



# Evaluating the Effectiveness of an Assertive Outreach Service for Street Drinkers in Liverpool

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## **1.0 Introduction**

### **1.1 Street Drinking in Liverpool**

The burden of alcohol related harm falls heavier on Liverpool than other areas in the North West (Anderson, Hughes & Bellis, 2007); in 2004/05 Liverpool had the highest rate of alcohol related hospital admissions for males and the second highest for females across England: 1,548 and 785 per 100,000 respectively (Hughes, Tocque, Humphrey & Bellis, 2004). *The Liverpool Alcohol Harm Reduction Strategy 2007-2010* aims 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). Many of the priorities focus upon education, early intervention and prevention, while there appears relatively less focus upon dependent drinkers and highly vulnerable groups, such as street drinkers.

However, the neighbourhood partnership working groups for city health, north and south central neighbourhood management areas, and other partners, expressed concerns about the apparent increase in chronic street drinking in various areas of the city and identified street drinking as a priority for address. Numerous groups of street drinkers, typically dependent drinkers, occupy drinking 'hotspots' around the city centre and broader Liverpool areas. Merseyside police have stated that initiatives to date have failed to reduce alcohol consumption or improve access and attendance at appropriate services among this group (Liverpool City Council, 2010). The partnership piloted a health orientated outreach service in order to better understand the particular needs of these groups and to provide insight into the kind of interventions which might assist street drinkers in reducing their levels of alcohol consumption and associated problematic behaviours. The main funding contributions were provided by Liverpool Primary Care Trust, the Public Health Neighbourhood Manager for City and north Neighbourhood, via Area Based Grant (ABC), with further contributions from city centre Joint Agency Groups and the Supporting People Programme.

An assertive outreach service was commissioned, which targeted street drinking hotspot areas, and sought to engage street drinkers in discussions about their health and social needs and to offer advice on physical, psychological and social harm reduction. The service also sought to establish whether these individuals need health interventions and to assist them in making and attending relevant appointments at appropriate alcohol treatment services, such as inpatient detoxification. The service specification was put out to tender and The Basement, Bolton Road, was successful in their bid. The assertive outreach team consisted of three trained street outreach workers, who operated in the city centre and surrounding areas to engage and support street drinkers (The Basement, 2010).

### **1.2 Aims & Objectives**

The Centre for Public Health at Liverpool John Moores University was commissioned, with a view to informing future commissioning intentions, to conduct an independent evaluation to provide insight into the effectiveness of the assertive outreach service provided by The Basement. The principle aim

of the assertive outreach service was to bridge the gap between street drinkers and mainstream alcohol and health related services and provide support to street drinkers, who are typically difficult to engage with, have frequently failed to comply with treatment programmes and exhibit poor social functioning.

Specifically, the service was also evaluated in terms of meeting the following objectives:

- Providing a coordinated approach response to street drinkers need.
- To link into other health related services, such as drop in centres.
- To provide evidence-based interventions and promote stabilisation and access into services.
- Increasing stability within service users' lives and providing opportunities for personal fulfilment and social inclusion.
- Providing a service that is sensitive and responsive to service users' cultural, religious and gender needs.
- Supporting the street drinker / service user for sustained periods.
- Promoting independence and maintenance of accommodation.
- Promoting effective interagency working.
- Advocating street drinker / service user needs within statutory services.
- Ensuring effective risk assessment and management.
- To provide harm minimisation through awareness and education.

Additionally, the evaluation considered the wider context of alcohol treatment in Liverpool with the following objectives:

- To conduct a review of Tier 4 alcohol service in Liverpool.
- To review the Liverpool Alcohol Strategy and relate evaluation findings to key priorities.

## 2.0 Methodology

### 2.1 Evaluation Methodology

- A thorough literature search was conducted to review local and national evidence, consult guidance literature on addressing street drinking and review the *Local Alcohol Harm Reduction Strategy for Liverpool*. Findings were compiled and translated into a concise review.
- Primary data were recorded via detailed questionnaires for street drinking participants; semi-structured interviews with street drinking participants; and semi-structured interviews with outreach workers.
- Questionnaires were designed and produced by researchers but were conducted by outreach or service workers. Participants were approached for recruitment at street drinking 'hotspots' in the city centre or selected areas a short distance out of the city centre. Soon after individuals had been recruited, questionnaires were conducted with participants within the service setting, typically upon the participants' first or second visit to The Basement.
- Questionnaires recorded information relating to; client characteristics and demographics, including; living situation; education and employment; patterns and volume of alcohol consumption; consumption of illegal drugs; experiences of physical or mental health issues and perceptions of wellbeing; access and uptake into relevant services, including perceived barriers to engagement; and perceptions and suggestions of overcoming barriers and improving services. Questionnaire data were securely transferred before being inputted and analysed using SPSS version 15; any identifying characteristics of participants were excluded at this point. Analysis included a variety of descriptive statistics, cross-tabulations and correlations between variables; appropriate statistical tests were conducted where appropriate.
- After the assertive outreach and support service had been in operation for several months, street drinkers were selected opportunistically to participate in semi-structured interviews. Interviews were conducted by a researcher, within The Basement service setting, in small groups or individually and sought to provide a detailed examination of arising issues and evaluate the impact of the service in the intermediate term. Interviewees received a participant information sheet before giving informed written consent. Participants were assured that all recorded information would be treated anonymously and in strict confidence and that they had the right to withdraw at any point during the interview. Interviews were transcribed and collated before being analysed thematically.
- During the same period, semi-structured interviews were conducted, by a researcher, within The Basement service setting, with outreach workers. These interviews sought to provide an overview and an informed perspective on the characteristics and well being of participating street drinkers, in addition to highlighting areas of good practice and persisting barriers relating to the assertive outreach service and mainstream services. Interviewees received a

participant information sheet before giving informed written consent. Participants were assured that all recorded information would be treated anonymously and in strict confidence and that they had the right to withdraw at any point during the interview. Interviews were transcribed and collated before being analysed thematically.

- Quantitative questionnaire results were combined with qualitative themes derived from the semi-structured interviews. Conclusions were drawn from overall findings and utilised to derive sensible and realistic recommendations. Such recommendations may include highlighting potential areas for further research, suggesting possible application or change regarding relevant policy and practice and ultimately informing commissioners of the potential and effectiveness of the assertive outreach service. Outcomes and findings were disseminated to relevant commissioners and stakeholders, before being formally presented in the final report.

## **2.2 Outreach Service Methodology**

- The assertive outreach service was commissioned to respond to the needs of street drinkers and establish an overview of street drinking. The outreach service was provided by The Basement and utilised mixed methods to engage and support the participating street drinkers. Flexible and adaptive approaches were required owing to the unpredictable and varied nature of individuals from street drinking communities.
- Street drinkers were approached on the street or other communal public places, such as parks or cafes, in order to establish initial contact. Pairs of outreach workers worked four hour shifts, five days per week between 10.00am-14.00pm, 14.00pm-18.00pm and 16.00pm-20.00pm. Recruitment was continually undertaken in addition to support and monitoring of engaged participants. Outreach workers operated between the last week of October 2009 until the last week of March 2010; this period was extended on an ad-hoc basis.
- The recruitment and monitoring routes typically included Mount Pleasant, Hope Street, Rodney Street, Bold Street, Seel Street, the L1 area, Cheapside, Dale Street, London Road, the West Kensington area, Aigburth Road, Park Road, Lark Lane, Sefton Park, Ullet Road, Princess Park, Princess Drive, Breck Road, West Derby Road, Green Lane and Newsham Park.
- Once recruited, participants were offered a variety of services including; support from outreach workers; a drop in centre; shelter, typically occupied during cold weather, often in the evening time; facilities to wash themselves and their clothes; hot drinks facilities and occasional food nights; harm reduction advice; healthy living advice; 'away days' in Wales, including supported detoxification; and referral, support and accompaniment to mainstream services. Such services were typically tier 3, including access to a General Practitioners (GP) or community based services, and tier 4, including inpatient detoxification or residential rehabilitation.
- Questionnaires were completed in The Basement service setting under the supervision of outreach workers. Participants received a participant information sheet before giving



informed written consent. Participants were assured that all recorded information would be anonymous and treated in strict confidence and that they had the right to withdraw at any point during completion of the questionnaire. Once questionnaires were completed they were kept securely within the service until collected by a researcher.

### **2.3 Ethics**

Ethical approval was granted by the Liverpool John Moores University Research Ethics Committee. Potentially problematic issues for respondents, levels of co-morbidity and responses that could be used to support or evoke behaviour change were considered.

## 3.0 Results

### 3.1 Results – Literature Review

Alcohol misuse is associated with a wide range of problems, including; physical and mental health problems, which co-exist with alcohol use; offending behavior, including anti-social behavior and domestic violence; social problems, such as homelessness; suicide and deliberate self harm; and child neglect (*Model of Care for Alcohol Misusers*, MoCAM, 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 (ANARP, 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 variations in overall prevalence between areas range from 1.6% to 5.2% (ANARP, 2004). In addition to the individual and social benefits, alcohol treatment has also 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 saved about five times as much in expenditure on health, social, and criminal justice services as they cost (2005). MoCAM 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.

#### 3.1.1 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). 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). 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, 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). 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). More recent data demonstrates homelessness

acceptances during the April to June 2007 quarter were 18 per cent lower than in the same period in 2006 and represent the lowest quarterly level since the early 1980s (Communities & Local Government, 2007). 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, 2010).

Research suggests that substance 'abuse' places individuals at increased risk of homelessness (Spinner & Leaf, 1992; Winkleby et al. 1992). While the reported prevalence of alcohol and drug use among the homeless varies, alcohol use is considered to be one of the most pervasive health problems among the homeless (Garrett, 1989). One study found that up to one third of rough sleepers were heavy drinkers, that between 16% and 51% showed symptoms of alcohol dependence and between 10% and 35% were severely dependent (Gill, 1996). A dependent drinker is defined as a person who drinks above 'sensible' levels and experiences harm and symptoms of dependence; or more quantifiably, one who scores 16 or over on the standardised Alcohol Use Disorder Identification Test (AUDIT) (Department of Health, 2004). The AUDIT has been found to have a high degree of sensitivity and specificity in detecting hazardous drinking in a UK population (Coulton et al. 2005; Department of Health, 2004). Awareness of alcohol services has been demonstrated to be low in street drinking groups (Ross et al. 2005) and it has also been documented that nationally, street drinkers have difficulty in gaining access to healthcare services, especially psychiatric services (Cullen, 2005). Studies have also demonstrated that street drinkers may be generally happy with their public drinking, which raises issues of the extent of service responsibility for people who may not wish to change their behaviour (Lamb, 1995).

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 of whom were not engaged with alcohol services (Cullen, 2005). A similar study revealed that public concern regarding street drinkers mostly related to the visibility of groups and the negative impact this was perceived to have on the community (Ross et al. 2005). The prevalence of street drinkers has been demonstrated to increase in the summer months and, while such drinking may occur at any time of day, the majority occurs between four in the afternoon and four in the morning (Cullen, 2005).

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, and who may be using controlled drugs; perhaps also 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 between half and two thirds, or the majority of street drinkers live in their own (rented) accommodation, citing social aspects and the cost of drinking in public houses as reasons for street drinking (Ross et al. 2005). However, it has been suggested that city centre street drinkers may be more likely to be homeless than suburban street drinkers.

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 friends (Ross et al. 2005). 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 of street drinking groups by fieldworkers (Ross et al. 2005).

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

The substance using homeless represent a special 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). Past studies have indicated that as many as 50% of the total homeless population in the United States have some form of mental illness with 70-80% having a lifetime diagnosis (Scott, 1993).

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 drinking; housing needs, especially 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 much of their time and something is needed to 'fill the gap'; and drinking needs, which may include a range of service options since some may not be ready for dramatic change and others may not wish to address the problem (Alcohol Concern, 2003).

Services that have been suggested to be appropriate and effective for the substance using homeless and street drinkers include; outreach teams, primarily to provide referrals and support; day centres, which provide assessment, educational sessions and referral to mainstream services; 'wet' centres, which give street drinkers a safe space in which to drink; and floating support, designed to help clients maintain tenancies (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; that there was a statistically significant relationship between clients' motivation level and completed referral, and between referrals made and program acceptance (Fisk, Rakfeldt & McCormack, 2006). Such evidence indicates that assertive outreach can be effective at engaging and linking homeless persons with substance use disorders to substance use treatment services (Fisk, Rakfeldt & McCormack, 2006). Studies have also demonstrated that assertive community treatments offer significant advantages over standard community case management models in reducing homelessness and symptom severity in homeless persons, especially among those with severe mental illness (Coldwell & Bender, 2007).

It has been suggested that wet day centres, can be an important first point-of-contact for street drinkers, who are excluded from or unable to use mainstream services (Crane & Warnes, 2005), however opinions vary regarding the effectiveness of wet centres (Community Care, 2001). There is some evidence that such approaches can be beneficial and that drinking levels within wet centres can be reduced from previous street levels (Community Care, 2001). Wet day centres generally have two overarching aims: (i) to provide support, help and treatment for severely disadvantaged and

chaotic people, including street drinkers; and (ii) to tackle an anti-social behaviour problem in a constructive, non-criminalising way. However, it has been expressed that managing and maintaining a wet centre so that bullying, intimidation or immoderate drinking does not occur is very difficult; it has also been suggested that managing the local environment to minimise the centre's impact on the neighbourhood presents many challenges (Community Care, 2001).

While there is little evidence regarding the effectiveness of wet centres, one example of an innovative wet service for street drinkers is The Booth Centre, Manchester, which is an "activities and advice based day centre, which enables homeless people to rebuild their lives" (The Booth Centre, 2010). The Booth Centre provides; a drop in facility for people who are homeless; advice to help resolve problems; a base for creative, therapeutic and challenging activities; in addition to helping clients to move on to education, training and employment (The Booth Centre, 2010).

### **3.1.3 Perceptions & Enforcement**

Street drinking is considered to be an important issue by the general public and the media; people perceive street drinkers to be aggressive and violent and a danger to society, even if this is often not the case (Alcohol Concern, 2003). Studies have shown that 'people resent and fear the presence of street drinkers though there is no evidence to substantiate any real threat to public safety' and that there is an expectation that police and other services should 'do something' (Shimwell, 1999).

Formal enforcement measures include: Anti-Social Behaviour Orders (ASBOs); Acceptable Behaviour Contracts (ABC) or Agreements (ABA); dispersal orders; arrests for begging; arrests for sleeping rough; civil injunctions; controlled drinking zones; rough sleeping hotspot closures; and 'designing out', which entails adapting urban environments to 'design out' street activity. A study which pooled multiple case studies of enforcement measures found that street outreach workers reported enforcement measures generally caused rough sleepers to 'go underground', that is to sleep and beg, in more hidden and less heavily policed places; consequently many outreach workers reported difficulty locating and supporting their clients (Johnsen & Fitzpatrick, 2007).

The same study (Johnsen & 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 discrete. Similarly, with the threat of confiscation, street users 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 the anti-social (and criminal) behaviours of aggressive beggars and street drinkers (Johnsen & Fitzpatrick, 2007).

### 3.1.4 Tier 4 Services in Liverpool

As defined by *Models of Care for Alcohol Misusers*, tier 4 is comprised of inpatient detoxification and residential rehabilitation, although aftercare is closely associated with tier 4 service provisions (NTA, 2006). Dependent drinker interviewees, as part of a review of tier 4 inpatient services in Cumbria and Lancashire, described that tier 4 alcohol detoxification treatment is a ‘completely essential’ service; suggesting that community based detoxifications were generally insufficient for dependent drinkers (Russell, Hurst & Marr, 2010). 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 take themselves out of area in order to receive quicker interventions. 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 (Russell, Hurst & Marr, 2010).

If, as reported in the literature, the majority of street drinkers are dependent drinkers, a substantial proportion may be in need of 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, Hurst & Marr, 2010). 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).

#### ***Information Box: Tier 4 Services in Liverpool***

*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.*

*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. Any evidence of current use of illegal drug use 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. It was reported that waiting lists varied but were typically less than six weeks and that priority clients were admitted quicker via a triaging system.*

*The Parkview project in Aigburth, is a residential rehabilitation only facility and employs relatively strict entry criteria. Clients must demonstrate sobriety pre-admittance and, certain medications and opiate substitutes are not allowed.*

### 3.2 Results – Questionnaire Data

#### 3.2.1 Street Drinker Demographics

Of participants, 79.4% (27) were male and 20.6% (7) were female; 88.2% (30) were White British, 8.8% (3) were White European and 2.9% (1) were Chinese. Figure 1 displays the percentage of participant age groups; as displayed, 88.0% of participants were over the age of 35 and 35.0% of participants were over the age of 45.

**Figure 1: Percentage of Participant Age Groups (N=34)**

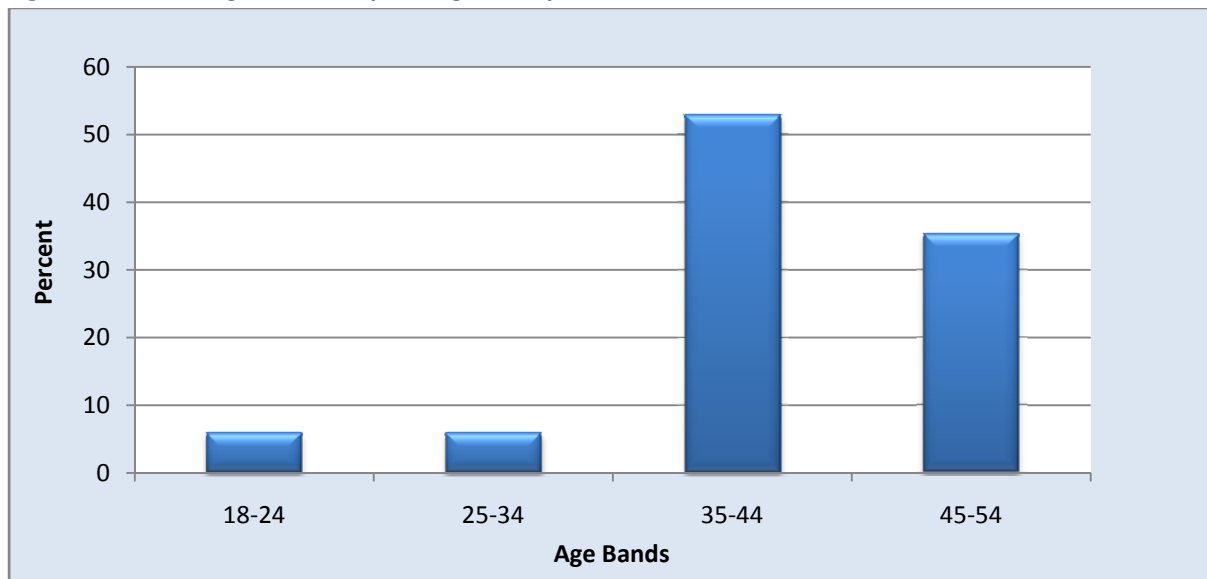
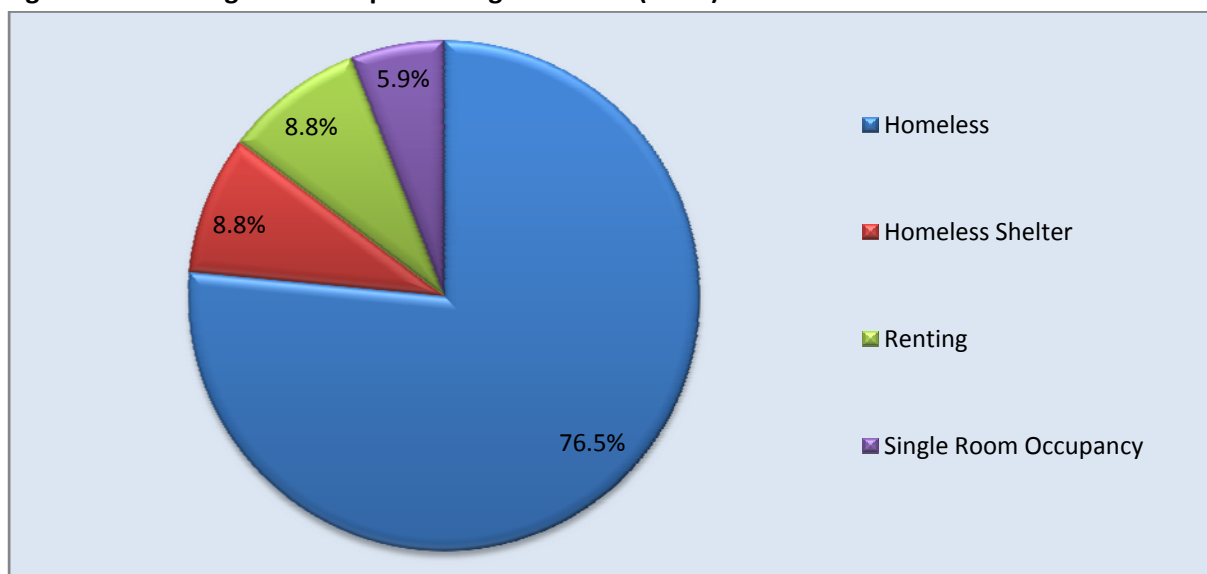


Figure 2 displays participant's living situations, as displayed, 76.5% (26) were homeless, 8.8% (3) were living in homeless shelters, 8.8% (3) were renting and 5.9% (2) were in single room occupancies.

**Figure 2: Percentage of Participant Living Situations (N=34)**



Participants (N=34) reported drinking on the street for between three months and 30 years; the mean duration of time spent drinking on the streets was eight years and 10 months. In terms of employment, 97.1% (33) of participants reported being currently unemployed and 2.9% (1) reported being on long term sick leave.

Table 1 displays the level of education among participants, as demonstrated, 73.6% (25) had no qualifications, 5.9% (2) and 2.9% (1) had 'O' levels and GCSEs respectively, 5.9% (2) had 'A' levels, 2.9% (1) had a degree, 2.9% (1) had an NVQ and 5.9% (2) had 'other' qualifications but did not specify.

**Table 1: Level of Education among Participants (N=34)**

Qualification	Frequency	Percent
No Qualifications	25	73.6
'O' Levels	2	5.9
GCSEs	1	2.9
'A' Levels	2	5.9
NVQ	1	2.9
Degree	1	2.9
Other (not specified)	2	5.9

### 3.2.2 Alcohol Consumption

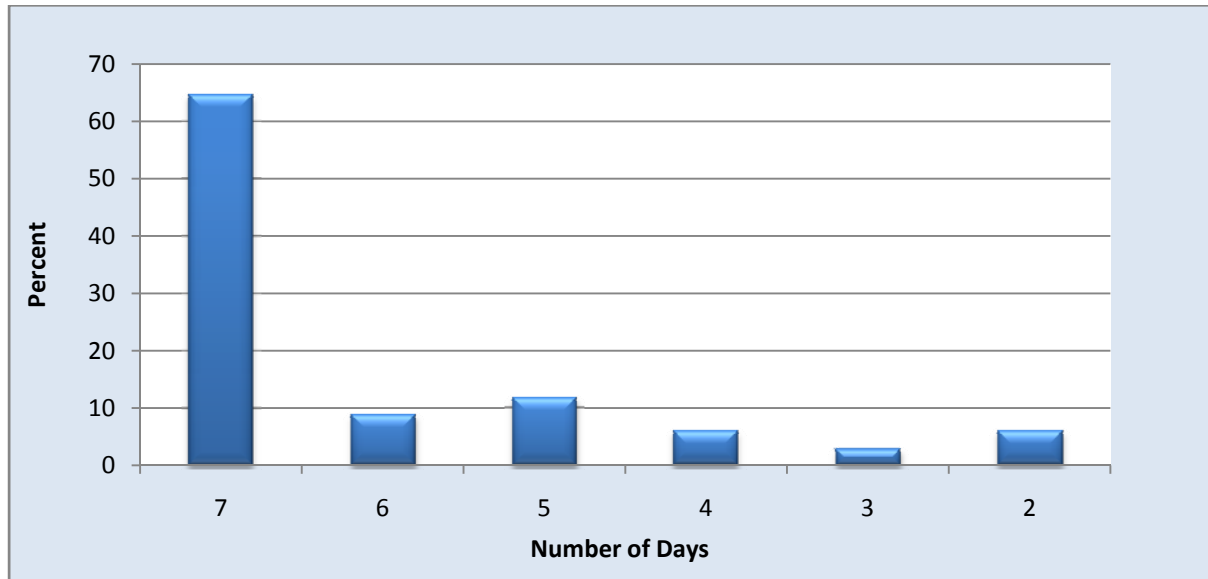
In terms of alcohol use, 100.0% (34) of participants indicated they had consumed a drink in the last four weeks. In terms of other substance use, 53.1% (17) of participants reported using other substances in the last four weeks; of those, 52.9% (9) reported using heroin and crack, 17.7% (3) reported using heroin and 29.4% (5) reported using methadone.

Of participants, 85.3% (29) indicated they had consumed a drink in the last 24 hours, while 14.7% (5) indicated they had not consumed a drink in the last 24 hours. Participants indicated they typically consumed their first drink at approximately 5.00pm, however this question was answered vaguely by participants, for example some participants specified "20 minutes ago" but without indicating the time the questionnaire was conducted.

Of participants, 64.7% (22) indicated they had consumed alcohol every day of the last week, 8.8% (3) had consumed alcohol on six days, 11.8% (4) had consumed alcohol on five days, 5.9% (2) had consumed alcohol on four days, 2.9% (1) had consumed alcohol on three days, and 5.9% (2) had consumed alcohol on two days. However, five individuals who stated they had consumed alcohol less than every day indicated they usually drank more. Figure 3 displays the number of days participants consumed alcohol in the last week.

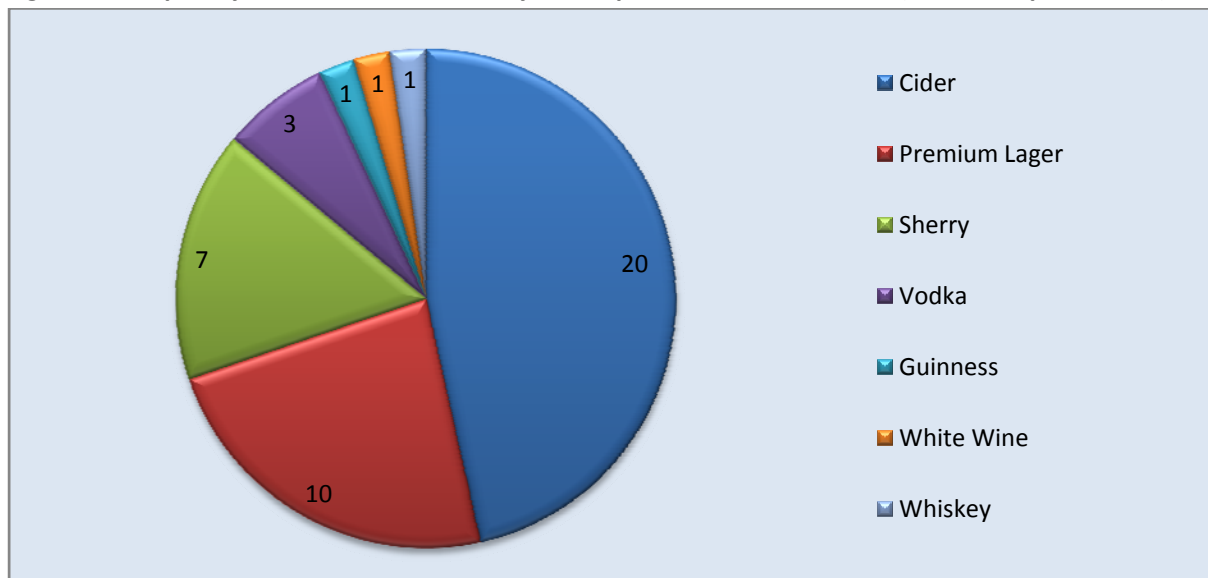


**Figure 3: The Number of Days Participants Consumed Alcohol in the Last Week (N=34)**



Participants indicated the types of drinks consumed in the last week; some participants specified more than one type of drink. Figure 4 displays the frequency of drinks consumed, as demonstrated cider, premium lager and sherry comprise 86.0% of drinks consumed by participants. Of participants 82.4% (28) reported wanting to cut down their drinking, while 17.6% (6) reported that they did not want to.

**Figure 4: Frequency of Drinks Consumed by Participants in the Last Week (N=34, Responses=43)**



Participants were asked to indicate the quantity and volume of drinks they had consumed over the last week, from this information unitary consumption was calculated. One unit of alcohol is equal to 10ml, or 8grams of pure alcohol; for example, if a given drink is 5.5% alcohol then there is 55ml of pure alcohol in 1000ml, or 5.5 units. Table 2 displays the units contained in 1000ml of alcoholic drinks specified by participants.

**Table 2: Units Contained in 1000ml of Drinks Specified by Participants**

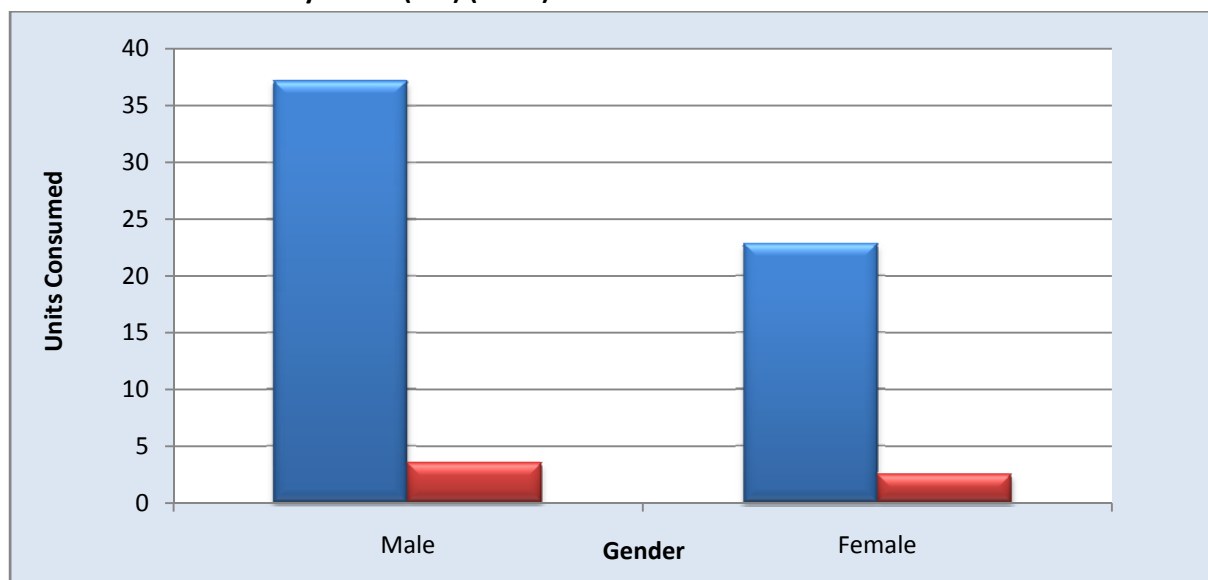
Drink	Percentage Proof Alcohol	Units
Cider	5.5%	5.5
Premium Lager	5.2%	5.2
Guinness	4.1%	4.1
White wine	13.5%	13.5
Sherry	17.5%	17.5
Vodka	37.5%	37.5
Whiskey	40.0%	40

(Drinkaware, 2010)

Unitary intake was calculated for participants, who reported that their intake represented a ‘normal day’. Table 3 displays unitary intake, as demonstrated the mean units consumed by males per day was 37.2 and the mean units consumed by females per day was 22.8. Figure 5 displays the mean units consumed by males and females compared to the recommended safe daily limits.

**Table 3: Range and Mean Units Consumed by Participants on a ‘Normal Day’ (N=22)**

Sex	Range of Units Consumed	Mean Units Consumed
Male	9.7 – 99.0	37.2
Female	11.0 – 33.0	22.8

**Figure 5: Mean Units Consumed by Males and Females on a ‘Normal Day’ (blue) compared to the Recommended Safe Daily Limits (red) (N=22)**

Of participants, 44.1% (15) indicated they had attempted a period without drinking in the last 12 months; of those the number of attempts made per individual ranged from one to seven, the mean number of attempts was 3.3. Table 4 displays the difficulty expressed by participants in overcoming specified barriers in attempting a period of abstinence.

**Table 4: Frequency of Participant Responses describing the Level of Difficulty in overcoming Specified Barriers while Attempting Periods of Abstinence**

Aspect	N	Not at all difficult	A little difficult	Moderately difficult	Very difficult
Dealing with feelings	21	1	1	3	16
Working, finding work, or keeping a job	20	4	0	1	15
Fear of relapse	20	0	2	4	14
Having money problems	20	2	0	3	15
Dealing with inner conflicts	20	3	3	5	9
Not being understood	20	2	5	4	9
Things are not happening fast enough	20	2	1	3	14
Being bored	20	0	0	2	18
Feeling helpless	20	2	1	4	13
Not getting frustrated with the system	18	1	4	1	12
Overcoming fear of change, taking risks	21	1	2	5	13
Dealing with stability, with a clear head	19	0	2	4	13
Fear of never getting better	21	1	1	4	15
Overcoming confusion	20	3	4	1	12
Overcoming isolation	20	3	3	5	9
Identifying and dealing with triggers	19	1	1	4	13
Coping with mental disorder	19	4	4	1	10
Overcoming stigma of dual-diagnosis	20	6	2	2	10
Dealing with the system, with providers	20	2	4	4	10
Feeling good about yourself	20	1	3	4	12
Having or getting structure in your life	19	0	2	5	12
Accepting yourself and your dual-diagnosis	20	5	2	3	10
Admitting powerlessness	19	3	2	3	11
Dealing with medications	20	5	4	3	8
Asking/accepting help and support	20	3	5	3	9
Being open-minded, listening	20	4	7	1	8
Not being accepted onto treatment groups	20	4	5	1	10
Following a treatment programme	20	1	3	5	11
Accepting a 'Higher Power'	19	4	4	0	11

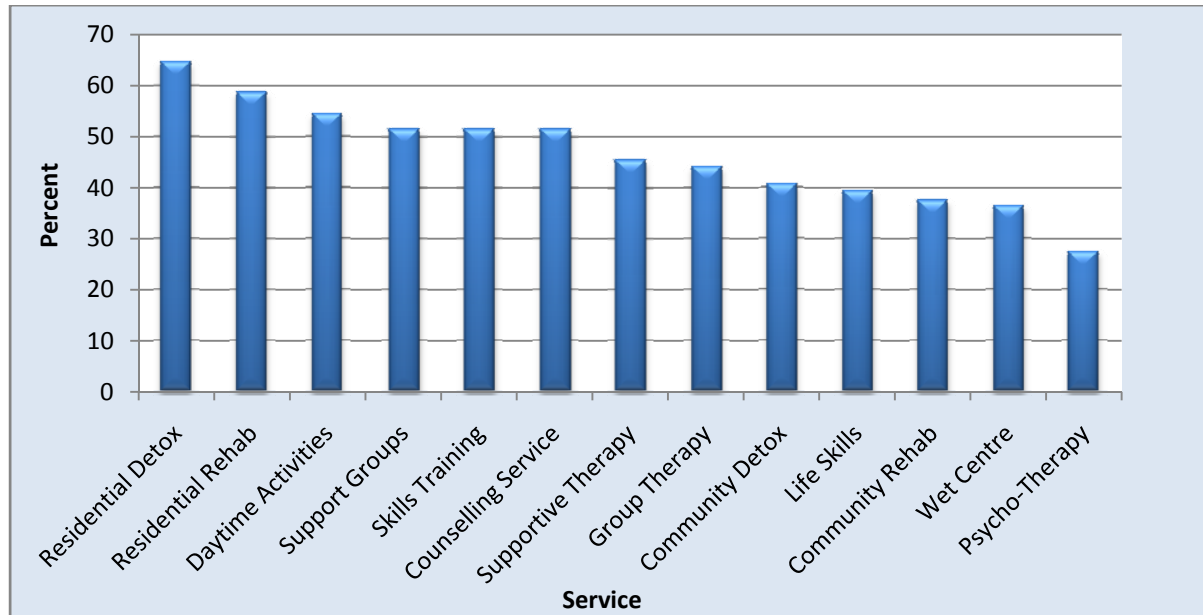
### 3.2.3 Access and Engagement with Alcohol Services

Of participants, 82.4% (28) reported currently getting help from alcohol services, compared to 17.6% (6) who were not currently getting help from alcohol services. However, only four participants specified which service they were receiving help from and it is likely that participants included the assertive outreach service in their responses.

Of participants, 17.7% (6) reported attending self help groups; of those 33.3% (2) reported 'always' gaining benefits from the group, 50.0% (3) reported 'often' gaining benefits from the group and 16.7% (1) reported 'sometimes' gaining benefits from the group. Figure 6 displays the percentages of

participants that would be interested in specified services; the highest percentages of participants stated they would be interested in residential (inpatient) detoxification (64.7%) and residential rehabilitation (58.8%).

**Figure 6: Percentages of Participants that would be Interested in Specified Services (N=33)**



Participants were given the opportunity to qualitatively describe what help they would like accessing or attending alcohol services. Of those that responded, eight identified assistance in accessing detoxification or rehabilitation, five identified the assignment of a key worker or personal support, while individuals also identified out of area treatment, Librium treatment, reduced waiting times and assistance attending group sessions. Participants were given the opportunity to identify the factors preventing them from accessing or maintaining contact with alcohol treatment. Of respondents, 23 identified accommodation status, eight identified excessive alcohol usage, seven identified mental or emotional health or well being and one individual identified their peer group as the most significant barriers to accessing alcohol services.

### 3.2.4 Health and Well Being

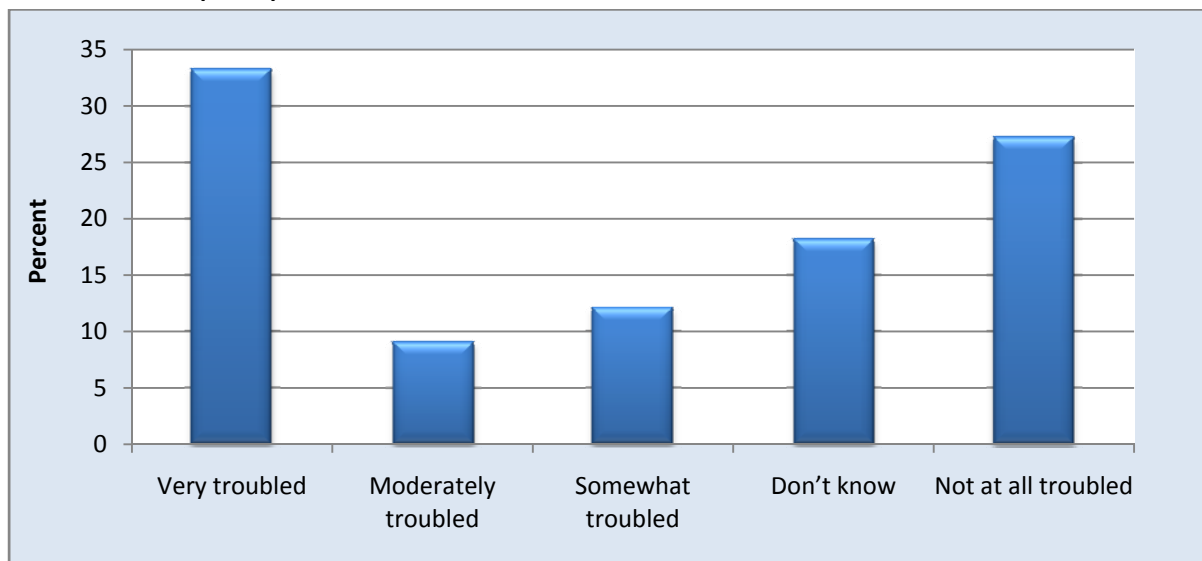
Of participants, 65.6% (21) reported experiencing a physical health problem within the last year, compared to 32.4% (11) who reported not experiencing a physical health problem within the last year. A higher percentage of females than males were found to report physical health problems, however the sub sample of females (n=6) was too small to make a valid comparison. Similarly, a higher percentage of over 35 year olds were found to experience physical health problems compared to the under 35 years olds, however the sub sample of under 35 years olds (n=3) was too small to make a valid comparison.

Of participants, 41.9% (13) reported experiencing mental health problems within the last year, compared to 51.6% (16) who reported not experiencing mental health problems within the last year and 6.5% (2) who indicated they didn't know. A higher percentage of females were found to report mental health problems than males, however, as previously, the sub sample of females (n=6) was

too small to make a valid comparison. A higher percentage of over 45 year olds (N=10) were found to experience mental health problems compared to 35-44 years olds (N=16); 60.0% (6) compared to 29.4% (5). The Man-Whitney U-test found the difference between these groups not to be statistically significant ( $p>0.05$ ).

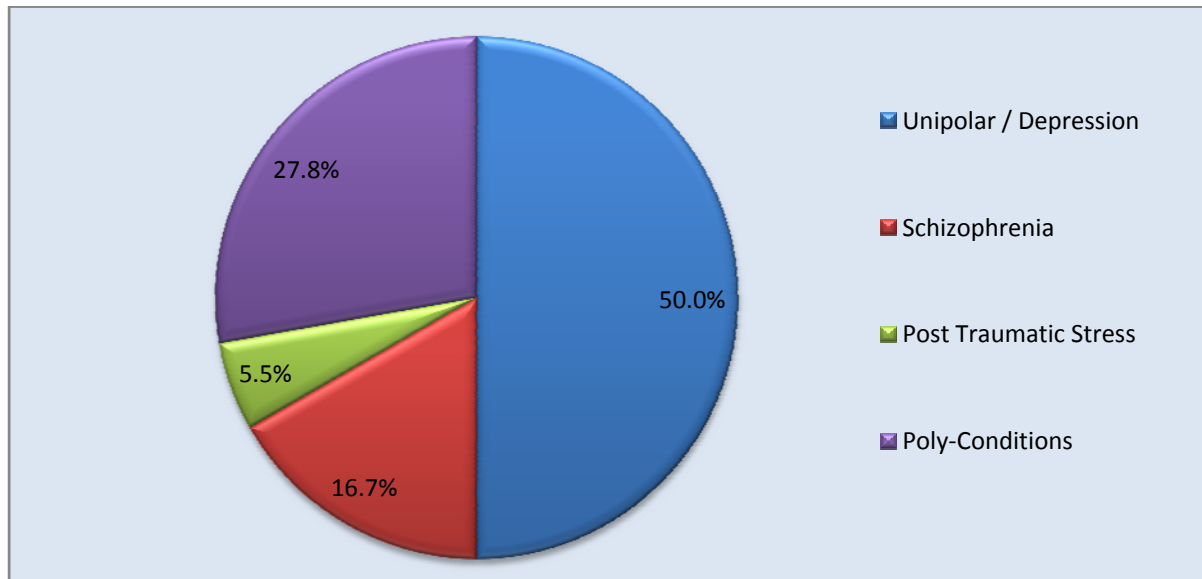
Figure 7 displays the extent to which participants felt troubled by their physical or mental problems in the last month. As displayed the majority, 33.3% (11) felt 'very troubled', while 9.1% (3) felt 'moderately troubled' and 12.1% (4) felt 'somewhat troubled'; 18.2% (6) indicated they 'didn't know' and 27.3% (9) felt 'not at all troubled'.

**Figure 7: The Extent to which Participants Felt Troubled by their Physical or Mental Problems in the Last Month (N=33)**



Of participants 54.5% (18) reported suffering from a psychological disorder. Figure 8 displays the proportion of conditions of those who reported currently suffering from a psychological disorder, of those, 50.0% (9) reported suffering from Unipolar disorder / depression, 16.7% (3) reported suffering from Schizophrenia, 5.5% (1) reported suffering from Post-traumatic stress and 27.8% (5) reported suffering from Poly-conditions. Of those suffering from Poly-conditions, 1 individual reported suffering from Unipolar disorder and Anxiety; 1 individual reported suffering from Post-traumatic stress and Unipolar disorder; 1 individual reported suffering from Schizophrenia, Post-traumatic stress and Unipolar disorder; 1 individual reported suffering from Schizophrenia, Schizoactive disorder and Post-traumatic stress; and 1 individual reported suffering from Schizophrenia, Bipolar disorder, Schizoactive disorder, Post-traumatic stress and Unipolar disorder.

**Figure 8: The Proportion of Conditions among Participants who Reported Currently Suffering from a Psychological Disorder (N=18)**



Of participants, 58.6% (17) indicated that drinking ‘came before mental health issues’, 24.1% (7) indicated mental health issues ‘came before drinking’, 6.9% (2) indicated that ‘mental health issues and drinking occurred at the same time’ and 10.3% (3) indicated that they didn’t know which came first. Of participants, 51.7% (15) indicated that they thought their mental health issues and drinking were linked, 13.8% (4) indicated that they thought their mental health issues and drinking were not linked and 34.5% (10) indicated that they didn’t know if they were linked.

In terms of prescribed medication, 57.1% (19) indicated that they were currently using medication, while 42.4% (14) indicated that they were not currently using medication. Of those currently using medication, 77.7% (14) reported using methadone or buprenorphine (opiate substitutes), 16.7% (3) reported using diazepam (prescribed for anxiety or insomnia), 16.7% (3) reported using thiamine (Vitamin B), 16.6% (3) reported using amitriptyline or citalopram (anti-depressants), 5.5% (1) reported using olanzapine (anti-psychotic medication) and 5.5% (1) reported using zopiclone (prescribed for insomnia). Participants indicated use of medication for between two months and 20 years; the mean length of use, of those currently using prescribed medication was 6.5 years.

### 3.3 Results – Semi-structured Interviews – Participants

Interviews were conducted with six street drinking participants, either individually or in small groups. Interviews were analysed thematically although the extent and depth of data analysis was limited owing to the level of interviewee intoxication; only in one case did the interviewee claim to be currently abstinent from alcohol, the other five interviewees reported to be dependent alcohol users. All of the interviewees were currently homeless and expressed a desire to cut down their drinking or move to abstinence.

*“It’s a sickness, a disease; I’d love nothing more than to get off it.”*

*“After a week off the booze I start to feel good again.”*

*“I’d love to work, I’d love to have my own ‘gaff’ but it’s not as easy as that.”*

*“I was stuck in town, it was my home.”*

#### 3.3.1 Participant Characteristics & Alcohol Use

Interviewees described a high level of current alcohol use and expressed feelings of depression and anger. Interviewees generally expressed that their alcohol use and associated problems were primarily their responsibility to address. Several interviewees described how they had ‘become alcoholics’ when addressing their heroin and crack use and identified the common trend to ‘switch addictions’.

*“One day I decided not to use drugs anymore, I bought a litre bottle of vodka; I drank it straight. That day I drank the bottle between 7.00(am) and 12.00(pm), got really drunk all day, people had asked me if I wanted to take drugs that day and I’d said no. ‘I’m just having a ‘bevvie’, I was getting such a rush off saying no. I never did drugs again.”*

*“That’s how I came off the heroin, by picking up the drink...I’m a cross addict, you change one for the other. [Do you think alcohol is less of a problem?] No, I think it’s one of the worse going; the addiction stays there unlike heroin. You walk past ‘offies’ and pubs...I was off alcohol for weeks but you can only say no so many times. As an alcoholic once you’ve relapsed and had that first drink, that’s it.”*

*“It’s the worst (alcohol), it worse than heroin because every shop window sells drink.”*

Interviewees described how at times, their drinking had been affected by their personal lives suggesting that previous attempts to move to abstinence had been negatively affected by adverse

circumstances. Interviewees commonly agreed that gaining stable accommodation was important in attempting to cut down or stop drinking, however, several interviewees described losing stable accommodation because of their alcohol dependence; often failing to maintain rent payments because of their expenditure on alcohol. Interviewees described how living on the streets as a dependent drinker was often accompanied by a chaotic lifestyle, suggesting that at times they were ‘in and out’ of hostels and prison.

Interviewees described how they experienced difficulties addressing their alcohol use while living on the streets and surrounded by dependent drinkers; for this reason several interviewees expressed an interest in accessing out of area services. Some interviewees reported undertaking inpatient detoxification programmes out of area but described difficulties in maintaining abstinence upon their return to Liverpool and the community they left. Interviewees also described feeling stigmatised by the general public, expressing they thought the public felt intimidated by or ‘looked down’ on street drinkers.

*“Places I was going back to were getting me back into the rigmarole (drinking).”*

*“They just treat you like a piece of shit, they walk past and look at you like (you’re) a tramp. They should try living on the streets for a few days; it’s hard, really hard.”*

*“People just don’t know what it’s like being an alcoholic, I wake up every morning shaking like that (vigorously shakes hands) I can’t get up, I can’t get my head straight without a drink.”*

However, one interviewee, after a filming exercise as part of an art project, described feeling uncomfortable watching himself begging and described empathising with the public, describing how he ‘would have felt the same’.

*“They feel intimidated, they are scared. I did that Hollywood for the homeless in the bombed out church and we went out taking pictures (and filming) one day; I was drunk and watched myself tormenting people for money and ‘ciggies’ and watched them all crossing the street.”*

### **3.3.2 The Assertive Outreach Service**

Interviewees did not uniformly express that they thought The Basement outreach service was the first step to abstinence but outlined examples of assistance and support that would greatly benefit an individual should they choose to attempt a move to abstinence. Interviewees agreed that The Basement would assist in gaining access to services or accommodation where possible but expressed difficulties in maintaining accommodation or treatment programmes. Interviewees uniformly expressed that The Basement provided invaluable support as a ‘front line’ service, functioning to help reduce drinking, and cited the ‘away days’ as potential springboards into periods of abstinence.



'Away days' were typically a week or two in a relatively quiet location in Wales; the format of one such trip allowed moderate drinking the first week but participants were required to be abstinent during the second week which, it was hoped, would continue as a period of abstinence.

*"Most people are still drinking but some are weaning themselves off."*

*"[What do you want to get out of this service?] Primarily support but they do help you get into other services. [Are there any improvements they could make?] No, they do as good as they can here."*

*"This place (The Basement) will get you hostels and stuff. If I got thrown out these guys would find me another hostel but I can't pay my rent so I would end up just staying out on the streets."*

*"I have asked The Basement to help me do it because I did need help. I did ask for help to get into [service name], The Basement helped me get in to there, they can help reduce waiting lists and actually tell programmes that Mr [client name] has stopped drinking...they won't take you if you have alcohol in your system."*

*"When I was asked to go to Wales I jumped at the chance. I had been on another Wales trip for a week, but this was 2 weeks. I got such enjoyment out of it, (I spoke about) things that I hadn't spoken about for years, because of drink and drugs."*

Interviewees generally expressed that the recruitment process for inclusion on the outreach programme was agreeable and that outreach staff and service staff were respectful and understanding without pressurising individuals to participate. Interviewees emphasised the importance of the respect shown to them, and described the value of the relationship they had with outreach workers and members of staff. Interviewees also described structured activities and alcohol awareness sessions, as organised on the 'away days', as useful; one interviewee also described being involved with the preparation and cooking of meals as particularly satisfying.

Interviewees were divided over the potential benefit of The Basement's proposed move to another area of Liverpool city centre. While some expressed that the move to more developed premises would be welcomed, others thought the proposed location, which was closer to street drinking hotspots may cause problems for participants if they were currently attempting a period of abstinence.

*"They're brilliant here, they give you support and a place to sit off; they do everything for you."*

*"You need a mentor, and you get it from members of staff here, even the volunteers that come in."*

*"I would like to hold my hand out to them and thank them so proudly for what they have done, and what they do here. There is nothing more I could ask of them."*

### 3.3.3 Enforcement & Mainstream Services

Interviewees generally expressed a desire to become abstinent and cited inpatient detoxifications as the most appropriate mechanism to achieve this. Most interviewees had undertaken such programmes in the past but described limited recent contact with mainstream services. Interviewees reacted adversely to questions regarding methods of enforcement employed by Police and Community Wardens, generally reporting not feeling respected by law enforcement workers. Several interviewees also felt that on occasions Police and Community Wardens acted in a deliberately antagonistic manner. Interviewees refuted the effectiveness of fines and confiscation of alcohol, expressing that such measures typically led to shoplifting or more aggressive begging.

*“They’re just aggressive, you feel like they are just doing it to piss you off half the time. You think I paid for that, with my money and you are tipping it down the drain. You wouldn’t go up to someone who is drinking outside a pub and tip their drink away would you? You just go and get another one, any way you can.”*

*“We move around quite a lot, you can never really stay in the same place for too long.”*

Several interviewees felt wet houses would be a good idea and described some of the benefits they observed whilst attending The Booth Centre in Manchester. Interviewees especially liked the contribution made by attendees at The Booth, where street drinkers and the homeless work to maintain the garden. Interviewees were unsure whether such facilities would be introduced in Liverpool.

### 3.3.4 Barriers to Abstinence

Interviewees described barriers they had faced when attempting or maintaining periods of abstinence. Interviewees described not having stable accommodation as a major barrier but discussed the problems of maintaining such housing. Several interviewees expressed doubt that they were capable of going through mainstream services and achieving abstinence, followed by stable accommodation and eventually employment. Interviewees also cited their peer groups and use of other drugs as barriers to services and ultimately moving towards abstinence.

*“We are like a family, sometimes when you want to stop drinking you can’t because of the people around you. But we help each other; we all look out for each other.”*

*“I’m on a waiting list now for detox but I’ve been on it for a while. I wanted to get in straight away but they don’t let you if you’ve got any alcohol in your system.”*

Interviewees reported the requisite to be alcohol free at some inpatient units to be a major barrier, describing how the urge to detoxify or rehabilitate may be fleeting and the potential adverse significance of being 'turned away' at a given time. For a similar reason, interviewees also described how excessive waiting times for some services could also provide a major barrier for street drinkers.

*"If I had alcohol in my system they wouldn't have let me in. [Is that a barrier?] Yeah, people are ready there and then but they get turned away or put on a waiting list. If after your waiting time you still have any in your blood they won't entertain you."*

*"I was in (residential rehabilitation unit) for three months (of six months); they were very strict if drink was found on yer or in yer, that was it (you were out). On fourth month, the office asked to see me, 'your dad has phoned, can you phone him back'. I felt something was going wrong. He said '[client name] look I'm sorry lad, our [name] has killed herself', that was me elder sister, she'd hung herself the night before in a phone box up in [name] park; it really hit me bad. They knew what I'd been told. I bought a bottle of vodka and drank it; it was only a little one. They said '[name] can we have a word with you? Have you had a drink? We can smell it on your breath.' They gave me a blood test and when they found out, they asked me to leave. It was like walking out into a blitz with all me clothes and everything, walked out into nothing. Back on the streets in town; I didn't do drugs again, just drank."*

### 3.4 Results – Semi-structured Interview – Outreach Worker

A one on one interview was conducted with the lead outreach worker, who had previously been a dependent drinker and was at the time of interview becoming increasingly involved in broader practices of The Basement and mainstream alcohol services.

#### 3.4.1 The Nature of Participant Street Drinkers

The outreach worker described the street drinker participants generally to be alcohol dependent, estimating at least 80% were heavy drinkers and ‘some verging on last year or two of their lives’. The outreach worker confirmed that the majority of participants were homeless, especially in the city centre; it was reported that out of town street drinkers were more likely to have a form of accommodation. It was reported that street drinkers could cause distress to local residents but that they didn’t generally cause a lot of harm to the general public. It was suggested that city centre street drinkers were less likely to have a form of accommodation because areas were regularly policed and ‘nobody given choice would go there and have a drink; they know the consequences’.

The outreach worker confirmed that many street drinkers were ex-heroin users, estimating a proportion of approximately 60%. It was reported that drug using individuals engaged with during outreach sessions also very often drank and that such poly-use would require a ‘frontline’ service that adopts a flexible or poly-approach.

*“One is too many, 1000 is not enough.” (On relapsing with alcohol).*

*“Get them into detox, sober, straight, plant some seeds. When they come back from residential (inpatient services) 90-95% within a week, without onward services, are back to where they started.”*

*“Alcohol is so harmful if you have been a user because lots have hepatitis and drinking on top is extremely harmful; rapid deterioration. They are quite aware of their health issues...many have been tested in services.”*

#### 3.4.2 The Assertive Outreach Service

The outreach worker estimated that approximately 70% of individuals approached were recruited onto the assertive outreach project. It was suggested that patience and persistence were required in approaching and engaging with street drinkers, especially since dependent drinkers may not often think about making changes to their drinking. It was expressed that timing was important and frequent interactions with street drinkers increased the chances of a worker being available at a moment when an individual chose to address their drinking.

It was reported that street drinkers who had never engaged with alcohol services were more difficult to recruit, suggesting that they were occasionally defensive and that accumulated trust was required

with such individuals. The uses of luminous clothing and, to a degree, official logos on research materials, were reported to be a barrier to gaining the trust of street drinkers; it was suggested that such 'officialdom' was associated with law enforcement workers.

*"We have polo shirts now which are much better; same writing but (we are) more accepted and approachable."*

*"Even if it is just support, it is still a valuable service. We see them in a state, we can get them changed, showered. [Name] service provides similar hands on outreach service; we meet to discuss any major concerns. We all work at different times to give extra coverage."*

*"(There are) some with profound behavioural issues, some with mental health problems. Outreach needs to adopt a poly-approach, we need to engage. I think it would be much better if we had a bigger remit when we go out, but we are told, just to look at this bit; but you can help when you talk to people."*

The outreach worker suggested the 'away days' were extremely well received and served to reduce drinking and potentially act as a springboard to a period of abstinence. Areas of good practice from the 'away days' included educational sessions, such as insight into harm reduction, recognising triggers, supporting each other, in addition to an introduction to a peer to peer course.

### **3.4.3 Enforcement & Mainstream Service**

It was suggested that better integration of assertive outreach projects with mainstream services would have significant benefits for the treatment of street drinkers. It was expressed that referral processes were not smooth, which invariably led to missed opportunities to administer treatment, especially critical with admittance to inpatient detoxification. It was reported that the needs for specific services were not adequately met and that service availability was disproportionate, when compared to drug services. The outreach worker was also a keen advocate of wet centres and cited The Booth as a positive case study.

*"We are not part of recognised tiers of alcohol services, we don't have access. If someone expresses desire to act on their drinking, it may only last a week, days or even hours. If you can't demonstrate positive action, you lose momentum; now we don't have direct access to detox. (It's) very frustrating."*

*"If you look at alcohol problems, it's far bigger than drugs but if you look at the resources going to people with addiction problems, the money going to each corner doesn't reflect the size of the problem."*

*“For many people even if they've done detox or 3/6 months rehabilitation, if you bring them back into the environment where they know where the drinks are or the drugs are, they've got the acquaintances of the bad old days.”*

*“You will never stop them drinking on the streets even if you got really draconian, it will still happen, we need to accept it and find a way of managing, you won't eradicate it so we have to manage it.”*

*“There have been a number of success stories; reductions in drinking but not as many as we would have liked. People out there drinking are aware of where they stand regarding the law, wardens and police. I have spoken to a few wardens who say that they don't pour it away but from the same wardens I've heard that there are other wardens who deliberately target street drinkers, that perception from drinkers is absolutely true. One woman had begged all morning to buy some sherry and it got tipped away; she was shaking, in early stages of withdrawal, and withdrawal is dangerous, it can be fatal. There are no positives in pouring drinks away, my views on that are very strong, I think it's diabolical.”*

*“The barriers are so obvious; the important things that have come up in this project stand out a mile, yet you can break it all down into bits and pieces but you have to address the big issues.”*

## 4.0 Conclusions & Limitations

### 4.1.1 Conclusions - The Street Drinker Demographic in Liverpool

As suggested by the literature, street drinking participants in this project were typically male, over 35 years old and demonstrated extremely heavy drinking behaviour. While heavy drinking may be expected of street drinkers, the average consumption on a normal day for a participant here was demonstrated to be ten times the recommended safe daily limit for males and females. As predicted by the literature, very few individuals in this group reported having any qualifications and all individuals reported being unemployed. Contrary to suggestion in the literature, the majority of street drinkers reported having no fixed abode, however it was suggested this may be typical in city centres groups, from where more participants were recruited, compared to out of town groups of street drinkers.

It was suggested that the health of this group of street drinkers was particularly concerning since a high proportion were ex-heroin users. The trend to address heroin use by use of alcohol was reported to be relatively common. Such a trend was reported to be particularly concerning owing to associated problems or conditions of intravenous drug use, such as hepatitis, being exacerbated or adversely affected by alcohol use.

Street drinkers were not reported to be perpetrators of 'high end' but more typically 'lower level' criminality such as begging. It was suggested that while the offending of street drinkers was an issue for address it was not such an urgent priority as the drinking levels and physical and mental health problems displayed by these groups.

Enforcement issues such a drink confiscation and dispersal of drinkers were reported to create more problems than they solved and such practices were described to be deeply antagonistic for street drinkers. There was a reported mistrust and lack of respect between street drinkers and law enforcement workers, specifically the Police and Community Wardens. Street drinkers described the potential access and use of a wet garden to be a viable solution but suggested that wet gardens were not uniformly successful and that the commissioning of such an area in Liverpool was unlikely.

Street drinker and outreach workers uniformly suggested that, owing to the high level of alcohol dependence, the most appropriate treatment for this population was inpatient detoxification followed by residential rehabilitation. There were several key barriers outlined that prevented efficient detoxification; the most significant were described to be the quantity of local specialist alcohol units, the requisite to demonstrate relative or total sobriety pre-admittance and the 'excessive' waiting lists for Liverpool based detoxification units.

Participants and outreach workers highlighted the complexity of problems faced by street drinkers, citing co-morbid mental health problems and poly-drug use as the principle reasons that cause such complexity. It was commonly suggested that assertive outreach projects, must adopt a holistic approach when supporting street drinkers and when acting as a bridge to mainstream services. For example, outreach workers suggested it would be of substantial benefit if their remit was broadened, enabling them to make referrals to appropriate assessment professionals for mental or physical

health problems, to make direct referrals for drug problems and to offer more varied support in line with street drinker's complex needs. Additional training for outreach workers may be beneficial, especially in identifying and reacting on behalf of a street drinker's immediate health needs, while better integration of outreach teams with mainstream services would also streamline referral and harm reduction processes.

#### **4.1.2 Conclusions - Outreach Service**

It was suggested by participants and outreach workers that the outreach service provided by The Basement was a source of continued and beneficial support, providing a valuable 'hands on' or frontline service. The capacity or potential for the assertive outreach to act as a bridge to mainstream services was discussed and it was generally expressed that there were significant barriers impeding the achievement of this aim. While referrals were frequently made, the lack of integration of the outreach service with official tiers of treatment was identified as a key barrier to the successful admittance of street drinkers into inpatient detoxification or appropriate treatment.

The 'away days' were generally suggested to be extremely valuable, well received by attendees, and perceived to be effective at reducing drinking and acting as a 'springboard' to attempting periods of abstinence. Additionally, the time away was suggested to be valuable in terms of providing harm reduction advice and introducing participants to peer networks, which could act as a source of continuing support and encouragement. Such 'away days' were also reported to be extremely important for the self esteem of several street drinkers, whose contributions to day to day tasks, such as preparation and cooking of meals, provided a welcome sense of purpose.

It was generally suggested that gaining stable accommodation for this group of street drinkers would not necessarily reduce their alcohol use and associated problems. In some cases it was suggested that living on the streets was symptomatic of individuals' drinking behaviour rather than being a root cause of it. While several participants identified their homelessness as a major barrier to addressing their drinking, many expressed that their drinking behaviour was likely to jeopardise their accommodation status; with several participants suggesting that their alcohol expenditure would be likely to prevent payment of rent.

Further research would undoubtedly help to define the characteristics and needs of street drinking groups. Research groups and outreach services would benefit by continuing to operate cooperatively, with close feedback links and responsive actions based on outcomes and findings. Such cooperative working would be of great benefit since street drinking groups are both chaotic and difficult to access and engage with but also highly vulnerable with complex needs. For these reasons, suggestions were made that assertive outreach projects ought not employ a 'fixed approach' but that working outreach models must be adaptive to local needs and particularly street drinking populations.

#### **4.2.1 Limitations – The Outreach Service**

There were several identified limitations regarding the outreach service. As described, the remit of the outreach worker was suggested to be limited principally in terms of the remit of problems



deemed appropriate to address and in terms of their referral capabilities. It was also suggested that the successful operation of such an outreach service would depend on workers being available as often as possible, since the time period a street drinker may wish to address their drinking may be temporary and often short; the importance of being available during this window was emphasised.

In terms of the duration of the programme, one suggested potential limitation was the time period in which the assertive outreach project operated. Outreach and data capture occurred from the months of October to March, and typically street drinking is significantly more prevalent during the summer months. Similarly, outreach workers described how often street drinking occurs through the night, and often outreach sessions were conducted during daytime hours.

#### **4.2.2 Limitations – The Evaluation**

While the evaluation provided valuable insight into the street drinking population and the effectiveness and requirements of an assertive outreach response service, there were limitations on the evaluation data and the application of the findings. For example, it may have been beneficial to record outcomes in a more quantifiable way; for example recording questionnaires at a consistent point of engagement and subsequently following up participants at a later time would have provided before and after data, and a more robust insight into the effectiveness of the outreach service. However, such consistency in the first instance was not possible owing to the chaotic and sceptical nature of engaging clients; in some cases questionnaires were not completed until the third or fourth visit to The Basement after initial contact on the street.

Another limitation of the data collection was the level of participant intoxication during semi-structured interviews. While it was expected that not all participants would be attempting abstinence or sober upon interview; the level of intoxication in one or two cases was detrimental to the interviewing process and, in one instance two participants were asked to leave the small group interview.

A further limitation, observed by researchers, was the difficulty in disentangling the assertive outreach service from the existing support service provided by The Basement. The Basement was the ideal service to carry out the assertive outreach work and, while such overlap had positive ramifications for the practical functioning of the services, evaluating the effectiveness of the specific outreach service was difficult since many participants were already engaged and receiving support from The Basement.

Evaluating the assertive outreach project in terms of broader alcohol treatment processes would give a reliable indication of the potential application of such outreach projects. While outreach of this kind is technically part of tier 2 of the official tiers of alcohol treatment, outreach workers found difficulty identifying where and how, among structured interventions, the outreach service operates. Unless outreach programmes are practically integrated and maintained in strategic frameworks, their power and potential may remain limited. Strengthening such links would be especially important with tier 3 general practitioners, owing to the high proportion with mental health disorders, and with tier 4 inpatient detoxification units, owing to the appropriateness of such treatment for the majority of street drinkers, who are alcohol dependent.

## 5.0 Recommendations

### 5.1 Recommendations for Service Commissioners

- Continue to commission the assertive outreach project. Attempt to increase their proactive action, since street drinkers may lack interest and motivation to address their drinking; work to strategically improve availability of outreach workers by commissioning a year-round service.
- Invest in training to help expand the remit of outreach workers, enabling them to make appropriate referrals and provide support for those street drinkers with mental health conditions and poly-drug use. Explore the potential to add a 'clinical edge' to outreach and frontline services.
- Encourage the development of peer to peer groups, with the ultimate aim of creating a smooth gradient of support between self sufficient peers, outreach workers and mainstream services.
- Consider expanding the provision of food, owing primarily to the poor nutritional intake of street drinkers.
- Commission and implement systematic monitoring of the street drinking population in Liverpool; assess the potential to use monitoring process to help integrate such tier 2 outreach with the other tiers of structured treatment.
- Consider the commissioning of trial wet areas or wet centres. Should such a trial be rolled out; commission an evaluation to ascertain the effect of such a facility.
- Consider the possibility of making 'out of area' tier 4 (inpatient detoxification and rehabilitation) referrals; explore the potential of such referrals to reduce waiting lists in the Liverpool area. Consider a review of post-inpatient treatment wrap-around services and community support, owing to the vulnerability of clients making a transition from inpatient services back to the community. Assess the feasibility of supporting individuals in 'out of locality' accommodation.
- Consider evaluation of local tier 4 service entry criteria; especially requisitions to demonstrate sobriety or not to be taking prescribed anti-psychotic medication or opiate substitutes. Explore the potential to prioritise street drinkers for tier 4 services owing to their typically vulnerable and chaotic lifestyles.

### 5.2 Recommendations for Research

- Commission further work to accurately appraise the specific needs of street drinkers, including estimates of the proportion that express a desire to address their drinking behaviour.
- Consider the best method to address drinking among those who are 'happy' drinking on the streets and do not see their alcohol use as a problem or do not wish to change their drinking behaviour.
- Include in further work exploratory analysis designed to ascertain whether homelessness is a symptom or root cause of heavy drinking and, if both patterns simultaneously exist in street drinking populations, whether and how treatment should be adapted accordingly.

- Explore and analyse what preventative measures may be undertaken to prevent an escalation of drinking in vulnerable groups; this may include research into street drinker circumstance history in order to ascertain from which demographics street drinkers are most likely to come from.
- Consider the full and extensive review of tier 4 service providers in Liverpool and compare and relate findings, including entry criteria, to tier 4 service provisions in Greater Manchester, Cumbria and Lancashire.
- Continue close involvement with assertive outreach teams; consider the potential to fund the initiation of a street drinking monitoring system.
- Assist with the development of peer networks where possible.
- For future research of this nature, ensure adequate time scales and clearly defined service practice in order to record quantitative assessments before and after outreach interventions.
- Consider evaluating The Booth in Manchester as a successful case study of a wet garden.
- Consider further local research to identify sub-groups of street drinkers, for example inner city and suburban drinkers. Utilise findings to tailor outreach teams according to the patterns of substance use and specific needs of identified groups.

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