHA merged with Macedon to form Framework Housing Association

on one site would be too difficult to control, and levels of violence were likely to be unacceptably high. It was finally agreed that both a wet hostel and a wet day centre would be run by a single staff team. The hostel opened 14 months after the day centre. The day centre occupies a former warehouse in a former retail market area with comparatively few residents, and is surrounded by car-parks and warehouses, and is close to three homeless sector hostels. Nonetheless, there was strong local opposition to the project at the planning stage. It initially opened every day from 10 a.m. to 6 p.m., and in its first year attracted 558 users. Of these, 93% were men, 58% aged 40-59 years, and 92% were homeless. An evaluation of the performance during the first year was undertaken by a team from Nottingham University (Williams, 1992). The centre is described in more detail in R4.

Contact details: Handel Street Centre, 4 Handel Street, Sneinton, Nottingham, NG3 1JE. Tel: 0115 841 7725. <http://www.frameworkha.org>

#### *Tollington Way, north London*

Tollington Way (formerly known as the Finsbury Park Street Drinkers Initiative) was established following research commissioned in 1993 by the London Boroughs of Haringey, Islington and Hackney into the needs of the drinkers that congregated in Finsbury Park, north London. The local community had been concerned about the threatening behaviour of drinkers and beggars in the park. Most were Irish men over the age of 40 years who had physical health problems and were not in contact with local services. Following the study, an outreach worker (seconded from Equinox) was funded by the three boroughs for 18 months to link the drinkers into services, but found that few local services were prepared to work with the client group.

In 1996, a Development Co-ordinator was appointed to explore the possibility of developing a wet centre in the area. One of the major obstacles was the scarcity of suitable premises. As an interim measure, a local vicar (who was on the project's Management Committee) offered the church hall of St Thomas the Apostle two afternoons a week as a drop-in centre. Islington and Shoreditch Health Authority then provided a building for the centre at Blackstock Mews, Finsbury Park. The project opened at these premises in January 2000, but from the outset there were problems. The building was at the entrance to a mews with small businesses which alleged that the project had damaged trade, and there were complaints from local residents. After a few months, Islington Council confirmed their support for the centre but advocated a new location. In September 2001, it moved to Tollington Way, off the Holloway Road in North London. The building is owned by Islington Council and had been a day centre for Afro-Caribbean older people. The centre is described in more detail in R4.

Contact details: Tollington Way, 91 Tollington Way, London N7 6RE Tel: 0207 263 4140.

#### *Old Steine Day Centre, Brighton*

The Old Steine Day Centre in Brighton was opened as a wet centre by Equinox in September 1998. Street drinking had been a problem in Brighton town centre from the early 1990s. A multi-

agency forum, the Alcohol Partnership for East Sussex, was established to examine alcohol-related issues, and the absence of a 'wet' facility was identified as a major gap in local service provision. A 'Drink Crisis Planning Group' was convened, and a needs assessment undertaken to identify the size and location of the street drinking population, and to audit existing service provision. The Planning Group identified the need for a 'low-threshold' specialist day care service that offered an alternative to street drinking and access to other services. The recommended principles were that: (i) the service should not insist upon a high level of motivation and commitment to eventual abstinence as a precondition of access; and (ii) there should be a co-ordinated response by all relevant services to the needs of street and inadequately housed drinkers, which took account of their reluctance to stop drinking, their chaotic lifestyles, and their social isolation (Squires and Measor, 1999).

It took four years from the identification of a need for a wet centre in Brighton to its establishment. Equinox agreed to manage the centre and spent more than a year in an unsuccessful search for premises. The organisation eventually informed the Council that they would have to withdraw if a building could not be provided. The Council offered a rental building which used to be a bank and is adjacent to the Royal Pavilion gardens. This location immediately raised concerns from local people, but the police who were represented on the Planning Group supported the proposal. A three-year funding package was secured, comprising money from the Single Regeneration Budget (SRB2), the National Lottery, Brighton and Hove Council, the Department of Health Specific Grant, and the Tudor Trust. An evaluation of the centre was carried out in 1999 by a team from the University of Brighton (Squires and Measor, 1999).

Contact details: Old Steine Day Centre, 62 Old Steine, Brighton BN1 1EH. Tel: 01273 202894.

### **Wet centres developed since 2000**

#### *Anchor Centre, Leicester*

In June 2000, the Anchor Centre in Leicester, which had been an evening centre for male ex-offenders for 30 years and a day centre since 1994, became a wet centre. Street drinking had been a significant problem in Leicester for several years, and was dealt with by the police mainly by arrests and detaining street drinkers. In 1997, the City Centre Forum (of businesses, police and other city organisations) proposed the introduction of a byelaw to ban street drinking. The City Council Community Safety Partnership set up a Working Group in 1998 to examine the extent of the problem and possible solutions. It found that the city centre and parks were particularly affected; that young people and the homeless were believed to be the most common street drinkers, and that 70% of the public supported the idea of a day centre to manage the problem. There was little evidence to suggest that a byelaw would be effective, and therefore a wet day centre was proposed. An estimated £248,000 per year would be saved through savings on arrests, tenancy failures, hospital stays, policing, casualty admissions, health care, custodial sentences,



street maintenance and security. It was also estimated that £45,600 would be saved through a street drinking ban (Leicester City Council, 1999).

The proposed wet centre became a priority in Leicester's 'Single Homeless Strategy' and 'Health Action Zone' plans. Leicester City Council Housing Department became the lead partner, and drew up a 'memorandum of understanding' with other partners, namely Leicestershire Health, Leicestershire and Rutland Healthcare Trust, Leicestershire Constabulary, The Benefits Agency, and the Leicestershire and Rutland Probation Service. Forge Midlands, part of Novas Ouvertures, agreed to manage the wet centre, which was to be in an existing day centre. Funding was obtained for two years from the Department of the Environment, Transport and the Region's 'Invest to Save Budget', with matched funding from the partners equating to 42% and 25% in each year. A ban on street drinking came into operation in the city centre in June 2002 (it includes the area around the Anchor Centre). The centre is described in more detail in R4. Contact details: Anchor Centre, 21-23 Dover Street, Leicester LE1 6PW. Tel: 0116 2551608.

#### *Booth Centre, Manchester*

The Booth Centre at Manchester Cathedral was opened in May 1995 as a drop-in and activity centre for homeless people by an independent charitable organisation (*The Booth Centre*). Since at least the late 1960s there had been recurrent problems with drinking schools in Piccadilly Gardens at the eastern edge of Manchester's main central shopping area. In August 2000, a byelaw banning drinking on the streets in the city centre was introduced, and the area around the Booth Centre became part of the ban. This had implications for the centre's clients as some used to congregate on the steps outside the centre and drink, and the staff would work with them outside.

The decision was therefore made to establish a 'wet garden' adjacent to the Booth Centre on a disused plot which belonged to and abutted the cathedral and had previously been a builder's yard. The idea for an 'outdoor area' originated from the centre users, and was put into action by the centre staff and the Cathedral. The police and other statutory and voluntary agencies also supported the proposal. The centre users were involved in the planning and building of the garden with assistance from CRASH and the Community Technical Aid Centre. The wet garden opened in September 2001 for two mornings a week, and funding was obtained from the Central and North Manchester Primary Care Trust for a worker to provide support and help to the clients in the garden. The centre is described in more detail in R4.

Contact details: The Booth Centre, Manchester Cathedral, Victoria Street, Manchester M3 1SX. Tel: 0161 835 2499. <http://www.boothcentre.org.uk>

#### *Oxford Day Shelter, Oxford*

The Oxford Day Shelter (formerly known as the Luther Street Drop-in Centre) has been in operation since 1999, partly to provide shelter and services during the day for Oxford's night-

shelter's users who were required to vacate the premises between 8 a.m. and 7 p.m (the night-shelter and drop-in centre are at the same premises).

There had been strong pressure from Oxford's business community to deal with the problem of street drinking, and Oxford Night Shelter had worked with Thames Valley Police, Oxford City Council and other agencies to tackle the problem. In May 2001, Oxford City Council developed a 'Street Scene Task Force' to tackle street drinking, aggressive begging, rough sleeping and drug misuse. In November 2001, with financial support from the *Rough Sleepers Unit* and the organisation's own funds, a wet room was established where users are allowed to drink alcohol. In October 2002, the council introduced six alcohol-free zones in the city centre. It now wants to extend the alcohol-free zones to include the area around the project. The Oxford Day Shelter is adjacent to the Luther Street Medical Centre.

Plans for a purpose-built night shelter and day centre on the site have been under consideration for several years (whereupon the existing building would be demolished). The Housing Corporation have agreed to fund the construction work which is due to start in September 2003 and will take about 14 months. The new building will be managed by Warden Housing Association, and the project will focus on rough sleepers and resettlement. During the interim, the project will operate from portakabins in a nearby car-park.

Contact details: Oxford Day Shelter, PO Box 177, Luther Street, Oxford OX1 1SF. Tel: 01865 250153.

*Specialist Dependency Service, Camden Town, London*

The Specialist Dependency Service in Camden Town, London, opened in May 2003 as a wet centre. It is managed by Bridge Housing Association, part of Novas Ouvertures, and uses the same premises as the Spectrum Day Centre, a generalist day centre for homeless people managed by the same organisation. Street drinking and begging had been a problem in Camden Town for several years. In 2000, the Camden and Islington Street Population Strategy Group commissioned a survey into patterns of street drinking and begging in the two boroughs. It was found that the majority of the street population were not rough sleepers, and that many street drinkers had been drinking outside for more than five years, were sceptical of services, and had difficulty changing their way of life (Vision Twentyone, 2000).

It was proposed that there should be a wet centre in Camden Town, but neither Bridge Housing Association nor the council could find premises. This was partly due to local opposition to the scheme. The project was therefore established in an existing day centre. The wet centre operates in the evenings and at weekends when the generalist day centre is closed. It is a one-year pilot project, and is funded by the Borough housing department as part of its 'Street Population Strategy Action Plan'. According to the centre manager, the Borough social services department have expressed an interest in funding the project if the housing department withdraws funding at the end of the pilot phase. The building is leased from a church which does not allow it

to be used on a Sunday. An exception has been made for the life of the pilot project but it is unknown whether this could continue. At present there is no street drinking ban in Camden Town but the idea is being considered.

Contact details: Specialist Dependency Service, 6 Greenland Street, London NW1. Tel: 020 7267 4937.

### **Other day centre provision for street drinkers**

#### *Anchorage Resource Centre, Omagh, Northern Ireland*

The Anchorage Resource Centre in Omagh, Northern Ireland, was established in January 2000 and is open six days a week (not Sundays). It was initiated by the Omagh Street Drinkers Consortium, and is managed by the Foyle Homeless Action and Advice Service. It targets street drinkers but users are not permitted to drink alcohol on the premises. If they bring drink, it is taken from them and returned when they leave. Entry is refused to anyone who is intoxicated. Services provided include free food, an educational programme, computer-skills training, recreational activities, and tenancy support work for clients who are housed. The staff arrange medical appointments for the clients with local doctors, and the community addiction team has weekly sessions at the centre.

Contact details: The Anchorage Resource Centre, 6a Old Market Place, Omagh, County Tyrone, BT78 1BT, Northern Ireland. Tel: 028 8225 9444.

#### *Ben's Place, Sheffield*

Ben's Place in Sheffield is run by the charitable organisation *Ben's Centre for Vulnerable People*. It was opened in October 1996 by a town centre policeman, Ben Sherman, who perceived that it was futile to lock up street drinkers. His vision was to provide a safe and warm environment for Sheffield's street drinkers where they could get nourishment and help. It was steered by a 'lay partnership committee' drawn from Sheffield City Council, Yorkshire Water, the town centre manager, and the police, with the City Council providing the premises. Ben's Place targets street drinkers but does not allow alcohol consumption in the centre. About four years ago it moved to its current building which belongs to a church and is now for sale. The organisation therefore seeks alternative premises.

Over the last few years it has had revenue problems. Its main funding was formerly from the local authority social services department and the Health Action Zone. These monies were withdrawn and it now relies solely on donations and funds from charitable trusts. This has reduced the services that can be provided. It now opens just three days a week, and has had difficulties in recruiting experienced staff.

Contact details: Ben's Place, 2 Institute Buildings, Rockingham Lane, Sheffield S1 4FW. Tel: 0114 276 7302.

*Cornerstone Day Centre, Manchester*

The Cornerstone Day Centre in Manchester is a generalist day centre for home less people which opens five days a week (Monday to Friday). It has been in operation for 11 years and is run by the Catholic Welfare Society. It moved about three years ago from a portakabin to its current premises one mile south of the city centre. It is adjacent to a hostel for 14 men, the Morning Star, which requires the residents to leave the premises between 10.30 a.m. and 4 p.m. This led to complaints by the neighbours to the police about street drinking during the day, primarily by the men from the hostel. One resident became very abusive to the local children when under the influence of alcohol. In May 2003, the Cornerstone Day Centre designated one room as a wet facility exclusively for the men from the Morning Star hostel. About eight older men use the room regularly.

Contact details: Cornerstone Day Centre, Denmark Road, Manchester M15 6JS. Tel: 0161 232 8888.

*Harold Tomlins Day Centre, Chester*

Harold Tomlins Day Centre in Chester was opened in September 2001 by 'Chester Aid to the Homeless' as a day centre for homeless people. Street drinkers had been causing problems in the town centre and there had been complaints from shopkeepers, so the Council allocated a building to be used as a day centre for homeless people on the proviso that it had a wet area for drinkers. The day centre is open seven days a week from 8 a.m. to 6 p.m., and provides meals, physical and mental health services, chiropody, counselling, IT and literacy training, and resettlement (<http://www.homelessnessinchester.org/htdc.html>). There is a small, designated wet room in the centre where alcohol can be consumed, and it can accommodate six people at any given time. The amount of alcohol brought into the centre is restricted to four cans of beer, or half a bottle of spirits, or two litres of cider. People who are severely intoxicated are not allowed in.

Contact details: Harold Tomlins Day Centre, Grosvenor Street, Chester CH1 2DD. Tel: 01244 409158. <http://www.homelessnessinchester.org/htdc.html>

*Homeless Alcohol Recovery Project (HARP), Birmingham*

The Homeless Alcohol Recovery Project (HARP) in Birmingham was established in 1983 with support from the Probation Service to provide help for homeless street drinkers in central Birmingham. Starting with a drop-in service, the organisation has over the years developed various services for drinkers and now has a staff of 22. It has two drop-in centres (both open five days a week; the main one for 1½ hours, and the other for one hour). Clients are not allowed to drink alcohol at these sessions. After the drop-in sessions, key-working and counselling is undertaken with the clients at the main drop-in centre. Other HARP services include street outreach work, advice work, counselling, resettlement, tenancy support work, and criminal justice work. The organisation also has three supported houses with a total of 27 beds where residents stay for six months. Other services that visit the main drop-in centre include drug workers, a

nurse, a chiropodist, and a worker from Crossmatch Solutions (basic skills, training and employment).

Contact details: HARP, Ground Floor, 18/28 Lower Essex Street, Birmingham B5 6SN. Tel: 0121 6667023. <http://www.harpbirmingham.org.uk>.

*Teesside Homeless Action Group Information and Resource Centre, Redcar, Teesside*

The Teesside Homeless Action Group is a self-help group of homeless and ex-homeless people which formed in 1997. It has established an Information and Resource Centre in Redcar for homeless people which opens six days a week (not Sundays) from 9.30 a.m-7 p.m. (12p.m - 4 p.m. on Saturdays). There are various activities for the clients, including Internet access and a community gardening project. There is a yard at the back of the centre where attenders are permitted to consume alcohol. The organisation is also involved in setting up a wet centre in Middlesbrough.

Contact details: Teesside Homeless Action Group, 145 High Street, Redcar TS10 3DQ. Tel: 01642 478885. <http://www.oneworld.org/teeshomeless>

## **Summary**

There are only a few wet centre facilities for street drinkers in the UK. Most have been established as a direct response to a local problem and need, and are in very restricted premises. They have diverse origins, organisational structures, funding and service profiles. For some, it took several years from the recognition of a need to their establishment. Finding premises and local opposition have been common problems. There have been no recent rigorous evaluations of their performance or effectiveness. All have however met a manifest need and all have strong advocates and supporters.

**Table 3.1 The origins, funding and staffing of wet centres**

<b>Centre</b>	<b>Organisation</b>	<b>Origins</b>	<b>Funding</b>	<b>Core staffing</b>
Anchor Centre, Leicester	Forge Midlands	Evening centre for male ex-offenders for 30 years. Day centre from 1994. Wet centre from July 2000.	Statutory. Leicester City Council (50%); Drug and Alcohol Action Team (50%)	Manager, 3 project workers, 2 day centre workers.
Booth Centre, Manchester	The Booth Centre	Drop-in and activity centre since 1995. Wet garden since September 2001.	Insecure and time-limited. Homelessness Directorate; The Community Fund; Central and North Manchester Primary Care Trust; charitable funding.	Manager; 2 project workers; 4 sessional activity workers; 30 volunteers (15 are clients).
Handel Street Centre, Nottingham	Framework Housing Association	Started as a wet centre in 1991.	Mostly statutory from Nottingham City Council. Time-limited funding from Homelessness Directorate.	Manager, 2 deputy managers, 12 tenancy support workers.
Old Steine Day Centre, Brighton	Equinox	Started as a wet centre in September 1998.	Insecure. Brighton City Council (33%); National Lottery (33% for 3 years); Health Authority (20%); Supporting People; Drug and Alcohol Action Team, and private trusts.	Manager, assistant manager, 3.5 project workers, housing support worker, and four volunteers.
Oxford Day Shelter, Oxford	Oxford Night Shelter	Night shelter since 1982; and drop-in centre during day since 1999. Wet centre from Nov. 2001.	Mostly statutory. Oxfordshire Health Authority and Oxford City Council. Some public donations, and subsidised by night shelter.	Separate staff team for wet centre: 6 full-time and 2 part-time staff.
Tollington Way, London	Finsbury Park Street Drinkers Initiative	Started as a wet centre in January 2000	Mostly statutory. Islington, Hackney and Haringey Councils; Islington Primary Care Trust; Neighbourhood Renewal Fund; Dion Committee and the Irish Government; Islington Drug and Alcohol Action Team; charitable funding.	Manager; three project workers; two outreach and resettlement workers; front-of-house coordinator, and one volunteer.
Specialist Dependency Service, London	Bridge Housing Association	Day centre in premises since 2002. Wet centre since May 2003 when the day centre is closed.	Statutory from London Borough of Camden.	Manager; 3 project workers; 4 centre workers.
Wishart Centre, Dundee	The Wishart Centre	Started as a wet centre in 1978.	Mostly statutory. Dundee City Council Social Work Department; NHS Tayside; charitable funding.	Manager, deputy manager, 8 project workers.

*Sources:* Compiled in August / September 2003 from information supplied by the centre managers, and written reports about the centres.

**Table 3.2 Basic provision at the wet centres**

Centre	Opening times	Clients	Basic services	Activities	Drinking rules
Anchor Centre, Leicester	<b>Wet centre: Mon-Sat 10 am-4 pm (open access 12.30-4 pm). Mon, Tues, Thurs 7-9.30 p.m. (no drinking)</b>	Caseload of 60-70 clients. Maximum 30 in centre at a time.	Sandwiches / rolls; showers; clothing.	REMIT runs computer sessions; art group; and women's group. Also board games; quizzes.	Amount restricted. Drink in one room and garden.
Booth Centre, Manchester	Mon-Fri 9 am-3 pm. Drop-in sessions: Tues and Thurs am; Wed pm for over 50's.	60-100 at drop-in sessions. No limit on numbers.	Sandwiches; cooked meal Mon., Weds. and Fri; toiletries; fruit.	Education and training courses, e.g. English and maths, first aid; computing; music; cookery; creative arts; sports; outdoor activities, e.g. walking; gardening; conservation work in parks; and weekend outdoor pursuits.	Amount not restricted. Drink in the garden.
Handel Street Centre, Nottingham	Tues, Weds, Thurs: 9.30 am-3 pm as drop-in, and 3 pm-4.30 pm for activities Fri, Sat, Sun, Mon: 9.30am-4 pm.	Average 75 a day. Maximum 25 at a time.	Breakfast and dinner; showers; laundry.	Music workshops; day trips; computer sessions; cookery; arts and crafts.	Amount not restricted. Drink in one room.
Old Steine Day Centre, Brighton	Mon-Fri 10 am-4 pm. Sat-Sun 10 am-2 pm.	40-55 daily. Maximum 30 at a time.	Breakfast (not week-ends); showers, laundry; clothing.	Foundation Programme for clients after detox.	Amount restricted. Drink in one room.
Oxford Day Shelter, Oxford	Wet centre: 10 am-4 pm daily.	80-110 daily. No limit on numbers.	Dinner; showers; laundry.	Art groups; football; day trips.	Amount not restricted. Drink in one room.
Tollington Way, London	Mon-Thurs, 8am-3 pm	Average 60 clients daily. No limit on numbers.	Dinner; showers; laundry.	Literacy Group by Islington College.	No rules
Specialist Dependency Service, London	Wed-Fri, 4.30-7 pm. Sat-Sun, 10 am-12.00 and 2-4 pm	10-30 daily. Limit to staff / client ratio of 1:5.	Showers; laundry; clothing.	Arts; writing; music; football; board games; bingo; films; quizzes; outings.	No rules. Free beer (5%) given out at times.
Wishart Centre, Dundee	Mon-Fri, 9 am-5 pm.	Average 24 daily. No limit on numbers.	Dinner; laundry; showers; clothing.	Pool; quizzes; outings; alternative therapies, e.g. reflexology.	Amount restricted. Drink in one room.

**Table 3.3 Specialist services at the wet centres**

<b>Centre</b>	<b>Health care</b>	<b>Substance misuse</b>	<b>Street outreach</b>	<b>Resettlement and tenancy support</b>
Anchor Centre, Leicester	Homeless Healthcare Team. GP at centre 4 afternoons, and nurse 3 afternoons. Clients referred to CPNs in team.	GP and nurse provide 'home detox'. Weekly session by social worker from I.a. Substance Misuse Support Team.	Outreach by Leicester City Council Outreach Team. Outreach team at centre most days.	Leicester City Council Resettlement and Tenancy Support Team.
Booth Centre, Manchester	Homeless Advocacy Project nearby, with GP and primary care nurses; Homeless Mental Health Team weekly.	Turning Point drugs worker weekly; Manchester Drugs Service outreach worker weekly; Soc. Serv. Alcohol Team Care Manager weekly.	Outreach by Contact and Assessment Team for city. Outreach team at centre most days.	Weekly visits by local authority housing departments. Centre staff undertake tenancy support, and occasional home visits.
Handel Street Centre, Nottingham	Close link to Windmill Health Centre: GP visits weekly. Nottingham Health Team for Homeless People and Mental Health Support Team twice weekly.	Needle-exchange service twice weekly. Drug and alcohol liaison nurse from Sneinton Hermitage (alcohol treatment project) visits weekly and assesses clients.	Outreach by Contact and Assessment Team for city. Outreach team at centre most days.	Centre staff undertake resettlement and tenancy support. Home visits to clients.
Old Steine Day Centre, Brighton	GP surgery for homeless people (10 minutes walk). Mental health team visits centre weekly.	'Addaction' open-access clinic nearby, and worker visits wet centre weekly. Outreach nurse from substance misuse team visits weekly.	Outreach by Rough Sleepers Street Services Team. Centre staff do one session a week with the team.	House for 5 heavy drinkers (since Feb 03). Centre staff undertake tenancy support, mainly within the centre.
Oxford Day Shelter, Oxford	Physical and mental healthcare provided by Luther Street Medical Centre (next door).	Luther Street Medical Centre (next door). Has specialist addiction nurses. Provide 'home detox' for clients.	Outreach by the St Thomas's CAT and Salvation Army outreach teams.	Five resettlement workers for night-shelter and wet centre. Supported housing for 60 clients (Julian Housing).
Tollington Way, London	No health care service at centre. Clients referred to local GPs.	Worker from Angel Drugs Project visits weekly. Referrals to nearby North Islington Drug Service.	Centre staff do street outreach work. Joint outreach work with other agencies.	Centre staff undertake resettlement and tenancy support. Home visits to clients.
Specialist Dependency Service, London	Clients referred to local GPs. Nurse and mental health support worker at main day centre Mon-Fri.	Alcohol worker at main day centre Mon-Fri.	Outreach by Crime Reductions Initiative team, but not work when wet centre open.	Centre staff undertake resettlement. Refer to Tenancy Sustainment Teams for tenancy support.
Wishart Centre, Dundee	GP clinic twice weekly; full-time specialist nurse based at the centre; visiting podiatrist monthly. Link with local dentist. Referrals to mental health services.	Referrals made to Social work Department Drug & Alcohol Team.	Outreach by city's Outreach and Resettlement Team.	Resettlement and tenancy support by city's Outreach and Resettlement Team.



## R4

### The performance of four wet centres

This chapter provides information about four wet centres that were studied in depth for the research: Tollington Way in north London, the Anchor Centre in Leicester, the Booth Centre in Manchester, and Handel Street Centre in Nottingham. The chapter describes the centres' facilities, staffing and funding, links with specialist agencies, and their clients. It also presents statistical information about the work with the clients and the outcomes. The information was gathered from interviews with the staff and sessional workers, and from the centres' statistical reports.

#### **Tollington Way, London**

Tollington Way (formerly the Finsbury Park Street Drinkers Initiative) is open Mondays to Thursdays from 8 a.m. to 3 p.m. It is on a residential street and occupies two terraced houses which have been combined. The premises are rented from the council (£18,000 per annum) and have three floors. The ground floor stretches across both houses, and has two dining rooms for the clients, toilets and showers, and a garden. The upper two floors of just one of the houses are used as staff offices and a kitchen. The first and second floor of the other house is rented to a man who is at work during the day. Drinking is permitted anywhere in the centre and in the garden. There is no limit on the amount of alcohol that can be brought into the centre.

#### *Funding*

Most of the funding for Tollington Way during 2002-03 has been from statutory agencies. It receives a substantial grant from Islington Borough Council through 'Supporting People', and smaller amounts from Hackney and Haringey councils. Islington Primary Care Trust and The King's Fund each fund one worker, and other funds are obtained from The Dion Committee and the Irish Government (for 2 posts), the Neighbourhood Renewal Fund, Islington Drug and Alcohol Action Team, and charitable funding. Until two years ago nearly all the centre's funding was charitable money. According to the centre manager, being in receipt of statutory funding provides an opportunity for the staff to attend meetings with other agencies and to discuss the clients' needs.

#### *Core staff and their roles*

The centre has a manager, two outreach / resettlement workers, two project workers (one co-ordinates access to substance misuse services, and the other access to mental health services), a part-time project / outreach worker, a front-of-house co-ordinator, and a cook. A volunteer does the clients' laundry and helps serve meals.

Some staff are involved in front-line work and are responsible for the day-to-day running of the centre, and engage with new attenders, build their trust and find out about their problems. They then refer the clients who need help to other staff who are involved in individual case-work. The team meets every Friday to discuss the progress of the clients and issues that have arisen. The staff carry out street outreach work to meet new street drinkers and encourage them to use the centre. They are also involved in resettling clients and provide tenancy support in their homes. Most of the staff have worked in the fields of homelessness and substance misuse for many years, and have been employed at the centre for more than two years.

#### *Links to specialist agencies*

Few specialist agencies provide services at Tollington Way, and there are no sessions by primary health care or mental health teams. Weekly sessions by a nurse from the Primary Care for Homeless People team started in 2002, but were discontinued after a short while. Clients with health problems have to be referred to local GPs. One in particular has an interest in the client group and will register those who are living in his catchment area. The staff liaise with Focus (a specialist mental health team for homeless people) and with community mental health teams, but find it difficult to get mental health assessments and services for the clients, particularly for those who are heavy drinkers. There are also great difficulties in getting local authority social services to carry out community care assessments for vulnerable clients.

As for substance misuse services, a worker from the Angel Drugs Project who has both substance misuse and mental health training attends the centre weekly. Clients are also referred to the North Islington Drug Service which offers assessments on the same day. Access to alcohol detoxification services is a big problem, and the wait for a bed is two or three months. The centre used to have priority rights to some detoxification beds at Rugby House, a nearby substance misuse residential treatment facility. This arrangement was funded by *Healthy Islington* for six months as a pilot project and was well-utilised, but funding was subsequently discontinued.

Joint street outreach sessions are conducted by the centre staff and other agencies, including the Angel Drugs Project, New Roots (a black and minority ethnic group outreach service), and St Mungo's. The staff make use of the free legal services provided by the Mary Ward Legal Centre in central London. It has drop-in sessions for debt problems on Tuesdays and for housing problems on Thursdays.

#### *Services and activities*

Beverages and dinner are provided free of charge, and the clients have access to showers and laundry facilities. Other services include help with sorting out social security benefits, assistance with accessing housing, health, substance misuse and legal services, and help with rehousing and tenancy sustainment. A worker from Islington College runs a Literacy Group at the centre each week, but there are few other activities, partly due to limited space. Some staff believe that there should be more activities at the centre.

### *The clients*

Few statistics are gathered about the clients, the help that they receive, or the outcomes. The staff recognise this as a problem and believe that computerised records need to be kept. Between July 2002 and June 2003, 360 clients used the centre. Of these, 240 were regular users and the others intermittent or occasional users. 65% were from the London Borough of Islington and the rest from the Boroughs of Hackney, Haringey and Camden. Of the attenders, 30 (8%) were sleeping rough at the time of their initial contact. Many others were in insecure, unsafe and unsupported accommodation. Most had alcohol or drug problems. During the 12 months, 25 people were registered with local GPs, 30 were accompanied to various hospital and clinic appointments, and 30 were referred to residential drug and alcohol services. In the spring of 2003, however, there were waits of up to 14 weeks for an alcohol assessment, and few people received treatment.

An evaluation of the centre was undertaken in early 2002 (Meldrum, 2002). It found that 87% of the clients were men, many were aged 30-49 years, and most were classified as British (50%) or Irish (35%). Most were housed in council accommodation. 76% had a longstanding illness or disability, and 40% were registered as disabled. 28% were not, however, registered with a GP.

### *Local community relations*

As described in Chapter R3, the centre experienced problems with local residents and businesses at its former location in Blackstock Mews. It is now next door to a fish-and-chip shop, and very close to a school and nursery school. There are also three parks in the area (Elthorne, Finsbury and Whittington Parks) where street drinkers congregate. Some use the wet centre but others do not. There is no ban on street drinking in the vicinity.

Since moving to its current premises in September 2001, there have been intermittent problems with the local community. A meeting was held with local residents and businesses when the project first opened, at which concern was expressed about the centre. Another meeting was held in May 2003 following many complaints. These featured the behaviour of the wet centre clients, including urinating in the street, drunk and disorderly behaviour, damage to property (a client had fallen against a fence and broken it, and another was alleged to have thrown a brick through a car windscreen), and that a client tied up two Rottweiler dogs outside the centre and people were worried about passing by these dogs. There have been concerns that the project closes and the clients disperse onto the streets at the same time as the children leave the school and the nursery.

The staff believed that the complaints were justified and have taken action to remedy the situation. A code of conduct was drawn up with the clients: this advises that the clients use the toilet before leaving the centre and disperse using different routes. The man who owned the dogs stopped bringing them to the centre. Discussions are also underway to change the time that the centre closes so that it does not coincide with the closure of the school and nursery.

The owner of the fish-and-chip shop alleges that he has lost trade since the centre opened, as women and children tend to avoid his shop. He has complained to the local council. The local police do not believe that street drinkers are a major problem in the area, and that drugs are a bigger issue. They have little involvement with the centre and have had few complaints from the local residents.

### **Anchor Centre, Leicester**

The Anchor Centre in Leicester is open six days a week (not Sundays) between 10 a.m. and 4 p.m., and on Monday, Tuesday and Thursday evenings from 7 p.m. to 9.30 p.m. It is spacious and has four rooms on the ground floor for clients (including an open-access computer room), a kitchen, toilets and showers, a back yard, and offices on the ground and first floors. There are CCTV cameras in all rooms on the ground floor. The building used to be a factory and is leased from the council. It was renovated in 2002 with a grant from the Community Action Against Drugs Team. According to the staff, the environment and furnishings have much improved since the refurbishment.

It operates both as a wet project and a day centre: the mornings (until 12.30 p.m.) are restricted to drinkers, whereas in the afternoons and evenings it is open-access. Up to 30 clients are allowed in the centre at any given time. One room and the back yard are designated wet areas where alcohol can be consumed. Drinking is allowed during the day but not at the evening sessions. The amount of alcohol brought into the centre is restricted to four cans of strong beer or 2½ litres of cider per client. They clients sign an attendance sheet when they come into the centre and record the amount of alcohol that they have.

### *Funding*

50% of the centre's funding comes from Leicester City Council, and the rest from Leicester Drug and Alcohol Action Team (DAAT). It originally received substantial but time-limited funding from the *Invest to Save Budget*. Once this ceased in 2002, funding was obtained from DAAT, which increased its responsibilities for drug users. The staff believe that this is beneficial as an increasing number of clients misuse alcohol and drugs alternately or simultaneously.

### *Core staff and their roles*

The centre has a manager, three project workers for the wet centre, and two day-centre workers. According to the manager, there are difficulties in recruiting experienced staff. In August 2003, two workers had been in post less than six months, one had been a locum worker for 18 months, and two had been employed at the centre for more than two years (one left that month). There are no volunteers at the centre.

The three project workers have caseloads and work with individual clients, assessing their needs, helping them to sort out problems, making referrals to other agencies, and supporting those in tenancies. The two day centre workers are responsible for the open-access afternoon and

evening sessions, and do not have caseloads. They engage with clients when they attend the centre, offer general advice, and refer those who require help to the project workers. The latter undertake key-working sessions with individual clients. The staff do not generally undertake street outreach work or home visits to clients in tenancies. These tasks are undertaken by other workers (see below).

#### *Links to specialist agencies*

Since opening, the Anchor Centre has received a great deal of input from various agencies. Street outreach workers employed by the City Council visit the centre several times a week – one is a substance misuse worker. They use the centre as a venue for contacting rough sleepers, and for meetings with clients. The Leicester Homeless Primary Health Care Service provides medical services at the centre five days a week (GP four days, and specialist nurse practitioner three days), and has Personal Medical Services status. It thus provides a full range of primary care services to clients who are registered, including 24-hour medical cover, health screening, family planning, and a community detoxification programme for some clients.

A social worker from the local authority Social Services Substance Misuse Team visits the centre weekly. He carries out community care assessments to help clients access rehabilitation programmes and residential care, and either advises or makes onward referrals for clients who have housing and benefit problems. It can take six to nine months to get a place for a client with an alcohol problem into a rehabilitation programme, partly because there are no such services in Leicester and they have to be referred elsewhere. There have been placements in Bournemouth, Sheffield, Newcastle and Shropshire.

Some agencies do not have regular sessions at the centre but accept referrals as required. These include Leicester City Council's resettlement and substance misuse tenancy support team, a specialist homeless mental health team, and a psychologist employed by the local NHS Trust. The psychologist works directly with clients, and also provides training for the centre staff and helps them construct clients' care-plans. The centre staff also liaise with the Probation Service, as many clients have a criminal history.

A multi-disciplinary team meeting is held every Tuesday at a nearby day centre, and is attended by staff from the Anchor Centre, hostel managers, health care staff, and staff of other agencies in Leicester that work with homeless people. The wet centre has its own team meeting every Wednesday morning to discuss the progress of clients and issues that have arisen.

#### *Services and activities*

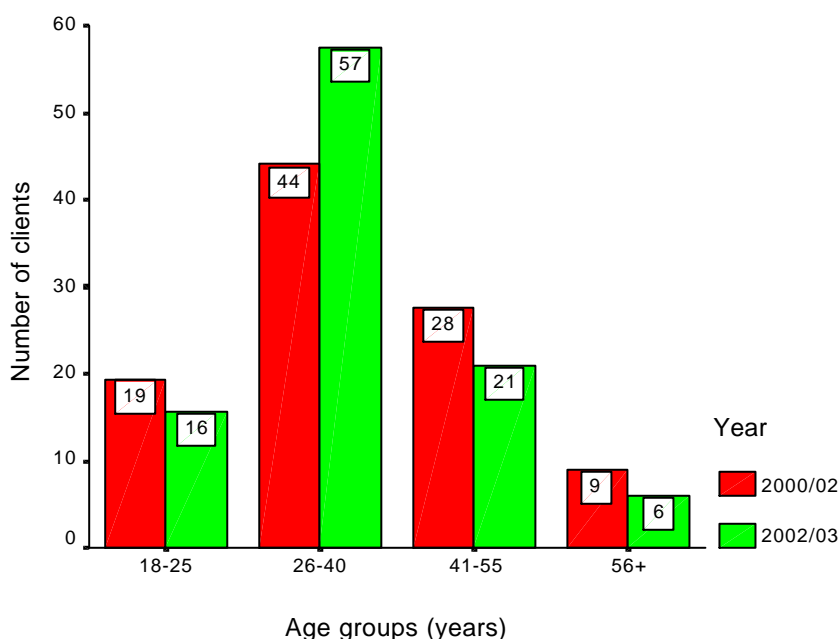
Snacks such as rolls and cereals are provided at the centre for a nominal charge. There used to be a cooked meal at midday but there was little demand. There are showers but no laundry facilities. The clients can launder at a day centre nearby. Other services offered to clients include help with sorting social security benefits, assistance with finding housing, health care services, help with tackling alcohol and drug problems, and support with sustaining tenancies.

With funding from the Department for Education and Skills, an external organisation, REMIT, runs a weekly women's group, computer sessions and a twice weekly art group at the centre. The day centre workers organise board games and quizzes. The staff are keen to have more activities at the centre.

#### *The clients*

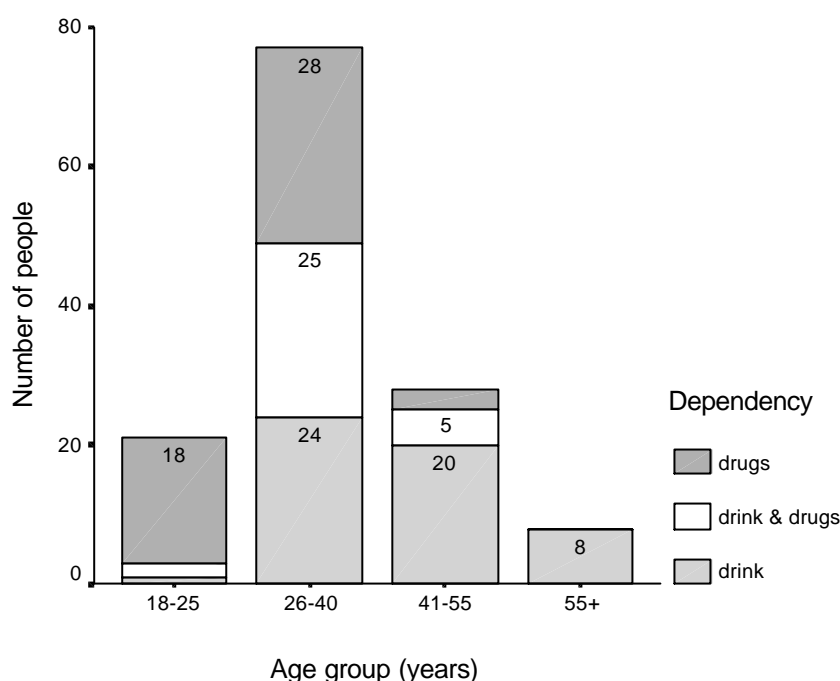
Between April 2002 and March 2003, 134 clients with alcohol or drug problems who are on the caseload of a project worker used the wet centre. This count does not include clients who attend the drop-in centre only casually. As shown in Figure R4.1, there has been a slight change in the ages of the clients since it opened. Fewer attenders now than two years ago are over the age of 40, while more are aged 26-40 years. The number of very young clients (18-25 years) has also fallen. In 2002/03, 23% of the clients were women and just 11% from minority ethnic groups. 38% were in tenancies, 18% were in hostels, and most others were classified as 'no fixed abode'. Only one person was currently sleeping rough, although 32 clients had slept rough at some time during the previous 12 months.

**Figure R4.1** Ages of the clients, Anchor Centre, Leicester



Among the 134 wet centre caseload clients, 39% had alcohol dependency problems, 37% drug problems, and 24% were dependent on both alcohol and drugs. Among the 81 drug users, heroin was the most common drug used (67%) although many alternated with crack and some with alcohol. Drug problems were characteristic of the younger clients, while alcohol dependency was the main problem for the older age groups. Those aged 26-40 years were the group most likely to be polyusers (Figure R4.2).

Figure R4.2 Substance dependency problems by age



#### Performance and outcomes

At the Anchor Centre, performance and outcome targets were set for the year 2002/03 which included: (i) providing case-work to 60 clients, of whom 30 were to be drug users; (ii) improving the health and well-being of 17 service users and thereby making an impact on their life expectancies; (iii) ensuring that 60% of service users reduce their alcohol consumption and 60% control or reduce their drug use; (iv) enabling 15 service users to retain their tenancy or achieve housing stability for at least three months; (v) assisting 40 service users with rent arrears; and (vi) directing 75 users to housing services, and 85 to other statutory and voluntary services.

Information about the situation of clients who use alcohol or drugs is monitored by the staff in two ways: through observations by the staff and details gathered during assessment and key-working sessions, and through the use of *Christo Inventory for Substance Misuse Services* forms which are completed every three months by the key-workers and record information about the client in the previous month. Topics covered include: general health, social functioning, drug and alcohol use, criminal involvement, psychological state, support received, and compliance with services. The form is only completed with people who currently attend the centre, and therefore does not identify the number of people who have been helped and have stopped attending.

From April 2002 to March 2003, the centre worked with 53 alcohol dependent clients, 49 drug users, and 32 people who had both alcohol and drug problems. Information was available about the drinking habits of 76 clients. As shown in Table R4.1, there was no change for one-quarter of the clients, seven-tenths had periods of reduction or abstinence, and only a minority appeared to have increased their alcohol consumption. Nearly one-quarter accessed alcohol services, ten clients attended detoxification programmes although only one has remained

abstinent, and three were accepted for a residential rehabilitation programme. Of the latter, one died before entry, one failed on the first day, and one did not attend although she has remained abstinent. 45% of the clients still drank on the streets at times, mostly when the centre was closed, during hot weather, or if they had been barred from the centre.

**Table R4.1 Drinking habits and access to alcohol treatment services, 2002/03**

<b>Characteristic</b>	<b>Number</b>	<b>%</b>
Drinking habit:		
periods of abstinence	12	16
periods of reduction	41	54
no change	20	26
increased drinking	3	4
Treatment:		
uses alcohol services	18	24
detoxification service	10	13
Number of clients	76	

**Table R4.2 Service referrals by Anchor Centre workers, 2002/03**

<b>Agency</b>	<b>Number</b>
Emergency accommodation	36
Other hostels	35
Outreach services	49
Housing Options	40
Local authority substance misuse support team	20
Other support teams	11
Alcohol services	7
Drug services	9

The number of clients referred to other services during the 12 months ending March 2003 is shown in Table R4.2. This relates only to referrals made by the wet centre staff and does not include those made by other local agencies. Many clients were referred to housing and tenancy support services, while direct referrals to substance misuse services were few. The latter are often made, however, by the healthcare team or by hostels or support services once a client is engaged.

During 2002/03, 24 clients were resettled. There were also 16 failed tenancies, nine within 12 months. Reasons for tenancy failures included rent arrears and eviction or abandonment, eviction for anti-social behaviour, and loss of tenancy when taken into custody. Some clients were



not ready for resettlement, some required high support accommodation, and several failed to engage with their support workers.

#### *Local community relations*

The Anchor Centre is in a side street near the city centre, next door to a theatre, and opposite a block of flats owned by a housing association. In front of the flats is an area of grass where the clients sometimes sit. There is a public house opposite and another at the end of the street. The city centre has a ban on street drinking in public places, and the restriction area includes the Anchor Centre. At times, the local police and community safety officers move people on when they congregate on the grass opposite the centre, but they return after a while. According to the outreach workers, most street drinkers use the wet centre.

There have been several complaints from local residents and the theatre about the behaviour of the clients and about loitering on the grass (which local residents find intimidating), and empty beer cans and bottles left on the street. The staff do not believe that all the complaints are justified, as some discarded cans and bottles are for types of alcohol that the clients do not drink. Nevertheless the staff have responded to the problems. The centre's closing time previously coincided with the opening of the theatre and has been changed, and the council gave funds to the theatre to install CCTV cameras and shutters outside (drinkers used to sit on some entrance steps). The street cleansing team now clean the area around the centre twice weekly instead of once a week, and the centre staff clean up if, for example, a client urinates on the theatre steps. Meetings every three months are held with the local housing manager, a representative from the tenants' association, the theatre manager, the city council and the wet centre manager, but some local people feel that not enough is being done.

#### **Booth Centre, Manchester**

The Booth Centre in Manchester is open Monday to Friday between 9 a.m. and 3 p.m. On Tuesday and Thursday mornings drop-in sessions are held and the wet garden is open from 9 a.m. to 12.30 p.m. There are also drop-in sessions for people aged 50+ years on Wednesday afternoons. During the rest of the week, there are group activities which anyone is welcome to attend. The centre is small, has just one room for the clients with a small kitchen area, a toilet, an office, and an adjacent wet garden. It is bright and has numerous photographs around the walls of clients engaged in activities. Manchester Cathedral owns the building, does not charge rent, and pays for the utilities.

Alcohol is not permitted in the centre but can be consumed in the garden during the Tuesday and Thursday drop-in sessions. The garden was set up to safeguard and extend the centre's work with street drinkers (see Chapter R3), and is a supervised setting where people can drink and receive support, advice and encouragement to engage in activities so as to reduce their drinking and improve their health. Staff are always in the garden when it is open. There is no restriction on the amount of alcohol brought into the garden, but no glass bottles are allowed.

### *Funding*

The centre receives funding from the Homelessness Directorate (through Manchester City Council), The Community Fund, Central Manchester Primary Care Trust, and various charities. The North Manchester Primary Care Trust funds a worker for the wet garden. The various funding sources are time-limited and there are difficulties in securing money.

### *Core staff and their roles*

The centre has a manager, two project workers, four sessional activity workers *e.g.* art teacher and photographer, and about 30 volunteers. One-half of the volunteers are clients who are participating in a Supported Volunteering Project (described below). They work at the centre one session a week, but not at the drop-in sessions. One of the project workers is a move-on activities worker and is responsible for helping the clients to access education, training and work schemes. The other is a volunteer co-ordinator and is responsible for the recruitment, induction, training and supervision of the volunteers. There is a low turnover of paid workers and volunteers.

Using volunteers is not a cheap option as it takes time and resources to provide the support, training and supervision that they need. The staff believe, however, that volunteers have an important role at the centre which cannot be provided by paid workers. The clients are aware that the volunteers choose to help them and are not paid, and during the drop-in sessions the clients have someone to engage in general conversation and to talk to about how they are feeling. This can increase self-esteem and motivation, and reduce friction and aggression. It also helps to create an environment where the views and contributions of users are valued.

### *Links to specialist agencies*

According to the centre manager, it took a long time to involve specialist agencies at the Booth Centre, but now several provide input, particularly during the drop-in sessions. There are weekly visits by a community psychiatric nurse from the Homeless Mental Health Team, and a health linkworker from the Homeless Advocacy Project. The latter is a member of the primary health care team based at a nearby GP surgery for homeless people, and the linkworker's role is to encourage clients to register with the GP and to keep appointments with health and allied workers. The nurses sometimes use the Booth Centre as a facility where they can contact clients and, for example, administer treatments.

A social services care manager from the local authority drug and alcohol team visits each Tuesday. His role is to undertake community care assessments for clients who wish to access alcohol rehabilitation services, and to assess the needs of those who have tenancies and arrange for services such as home care, meals-on-wheels, aids and adaptations, and tenancy support workers. There are weekly visits by a drugs worker from Turning Point, and by a worker from Manchester Drugs Service Team who can arrange methadone scripts. Arrangements are also in place with Turning Point for clients to be admitted to its alcohol detoxification beds.

The street outreach team, Counted In, visits the centre most days to make contact with rough sleepers. Specialist drug, alcohol and mental health workers are in the team. Two staff from the local authority housing department also have weekly sessions at the centre. The staff attend Case Intervention Group meetings as part of the Crime and Disorder Strategy.

### *Services and activities*

The Booth Centre provides a free cooked meal on Mondays, Wednesdays and Fridays for clients who have attended the morning activities, and beverages and sandwiches at other times. Fresh fruit is given out daily, and toiletries and socks are provided. There are no showers, but there is a day centre at Salford Roman Catholic Cathedral (about 15 minutes walk away) where the clients can have showers. Advice and help is given with sorting out social security benefits, accessing housing, health and other services, tackling alcohol and drug problems, and with sustaining tenancies. Home visits are occasionally carried out by the staff, but most of the tenancy support work takes place at the centre. In September 2002, an Internet cafe was started in the centre, and clients use it to register online for council housing and to keep in contact with family and friends.

The Booth Centre has a strong focus on indoor and outdoor activities that are creative, therapeutic, challenging and enjoyable. The aims are to empower people to make informed choices, to provide them with positive experiences to help build self-respect and self-confidence, to enable them to structure their time positively and work together in groups, and to provide an alternative to drinking on the streets or alone in a tenancy. The long-term aim is to get the clients involved in education, training, employment, volunteer work or other activities outside the centre. The staff find that the clients use the activities as a way of controlling their alcohol intake: they are occupied and tired by physical exertion and delay drinking until late in the day when the activities finish.

The centre runs 10 week 'activity courses' which conclude with a presentation session at which the clients are awarded certificates for their achievements. Each client has a 'course work' folder or portfolio, which contains their certificates and other work. The activities are selected by the clients and include: art, computer courses, English and mathematics classes, cookery, carpentry, music, swimming, badminton, photography, pottery, bowling, golf, walking, canoeing, pony trekking, tending the wet garden and the centre's two allotments, and conservation work in parks and forests. Among the street drinkers, the most popular activities are art, English and maths classes, fishing, gardening and decorating.

A Supported Volunteering Project has been in operation since 2001, whereby clients work as volunteers at the centre one session a week. This enables them to experience volunteering in a safe environment, and to gain confidence and new skills. They receive induction training, and attend team-building weekends with the staff and various in-house courses, such as food hygiene, health and safety, first aid, and customer care. Clients are also helped to move on to education,

training and voluntary work in the community, and four part-time jobs have been created by the Cathedral which provide a first step into employment for people who have not worked for years.

#### *The clients*

Between April 2002 and March 2003, 176 people attended activity sessions at the Booth Centre, and each week 120 people used the drop-in sessions and 50 used the wet garden. Most clients were men (92%), 23% were rough sleepers, 19% lived in hostels or squats, and 47% had tenancies. Most were aged 26-35 years (33%) or 36-55 years (43%). Just 9% were aged 25 years or under, and 15% aged 55 years or over. Most had alcohol or drug problems, and several also had mental health problems. Some alternate between drugs and drink when they are trying to reduce their drug use or are unable to afford drugs. 37% of the activity attenders were street drinkers.

Between April to June 2003, 72 clients attended activity sessions at the centre. Of these, 35% were rough sleepers and 58% were street drinkers. Among those who worked as volunteers at the Booth Centre during this period, seven were street drinkers.

#### *Performance and outcomes*

Information is recorded about the work that is carried out with clients and the activities in which they participate, and quarterly reports are prepared of performance and outcomes. In addition, monitoring sheets record the type of help or advice that is given by staff each day to vulnerable clients who have tenancies. Table R4.3 shows the number of clients that were linked into housing, health care and other services over two periods: April 2002 to March 2003, and April to June 2003. During the 12 months ending March 2003, 452 activity sessions were held for the clients.

**Table R4.3 Help given to the clients at Booth Centre, 2002-03**

Help given	12 months <sup>1</sup>	3 months <sup>2</sup>
	Number	Number
People moved into temporary accommodation	52	4
People moved to permanent / supported accommodation	20	26
Rough sleepers referred to outreach team	49	11
New GP registrations	59	15
Newly referred to other health services	49	6
Birth certificates obtained	72	13
Referred for alcohol detox	22	9
Participated in Supported Volunteering Programme	23	12
Started education, training, employment or voluntary work	21	7

*Notes:* 1. April 2002 to March 2003. 2. April to June 2003.

### *Local community relations*

The shopping centre in central Manchester is one of the largest in the country, and the inter-mixed financial, commercial, professional and governmental offices are also an important element of the city's economy. Street drinking and anti-social behaviour have been problems in the past. The reconstruction of the northern end of Market Street following the devastating 1996 IRA bomb was co-ordinated by a 'City Centre Task Force', and the redesign included the largest Marks and Spencers in the world and a new Shambles Square with the Tudor-style wood frame Wellington Inn is 100 yards away from the Cathedral (see [www.manchester2002-uk.com/buildings/bombing.html](http://www.manchester2002-uk.com/buildings/bombing.html)).

The Booth Centre is accommodated in an annex of Manchester Cathedral and is surrounded by grass banks. The cathedral is a tourist attraction and particularly during the summer, many people sit on the grass banks. Street behaviour which intimidates or upsets shoppers and tourists and could lead to the decreased attractiveness of the rebuilt shopping areas close to the Cathedral therefore produces quick censorious reactions. There has been a ban on street drinking in the city centre since 1998 when byelaws were introduced, and the area around Manchester Cathedral is included in the ban. Even before the reconstruction the police established a Homeless and Begging Unit in 1995 to tackle the large number of beggars in the city centre.

According to the outreach workers, the street drinking ban has dispersed many street drinkers beyond the city centre where the ban ends, and there are now two clusters of street drinkers. One group congregates to the north around Manchester Cathedral and Victoria Station and they tend to use the Booth Centre. The other to the south is around Oxford Road and they do not use the Booth Centre. According to the police and the outreach workers, many drinkers linger on the grass banks around Manchester Cathedral and the Booth Centre, and some sleep there at night. The problem worsened since an off-licence opened in the area, and there have been complaints of intimidation and violence from local businesses and other people. A hotel facing the Cathedral has alleged that the problem is affecting their business. The centre staff work closely with the police, the street wardens, local businesses and the Cathedral managers to address the problem, which is not entirely associated with the centre users. The police believe however that the centre is too close to the shopping centre and to the cathedral.

### **Handel Street Centre, Nottingham**

The Handel Street Centre in Nottingham is part of *Framework Housing Association's* Handel Street Alcohol Support Project and Albion Supported Housing scheme (HASP/ASH). The project comprises the wet centre at Handel Street, Sneinton Hermitage (a ten-bed alcohol treatment project for people who want to control or reduce their drinking), and seven shared houses which accommodate 17 people with alcohol, drugs or mental health problems.

The wet centre is open seven days a week. On Mondays, Fridays, Saturdays and Sundays it is open from 9.30 a.m. to 4 p.m.; and on Tuesdays, Wednesdays and Thursdays from 9.30 a.m.

to 3 p.m. there are drop-in sessions, and from 3 p.m. to 4.30 p.m. activity sessions. The centre is small and on just the ground floor. It has a day room with adjoining kitchen, a wet room, unisex showers and toilets, a small staff office at the front of the building with adjoining laundry facilities, and two rooms which are used as a clinic by the medical team and at other times as offices. Entry to the centre is electronically monitored and controlled from the staff office. The wet room was a meat store for the market and is dismal. It has benches around three walls, windows high up on one wall, and a drain grid in the centre of the room. The building is owned by the council. The staff acknowledge that it is not ideal and is too small, and new premises are being sought.

Up to 25 clients are allowed in the centre at any given time. Alcohol can only be consumed in the wet room, and there is no restriction on the amount that can be brought into the centre. The centre targets people with alcohol problems and rough sleepers with substance misuse problems, and refers other attenders to alternative services. New clients are assessed by the manager of Sneinton Hermitage (an alcohol and drug liaison nurse) to determine the extent of their substance misuse problem.

#### *Funding*

The centre's funding is mainly from the City Council. Some time-limited funding has been obtained from the Homelessness Directorate. The centre staff also undertake tenancy support for 35-40 clients, and so receive funding from 'Supporting People'.

#### *Core staff and their roles*

The core staff team are a manager, two deputy managers, 12 supported housing workers, 1.5 cooks, and 1.5 cleaners. According to the manager, there was a high turnover of staff until about three years ago. Tenancy support services were then introduced, whereby the staff work three days a week at the wet centre and two days supporting clients in their tenancies. This meant that the staff team has increased, and therefore the number of weekends that staff have to work has reduced. In the past, the centre had occasionally to close when there was not enough staff to cover holidays and sickness. One-half of the current staff team are former volunteers at the centre.

Most staff are involved in both day centre and tenancy support work. There is no keyworking system in operation for the wet centre users, but the staff assess the needs of new clients and make referrals accordingly. They also have a caseload of tenancy support clients some of whom are former users. The staff are encouraged to develop skills in one aspect of the day centre work, such as welfare rights or mental health issues. One worker is the activities co-ordinator and does not do tenancy support. Street outreach work is carried out by the city's Contact and Assessment Team and not by the wet centre staff. Both the outreach team and the wet centre staff are involved in resettling the clients.

### *Links to specialist agencies*

Three nurses from the Nottingham Health Team for Homeless People have drop-in clinics at the wet centre on Mondays and Thursdays, and a needle-exchange service is run by The Health Shop (Primary Care Trust) twice weekly. The Mental Health Support Team run sessions twice weekly at the centre, and for the past six months a GP has held a surgery at the centre on Mondays and provides methadone treatment for drug users. When the patients are assessed, treatment has begun, and confidence is established, they are encouraged to attend the nearby Windmill Health Centre. The street outreach team visits Handel Street several times a week to make contact with rough sleepers.

The centre has close links with Sneinton Hermitage (described earlier) and is thus able to offer prompt treatment for alcohol and drug problems. One bed at the project is reserved for people who enter detoxification, while the other nine are for those who want to abstain, control or reduce their drinking. The manager of Sneinton Hermitage visits the wet centre weekly to assess the needs of new clients, and to offer help to all users. Clients requesting detoxification can be admitted to Sneinton Hermitage within two to three weeks, and the project staff also undertake home detoxification with some people. Approximately four-fifths of people admitted to Sneinton Hermitage have had links with the wet centre. In the near future, the manager of Sneinton Hermitage will be running a clinic at the wet centre to administer Pabrinex. Pabrinex is concentrated Vitamin B1 (thiamine) which is given to heavy drinkers, particularly during withdrawal from alcohol, to prevent Wernicke Korsakoff Syndrome (brain damage caused by lack of thiamine).

### *Services and activities*

A free breakfast and dinner are provided, and the clients have access to showers, clothing and laundry facilities. Other services offered to clients include help with sorting out social security benefits, assistance to access health and other services, help with tackling alcohol and drug problems, resettlement and tenancy support.

Various activities for the clients are arranged by the staff, including a weekly cookery class with a certificate on completion, canal-side walks, and trips to the museums, ice skating rink, and bowling alley. Other activities have included arts and crafts, canoeing, abseiling, and a 10-week course on playing drums. The staff find that the clients are more relaxed and prepared to talk when they are on excursions.

### *The clients*

Very few statistics are recorded about the clients, the help that they receive at the wet centre, or the outcomes. In 2002/03, the target was that 700 clients would use the wet centre. The actual number of attenders during this period was 823. Of these, 379 had slept rough at some time. During the year, 122 alcohol and drug assessments were carried out by the manager of Sneinton Hermitage with the clients, 163 resettlement interviews were undertaken with them, and 252

clients attended educational and social sessions (36 were held during the year). Four clients received certificates at the end of their cooking course. Little other information is currently available, but the staff are in the process of setting up a database to record details of the clients.

#### *Local community relations*

The Handel Street Centre is about 10-15 minutes walk from the city centre in a former retail market area and surrounded by car-parks, business premises and warehouses. Three hostels and the Emmanuel Day Centre for homeless people are nearby, but there are few local residents. One public house opposite the centre is boarded up, but another trades further down the street. There is a ban on street drinking in the city centre and the wet centre is on the edge of the zone. Most street drinkers in the city use the centre.

There have been relatively few complaints from local people or the market management about the wet centre, and the police have very little contact with it. According to some workers who have been involved with the centre for some time, there were complaints in the early days but these have declined. Just one local property freeholder still voices concern. The police (and the local media) are now more preoccupied with begging in the city centre than street drinking.

#### **Summary**

There are similarities and differences among the four wet centres described in this chapter. The services that they provide and their rules around the use of alcohol at the projects differ, as do their staffing arrangements and funding. At the London and Leicester centres, some staff are involved in front-line work and the day-to-day running of the project, while others are engaged in case-work. In Nottingham, the staff undertake both of these roles and tenancy support, while in Manchester volunteers play a key role. Most centres work closely with specialist agencies that provide sessional services, and all recognise the importance of these inputs. Apart from the London centre where staff do street outreach work, the others rely on established street outreach teams for referrals of new clients.

One common feature is the mixed profile of the client group. They all work with a large number of street drinkers and other needy groups, such as drug users, ex-offenders and sex-workers. The majority of the clients are men aged in their thirties and forties. The work that is carried out with them varies. The Anchor Centre provides a large amount of casework, while at the Booth Centre much of the work focuses around activities. The record-keeping and monitoring of the help that is given also varies, and not all centres can easily demonstrate their achievements with clients. Although the centres have been running for some time, most still experience intermittent problems with the local community.



## R5

### Wet centre clients

Face-to-face interviews with semi-structured questionnaires were conducted with 101 wet centre clients. Of these, 26 were at the Anchor Centre in Leicester, and 25 each at the Booth Centre in Manchester, Handel Street Centre in Nottingham, and Tollington Way in north London. This chapter summarises the subjects' problems, the help that they have received, and their opinions of wet centres. There are differences by centre at which the subjects were interviewed, but there should be caution in their interpretation. The clients were selected for interview using convenience samples, *i.e.* they attended the centre during the period when the research was conducted, and they agreed to be interviewed. Clients who use the centres only occasionally are less likely to be represented. In addition, only a small number of attenders at each centre were interviewed, and the information has been provided only by the clients and not corroborated by the staff. Some clients with serious alcohol and mental health problems, for example, may not recognise problems or recollect the help that they have received.

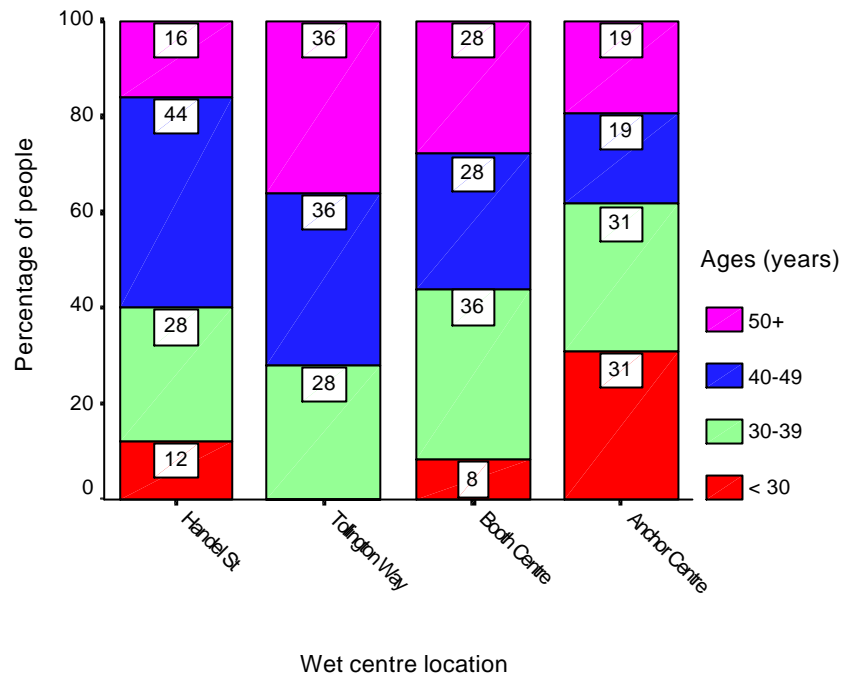
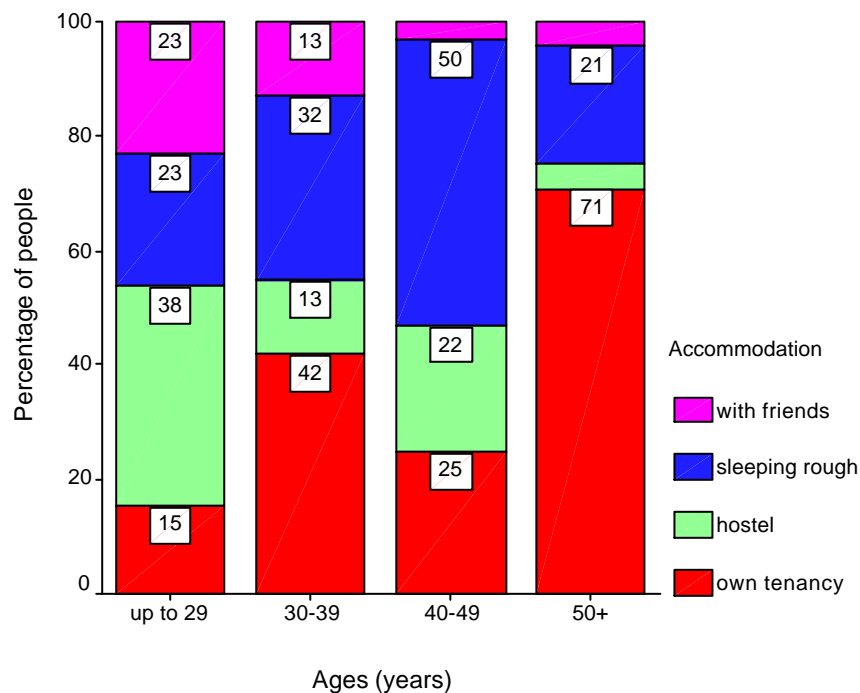
#### **The subjects' characteristics**

The majority of interviewees were with men (86). Attempts were made to include women wherever possible, and 15 were interviewed. Among the 101 participants, 62% were aged in their thirties or forties, 20% were in their fifties, 13% were aged under 30 years and just 5% aged 60 years or over. There were age differences among the centres (Figure R5.1). The London interviewees tended to be older (72% were aged 40+ years and none were less than 30). In comparison, just 38% of those interviewed at the Leicester centre were aged 40+ years, and almost one-third were less than 30. This reflects however the overall age profile of the users at the two centres.

As to ethnic group, 60% of the clients were English, 12% were Scottish, and 3% were Welsh. 11% were Irish and 14% were from other minority ethnic groups. A slightly lower proportion (48%) of the London subjects were English and a slightly higher proportion were Irish (16%), but there were no other clear differences.

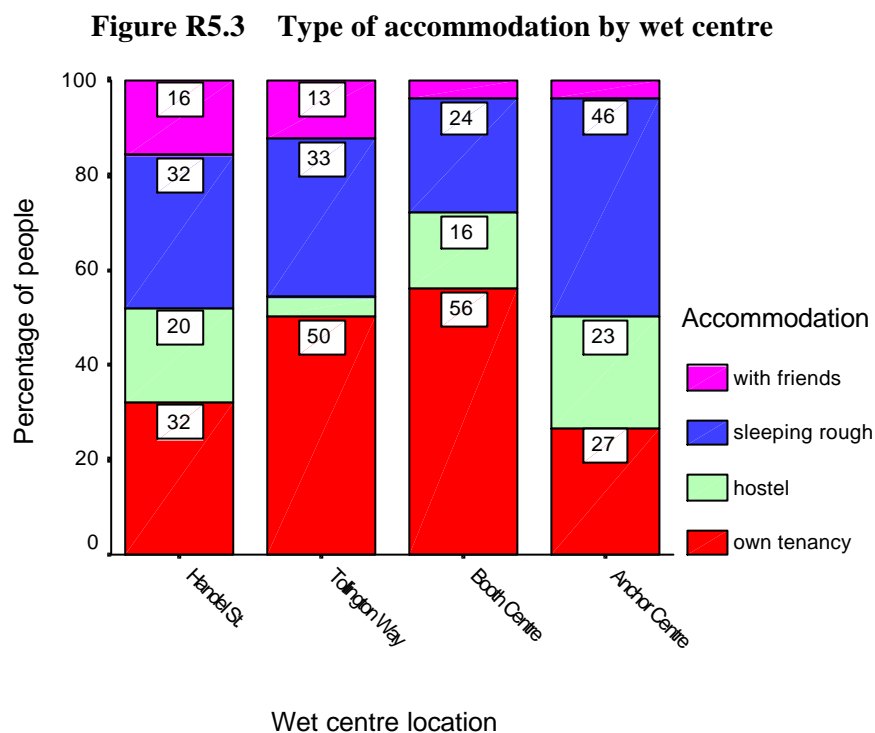
#### *Current accommodation*

The clients' housing circumstances varied. At the time of interview, 34% were sleeping rough, 17% were in a hostel or night-shelter, 9% were staying with friends, and 40% had their own tenancy. The older clients were more likely than the younger to have a tenancy. 71% of those aged over 50 years were housed compared to 15% of those less than 30 years of age. One-half of those aged in their forties were sleeping rough, while those aged in the twenties were most likely to be staying in hostels (Figure R5.2). Other studies have noted that a high proportion of older attenders at homeless people's day centres have a tenancy (Crane and Warnes, 2001).

**Figure R5.1 Age groups of attenders by wet centre****Figure R5.2 Type of accommodation of attenders by age group**

The subjects' housing circumstances differed at the four centres. One-half in London and Manchester were in permanent accommodation, reflecting the overall profile of the users at these two centres. In comparison, just under one-third at the other centres had their own tenancy (Figure R5.3). Nearly one-half of those in Leicester claimed to be sleeping rough, compared to

one-third in Nottingham and London, and one-quarter in Manchester. (According to the manager of the Anchor Centre in Leicester, some clients claim to be rough sleepers although they are staying with friends). Several in Nottingham and a few in London were staying with friends. Very few at Tollington Way were staying in hostels, which probably reflects the lack of hostel provision in this inner-suburban London area.



The reasons why a higher proportion of clients at the centres in London and Manchester are housed are unclear. Tollington Way in north London was established to work with *local* street drinkers, and many of this group are not homeless. The centre is about four miles from central London where rough sleepers congregate and there are many hostels and day centres for homeless people. Many heavy drinkers in central London would find it too far to walk to Tollington Way, and fares on public transport are high (particularly for those of working age). The Booth Centre in Manchester has many activity sessions, and it may be that clients who are motivated to participate in activities are also more likely to be resettled and to sustain tenancies.

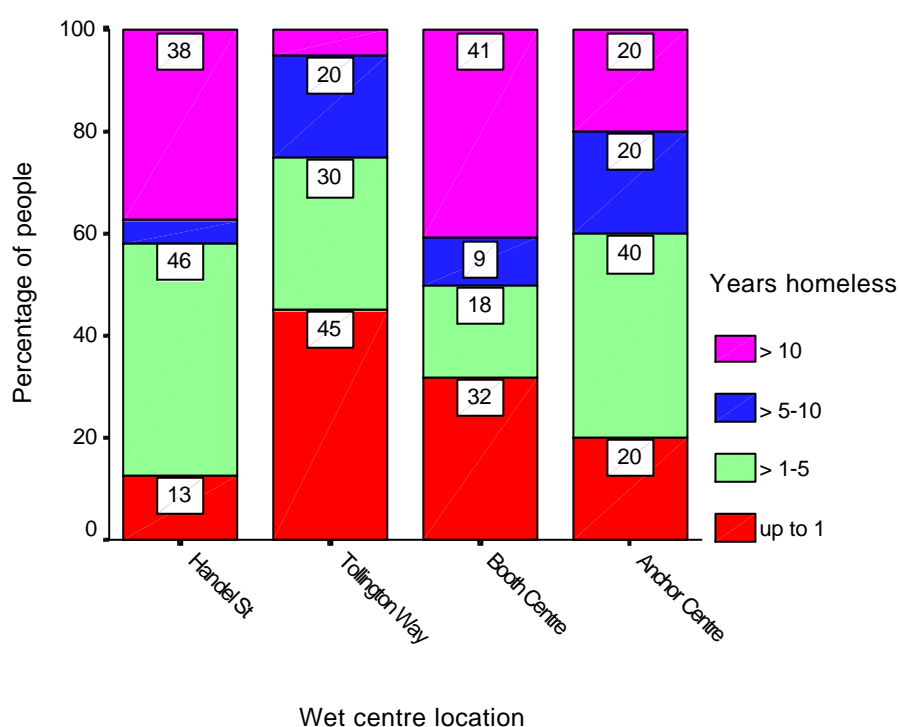
There may also be a connection between resettlement, tenancy support and the use of wet centres (or other day centres for homeless people). At the Booth Centre, 26 clients were rehoused between April and June 2003. The staff at Booth Centre do not normally provide tenancy support to clients at home, so some may have continued to use the centre for support. On the other hand, the staff at Handel Street in Nottingham work with many housed clients through their tenancy support service at home: only one-third of the interviewees at the centre were in permanent accommodation. It may be that if support is provided at home to resettled clients it reduces their need to attend day centres. This would require further investigation.

### *Histories of homelessness*

Nearly all the subjects (97%) had been homeless at some time, and many had long histories of homelessness. 40% had been homeless for more than five years, including 26% for more than ten years. The distribution of homeless durations differed greatly by centre (Figure R5.4). Nearly one-half of the interviewees in London had been homeless for less than one year, and only a small minority had been homeless for more than 10 years. In contrast, only a few in Nottingham and Leicester had short histories of homelessness, while two-fifths of those in Nottingham and Manchester had been homeless for more than 10 years.

The reasons for the differences are unclear. As mentioned in the previous section, Tollington Way in London is away from the ‘homeless circuit’ and may not be attracting entrenched homeless people. The variations may also reflect the effectiveness of services in a city in quickly identifying and helping homeless people. Housing factors may also be an important element, with housing opportunities for homeless people being more available in Leicester than in Nottingham and Manchester.

**Figure R5.4 Duration of homelessness by wet centre**



### **Health and substance misuse problems and treatment**

#### *Physical health problems*

Among the 101 interviewees, 90% reported one or more physical health problems. Two-fifths rated their health as poor, and a similar proportion reported being very worried about their health. Respiratory and gastric problems were common, as were seizures due to alcohol use, and

numbness and trembling in the arms and legs (Table R5.1). One-half associated their illnesses with heavy drinking. Those in the younger age groups were just as likely as the older subjects to report physical health problems.

81% of the subjects were registered with a GP, and most had seen their GP within the previous six months. 19% were unregistered (varying from 28% in London to 8% in Nottingham). One reason for the difference is likely to be the lack of input from primary health care services at Tollington Way. Most subjects who did not have a GP had not tried to register. Many of this group used hospital A&E departments for medical care.

**Table R5.1 Self-reports of physical health problems**

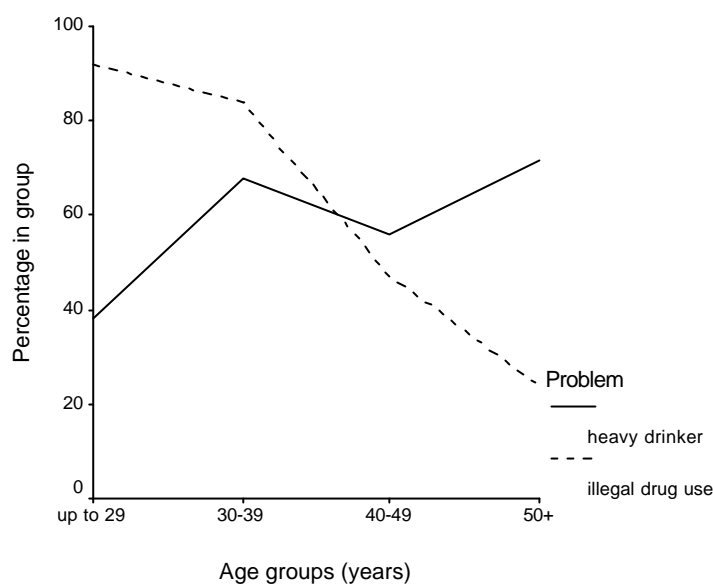
<b>Problem</b>	<b>%</b>
Breathing / respiratory problems	54
Heart / circulation problems	32
Gastric problems	47
Numbness / trembling in arms / legs	63
Liver / kidney problems	25
Epilepsy	6
Seizures due to alcohol (not epilepsy)	44
Other health problems	50
<i>Number of subjects</i>	<i>101</i>

#### *Mental health problems*

A high proportion (84%) of the subjects reported being depressed and low in mood. In addition, one-half described other mental health problems including a psychotic illness (10%) and anxiety and panic attacks (22%). Only one-quarter said that they were having treatment for their problems, mainly through their GP. Just 8% said that they were receiving treatment for mental health problems at a psychiatric clinic or through a specialist mental health team.

#### *Use of alcohol*

At the time of interview, 85% of the subjects reported that they currently drank alcohol and 93% admitted to drinking during the past 12 months. Hence, a few were in respite when they were interviewed. 62% said that they had drunk alcohol most days in the previous 12 months, 5% had drunk heavily two or three times each week, and 12% had been binge drinkers with periods of heavy drinking and abstinence. The older interviewees were most likely to report drinking most days: this applied to 38% aged in their twenties compared to 72% aged over 50 years (Figure R5.5). Similar differences between age and heavy drinking among homeless people have been reported elsewhere (Crane and Warnes, 2001).

**Figure R5.5 Heavy drinking<sup>1</sup> and illegal drug use by age groups**

Note: 1. Drinks most days.

One-third admitted to being very worried about their alcohol consumption, and almost three-fifths said that they sometimes spent money on alcohol instead of buying food and paying bills. For many, alcohol had had a negative impact on their lives. It has caused or contributed to marital and relationship breakdowns, loss of tenancies and jobs, affected relationships with children and other relatives, and resulted in loss of self-esteem, motivation and confidence (Table R5.2). More than two-fifths had been arrested by the police during the previous 12 months for offences related to alcohol.

**Table R5.2 Problems caused through heavy drinking**

<b>Problem</b>	<b>%</b>
Loss of a tenancy <sup>1</sup>	39
Problems at work / loss of a job	40
Marital / relationship breakdown	54
Affected relationship with children / other relatives	49
Ill-health	50
Loss of self-esteem, confidence and motivation	35
Arrested by police in last 12 months <sup>2</sup>	42
<i>Number of subjects</i>	<i>101</i>

Notes: 1. Through rent arrears, disturbing neighbours, or an inability to cope.

2. For drunk and disorderly conduct (25%), or for shoplifting (12%).

The majority of the interviewees (77%) continued to drink alcohol on the streets and in parks, with 55% drinking outside most days, and 7% said they drank in public places at least twice a week. Most in Nottingham reported drinking on the streets (92%), compared to 84% in Manchester, 68% in London, and just 58% in Leicester. One-half had been drinking outside for more than five years, and for some the habit dated back more than ten years. Only a small proportion (12%) drank alone; most congregated in small groups with other drinkers. In London, however, one-quarter said that they drank alone in public places.

Just over one-third (36%) said that they had received help from the wet centre staff or from other agencies with their alcohol problems but there was considerable variation: from 60% in Nottingham, to 48% in Manchester, and just 20% in Leicester and London. 15% had been in a detoxification unit and a similar proportion had received individual counselling or group therapy. The figures have to be treated cautiously as many clients who are referred to alcohol services are unlikely to continue to attend the wet centres. Those seeking to abstain or reduce their drinking are more likely to succeed if they break away from the street drinking culture and from their peers at wet centres.

#### *Use of illegal drugs*

Three-fifths of the subjects used illegal drugs, and 31% were poly-drug users. The use of illegal drugs declined with age (as reported in other studies, see Crane and Warnes, 2001). 92% aged in their twenties took drugs, compared to 84% aged 30-39 years, 47% aged 40-49, and 24% aged 50+ years (Figure R5.5). One-fifth were receiving help from a specialist drugs agency.

#### *Dual problems and differences in problems by centres*

Many subjects had combined mental health and alcohol problems (38%), or combined drug and alcohol problems (46%). Almost one-quarter had all three problems. There were age differences (Table R5.3). Similar proportions in all age groups had both mental health and alcohol problems, but the younger subjects and particularly those aged 30-39 years had the highest prevalence (74%) of combined drug and alcohol problems. Nearly two-fifths of those below the age of 30 years, but only 8% over the age of 50, had all three problems.

**Table R5.3 Health and substance misuse problems by age groups (%)**

Problem	Age group (years)				Total
	Up to 29	30-39	40-49	50+	
Mental health & alcohol <sup>1</sup>	38	39	41	32	38
Drugs & alcohol <sup>1</sup>	54	74	38	20	45
Mental, alcohol <sup>1</sup> & drugs	38	32	19	8	26
<i>Number of subjects</i>	13	31	32	25	101

*Notes:* 1. Drinks most days, or heavily two or three times a week, or binge drinks.

The subjects' problems are different at the four centres (Table R5.4). Alcohol, mental health and drug problems were most prevalent among the Nottingham interviewees, and they also had the highest occurrence of dual and triple problems. Nearly one-half had combined alcohol, mental health and drug problems. In contrast, most subjects interviewed in Manchester had alcohol problems, but they were the group least likely to have mental health or drug problems, and only a small proportion had dual mental health and alcohol problems.

Fewer in Leicester and London reported alcohol problems compared to the other two cities, although many without a drink problem used drugs. In Leicester, this reflects the changing nature of the Anchor Centre with its increased responsibility since 2002 to provide a service to drug users (see chapter R4). The reason for the low prevalence in London is less evident. It suggests that the centre may be a resource for local people with any substance misuse problem.

**Table R5.4 Health and substance misuse problems by wet centre (%)**

<b>Problem</b>	<b>Handel St.</b>	<b>Tollington Way</b>	<b>Booth Centre</b>	<b>Anchor Centre</b>	<b>Total</b>
Physical health	96	84	88	92	90
Mental health	78	32	16	50	43
Alcohol <sup>1</sup>	100	67	96	58	79
Drugs	71	60	44	61	58
Mental health & alcohol <sup>1</sup>	72	24	12	42	38
Drugs & alcohol <sup>1</sup>	68	40	44	35	46
Mental, alcohol <sup>1</sup> & drugs	48	16	4	23	23
Arrested by police <sup>2</sup>	64	22	52	31	42
<i>Number of subjects</i>	25	25	25	26	101

*Notes:* 1. Drinks most days, or heavily two or three times a week, or binge drinks. 2. In last 12 months for offences related to alcohol (drunk and disorderly conduct, or shoplifting).

The Nottingham and Manchester interviewees were most likely to have been arrested by the police for alcohol-related offences in the previous 12 months (Table R5.4). Both these groups reported the highest prevalence of alcohol problems. It may also indicate police activity in the area and the extent to which street drinking is curbed.

### **Daily living activities**

Two-thirds of the subjects mentioned that they are in contact with at least one relative or family member, but only one-third sees the person at least once a month. Those who were housed were more likely to report family contact than those who were homeless (43% compared to 30% respectively).



Most subjects (88%) were receiving social security benefits. Among those who were not, two were waiting for their benefits to be sorted out while eight said that they could not be bothered to claim. Difficulties with budgeting were common. 72% said that they had problems ‘most of the time’ with managing their personal income, and 16% ‘occasionally’ had difficulties. Just 12% reported no budgeting problems. One-fifth received help with budgeting, from friends, relatives or workers. Those in Nottingham were most likely to receive help – this may reflect the dedicated tenancy support work that is carried out with clients (Table R5.5).

The subjects’ eating habits varied. Many (36%) described their appetite as ‘poor’, and only 46% had a cooked meal most days. 27% ate a meal only once a week or less. Those in Manchester were least likely regularly to have a cooked meal.

**Table R5.5 Daily living tasks, all subjects (%)**

Tasks and help	Handel St.	Tollington Way	Booth Centre	Anchor Centre	Total
Problems with budgeting:					
most of the time	76	68	76	69	72
occasionally	20	16	12	15	16
Receives help with budgeting <sup>1</sup>	40	16	8	15	20
Rates appetite as poor	52	20	36	35	36
Has meal less than twice a week	32	8	48	19	27
<i>Number of subjects</i>	25	25	25	26	101

Notes: 1. From friends, relatives or workers.

**Table R5.6 Daily living tasks, permanently housed subjects (number)**

Tasks and help	Handel St.	Tollington Way	Booth Centre	Anchor Centre	Total
Difficulty with household tasks <sup>1</sup>	5	6	2	4	17
Problems with bills	4	7	9	1	21
Has rent arrears / other debts	3	7	5	2	17
<b>Reported at least one problem</b>	<b>7</b>	<b>12</b>	<b>11</b>	<b>5</b>	<b>35</b>
Receives help at home with tasks <sup>2</sup>	6	10	4	5	19
Number of subjects	8	12	13	7	40

Notes: 1. With cooking, cleaning and laundry. 2. From friends, relatives or workers.

#### *Interviewees who had permanent housing*

Forty subjects had permanent housing when interviewed, and most were living alone. 34% had been in their accommodation for six months or less, while 29% had been so housed for more than five years. Many described problems with coping at home (Table R5.6). Twenty-one had

problems with paying bills, including 17 who had rent arrears or other debts. Seventeen described difficulties with managing household tasks such as cooking, cleaning and laundry. The subjects interviewed in Manchester were least likely to report having help at home with household tasks or with paying bills (although one person was helped with the latter by the centre).

### Use of wet centres and services received

Almost two-thirds of the interviewees (62%) used the wet centres at least four days a week, and many also used other centres (Table R5.7). One-quarter had been attending the wet centre for less than one year, while almost three-fifths had been attending for more than two years. The subjects at the Booth Centre were most likely to have used the centre for more than two years (72%), and just a small proportion were very recent attenders. Similarly in Nottingham, two-thirds had attended for more than two years. In contrast, only 40% at the Anchor Centre in Leicester had attended for this length of time.

Apart from the subjects interviewed in Leicester, many others had meals or snacks while at the wet centre. The centre in Leicester was the only one that charged for food, albeit a nominal amount, and it provided only rolls and no hot meals. These factors may have deterred some clients from eating at the centre. Where available, showers and laundry facilities were used by several clients, who tended to be rough sleepers. Very few who had tenancies or were in hostels used these services.

**Table R5.7 The subjects' use of the wet centres (%)**

Features of service	Handel Street	Tollington Way	Booth Centre	Anchor Centre	Total
Uses wet centre 4+ days / week	76	64	48	61	62
Uses other centres	68	80	72	77	74
Attendance at wet centre:					
less than one year	29	36	12	28	26
more than two years	67	54	72	40	58
Services used at wet centre					
showers	40	40	<i>n.a.</i>	46	32
laundry	60	32	<i>n.a.</i>	<i>n.a.</i>	27
meals or snacks <sup>1</sup>	64	60	76	38	59
Help from staff:					
with social security benefits	36	40	52	19	37
with housing problems	32	28	28	35	31
with sorting out bills / debts	12	8	16	8	11
emotional support	48	4	52	15	30
Number of subjects	25	25	25	26	101

Notes: n.a. not available. 1. 3+ times a week

The help that the subjects received from health care workers and specialist substance misuse teams has been noted earlier. They also received various types of assistance from the wet centre staff, most commonly with sorting out social security benefits and housing (Table R5.7). One-half in Nottingham and Manchester said that they received emotional support from the staff and were able to talk about their problems. This was rarely reported by the London interviewees. The difference does not reflect whether or not a centre has a key-working system, as only Leicester and Nottingham had it in place for some clients. One important factor may be that in Nottingham and Manchester the staff were involved in activities and outdoor pursuits with the clients. Many staff at these centres said that they had developed better rapport with clients while pursuing activities as the clients were more relaxed and willing to talk about their problems. This suggests that engaging with clients in this way is effective for some people with serious mental health and substance misuse problems and chaotic behaviour who may be wary of traditional case-work.

Information was obtained about changes in housing circumstances and alcohol consumption since attending the wet centre. It has to be remembered, however, that many clients who have experienced such changes will have stopped attending the centre. The following figures provide therefore only partial evidence of the extent to which wet centre users' circumstances have changed. More than one-third at the Booth Centre in Manchester had acquired permanent or temporary housing, as had slightly fewer at the centres in Leicester and Nottingham (Table R5.8). The loss of a tenancy was most commonly reported by the Leicester interviewees, and the overall statistics for the Anchor Centre showed that 16 tenancies had failed during 2002/03 (see chapter R4). Relatively few London interviewees described changes in their housing circumstances.

**Table R5.8 Changes in housing and alcohol consumption since attending wet centres (%)**

Characteristic	Handel St.	Tollington Way	Booth Centre	Anchor Centre	Total
Housing situation:					
Obtained temporary housing	8	4	16	12	10
Obtained permanent housing	16	8	20	15	15
Lost a tenancy	12	12	16	27	17
Alcohol consumption:					
reduced / more controlled	24	8	20	23	19
increased	24	8	16	12	15
Number of subjects	25	25	25	26	101

One-fifth of the subjects said that their drinking had reduced or was more controlled since attending the wet centre. Nearly as many, however, reported an increase in their alcohol consumption. As with their housing circumstances, relatively few London interviewees described changes in their drinking habits. These findings have to be interpreted carefully as they are only

the clients' estimation of their alcohol intake. According to several staff, some clients used alcohol as a substitute for drugs and their drinking increased as their drug habit reduced. The findings suggest however that wet centres do not intensify drinking among the users, contrary to the belief of many agencies and reports. For example, a health impact assessment of a proposed wet space in the grounds of a hostel in Exeter suggested that one of the negative impacts was that 'creating a group-drinking environment could lead to people drinking more because of sociable circumstances' (Health Forum, undated, p. 13). More comprehensive information is needed about the impact of wet centres on alcohol consumption before conclusions can be reached.

### The subjects' opinions of wet centres

Most subjects (84%) believed that wet centres are beneficial, and the most frequently cited reason was the social aspect (Table R5.9). Seven-tenths described the centres as a place where they can meet friends, socialise and overcome loneliness. 44% mentioned being able to drink on the premises as an advantage, and almost as many referred to the basic services that are provided. Just one-quarter believed that wet centres are useful in helping to sort out personal problems. One likely reason is that in many cases alcohol is used as a means to escape from personal difficulties. To overcome these problems it is necessary to distance oneself from a wet centre.

**Table R5.9 The subjects' opinions of the wet centres (%)**

Opinions	Handel Street	Tollington Way	Booth Centre	Anchor Centre	Total
Benefits of wet centre:					
allows drink / has few rules	76	48	20	31	44
basic services, e.g. meals	40	40	12	54	37
sort out personal problems	32	8	32	23	24
social contacts	72	72	64	73	70
Mentioned any benefit	92	92	64	88	84
Ways to improve wet centre:					
open longer hours	96	50	44	64	63
better facilities <sup>1</sup>	36	8	44	0	22
more basic services <sup>2</sup>	44	20	36	23	31
more personal help from staff	20	12	16	19	17
more help with housing	44	32	36	15	32
more activities	12	32	4	27	19
more staff control of clients	20	4	4	15	11
Number of subjects	25	25	25	26	101

Notes: 1. e.g. larger premises, better shower and toilet facilities. 2. e.g. more meals or drop-in sessions.

Various ways of improving the wet centres were proposed, and these differed by location. Almost two-thirds of the subjects believed that the centres should be open longer, and almost all at Handel Street in Nottingham had this opinion. The Nottingham and Manchester interviewees also believed that there should be better facilities, such as larger premises, showers and toilets, and more basic services, such as meals and drop-in sessions. Both these centres are small, and have restricted hours for drop-in sessions. Booth Street does not have showers, while the showers and toilets at Handel Street are unisex. Since the interviews were conducted, Handel Street Centre has extended its opening hours.

The subjects in Leicester and London suggested that there should be more activities at the wet centres. Both these centres have few activities, although the Anchor Centre is planning to increase this provision. Just 17% of the subjects were of the opinion that more personal help should be provided by the staff, although several in Leicester said that they would like to have counselling. This is consistent with the earlier observation that some clients prefer that the personal support from centre staff is through engagement in activities rather than formal case-work.

## **Summary**

This chapter has described the vulnerabilities and multiple problems of many people who attend wet centres. Most interviewees had physical health and alcohol problems, and many had dual or triple mental health, alcohol and drug problems. For many, alcohol contributed to the loss of tenancies and jobs, and to marital and family breakdown, and nearly all had been homeless at some time. Even among those who were housed when interviewed, most had problems with managing at home and several had rent arrears and debts. At the wet centres, they accessed basic services such as meals and showers, and received help from the centre staff and specialist workers with obtaining and sustaining housing, with sorting out bills and social security benefits, and with addressing health and substance misuse problems. Many used the wet centres several times a week, and three-quarters also used other centres. Despite their frequent attendance at various centres, several still said that they would like the wet centres to be open longer.

One-half continued to drink alcohol on the streets and in parks most days. According to the Anchor Centre staff, some clients drink on the streets only when the day centre is closed. Surveys by the local police and outreach workers indicate that drinking in certain public places has ceased during the day. This suggests that wet centres play a crucial role in providing essential services for street drinkers and other vulnerable groups, and that they lessen but do not entirely stop street drinking.

## **The roles and operation of 'wet' day centres in British towns: A guidance manual**

### **Aims and structure of the manual**

The remainder of the report is a manual and guide to the design, planning and running of 'wet' day centres for the street drinkers and other indigent and exceptionally vulnerable people who are found in towns and cities throughout the United Kingdom. It is based on the findings of a short study of wet centres in England, as described in the preceding research report. It has been informed by our interviews with not only the commissioners and staff of the existing centres, but also with the clients and with housing, health, social service staff and the police who have had close involvement with the centres or with services for equivalent vulnerable people.

The aim of the document is to provide a concise and clear guide to the important roles that 'wet' centres play, to the necessary and optional design requirements, and to the demonstrably effective (and ineffective) ways of working. The research has led us to a challenging threefold conclusion, that in the spectrum of a town's services for homeless and vulnerable people:

- Wet centres can be an important element of an essential role, to provide a first point-of-referral and contact for those who are excluded or unable to use conventional or mainstream housing, health, addiction and social services, where help is provided and people are started on a path to treatment and a return to less problematic and more conventional lives.
- There is no single optimal specification of the roles, ownership, management and day-do-day operation of such a centre, for the most effective configuration is a function of local needs, agencies, services, and political and professional environment.
- Wet centres can be difficult to run and can become less effective than they should be. Their continuing success depends upon close attention to several internal and external operational requirements, the maintenance of which requires vigilance and frequent attention. These include keeping the objective of helping clients to control drinking to the fore, and of maintaining good local community relations.

In short, the role is vital but its delivery is by nature fragile or unstable. The remainder of the document elaborates the above three propositions.

The manual has four chapters. They have been compiled on the assumption that, as part of a local homelessness review and in association with a local (town centre) management policy, consideration is being given to the establishment of a facility for street drinkers, that connects them with services, and makes a contribution to the reduction of the problems associated with street drinking. The first chapter discusses the choices that have to be made about which client groups are to be served by a wet day centre and therefore is also concerned with the aims of the centre. Chapter M2 is a digest of the issues that must be considered and the decisions that have to be made when designing and planning a centre, and its role in a local spectrum or network of

services. The third chapter is a synthesis of good practice points on working with street drinkers and other vulnerable groups, while the last chapter concentrates on various management issues and gives particular attention to the difficult task of keeping the more challenging aims to the fore.

## M1

### Determining the clients to be served and the centre's aims

#### The client group

The wet centres that are operating in England today have had different origins and patterns of development, and the profiles of their clients are not identical. It is clear, however, that they are not only providing help to street drinkers, but are also working with people who have mental health and drug problems, rough sleepers, ex-offenders, sex workers, and those who are unsettled and move from town to town. The client group has several distinguishing characteristics: problematic and self-harming behaviour; poor motivation to seek help and address problems; disconnection from family and friends; and exclusion from conventional welfare services which they either will not or cannot use. The clients are therefore among the socially weakest and most vulnerable in our society.

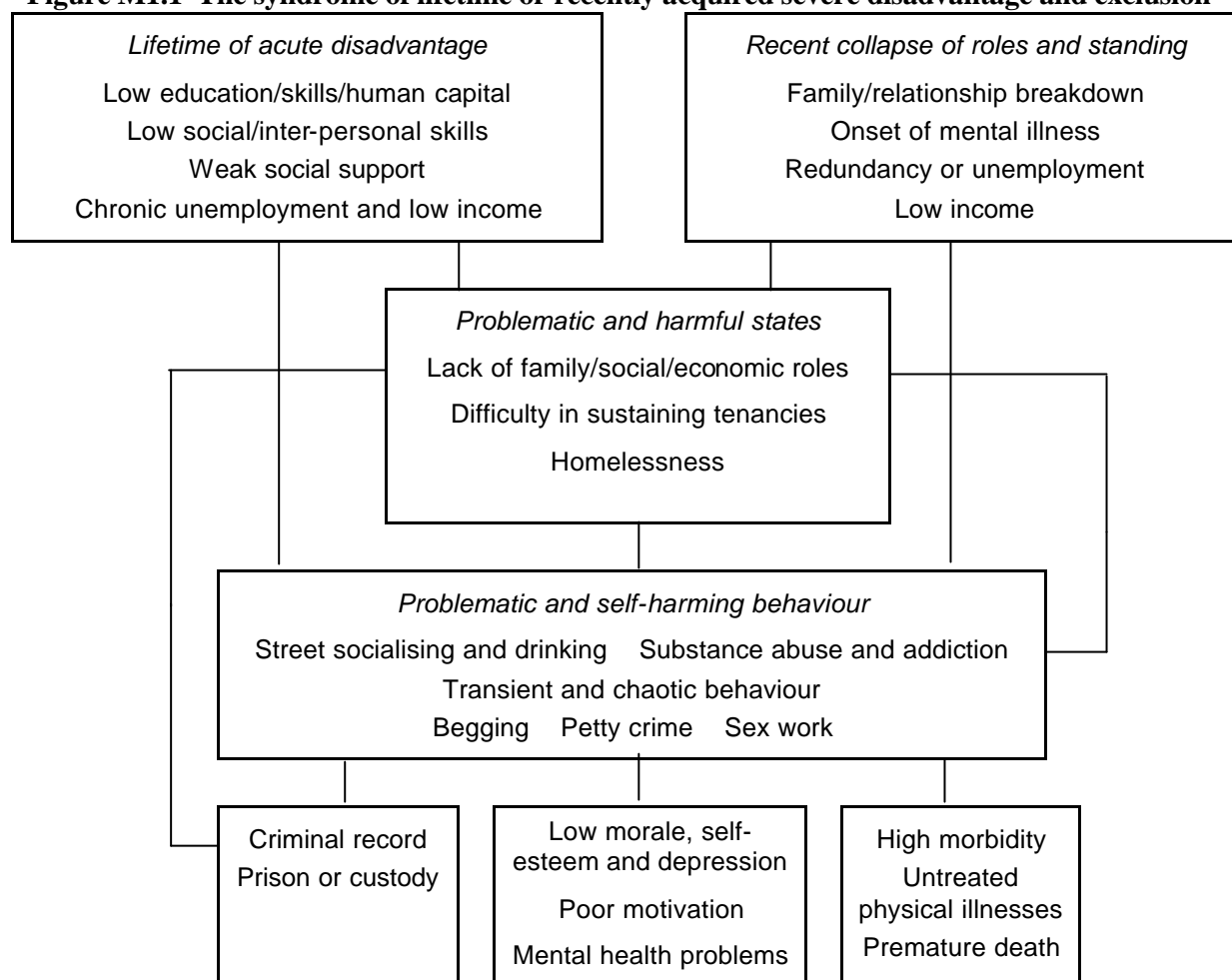
There is still remarkably little systematic evidence or well-grounded understanding about the causes of and pathways into homelessness and street behaviours in contemporary Britain. Figure M1.1 presents a schema of the main biographical features, negative events, and problematic behaviours that are associated with, and sometimes cause, homelessness and acute social deprivation and disadvantage. At any one time, some people have recently entered this state having experienced traumatic events or the collapse of roles and standing. Others are entrenched in a syndrome of disadvantage and exclusion that began early in life with problems at home and in school, and is characterised by few social or productive skills and little 'human capital'. Such disadvantage and deprivation is often reinforced later by failures in personal relationships and work.

There are in fact several groups of severely disadvantaged people in every contemporary town and city, and many have multiple neglected problems. When designing a 'wet' day centre in a town or city, it is important to consider the client group to be targeted because it will quickly be found that, for example, not all street drinkers are homeless and not all the users who can benefit from such a facility will be street drinkers. It is therefore important not only to review the services that are available for street drinkers, but in parallel to examine those that serve closely related groups of the disadvantaged and socially excluded population.

#### *The distinctiveness of street drinkers*

The 'wet' name implies a service dedicated to (although not necessarily exclusive to) clients who are heavy drinkers, have health and social problems, and are poorly motivated to stop drinking. The problem manifests in drinking in unlicensed places, particularly town and city squares, doorways and public parks, by people who engage in the habit not occasionally (as do football supporters or arts festival attenders) or as an element of a social excursion, but for many hours on



**Figure M1.1 The syndrome of lifetime or recently acquired severe disadvantage and exclusion**

many days. Other characteristics are the type of alcohol that is consumed, and the sharing of drinks. Street drinkers often consume cheap but strong beer, cider or sherry, which some conceal in plastic bags. Some share bottles of cider or sherry and are seen drinking from the bottles. It is unusual to observe these drinking habits among social drinkers.

The client group is not defined exclusively by its drinking habit, but also by its social marginality. They are people who drink alone or in groups who are perceived not as 'lads on a night out', but as down-and-outs, the chronically unemployed, the homeless, rough sleepers and beggars. Linking all these states, in many people's perception, is failure, exceptional bad luck and low personal resolve, and for that reason the group is unsettling and discomfiting to many. Some members become intoxicated and boisterous, flirtatious, argumentative or aggressive. Some may behave indecently and, for example, urinate in the street. Some have mental health problems that associate with bizarre and occasionally intimidating behaviour. Individuals therefore can sometimes be problematic and generate incidents which are a public nuisance.

### **Aims of wet day centres**

Wet day centres have two over-arching aims: (i) to provide support, help and treatment for severely disadvantaged and chaotic people, including street drinkers, who are excluded from other services; and (ii) to tackle an anti-social behaviour problem in a constructive, non-criminalising way.

The first aim has multiple elements which can be grouped as follows:

- A point-of-contact for the most vulnerable who are disengaged or excluded from services and have multiple or serious unmet needs.
- A safe, non-judgmental environment at which basic needs for food, shelter, safety, personal hygiene and sociability are provided.
- A setting at which a vulnerable person's housing and other more specialised needs can be assessed, and from which the help of other agencies can be enlisted.
- A setting at which those with alcohol dependency can be encouraged and helped to develop new interests, activities and occupations, in order to build confidence and self-worth and reduce or control alcohol problems.
- A point-of-contact for outreach workers and other agencies who can meet and work with clients who are hard-to-reach or have challenging behaviour.

In October 2002, the NHS National Treatment Agency for Substance Misuse published *Models of Care* for the treatment of adult drug misusers (National Treatment Agency for Substance Misuse, 2002). Although the primary focus is adult drug treatment, its relevance to the development of alcohol services is explicitly stated. It asserts that drug misusers in all local areas should have access to four tiers of services: (i) non-substance misuse specific services requiring interface with drug and alcohol treatment; (ii) open access drug and alcohol treatment services; (iii) structured community-based drug treatment services; and (iv) residential services for drug and alcohol misusers. Wet centres are the equivalent of the second tier of services. These are low-threshold projects which aim to engage substance misusers in treatment and harm reduction services, who do not necessarily have a high level of commitment to structured programmes.

## M2

### Planning and setting up a wet centre

All local authorities in Great Britain are required to produce both homelessness strategies and community safety strategies, and many are contemplating town and city centre management policies with more coercive measures against beggars, street drinkers and others who engage in anti-social behaviour. For these reasons, several are considering providing wet day centres as an alternative venue to the streets for drinkers and, more importantly, as a point-of-contact into services for those who are excluded and have unmet needs. This chapter describes many of the issues that need to be taken into account, and many of the steps that should be taken, when planning and setting up a wet centre.

#### Review of needs and the adequacy of current services

A Working Group, possibly of an existing multi-agency homelessness forum, should be set up to examine the extent of street drinking and other street behaviours in the locality and decide if a wet centre is needed. It should have representatives from statutory and voluntary sector agencies, including housing, health, substance misuse and social services. If the decision is made to go ahead, the Group should steer the project through its development phase, with one agency taking the lead. For example, Leicester City Council Housing Department became the lead partner for establishing the Anchor Centre, but worked in partnership with many other agencies (described in Chapter R3).

The first steps are to establish the number of street drinkers in the area, to map the locations that are used, to gauge the nuisance that is caused, and to produce an annotated inventory of the services that are available for drinkers and their usage. A simple survey of the numbers of street drinkers who are homeless, are not registered with GPs, have untreated health problems, and their eating habits would normally show substantial and serious unmet needs. Some drinkers and other street groups make heavy use of hospital accident and emergency departments for primary health care needs. It will not be difficult to make a strong case for the creation of a drop-in or day centre if there is no equivalent facility. The strength of the case for dedicated 'wet' provision will depend on the number of local street drinkers who are excluded from or not in contact with services.

In reviewing the adequacy of services, information should be sought not only from the provider agencies but also from (i) workers of outreach teams and homeless advocacy organisations that have detailed knowledge of the client groups and their use of local services, (ii) agencies such as hospital accident and emergency staff, the police and street wardens, and (iii) a sample of the drinkers. On paper it may appear that a required service is available, but the users may explain that they are barred from services or have to leave hostel premises during the day. Other reasons, including intimidation or aggression from existing clients, may also explain why

some people are reluctant to use a service. The creation of a wet centre may not be necessary. It may be that existing projects should be given more resources to remain open during the day, to employ additional staff so that the environment is less threatening for users, or to restructure or expand their services to include specialist help for street drinkers.

### **Who will the centre serve?**

In most towns different groups of highly disadvantaged, vulnerable and chaotic people are well and less well served by its statutory and voluntary sector services (described in Chapter M1). The best configuration and setting of a 'wet facility', *i.e.* as a discrete, dedicated service or as part of a day centre complex for multiple client groups, should be decided after discussion with several agencies. There are different views about whether there should be separate day centre facilities for drinkers, but little evidence about the relative merits and effectiveness of separate or integrated facilities. At the Anchor Centre in Leicester, the staff have found it difficult to run a combined wet and generalist day centre, and believe that the best option would be for the centre to serve only drinkers and drug users. Although it is open all day for the drinkers and in the afternoons as a drop-in service, the afternoon sessions are often very busy and the staff's time is sometimes diverted from the drinkers who need a great deal of support. There are also concerns that mixing day centre users with heavy drinkers may encourage drinking among the former, and that clients who want help to overcome a drinking problem find little reinforcement when interacting with people who are drinking. It has been suggested that the centres should provide separate sessions for those who are reducing their alcohol intake.

Other staff believe that the centres should not be exclusively for drinkers. Providing for various client groups creates a more balanced and less stigmatising environment, and means that people do not have to stop attending the centre if they stop or reduce their drinking. By mixing with non-drinkers, the drinkers would see how they manage and what they achieve, and this may encourage them to tackle their own alcohol problem. In addition, many clients have multiple problems and separating different groups results in some being excluded (many are already excluded from mainstream services). The Booth Centre staff have found that it is possible for people to stabilise and reduce their alcohol intake while attending wet centres.

The decision about the client group to be served will probably be influenced by the availability of premises (discussed later), the extent of the problem, and the local service configuration. For example, if a town has a small-scale problem of rough sleeping and street drinking but no day centre facilities for homeless people, it would be more appropriate to establish a single first-point-of-contact centre, with provision for the drinkers. This was the case in Chester (the Harold Tomlins Day Centre, described in Chapter R3). On the other hand, in a large town or city where there are day centres for homeless people which are well-attended, a separate centre might be needed for street drinkers and other problematic client groups whose needs are not met by existing services.

### **What kind of organisation should run the centre?**

Two of the four centres that have been closely studied are run by independent, single facility charities (The Booth Centre and Tollington Way), and two by multi-facility specialist housing and welfare agencies (Handel Street and The Anchor Centre). While it cannot be said that any one form of ownership and management has a net advantage over others, our observations of these and other homeless people's facilities, together with substantial research on the contribution of voluntary organisations to welfare services (Craig and Manthorpe, 1999; Middleton, 1999), suggest that different types of organisation have specific strengths. This section compares the most apparent management strengths of specialist, single facility organisations, multi-facility non-profit welfare and housing organisations, and statutory agencies.

In recent years across the British Isles, several groups and formal charities have established drop-in and day centres for street drinkers and homeless people. Many have had a precarious existence, principally because of uncertain funding, but also through stormy relations with their landlords, neighbours, the police, the general public and the local media. On the other hand, many dedicated groups and organisations demonstrate exceptional enterprise, innovation and tenacity. It should be remembered that several of the largest and best known specialist regional homelessness organisations and housing associations began as single facility initiatives, as for example St Anne's Shelter and Housing Action, based in Leeds, that began as a day centre for shelter and hostel residents that were excluded from their accommodation during the day (See <http://www.st-annes.org.uk/> and Spiers 1999).

Now that local (authority) homelessness reviews and strategies have been instituted, and local multi-agency forums and co-ordination groups have spread, it may be that there will be fewer opportunities for new organisations to fill service gaps. The most feasible form of facility development in the future is likely to be for an established social housing (and welfare) provider or a statutory agency to be commissioned by a strategic statutory body to organise and provide a service. In practice, many developments will arise from agency partnerships. Some local authorities are planning an elaboration and consolidation of services for rough sleepers, other single homeless people and those with substance abuse problems in expanded 'one stop' centres. The local authority housing department (that has overall responsibility for homelessness services) will organise the capital funding, but the staff and services operating from the centre will very often be funded by several non-governmental and statutory agencies.

The best local arrangement will be a function of the availability of funding for the centre and of the duty upon, capacity and enthusiasm of the town's various statutory and voluntary housing, primary health care, mental health and addiction agencies to provide services for the centre's clients. Some general associations can however be observed or suggested, as is attempted in Figure M2.1.

**Figure M2.1 Administrative and management strengths of different types of organisation**

	<b>Single facility charity</b>	<b>Multi-facility RSL or welfare charity</b>	<b>Statutory agency</b>
<b>Funding</b>	Normally highly insecure	Dependent on public funding priorities	Dependent on public funding priorities
<b>Administrative and developmental capacity</b>	Variable, legal and financial experience often with advisers and trustees rather than staff. Little capacity to develop move on (or vertically integrated) services.	Established and experienced support with planning and with legal, employee and client responsibilities. Demonstrated capacity to develop move on and specialist services.	Established and experienced support with planning and with legal, employee and client responsibilities. Demonstrated capacity to develop move on and specialist services.
<b>Volunteer involvement</b>	Considerable goodwill encourages volunteers	May be difficult to reconcile with staff interests	Weak tradition of working 'alongside'
<b>Staff levels, training and support</b>	Rarely able to provide back-up for sickness or holiday leave, or to have sufficient funds and leeway for training. No opportunities for in-house career progression.	Can deploy back-up staff, and have capacity for training, appraisal, staff development and progression.	Can deploy back-up staff, and capacity for training, appraisal, staff development and progression.
<b>Onward referral to specialised agencies</b>	Possible, but only with exceptional collaboration from other (competing) charities and statutory agencies. Highly dependent on charisma of leading personnel.	Normally extensive and to a high standard, although the links are vulnerable to the loss of statutory agencies' goodwill.	Normally extensive and effective although the general problems consequent upon boundaries between various agencies and welfare sectors.

There are many instances of the enterprise, drive and enthusiasm of a dedicated charitable organisation delivering high quality and effective work with clients in a specialist facility, often with substantial contributions from volunteers. These strengths are however counterbalanced by the heavy dependence on a small team, and by the 'separateness' of the facility from the wider network of local services. The lack of the administrative and management capacity and experience of a larger organisation creates several difficulties, especially with external relations, development and continuation. Larger employers are likely to have more ability to deploy back-up staff, for example, to avoid the closure of a facility because key staff are sick or on leave, and to have staff support, mentoring, development and training capacity.

The other important differentiator of the single facility charity from either large, well established non-governmental organisations or statutory agencies is likely to be their ability to establish and *maintain* the inward and onward referral pathways. The problem arises from both the little time that a small team has to spend on networking, negotiation and inter-agency relations, and from the professional and organisations barriers that normally exist between statutory and voluntary agencies and between established and new organisations. On the other hand, whatever the type of organisation providing a specialist welfare service for 'marginal' client groups, the vagaries of changing policy priorities will affect continued funding. There may be different funding insecurities for the different types of organisation, but none are immune. Further comments on the management of centres are made in Section M4.

## **Premises and location**

Finding suitable premises and gaining the necessary approvals and permissions for their use as a facility for homeless people is not easy. The usual difficulties are compounded when setting up a wet centre given the generally negative public reputation of the client group, and the possibility that the centre will attract street drinkers to a new location.

The centre should be in neither a residential area nor adjacent to schools, children's playgrounds or other sensitive facilities, nor should it be in or next to a shopping or tourist area with high pedestrian densities and many visitors. Some users will inevitably drink in the street on their way to or from the centre, and a high frequency of problematic behaviour will be noticed and brought to the attention of the police, who will be obliged to intervene. Areas should also be avoided that already have extensive provision for other social problems, such as hostels for homeless people or for ex-offenders, and that are very run down, uniformly depressing or the 'back of beyond'. The location should be accessible, which means principally that it is in walking distance from the town centre for the great majority of the likely clients. In summary, the ideal area should be an unremarkable part of the inner city in which 'life goes on' but there is not a high density of residents.

It is a great advantage if a wet centre is near a local health centre or practice that accepts homeless and chaotic patients (unless comprehensive health care is to be provided at the wet centre). There are similar advantages if the centre is proximate to benefits, housing advice and citizens' advice bureaux. If a centre is designed to have sessions or clinics with many visiting specialist workers, inadequate or unsafe car parking provision may reduce the co-operation of other agencies and thus the effectiveness of the centre's work.

Most of the existing wet centres are small and the working conditions are cramped. The centre needs to be of a reasonable size to accommodate clients who have disturbed behaviour, or are wary of or irritated by being in close proximity to others. Overcrowded conditions are likely to increase tensions and lead to arguments and possibly aggression. The centre also needs to have sufficient offices so that staff and specialist agencies can see clients individually in a quiet environment. The clients cannot be expected to discuss personal problems or care-plans in a noisy room in front of other users. Ideally, the centre (or at least the area used by clients) should be confined to a single floor. The Brighton centre occupies two floors, with a wet room downstairs and a dry room and dining room on the first floor. It is difficult to observe the clients and staff are required on both floors at all times.

## **Overcoming local opposition and gaining planning approval**

Gaining planning approval is often refused for a homeless people's service proposal, and commonly the main reason is the strength of local objections. This means that acquiring the early approval and support of the local authority and of the local councillors is a critical step. If the

need for a facility is stated in the local authority's homelessness strategy, the relevant committees will be less readily swayed by objectors.

Local authorities, NHS agencies and churches (in that order) probably have a head start in getting planning approval for homeless service proposals. The first can through its committees and elected representatives 'test' the levels of support and objection for a proposal before it is submitted. Health agencies and churches draw on special goodwill and (even today) deference. Nonetheless, many homeless service proposals made by these most influential and well connected bodies face vociferous opposition. It is therefore important that high quality information about the aims and running of a wet day centre is prepared well in advance of any publicity about a proposal, and that there is intensive consultation with the immediate neighbours and local resident groups and businesses. Organisations that are inexperienced in these matters should seek advice from many quarters before embarking upon a planning application.

At Tollington Way in London, the staff consulted widely with the local community before the project was established through meetings and door-to-door calls. They introduced themselves to local residents and businesses, explained the centre's aims and intended work, and distributed information leaflets. They also asked local residents to join the Management Committee, so that the local community perceived that they had some input into the centre's development. Similarly, at the Specialist Dependency Service in Camden Town, London, the most vocal opponents to the day centre were invited onto its Steering Group. The Camden Town centre also designed a 'Neighbourhood Management Policy', which states the staff's responsibilities and commitment to the local community, and was distributed to local businesses and residents (the policy is described in Chapter M4).

## **Funding**

Every local authority has access to several possible sources of funds to support the creation and running of a wet day centre. Special project funding is available from the *Homelessness Directorate* of the Office of the Deputy Prime Minister (ODPM), and other sums can be made available through 'Supporting People' and 'Floating Support' contracts, and from various Home Office and ODPM 'community development' and 'regeneration' programmes. The larger British city councils now organise and direct substantial sums into services for homeless people.

Reducing health inequalities and reducing unmet health care needs are priorities for the National Health Service. Developing services for homeless people was a named priority for Personal Medical Services funding, while more generally the new NHS Primary Care Trusts have been charged to develop services for homeless people and other high needs groups. General medical practices and health centres that work with homeless people generate high rates of patient contacts and of prescriptions for both medication and addictive-drug surrogates. They must formulate a clear prescribing policy, make this widely understood among the relevant client groups, and be able to demonstrate to the NHS commissioners and auditors that the policy and



prescribing practice is rational and responsibly applied. The evidence from Nottingham and Manchester suggests that when this is done, there is no ceiling on the drugs budget although all practices with high spending find that it is repeatedly challenged.

Recent years have seen substantial funding programmes to tackle drug addiction. A well argued case for a specialist worker has a good chance of funding. On the other hand, there are many reports of too few resources for alcohol services. The Anchor Centre in Leicester originally focused on street drinkers, but later extended its responsibilities to include drug users. This attracted funding from Leicester Drug and Alcohol Action Team. The staff believe that the move was beneficial as many of their clients have both alcohol and drug problems, and the funding has allowed them to improve their service.

Nottingham City Council has taken an interesting initiative in creating the post of 'Homeless Strategy Co-ordinator' with a responsibility to seek out and win new sources of funds for homeless people's services. It is thought that while 'Housing' and 'Social Services' will always be the 'big players', additional funds might be won for programmes in the 'Leisure and Community Services' and 'Education' areas. The ambition is also to look for additional funds from regional, national and European programme sources. On the former, the devolution of substantial sums from the Housing Corporation budget to regional housing agencies linked to the regional Government Offices and Development Agencies is thought to be a pattern that will be repeated with other programme budgets.

### **The involvement of specialist service providers**

If a wet centre is to be effective, it will require input from specialist agencies to deal with the complex health, substance misuse, housing and social problems of the client group. It is critical that these agencies and others, such as the probation service, are involved at an early stage in the centre's development. In Leicester, all relevant agencies were committed to the wet centre through a 'memorandum of understanding' drawn up at the planning stage. As a result, the centre receives a great deal of input from the various agencies. In contrast, no partnership arrangements were sought when Tollington Way in London was established, and after opening the clients' unmet needs soon became apparent. The centre has since had great difficulty in getting help from specialist services, and more than three years later no primary health care service is linked to the centre.

A wet day centre either needs primary health care services on-site or to be closely linked and jointly planned with a nearby health centre with an interest in the client group, as in Nottingham, Manchester, Brighton and Oxford. Specialist health services enable screening, disease management and health promotion work to be carried out with clients who may not comply with traditional services. In Leicester, Nottingham and Oxford, the GPs and nurses provide a home detoxification programme. Good links with community mental health teams also need to be developed. Many wet centre clients have apparent or underlying mental health problems, and will

require mental health assessments and possibly treatment. Several of the current wet centres have input from specialist mental health teams for homeless people, but find it difficult to link the housed attenders into mainstream mental health services.

Links to specialist substance misuse workers are essential. Clients will require expert advice on reducing or controlling alcohol intake, on the effect of alcohol and harm minimisation strategies, and on the types of treatment and support programmes that are available. The workers will also play a crucial role in assessing the clients' needs and motivation for treatment, and in linking them into alcohol and drug services. If the workers visit the centres regularly, the clients will become familiar with them, and may be encouraged to accept advice and help.

The involvement of local authority social services departments (SSDs) should be sought. At the centres in Leicester and Manchester, social workers visit weekly and fulfil many useful functions. They carry out community care assessments of the clients who wish to be admitted to alcohol rehabilitation programmes or residential care (both of which are funded through local authority SSDs), and arrange the placements. They also help clients obtain housing and social security benefits, and assess the needs of those who are housed and arrange for services at home such as meals-on-wheels, home care, aids and adaptations, and tenancy support.

#### *Housing and support services*

Attention has to be given at an early stage of the planning to the housing and support needs that will be generated. Through years of heavy drinking and related physical and mental health problems, many street drinkers require supported housing or residential care as either an interim or long-term measure. Links need therefore to be established with social housing providers, and housing quotas and referral procedures set up.

There are difficulties in finding suitable accommodation for clients who continue to drink. In some cases, statutory services refuse to accept responsibility for a person until their situation has deteriorated and they require a residential care-home. Many towns and cities have no residential homes for heavy drinkers and so clients are placed in homes for older people. This can lead to problems for the clients, the staff and the residents of the home. Moreover, many heavy drinkers who require supported housing are young or middle-aged.

In response to the shortage of suitable accommodation, some organisations have developed their own housing. Equinox, which runs the wet centre in Brighton, in early 2003 opened a 'wet house' nearby as permanent accommodation for five heavy drinkers. It is funded through Housing Benefit and Supporting People revenue. Most of its residents are in their late forties or older and disabled or physically frail. The Oxford Night Shelter manages the city's wet centre and developed supported housing for 60 clients in eleven houses rented from private landlords. The organisation renovated the properties and the tenants receive help from four supported-housing workers based at the project.

## **The role of the police**

The police have supportive, restraint and punitive roles in relation to street drinkers and wet centres. Local beat or town-centre team officers have detailed (if particular) local knowledge of both ‘street people’ and the agencies and facilities that offer help. Very often, a police officer is the first to make contact with a rough sleeper or street loiterer new to the area, and can play a very useful role in informing them about a wet centre and the services that it offers. They are also responsible for maintaining law and order, including ensuring that alcohol bans in designated areas are adhered to. They may thus be required to caution a street drinker or take further action if the person is breaching rules or their behaviour has raised public concern. As one police officer reported when interviewed, ‘there is a fine line between policing the streets and supporting the work of the wet centre’. The police have special responsibilities with inconsistent elements that can be readily misunderstood

The local community police, and those attached to homeless, anti-begging and sex work teams, should be involved at an early stage in the planning and setting up of a wet centre. They will undoubtedly be involved if an increasing number of street people in the locality produces complaints from local residents and businesses, and more serious offences such as drug dealing occur. They should also be encouraged to refer new street contacts to the centre. It is therefore vital that they have up-to-date knowledge about wet day centres and the services that are provided. This is not a one-off task, because personnel change and memories are short. When the Old Steine Day Centre in Brighton was established, the police set up a ‘drunk and incapable policy’ and regularly brought street drinkers to the centre. Some had tenancies but were about to be evicted, and thus the centre staff could intervene to prevent tenancy breakdown. The policy initially worked well, but over time there was a turnover of police and the protocol was discontinued. In Oxford, the police direct drinkers to the wet centre, but in some cities the local police have little or no contact with the local wet centre.

## **How will the centre attract the users?**

The specification of the premises, the services it offers and the opening times must ensure that the centre serves the intended client group. The next step is to encourage street drinkers and others to use the centre. Some first contacts will be referrals from the police or street wardens, or self-referrals that have been prompted by work-of-mouth recommendations. Local ‘grapevines’ among street people about the locations and opening times of soup runs, day centres and hostels can be highly effective. Self-referrals should therefore be encouraged.

Not all street people are however connected. Some have newly arrived in a town or city, while others are isolates or ignorant of services. It is therefore essential that regular and persistent street outreach work is carried out to locate disengaged street people, build up rapport and trust, and inform them about the centre and encourage them to attend. At a few centres, the staff undertake this work but most rely on the city’s dedicated street outreach team for rough sleepers. Many staff believe that it is best for existing outreach teams to carry out the initial street work

with drinkers, as they have the time to go around the streets and have knowledge of the sites where street people congregate. To use wet centre staff for outreach work would restrict their day centre hours, and as for safety reasons street work needs to be carried out by two workers, additional staff would be required. There is however value in centre workers accompanying the outreach team on occasions, so that they can be introduced to new clients and re-establish contact with those who have stopped attending the centre. This is the procedure in Brighton.

## **M3**

### **Working with the clients**

This chapter describes the work that needs to be undertaken with wet centre users who have alcohol problems. It draws on the experiences of the interviewed samples of clients and the staff of the four wet day centres that were closely studied as well as the experience of other centres.

#### **Engaging with clients**

It is important that a wet centre is welcoming and attractive to new clients. Both the environment and the staff's responses have an influence. The rooms should be bright and spacious so that the clients do not feel cramped. Some who attend may have been on their own for a long time and have had little close contact with others. There should be posters and leaflets to inform new users about the available services. The clients should feel safe at the centre, and not fear being bullied or intimidated by other users. The 'front-line' staff should welcome new clients and explain what the centre offers. They should take every opportunity to sit with and get to know the clients. Volunteers can play an important role in engaging with clients and making them feel at ease. If the staff team is sufficiently large, one could be designated the 'welcoming worker', and this role be rotated periodically. The staff at the Booth Centre find that the wet garden is a useful setting for engaging with clients. It is a relaxing environment and a 'half-way step' into the centre for people who are wary.

Early contacts with a new client have to be handled carefully and tactfully. It is essential to find out whether a new attender has a pressing problem, but insensitive probing may scare a person away. Different approaches will be required for different clients. Some may wish to talk to staff, while others may initially want to be left alone. The staff need to assess each situation and interact with the clients accordingly. Once a client has engaged with the centre, the staff can begin to collect information about his or her problems and needs.

Most centres do not have the space to provide separate facilities for women, and some staff doubt whether these would be popular because many women have a male partner and do not want to be separated. Many staff believe however that women attenders have particular issues that they wish to discuss, and that a women's group would be useful.

#### **Assessing needs**

Most wet centres collect basic personal information from a client when they first attend, but not all undertake detailed assessments of the client's problems and needs. In order to provide significant help to a client, information is required about:

- Recent housing history, including whether housed, in temporary accommodation or sleeping rough; recent and current problems with tenancies, including rent arrears and condition of present tenancy; experiences of homelessness and reasons.

- Family contacts and relationships, and social contacts with drinkers and non-drinkers.
- Income, state benefits received, and financial problems or debts.
- Physical health problems and nutrition.
- Morale and indications of depression, mental illness, unresolved stresses or memory difficulties.
- Alcohol consumption, including types of alcohol, drinking pattern, history of heavy drinking, reasons for heavy drinking, and involvement in alcohol treatment programmes.
- Use of illegal drugs or substances, and involvement in drug treatment programmes.
- Recent history of offending and contact with the probation service.
- Daily-living, personal care, literacy and social skills.
- Activities and engagement in community, work and training schemes.

Given this long list, the assessment must be carried out over time and cannot be completed at a single interview. Opportune moments will have to be sought when a client is fairly sober and willing to talk. Some clients will have mental health problems or cognitive deficits and be unable to give accurate details, while some will be reluctant to provide information or will deliberately mislead. Wherever possible, and if the client consents, information should be obtained from other agencies who have had contacts with the individual. Needs, abilities and attitudes will change as problems are resolved or ameliorated, and therefore assessments have to be frequently updated.

Several wet centre staff believe that not enough attention is given to assessing the daily living skills of clients and their suitability for different types of housing. Even among the housed clients interviewed for this study, many struggled to cope at home (Chapter R5). There should be thorough assessments of clients' daily living skills before long-term housing options are considered.

#### *Assessing risks*

Most clients who attend wet centres are vulnerable, and some will have challenging behaviour. The staff will be unaware of the histories of some clients, and it is essential that risk assessments are undertaken and updated. A comprehensive document, *Risk Management Policy and Procedure*, has been prepared by Broadway (2001) in London and can be downloaded from the Internet (<http://www.serviceaudit.org>). As it states, an assessment aims for as realistic a picture as possible of the risk that an individual poses to themselves and to other people. It is not normally used to exclude a person from services but to ensure that the best possible service is provided by:

- Assessing whether the risk can be managed within a service.
- Assessing how to minimise risks to the individual concerned and to other people.

Risk assessments need to consider: (i) behaviour, including violence, abuse, harassment, the likelihood of dangerous accidents linked to substance misuse or smoking, and persistent

provocative behaviour; (ii) physical health, and risks associated with mobility, weight, self-neglect and substance misuse; (iii) mental health, and the risks of self-harm and of bizarre behaviour; (iv) daily living skills, including risks associated with preparing food and managing appliances at home; and (v) the condition of the premises including the risks deriving from outstanding repairs, infestation and faulty appliances, furniture and flooring.

## **Meeting basic needs**

### *Nutrition*

Many heavy drinkers have poor diets, partly because they spend their money on alcohol rather than food, and partly because they are prone to health problems which affect their appetite and digestion. Most wet centres provide free food (either a cooked breakfast or a dinner). The Old Steine Day Centre in Brighton also gives out multivitamins and Vitamin B tablets. Staff have mixed views about whether there should be a nominal charge for food. Some believe that free food encourages people to attend the centre, and ensures that they are getting at least one meal a day. Others believe that it enables the clients to spend more money on alcohol and encourages dependency.

It is important that wet centres address the nutritional needs of clients. An adequate supply of free tea, coffee, soft drinks and water should be available at all times. Nutritious food should be served at least once a day, including fresh vegetables and fruit. Bananas are popular among clients with dental problems who find apples hard to eat. Attention should be given to whether clients are eating, and some may need encouragement. If there is cause for concern, a client should be referred to a primary health care nurse or a GP. If there is a charge for food, it should be discretionary and depend on a client's circumstances.

### *Personal hygiene*

Some heavy drinkers neglect their personal hygiene, do not launder their clothes, and become incontinent when drunk. Skin infestations, especially lice and scabies, are common among those sleeping rough or living in neglected tenancies. Most wet centres have showers and laundry facilities, or are close to other day centres with these services. The staff need to encourage clients to attend to personal hygiene. Providing clean socks, underwear, other clothing and toiletries may prompt some clients to shower and change their clothes. Leaflets about hygiene may encourage interest. The nursing staff at Handel Street Centre distribute leaflets about health, and have found that some clients will read them and respond with questions. There needs to be a clear policy about managing clients with skin infestations. At the Anchor Centre in Leicester, the nurses treat clients with lice.

## **Individual case-work**

### *Care planning*

Only a few wet centres carry out individual case-work with clients by a named worker (a key-worker), who is responsible for ensuring that the person receives the help required. Most of the

staff that were interviewed recognised the value of this system, which ensures that interactions with clients are followed through, and that the needs of withdrawn or undemanding clients are not neglected.

Key-working implies that each established client has a key-worker who is responsible for assessing their needs, designing a care-plan (action plan) with realistic goals, referring the person to specialist agencies, and co-ordinating the person's care. The care-plans should be prepared in collaboration with the client and reviewed regularly. The plans should address immediate problems, such as lack of income, poor nutrition, untreated illness, poor hygiene, and lack of accommodation. They also need to tackle more complex issues such as alcohol abuse, long-term housing and support needs, and building confidence, self-esteem and motivation. The ordering of the actions should vary according to individual needs. Some rough sleepers may not be willing to consider temporary accommodation until their confidence and self-esteem has increased. Likewise, some heavy drinkers will not attend to personal hygiene until their alcohol problems are controlled.

Many clients have long-standing problems and work with them will be slow. Key-working should be paced to meet individual needs, and care-plans should be agreed when the clients are sober and coherent. The key-worker will be able to carry out some of the agreed actions, such as completing social security benefit forms, but they will also require the help of specialist workers, such as primary care nurses and mental health teams. In such cases, care-plans should be co-ordinated by the key-worker, but there should be regular reviews and liaison among the contributing agencies.

#### *Linking clients into services*

Many clients will have had little or no contact with services for some time, and to address their health and welfare problems it is imperative that such contacts are made. At some wet centres, specialist agencies hold regular sessions, and the key-worker should ensure that the clients are seen by these workers. In other instances, it will be necessary for the key-worker to arrange an appointment for the client with a specialist agency. This will not be an easy task as some clients may fail to keep or forget appointments, or become restless and leave a GP surgery if they are kept waiting. Early morning appointments (before the person has drunk much alcohol), and escorting the client to ensure that they keep the appointment have proved useful.

#### *Tenancy support*

Several clients at wet centres have tenancies and live alone. But many who drink heavily find it hard to manage at home. They neglect to clean their home and pay bills, some live in squalid conditions, and rent arrears and tenancy failures are common. To combat loneliness, some have their friends round, host 'drinking schools' and allow those without accommodation to stay. This can lead to noise, disruptive behaviour and complaints from neighbours. Some do not report problems or seek help until they are taken to court and evicted. It is very difficult to get home



care services for these clients as home-helpers are intimidated and refuse to go to flats where there are several drinkers, and the clients are often not at home or refuse to answer the door when the workers visit.

Many housed clients need tenancy support, some for a prolonged period if homelessness is to be prevented. The centres have to decide whether to undertake this work or to refer clients to other agencies (assuming that tenancy support teams are available). The advantages of the wet centres being directly involved are that the clients already know the staff, and the staff are in frequent contact with those who attend the centre. Moreover, as at the Handel Street Centre, it brings variety to the work and enables the staff to follow the progress of the people that they are helping through (for some) significant changes. Much of the satisfaction that staff and volunteers draw from working with chaotic and vulnerable people is knowing that they have helped them make a difference in their lives. Those who are engaged in tenancy support work find that a great deal of their time is spent sorting out rent arrears, helping clients to pay bills, intervening in neighbour disputes, and arranging for the cleaning and furnishing of tenancies. Furthermore, joint home visits are necessary when there are safety concerns. 'Supporting People' funds may be obtainable for this work, which does require additional staff hours.

#### *The social dynamics of wet centres*

Among the clients of wet centres, characteristically there are many social relationships. The significance of these relationships is heightened among a group of people that in general lack intimate relationships and have only weak family contacts. Some have socialised with each other for years on the streets and in hostels, and the group camaraderie is usually strong. They share alcohol, lend each other money, visit each other at home, and generally support one another if not always in constructive ways. Arguments occur but these are usually sorted out among themselves. Their lives are interlinked. Past and present intimate relationships between users are found, and at some centres couples with their adult children attend. Hence, when planning care for a person, consideration has to be given to their relationship with peers, and how this might impact on the help that is given.

#### **Addressing alcohol problems**

There is little robust evidence of the most effective ways to tackle alcohol problems among heavy drinkers. Most staff who were interviewed believe that allowing clients to drink alcohol at wet centres is a positive move. It encourages people to use the facility who are excluded from other services, and it lessens the tensions between staff and clients who no longer have to be secretive about their drinking. At the Booth Centre, the staff find that the clients who drink in the wet garden are now more relaxed and their conversations are more meaningful.

It can however be extremely difficult (although not impossible) for clients to stabilise their drinking while attending a wet centre as: (i) they are at the centre for only a few hours each day; (ii) they are mixing with other centre users who are drinking heavily; and (iii) their social life away from the centre tends to revolve around other drinkers whom they have known for years. If

they wish to control or reduce their drinking, they may need to stop attending the wet centre, break away from their drinking friends, and be referred elsewhere for help.

#### *Rules around alcohol use*

The wet centres have different rules about drinking on the premises. Some restrict the amount of alcohol brought into the centre, while others do not monitor either the quantity or types – although none would tolerate the consumption of toxic liquids such as ‘meths’. Some allow drinking only in a designated room or garden, while others allow drinking anywhere on the premises.

Monitoring the alcohol that is brought into a centre ensures that large amounts are not consumed on the premises. It is no indication, however, of the amount of alcohol that a person consumes through the day. Many will have had alcohol before coming to the centre, some may share drink while in the centre, and others may go outside to drink.

The staff expressed diverse views about the restriction of alcohol at the centres, and there is little evidence to support or refute any of the various opinions. Those who oppose restrictions believe that it affects the relationship with the clients and puts the staff into a ‘policing role’. There is also concern that some clients might stop attending (although no such cases were reported at the centres with restrictions). Those who hold these views recommend other strategies for controlling the amount of alcohol consumed at a centre, including engaging the clients in activities and providing a pleasant environment for which they acquire a sense of responsibility.

Those who are in favour of restricting alcohol give the following reasons:

1. It lessens (but does not eradicate) argumentative, aggressive and challenging behaviour, and makes the environment more welcoming and safer for the clients and staff. Some needy clients stay away if a centre becomes rowdy and volatile.
2. The centre should promote ‘harm minimisation’ interventions, and aim to reduce the damage that clients do to themselves through alcohol. It should not be seen as a social drinking venue, for that communicates that it is acceptable to drink irresponsibly on the premises.
3. It is impossible to work constructively with clients or to organise appointments when they are very intoxicated.
4. Wet centre staff have responsibilities towards their clients, and it can be dangerous to allow them to drink liberally on the premises. It is unknown what drink and drugs they have had before coming to the centre, and heavy drinking at the centre could be lethal. Moreover, it is irresponsible to allow the clients to become intoxicated while at the centre and then to turn them out when the centre closes. There are health and safety implications for the clients, and implications for the neighbours and general public.

Among the staff’s mixed opinions, there are common themes about drinking restrictions. Firstly, most agree that it is irresponsible to allow clients to use the centre simply as a social drinking venue and to permit the consumption of large amounts of alcohol. Secondly, there should be

activities at the centre and other interests to engage the clients so that they do not drink just because there is nothing else to do (discussed further in a later section). Thirdly, the staff should 'monitor' the amount of alcohol that clients are drinking and intervene in individual cases where there is cause for concern.

There are several ways that the monitoring can be carried out. At the Booth Centre, staff are in the wet garden with the clients at all times and observe the amount that individuals drink. At the Anchor Centre, the clients record on an attendance sheet the amount of alcohol that they have. This is not verified by staff (so the clients do not feel that they are being checked on), but the staff are in the wet room with the clients and observe their alcohol consumption. In summary, if rigid alcohol restriction rules are not imposed (and we do not recommend that they are), then it is essential that the staff integrate with the clients, observe their alcohol intake, and intervene if a person drinks excessively.

### *Detoxification and rehabilitation*

Many clients who wish to tackle their alcohol problem require a period of detoxification while their alcohol intake is gradually reduced, followed by a rehabilitation programme that lasts several months. Extreme caution has however to be taken when encouraging clients to participate in detoxification. As reported in Chapter R2, recent evidence suggests that multiple episodes of alcohol withdrawal creates a risk of brain damage, and can contribute to seizures, alcohol-related neuropathology and cognitive dysfunction. If this is the case, then there should be very careful selection of clients for detoxification, and it should not be used for those who do not have the firm intention to stop drinking. Helping people to control and reduce their drinking may be more appropriate for those who are unlikely to sustain abstinence. Ways of tackling alcohol consumption among chronic drinkers needs further investigation.

In some cities there is a wait of up to 10 weeks for a place on a detoxification programme. In Nottingham, Framework Housing Association has both a wet centre (Handel Street) and a residential treatment project for heavy drinkers, with a bed earmarked for detoxification (see Chapter R4). This provides a fast and efficient alcohol treatment service for the wet centre users. At the wet centres in Leicester, Nottingham and Oxford, community detoxification services are available whereby a client partakes in the programme while at home. This is more accessible than residential treatment, as it can start promptly, but is only suitable if clients are in a hostel or accommodation where they have strong support.

Ideally, people need to start a rehabilitation programme immediately after the detoxification treatment but this is difficult to arrange. Detoxification services are funded by the National Health Service, but places on alcohol rehabilitation programmes are funded by local authority social services departments. The places are scarce (there are waits of 6-9 months in some areas) and costly (£400-550 per week per client). Because of inadequate move-on services, some people return to a wet centre and resume drinking after detoxification.

## The role of activities

The value of structured activities for people with mental health problems has been well documented, and stimulated the development of sheltered workshops and clubhouses to help people build confidence, skills and self-worth (Beard *et al.*, 1982). Until the late 1990s, however, only a few hostels and day centres for homeless people provided organised activities. With the establishment of the Rough Sleepers Unit in 1999, 'meaningful activities' were encouraged and have since spread widely through the homeless sector.

Activities are promoted at some wet centres, and the Booth Centre exemplifies this work. It has four activity workers and has secured support funding through education and health departments, the latter to provide 'healthy activities' such as sports and outdoor pursuits. Its activities include basic education and skills training (such as cookery and literacy courses), recreational and developmental pursuits (including computer use, artwork, gardening, sports and outdoor activities), and involvement in work and volunteer training schemes, such as conservation projects. The Anchor Centre in Leicester has secured funding from the Department for Education and Skills for an external agency to run activities, and at the Tollington Way wet centre in north London, tutors from Islington College run a literacy group.

Activities play an important role in helping people with alcohol problems and should be a central feature of wet centre provision. They provide opportunities for the constructive use of time as a diversion from drinking, and are a platform for building skills, confidence and a sense of achievement and self-esteem. They promote social interaction and integration through group work, and encourage decision-making and planning for the future. Many chronic heavy drinkers have cognitive impairment, short-term memory loss, and poor concentration and physical coordination. Activities help to improve or compensate for these deficits.

Running activities successfully is a complex task and it is strongly recommended that wet centres seek expert help. Success depends to some extent on the ability of tutors or activity leaders to engage and inspire participants. A useful guide on providing learning opportunities for homeless people, based on a programme developed by The City Literary Institute and homelessness agencies in central London, has been commissioned by the Learning and Skills Development Agency (Cameron *et al.*, 2003). The guide has case study examples and covers building partnerships, offering learners flexibility and choice, and health and safety. For homelessness agency staff who are interested in developing learning activities for their clients, it recommends that contacts should initially be made with: (i) the community education co-ordinator at a further education college; and (ii) the adult and community learning service of the local education authority.

## M4

### Managing the centre

Wet day centres have two linked roles, to engage with street drinkers and help them deal with their problems, and to reduce street drinking and its associated anti-social behaviour and negative environmental impacts. As has been made clear elsewhere in this report, these exceptionally demanding roles are difficult to sustain. This chapter details the most apparent problems of running a centre, how they arise, and how they have been contained and solved at the currently operating centres. The following accounts therefore draw almost entirely from the experience and successes of the centres that have contributed to this study.

#### Staffing

To be effective in delivering its functions, a wet centre requires sufficient staff:

- To provide a safe setting for its users, staff and volunteers.
- To provide basic services to the clients and programmes of constructive and rewarding activities.
- To facilitate individualised work with the clients that involves care planning, support, monitoring, and liaising with other agencies.
- To induct new members of staff and volunteers, and provide cover for holiday and sickness absence.
- To undertake routine performance recording and reviews.
- To enable the managers to develop and maintain contacts with other services, professionals and the local community.
- To allow time for the staff to attend appraisal, supervision and training sessions.

At least one staff member should be a trained first-aider, as accidents and seizures are common among the client group, and one responsible person should have detailed, up-to-date knowledge about how to enlist emergency support from primary health care professionals, the mental health services, and the police.

#### *Skills and roles*

There are two main kinds of work with the clients in wet day centres. *Front-line work* includes the day-to-day running of the centre and supporting the clients when they first attend. It involves delivering basic services such as drinks, meals, standard information and advice (for example about the payment of utility bills), and engaging, getting to know and building trust with the attenders. Front-line workers need to be capable of developing rapport with distrustful and disturbed clients, of managing boisterous exchanges, and directly controlling unruly, threatening or disallowed behaviour. Both staff and volunteers need a clear understanding of the situations in which they should intervene alone, only with support or help, or not at all. They also need a general awareness of what is happening on the streets and in the clients' lives.

The other type of work is with established clients and is individualised. It includes assessing clients' needs, and formulating, implementing and reviewing care-plans with the client. In some centres it is informally organised and even opportunistic; in others it is systematically organised as 'case-work'. The worker requires skills in assessing needs, identifying problems and working out ways to address them, and in developing the client's trust and co-operation. Case-workers also need wide-ranging and up-to-date knowledge of the local welfare system and especially about local specialist statutory and voluntary agencies, their roles, and the referral procedures. Implementing the care-plans requires not only a great deal of work in persuading other agencies to take on the clients, but also in promoting the client's compliance, and in record keeping, monitoring and reviewing progress.

There are also important and valuable forms of *intermediate work* that have, as it were, both 'front line' and 'developmental' functions. Broadly these are the activities for the attenders which are provided and promoted through the centre. Many are organised as group activities and initially presented as such, but provide settings in which individualised 'assessment', advice, encouragement and plans can gradually be introduced. This kind of gradualist approach is especially suitable for mistrustful and wary clients.

#### *Organisation of the work*

Regardless of how the staff are organised, a wet centre needs to have a complement of staff that can deliver front-line work, gradualist engagement and casework. At some wet centres, all core staff are involved in both front-line contacts with the attenders and case-work with established clients. At Tollington Way and the Anchor Centre, some staff are dedicated to front-line work, while others undertake case-work. The front-line workers refer clients who have been engaged and who consent to the case-workers. At the Booth Centre, the staff engage in both kinds of work, and give priority to (a) establishing contacts between the client and the specialist housing, health and substance abuse agencies, and (b) involving the clients in constructive activities. At Handel Street in Nottingham, the staff are involved in front-line work, case-work and tenancy support to housed clients.

#### *Staff supervision and support*

It is manifest that working with the client group is intrinsically challenging and that tensions, aggression, non-compliance and rejection are relatively common (which is why many mainstream services debar the clients). To counter these difficulties and stresses, however paradoxical it may seem, it is unusually important that alongside a strong client-oriented ethos, line management functions are vigilantly applied. They have a vital role in the support and retention of the staff, and in ensuring that the more ambitious but difficult aims of the centre are pursued. The staff require a high level of guidance and support for they have exceptionally challenging roles. Persuading the clients to make positive changes to their lives is far more difficult than providing a

welcoming setting and reassuring exchange. Without the encouragement, support and supervision of the staff, attention to the former can recede.

A tendency could occur for two departures from optimal ways of working. On the one hand, the need to build trust and friendly relationships with the clients can predominate and delay or exclude more reflective exchanges about a client's problematic behaviour. In other words, the alcohol-dependent lifestyle and dependency on the centre can go unchallenged. On the other hand, particularly as a reaction to frequent aggression or argumentative clients and in the absence of other forms of support, an 'us' and 'them' ambience can develop. One symptom is when the staff retreat into 'the office' and shun maximum contact with the clients. While not observed in any of the centres, in some homeless services the situation develops to the point at which the staff see their role as primarily to maintain order and 'keep the lid' on latent problems. In other words, an exceptional degree of what amounts to professional responsibility and dedication to the challenging roles of a wet day centre is required of the staff, and it must be expected that many will be junior, inexperienced and low-paid.

### *Staff training*

Staff training is essential for core staff, volunteers and sessional staff. They need to have an understanding of alcohol dependency issues, such as why people drink, the effects of alcohol abuse on the person and others, and the needs of heavy drinkers. Training is also necessary in managing aggressive and challenging behaviour, and in working with people who have drug and mental health problems. The staff who undertake case-work will additionally require training in assessing needs, and in designing, implementing and reviewing care-plans. Those who are to be involved in the running of activity groups will need group-work skills, while those who are to undertake tenancy-support work will require skills in assessing the housing vulnerabilities of clients and responding to those who are having difficulties.

Developed by 'Skills for Health' in collaboration with other training organisations with an interest in substance misuse, the *Drugs and Alcohol National Occupational Standards* (DANOS) were accredited by the Education Act Regulatory Bodies in October 2002, and launched in summer 2003. These describe the standard of performance required of staff working in the field of substance misuse and the knowledge and skills that they need. They form the basis of national vocational qualifications (NVQs). In the good practice handbook, *Drug Services for Homeless People*, prepared in 2002 by Geoffrey Randall and DrugScope, it is recommended that all staff working with homeless drug users are trained to the standards set by DANOS. The same could be applied to staff working with alcohol misusers. Key skills include:

- Assessing substance misusers' needs and care;
- Helping individuals access substance misuse services;
- Supporting individuals in difficult situations;
- Educating people about substance use, health and social well-being;

- Planning and reviewing integrated programmes of care for substance misusers;
- Supporting individuals' rehabilitation;
- Providing a healthy, safe, secure and suitable environment for the delivery of services.

Wet centres are in their infancy. Many staff at the centres reported little opportunity to meet with each other and discuss working practices. It is strongly recommended that resources are made available for more forums and seminars at which staff could share their knowledge about effective and ineffective ways of working with heavy drinkers.

#### *Recruitment and retention*

Some wet centres have experienced problems in recruiting and retaining staff, and have had a high turnover rate and few staying for more than two years. The low wages of many voluntary sector agencies, weekend work, and challenging and abusive clients are deterrents. Moreover, the work involves supporting people who have been drinking heavily for years, and little or no progress is made with a percentage. At most centres, success is achieved when a client ceases to attend and breaks away from the drinkers' network, while the protracted client contacts are mostly with those who progress slowly or do not accept offered help. Hence the staff only exceptionally learn about the successful outcomes of their advice and support: they are denied this source of job satisfaction and reinforcement of the value of their work. Quotations from the staff describe the work as 'emotionally draining', 'depressing to see the wasted skills of clients', and '[I've been] constantly faced with difficult behaviour; after a while it takes its toll'.

To encourage job satisfaction and staff retention and to provide continuity of care for the clients, Handel Street Centre added tenancy support work to the role of the day centre staff. This means that staff have to learn about both day centre and tenancy support work. On the other hand, job applications for new posts have since increased, and the tenancy sustainment element is believed to have been the attraction. For the staff of the Booth Centre, job satisfaction is associated with being involved in activities and helping clients to change, and being able to observe improvements in the clients. Hence, for wet centre staff, job satisfaction is likely to be achieved when staff have roles that enable them to see the progress of clients. Consideration also needs to be given to the nature of the work and the skills required when staff pay and conditions are fixed. Staff support sessions are essential as a forum for discussing the positive and negative aspects of working in a wet centre and as a means to improve staff morale.

#### *The use of volunteers*

The use of volunteers varies at the wet centres. The Booth Centre has both external volunteers and a Supported Volunteering Project, whereby clients work at the centre one session a week. The staff believe that volunteers have an important role in engaging with clients for they have the time to talk to them (described in Chapter R4). Both the wet centres in Nottingham and Brighton also use volunteers, many of whom have subsequently obtained jobs working with homeless



people. They are not however used at the centres in Leicester and Oxford. The Anchor Centre initially had volunteers but found them to be unreliable and it did not work.

Volunteers work in many social care settings, and some projects for homeless people, particularly drop-in centres, could not survive without their contributions. A great deal has been written about the benefits of volunteering to the volunteers, but less about their impact on clients. The National Centre for Volunteering, established in 1973, offers a range of services to support managers and organisations that work with volunteers, including practitioner networks, publications, and information services (<http://www.volunteering.org.uk>). An Institute for Volunteering Research has been established by the National Centre for Volunteering in association with the Centre for Institutional Studies at the University of East London (<http://www.ivr.org.uk>). A survey carried out by the Institute in 1998 found that four-fifths of 547 organisations (mostly in the voluntary sector) had a designated volunteer co-ordinator, and most had systems in place for supporting and supervising the volunteers. Three-fifths also had procedures for evaluating the volunteers' work.

Three important principles should govern the use of volunteers at wet centres. First, they should not be recruited to replace salaried staff but always to extend and improve the quality of service provision. Second, because of the problems and behaviour of the clients, volunteers must receive systematic training, supervision and support. The training requirement is greater than in a generalist day centre for homeless people and undoubtedly increases the workload of staff. Careful consideration therefore needs to be given to the benefits of having volunteers in wet centres, and whether these outweigh the additional workload for staff.

The third principle concerns engaging clients or former clients as volunteers. The Booth Centre trains clients as helpers on the activity programmes but not at drop-in sessions. They are involved in practical tasks but not in giving confidential advice to or decision-making with clients. Tollington Way in London also has one such volunteer. Involving clients as volunteer helpers is more complex than 'non-client' volunteers, as some may still be involved in the street networks. They will require a great deal of training, supervision and support, and clear boundaries around confidentiality and roles will have to be set. The clients who become volunteers obtain a constructive role in a safe and familiar setting, while they gain confidence and skills. Their involvement at the wet centre should therefore be an interim step to other voluntary work or training.

### **Maintaining links with specialist agencies**

The importance of establishing links with specialist agencies has been described in Chapter R2. These contacts should continue and develop once the centre is operating. The most appropriate and cost-effective ways of working for both the clients and the service-providers should be explored. When the Anchor Centre first opened, a social worker worked at the project one day each week but the workload was insufficient. The time was reduced to one-half day weekly, but the staff can contact the social worker at any time and arrange for clients to be seen.

Regular meetings should be held with all relevant agencies, including street outreach workers, to discuss (i) the wet centre's impacts on the local area, its effectiveness in targeting street drinkers and other street people, and its contribution to local homelessness strategies; and (ii) the services that are provided by the wet centre, and gaps in service provision.

### **Control in the centre**

The functions of wet centres include working supportively with people who have challenging behaviour and, at the same time, providing a safe environment where the attenders are helped. It is essential therefore that the centre is well-managed, the staff maintain control, and that clear boundaries are set for the clients. If this does not happen, there is a likelihood of bullying, intimidation and attempts by the clients to control who comes into the centre. These problems occurred at both Tollington Way and the Anchor Centre, and resulted in volatile and intimidatory situations and some vulnerable clients staying away. Since the introduction of stricter regimes and a barring policy at both centres, there are fewer arguments and less violence. Moreover, the clients who were barred have returned and their behaviour has improved. The staff believe that barring gives clients a reason to control their behaviour, and sends a message to other clients about unacceptable behaviour. Control in the current centres is maintained in the following ways:

1. Restriction of the number of clients admitted at any one time, particularly if the centre is small, and having staff at the entrance to admit clients.
2. Stipulating rules about behaviour in the centre and in its immediate environs, and adopting a barring policy. People are generally barred as a result of (i) violent or threatening behaviour which puts the safety of the clients or staff at risk, or (ii) infringements of the rules which have serious implications on the service, such as dealing in illegal drugs on the premises. People who are intoxicated and behave in a threatening manner are asked to leave that day, while bans of one week or more are imposed for more serious incidents.
3. Challenging clients who are abusive or threatening and working with them to control their behaviour, rather than imposing long-term bans. It is pointless to confront them on the day of the incident if they are intoxicated, but the problem should be addressed subsequently. The Anchor Centre has a 'behaviour contract' which barred clients have to sign before they are readmitted.
4. Recognising the practical limitations of the staff's ability to manage extremely difficult behaviour.

### **Managing the local environment**

It is essential that clear procedures are in place for the management of the local environment of a wet centre and to minimise its impact on the neighbourhood. Ways of initially gaining support and reducing opposition from local businesses and residents were discussed in Chapter M2. Regular meetings with the local community should continue once the centre has opened to provide opportunities to air views and raise concerns. Even at the centres which have been open for a few years, there are still intermittent concerns and complaints from the local community. At

Tollington Way in London, the meetings lapsed after the centre opened but the staff now realise that this should not have happened.

It is important that the wet centre managers and staff respond when concerns are expressed. At Tollington Way, for example, when the staff received complaints about the clients' behaviour outside the centre, they met with the clients and agreed a code of conduct. Similarly at the Anchor Centre, the council and the centre staff worked with the theatre next door to overcome problems (see Chapter R4). At the Specialist Dependency Service in Camden Town, London, one of the manager's roles is to liaise with local residents and businesses. They have the centre's phone number and can ring if, for example, someone is sitting in their doorway. The staff will come out and talk to the person. The centre's 'Neighbourhood Management Policy' describes the staff's responsibilities and commitment. Included are:

- The staff on duty will ensure that there is no disruptive behaviour in the immediate vicinity during the half-hour before opening and after closing.
- At the beginning of each shift, one member of the team will be designated to carry out health and safety checks every thirty minutes while the service is open. These checks will include the area immediately outside the entrance, and the team member will collect litter discarded by the clients.
- The service will not accept people who are behaving in a disorderly or aggressive manner. The team on duty will ensure that people behaving in an antisocial manner leave the immediate area and they will involve the police if necessary.

### **Standards, targets and performance monitoring**

A widespread weakness in many voluntary sector homeless people's services is that very little time and effort is given to setting standards and targets, and to performance recording and monitoring. Traditionally, it has been extremely hard for day centres to assess accurately the quality of their services, particularly those which attract many attenders and have a high client turnover. The organisations consequently have great difficulties in demonstrating their achievements and in securing competitive funding.

Over the last few years, progress has been made in the development of standards which are relevant to homeless people's services, although their implementation in the homeless sector is still in its infancy. *Quality in Alcohol and Drug Services* standards (QuADS) were commissioned by the Department of Health to help improve standards in the substance misuse field. Produced by DrugScope and Alcohol Concern in 1999, QuADS are measurable standards which describe minimum and good practice for the provision of drug and alcohol services. They fall into five groups: (i) core management standards; (ii) core service-user charter standards; (iii) core care standards; (iv) service specific standards; and (v) target group standards. DrugScope have since worked with more than 300 drug treatment services throughout England to implement QuADS, and because of its work with drug users, the Leicester wet centre is participating. Commissioners of alcohol services are increasingly expecting alcohol agencies to meet the QuADS standards.

The Service Audit Partnership, funded by the Association of London Government, is a mutual auditing scheme to improve the quality and safety of projects for homeless people through a programme of peer audits. It has developed a Day Centre Sub Group, with members from Broadway, The Passage, The London Connection and St Martin's Social Care Unit. The Group is adapting the auditing methods and tools of the National Housing Federation Framework for Housing with Support for use in day centres. Day centre characteristics and services are rated according to: (i) basic; (ii) high; and (iii) very high standards. The document can be downloaded (<http://www.serviceaudit.org>). The topics covered include the extent to which day centres have:

- clear aims and objectives, and strategies that encourage targeted groups to attend and collect participation data;
- written information for service users and referral agencies;
- procedures for the formal assessment of clients' needs and for planning care;
- procedures to manage and reduce risk;
- referral arrangements with other services;
- respectful and supportive relationships between staff and clients;
- staffing levels that reflect an appropriate workload to provide a safe service that meets users' needs;
- clear appraisal and supervision procedures for staff;
- staff and volunteers that are appropriately trained;
- buildings fit for their purpose with facilities that are required by clients.

#### *Targets and performance monitoring*

An intrinsic problem for wet day centres is that measuring the prevention and rehabilitation achievements is unusually difficult, partly because there is no way of counting none-events (such as a person *not* becoming homeless or *not* causing a disturbance in a public place), and partly because those who give up problematic drinking or a drug habit may do so when their contacts with a day centre cease. The Anchor Centre and Booth Centre have long lists of performance indicators which focus on the number of clients who are helped by the staff and who are linked into other services (Chapter R4). The Anchor Centre also uses an assessment form to determine individual changes in substance misuse, and information is gathered to monitor housing outcomes. Straightforward and more evaluative indicators of the ways in which a day centre's interventions 'change lives' can be readily recorded and compiled (Box 1).

### **Box 1 Performance indicators at a wet day centre**

#### *Straightforward indicators*

Referrals to temporary accommodation  
 Clients rehoused in permanent accommodation  
 Rough sleepers referred to outreach teams  
 Helped by substance misuse workers  
 Helped to register with a GP  
 Helped to claim (additional) social security benefits  
 Assessed by mental health services  
 Birth certificates and other identity papers obtained  
 Helped to make arrangements to pay off rent arrears or utility debts  
 Participated in a tenancy support programme  
 Helped to budget weekly income  
 Participated in activities  
 Started education, training, employment or voluntary work

#### *Evaluative indicators*

The outcomes after six and twelve months for clients who are rehoused  
 Improvement in eating habits, *i.e.* had cooked meals more frequently  
 Changes over time in alcohol consumption (amount or type of alcohol consumed)  
 Reduction in street drinking  
 Changes over time in morale and motivation  
 Learned (or rebuilt) life-skills such as budgeting or cooking at the centre

### **Summary**

The fundamental challenges that wet day centres face are to provide a welcoming and supportive facility for vulnerable groups of clients focussed on street drinkers (some of whom are chaotic, unco-operative and aggressive), to be pro-active in challenging their anti-social and self-harming behaviour, and to do both of these things with low paid and sometimes inexperienced staff. The work is far from conventional or routine, and many of the usual kinds of job-satisfaction and career progression do not apply. Relatively intensive and continuous supervision and staff support are required. A centre's management (or its parent organisation) must also work hard at developing and sustaining the collaboration and support of many other agencies, both to ensure that the people who can benefit from its services know about the facility and attend, and to gain access to the several specialist services that the clients will require. The aims, working practices

and 'tolerances' of the centre must be fully understood and accepted by the local police and the benefits, housing, primary health care, social service, addiction and mental health services. maintaining the effectiveness of these links is a continuing and demanding task.

If the 'internal focus' and 'external network' attributes are well maintained, the evidence suggests that a 'wet day centre' will directly provide and establish access to a remarkable range and volume of support and treatment services. They will make an impressive contribution to the reduction of unmet needs among the most vulnerable people in our society, and in very real ways change people's lives. If the collaborating agencies do not train new staff and update all staff on the work of the centre, its effectiveness will be reduced.

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