

***Evaluation of a Residential Alcohol Detoxification  
Programme Facilitated by The Basement:  
Safety, Perceptions and Effectiveness***

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# CONTENTS

<b>EXECUTIVE SUMMARY</b>	<b>1</b>
<b>INTRODUCTION</b>	<b>6</b>
<i>Alcohol Misuse</i>	6
<i>Street Drinking</i>	8
<i>Service Needs of Street Drinkers</i>	10
<i>Tier 4 Services</i>	10
<i>The Basement and the Residential Alcohol Detoxification Programme</i>	12
<i>Evaluation Aims</i>	12
<b>METHODOLOGY</b>	<b>14</b>
<b>FINDINGS</b>	<b>16</b>
<i>Residents Characteristics</i>	16
<i>Resident's Previous Experience of Treatment</i>	17
<i>The Programme and Residents' Perceptions of it</i>	17
<i>Session and Activities</i>	19
<i>After the Programme</i>	20
<i>Service Outcomes</i>	21
<i>Future Developments</i>	24
<i>Programme Cost</i>	24
<b>HEALTH AND SAFETY</b>	<b>26</b>
<i>Preparation</i>	26
<i>Whilst on site</i>	27
<b>CONCLUSIONS AND RECOMMENDATIONS</b>	<b>28</b>
<i>Health and Safety</i>	29
<i>Long Term Recovery</i>	29
<i>Future Work</i>	30
<b>REFERENCES</b>	<b>31</b>
<b>APPENDIX A</b>	<b>36</b>
<b>APPENDIX B</b>	<b>42</b>

## **EXECUTIVE SUMMARY**

### **Background**

Alcohol misuse poses a significant risk for individuals and a considerable burden on society. It can be a negative result of or in many cases a contributory factor in homelessness. Alcohol treatment is still an area where the range of services available can be limited, despite the most recent drug strategy's attempt to bring treatment for dependent drinkers into line with that for those dependent on illicit drugs. Levels of services available may be irrelevant to street drinkers who generally have difficulties accessing a range of available services including alcohol specific treatment, such as detoxification. The Basement, a homelessness support service based in Liverpool City Centre has established a residential detoxification programme in response to a perceived lack of service options for street drinkers. Up to eight individuals (single sex) attend each two week programme facilitated by three full time members of staff and one volunteer. Residential take place in one of two cottages in North Wales with the first week involving an alcohol reduction process which is not medically assisted whilst the second is a 'dry week'. Group and one to one work (if requested) take place across both weeks. The residential is preceded by six weeks of preparation sessions in Liverpool which all prospective residents must attend. The Centre for Public Health, Liverpool John Moores University was commissioned to conduct a rapid appraisal of the service's delivery and steps taken to ensure safety.

### **Methodology**

- Semi structured interviews with all eight residents and three employed staff facilitating one residential in order to assess the delivery of the programme. Interviews with residents were conducted once on the first week (wet week) and once in the second week (dry week).
- Observations on two separate days.
- A systematic risk assessment.
- A questionnaire assessing levels of well being and alcohol consumption administered 2-3 weeks before the residential and a similar period after return.

### **Findings**

Residents were very positive about the delivery of the programme and the impact it would have on their lives in the future. The alcohol reduction in the first week has the potential to be a point of tension, personal difficulty and conflict but this was not the case. Residents in many cases felt the reduction had been easier than they had expected and there were no adverse withdrawal effects.

Residents interviewed found group activities positive in enabling them to look at their personal relationships, their life choices and their relationship with alcohol. In addition they were able to take positive encouragement from the groups and activities, which they

believed, would increase their future confidence and coping strategies. Interactions between residents and staff were also felt to be positive with there being no incidents between individuals.

The importance of aftercare is recognised and there are established links to support agencies upon return to Liverpool. The construction of an individualised package of aftercare begins during the six week preparation phase. Difficulties sometimes arise in encouraging agencies to accept clients who they might have had problems with in the past.

As clients came from such negative circumstances, facilitators felt that expecting abstinence as an outcome upon return to Liverpool was not always realistic. Despite this six of the eight residents were still abstinent when followed-up 2-3 weeks after their return to Liverpool. Other measures of increased stability were felt to apply particularly in terms of individuals' confidence in their ability to change their lives, which according to questionnaire responses did appear to have improved upon return to Liverpool.

A number of processes are put in place to ensure that the residential is delivered in as safe a fashion as possible:

- 10 week preparation period (inc. client risk assessment)
- Behaviour contract
- Medical before departure
- Experienced staff with mandatory training
- Daily nurse visit
- Alcohol and other medication stored in locked location
- Established links with local GP and pharmacy
- Property has all the necessary health and safety certificates
- High levels of supervision through all activities
- High staff to resident ratio

## Conclusions

A rapid appraisal such as this cannot provide a full endorsement of the effectiveness of a programme such as this. However, the appraisal has led the research team to the following conclusions:

- The overwhelming impression of the delivery of the programme is one of quality, safety and preparation. The improvement witnessed by researchers in clients' physical appearance and expressed psychological state from initial contact a number of weeks before departure to the second to last day of the residential was marked and was supported by feedback on questionnaires.

- The Basement are responsive to the needs of the client group and the residential has changed in line with feedback to become more formalised and less focused on respite, although this is still an important aspect of the value of the programme.
- The residential fills a niche within treatment provision in Liverpool in that many of the clients attending the residential would have difficulties accessing other services.
- The six week preparation phase is essential in assessing risk, providing access to health care and ensuring that only suitably motivated individuals attend.
- The residential is run in a safe fashion with risk identified and mitigations put in place. However, this process has not been documented in a written risk assessment, an oversight which should be addressed as soon as possible.
- The programme has a focus on long term recovery and the use of aftercare that has synergy with current national policy. Future funding difficulties present a substantial potential risk to the availability of aftercare spaces for clients exiting the residential.
- The Basement need to consider the ways in which the profile of the residential can be increased with commissioners, other services and potential clients. The use of testimonies of previous residents should be central to this process.

## INTRODUCTION

### *Alcohol Misuse*<sup>1</sup>

Alcohol misuse is associated with a wide range of problems, including; physical and mental health problems; offending behavior, including anti-social behavior and domestic violence; social problems, such as homelessness; suicide and deliberate self harm; and child neglect (DoH, 2006). It has been demonstrated that there is a direct dose-response relationship between alcohol consumption and risk of death (White et al, 2002). Evidence indicates that problematic drinking and the associated harms can be preventable; one of the main aims of the *Alcohol Harm Reduction Strategy for England* (2004) is 'to better identify and treat alcohol misuse'. The Alcohol Needs Assessment Research Project (DoH, 2004), commissioned by the Department of Health, found that 6% of men and 2% of women in England (approximately 1.1 million people) are dependent drinkers, although overall prevalence between areas varies from 1.6% to 5.2% (DoH, 2004).

While alcohol plays an important part in the cultural life of the UK, there is an estimated £18-25 billion a year cost of alcohol misuse which includes health and social problems, disease, disorder, crime and loss of productivity in the workplace (Prime Ministers Strategy Unit, 2004); there is an estimated £2.7 billion a year cost to the NHS alone (DoH, 2008a). The Drug Strategy 2010 (HM Government, 2010) cites evidence that a dependent drinker costs the NHS twice as much as other alcohol misusers and that the largest and most immediate reduction in alcohol-related admissions can be delivered by intervening through the provision of specialist treatment (McKenna et al., 1996). The Drug Strategy also calls for community alcohol services to be more integrated and for better continuity of case management and support in order to avoid repeated assessments, disrupted treatment and process (rather than outcome) orientated targeting (HM Government, 2010). Models of Care for Alcohol Misusers suggests that commissioners should ensure that a range of services for alcohol misusers are available and that services should form a local alcohol treatment system designed to meet local needs (DoH, 2006). The Drug Strategy 2010 recommends placing the individual at the heart of any recovery system, which means that local services must account for the diverse needs of their community when commissioning services (HM Government, 2010). Furthermore, for the first time in the United Kingdom drug strategy, the treatment of severe alcohol dependence is considered alongside the treatment of other drugs of dependence. In addition to the individual and social benefits, alcohol treatment has been shown to have short and long term benefits to the economy. The United Kingdom Alcohol Treatment Trial (UKATT) found, when considering social behavior, network therapy and motivational enhancement therapy, that each treatment

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<sup>1</sup> As defined by the Department of Health (DoH) for the National Health Service (NHS) as hazardous, harmful or dependent drinking (NHS, 2011).

saved about five times as much in expenditure on health, social, and criminal justice services as they cost (UKATT, 2005).

A dependent drinker is defined as a person who drinks above ‘sensible’<sup>2</sup> levels and experiences harms and symptoms of dependence; or more quantifiably, one who scores 16 or more on the standardised Alcohol Use Disorder Identification Test (AUDIT) (DoH, 2004). Men who drink more than 50 units a week (or regularly drink more than eight units a day) and women who drink more than 35 units a week (or regularly drink more than six units a day) have the highest risk of developing alcohol-related illnesses or injuries or of being admitted to hospital (DoH, 2008b). Table 1 displays the relative risk of various conditions for men drinking 60grams+/day and women drinking 40grams+/day compared to zero drinking.

**Table 1: Relative risk of various conditions for heavy vs zero drinkers**

Condition	Men	Women
Liver cirrhosis	13.0 times	13.0 times
Mouth cancer	5.4 times	5.4 times
Larynx cancer	4.9 times	4.9 times
Oesophagus cancer	4.4 times	4.4 times
Hypertension	4.1 times	2.0 times
Liver cancer	3.6 times	3.6 times
Haemorrhagic stroke	3.6 times	3.3 times
Ischaemic stroke	3.0 times	2.7 times
Cardiac arrhythmias	2.2 times	2.2 times
Breast cancer (women)	-	1.6 times
Coronary heart disease (CHD) in middle age	1.7 times	1.3 times
Colo-rectal cancer	1.5 times	1.4 times

(DoH, 2008b)

The burden of alcohol related harm falls heavier on Liverpool than other areas in the North West (Anderson et al, 2007). In 2008/09 Liverpool had the highest rate in England of hospital admissions for alcohol attributable conditions for both males and females, 2,323 and 1,258 per 100,000 population respectively (NWPHO, 2011). *The Liverpool Alcohol Harm Reduction Strategy 2007-2010* aimed to reduce alcohol-related harm by implementing *The National Alcohol Harm Reduction Strategy* within a local context (Liverpool PCT, 2007). Ten key priorities were outlined for address by the Liverpool Alcohol Strategy, which included; improving access to and quality of alcohol treatment services; and reducing alcohol related crime, disorder and anti-social behaviour (Liverpool PCT, 2007).

<sup>2</sup> Based on the recommendation that drinking less than 21 units for men and 14 units for women per week is unlikely to damage health (Smith and Coles, 1986; Rosett et al, 1980) (1 unit of alcohol is 8grams, the equivalent of half a regular strength lager/bitter, a small glass of wine or a standard spirits measure).

## ***Street Drinking***

While legal definitions of homelessness vary, the homelessness and housing charity Shelter, defines it simply as not having a home. In some cases, a person may have a roof over their head but may still be homeless if, for example, they do not have rights to the property or the property is unsuitable for them (Shelter, 2010). Statistics of homelessness are estimated in a number of ways but are typically varied and definitions remain ambiguous and inconsistent. The last National Census in 2001 estimated those 'accepted as being homeless and in priority need' to be 28,260 in England, 2,980 in the North West, 510 in Merseyside, and 242 in Liverpool (ONS, 2001). However, homelessness acceptances peaked in 2003/04, with year on year reductions since then; the National Rough Sleeping Estimate for 2009 shows a 75% reduction in rough sleeping in England since 1998 (Communities & Local Government, 2011).

In addition to this, a recent study in Liverpool with homeless substance users found that over two-thirds (68%) had slept rough on the night prior to their interview with 94% of those participating reporting at least one health problem (Shaw & McVeigh, 2008). Research suggests that substance misuse places individuals at increased risk of homelessness (Spinner & Leaf, 1992; Winkleby et al. 1992). A 2001 study of 389 homeless people in London found that over half attributed their becoming homeless to drugs or alcohol (Fountain et al, 2002). While the reported prevalence of alcohol and drug use among homeless groups varies, alcohol use is considered to be one of the most pervasive health problems among the homeless (Garrett, 1989, Velasquez et al, 2000). One study found that between 16% and 51% of rough sleepers showed symptoms of alcohol dependence and between 10% and 35% were severely dependent (Gill, 1996). A study in Hounslow found the majority of street drinkers were long term and heavy drinkers who shared the profile of those who make up the high incidence of alcohol related deaths, and the majority were not engaged with alcohol services (Cullen, 2005).

Devine & Wright (1997) labelled the link between homelessness and substance use as a "socio-economic leveller", in that research shows that there is a pathway from drug use to job loss, family dissolution, social isolation and for many, homelessness. There is also the possibility that homelessness may lead to substance abuse to cope with the fear, deprivation, loss of dignity and depression associated with their situation (Orwin et al, 2005). Alcohol can play a significant role in contributing to some people's homelessness and alcohol dependence also serves to keep people on the streets, contribute to poor health and make people more vulnerable to abuse and violence. A street drinker is defined as a person who drinks heavily in public places and, at least in the short term, is unable or unwilling to control or stop their drinking, has a history of alcohol misuse and often drinks in groups for companionship (Lamb, 1995). Homeless people with substance misuse problems experience severe difficulties in accessing healthcare, education and employment



assistance. They may be unaware of, or excluded from, supported accommodation and experience difficulties finding social housing due to rent arrears, poor tenancy records and lack of knowledge about how to apply for housing (Centre for Social and Economic Exclusion, 2005, Home Office, 2006). Nationally, street drinkers have difficulty in gaining access to healthcare services, especially psychiatric services, and typically suffer from a wide range of illnesses which are exacerbated by drinking alcohol, a poor diet and sleeping rough for periods of time (Liverpool City Council, 2010).

There are limited national statistics regarding the number of persistent street drinkers in England and Wales, and information on street drinking is not collected systematically (Alcohol Concern, 2003). A street drinker is likely to be 'a white unemployed man, aged 35 or older; who is probably homeless and sleeping rough or in temporary accommodation; who may be alcohol dependent, certainly often drunk; who may be using controlled drugs; often suffering from psychiatric disorders of varying degrees of severity; often in a poor state of physical health; at risk of arrest for public drunkenness offences, shoplifting, begging and other minor public order offences; and at risk of being the victim of assault' (Mental Health Foundation, 1996). Studies have found that upwards of a half of street drinkers live in their own (typically rented) accommodation, citing social aspects and the cost of drinking in public houses as reasons for street drinking (Ross et al. 2005). However, there is evidence to suggest that city centre street drinkers may be more likely to be homeless than suburban street drinkers (Russell and McVeigh, 2008).

A study of street drinkers in Drumchapel, Scotland found over 95% of surveyed street drinkers were male, 80% reported they currently drank alcohol and that, when drinking, 85% reported drinking every day (Ross et al. 2005). Over half the group considered other street drinkers to be their friends. The group described being at some risk of physical assault but unwanted attention from police was suggested to be the main negative aspect of street drinking. It was reported that by-laws on street drinking can criminalise an already vulnerable group, which can exacerbate their social exclusion (Shenker, 1998). A low variety diet and tendency not to eat very much was also reported by fieldworkers to be a health problem encountered by street drinking groups (Ross et al. 2005).

A study by Johnsen and Fitzpatrick (2007) reported that street drinkers were generally sceptical of motives from authorities, claiming most enforcement measures were 'cosmetic exercises', further suggesting that enforcement could push street drinkers into other 'money generating activities', such as more serious crime or sex work. Many condemned controlled drinking zones describing that they would not remove the 'need', but required a street drinker to be more discreet. Similarly, with the threat of confiscation, street drinkers claimed to drink more quickly for fear of it being removed, and if drink was confiscated, turning to shop lifting or more aggressive begging to replace the money and drink. Some street drinkers also complained about an aggressive attitude, victimisation or lack of respect

on the part of the police or authority figures, such as Community Wardens. However, street users advocated the use of enforcement for anti-social behaviours and aggressive begging (Johnsen & Fitzpatrick, 2007).

### ***Service Needs of Street Drinkers***

The substance using homeless represent a specific subset of the population which are underserved by treatment programmes (Dixon & Osher, 1995). Substance use treatment for this group is a major need (Velasquez et al. 2000), however few treatment programmes exist specifically for the homeless and most programmes lack the resources to adequately address addictive disorders (Burt et al. 1995). Evidence suggests that awareness of alcohol services among street drinking groups is low (Ross et al. 2005) and that nationally, street drinkers have difficulty in gaining access to healthcare services, especially psychiatric services (Cullen, 2005). However, studies have demonstrated that street drinkers may be generally happy with their public drinking and may not wish to change their behaviour (Lamb, 1995).

It has been suggested that street drinkers need appropriate, accessible services which address their:

- Health needs, since many street drinkers suffer from a wide range of illnesses, which are exacerbated by their alcohol consumption
- Housing needs, since local authorities are unlikely to class people with alcohol problems as vulnerable or in priority need
- Social needs, since, for many, drinking takes up a large proportion of their time and something would be required to 'fill the gap'
- Drinking needs, which may include a range of service options, including alcohol detoxification. (Alcohol Concern, 2003).

A study of an assertive community outreach project demonstrated that 41% of participants who were referred to substance use services in a one-year period of time successfully entered treatment and that there was a statistically significant relationship between clients' motivation level and completed referral (Fisk et al, 2006).

### ***Tier 4 Services***

As defined by *Models of Care for Alcohol Misusers*, tier 4 is comprised of inpatient detoxification (IPD) and residential rehabilitation (RR), although aftercare (AC) is a closely associated feature of tier 4 service provision (NTA, 2006). Inpatient detoxification is a form of acute care for the purpose of completing a medically safe withdrawal and is typically indicated when there is a risk of severe withdrawal symptoms that cannot be safely managed in a less intensive detoxification setting (UBH, 2009). Tier 4 alcohol treatments

consist of a range of delivery models to address alcohol misuse, including medically assisted alcohol withdrawal, prescribing for relapse prevention and ~~opioid~~ <sup>opioid</sup> interventions within the context of residential accommodation (NATMS, 2009). In 2005, tier 4 provision was described to be insufficient to meet demand and such under-provision was predicted to intensify if tier 4 capacities were not increased (NTA, 2005). Tier 4 services are required to comply with a wide range of standards according to the service specification and registration status, in line with Drug and Alcohol National Occupational Standards (DANOS). Registered care homes are also expected to meet national minimum standards and are inspected by the Commission for Social Care Inspection (CSCI).

As part of a review of tier 4 inpatient services in Cumbria and Lancashire, dependent drinkers reported that alcohol detoxification treatment was a 'completely essential' service; and suggested that community based detoxifications were often insufficient for dependent drinkers. Participants described how waiting times were a major barrier to treatment success and that the lack of consistency between areas led some treatment seekers to travel out of area in order to receive quicker treatment. Interviewees described how contact ought to be extended from tier 4 services, including the incorporation of wrap-around support facilities, to help combat the psychological barriers to maintaining abstinence; interviewees also described aftercare and support services as crucial aspects of the treatment journey and emphasised the importance of peer support. The majority of street drinkers are dependent alcohol users and a substantial proportion may require inpatient detoxification and residential rehabilitation, although those with specific needs, such as physical or mental health conditions, may also benefit from specialist tier 4 care (Russell et al., 2010).

Research indicates that, of 80 Drug and Alcohol Action Team (D(A)AT) professionals, 11% identified homeless people as disadvantaged or underrepresented in tier 4 treatment (DoH, 2004). A study of 47 patients who required detoxification, reported that only 19% required inpatient care and the majority of the remainder successfully completed outpatient detoxification; the results of this study support the utility of outpatient detoxification as a cost-effective alternative to inpatient detoxification for the majority of acute alcoholics (Feldman et al., 1975). There is conflicting evidence on how the length of treatment affects outcomes (Barnett and Swindle, 1997). While observational studies have found that longer inpatient stay has resulted in better outcomes in therapeutic communities (Bleiberg et al., 1994), halfway houses (Moos et al., 1995) and hospitals (Welte et al., 1981), randomised clinical trials have found that longer inpatient stay has not resulted in better outcomes for patients being treated for alcoholism (Mattick and Jarvis, 1994).

At the time of this report, there were two inpatient detoxification facilities in Liverpool, The Windsor Clinic and The Kevin White Unit, and one residential rehabilitation facility, The Parkview Project, where clients must demonstrate sobriety pre-admittance and certain medications or opiate substitutes are prohibited. The Windsor clinic is an alcohol only unit

based in Fazakerley. Entry criteria are applied on a case by case basis, the presence of some alcohol would be allowed in the client's system as long as they were not too intoxicated, and prescribed medication is allowed. It was reported that waiting lists varied and were typically about six weeks and priority clients were admitted quicker via a triaging system (Russell et al, 2010). Any evidence of current use of illegal drugs would prevent admittance. The Kevin White Unit, based in Wavertree, is primarily an opiate detoxification unit but also admits some alcohol only clients. It was reported that entry criteria are applied on a case by case basis, that an alcohol test is administered before admission and that anti-psychotic medication and opiate substitution drugs were allowed (Russell et al, 2010). It was reported that waiting times varied but were typically less than six weeks and that priority clients were admitted quicker via a triaging system.

### ***The Basement and the Residential Alcohol Detoxification Programme***

The Basement officially opened in 2000 in response to an identified gap in service provision for the vulnerable homeless of Liverpool. The Basement was created to “bring back dignity and self respect to this much maligned and misunderstood group” (The Basement, 2011). In addition to assertive outreach, an evening drop in service and the provision of key facilities, The Basement also facilitates a Residential Alcohol Detoxification Programme, where small groups of homeless dependent drinkers go away for two weeks in Wales (a choice of cottages situated in Llangollen or Llanrwst) to address their alcohol use and related behaviours. The main aim of the programme is to reduce participant drinking in seven to ten days, which leads to a detoxification and period of abstinence for the remaining four to seven days. The programme also provides an opportunity for the delivery of key harm reduction messages, structured activities and relevant workshops.

Prospective residents are required to be engaged with The Basement for a minimum period of six weeks prior to departure to the Residential Programme, in which time participants are encouraged to identify and address their fears surrounding detoxification; engage with main stream services, in particular with General Practitioners (GPs); and complete a drinking diary, which is used to construct individual profiles and guide reduction of alcohol consumption before detoxification. An appraisal of relapse rates may be important to the long term effectiveness of the programme since many street drinkers have participated in numerous detoxification programmes and there is evidence to suggest that multiple episodes of alcohol withdrawal may increase the incidence and severity of seizures during detoxification, render a person more vulnerable to brain damage, and contribute to alcohol related neuropathology and increased cognitive dysfunction (Becker, 1998; Littleton, 1998). Funding for this research was provided by Liverpool Primary Care Trust (PCT).

### ***Evaluation Aims***

The main aims of this evaluation are:

- To consider the health and safety risks for facilitators and residents during the Residential Alcohol Detoxification Programme
- To analyse quantitative outcomes in the short term, primarily in terms of alcohol using data derived from questionnaires completed by participating residents.
- To gain an understanding of how the programme is perceived by participants
- To develop the foundations for ongoing structured monitoring of the Residential Alcohol Detoxification Programme in order to build an evidence base from which the short and long term effectiveness of the programme can be inferred.

## METHODOLOGY

- 1) Review relevant literature and evidence relating to street drinkers and appropriate interventions:

A thorough review of relevant literature and evidence relating to street drinkers and specific alcohol interventions was conducted.

- 2) Evaluate the process and outcomes of the Residential Programme:

Research techniques to achieve this key aim included observation, semi-structured staff and resident interviews and longitudinal participant questionnaires.

Observation was conducted for a period of two days, one during the first week and one in the second week of the Residential Programme. Observations were recorded in a structured way to reduce bias and with emphasis on general behaviours, rather than context-specific observations, which may be more likely to represent similar groups of street drinkers in other areas.

Semi-structured interviews were carried out with residents (seven in week one, eight in week two) and staff (three) to explore in detail perceptions of the programme. Interviews were guided by pre-identified issues, however the focus and emphasis of the interviews were guided by participant responses and individual perspectives and interests. Interviews were carried out with residents once during week one and once during week two of the Residential Programme. Interviews with staff and facilitators were carried out on one occasion during the Residential Programme.

Questionnaires were completed by each member of the group at two intervals; at baseline, one week prior to departing on the Residential programme and once at follow up stage, two weeks after returning from the Residential Programme. It was intended that the questionnaire could be repeated at subsequent follow up intervals to continue monitoring outcomes and changes over time. The questionnaire asked participants about their physical and mental health, their past and present drinking patterns and associated behaviours, their treatment history and their current emotional states and general well being. Questionnaire data were supplemented by information routinely collected and collated by The Basement, such data included demographic information and more detail information relating to drinking and treatment history.

3) Evaluate resident and facilitator safety:

A systematic risk assessment was conducted. Risk assessment domains were categorised as 'physical and mental health', 'risk of harm to self and others' and 'environmental risk and security of property'.

4) Assess the integration of the Residential Programme with mainstream structured services:

This assessment included an appraisal of the links of the Residential Programme with addiction treatment and ancillary services particularly in relation to aftercare and longer term recovery planning.

5) Create and initiate the structure and procedures for continued monitoring of treatment outcomes:

The Centre for Public Health has developed a monitoring system for agencies delivering interventions to drug or alcohol users which fall outside the remit of the National Alcohol/Drug Treatment Monitoring Systems. This system (Goliath) has been installed at the Basement and will enable the service to capture information about all clients engaged with the service including demographics, substance use, interventions provided and outcomes of engagement. In addition AUDIT and well being scales are collected at intake and at six month intervals thereafter and this data is stored on Goliath. Training has been provided to The Basement staff on the use of the system and ongoing support is provided. The questionnaire used for the rapid appraisal which as well as the AUDIT and well being scales included questions about clients perceptions of their control over the lives, has been provided to the service for them to use specifically with regards to clients attending the residential programme.

### ***Ethical Considerations***

This study received ethical approval from Liverpool John Moores University research ethics committee. Participants (staff and residents) were informed of the purpose of the study and made fully aware of their right to withdraw at any time without having to give a reason. Participants were made aware of the strict guidelines relating to confidentiality and anonymity at each stage of data collection. Where individuals may have been identifiable, data were suppressed to avoid potentially adverse circumstances for the individual. Prior to completing the questionnaire and prior to commencing the interview, participants were given an information sheet which included an explanation of the research project, the purpose of the study, an overview of question topics and an estimated completion time.

After being given the opportunity to ask questions, informed written consent was obtained from participants.



## FINDINGS

Interviews with residents and facilitators identified a number of key themes which are detailed in this section alongside findings from questionnaires where these support or contrasted with qualitative feedback.

### Residents Characteristics

As would be expected for a scheme such as this all of the residents were dependent drinkers characterised by daily or almost daily drinking in each case. Residents reported being dependent for between 2 and 24 years.

*'(I've been drinking) since I was about fourteen or fifteen. I'm thirty-five now so about twenty – twenty one years. I had had a taste of alcohol as a child and at fourteen – fifteen I was taking vodka to school in coke bottles. Other than when I have been ill – and I have been seriously ill through alcohol, I have had a drink every day. It's the only one thing that has been a constant in my life.'*

Alcohol was not the only substance that residents had experienced issues with, with all those interviewed having used other substances including heroin, cocaine and crack cocaine. However, in many cases residents had not used these substances for some time and most did not feel there was a risk of use of these other substances returning or escalating after the residential.

*'I have used all sorts – I have used heroin, crack, weed, cocaine, methadone – I have used everything and I got off all that on my own.'*

*'No (I won't go back to using drugs) without sounding bossy and macho I have been there and done it so many times – It took thirty five years but I know now – I can't be arsed with it.'*

Only one of the seven residents interviewed in the first week had their own accommodation in Liverpool with all of the other clients being homeless or living in hostels.

All of the residents reported physical or mental health issues. A range of conditions were identified, including cardio-vascular infection, blood borne viruses, liver disorders and pancreatitis. Some of which may be attributed substance use. Depression and anxiety were also reported (with all residents stating that their alcohol use had contributed to their poor mental health). However, contact with services for treating mental health issues was rare among the group.

*'I went for a CAT scan about two months ago and that's when I found out that I had a blockage in my pancreas. Some of these ailments that I have got are about three years old – so I don't know if I have still got them. Oh and I have got hepatitis C as well.'*

*'I have been treated for depression for about three years. I have spoken to various doctors and nurses and I don't know if the depression is caused by the drink, I think it is well known that drinking does cause depression – or and I haven't been off the drink for long enough to*

*know if that would make any difference. I haven't been off the drink long enough for the doctors to know if I have clinical depression.'*

Contact with the criminal justice system as a result of alcohol-related anti-social behaviour and/or violent behaviour was common among the group and for some this had resulted in prison terms.

### **Resident's Previous Experience of Treatment**

Whilst most residents had some experience of treatment there were three individuals for whom this was the first time they had addressed their alcohol use. There was also some experience of detoxification among the group, both supported and unsupported. Two residents had previously been on the Basement's shorter respite version of the programme (no longer running). They felt that a lack of a properly constructed aftercare programme and boredom had led to them not maintaining abstinence after this previous attempt.

*'Well I have done this residential before but it was only ten days. I was insisting that I could do it – I should have listened to (Basement staff) and gone into rehab. The day I came back last time I just started drinking again – things were still going on in my head – I should have listened – got more support.'*

Where they had not previously engaged in treatment residents felt this was due to a lack of insight into their problems and motivation.

*'If I had have wanted to get off I would have no matter what – you can't use excuses no matter what they are.'*

*'At first – it was hard to admit that I had a problem – a drinking problem. I thought – I'm not a piss head – I don't sleep on the streets. But that was the way that I was going – I was getting into all kinds of trouble – I have had all kinds of injures from it. So I admitted to myself that I was an alcoholic. I don't think that there was any particular barrier other than myself to be honest.'*

There was a feeling among residents that they had little knowledge of the services that exist in Liverpool before their engagement with the Basement and that there was potentially a lack of both services and information regarding how to access these services for clients not already engaged in some support.

*'It's not like they are advertised – you wouldn't know unless you went looking for them yourself.'*

### **The Programme and Residents' Perceptions of it**

Facilitators felt that the programme had developed as a response to waiting lists and difficulties of access for this client group in other services in Liverpool. The programme does not ascribe to any particular theory and facilitators incorporate elements of a number of theoretical approaches including Cognitive Behavioural Therapy. The key being that this is not a medical model supported by medication (for alcohol).

*'The waiting times to access some services could mean that a lot of people we bring here would never get a chance – everyone deserves a chance.'*

The residentials are single sex with facilitators feeling they should remain as such.

*'I have thought about it (mixed sex groups) and I have been asked but I think sometimes men and women need different space.'*

The programme has responded to residents needs. It had previously been shorter and acted more as a respite than detoxification however feedback from residents suggested it need to be longer which has led to the current structure. Two of the residents interviewed for this appraisal had been on the previous shorter version of the programme and claimed that it had not given them enough time to address their issues sufficiently.

*'When we started it was only a short programme – service users were telling us that it needed to be longer in order to be effective – we tried to incorporate what people were asking for – it has grown into this.'*

Central to the programme is the alcohol reduction process during the first week which has the potential to be the most trying period for both the residents and the facilitators. However, residents' responses universally suggested that they had found the process comfortable with no adverse withdrawal symptoms. Indeed a number of interviewees suggested the process had been easier than they had expected.

*'I haven't had any shakes or felt sick – it's the way they bring you down – I think it's better than the like of Librium.'*

*'At first I was scared – I'm not going to lie – I was scared thinking what would happen when I got down to my last bottle – in the end I couldn't wait to get rid of it – I was one of the last and I didn't think it was right to be drinking in front of the others.'*

*'I have never – even when I was on drugs or drink before – experienced a detox that has been so easy (physically) to do. The way it is cut down (the alcohol) is very well done. Everyone says the same thing.'*

All residents had a positive perception of the programme in week one which was maintained and built on in the second week. Residents cited the environment, location, the exceptional levels of care, commitment and support shown by the staff and full involvement with a structured programme of activities as being critical in providing the safe conditions for achieving detoxification.

*'It's good for taking your mind off what goes on in the hustle and bustle of Liverpool City – it's good to get away and take a good look at yourself and enjoy what is around you.'*

*'I don't think that I would have been able to do this on my own – I have made attempts – but I don't think I would have done it without the structure and environment here.'*

*'I feel brilliant – the staff are unbelievable – I can't thank them enough.'*

## Sessions and Activities

A number of specific group sessions are run throughout the two weeks including physical and social consequences of alcohol use, unit calculations (none of the residents reported thinking about their drinking in terms of units in week one), triggers, complementary therapies and lifestyle choices. Residents interviewed found group activities positive in enabling them to look at their relationships, their life choices and their relationship with alcohol. In addition they were able to take positive encouragement from the groups and activities, which they believed, would increase their future confidence and coping strategies.

*'I have been a bit reluctant to sit and talk – I haven't been here though – I was willing to sit and talk. The thing that I have got out of it – and this is where I have fallen down when I have tried to help myself in the past – is not to get complacent. That complacency can be your downfall. I have been more willing and open to discuss things here.'*

*'The groups make you aware of the damage you do to your body through the drink.'*

*'Trying to forget about my problems at the bottom of a glass or something where as now I have got the insight and the knowledge from being on some of these discussion groups and being here to give me the self confidence and belief.'*

As there is the potential for emotionally charged discussion one on one sessions are available if there are issues that people cannot or will not address in groups.

*'I had a one-one session with (facilitator) on the back of a group and we were talking about fears of staying sober and of drinking – and I was talking about things that had happened to me in the past two years – and I didn't realize until I started speaking – how many pretty bad things have happened to me.'*

*'It's very person centred so there are a lot of one-to-one sessions.'*

Residents reported that there was a satisfactory balance between task focused activity and recreational / relaxation time. All the residents interviewed believed this to be critical in creating the conditions and mutual trust amongst the group for personal exploration and group discussion.

*'The balance has been good – everyone has been relaxed – we all been having laughs – it's a nice environment – I am looking forward to going back to Liverpool – I want to get on with my rehabilitation – but at the same time – I want to enjoy these last two days.'*

Despite the potentially pressurised environment all residents interviewed reported positive interaction between individuals. None of the residents interviewed were aware of any tensions and none could recall any arguments between residents or between residents and staff.

In summarising their experiences at the cottage resident's comment best summed up their overwhelmingly positive views of the programme.

*'The best thing that has happened to me.'*

*'Life saver – absolute life saver – life saving and life changing.'*

*'It's meant a lot for me and I would say anyone who needs it – believe me come and do it. It is not as bad as people expect – I feel like I have cruised through it – anything that you need they will go out and get you it. Best detox I have ever done.'*

## **After the programme**

Central to the programme is the individualised nature of the approach and this is also the case where aftercare is concerned. Each resident has a long term individualised recovery plan in place the construction of which is started in the period prior to departing to Wales. Residents are not directed down a particular route e.g. 12 step and there is a recognition that abstinence once clients return to Liverpool whilst desirable is not always realistic.

*'Yes we have lots of links with services and as we said earlier we work on the individualized care plan incorporating aftercare so everyone has something in place for when they return. Care plans are constructed with the service user so if someone wants to do something – Park View or SHARP for example – we try and incorporate that with their care plan. That starts in the six-week process before we even get here.'*

*'We work very closely with organizations that run dry hostels, with Park View and SHARP but we try to give people as much choice as we can – people respond differently to different services.'*

Links into employment, education and training are also considered and the Basement work with Transit to facilitate these opportunities.

Whilst good links had been established with a variety of agencies there was recognition that sometimes, due to the nature of the types of clients accessing the residential and their previous poor engagement and behaviour, agencies could be reticent to accept some individuals back.

Whilst the Basement stay in touch with residents once they return to Liverpool through outreach and encourage them to re-engage if they relapse, facilitators felt that it is important to let people move on

*'We try to encourage people to make contact straight away if they do relapse so that we can engage them with a counsellor. The philosophy of the Basement is to support people when they lapse not to make them feel that they have failed. We try to look at why someone lapsed or slipped and work with people to identify triggers.'*

All residents interviewed had either a rehabilitation programme or supported accommodation with structured after care to return to on completion of the programme.

*'A lot of the groups have been looking at plans for the future – where people are going when they leave here – everyone has something set up to move on to.'*

*'I am looking forward to it – if I hadn't of done this I would be going back to jail. Being in a safe environment is good – I can't just walk out the door at Park View – if I do then I don't go back. You have got to think about what you are doing first and being here has given us the tools to think.'*

*'Yes – it's not a case of wanting to – it's a case of having to. I have a place to go to as soon as we finish here – I am going to SHARP meetings. I really respond well to the acupuncture. I know I have got to keep myself busy. I want to make something of myself.'*

Residents also recognised how critical having a structured plan in place was considering the pressures that they knew they would face upon returning to Liverpool. Despite this the confidence in remaining abstinent that they displayed during their first interview was maintained in the second week and they felt they would be better equipped to deal with cues and triggers for drinking than they had previously been.

*'Today I am very confident but I do take one day at a time. When I get back to Liverpool or a couple of days after – I may not be as confident. I am confident though about the things I have hooked up.'*

*'I know I have got to get back and face the problems – you are out in the middle of nowhere here – which is good in one way – it gives you time to reflect on yourself and learn to cope better - once you get back to Liverpool all the temptations are going to be there – but now you have got the strength and the will power to do what is right for yourself. It's about using those facilities that are in place and putting everything in order.'*

### **Service outcomes**

As already highlighted abstinence was not considered to be the only goal of the programme and the individualised nature of the programme was to the fore again here with facilitators emphasising the personal nature of recovery.

*'I see people who have been through the programme that now have their own flats – they may be drinking but not as much and they are not living on the streets – I see that as a positive outcome.'*

Despite abstinence not being the sole aim of the programme follow-up questionnaire responses (collected approximately three weeks after return from the residential) indicated that six of the eight residents had maintained abstinence in the short term following return to Liverpool.

Improving resident's confidence and allowing people to see that there is something other than the relationships that they have built up on the street was also felt to be important by facilitators and this was emphasised in residents' responses. The respite aspect of the programme, in terms of residents' health' was also highlighted.

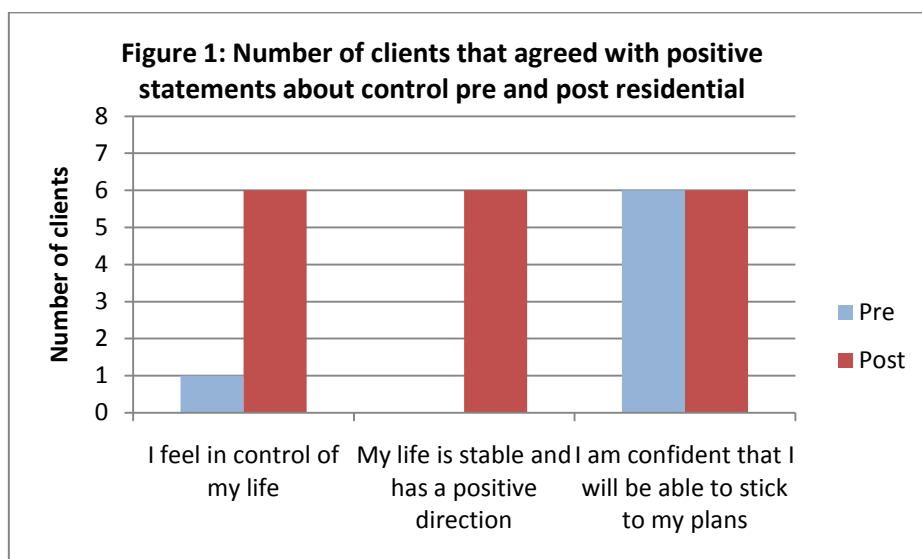
*'You see a change in people when they come here – even people that we have been working with for a while – people who may get a bit stuck – it's very hard when people's life is the street – other people on the street almost become their family and it can be hard to*

*move some people on from that. When people come away here you see such a change – you see their confidence grow – people become more positive.'*

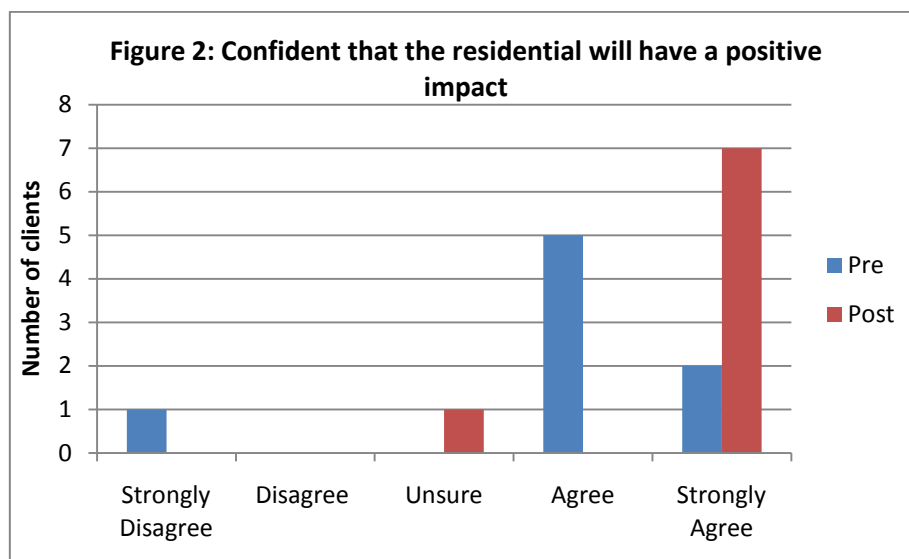
*'It has probably saved my life – given me freedom and given me the wakeup call that I needed. There are people here that can help – it is not as if everyone thinks that you are a lost cause – you can turn your life around and have a go – it can be done.'*

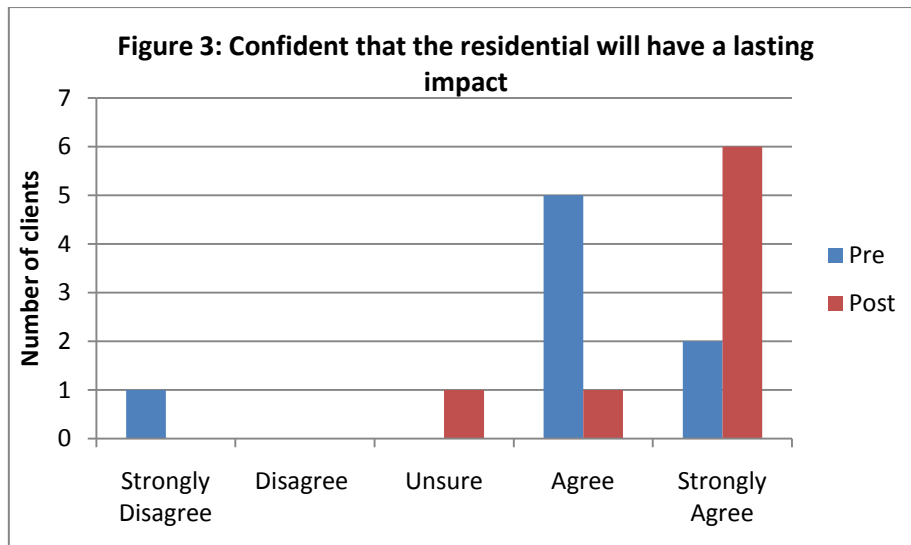
*'It's saved my life twice – especially this time because I was in a bad way.'*

The role of the residential in increasing individual's confidence can be seen when comparing responses to a number of statements regarding control prior to the programme and three weeks after their return. Resident's responses suggest an increasing of their perception of control over their own lives (Figure 1).

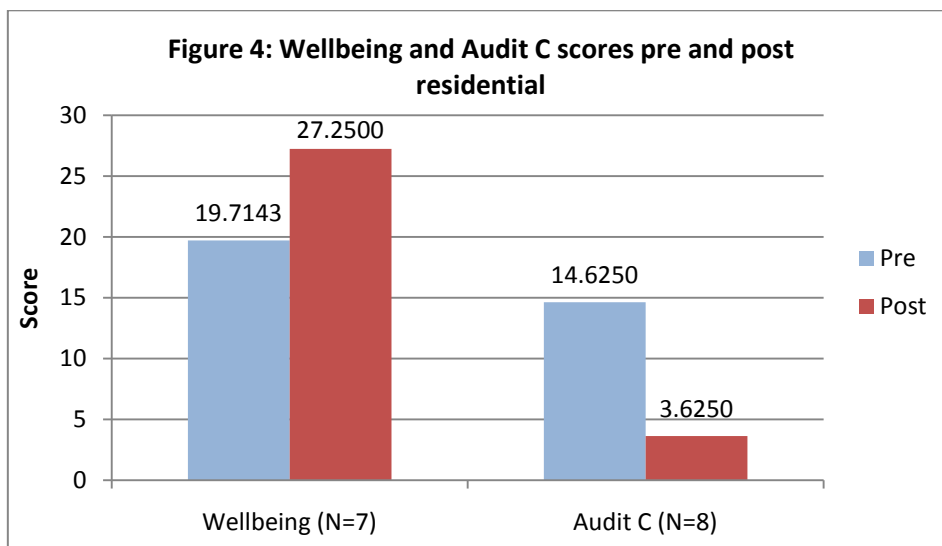


In addition, whilst most clients were confident about the residential's ability to have a positive, lasting impact on their lives before departing for Wales this confidence was increased upon return to Liverpool (Figures 2 and 3).





Alongside significant improvements in levels of alcohol consumption ( $z=-2.552$ ,  $p<0.05$ ) (as measured by AUDIT C) residents wellbeing also showed substantial if not statistically significant improvements at follow-up (Figure 2).



*Note: Higher scores reflect a more positive feeling of wellbeing (0-35), lower scores reflect less issues with alcohol consumption (AUDIT-C) (0-15).*

Facilitators also felt that the process involved in preparing for the residential in itself was an outcome as for many of these clients the links made to GPs may have been the first access to this level of healthcare for some time.

### Future Developments

Although residents generally felt there was little that could be done to improve the programme there were three main suggestions that emerged from residents and facilitators responses:

- The Basement owning a facility like the cottage



- Some form of supported housing run by the Basement in Liverpool for when people return from Wales
- Other basic opportunities for entertainment such as darts board, pool table, football etc.

*'The only thing that could be better about this would be if the Basement had dry houses that they run so people could come straight from here onto another step without having to rely on other agencies.'*

### **Programme cost**

The programme has a budget of £10,000 for the two week period. That covers all costs including:

- The rental of the cottage
- Staff overtime (bank staff rates for the evenings on call and week-ends)
- Agency staff to cover posts in Liverpool
- Food
- Alcohol for the reduction programme
- Medical provision
- Petrol
- Cost of any activities e.g. cinema, prizes
- The daily visit by the nurse
- Coach (return journey)
- Any other amenities

With a full complement of eight residents the cost per resident is £1,250 per person for two-weeks or approximately £89 pounds per day. Data used for the Drug Treatment Outcome Research Study suggested that nationally inpatient treatment costs £153 a day and residential rehabilitation £47 a day (Home Office, 2009). Communication with commissioners in Merseyside has suggested that a period in medically managed inpatient detoxification can cost up to £3,488 whilst a medically monitored detoxification costs £950 per week.

## Health and Safety

This section outlines the steps taken to attempt to maintain Health and Safety at the residential.

### Preparation

- All potential residents have weekly group sessions for six weeks before they are due to go away. Participation in the residential is dependent on attendance at these sessions. These sessions are used to assess risk (a written assessment is completed for each individual (See Appendix A) but also minimise/identify any potential for conflict between residents.
- Residents must sign a behaviour contract before attending the residential.
- All clients must undergo a medical at the Brownlow group practice prior to departure and if significant medical risks are identified then people will not be taken away.
- Staff have had a wide variety of training and are generally experienced drug and alcohol workers. Two members of the basement staff have been on all of the residentials so there is experience and continuity. The lead staff member on the residential has an NVQ level 4 in Health and Social Care. All remaining staff have, or are working towards an NVQ level 3 in Health and Social Care and have attended as well as in some cases delivered training in drug and alcohol awareness and harm reduction.
- The lead staff member (the most experienced member of the team) will construct residents' individualised alcohol reduction plans before leaving for Wales and these are agreed and signed by the client and lead staff member.

### Whilst on the site

#### Medical Support

- A nurse visits every morning to assess the health of residents. Arrangements are made in advance to ensure that it is always the same nurse ensuring and this familiarity with the client group, the staff and the context decreases risk. This nurse has contact with the nurse in Liverpool who is attached to the Basement so they are fully informed of any potential risk factors.

*'I arrange with her (the nurse) in advance over the dates – so we keep the same nurse – she has been doing this with us since the beginning. She is really good with the service users – non-judgmental very competent and knows exactly what we are about.'*

- Links have been established with a local GP and pharmacy to ensure that methadone is available (supervised consumption) for residents that need it.

*'They got my medication sorted out straight away – they have had other people sorted out with the doctor – everything has been run perfectly.'*

- All staff have first aid training and there are first aid facilities
- Lockable storage is available for medications and is supervised by Basement Staff.
- During the alcohol reduction process residents are monitored for signs of withdrawal and if this occurs the dose is increased.
- Transport is available to take people to hospital if the need arises.
- Basement staff are used to dealing with seizures (fitting) in the potentially less controlled environment in Liverpool. According to staff there have been very few serious withdrawal related incidents.

*'We are used to dealing with people fitting they do in the basement and that can be more worrying because we don't know what they have taken.'*

*'We have had two people experience fits - both had a history of epilepsy – on both occasions the GP was able to incorporate treatment to control the epilepsy. Apart from those two occasions we have had no problems and we have done over one hundred detoxifications in the past five years.'*

### **General Health and Safety**

- The site is let commercially and as such has all current versions of all the necessary certificates.
- Fire drills are undertaken immediately upon arrival at the site.
- Health and Safety procedures in place for the Basement site in Liverpool are applied to the residential (See Appendix B).

### **Supervision**

- Three staff facilitate each residential (for no more than eight residents).
- All outdoor activity is supervised by at least two of the three staff and is limited to relatively low risk activities. Whilst facilitators would like to offer a more expansive range of activities the risk involved is recognised as a barrier.
- The potential dangers involved in intoxicated individuals cooking are anticipated and residents are always supervised

## CONCLUSIONS AND RECOMMENDATIONS

This report is a rapid appraisal and as such cannot be considered a full evaluation of a residential programme such as this, where success must be measured in years rather than weeks and in such a wide range of domains such health, employment, accommodation, relationships - all aspects of 'recovery capital'. However the appraisal's value is in identifying the quality of the delivery of the programme in a number areas and the client experience. In this, the overwhelming impression is one of quality, safety and preparation.

The research team had four snap-shots throughout the appraisal process; a meeting with most of the prospective residents at the Basement Project one week before they left, meeting all eight residents as they left the Basement Project on the day of their departure, during the week-one (wet) interviews and during the week-two (dry) interviews. The visual difference from point one to point four was remarkable – not just improvement in physical appearance but people being visually more confident more optimistic, more sociable.

The most striking finding from this appraisal is the ease with which residents negotiated the first week's alcohol reduction process. This is testament to the accuracy of facilitator's calculations of dose, the substantial preparation period and the appropriateness of the setting. It also reflects the motivation reported by residents in week one.

Evidence suggests that awareness of alcohol services among street drinking groups is low (Ross et al. 2005) and this appraisal would support that point with resident's previous experience of treatment being mixed and knowledge of available services among the client group prior to engagement with the Basement being relatively low. This would also support the suggestion (from facilitators) that this programme is filling a gap in provision in Liverpool, not necessarily related to detoxification but regarding an accessible service for this client group. This service has a clearly identified specialist role within, what for many will be, complex multi-agency treatment journey.

The model of delivery of the residential programme has evolved over time and has moved on from a respite provision philosophy to a more formalised detoxification approach. The fact that this change has occurred as a result of feedback from previous residents demonstrates the responsiveness of the service.

The preparation sessions undertaken prior to departure for Wales are an essential part of the programme. As well as ensuring risk is appropriately assessed it means that resources are targeted at those individuals who will get the most benefit (i.e. those that are most motivated and attend preparation sessions). If the scheme is to be expanded it is important that this process is not diluted, substituting quantity for quality, thus increasing the risks, while reducing the efficacy. The preparation stage means that the potential residents know

each other before being taken to Wales and placed in the pressurised atmosphere that could exist whilst they undergo their reduction in the first week. Potential points of conflict can also be identified early on rather than proving to be a barrier at a later stage. The value of this was evidenced by the lack of conflict between residents that was experienced. In addition considering the difficulties that this client group can have accessing health care (Liverpool City Council, 2010) the role of the preparation stage in allowing the clients' access to a GP and a full health check should not be under-valued.

Whilst the ability of an appraisal such as this to assess the economic efficacy of the residential is limited it would appear that the cost of the programme compares favourably to that of equivalent services.

### **Health and Safety**

It is the conclusion of this appraisal determined via interviews, observations and examination of policies and procedures, that the residential is run in a safe fashion. A programme such as this cannot be risk free, but findings suggest that risk is anticipated and steps taken to mitigate it. Despite this there is a gap in protocols in that an overall written risk assessment for the residential has not been produced to document this process. The low number of previous incidents (in terms of severe alcohol withdrawal) suggests that the alcohol reduction element of the programme is structured and delivered appropriately. Staff have appropriate levels of training and the staff to resident ratio is acceptable.

***Recommendation 1: A written risk assessment should be produced for the residential that is reviewed before and after each trip. The anticipated risks, level of severity and steps taken to mitigate the risk should be detailed.***

***Recommendation 2: All aspects of the health and safety policies and procedures, together with staff training levels and staff client ratios should be collated and made available to both prospective clients and referral agencies.***

***Recommendation 3: For each residential there are three staff and one volunteer. The Basement should ensure that volunteers have received the same level of training as the employed facilitators in terms of health and safety.***

### **Long-term recovery**

The programme has an emphasis on long term personalised recovery. Both facilitators and residents emphasised the importance of continued engagement with services once residents returned to Liverpool. Clients are not forced down a particular philosophy of how to approach recovery but are linked into the agencies that each person believes can facilitate their longer terms goals, which on the evidence of this appraisal for the majority of clients is abstinence. As such the programme fits very well with the personalisation of recovery that is advocated in the latest Drug Strategy (HM Government, 2010).

Links with services in Liverpool would appear, on the whole, to be good. The longer term success of the programme is obviously inexorably linked to the availability and quality of the aftercare. Limitations on spaces in residential and non residential rehabilitation, a substantial potential concern as the reduction in funds from sources such as supporting people and Area Based Grant means pressure on the Pooled Treatment Budget is increased dramatically, could lead to the good work of the programme being negated as individuals return to previously negative circumstances and relationships. The current economic climate and inevitable spending cuts to support services for vulnerable populations may result in an increased need for services to cater for homeless street drinkers and services. This residential alcohol detoxification programme may become even more significant as a method of detoxification, an opportunity to stimulate positive change in those with entrenched drinking problems and potentially as a form of respite for clients from their chaotic street drinking lifestyle.

There is obviously still some work to do in ensuring that all services that might be useful for clients after the residential have an open mind to the progress that clients may have made whilst on the residential. It is important to avoid prejudicing future work on the basis of past difficulties services may have had engaging with particular individuals. In many ways clients leaving this detoxification model should be ideal for abstinence based rehabilitation programmes such as Park View because the lack of pharmaceutical intervention means that if clients have achieved abstinence there should be no barriers to entering services as there has been in the past with other detoxification programmes (Baldwin, McCoy & Duffy, 2009).

***Recommendation 4: Positive case studies should be provided to all agencies that clients returning to Liverpool might engage with alongside an explanation of the programme process. This dissemination should be repeated regularly to ensure that new members of staff in these services are made aware of the services value.***

### ***Future Work***

This rapid appraisal has indentified some promising early indications of the success of the programme but longer term positive outcomes for clients are currently anecdotal and are drawn from staff testimony. Recording and monitoring the longer term outcomes of the programme has the potential to form an integral component of a funding bid to a national commissioner, such as the National Institute of Health Research (NIHR), to undertake further research and conduct a case controlled evaluation. Continued monitoring would enable a quantitative comparison of the programme's outcomes with the outcomes of structured and clinical inpatient and community detoxification treatments. Establishing the effectiveness of the programme would provide the basis for securing longer term funding and overseeing the expansion of the programme through increased programme, the purchase of a property the Basement could dedicate to the programme and investigation of possibility of establishing a residential aftercare site in Liverpool. In addition a

demonstration of the effectiveness of this model could be the first step in establishing similar programmes for this client group based on short term respite and non pharmaceutical free detoxification.

***Recommendation 5: Despite the fact that goals are likely to vary between individuals the Basement should consider identifying outcomes in some core areas that can be examined in the future. Alcohol (and other substance) use would be central with other areas included that are identified as being difficult for street drinkers to address such as access to housing, healthcare, appropriate psychiatric care (something residents in this appraisal had not had access to) and education (Centre for Social and Economic Exclusion, 2005, Cullen, 2005, Home Office, 2006). Addressing these issues will be a long term goal and making progress in these domains will be reliant on a variety of agencies but the Basement does seek to play an enabling role in helping clients to achieve the stability they need to consider engaging with services that focus on these broader outcomes. It will be beneficial for the Basement to assess clients' longer term outcomes in these domains wherever possible.***

***Recommendation 6: The Basement should work to ensure that external agencies, potential referral agencies and commissioners are fully aware of the rigour by which the protocols have been developed and the professionalism of the service delivery. This will assist in ensuring that the residential becomes embedded in the service geography of Liverpool providing more stability and increasing the likelihood of ongoing core funding.***

***Recommendation 7: In order to further promote the scheme the Basement should look to develop promotional materials. These materials should highlight the six week preparation and the links into aftercare alongside information regarding the residential itself. The high completion rate of the programme should also be emphasised. Testimonials from previous residents would also be a useful tool to promote the detoxification among a client group who as this appraisal shows may have little positive previous experience of services. The expertise of 'graduates' should continue to be drawn upon in the delivery of future residential and their potential role as 'ambassadors' for the scheme in liaison with services and commissioners considered.***

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## Appendix A – Resident Risk Assessment

### Basement Safety Assessment

<b>Section One Personal Details</b>	
<b>Name</b>	
<b>Accommodation Details</b>	<b>Please state your last three addresses</b>
<b>Rough Sleeping</b>	
<b>Hostel</b>	
<b>Staying with Family and friends</b>	
<b>Sleeping in a squat</b>	
<b>Emergency contact Details</b>	
<b>Name</b>	
<b>Address</b>	
<b>Telephone number</b>	
<b>Relationship to person</b>	
<b>Section Two Health</b>	
<b>Does the applicant have any physical problems</b>	
<b>Is the Applicant Pregnant</b>	
<b>If yes what is your due date.</b>	

**Mental health Details**

**What is the applicants Primary Mental health Diagnosis**

**Have you ever been detained under the provisions of the Mental Health act /if so please give details**

**Details of all agencies currently involved in the applicants support**

**Organisation**

**Name of Key worker**

**Contact details**

**Organisation**

**Name of Key worker**

**Contact details**

**Organisation**

**Name of Key worker**

**Contact details**

**Details of hospital admission in the last two years**

**Details of current medication**

**Details of how these are administrated**

**Details of any suicide attempts in the last five years**

**Details of any incidents of significant self neglect in the last five years**

**Any other information that that may be relevant.**

**Section Three Drugs and Alcohol**

**What is the applicant's drug of choice?**

**Is the Applicant in treatment**

**Section Four Offending Behaviour**

**Does the applicant have a Criminal History?  
Provide details with dates**

**Is the applicant subject to any court orders**

**Provide details.**

**Does the applicant have any outstanding court appearances'?**

**Provide details**

**Has the applicant been convicted of arson**

**Provide details**

**Has the applicant any conviction or history of sex offences?**

**Has the applicant been convicted of exploiting, harming or abusing others?**

**Any other relevant information**



<b>Section Six Safety information</b>				
<b>Is the applicant subject to any of the following</b>				
<b>MAPPA 1, 2,3</b>		<b>Multi –Agency Protection order</b>		
<b>Probation Order</b>		<b>Restriction order</b>		
<b>Community treatment orders</b>		<b>Section 17</b>		
		<b>Other Pleases state</b>		
<b>What is the chance of the applicant at of self-injury?</b>				
<b>Low</b>	<b>Medium</b>	<b>High</b>	<b>Very High</b>	<b>Don't Know</b>
<b>What are the chance of the applicant attempting suicide</b>				
<b>Low</b>	<b>Medium</b>	<b>High</b>	<b>Very High</b>	<b>Don't Know</b>
<b>Is the applicant a safety issues to others</b>				
<b>Low</b>	<b>Medium</b>	<b>High</b>	<b>Very High</b>	<b>Don't Know</b>
<b>How vulnerable is the applicant</b>				
<b>Low</b>	<b>Medium</b>	<b>High</b>	<b>Very High</b>	<b>Don't Know</b>

## Appendix B – Basement Health and Safety Policy

### The Basement Advisory Centre

#### 1. Health & Safety Policy

**Date effective from:** May 2010                      **Due for review:** May 2011

**Approved by:** The Board of Trustees

#### **1. Objective**

1.1 It is the objective of the organisation that in the execution and supervision of its activities all reasonable measures will be taken to protect the health, safety and welfare of its employees and others by means of safe working practices and procedures.

#### **2. Policy**

2.1 In order to fulfil the above objective, so far as is reasonably practicable, the Health and Safety policy shall seek to establish working practices which will:

- a) regard legal compliance as the lowest acceptable standard and to ensure the organisation is moving towards "best working practice" in health and safety.
- b) regard health and safety as a core management function.
- c) develop a system of responsibility for and communications of health and safety matters.
- d) maintain a safe and healthy working environment and safe methods of operation.
- e) ensure the provision and maintenance of premises and equipment to a safe level.
- f) ensure the provisions of appropriate resources to meet health and safety issues.

- g) state in writing, to all employees (via the Staff Handbook) their responsibilities to ensure the health and safety of persons and the proper use of equipment provided.
- h) provide necessary information, instruction, training and supervision, to ensure the health and safety of employees at work.
- i) provide as appropriate, and ensure the correct use of, approved safety equipment and to ensure no charge will be levied on any employee in respect of anything carried out or provided in pursuance of any specified requirements of relevant statutory provisions.
- j) promote an attitude of safe working by employees in all aspects of the work of the organisation, underpinned by appropriate disciplinary procedures.
- k) encourage discussion between management and employees on safety, health and welfare matters.
- l) ensure immediate and accurate reporting and investigation of accidents and incidents
- m) ensure the provision of an appropriate number of specialist safety staff with responsibilities for safety, health and welfare and to ensure appropriate contingency arrangements are made during the absence of such staff to meet the relevant statutory requirements
- n) develop a system of inspection, monitoring and auditing procedures which will ensure acceptable standards are being achieved across the organisation.
- o) review this Health and Safety Policy not less than once every two years
- p) make specific arrangements on sites controlled by the organisation to ensure that contractors are carrying out their responsibilities for health, safety and welfare.

### **3. Responsibilities and Duties**

- 3.1 To ensure the fulfilment of the working practices specified above, those responsible for their execution and supervision should be made aware of their responsibilities.
- 3.2 Individuals holding management responsibilities are required to:
  - a) Ensure they are familiar with this policy statement.

- b) So far as is reasonable, ensure that where necessary, adequate health and safety facilities are provided and used. Such facilities may include but not be limited to, the provision of safety devices, personal protective equipment and clearly defined safe systems of working.
- c) Ensure, as far as reasonably practicable, the provision and maintenance of equipment to the standards required for a safe and healthy working environment.
- d) Ensure the provision of such information, instruction, training and supervision as is necessary to work in a safe manner and without risk to health.

3.3 The Health and Safety at Work Act 1974 places the following duties on all employees:

- a) To take reasonable care for the health and safety of themselves and others who may be affected by their 'acts or omissions.'
- b) To co-operate with management as far as is necessary in the carrying out of Statutory obligations imposed by the Health and Safety at Work Act 1974 or other Similarly allied legislation.
- c) Not intentionally or recklessly to interfere with or misuse anything provided in the interests of health, safety and welfare.

## Appendix C – Rapid Appraisal Questionnaire

### PARTICIPANT QUESTIONNAIRE - RESIDENTIAL DETOXIFICATION FACILITATED BY THE BASEMENT

*Please do not complete this questionnaire until you have given written consent*

What are your initials?      — —

What is your date of birth?   — — / — — / — —

What is your gender?        M / F

#### **Section 1 – Your Wellbeing**

*Please read the statements below and tick one option:*

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

#### **Section 2 – Drinking Audit**

*Please read the questions below and tick one option:*

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

#### **Section 3 – Control & Stability**

Please read the statements below and tick one option:

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
I feel in control of my life					
My life is controlled by accidental happenings					
My life is stable and has a positive direction					
My life may be influenced by other people					
I am confident that I will be able to stick to my plans					

#### **Section 4 – Residential Detoxification**

I have attempted an inpatient/residential detoxification before	<b><u>YES / NO</u></b>
---	------------------------

Please read the statements below and tick one option:

	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
I am confident that this residential detoxification <u>will have/has had</u> a positive impact on my life					
I am confident that the residential detoxification will have a lasting impact on my life					

**END**

Thank you for completing this questionnaire

If you have any questions or would like to discuss this research, please contact Simon Russell or Paul Duffy on 0151 231 4504