Wet day centres in Britain

How to plan and run a centre where drinkers can start to reverse years of deterioration without having first to stop drinking. This research-based distillation of experience to date will help authorities across Britain as they seek constructive solutions to street drinking. First, getting the planning right.

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of the Sheffield Institute for Studies on Ageing at the University of Sheffield. **Article adapted with permission from the report *Wet Day Centres in the United Kingdom: a Research Report and Manual* published by the Sheffield Institute for Studies on Ageing in 2004 based on research commissioned by the King's Fund and the Homelessness Directorate. We are grateful to the commissioners, publishers and authors for permission to adapt their work**

TYPICALLY ALCOHOL SERVICES require their clients to abstain on the premises. From the late 1970s, 'wet' projects were established in response to the recognition that for some homeless heavy drinkers this was an unrealistic requirement which excluded them from services and did nothing to address concerns over street drinking. Truly 'wet' projects allow drinking on the premises; 'damp' schemes target heavy drinkers but ban on-site drinking. Their common aim is to minimise harm by promoting controlled and less dangerous drinking and healthier and more stable lifestyles. Some are hostels and supported housing projects, others also or instead offer a place to stay during the day. The latter – wet day centres – were the subject of research we conducted in 2003 *The research behind the report* p. 28.

Based on that research we developed guidance on planning and running such centres, the subject of the present series. We tried to place ourselves in the shoes of planners thinking of establishing a facility for street drinkers. The need for a service would have to be established, choices made about its client groups and objectives, on how it will fit into local service provision, its location, and how and by whom it will be managed. The story up to this point is told in this part. In the next issue, part two will address issues that arise once the centre becomes a reality: how it will work with street drinkers and other vulnerable groups, and how it will be staffed and managed.

By the end of the research we had reached two broad conclusions. First, that wet day centres play a vital role in contacting people excluded by or unable to use mainstream housing, health, addiction and social services, and in starting them on a path to treatment and to less problematic lives. Second, that such services are inherently fragile, difficult to run, and can become less effective than they should be. The fundamental challenge they face is to provide a welcoming and supportive facility for vulnerable clients (some of whom are chaotic, uncooperative, and aggressive), yet to be proactive in addressing their anti-social and self-harming behaviour. Sustaining success depends on close and continuing attention to several internal and external operational requirements. What follows describes the forms these take and how they can be managed and mismanaged.

WHO ARE YOU TRYING TO REACH AND WHY?

Centres in England today help not only street drinkers but also people with mental health and drug problems, rough sleepers, ex-offenders, sex workers, and those who are unsettled and move from town to town. Across this range, the client group is distinguished by problematic and self-harming behaviour,

GOLDEN BULLETS Key points and practice implications

- Wet day centres are an important first point-of-contact for street drinkers excluded from or unable to use mainstream services. They also help tackle anti-social behaviour in a constructive, non-criminalising way.
- Their fundamental challenge is to be welcoming and supportive to their clients yet proactive in addressing their anti-social and self-harming behaviour.
- Before establishing a centre, planners should gauge the need for a service of this kind and whether this need can be met in other ways or by developing other services.
- A key planning decision is whether the service is to be for homeless street drinkers only, all street drinkers, or also for other similarly excluded and needy groups.
- There is no single optimal specification for roles, ownership, management and operations. However, services run by small, single-facility charities may be isolated from service networks and lack the capacity to maintain external relations and a consistent service.
- The ideal location is an inner-city neighbourhood without a high density of residents but close to street drinking areas, to a cooperative primary care service, and to benefits, housing and advice services.
- Gaining planning approval requires the early recruitment of allies in the local authority and council and energetic consultation and promotional work with local businesses and residents.
- To be maximally effective, centres must forge and then actively maintain close links with agencies specialising in the complex and multiple problems of the client group.

Background text
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The 'wet' garden at the Booth Centre in Manchester

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. They are among the socially weakest and most vulnerable in our society.

Our understanding of how people reach this point is poor. Some have recently 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, is characterised by few social or productive skills and little 'human capital', and later reinforced by failures in personal relationships and work

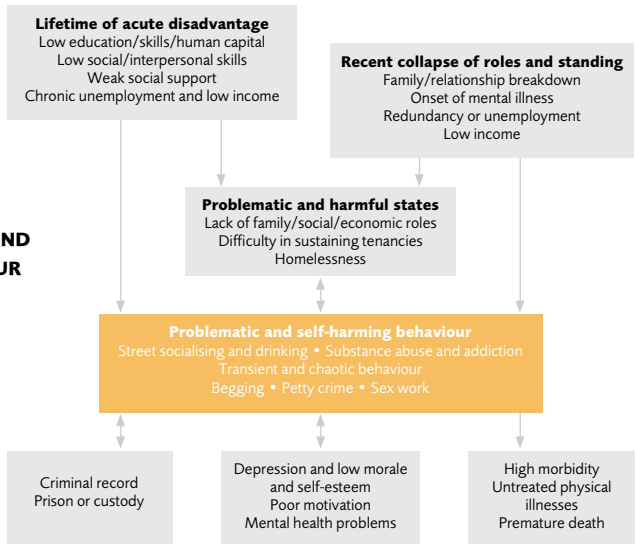
Pathways into homelessness and street behaviour problems p. 26.

Every contemporary town and city will host several such severely disadvantaged groups, and it is important to decide which to target. Is the centre to be for all street drinkers, or only those who are homeless? And what of people who could benefit from such a facility but are not street drinkers? Deciding these questions entails a review not only of current services for street drinkers, but also of those for other disadvantaged and socially excluded populations.

WHAT MAKES STREET DRINKERS DIFFERENT?

Though others may benefit, the term 'wet' implies a service which caters for heavy drinkers with health and social problems who are unwilling or unable to interrupt their drinking. Unlike occasional public drinkers (such as football supporters or arts festival attenders), frequently they drink for many hours in unlicensed spaces in urban squares, doorways and parks, often consuming and sharing cheap but strong beer, cider or sherry drunk from bottles or cans sometimes concealed in bags – unusual behaviour for social drinkers.

PATHWAYS INTO HOMELESSNESS AND STREET BEHAVIOUR PROBLEMS



The client group is also distinguished by its social marginality. They either drink alone or in groups – not of 'lads on a night out', but of down-and-outs, the chronically unemployed, homeless, rough sleepers and beggars. To the public they embody failure, exceptional bad luck, and low personal resolve, an unsettling and uncomfortable spectacle. Sometimes too their behaviour can be problematic and generate public nuisance. They may become intoxicated and boisterous, flirtatious, argumentative or aggressive, or behave indecently, for example, urinating in the street. Mental health problems may manifest in bizarre and occasionally intimidating behaviour.

WHAT DO YOU WANT TO ACHIEVE?

Given this client group, wet day centres have two overarching aims:

1. to help street drinkers and other severely disadvantaged people whose multiple or serious unmet needs are not being met by other services;
2. to tackle an anti-social behaviour problem in a constructive, non-criminalising way.

The first of these is met by providing:

- a contact point for vulnerable people disengaged from or excluded by other services;
- a place for outreach and other agencies to meet and work with clients who are hard to reach or have challenging behaviour;
- a safe, non-judgmental environment which satisfies basic needs for food, shelter, safety, personal hygiene and sociability;
- a base where housing and other needs can be assessed, and from which the help of other agencies can be enlisted;
- and within which those dependent on alcohol can be helped to develop new interests, activities and occupations, in order to build confidence and self-worth and to help control their alcohol problem.

According to the four-tier schema from the National Treatment Agency for Substance Misuse,[1] wet day centres are a tier two, 'open access' service – low-threshold projects which engage substance misusers in treatment and harm reduction services without requiring commitment to a structured therapeutic programme.

KEY ISSUES IN THE PLANNING PROCESS

Wet day centres fit under several local planning headings. Local authorities in Great Britain are required to produce strategies on homelessness and community safety and many are contemplating town and city centre management policies with more coercive measures against beggars, street drinkers and others seen to engage in anti-social behaviour. As part of these strategies, several are considering wet day centres. This section is about the issues they will need to take into account and they steps they should take when planning and setting up a centre.

IS A NEW CENTRE REALLY NEEDED?

The first step is to establish a working group (possibly a sub-group of a homelessness forum) to decide if a wet centre is needed. It should include representatives from statutory and voluntary sector housing, health, substance misuse and social services.

The strength of the case for dedicated wet provision depends largely on the number of street drinkers not currently in contact with services, so initially the group's main tasks are to establish the extent of street drinking and related problem behaviour, to map its locations, to gauge the nuisance caused, and to catalogue the services provided by and the use made of existing centres for drinkers. Often a simple survey of the number of street drinkers who are homeless, not registered with GPs, have untreated health problems, and of their nutrition, will evidence substantial and serious unmet needs. Some drinkers and other street groups rely on accident and emergency departments for primary health care needs, aggravating workload and expense. In these circumstances, it will not be difficult to make a strong case for a drop-in or day centre if none currently exists.

By definition, unmet need may be invisible to existing service providers. To review the adequacy of services, information should be sought not only from the providers but also from relevant outreach workers, homeless advocacy organisations, accident and emergency staff, police, street wardens, and from a sample of drinkers. On paper it may seem that the required provision is already in place, but users may explain that they are barred from services, have to leave hostels during the day, or are deterred by intimidation or aggression from existing clients.

Nevertheless, creating a wet centre may not be the only answer. The solution may be to resource existing projects to remain open during the day, to employ enough staff to ensure a less threatening environment, or to restructure or expand to cater for street drinkers. If the decision is made to go ahead with a wet centre, the working group should steer it through the development phase, with one agency taking the lead. For example, Leicester's housing department took the lead in setting up the Anchor Centre, but worked in partnership with many other agencies.

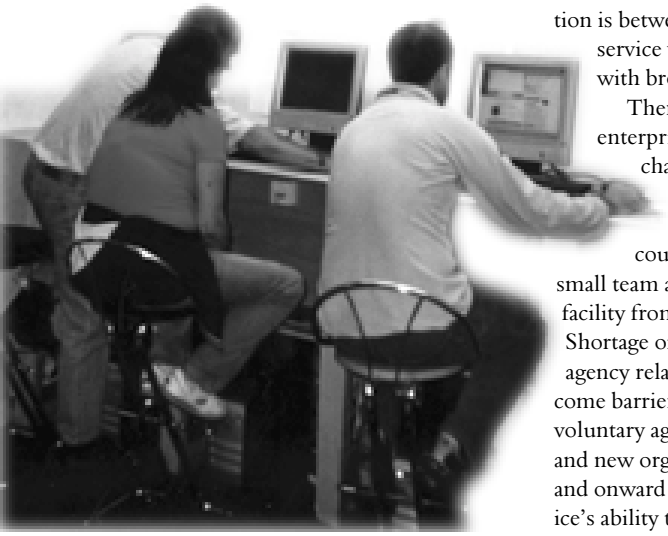
JOHN CHALMERS, ANCHOR CENTRE, LEICESTER

JUST FOR STREET DRINKERS?

In discussion with several agencies, a decision will need to be made about whether to establish a standalone facility or to incorporate wet provision within a day-centre complex for multiple client groups. On this there are different views but little evidence of relative effectiveness.

Staff at the Anchor Centre in Leicester found it difficult to combine a wet and generalist day centre and believe that the best arrangement is a service specifically for drinkers and drug users. During general access drop-in sessions, staff are sometimes diverted from addressing the considerable support needs of the drinkers. There are also concerns that mixing with committed heavy drinkers may encourage other visitors to drink and hinder those who want to overcome their drinking problem.

In contrast, staff in other centres argue that a mixed client group creates a more balanced and less stigmatising environment and means that people do not have to stop coming if they stop or reduce their drinking.



Inside Leicester's Anchor Centre, the computer room offers new horizons and new skills.

Outside, street drinkers on a car park wall.

The Booth Centre in Manchester found that it is possible for drinkers to stabilise and reduce their drinking while attending a wet centre. Non-drinkers can help by providing a model which encourages drinkers to tackle their alcohol problem.

In practice, these decisions will probably be influenced by the availability of premises (◤ below), the extent of the problem, and by local service provision. For example, in a town with a small problem of rough sleeping and street drinking and no homeless day centre, it would make sense to establish a service which incorporates provision for both groups. On the other hand, a large town or city with existing, well attended homeless day centres, might well consider supplementing these with a centre dedicated to street drinkers and other problematic client groups whose needs are not met by current services.

WHICH AGENCY SHOULD RUN IT?

Two of the centres we studied closely were the sole service provided by a small charity and two were run by large, multi-facility specialist housing and welfare agencies. Different structures have different strengths and weaknesses.[2,3] The optimal arrangement will be a function of funding, availability, and the capacity and enthusiasm of local statutory and voluntary housing, primary care, mental health and addiction agencies. Some general observations, however, can be made about the three main options for running a centre: by a statutory agency; as one arm of a multi-facility social landlord or charity; or as the sole service provided by its own dedicated charity.

All share the insecure funding typical of specialist services for marginal groups, if for different reasons. Perhaps the main distinction is between the capacities of a standalone service versus one run by a larger body with broader functions.

There are many examples of the enterprise and enthusiasm of a dedicated charity delivering high quality work, often drawing heavily on volunteers. But these strengths are counterbalanced by reliance on a small team and by the 'separateness' of the facility from the network of local services. Shortage of staff time to devote to inter-agency relations makes it difficult to overcome barriers between statutory and voluntary agencies and between established and new organisations, weakening inward and onward referral pathways and the service's ability to attract a constellation of specialist inputs from external agencies. Lack of administrative and management capacity and experience hinder staff and service development, and threaten continuity of the service.

Larger employers are more likely to have networks in place or the capacity to create them, to be able to deploy back-up staff to avoid closure because key staff are sick or on leave, and to have staff support, mentoring, development and training capacity.

Nevertheless, small standalone services have played a pioneering role, overcoming funding difficulties and sometimes stormy community relations to establish drop-in and day centres for street drinkers and homeless people across the British Isles, in the process demonstrating exceptional enterprise, innovation and tenacity. Several of the largest and best known regional homelessness organisations and housing associations grew from these roots.[4]

This process may not be at an end, but it is likely to become less prominent. In a landscape populated by existing, proven providers, where service development is channelled through local authority strategies and multi-agency groups, there may now be fewer opportunities for new organisations to spring up to fill the gaps. Services are more likely to be commissioned by a strategic statutory body from an established social housing and welfare provider or to be constructed by a partnership of existing agencies.

For example, some local authorities are planning to consolidate services in to an expanded, one-stop centre for rough sleepers, other single homeless people, and substance misusers. With overall responsibility for homelessness services, housing departments organise capital funding, but operational funding will very often come from several non-statutory and statutory agencies.

STREET DRINKERS EMBODY FAILURE, BAD LUCK, AND LOW PERSONAL RESOLVE, AN UNSETTLING AND UNCOMFORTABLE SPECTACLE

PATCHING TOGETHER THE FUNDING

Every local authority can access several potential sources of funding for homelessness services. Special project funding may be available through Supporting People contracts, and from various community development and regeneration programmes administered by the Home Office and the Office of the Deputy Prime Minister (ODPM). Drawing on these sources, larger city councils now organise and direct substantial sums into services for homeless people.

Nottingham City Council has created a Homeless Strategy Coordinator post to take responsibility for seeking out and securing new funding sources for homeless people's services. While housing and social services departments will always be the 'big players', the council believes additional funds might be won under the umbrella of leisure and community or education services and from regional (especially regional housing agencies), national and European sources.

Health funding might also be available. National Health Service priorities include addressing health inequalities and unmet health care needs. Developing services for homeless people is an explicit priority for personal medical services funding, while more generally, NHS primary care trusts have been charged to develop services for homeless people and other high needs groups. Nevertheless, primary care services working with homeless people can expect to face repeated challenges from health funders because they generate high and costly rates of patient contacts and prescriptions. But as long as these services formulate a clear prescribing policy, make this widely understood among relevant patient groups, and can show commissioners and auditors that their policy

and practice is rational and responsibly applied, the evidence from Nottingham and Manchester is that there is no ceiling on the drugs budget.

Adaptation to tap into relatively generous drug misuse funding streams is a common strategy among alcohol services, and one adopted by the Anchor Centre. Originally this focused on street drinkers but then extended to include drug users, attracting funding from Leicester's drug and alcohol action team. The staff believe the move was beneficial; many clients have both alcohol and drug problems and the funding allowed them to improve the service.

UNOBTRUSIVE BUT ACCESSIBLE LOCATION

Finding suitable premises for homeless people's services and gaining the necessary approvals is not easy. The difficulties are compounded when setting up a wet centre for clients with a generally negative public image, especially since it may attract more of these 'undesirables' to the area.

First, where the centre should *not* be: high density residential neighbourhoods; near schools, playgrounds, or other sensitive facilities; 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. In such areas this will be noticed and brought to the attention of the police, who will be obliged to intervene. Also avoid areas which already have extensive provision for other social problems, such as hostels for homeless people or for ex-offenders, or that are very run down, uniformly depressing, or in the 'back of beyond'.

On the other hand, the location should be accessible, which probably means within walking distance of the town centre or wherever most potential clients congregate. The ideal would be an unremarkable inner city neighbourhood in which 'life goes on' but without a high density of residents. It is also a great advantage (unless comprehensive health care is to be provided at the centre) to be near a health centre or GP practice which accepts homeless and chaotic patients. Similarly with benefits and housing advice offices and citizens' advice bureaux. If sessional workers are envisaged, adequate and safe parking will encourage their agencies to cooperate.

Most of today's wet centres are small with cramped working conditions – not ideal. Reasonable space is needed to accommodate disturbed clients or those wary of or irritated by being too close to others. Overcrowded conditions are likely to aggravate tension leading to arguments and potential aggression. Rooms are needed for clients to talk privately to workers in a quiet environment. Ideally, the area used by clients should be confined to a single floor which can be supervised by the minimum of staff.

ORGANISE TO OVERCOME NIMBY

Planning applications for homeless people's services are often refused after local objections. Due to connections and credibility, local authorities, NHS agencies and churches (in that order) probably have a head start in gaining approval, but can still face vociferous opposition. Gaining early support from the local authority and councillors is critical; it helps if the authority's homelessness strategy identifies the need for such a facility. High quality information about the aims and running of a wet day centre should be prepared well in advance of the proposal being made public, and once it has been, there should be intensive consultation with immediate neighbours and local resident groups and businesses.

WET CENTRES ARE INHERENTLY FRAGILE, DIFFICULT TO RUN, AND CAN BECOME LESS EFFECTIVE THAN THEY SHOULD BE

Before setting up Tollington Way in north London, staff consulted widely with the local community 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 residents to join the management committee, so that the local community had – and felt they had – input into the development. Similarly, at the Specialist Dependency Service in London's Camden Town, the most vocal opponents of the day centre were invited on to its steering group. Staff also designed a Neighbourhood Management Policy detailing their responsibilities and commitment to the community which was sent to local businesses and residents.

NO GOOD UNLESS PEOPLE KNOW ABOUT IT

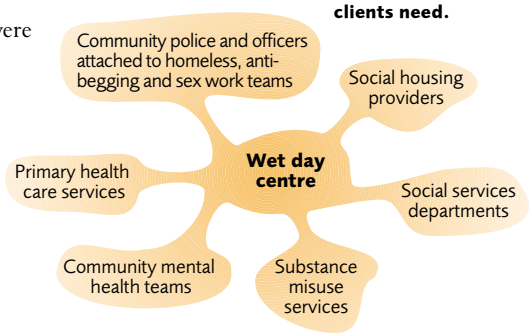
Suitable premises, services, and opening times create the potential to attract the intended client groups. The next step is to encourage them to actually use the centre. Some first contacts will be referrals from police or street wardens, others self-referrals prompted by word-of-mouth – 'grapevines' among street people about soup runs, day centres and hostels can be highly effective. Self-referral should therefore be encouraged.

But not all street people are connected to the grapevine. Some are newly arrived, others are isolates or ignorant of services. Regular and persistent street outreach is essential to locate these people, build rapport and trust, tell them about the centre, and encourage them to attend.

In a few cases, centre staff themselves undertake this work, but most centres rely on street outreach teams for rough sleepers. Using centre staff diverts them from their core work, especially since street work must be done at least in pairs. Many staff also believe existing outreach teams can do the work better; they have the time to go around the streets and know where street people congregate. There is, however, value (as in

THE SERVICE NETWORK

Wet centres can only function effectively when they have access to the services their clients need.



THE RESEARCH BEHIND THE REPORT

The arguments and practice guidance in this article were based on a review of relevant literature and site visits and interviews with the managers of eight wet day centres in England. An in-depth study of four centres was also conducted which included interviews with staff and clients, reviews of records and reports, and interviews with staff in housing, health, social, and police services involved with the centres. An attempt was also made to assess the centres' role within and impact on the local community.

The four centres were:

- Tollington Way, north London;
- Booth Centre, Manchester;
- Handel Street Centre, Nottingham;
- Anchor Centre, Leicester.

These were selected to represent a range of different ways of working 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 (managed by Framework Housing Association) also provides a tenancy support service.

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OFFCUT 2

Crime and disorder reduction partnerships in England and Wales acknowledge alcohol's role in crime and disorder but most have yet to commit to tackling these issues. [1] Home Office researchers analysed the partnerships' audits of crime and disorder in their areas in 2001/02 and their strategies for the following three years. Almost all the audits mentioned alcohol, with about half or more linking it to disorder or anti-social behaviour, the night-time economy, or violence. However, only a around a fifth of partnerships which identified a link to violence or disorder (and virtually none which mentioned the night-time economy) prioritised alcohol in their plans and few set explicit targets. When it was among the priorities, alcohol was often subsumed under a 'drug and alcohol' or 'substance misuse' priority with illegal drugs the prime focus.

[1] Richardson A. et al. *Alcohol audits, strategies and initiatives: lessons from crime and disorder reduction partnerships.* Download from www.homeoffice.gov.uk/rds.

Brighton) in centre workers occasionally accompanying them to be introduced to new clients and to recontact former attenders.

HOLISTIC CARE REQUIRES PARTNERS

To be maximally effective, wet centres require input from agencies specialising in the complex health, substance misuse, housing and social problems of the client group ◤ *The service network*. It is critical that these and other agencies such as the probation service are involved early in the centre's development. In Leicester, their commitment was secured through a memorandum of understanding drawn up at the planning stage. As a result, the centre now receives substantial inputs from partner agencies. In contrast, no partnership arrangements were sought before Tollington Way opened. The clients' unmet needs soon became apparent but the centre had great difficulty in securing specialist help. Three years later, it had yet to forge links with a primary care service.

HEALTH AND WELFARE INPUTS ARE ESSENTIAL

Centres need primary care services on-site, or to be closely linked and jointly planned with a nearby health centre with an interest in the client group. Specialist health services enable screening, disease management and health promotion to be carried out with clients who may not comply with traditional services. For example, in Leicester, Nottingham and Oxford, GPs and nurses provide a home detoxification programme.

The prevalence of mental health problems in the client group dictates a need to forge good links with community mental health teams. Several wet centres have input from specialist teams for homeless people, but find it difficult to link housed clients into mainstream mental health services.

Links to substance misuse workers are also essential. They can counsel clients on how to control their substance use and reduce the harm it causes and advise them about treatment and support programmes. They also play a crucial role in assessing a client's needs and motivation for treatment and in linking them to services. If workers regularly visit, clients become familiar with them and more readily accept their help.

Social workers visit centres in Leicester and Manchester weekly to carry out community care assessments for admission to alcohol rehabilitation programmes or residential care (both funded through social services) and to arrange the placements. They also help clients obtain housing and benefits and (for those who have a home) assess for and arrange services such as meals-on-wheels, home care, disability aids and adaptations, and tenancy support.

HOUSING AND HOUSING SUPPORT

Many street drinkers require interim or long-term supported housing. Occasionally they also need residential care to cope with the aftermath of years of heavy drinking and physical and mental health problems. These key needs should be addressed early in the planning process through links with social housing providers and by establishing housing quotas and referral procedures.

However, there are difficulties. Statutory services sometimes refuse to accept responsibility for a person until they deteriorate to the point where they need admission to a residential care home. Lacking residential homes for heavy drinkers, many towns and cities place them in homes for older people, creating problems for drinkers, staff and residents. Moreover, many who need supported housing are young or middle-aged.

Some centres have responded by developing their own housing. In 2003, Equinox opened a 'wet house' near the wet centre it runs in Brighton. Funded through housing benefit and Supporting People revenues, it can permanently house five heavy drinkers. Most residents are in their late forties or older and disabled or 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 which are staffed by four supported-housing workers.

MIXED ROLES FOR THE POLICE

Local community police and officers attached to homeless, anti-begging and sex work teams, should be involved early in the planning process. This is better than leaving it until their involvement is perhaps forced by complaints from residents and businesses concerned by the influx of street people or by serious offences such as drug dealing.

Police have multiple and seemingly contradictory roles in relation to street drinkers and wet centres. A primary duty is to maintain law and order, including enforcing drinking bans in designated areas. They may need to caution or take further action against street drinkers breaching the ban or whose behaviour has raised public concern.

But they can also be supportive. Local beat or town-centre team officers have valuable (if particular) local knowledge of street people and of helping agencies. Often a police officer is the first to contact a rough sleeper or street loiterer new to the area. They should be encouraged to tell these contacts about the centre and make referrals. To do this well, they must be provided with up-to-date knowledge about the centre and its services. This is not a one-off task; personnel change and memories are short. For example, at first police regularly brought street drinkers to Brighton's day centre as part of their 'drunk and incapable' policy. It sometimes enabled staff to intervene early to prevent tenancy breakdown. But over time there was a turnover of police and the protocol was discontinued.

HIGH WIRE ACT ON A SHOESTRING

So far we've seen that to create the possibility of an effective service, centre managements must first prepare the ground thoroughly and work hard at developing and sustaining the collaboration and support of many other agencies. The aims, working practices and 'tolerances' of the centre must be fully understood and accepted by police, benefits offices, and by housing, primary care, social, addiction and mental health services.

In the next part we'll address the staffing and management issues which arise once a centre starts work. Despite the difficulty and importance of the work, staff are poorly paid and sometimes inexperienced, their work is far from conventional or routine, and many of the usual job satisfaction and career progression benefits do not apply. Yet with adequate supervision and continued focus on core objectives and tasks, they can make an impressive contribution to the reduction of unmet needs among the most vulnerable people in our society.

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LINKS Nugget 3.5