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.

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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

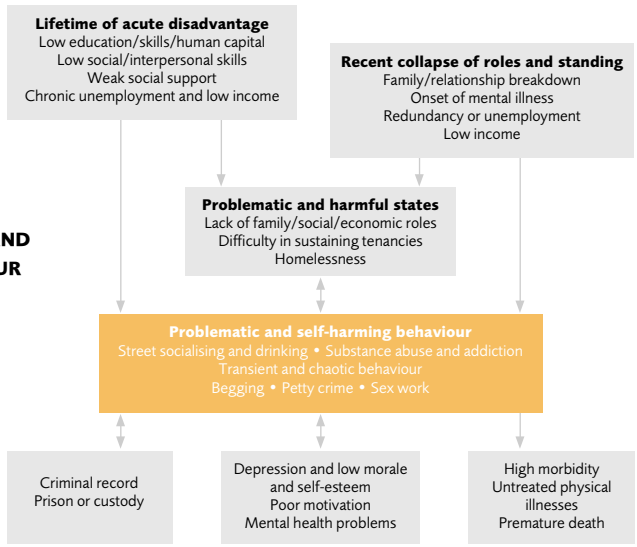
Pathways into homelessness and street behaviour problems p. 26.

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.

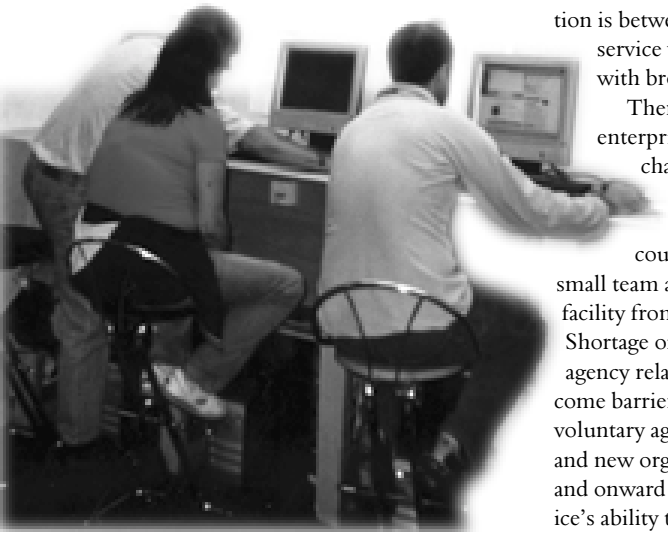
JOHN CHALMERS, ANCHOR CENTRE, LEICESTER

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

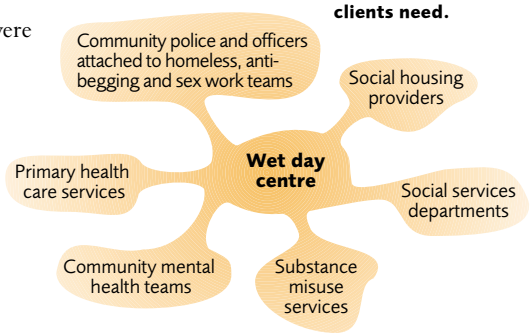
Suitable premises, services, and opening times create the potential to attract the intended client groups. The next step is to encourage them to actually use the centre. Some first contacts will be referrals from police or street wardens, others self-referrals prompted by word-of-mouth – 'grapevines' 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

DRUG & ALCOHOL FINDINGS

Care Control Challenge

A wet day centre can only cohere into an effective force for change when seemingly contradictory elements are made to interlock – when challenge and control promote care rather than exclusion and care enables challenge rather than encouraging stagnation.

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WET DAY CENTRES offer drinkers a place to stay during the day where they don't have to stop drinking, a vital first point of contact for people who would otherwise be excluded from services. But these centres are inherently fragile and difficult to run. They must be welcoming, yet proactively address anti-social and self-harming behaviour, and do both with low paid and at times inexperienced staff.

Part one of this series (◤ issue 12) dealt with how to plan and set up a service. This final part takes up the story when a centre has become a reality, and its management and staff face the demanding task of maintaining order yet retaining focus on the more challenging objectives: helping clients control their drinking, and maintaining good community relations. First we describe how centres engage and work with their clients, then the management structures needed to keep the work on track.

Working with the clients: safety, welcome and challenge

To describe the work that needs to be undertaken with wet-centre users we draw on interviews with clients and staff at the four British centres that we studied closely and the experiences of other centres ◤ *The research behind the report*, p. 20.

EMBRACE NEWCOMERS (BUT NOT TOO TIGHTLY)

It is important that a centre's environment is attractive, safe, free from intimidation, and welcoming to new clients. Ideally rooms are bright and spacious, so clients who normally have little close contact with others do not feel cramped. Front-line staff should welcome new clients (one might be designated for this role), explain what the centre offers, and take every opportunity to sit with and get to know them. Staff at the Booth Centre find the wet garden a relaxing 'half-way step' in to the centre for the more wary. Volunteers can play important roles in engaging clients and making them feel at ease.

First contacts have to be handled tactfully, eliciting any pressing problems without probing so insensitively that the client is scared off. Some wish to talk, others initially to be left alone. Staff need to be aware and respond accordingly. More information can be collected once they have engaged with the centre. Women may have particular issues they wish to discuss, and a women's group might be useful.

CONDUCT A BROAD, PHASED NEEDS ASSESSMENT

Most centres collect basic personal information from a client when they first attend, but not all later undertake a detailed assessment of problems and needs. To best help a client, information is required about:

- recent housing, including tenancies, temporary accommodation, or rough sleeping; recent and current problems with tenancies, including rent arrears; and experiences of homelessness;
- family and social contacts, and contact with drinkers and non-drinkers;
- income, state benefits, and financial problems;
- physical health problems and nutrition;
- morale and indications of depression, mental illness, unresolved stresses or memory difficulties;
- alcohol consumption, including types, drinking pattern, drinking history, reasons for heavy drinking, and involvement in alcohol treatment;
- use of illegal 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 list, the assessment cannot be completed at a single interview. Moments will have to be sought when a client is fairly sober and willing to talk. Mental health or cognitive problems will leave some unable to give accurate details, while others will be reluctant or deliberately mislead. If the client consents, information should also be sought from other agencies. Needs, abilities and attitudes will change as problems are resolved or ameliorated, so assessments have to be frequently updated. There needs to be a thorough assessment of a client's daily living skills as a basis for determining their suitability for different types of housing. Even among those who are housed, many struggle to cope at home.

PROFILE RISK TO SELF AND OTHERS

Most clients are vulnerable and some have challenging behaviour, so it is essential that risk assessments are undertaken and updated. These assess whether someone poses a risk to themselves or others and whether the risk can be managed within a service. A

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comprehensive guide, *Risk Management Policy and Procedure*, is available from www.serviceaudit.org. Such assessments are not normally used to exclude people but to ensure they receive the best possible service.

Risk assessments need to consider:

- behaviour, including violence, abuse, harassment, likelihood of dangerous accidents linked to substance misuse or smoking, and persistent provocative behaviour;
- physical health, and risks from mobility, weight, self-neglect and substance misuse;
- mental health, and the risks of self-harm and of bizarre behaviour;
- daily living skills, including risks while preparing food and using appliances at home;
- the condition of clients' accommodation, including outstanding repairs, infestation, faulty appliances, furniture and flooring.

FIRST THINGS FIRST: FEED AND CLEAN

Many heavy drinkers have poor diets, partly because they spend their money on drink, and partly because they are prone to health problems which affect appetite and digestion. Most wet centres provide a free cooked breakfast or dinner, and the Brighton centre also gives out vitamin tablets. Meeting nutritional needs is important. Free hot and cold drinks should be available at all times and nutritious food served at least once a day. If there is a charge for food, it should be discretionary and dependent on circumstances. Some staff believe free food encourages attendance and ensures at least one meal a day, others that it enables clients to spend more on alcohol. Attention should also be paid to whether clients are eating; some may need encouragement. If there is cause for concern, clients should be referred to a primary care nurse or GP.

Some heavy drinkers neglect personal hygiene, do not launder clothes, and become incontinent when drunk. Skin infestations, especially lice and scabies, are common among those sleeping rough or in neglected tenancies. Most wet centres have showers and laundry facilities or are close to centres which do. Staff need to encourage personal hygiene. Clean clothing and toiletries may prompt some clients to shower and change, and leaflets about hygiene may encourage interest. A clear policy is needed for managing clients with skin infestations. For example, at Leicester's Anchor Centre, nurses treat clients with lice.

PLANNING FOR THE FUTURE

Only a few wet centres carry out individual casework with clients by a named worker, but most staff we interviewed recognised the value of assigning each client a named keyworker who is responsible for seeing they get the help they need. It ensures that interventions with clients are followed through and that the needs of the withdrawn or undemanding are not neglected.

Keyworkers assess needs, design a care plan with realistic goals, refer to specialist agencies, and coordinate the client's care. Care plans should be prepared and agreed with the client when they are sober and coherent, and regularly reviewed. They must address immediate problems, such as lack of income, poor nutrition, untreated illness, poor hygiene, and lack of accommodation, and more complex issues such as alcohol abuse and long-term housing and support needs. They should also seek to build confidence, self-esteem and motivation. What comes first will depend on the individual. Some rough sleepers will not consider temporary accommodation until their confidence and self-esteem has been boosted, and some heavy drinkers will not attend to personal hygiene until their drinking is controlled.

CENTRES MUST BE WELCOMING YET PROACTIVELY ADDRESS ANTI-SOCIAL AND SELF-HARMING BEHAVIOUR

Many clients have long-standing problems. Working with them will be slow and should be paced to the individual. The keyworker will be able to complete some agreed actions, such as filling in benefit forms. For others they will need the inputs of primary care nurses and mental health teams. In such cases, care plans should be coordinated by the keyworker with regular reviews and liaison across agencies.

Despite their problems, clients have often had little or no contact with services for some time. To address health and welfare problems, it is imperative that such contacts are made. At some wet centres, outside agencies hold regular sessions, and the keyworker should ensure that their clients are seen by these workers. In other cases they will need to arrange for the client to attend an outside agency – no easy task, as some fail to keep or forget appointments, or leave if they are kept waiting. Early appointments (before the person has drunk a lot) and escorting the client have proved useful.

HELP HOUSED CLIENTS STAY THAT WAY

Many heavy drinkers with tenancies live alone and find it hard to manage. They neglect to pay bills and clean and some live in squalid conditions. Rent arrears and tenancy failures are common. Home care services are difficult to arrange because staff refuse to go to flats where there are several drinkers, and the clients are often not at home or refuse to answer the door. 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 clients do not report problems or seek help until taken to court and evicted.

Given these problems, many housed clients need tenancy support – some for a long time – if homelessness is to be avoided. Centres have to decide whether to undertake this or to refer clients to tenancy support teams (if available). The advantages of wet centres being directly involved are that clients already know and are in frequent contact with the staff. Sorting out rent arrears, helping clients pay bills, intervening in neighbour disputes, and arranging for cleaning and furnishing, is, however, time-consuming work, and joint home visits may be necessary when there are safety concerns.

TAKE ACCOUNT OF THE SOCIAL DYNAMICS

There are many social relationships among clients at wet centres. The significance of these relationships is heightened among a group of people who in general lack

GOLDEN BULLETS Key points and practice implications

- A key management task is to provide a welcoming and reassuring service which does not neglect the more challenging role of prompting clients to move forward in their lives.
- It is essential to maintain order within the centre by enforcing clear boundaries, to minimise local nuisance, and to respond to community concerns.
- Detailed assessments of problems and needs should incorporate assessments of risk to self and others and of whether and how these can be managed by the centre.
- To address health and welfare problems, it is imperative that contacts are made and sustained with external agencies including (unless this is done in-house) those providing tenancy support.
- Clients who wish to tackle their alcohol problems commonly require detoxification followed by several months of rehabilitation.
- Staff should monitor clients' alcohol intake and intervene if someone drinks at unsafe levels.
- Meaningful activities provide opportunities for the constructive use of time and a platform for building skills, confidence and a sense of achievement and self-esteem.
- Staff have exceptionally challenging roles and require a high level of guidance and support. Job satisfaction is improved when they are enabled to witness client progress.
- Given attention to these priorities, wet day centres can make an impressive contribution to reducing unmet need among the most vulnerable people in our society.

intimate relationships and family contacts. Some have socialised for years on the streets and in hostels, and 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. Their lives are interlinked. When planning care, consideration has to be given to the individual's relationships with peers and how this might impact on the help that is given.

HOW TO ADDRESS ALCOHOL PROBLEMS

Little is known about how best to tackle alcohol problems in this client group. Most staff we interviewed believed that allowing clients to drink at wet centres is a positive move. It encourages people excluded from other services to use the centre, and it reduces tensions and facilitates communication between staff and clients, who no longer have to conceal their drinking.

It can, however, be extremely difficult (though not impossible) for clients to stabilise their drinking while attending a wet centre. They attend for just a few hours a day and mix with other attenders who drink heavily, and life away from the centre tends to revolve around other drinkers they have known for years. To control or reduce their drinking, they may need to stop attending, break away from drinking friends, and be referred elsewhere for help.

DETOXIFICATION AND REHABILITATION

Clients who wish to tackle their alcohol problems commonly require detoxification followed by months of rehabilitation. However, multiple episodes of alcohol withdrawal may (the evidence is contested) risk neurological damage and cognitive dysfunction. If this is the case, clients should be very carefully selected. Helping to control and reduce drinking may be more appropriate for those unlikely to sustain abstinence.

In some cities the wait for a detoxification place is up to 10 weeks but in Nottingham, Framework Housing Association runs both a wet centre (Handel Street) and a residential treatment project for heavy drinkers with a detoxification bed, providing a fast and efficient alcohol treatment service for wet centre users. Elsewhere, home detoxification services are available. These can start promptly and are more accessible than inpatient treatment, but are only suitable for stably-accommodated clients with strong social support.

Ideally, rehabilitation starts straight after detoxification, but this is difficult to arrange. Detoxification is funded and arranged by the NHS, rehabilitation by social services. Places are scarce (waits of six to nine months in some areas) and costly (£400–550 per week per client). Inadequate move-on services mean some return to a wet centre and resume drinking after detoxification.

RULES AND RESTRICTIONS

Wet centres have different rules about drinking on the premises. Some allow drinking only in a designated room or garden, others anywhere. Some restrict the amount of alcohol brought in, others monitor neither quantity nor types. It is important to remember that whilst monitoring can limit the 'import' of alcohol on to the premises, it cannot restrict the amount of consumed throughout the day. Many clients have drunk alcohol before arriving, some share drinks in the centre, and others go outside to drink.

On this issue, staff views were diverse. Some opposed restrictions because these affect relationships with clients and place staff in a 'policing' role. They also feared some clients might stop coming, though no instances were reported. Instead, they preferred other strategies for controlling alcohol consumption, including engaging clients in activities. Those in favour of restricting alcohol argued that:

- It improves behaviour and makes the environment more welcoming and safer for clients and staff. Some needy clients stay away if a centre becomes rowdy and volatile.
- The centre should aim to reduce the damage clients do to themselves through alcohol. It should not communicate that it is acceptable to drink irresponsibly.
- It is impossible to work constructively with highly intoxicated clients.
- It is irresponsible to allow clients to drink liberally on the premises. Their drink and drug use before coming to the centre is unknown, and heavy drinking can be lethal. Moreover, if clients become intoxicated, when the centre closes there are health and safety implications for neighbours and the public as well as for clients.

Despite mixed opinions, most staff agreed that it is irresponsible to allow clients to use the centre simply as a social drinking venue and to permit consumption of large amounts of alcohol. They also believed that there should be activities at the centre and other interests to engage the clients, so they do not drink because there is nothing else to do, and that staff should keep an eye on the amount being drunk and intervene when there is cause for concern.

In summary, if rigid alcohol restriction rules are not imposed (and we do not recommend they are), then it is essential that staff integrate with the clients, observe their alcohol intake, and intervene if a person drinks excessively.

SOMETHING MEANINGFUL TO DO

The value of 'meaningful', structured activities for people with mental health problems has been well documented, stimulating the development of sheltered workshops and clubhouses to help build skills, confidence and self-worth.[1] These have spread widely in day centres for homeless people, particularly since the Rough Sleepers Unit was established in 1999.

Several wet centres promote activities, as exemplified by the Booth Centre. It has four activity workers and has secured education and health funding, the latter for sports and outdoor pursuits. Other activities include basic education and skills training (such as cookery and literacy courses), recreational and developmental pursuits (including computer use, art and gardening), and work and volunteer training schemes such as conservation projects. The Anchor Centre has secured education funds for an external agency to run activities. At Tollington Way, local college tutors run a literacy group.

Activities should be central to wet centre provision. They provide opportunities for

Years of heavy drinking and homelessness mean progress can be slow.

JOHN CHALMERS, ANCHOR CENTRE, LEICESTER

Recreation, rest and referral at the Anchor Centre in Leicester.

the constructive use of time, a diversion from drinking, and a platform for building skills, confidence, self-esteem and a sense of achievement. They promote decision-making, planning for the future, and social interaction and integration through group work. Activities may also compensate for the cognitive deficits and poor physical coordination suffered by many chronic drinkers.

Running activities is a complex task on which wet centres should seek expert help. Success depends to some extent on the ability of tutors or leaders to engage and inspire. A useful guide for working with homeless people has been commissioned by the Learning and Skills Development Agency.[2] It recommends that staff initially contact the community education coordinator at a further education college and the local authority's adult and community learning service.

Managing a wet centre: facing in, facing out; containing chaos, staying focused

Wet day centres have two linked and demanding roles: to engage with street drinkers and help them deal with their problems; and to reduce street drinking and associated anti-social behaviour and negative environmental impacts. This section details the most apparent problems of running a centre, how they arise, and how they have been contained and solved, drawing almost entirely on the experiences of the centres which contributed to this study.

ENOUGH OF THE RIGHT PEOPLE

A wet centre requires enough staff to:

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

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

BALANCE FRONT-LINE AND CASE WORK

There are two main kinds of work with clients in wet centres. 'Front-line' work includes the day-to-day running of the centre and supporting clients when they first attend – delivering basic services such as drinks, meals, standard information and advice, and engaging, getting to know and building trust with attenders. Front-line workers need to be able to develop rapport with distrustful and disturbed clients, manage boisterous exchanges, and control unruly, threatening or disallowed behaviour. Staff and volunteers need a clear understanding of the situations in which they should intervene alone, only with support, 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 individualised 'developmental' work with established clients to help them make positive changes in their lives. It includes assessing needs, and formulating, implementing and reviewing care plans. Workers require skills in carrying out these tasks but also in gaining the client's trust and cooperation. Caseworkers also need wide-ranging, up-to-date knowledge of the local welfare system and the roles and referral procedures of specialist agencies. Implementing care plans requires a great deal of work, not only to persuade other agencies to take on the clients, but also to promote the client's compliance, keep records, and to monitor and review progress.

There are also valuable forms of intermediate work with both 'front-line' and 'developmental' functions, primarily the activities 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, an approach specially suitable for wary clients.

Every wet centre needs staff who can deliver front-line work, gradualist engagement and casework. At some, all core staff take on these roles, at others, some are dedicated to front-line work and refer clients who have been engaged and who consent to dedicated caseworkers.

INTENSIVE STAFF SUPPORT IS ESSENTIAL

Working with this client group is intrinsically challenging; tensions, aggression, non-compliance and rejection are common – why many mainstream services bar the clients. To counter this, it is unusually important that, alongside a strong client-oriented ethos, line management functions are vigilantly applied. These have a vital role in supporting and retaining staff and ensuring that the more ambitious but difficult aims of the centre are pursued.

Challenging roles demand a high level of guidance and support for staff who in turn require an exceptional degree of professional responsibility and dedication. Persuading and enabling clients to make positive changes is far more difficult than being welcoming and reassuring. Without support and supervision, the former can lose out.

The temptation is to drift from optimal working methods in at least two ways. First, building relationships with clients can eclipse more reflective exchanges about problematic behaviour, leaving alcohol-dependent lifestyles and dependence on the centre unchallenged. Second, unsupported

staff may react to aggressive or argumentative clients by allowing an 'us' and 'them' ambience to develop, retreating to 'the office' and shunning maximum contact. They may come to see their jobs as primarily to maintain order and 'keep the lid' on latent problems.

TRAINING AND PEER EXCHANGE

Training is essential for staff and volunteers. They need to understand alcohol dependence and the needs of heavy drinkers, develop skills in managing aggressive and challenging behaviour, and learn how to work with people who have drug and mental health problems. Casework staff will also require training in assessment and care planning, those involved in activity groups will need group-work skills, and those undertaking tenancy support will require skills in assessing housing vulnerabilities and responding to difficulties.

Drugs and Alcohol National Occupational Standards (DANOS) describes the performance, knowledge and skills required of substance misuse workers and forms the basis of national vocational qualifications (NVQs). A government-sponsored handbook recommends that all staff working with homeless drug users are trained to DANOS standards;[3] the same could be said of staff working with alcohol misusers. Key skills relevant to wet centre workers include: assessment; helping individuals access services; supporting them in difficult situations; educating about substance use, health and social well-being; coordinating care; supporting rehabilitation; and providing a healthy, safe, secure and suitable environment for the delivery of services.

Training is one way to develop skills, peer contact is another. Wet centres are in their infancy, yet staff report little opportunity to meet and discuss working practices. It is strongly recommended that resources are made available to enable staff to share good (and bad) practice.

SEEING SUCCESS IMPROVES MORALE

Some wet centres have problems recruiting and retaining staff. Low wages, weekend work, and challenging and abusive clients are among the deterrents. Moreover, the work involves supporting people who have been drinking heavily for years. Some will make little or no progress. Clients who do make major progress are likely to stop attending and break away from the drinkers' network, while the less improved and more resistant stay in contact. Hence, staff may not see their successes. Not surprisingly, they describe their work using phrases such as: "emotionally draining"; "depressing to see the wasted skills of clients"; and "constantly faced with difficult behaviour; after a while it takes its toll". Job satisfaction is likely to be greater when staff are enabled to witness client progress.

To improve job satisfaction and staff retention, and to provide continuity of care, Handel Street extended the roles of its staff to tenancy support. It added variety to the work and enabled staff and volunteers to witness satisfyingly concrete client benefits. As a result, job applications increased. At the Booth Centre, job satisfaction is associated with being involved in activities, helping clients change, and seeing the changes. Staff support sessions are essential for discussing the positive and negative aspects of the work and improving morale.

MIXED VIEWS ON VOLUNTEERS

Wet centres vary in their use of volunteers. In addition to external volunteers, the Booth Centre's Supported Volunteering Project recruits clients to work at the centre one session a week. Staff believe that volunteers have an important role in engaging with clients for they have the time to talk to them. The Nottingham and Brighton centres also use volunteers, many of whom later obtain jobs working with homeless people. The Anchor Centre initially had volunteers but found them unreliable and the arrangement did not work.

AN IMPRESSIVE CONTRIBUTION TO THE REDUCTION OF UNMET NEED AMONG THE MOST VULNERABLE PEOPLE IN OUR SOCIETY

Three important considerations should govern the use of volunteers. First, they should not replace salaried staff but extend and improve service provision. Second, because of the nature of the clients, an unusually high level of systematic training, supervision and support is essential. This extra burden on staff needs to be carefully weighed against the benefits.

The third is about engaging clients or former clients as volunteers, potentially complicated if they are still involved in street networks. They require a great deal of training, supervision and support to establish clear boundaries around confidentiality and roles. The Booth Centre trains clients to help with activity programmes but not with drop-in sessions; they are involved in practical tasks, but not in giving confidential advice or decision-making with clients. They benefit from playing a constructive role in a safe and familiar setting while gaining confidence and skills, ideally an interim step to voluntary work or training outside the centre.[i]

DON'T LOSE CONTROL

While working supportively with people who have challenging behaviour, wet centres must also provide a safe environment. It is essential that the centre is well managed, that staff maintain control, and that clear boundaries are set. If this does not happen, the likely results are bullying, intimidation and attempts by the clients to control who comes in to the centre.

These problems occurred at Tollington Way and the Anchor Centre, creating a volatile and intimidatory atmosphere which some vulnerable clients preferred to stay away from. Since introducing stricter regimes and barring policies, arguments and violence have decreased. Moreover, barred clients have returned and their behaviour has improved. Staff believe barring gives clients a reason to control their behaviour and sends a message to other clients about what is unacceptable.

Control in the current centres is maintained by:

- restricting the number of clients admitted at any one time, particularly if the centre is small, and having staff at the entrance to admit clients;
- stipulating rules about behaviour in and around the centre;
- adopting a policy of barring, generally in response to violent or threatening behaviour which risks the safety of clients or staff, or infringements of the rules which have serious implications for the service, such as dealing illegal drugs on the premises; and
- challenging clients who are abusive or threatening (not that day but later if they are intoxicated) and working with them to control their behaviour, rather than impos-

THE RESEARCH BEHIND THE REPORT

This article was based on research which included an in-depth study of four wet day centres:

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

These were selected to represent 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.

Download **Wet Day Centres in the United Kingdom: a Research Report and Manual** from www.kingsfund. org.uk or purchase hard copy from Kate Smith, Sheffield Institute for Studies on Ageing, Community Sciences Centre, Northern General Hospital, Herries Road, Sheffield S5 7AU, price £12.50, cheques payable to University of Sheffield.

ing long-term bans.

People who are intoxicated and behave in a threatening manner are barred for that day, while bans of a week or more are imposed for more serious incidents. The Anchor Centre has a 'behaviour contract' which barred clients have to sign before they are readmitted.

NURTURE LINKS WITH OTHER AGENCIES

In part one of this series we stressed the need to establish links with external specialist agencies at the planning stage. Once the centre is operating, these contacts should continue and develop, not least to explore the most appropriate and cost-effective ways of working together. For example, when the Anchor Centre first opened, a social worker came one day a week, but the workload was insufficient. Hours were reduced to a half a day, but staff can contact them any time to arrange for clients to be seen.

Regular meetings should be held with all relevant agencies, including street outreach workers, to discuss the centre's impacts on the locality, its effectiveness in targeting street drinkers and other street people, its contributions to local homelessness strategies, the services it provides, and gaps in service provision.

KEEP THE NEIGHBOURS ON SIDE

Clear procedures are essential for managing the area adjacent to the centre and minimising impact on the neighbourhood. Ways of initially gaining local support and reducing opposition were discussed in part one. Regular meetings with the community should continue once the centre has opened, providing opportunities to air views and raise concerns. After opening, Tollington Way allowed these to lapse, now seen as a mistake. Even centres open for years still hear intermittent concerns and complaints from the local community.

It is important that centre managers and staff respond when concerns are expressed. After complaints about client behaviour outside the centre, staff from Tollington Way met with the clients and agreed a code of conduct. At the Anchor Centre, council and centre staff worked with the theatre next door to overcome problems. At the Specialist Dependency Service in Camden, one of the manager's roles is to liaise with local residents and businesses. They have the centre's phone number and can ring, for example, if someone is sitting in their doorway; staff respond by coming to talk to the person. The centre's neighbourhood policy stipulates that:

- staff will ensure that there is no disruptive behaviour in the vicinity during the half-hour before opening and after closing;
- one team member will carry out health and safety checks every 30 minutes while the service is open, including the area immediately outside the entrance, and collect litter discarded by clients;
- the service will not accept people who are disorderly or aggressive and ensure that they leave the vicinity, calling police if necessary.

KNOW AND SHOW WHAT YOU ACHIEVE

Many voluntary homeless people's services devote little time and effort to setting standards and targets and monitoring performance. Doing so is hard for day centres, particularly those which attract many attenders and have a high client turnover. Consequently, they have great difficulties in demonstrating achievement and securing competitive funding.

Progress has recently been made in developing standards relevant to the homeless sector, though implementation in this sector is still in its infancy. *Quality in Alcohol and Drug Services* (QuADS), commissioned by the Department of Health, offers measurable minimum and good practice standards for the provision of drug and alcohol services and has been widely adopted by drug treatment services in England. The Leicester wet centre is participating because of its work with drug users. Commissioners of alcohol services increasingly expect alcohol agencies to meet the QuADS standards.

Funded by the Association of London Government, the Service Audit Partnership aims to improve the quality and safety of projects for homeless people through peer audits. For day centres, a sub-group is adapting the auditing methods and tools of the *National Housing Federation Framework for Housing with Support*.[ii] Their work can be downloaded at www.serviceaudit.org.

OUTCOMES AS WELL AS ACTIVITY

For wet day centres, measuring prevention and rehabilitation outcomes is unusually difficult, partly because there is no way of counting *non*-events (*not* becoming homeless, *not* causing a disturbance), and partly because clients who break free of problem substance use may also break contact with the centre. Some centres record what they do, such as the number of clients helped by staff and linked in to other services. The Anchor Centre also uses an assessment form to track individual changes in substance misuse and monitors housing outcomes. Both kinds of indicators can in fact readily be recorded and compiled ◤ *Performance indicators*, above.

IT'S NOT EASY, BUT IT IS WORTH IT

The challenges facing wet day centres are truly daunting. Relatively intensive and continuous supervision and staff support are required, yet a centre's management (or its parent organisation) must also work hard at developing and sustaining the collaboration and support of external agencies. Maintaining the effectiveness of these links is a continuing and demanding task.

But if the 'internal focus' and 'external network' are well maintained, wet day centres directly provide and establish access to a remarkable range and volume of treatment, support and services, making an impressive contribution to reducing unmet need among the most vulnerable people in our society – in very real ways, changing people's lives.

LINKS Nugget 3.5

PERFORMANCE INDICATORS

Activity 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 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.

Outcome indicators

- ☐ Tenancy outcomes after six and 12 months for clients who are rehoused.
- ☐ Improved eating habits, eg, more cooked meals.
- ☐ Changes in alcohol use (amount or type consumed).
- ☐ Reduction in street drinking.
- ☐ Changes in morale and motivation.
- ☐ Learned or rebuilt life-skills such as budgeting or cooking at the centre.

NOTES

i Managers can turn to national bodies for guidance and research on using volunteers. 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 ◤ www.volunteering.org.uk. This body in association with the Centre for Institutional Studies at the University of East London has established an Institute for Volunteering Research ◤ www.ivr.org.uk.

ii Topics covered include the extent to which day centres have: clear aims and objectives; strategies that encourage targeted groups to attend; procedures for collecting 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 staff appraisal and supervision procedures; appropriately trained staff and volunteers; and buildings fit for their purpose with the facilities required by clients.

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