Tackling street drinking

Police and Crime Commissioner guidance on best practice

SUPPORTING EVIDENCE & RESOURCES

This document supports *Tackling street drinking: PCC guidance on best practice*. It provides background, supporting evidence, practice examples and resources which will be of use to those seeking to implement the framework in the guidance.

This document is not designed to be read as a single report. It is for use in conjunction with the guidance.

Each section of this document supports part of the main document and the paragraphs supported are indicated at the start of each section.

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Support material part 1

The nature of client group and the need to tackle them (including the East European community)

This section supports sections 4 & 5 of the main document: **The nature of the client group and the need to tackle them**

It contains more detailed information on:

- **The number of street drinkers**
- **The impact of street drinking**
- **Street drinking as an indicator of other problems**
- **Who are the street drinkers?**
- **Cost burden**
- **East European street drinkers**

How many street drinkers?

It is impossible to be certain how many street drinkers there are locally or nationally. The problem is too ill-defined, variable and hidden to be reliably counted. In the middle of the last decade the Cabinet Office estimated that 5,000 to 20,000 people were street drinking nationally in any one year. This would equate to around 40 different people street drinking in an average sized unitary or lower tier council each year with a range of 15-60 street drinkers.[1]

No more recent national estimates exist. However, various communities across the country have assessed the number of street drinkers in their area. This report has gathered 16 local estimates which are set out below:

• Weymouth (65,167) - probably about 10-12 altogether. = 0.17 per 1000 pop [2]
• Bury (185,060) - 12-13 people = 0.07 per 1000 pop [3]
• Kingston upon Thames (160,060) - There is probably a hard core of 20-30 long term drinkers within a larger group of about 50 people who dip in and out of drinking on the street = 0.22 per 1000 pop [4]
• Worcester (98,768) - In 2016, police in Worcester estimated a population of about 25 street drinkers, although this is not static and will vary was people go into prison or move away. = 0.25 per 1000 pop
• Ipswich (133,384) - 75 street drinkers with a hard core of 20 = 0.56 per 1000 pop [5]
• Stafford (130,869) -10-15 street drinkers of whom 10 are regular = 0.12 per 1000 pop[6]
• Portsmouth (205,056) – 69 three years ago, now about 45 = 0.22 per 1000 pop [7]
• Clacton (138,048) - 60 street drinkers for the locality = 0.44 per 1000 pop [8]
• Merton (199,693) – 25 street drinkers = 0.13 per 1000 pop
• Hereford – (183,477) 50 = 0.14 per 1000 pop
• Brighton - 93 (2013) -73 (2014)-64 (2015) = 0.23 per 1000 pop [9]
• Bristol - (428,234) - A 2013 report estimated that there were about 200 street drinkers in the city of Bristol…The groups have a core of persistent street drinkers with a fluctuating number of other drinkers who join them. = 0.46 per 1000 pop [10]
• Middlesbrough (138,412) - In November 2014 Middlesbrough undertook an 18-hour count of street drinking which identified 21 possible street drinkers. = 0.15 per 1000 pop [11]

• Luton (203,201) Identified 70 street drinkers in 2015. = 0.34 per 1000 pop
• In the summer of 2005, Hounslow (253,957) identified a group of 65 who appeared to fit the definition of street drinkers.[12] =0.25 per 1000 pop
• Liverpool wet centre had visits from 388 separate individuals in a four-month summer period. Not all were street drinkers. They had a hardcore of 30 individuals who each attended more than 30 times.[13]

These estimates are crude but suggest that:

- In smaller / lower risk unitary and lower tier authorities the number of street drinkers identifiable each year will be in the range of 15-25.
- In larger or higher need areas the number can reach 50-90.
- In large urban areas the number may be 200 or more.

This equates to a range of 6,000-30,000 people street drinking each year nationally.[14]

It is impossible to be certain whether the number of street drinkers is increasing. Some interviewees argued that a growing number of East European drinkers and a rise in the number of problem drinkers in the community with mental health problems has increased this population. However, the data does not allow a comparison over time and some areas have managed to reduce the level of street drinking e.g. Portsmouth and Brighton.

Impact of street drinking

Street drinkers do not set out to harm others or cause a nuisance, and some have argued that the problem is society's intolerance. Nonetheless, the research has identified repeated problems caused by street drinking across the country including:

- anti-social behaviour
- litter
- low level crime including shoplifting of alcohol, fights between drinkers and criminal damage
- intimidation of members of the public (whether deliberate or not)
- creating an environment which deters people from visiting and using the shops or entertainment areas.

In 2012-13, 69 street drinkers were responsible for 2,010 police incidents ranging from anti-social behaviour to sexual assaults and robberies. The Safer Portsmouth Partnership also conducted a survey of residents: 57% felt intimidated by the high level of public drunkenness and avoided areas as a result.[15] A report on another area commented: *The zone's main problem is street drinking and its associated litter - cans and bottles, sometimes smashed - of which there are huge quantities…Alcohol litter can be found in virtually every park, public space and even the gutters of residential streets and residents' gardens away from street-drinking hotspots.*[16]

The Local Government Association suggests that *"Street drinking can have an extremely damaging impact on local communities and peoples' perception of them, including on businesses in close proximity to places where street drinkers congregate."*[17]

Street drinking as an indicator of other problems

Street drinking is mainly associated with low level nuisance, litter and threatening, or perceived threatening, behaviour. However, those involved may be:

- associated with more serious harms - street drinking is always just one part of a life, albeit the most visible; other parts may involve abuse, serious physical and mental ill-health and domestic violence.
- at risk - in one study 29% of street drinkers had been physically abused by the public and 42% had been verbally abused.[18] An outreach worker commented: *People locally are abusing them, urinating on them, threatening violence to them…One man had his dog stolen by people believing it would be a begging aid.*[19]

The main report highlights that street drinking will provide a gateway into addressing a range of other serious problems. Street drinkers may:

- be involved in relationships with intimate partner violence, e.g. Guildford DHR (see box below);
- be being abused and exploited;
- be at risk of dying in public;
- make constant demands on police (and ambulance service) time;
- have mental health problems;
- be placing a significant burden on health services.

- *A Domestic Homicide Review from Guildford (Report into the death of Adult A 2013) shows a couple with chaotic patterns of alcohol and drug use. Street drinking was the publicly visible indicator of a much wider problem that included: shoplifting, ill-health and domestic violence which ended in homicide.*[20]

Street drinking is a problem but it is also an indicator of other problems. It will:

- be a gateway into tackling a range of problems associated with chronic, change resistant drinkers;
- offer a point at which PCCs can link to other public service agendas and build a wider coalition – particularly with the health service. Health services are more likely to become involved if it can be shown that street drinkers are also a high burden group on hospitals or similar services.

An important theme of this guidance is that street drinkers are likely to be one example of a wider group of *change resistant* drinkers who are causing a range of problems to the local community. Alcohol Concern has written extensively on the need to tackle this group in its *Blue Light* project. Details on this can be found at: http://www.alcoholconcern.org.uk/wp-content/uploads/2015/01/Alcohol-Concern-Blue-Light-Project-Manual.pdf

Who are the street drinkers?

Local studies and interviewees give a very consistent picture of the demography of this group. The following section summarises the findings from between 10 to 20 studies and interviews.

Gender: Five research studies gave a consistent picture of 80% or more of street drinkers being male, but nonetheless confirm a small group of female drinkers. (5% to 23%).[21] [22] [23] [24] [25] Although not British data, an Australian study suggested a higher proportion of female street drinkers among those who were also heroin users: in this group 50% of street drinkers were female.[26]

Gender – data from local studies and interviews

- Weymouth - mainly white men (10) we have seen one white female[27]
- Bury - 12-13 people of whom two are women. [28]
- Bournemouth - anecdotally about 80% male. [29] [30]
- Kingston - the majority are male – they have identified 4-5 women out of 20-30 street drinkers. [31]
- Stafford - half are female[32]
- Portsmouth - 80% male[33]
- Clacton - 90% male[34]
- Liverpool wet centre – 77% male – 23% female – but this was an in-service count rather than a street count which may change the ratio [35]
- Lambeth - Probably 80-90% male[36]

- Brighton - 80% male[37]
- Luton - 88.5% male. [38]

NB: During the research, concerns were raised that people may make dangerous assumptions about women street drinkers. For example, not understanding that the women may feel safer in a group of street drinkers than either being alone or at home where there is less likelihood of help if they are assaulted. Separate research is needed into the best approaches to understanding and helping female street drinkers.

Age range: Six research studies provide data on age range. These provide a consistent picture of street drinkers as a group with an average age in the early 40's i.e. older than the average for the national population (39.3). Relatively few street drinkers were identified under 30 (9.3% in one study). It was suggested that the younger age groups are more likely to be involved in drug use. Those over 50 and over 60 made up a diminishing proportion of this group (over 60s were 5% in one study).[39] [40] [41] [42] [43] [44]

Age – data from local studies and interviews

- Kingston - cluster in the 30s and 40s with two who are in 60s[45]
- Bournemouth - Generally middle – aged. [46]
- Portsmouth - 30-50 most under 40[47]
- Clacton - 30-50 is the general age group[48]
- Lambeth - 30-50[49]
- Brighton – 30-50[50]
- Luton - 77.1% were over the age of 35 and 34.3% were over the age of 45.[51]

Ethnicity: Five research studies report ethnicity and nationality. They present a group that is 80-90% white British. In London particularly, and in one or two other areas (e.g. Middlesbrough, Portsmouth), small populations of either Asian or African Caribbean drinkers were identified.[52] [53] [54] [55] [56] In South London a group of Tamils were identified drinking on the street. East Europeans are a significant, but usually separate, population (see section below).

Ethnicity – data from local studies and interviews

- Bury - All White British[57]
- Bournemouth – White British and some white European[58] [59]
- Kingston – One African-Caribbean man out of 20-30 street drinkers [60]
- Portsmouth - Mostly White British: one African-Caribbean[61]
- Clacton - All White British[62]
- Lambeth – White British / European: small number of individuals from Caribbean or Eritrean and Somalian / very few Indian [63]
- Brighton – All White British[64]
- Luton - 48.6% (34) were White British, 35.7 % (24) were white other with 80% (20) of these being Polish.[65]

Degree of alcohol related harm: In most studies it is clear that the street drinkers are either alcohol dependent or have serious alcohol problems. In one study it was estimated that at least 80% were heavy drinkers, with 'some verging on the last year or two of their lives'.[66] Three studies identify the length of time people have been street drinking. In one study 68% had been drinking outside for more than five years. In another the range was between three months and 30 years with the mean duration of time spent drinking on the streets being almost nine years.[67] [68] [69]

Housing type: Street drinking is stereotypically associated with homelessness but many street drinkers do have accommodation. The studies and interviews suggested that one quarter to one third are sleeping rough with 40-50% having their own accommodation and the rest in hostels, squats or sleeping with friends. The pattern will vary from area to area and with the weather. In cold weather, people drinking on the streets are more likely to be drinking outside because they are homeless. [70] [71] [72] [73] [74] [75]

Housing – data from local studies and interviews

- Portsmouth - The majority are housed: often hostels, supported housing, low quality bedsits. The homeless ones are less likely to be street drinkers.[76]
- Clacton - Estimate – Half in permanent, rest homeless or sofa surfing or in temporary accommodation.[77]
- Brighton - 40% hostels, 35% rough sleeping, 25% council flats, private rented and emergency accommodation.[78]
- Luton - 44.3% are homeless with 48.4% of these rough sleeping. [79]
- Liverpool wet centre – 54% street homeless during the summer period that it was open.[80]

Drug use: Three studies identify significant levels of other drug use among the street drinking population. Estimates range between 25% and 60% using opiates as well as alcohol.[81] [82] [83] Some interviewees expressed concern about the use of new psychoactive substances (NPS); however, this varied: some areas reporting marked levels of use, others being unaware of this as a problem for street drinkers. This data needs to be treated with caution: the interviews took place before the recent legislation banning NPS.

Drug users with an alcohol problem – data from local studies and interviews

- Weymouth - Not aware of NPS coming to attention. [84]
- Bury - They have had information about the use of NPS: paraphernalia is being found but it may be young people.[85]
- Bournemouth - At the moment there are concerns with street based behaviour and NPS and begging. Where you used to see the cans, you now see the paraphernalia of NPS use. 19% of evictions from hostels in one quarter of 2015 were about NPS use.[86] [87]
- Kingston - a lot of polydrug use. Some are using heroin/crack cocaine - these are more the White British clients. Polish drinkers are also using NPS. Not seeing NPS with the white British street drinkers.[88]
- Liverpool - NPS were acknowledged as a problem. There is a significant issue about opiate users street drinking.[89]
- Portsmouth – Massive crossover with NPS – particularly in the younger age group. Don't think there will be a crossover after the new legislation.[90]
- Lambeth - Seen some use of legal highs but I think it is more popular in the general and younger population.[91]
- Brighton - NPS have had a big impact. Probably the majority of street drinkers are using. It is not replacing the drinking but is alongside it. It makes the whole scene more frantic: more psychotic episodes, more chaos. [92]

Health: In 2014 the city of Hereford identified a group of about 50 street drinkers. Five of this group died in the subsequent six-month period. This indicates the scale of health problems among this group. In Northampton a group of 10 street drinkers were identified of whom 3 died during a targeted initiative. Three other studies identified very high rates of physical health problems.[93] [94] [95] [96] [97]

Cost burden

Few would argue that street drinking is a problem, but what is the cost of that burden? This is a difficult calculation. Street drinkers will incur costs which are not directly associated with their street drinking. Are costings based only on the impact of the behaviour on the street or all the costs associated with a street drinker e.g. the hospital visits, the lost tenancies and the missed appointments?

Alcohol Concern's *Blue Light* project estimated the average annual cost to public services of a high risk, change resistant drinker. This calculation is very detailed and is summarised in the *Blue Light* project manual (see link above).[98] A separate document setting out the calculation is available from Alcohol Concern.[99] This looked at the average annual cost of the small group of problem drinkers who were making the greatest demands on public services by falling in to one or more of the following groups:

- 12 or more emergency department attendances per annum
- 3 or more hospital admissions per annum
- 3 or more arrests / police reports / fixed penalty notices per quarter
- 3 or more failed tenancies in 5 years
- 3 or more ASB complaints in 6 months.

Street drinkers were specifically identified as a risk group.

Using national costings data it was calculated that the average high impact change resistant drinker would cost around £35,000 per annum in health, criminal justice and anti-social behaviour costs. This data was then compared with estimates from:

- Making Every Adult Matter which costed the average multiple need client in England at £36-48,000 per annum.[100]
- An Australian study that looked at the average lifetime costs for 11 complex case studies, aged between 23 and 55. The lifetime costs ranged from £495,000 to £3 million. The average period engaged with services was 27 years giving an average annual cost of between £18,000 and £100,000.[101]
- A study in Sandwell which identified 16 high impact change resistant drinkers, including street drinkers. A calculation based on only partial data from local agencies, identified costs of £308,000 per annum – an average of £20,000 per person.[102]
- A south London hospital has identified 324 patients with 3 or more admissions for alcohol specific conditions, who are calculated to cost local hospital and criminal justice services £3.8m p.a. (£12,000 per patient). This estimate does not take into account ambulance, primary care, criminal justice or social care costs, which are also likely to be considerable.[103]
- Resolving Chaos - a Big Lottery funded project working on individuals with multiple needs which identified a single client who cost over £70,000 per annum [104]
- Nottinghamshire Alcohol Long Term Conditions Team – One client cost of £130,000 per annum[105]

All of these figures include people who are high impact drinkers and people with patterns of street drinking. It suggests that a cost estimate of £35,000 per annum for high impact change resistant drinkers is reasonable and is likely to be applicable to street drinkers.

However, to be on the conservative side, if a lower estimate of £20,000 per street drinker is taken and applied to a midpoint of the earlier estimate of the number of street drinkers (17,500 nationally) this equates to a national annual cost from street drinking of £350 million or an average of around £1 million for each borough, district and unitary local authority in England and Wales.

Tackling street drinking offers the opportunity for real and measurable cost reductions across public services.

East European street drinkers

The number of East Europeans drinking in public has risen markedly since 2005, reflecting wider patterns of migration. Interviewees generally argued that this group has added a new dimension to street drinking, however, data on the impact of East European street drinkers remains poor and will vary from area to area dependent on migration patterns.[106]

People from East European communities – data from local studies and interviews

- Weymouth - Not in our area[107]
- Bury - Not an issue that I have dealt with.[108]
- Bournemouth - Relatively low East European population in this area. [109]
- Kingston - East Europeans constitute a group of 20-30. The East Europeans either work during the day and drink and eat in groups in the evening, those who are not working tend to move in ones rather than in groups. [110]
- Portsmouth - Minor issue in Portsmouth but there is smaller population there, Southampton much larger.[111]
- Clacton - There is a growing East European community and a lot are drinkers. Mainly Polish, sleeping rough because they cannot find work. [112]
- Brighton - Keep themselves to themselves. It is a close knit community. The primary issue is rough sleeping and the drinking is an annexe to that.[113]

It is important to remember that "East European" covers a wide range of drinking patterns encompassing Europe's highest per capita levels of alcohol consumption (e.g. Russia and Poland) to below European average levels (e.g. Bosnia and Albania).[114] *A rough sleepers' service in Luton has seen an influx of Rumanian migrants but no consequent increase in alcohol problems.* (The table below sets out international data on alcohol consumption by national/ethnic group for East European communities.)

WHO data on alcohol consumption by national/ethnic group for East European communities

	Litres per capita
Russian	15.1
Other Eastern European	13.3
Baltic: Lithuania, Latvia and Estonia	12.67
Kosovan	12.6
White: Serbian	12.6
Polish	12.5
White: Croatian	12.2
White: English/Welsh/Scottish/Northern Irish/British	**11.6**
Bosnian	7.1
Albanian	7

It has been argued by some that public drinking is a cultural feature of East European communities. The research suggests that this is untrue. It is more likely that public drinking is a function of economics or accommodation: people do not wish to drink in expensive on-licensed premises or may live somewhere where drinking is difficult.

The vast majority of these drinkers will not have significant alcohol problems or be dependent. As a result, it has been argued that East European street drinkers should be treated in the same way as anyone else: a request to disperse, followed by enforcement if the problem continues.

The challenge will be to engage those with more serious alcohol problems who may not be working. These drinkers will not only be difficult to engage but may have a concern that engagement with services could threaten their status in the UK. As with other street drinkers, outreach will be required and in some areas this has involved workers with specific languages.

Support material part 2
Action is possible

This section supports section 6.1 of the main section: **Action is possible**

It contains more detailed information on:

- **The evidence on the effectiveness of interventions with high impact problem drinkers**

Intervention works

This report challenges the belief that nothing can be done about the problems in this group. It is easy to view these drinkers as having an engrained problem that will resist intervention. This is not the case. Useful interventions do exist for this group and pursuing them will assist a wider group of change resistant problem drinkers.

Data from a rage of studies shows that action can impact on this group:

- Data from Wigan's Active Case Management Team, which works to engage frequent attenders in the hospital system, shows a 52% reduction in hospital admissions by people who receive outreach.[115]
- A similar impact has been seen in the Nottinghamshire Alcohol Long Term Conditions Team. [116]
- Salford Royal NHS Foundation Trust's hospital-led alcohol assertive outreach service has achieved a 59% reduction in Emergency Department attendances and a 66% reduction in average monthly hospital admissions among the top 30 frequent alcohol-related patients in the three months post intervention.[117]

This health-based data is now being supplemented by figures from Alcohol Concern's *Blue Light* project pilots:

- Data published by the Home Office indicates that in Lincolnshire, after five months of operation, there has been a 30% reduction in police incidents relating to the targeted Blue Light clients.
- In its first six months of operation (2015) the Medway *Blue Light* multi-agency management group took referrals for 12 high impact clients. Of the 12, 3 showed marked improvement: improved housing status, engagement with substance misuse services and fewer problems to the criminal justice system and 6 have seen improved multi-agency working including one safeguarding referral.[118]
- In Sandwell, the Blue Light group has worked with 16 individuals. Of these, 4 have now successfully completed a course of treatment with community alcohol services, another 3 (15%) are currently accessing community alcohol support services with some degree of sustained engagement, and all other individuals are subject to a range of on-going harm reduction and engagement approaches.[119]

The myth of denial

It is also easy to assume that street drinkers, and chronic drinkers generally, are uninterested in change: they are "in denial". This view needs to be challenged. Behind that veneer of denial is usually a more ambivalent person. They may be uncertain about whether they can change, they may believe that family history destines them to be a drinker, they may be scared of what change entails. Evidence has shown that 40% of apparently non-changing higher risk and dependent drinkers try and change each year.[120] Three separate studies of street drinkers identify that between 40% and 70% of the street drinkers reported being unhappy with their current drinking levels and wanting to change their drinking.[121] [122] [123]

Support material part 3
A multi-component approach

This section supports sections 6.2-6.3 of the main document: **A multi-component approach**

- **It contains further referencing of support for a multi-component approach and case studies**

No single intervention can demonstrate robust evidence of effectiveness in tackling street drinking and no single intervention will provide a solution to the range of challenges posed by street drinkers. This does not mean that nothing works but rather that in the view of those who have worked actively in the field the best response is a multi-component approach.

For example, Ipswich's approach to street drinking has been praised for its work with retailers. The actual response involved the provision of treatment, education and alternative accommodation, in addition to removing selected products from the shelves of off-licences. It was felt locally that it was this package that achieved the significant reductions in problems; one measure in isolation would not have been as effective.[124] (See case study below).

The Demos report on tackling alcohol misuse recommends that: *local authorities and retailers should work together on local partnerships that take comprehensive approaches to tackle street drinking effectively.* The report argues that tackling the price and availability of alcohol in isolation will be insufficient. *Local authorities need to foster a multi-agency approach that targets the kind of 'deep exclusion' that many of these particular drinkers face.*[125]

The Alcohol Academy commented that: "both staff training and police enforcement are important, (but) they rarely achieve sustainable impacts when applied in isolation. Rather, 'multicomponent' approaches, which seek to change retail environments, improve community engagement and raise public awareness alongside changing retailer and police practices, are more effective." [126]

Case studies

The Local Government Association's *Reducing the Strength Guidance*[127] presents Ipswich as an example of a multi-component approach. This is quoted below:

Case study Suffolk Reducing the Strength

Suffolk has led the way in tackling the consumption of high-strength, cheap alcohol. Their campaign was launched in Ipswich in September 2012 in a partnership between Suffolk County Council, Ipswich Borough Council, Suffolk Constabulary and the East of England Co-operative Society after complaints from the public and businesses that street drinking was getting out of hand.

The scheme is three-pronged. Off-licences have been asked to agree to stop selling cheap high-strength alcohol of 6.5% abv and above, while the police have taken action where regular street drinking causes disturbances and the county council has invested in outreach workers to encourage drinkers into treatment.

The campaign was kick-started with a launch event for retailers at Ipswich Town Football Club with a film about the damaging effects of street drinking from an individual and a business point of view. The latter included loss of custom from people being put off by street

drinkers congregating outside shops. This event was accompanied by media coverage and followed up by the partners visiting local businesses to discuss the benefits of supporting the campaign.

The responsible authorities have also used the licensing process to nudge retailers into taking part. When applications are approved the council visits businesses to ask them to consider signing up to the campaign outlining the benefits to the local area and potential gains for traders – although the scheme remains voluntary. The only situations where the council might impose restrictions on the sale of cheap strong alcohol are if there is evidence of sales of high-strength alcohol to drunk persons, which is an offence, and/or there is a direct link to problems in the wider area which can be attributed to such. In these cases, competition law does not apply and a restriction on sale of certain products can be enforced. However, this has only been used four times.

The campaign has proved incredibly successful. Ninety out of 138 off-licence premises have signed up, including big chains like Tesco, Sainsbury's and Morrisons.

In terms of street drinking; numbers have dropped from a total of 70 individuals before the campaign was launched to just over 20. Street drinker events – defined as incidents in which the public have contacted the police – fell by nearly 25 per cent in the year after the launch of the campaign.

The most important principle is that you work together. The police have a dedicated officer for the campaign, while public health has funded two outreach workers for it. One type of intervention alone – enforcement, restricting supply or enhanced treatment - doesn't work; for schemes to be successful all three elements must be implemented. You will need to have medium to long term commitment from all partners."

A more recent initiative in Nottinghamshire shows the role of joint working:

Bassetlaw, Newark & Sherwood Community Safety Partnership has embraced the principles of Alcohol Concern's Blue Light Project in working with change resistant drinkers. This has involved wider engagement with the alcohol service provider (CGL), East Midlands Ambulance Service, Nottinghamshire NHS Healthcare Trust and Doncaster and Bassetlaw NHS Trust to help those in greatest need due to alcohol misuse. The aim is to reduce community impact and demand on services and improve health outcomes for the client.

The pilot in Worksop, Bassetlaw has involved the co-opting of a member of the long term condition nursing team to engage with those who have historically resisted engagement with traditional service provision. The team leader will provide training to all frontline partners around the *Blue Light* project enabling the delivery of a universal message of support from all agencies.

The pilot is funded by the Nottinghamshire Office of the Police and Crime Commissioner. The frontline work commenced in September 2016.

Ealing has also used a multi-component approach.

The Safer Ealing Partnership helped establish a controlled drinking zone (CDZ) in Acton to address the ongoing problem of street drinking and associated anti-social behaviour. Enforcement activities were complemented by an Alcohol Link Officer from St. Mungo's, (a homelessness charity) whose role focused on referrals, case management and tailored outreach: ensuring the most vulnerable received the support and services they need. [128]

Support material part 4
The lack of research and the evidence base

This section supports section 7d of the main document: **The lack of research**

It contains more detailed information on:

- **The lack of a research base**
- **The methodology for this report**

It also contains a reading list.

The main driver for this document is the lack of research or guidance on the best way to tackle street drinking.[129] Over 4,000 studies have been undertaken into Foetal Alcohol Syndrome but this research identified under 50 studies into street drinking. Existing evaluations also tend to lack a robust, comparable methodology.[130]

This problem is almost inevitable. Discussions with academics have highlighted the difficulty of designing robust evaluations which are focused on small numbers, in different social contexts without the ability to control the very wide range of factors, including the weather, that could impinge on levels of street drinking.

This guidance cannot solve that problem. It is not offering original research. Instead it pulls together the research that does exist with the experience of professionals across the country to provide a consensus on best practice.

A range of techniques were used to gather the evidence for this report:

- Desk research;
- A request for information on local best and interesting practice was disseminated across England and Wales;
- Local interviews;
- Visits to local areas to describe and analyse best and promising practice.

The draft documents were circulated for consultation and revised as a result of the feedback.

Reading list

- Alcohol Concern Factsheet 19: Street Drinking
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Support material part 5
Developing a local consensus on tackling street drinking

This section supports section 7.1 of the main document: **Developing a local consensus on tackling street drinking**

It contains more detailed information on:

- **Developing a strategic framework**
- **Potential partners**
- **Needs assessment**
- **Communication**

A strategic framework

Any response to street drinking should be set within a local strategic framework. This does not need to be a specific street drinking strategy: indeed, it could be argued that would be poor practice. It is preferable that the strategy is embedded in a wider approach to alcohol problems and/or anti-social behaviour.

In the current local government framework any approach would be best led by either the community safety partnership or the health and wellbeing board: ideally both in concert. A sub-group of these bodies, (perhaps a task and finish group) could develop an agreed approach which would feature in the following:

- Health and Wellbeing Board plan
- Community Safety Partnership plan
- NHS Sustainability and Transformation plan
- Policing plan
- Police and Crime Commissioner plan
- Local alcohol strategy.

If the problem is not being consistently identified in these documents, the local partners need to ask whether:

- tackling street drinking is a shared local priority?
- consideration has been given to how street drinkers impact on a range of agencies?

Beyond this high level strategic recognition, the response could usefully be set within the framework of a jointly owned operational plan.

Partners

A large variety of agencies work with street drinkers. Each area will need to consider which of these various bodies need to be engaged. Partners could include:

Police (inc. British Transport Police)	Ambulance / Fire and Rescue Service
National Probation Service / Community Rehabilitation Companies / Prison service	Local authority Anti-Social Behaviour Team, Housing Department & Adult Care Services
Clinical Commissioning Groups / NHS trust / hospital services	Mental health services
Licensed trade including supermarkets and convenience stores	Community alcohol services / Arrest Referral Service, Hospital alcohol liaison and drug services

Homelessness services, hostels and shelters	Other charity / third sector organisations
UK Border Authority (for East European drinkers)	

Needs assessment
The strategic approach will require a clear understanding of the local need. Local joint strategic needs assessments, community safety and other public consultations should ask questions about street drinking and hear the voices of street drinkers and those who work with them.

These assessments will require information on both impact and location. Useful information will include:

- reports from local residents;
- counts of crime and anti-social behaviour linked to street drinking;
- mapping out locations of this crime and anti-social behaviour;
- emergency department and other hospital data;
- alcohol services information; and
- ambulance service data.

A specific street drinker count may be useful. The main report identified that these have taken place in both Brighton and Middlesbrough. *In Brighton, Equinox and its partners have undertaken a street drinker count for each of the last three years. A six-day period in late July is chosen and shifts of workers walk the same route 3 times per day recording the number of` street drinkers.* Middlesbrough has recently held a one-day count.

This approach can only give an impression of the number and will be subject to changes in the weather and other environmental issues. However, it is a useful tool that could be usefully repeated in a comparable manner in other parts of the country. PCCs should support a national approach to identifying the numbers of street drinkers with a national count based on an agreed methodology.

Further support can be drawn from the evidence in Support Material part 2 above, such as the burden from frequent hospital users.

Communication
Street drinking is, in part, a matter of perception rather than actual impact. Misconceptions and prejudice can influence the public and professional response. Local partnerships may wish to accompany any action with a communications plan to explain why particular actions are being taken or not taken. This may help both the professionals and street drinkers.

Partnerships might also consider:

- engagement with local communities to encourage them to report e.g. *in the Arboretum ward of Nottingham local authority staff have worked with the community to encourage reporting of street drinking and anti-social behaviour.*
- a campaign against giving money to beggars and encouraging giving to charities instead e.g. *Portsmouth sent out "Killing with Kindness" leaflets to all households in the city.*

Support material part 6
Establish a multi-agency operational group

This section supports section 7.2 of the main document: **Establish a multi-agency operational group**

It contains more detailed information on:

- **Multi-agency groups.**

&

- **Terms of Reference for a multi-agency operational group focused on change resistant drinkers**

The latter is designed to be a complete document which can be pulled out and used locally.

As part of a multi-component approach many areas have set up a local multi-agency operational management group. This is focused on either street drinkers or the wider group of high-impact change resistant drinkers placing the greatest burden on services. Groups can be found in areas as diverse as Leicester, Hastings, Weymouth, Nottingham, Swindon, South Tyneside, Lincoln, Sandwell, Medway and Devon.[131]

Many street drinkers will be in contact with a number of agencies, therefore, consistency is vital: people should not shuttle around the system. Multi-agency planning will help ensure a consistent approach, identify risks and facilitate information sharing. The group will integrate joint efforts into a single plan. Identifying a care coordinator to lead work on each individual will further aid joint management.

As with groups like MAPPA and MARAC, it is difficult to disentangle the effectiveness of the group itself, from the effectiveness of the interventions that the group recommends. However, the evidence from the Blue Light project in Support Material part 2 above demonstrates that these multi-agency groups are having a measurable impact.

At its most basic level, groups will ensure good information sharing, *e.g. in London the first ever client of one such group was presented by police and ASB officers as a persistent drunken nuisance. Health services revealed that this man was actually not drunk but was the chronic victim of a serious head injury.* Such information sharing will prevent criticism in the event of serious untoward incidents.

Multi-agency groups will also support the assessment of need and the identification of gaps in the pathway.

The main element of this section is:

- Sample Terms of Reference for a multi-agency operational group focused on change resistant drinkers.

Resource document

Terms of Reference for the Blue Light multi-agency group in XXXXXX

1. Introduction

The perception exists that if a problem drinker does not want to change, nothing can be done to help until the person discovers some motivation. Alcohol Concern's *Blue Light* project has challenged this approach. It has shown that harm reduction, risk management and motivation enhancement strategies exist and can be used with change resistant drinkers. More importantly tackling this group will target some of the most risky, vulnerable and costly individuals in society.

- XXXXXX Council and its partners aim to work together to target the burden on our community from high-impact, change resistant, problem drinkers.

2. A multi-agency group targeting the highest risk drinkers

An intensive response cannot be offered to the vast number of problem drinkers who are not engaging with services. Alcohol Identification and Brief Advice and the offer of services are a reasonable approach to a large swathe of these drinkers. However, a small group require a more targeted approach.

The council has set up a multi-agency framework for managing high risk change resistant drinkers. At the heart of this process is a multi-agency operational group which meets at least monthly.

3. Aim

The aim of this group will be to:

- improve the management of change resistant drinkers and thereby reduce the impact that they are having on the community generally and public services specifically.

4. Membership

The group will have core membership of:

- Police
- Hospital
- CCG
- Probation
- Local authority social care
- Local authority community safety/ASB teams
- Local alcohol services
- Mental health services
- Housing

Other relevant services include:

- Ambulance / Fire Service
- Primary care
- Women's Aid
- Drug Services

A quorum of 5 members will be required for the meeting to proceed.

5. Level of attendance

It is vital that the person representing each agency is of the appropriate level to engage with this process, i.e. operational but with some seniority to ensure that actions are taken.

6. Identifying the clients

The group members will individually be responsible for identifying the change resistant drinkers that they want to see being discussed at the meeting. A single definition of this client group is not possible but the people to be managed by the group are likely to meet the following criteria:

i.	**An alcohol problem**
	• Have an enduring pattern of problem drinking, dating back at least ten years **&** • Score 20+ on AUDIT **or** • Be classified as dependent on SADQ (16-30 = moderate dependence/30 is severe dependence range is 0-60) **or** • Have other markers of dependence on alcohol (Ethanol levels or biomarkers such as Liver Function Test scores may also be used)
ii.	**A pattern of not engaging with or benefiting from alcohol treatment**
	Clients will: • Have been subject to alcohol Identification and Brief Advice (IBA) **&** • Have been referred to services, usually on more than two occasions, and have not attended, attended and then disengaged, or remained engaged but not changed.
iii.	**A burden on public services**
	Clients will either directly, or via their effect on others e.g. their family, be placing a burden on the following services: • Health • Social care including adults involved with children's services • Criminal justice / anti-social behaviour / domestic violence services • Emergency services (999) • Housing and homelessness agencies The burden will mainly be due to: • multiple use of individual services
	Exception 1 – level of risk
	A person may meet the first two criteria (dependence and non-engagement) but the burden on public services is due to a single exceptional risk.
	Exception 2 – engaged with other multi-agency groups
	If a person is already engaged with another multi-agency group e.g. MARAC or MAPPA they will not be taken on by the Blue Light Group without a clear decision from the other group. The assumption will usually be that management will remain with the existing group.

It is recognised that this group can only manage a small number of high burden clients at any one time. Therefore, as a check and control on the process:

- when a new client is presented to the meeting, the partner agencies will need to agree that it is an appropriate and manageable referral at that point in time.

7. Chair and note taking

The chair of the meeting (and a deputy) will be agreed by the members of the group. For the sake of consistency, the chair should remain the same from meeting to meeting.

Notes of the meeting will be in the form of a spreadsheet which will be updated at each meeting.

Each partner agency who is involved with the client will be expected to update their notes on the client after each meeting.

8. Information sharing

This guidance is based on HM Government's *Seven golden rules for information sharing*. The phrases in bold below are quotes from the *rules*.[132]

The multi-agency group operates within the council's information sharing protocol which is available on the council website. All participating agencies must be signatories to this protocol.

Information cannot be shared about these clients unless the basis on which the sharing occurs is clear and agreed by the members. This will be either because:

- Client consent has been secured; or
- Public interest supports it. The Data Protection Act recognises that public interest allows the sharing of information in certain circumstances, as do other laws such as the Human Rights Act. The public interest generally lies in the prevention of abuse or harm, or the protection of others, including the protection of public safety.[133]

Consent forms

Many partners will have their own client consent forms. These will be acceptable to the group as long as these are clear that appropriate information sharing is permitted with the group. Alternatively, the consent form attached at protocols annex 2 can be used.

Confidential person-identifiable information that is disclosed in the public interest will be proportionate and relevant and not excessive to the case concerned.

As a result, the following process is followed:

- **Information will be ideally shared with consent:** The referring agency will secure consent to share information with the members of the multi-agency group.

If this is not possible:

- Outline, but anonymous, details of the client will be presented to the group. Discussion and agreement will take place as to whether: safety and well-being of the person and/or others who may be affected by their actions, create **a public interest case for sharing the information** under relevant legislation e.g. the Crime and Disorder Act (1998).

If this is agreed:

- The agreement will be **recorded in the minutes** with the reason for the decision and the relevant legal framework.
- The referring agency, or other member of the group, will inform the service user of the decision to disclose. This will happen even where their consent is not required, unless

it would not be safe to do so or would otherwise undermine the purpose of the disclosure e.g. allow a perpetrator to avoid detection.

If there are any doubts about the legality of sharing a particular set of information, further advice should be sought from the relevant organisation's Information Governance Lead or Caldicott Guardian.

9. Security and data management

Confidentiality of data must be maintained when case details need to be circulated for panel meetings. (See the meeting confidentiality form at annex 1)

At all stages of the exchange the principle that the information should be available only to those who have a specific and legitimate need to see it must be maintained by all parties.

Data must only be sent if the means of transmission is secure and it can be established that the appropriate recipient's access to the transmission is equally secure. Only the original paper copies of papers are retained by the coordinator. All other copies are returned and destroyed.

Data must be stored securely, regularly reviewed, and disposed of in accordance with the receiving organisation's Retention and Disposal policy and procedures, when no longer required for the original purpose.

10. Facilitating data collection and performance management

The performance of the group will be measured by looking at whether the process has reduced the burden on public services. Therefore:

- at entry into the process, the referring agency will provide details on service usage over the last 6-12 months e.g. number of arrests, ASB complaints, 999 calls, hospital admissions. This will allow monitoring over time. It will also allow a judgement about the appropriateness of the client for the group.

11. Process

This section sets out a process for managing the multi-agency meeting.

►The chair of the meeting reminds all concerned of the information sharing protocols.
►The chair ensures the identity and agency of all people in the meeting is clear, to ensure that all are covered by the information-sharing protocol.
►All participants sign the confidentiality agreement at annex 1.

►New clients for the process will be presented.
►The chair will ensure the information-sharing permissions are in place for this person, using the process above.
►The referring agency will present a short case history of the person. Other agencies will share any available information on that person.

►The partner agencies will develop and agree a set of actions and agree who will carry these out. These will be recorded on the spreadsheet.

►Each partner agency will ensure that, where relevant, their staff are aware that when this service user is identified a specific response is required e.g.:

- positive encouragement will be given to promote client self-belief.
- harm reduction and risk management advice will be given.

This should draw on the approaches set out in the *Blue Light* manual.

►It should be clarified whether signed permission for *the local alcohol service* to make contact has been secured. If not, all agencies who come into contact with this person, should be seeking this consent.
►If consent is secured, *the local alcohol service* should be contacted within two working hours.

►If consent is not secured, the multi-agency meeting will ensure that other agency staff continue to seek opportunities to engage, and the group will consider alternative approaches e.g.

- Barriers which may be preventing engagement in services.
- Alternative approaches to engaging the person.
- Other local resources, such as faith groups, which could be utilised to work with the individual.
- Involving family members.
- Identifying incentives to engage the person in treatment.
- The possible use of compulsory powers.

►This process will be repeated for all new and existing clients.

►In some cases, it will be decided that a small sub-group (or conference-call) will be set up for an individual, involving a group of workers more specific to that person. This will operate under the same confidentiality / information-sharing protocol and will report back to the main group.

►If appropriate, the group will:

- ask the borough to consider an expedited process to assess the person for local authority Care Act funding;
- consider the use of legal powers such as civil injunctions.

►In some cases, this group will be responsible for identifying, recording and reporting unmet need to commissioners. In the light of this data, the partner agencies will review whether specific service development is required e.g. an expansion of outreach capacity.

12. *The local alcohol service* role

Once *the local alcohol service* has consent to make contact:

- They will offer an assertive response including a swift appointment, a home visit or a meeting at a convenient location.
- Wherever possible the referring agency, or other relevant agency, should undertake an initial joint visit with the alcohol service.
- *The local alcohol service* will require the provision of relevant risk information.
- Partner agencies will work in concert by reinforcing messages to the person about harm reduction and encouraging change.
- All agencies involved with the person will report back to the monthly meeting on progress and next steps.

►Once the *local alcohol service* manages to engage the person, they will work within their existing resources to:

- maintain engagement
- assess risk
- reduce harm and manage risk
- encourage engagement with general services such as primary care
- encourage engagement with a process of change.

►Where appropriate *the local alcohol service* will engage other agencies to support their work. This involvement should be agreed wherever possible, e.g. the ambulance service jointly visiting a client to talk about inappropriate 999 calls.

13. Terminating the process

The group's oversight will be terminated:

- If the person is successfully engaged with specialist services and it is agreed by the group that client's behaviour is more stable.
- If the person is sentenced to prison or enters hospital as a long stay patient.
- If the person moves away from the area. However, in these circumstances, the group will ensure that information has been shared, if appropriate, with local agencies in the new area.
- In some cases, a decision will be taken to remove the person from the group's consideration if it is felt that no further benefit will be gained from the process. In this case the group needs to be sure that at least one agency has ongoing oversight.

If the person dies during the process, consideration will be given to whether an alcohol related death review process should be recommended.

14. Measuring the impact

The impact targets for this work are very straightforward and will encompass output and outcome targets.

Output: The number of clients identified by the multi-agency group who are engaged and the period of engagement
Outcome: The reduction in the behaviours which had brought the client to the attention of the multi-agency group e.g. hospital attendances, arrests, 999 calls etc.

The key outcome target will be to reduce the cost burdens presented by the clients meeting the definition and brought to the multi-agency group by 20% per annum.

15. Equality and diversity

The organisations participating in this process are committed to ensuring that it treats service users fairly, equitably and reasonably and that it does not discriminate against individuals or groups on the basis of their ethnic origin, physical or mental abilities, gender, age, religious beliefs or sexual orientation.

16. Reviewing these arrangements

These arrangements will be reviewed after 6 months and annually thereafter. This review will ensure the process is relevant and fit for purpose.

Agreement to Terms of Reference

I confirm that our agency will be a partner to the Blue Light Multi-Agency process and will adhere to the Terms of Reference above and the associated information sharing protocol indicated.

For and on behalf of the agency

Signature

Name

On behalf of (Agency)

Date

Position

Address

Email

Telephone number

Protocols annex 1 Confidentiality Statement for meetings

Name of meeting:
Date/time:
Venue:

Confidentiality Statement: I agree that information shared at this meeting is only to be used in relation to working with adults, as outlined within the meeting's terms of reference. Information shared at this meeting will not be used outside of this group for any other purpose than that agreed within this meeting. All personal information shared should be treated as highly confidential and all data should be transported and stored in accordance with each agency's information security policy and procedures.

Name	Organisation	Contact details	Signature

Signature of the chair as witness to the above signatures
_____ **Date**_____

Protocols annex 2 Multi-Agency Information Sharing Protocol - Consent Form

The professional stated below, believes that you may be at risk of harming yourself or other people and is seeking your consent to make a referral to the multi-agency management group.

If you agree to give your consent, some or all of the following information may be shared - your personal details, information about your carers, your current environment and details of the risk. This may be shared with a multi-agency group, which could include representatives from health, police, emergency services, the local authority, housing providers and substance misuse services.

These people are qualified and will consider the information put forward and make recommendations on how the care you receive might be extended to support you further with any difficulties you may be experiencing. The professionals involved are trained to protect your rights to privacy and confidentiality and this will be respected at all times.

(If we believe you are at significant risk, or if other people are at risk, professionals can still disclose information under common law "Duty of Confidence" without your consent, or if we have a legal obligation to do so, such as under the Crime and Disorder act 1998)

Please provide the relevant information below:

Is this information about you? ☐ Yes ☐ No

If 'No', who is the information about?

Name of data subject:

Address:

DOB (ddmmyyyy):

Are you are acting as: Parent/Guardian/Carer

Other (please describe)

Have the reasons for requesting consent been explained to you? ☐ Yes ☐ No

I give (name of agency/person)…….. consent to process information in relation to a safeguarding concern in relation to myself and I am the above named person.

Client signature…….
Date…….

To be filled out by the relevant professional the information is being obtained by.

Organisation:

Name of professional:

Professional's role:

Contact details:

If consent was not obtained please state why below: (e.g. not given, not practicable due to risk, mental capacity)

Support material part 7
Support the commissioning of alcohol services which focus on change resistant drinkers

This section supports section 7.3 of the main document: **Support the commissioning of alcohol services which focus on change resistant drinkers**

It contains more detailed information on:

- **Alcohol interventions that are likely to work for street drinkers**

A guide on assertive outreach techniques with street drinkers is included. (This was developed from interview material gathered during this research). ***This is designed to be a complete document which can be pulled out and used locally. Therefore, it may repeat some content elsewhere in these documents.***

The best solution to street drinking is to encourage the drinkers to change their behaviour. This is not simple; however, it is possible and should be part of the response. This will probably require action to:

- improve the specialist alcohol service response to street drinkers.

A range of specialist alcohol treatment services exist in most parts of the country. The accessibility of these services will vary but, in general, if a street drinker *wants* help it will be available.

However, if local alcohol services are to attract street drinkers they will also need to work with people who are ambivalent about, or unwilling to, change their drinking. Alcohol Concern's Blue Light project has highlighted that many alcohol services work mainly with the motivated, thus excluding many street drinkers.

- *The impression given is that this is the client's fault. There still remains a culture of those missing appointments do not require help or can't be bothered to turn up. Little consideration is given to the dysfunction this client group exhibits and addressing this.*[134]

PCCs and other non-alcohol specialists such as police, housing and community safety staff can change this. They need to present public health teams with the case for commissioning services, or service elements, that outreach to, engage and motivate people whose drinking is causing considerable nuisance or harm rather than simply working with those who are motivated to change.

If alcohol services are to help street drinkers more effectively, they will need to:

- recognise that alcohol interventions are not simply "treatment" but include engagement, motivation and preparation for treatment;
- ensure that alcohol services caseloads are driven by risk and vulnerability and not by willingness to enter a service;
- develop harm reduction approaches;
- develop outreach approaches.

Alcohol interventions are more than "treatment": "Alcohol interventions" can easily be equated to "alcohol treatment". Detoxification, one to one counselling and groupwork are vital but they are only a part of intervening with an alcohol problem. A comprehensive alcohol intervention embraces:

- Identification
- Engagement
- Motivation
- Preparation
- Treatment
- Aftercare
- Picking up those who relapse.

Indeed, treatment is one of the easier elements in this list. The real challenge is to engage, motivate and prepare people and to pick them up when they disengage. Alcohol intervention is more than a brief, change focused, transaction following a standard model.

Risk and vulnerability as a driver: If services are to meet the needs of street drinkers, the overall design, and the actual delivery, of interventions must be driven by risk and vulnerability.

- Services should be focused on risk management as a first order priority.
- Decisions about who to work with will target the people who are of the greatest concern to public services – these are likely to be the most risky and most vulnerable.
- It should be impossible to discharge or not follow up someone who is a vulnerable or risky individual.
- Such clients should not be sidelined because they are not ready to engage.
- Services should be designed to maximise engagement in this group.

Harm reduction approaches: A key part of risk management is harm reduction. In tackling drug misuse, despite the movement to a change focused recovery approach, the tradition of harm management via needle exchange, substitute prescribing, or providing condoms and other paraphernalia is still strong, well evidenced and has been highly effective, for example in containing the spread of blood-borne viruses. The use of a parallel approach in the alcohol field is less well developed. Nonetheless options do exist. Alcohol services for street drinkers will require the development of skills and techniques in harm reduction. The *Blue Light* project has demonstrated both the feasibility of this option and the widespread recognition of the need for it. Visit:
http://www.alcoholconcern.org.uk/wp-content/uploads/2015/01/Alcohol-Concern-Blue-Light-Project-Manual.pdf

Assertive outreach: Outreach teams targeting street drinkers are running in various parts of the country. These workers will aim to provide a gateway to health, housing, social services and treatment as well as harm minimisation and motivational services. The success of such interventions is measured in terms of health gains, fewer arrests, reduced emergency hospital admissions tenancy sustainment and engagement with services. Evidence in Support Material part 2 above highlights the impact of outreach approaches.

> *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…Such evidence indicates that assertive outreach can be effective at engaging and linking homeless persons with substance use disorders to substance use treatment services.*[135]

Befriending is a possible alternative. It is a less intensive approach than assertive outreach but will involve someone, perhaps a volunteer from a faith group or a street pastor, going out and linking in to someone at a quasi-social level, building a friendly relationship and encouraging alternative activities, building self-esteem and encouraging positive changes.

Resource document

Assertive Outreach with Street Drinkers
Practical approaches

Introduction

The research for this guidance drew on a wide range of interviews and local visits. As a result, it identified not only strategic planning material but also practical "tips and hints" about what had worked locally to engage, motivate and reduce the harm associated with individual street drinkers. This resource has gathered all those ideas into a single document which will inform the practice of anyone who encounters street drinkers in a professional capacity.

The target audience embraces not only specialists such as alcohol service staff working in an outreach capacity or hospital alcohol liaison staff, but also PCSOs, neighbourhood wardens and other community safety staff.

Part 1 - A robust management framework

Later sections look in detail at face to face techniques that are being used to engage street drinkers. However, those techniques can only be used within a robust management framework. This section sets out themes that need to be considered in the management of an outreach service.

Risk to workers

Workers undertaking outreach to street drinkers are putting themselves at risk. The risk should not be overstated: street drinkers are probably more at risk than those who work with them. Nonetheless, anyone encountering intoxicated individuals should be alert to:

- Potential health risks &
- The risk of violence.

Street drinkers may carry infectious conditions. These will range from the common cold to tuberculosis. Workers need to take sensible precautions. Most obviously carrying hand wipes and disinfectant sprays and ensuring they are appropriately vaccinated.

When working with people who are disinhibited, there is undoubtedly a heightened risk of physical and verbal abuse and sensible precautions should be taken to ensure worker safety.

Some street drinkers may feel unsafe on the streets and as a result may carry a weapon.

Worker support

As a result of these risks, any street outreach work needs to be supported by:

- Appropriate policies / procedures i.e. a lone working policy, health and safety policy and management of violence policy.
- Training in relevant competencies.
- Good peer and management support.

The latter is important but easily overlooked. Outreach work is stressful and workers will need regular support. Workers can easily become cynical and lose sight of the possibility of change in street drinkers. This is not a failing on the part of the worker and should not be treated as such: it is an occupational hazard.

Managers and colleagues need to be alert to this possibility and provide support, and supportive challenge, if someone is losing sight of the needs of the client group. Workers need to practice self-care.

Support will also be important to ensure that:

- resources are well focused;
- workers are pursuing the most appropriate approaches; and
- good communication occurs both internally and externally.

It may be useful to taper the recruitment of street drinkers to the scheme at the start so that the workload does not immediately become too onerous.[136]

The management challenge

Managing people who work on the streets will also be a challenge to managers. How does the manager know what workers are doing, and whether what they are doing is appropriate? This is not an argument for big brother type surveillance; outreach workers need to be flexible but a sensitive oversight of what they are doing is appropriate. Moreover, a worker who is either beginning to avoid their task or alternatively taking unnecessary risks, is someone who needs support.

Team approach

Different views exist on whether workers should have their own individual clients or whether outreach workers should manage clients as a team. The advantage of team working is that:

- Each worker will know what is happening with every case.
- Clients support can continue if a worker is absent.
- The client learns to relate to a range of people.

On the other hand, there is advantage in a client building a trusting relationship with one worker who understands their situation in greater detail.

This guide will not express a view on which approach should be pursued. Clearly both have benefits.

A multi-agency group

Best practice will be further assisted by setting this work within the context of a local multi-agency operational management group which is focused on one of the following:

- street drinkers
- rough sleepers
- the wider group of change resistant drinkers placing the greatest burden on services: or
- a multi-agency hub focused on the wide range of vulnerable and risky individuals in the community

Model groups can be found in areas as diverse as Leicester, Nottingham, Swindon, South Shields, Lincoln, Sandwell, Medway and Devon. This approach will also provide intelligence for outreach services about the location of clients.

Paperwork

Keeping records will be more challenging for outreach workers than other staff. Squatting beside someone sitting on a low wall is not conducive to completing forms and, more importantly, can be a real barrier to engagement. Nonetheless, outreach workers are working with some of the most risky and vulnerable drinkers in the community and good record-keeping is going to aid work and act as a protection for the worker in the context of a serious incident review.

The dictate function on recent smartphones should allow workers to dictate and email anonymised memos immediately they leave the client.

Part 2 - Risk assessment

Clients are at risk

Street drinkers are a risky and vulnerable group. The concern is often that they will verbally or physically abuse passers-by. This is possible but it is just as likely that they will be vulnerable. At the outset, and throughout the work, staff need to be alert to a range of risks:

- Serious illness.
- Local people abusing them by urinating on them, setting fire to them or otherwise threatening violence to them.
- The risk of "modern day slavery" in exchange for a roof. An East European man with no recourse to public funds fell into this situation because if he was kicked out he was homeless. [137]
- People having their dog stolen by other beggars who believe a dog is a begging aid.
- Bullying of people with brain injury. [138]

A number of interviewees commented on seeing a small group of male street drinkers accompanied by a lone woman. This is obviously a cause for concern, but it will be important not to rush to judgement about the risk:

- *The men in the groups of drinkers could be acting as a protection for the woman.* [139]
- *The woman may feel more vulnerable in a flat or house than in a public place with passers-by and CCTV.*

It is also important to remember that street drinkers are not always street drinkers. The label "street drinker" suggests that the person's sole activity is drinking on the street, but of course this is wrong. The street drinking is just one part of a life, albeit the most visible; other parts may involve violence, domestic violence, abuse, exploitation and serious ill health.

A Domestic Homicide Review from Guildford (Report into the death of Adult A 2013) shows a couple with chaotic patterns of alcohol and drug use. When together, this created a very volatile situation. Street drinking was the publicly visible indicator of a much wider problem that included: shoplifting, significant physical ill-health and domestic violence which ended in homicide.[140]

- The risk assessment of street drinkers needs to be alert to a wide range of risks.

Part 3 - Engaging street drinkers

Overview

No short cut exists to engaging street drinkers. It will require going out on the streets and building relationships where people are drinking.

The *Blue Light* project has highlighted a number of characteristics of working with this client group. The key features are an approach which is:

- Assertive
- Focused on building a relationship
- Flexible
- Holistic
- Persistent
- Consistent
- Co-ordinated. [141]

In Nottinghamshire the Alcohol Long Term Conditions team identified additional features which have characterised their work and helped tackle this client group.
Passion: *We all love what we do and the passion that we have to be advocates for the people we work with, has helped us become a strong team.*[142]
A port of call: *Clients have a mobile number they can call. It's someone they can easily contact if they have a problem.*[143]
Overcoming barriers: *We try to break down the barriers…They have probably been in services for a long time so we try and look at a different way of working with them...*[144]

The role can appear relatively unstructured. Fixed appointments and desk-bound work is rare. The role can be very reactive: responding to opportunities and crises presented by clients. The workers described the job as "running to keep all the plates in the air". The work goes backwards and forwards and workers can often feel like they have failed or face an impossible challenge. [145]

The rest of this guide is structured around the four key stages of the outreach process:

- Making contact
- Building and maintaining the relationship
- Encouraging engagement with services
- Moving to closure.

Making contact: the starting point

Street drinkers are generally not hard to find. Workers will learn the key locations by walking around an area. However, liaison with other agencies will provide a more detailed picture, in particular, liaison with the police and neighbourhood wardens.

In any area, locations will be determined by geography and design; however, possible places may include:

- Pharmacies where they collect prescriptions,
- Jobcentre, &
- Post office.

We identified a pick up point for cash in hand work outside a betting shop and people, mainly East Europeans would come back from work, bet and drink outside. [146]

Many street drinkers will visit the A&E department which offers a real opportunity to engage people. Workers should be asking the nurses to notify them, or notify the hospital alcohol liaison service, if particular clients turn up.

The time of day, weather and season will make a difference to location and state of intoxication. As a general rule, morning is probably the best time to engage with street drinkers because they are just starting off drinking.

Don't label people as street drinkers or the workers as street drinker outreach workers. You need an equal relationship. [147]

Some people have the ability to walk up to someone on the street and make contact, in the same way that some people are able to talk to a stranger on a train or at a party. An outgoing personality is a useful asset, but it is not a necessity for an outreach worker.

Nor should people feel that they won't be a good outreach worker because they feel nervous about making contact. Outreach is about more than the initial contact. It is worth bearing in mind that:

- most lone street drinkers will welcome conversation;
- even groups of drinkers may welcome some variety;
- most street drinkers will be more concerned about you than vice versa. You will be seen as representing authority and, therefore, a potential threat.

Kingston

To go to them is the first thing. We just walked out on the street, no pens and paper. Then say hello my name is xxxx and this is who we are. There are times we are rejected, but in the majority of cases they are happy to meet us and be listened to. [148]

The best starting point is to have something to offer:

- The outreach service in Kingston went out and invited people to a barbeque and a free haircut on a Wednesday afternoon in the grounds of a local church.
- Telling people about a drop in session, access to health care or a new food bank will be useful.
- Having something to give away may be attractive – breakfast, a packet of pot noodles or an energy bar.
- Offer access to flu jabs.[149]

Bedford

Street drinker engagement days have been established in Bedford – PCSOs go out on one day, twice a year, and invite people to come to a Salvation Army hall where they can get food and drink, but can also access various stalls where they can encounter agencies, receive, health checks and begin to engage with services. [150]

Framework from the East Midlands have described the process as follows:

- Introduce yourself by name.
- Ask another drinker to introduce you
- Always be approachable. Body language says a massive amount about you. Carry yourself in an easy going and confident manner. Smile.
- Have a sense of humour.
- Listen to what a person says to you. Repeat what the person has said. This assures them that you are listening.
- Make sure you identify and use the person's name. Not "chuck, mate etc.
- Do not stand over someone, always talk at their level even if this means squatting down.

- Don't promise anything that you cannot deliver.
- Be honest.
- Be persistent but be friendly.[151]

We don't realise how powerful the following question can be…"How are you today?"[152] *And what about…"Tell me more about that"*[153]

On the other hand, sometimes it won't be convenient to talk to them. If they are begging you should realise that they are at work and conversation may not be welcome.[154]

Building and maintaining the relationship

We go and get involved with things they are already doing – go to the places they go. The skill is empathy – listening, being non-judgemental, going to where they are. Sometimes you just have to listen.[155]

Workers described a number of important elements in building the relationship.

- Time
- Building trust through a focus on the ordinary
- Building client confidence and self-belief
- Working on activities
- Making and keeping commitments
- Accessing health care
- Harm reduction

Once contact has been made, the outreach worker will need to build the relationship. This will take time. Building a positive engagement can be slow and workers need to be prepared to take as long as is needed. Any expectation that things will move swiftly will simply set client and worker up to fail.

Building trust and rapport is central. This can involve ordinary conversations about everyday things. The workers will "look around" the person and, usually, focus on things other than alcohol. In the early stages this may be all that can be expected.[156] [157] [158]

- *You need to listen to their story, understand them, their family background and what we can do for them*[159]
- *It is vital to find out what they want – it is often not about alcohol.*[160]

A target will be to build confidence and self-esteem. With confidence, the person can start to move on with their lives. To build confidence the workers will say things like:

- *I'm proud of you*[161]
- *You look better*[162]

Low level physical contact: a hand on the arm or shoulder or a handshake can be useful…Many street drinkers will not receive much human contact and a person being willing to touch them is a real sign of acceptance and can build self-esteem.

The one thing a worker can do more than any other is to demonstrate a belief that the person can change. Promoting self-belief is crucial. Workers will help drinkers believe they can change if they demonstrate that belief themselves. Street drinkers need to believe that they can be better. People can change themselves, what they need is the desire and the confidence to do it.

At times this will be tough – some clients seem set on a course that will destroy their lives or the lives of others. However, people do change. Even people who seem to have abandoned all hope of a different life can turn themselves around.

If we do not demonstrate a belief in the possibility of change then we will reinforce a sense of hopelessness in clients.[163]

A repeated message from outreach workers is the need to keep commitments. This is a group of clients who are used to people letting them down. Workers should be careful not to make too many promises but to ensure that every one is kept. This builds trust and self-esteem. It says that the client is important to the worker and that they were considering their needs when they were not in their company.[164]

Ongoing contact via phone or text will be useful if this is possible; some street drinkers will have access to phones and a message or call will remind the drinker that someone is interested in them.

> *…forgetting to call back, or missing a scheduled check in with a street drinker, can often scream rejection, again, "there's no point", again, "what a waste of time", again, "hopeless". Some of these vulnerable or at risk drinkers should be a priority, that call back could make a huge difference.*[165]

Workers describe the early stages of the relationship as being about "hand holding". The clients often have little confidence and few social skills. Occupying time will be a main focus. Drinking is often to do with boredom. Outreach workers described a range of approaches they have used to build engagement:

- *Taking on practical tasks with clients e.g. cleaning out a flat*
- *Taking the client to the funeral of a street drinking friend*
- *Focus on harm minimisation*
- *Telephone calls / texts to remind clients of appointments*
- *Renting storage space for client's belongings*
- *Holding spare sets of keys for client's accommodation*
- *Recreational activities with the client*
- *Providing access to acupuncture and other complementary therapies*
- *A gardening project*
- *Accompanying to appointments*[166] [167] [168]

So far the outreach work has concentrated on what the client wants. Nonetheless, at this early stage one worker driven target might be to persuade someone to have a health check. It may be too much to expect them to come to engage in alcohol treatment but a health check will be an important goal. Ideally this will involve registering with a GP.

The outreach project in Clacton summarised the overall process thus:
We try to do something, anything. Even if it's letting them use the phone. Little things, often unrelated to their alcohol consumption. Things like…

- *Making them smile!*
- *Building trust*
- *Buying them breakfast*
- *Providing access to a phone*
- *Making referrals to services*
- *Listening to their story and reflecting back what they say!*
- *Ensuring they're housed*
- *Checking they're healthy*[169]

The one thing that the worker should avoid is trying to persuade the drinker to change their drinking. This is a central tenet of motivational interviewing (MI). MI argues that the worst thing to do is to try and persuade the client to change. Instead workers should give information and options in a non-judgemental way. If the client responds negatively, MI says that workers should *roll with resistance* and simply move on. Persuasion will allow the client to articulate and, thereby, entrench all the reasons they should not change.

Workers in a number of situations have noted that people often open up most when they are not in direct eye contact e.g. sitting in a car or walking to the shops.[170] [171]

Much of this work will happen on the streets. However, some services will mix outreach with fixed site work. In Kingston the service runs a drop-in on a Wednesday where they provide food and clothes, blankets etc. However, the rest of the time they are working on the streets and reaching out to people. [172] Some work may occur in the drinker's home: not all street drinkers are homeless.

Encouraging engagement with services

Underlying these efforts at engagement is a clear purpose. The role is not simply about being a friend. The workers are building a relationship in order to try to move the person to a less harmful lifestyle.

I am a friendly professional not a professional friend. [173]

In general, the outreach worker is aiming to move drinkers into services that can help them rather than to be the main provider of change focused interventions. This line is inevitably blurred, but encouraging engagement with a range of services is the ultimate goal of an outreach worker.

Encouraging engagement will involve a number of elements:

- Understanding any barriers to change
- Mapping the person's existing service contacts
- Seeking consent &
- Building links with various services.

- *We begin our work with a readiness to change ruler and the Barriers to Change checklist from the Blue Light manual.*
- *When we look at barriers – depression is top.* [174]

Understanding any barriers to change: An important step on the journey to change is to understand why someone is not changing. It is easy to dismiss the person as simply "unmotivated" or "in denial". The situation will always be more complex:

- Early stage alcohol related brain injury and other patterns of head injury will make it difficult for clients to motivate themselves.[175]
- Poor nutrition not only contributes to brain injury but also reduces energy levels.[176]
- Conditions like liver disease can reduce energy and create sleep problems.[177]
- A large proportion of drinkers will be in depressed states as a result of alcohol's effects on the central nervous system.

Something as simple as chronic tooth pain experienced when someone stops drinking can be a disincentive to change. [178]

Putting these factors together we can see that the problems of engagement are not simply "denial", but the fact that the person is at the centre of a "perfect storm" of conditions which

make it harder and harder for them to organise and motivate themselves. Requiring motivation of such clients is as sensible as requiring the drowning person to swim to shore for help.

Workers should try and identify barriers to change and engagement. Other barriers could include low self-esteem, mental health problems or peers who sabotage change.

Mapping the person's existing service contacts: Most street drinkers will have contact with other agencies even if it is compelled contact. It is important to understand who else is working with the drinker. This will ensure that messages are being re-enforced and that workers are not being played off against one another.

At times it will be useful to have a network meeting around a particular person to coordinate activity.

Seeking consent: In order to ease the path into services, it will often be necessary to seek client consent to refer and share information. This will allow some services to make proactive contact with the drinker e.g. alcohol treatment services.

Clients are unlikely to give consent the first time they are asked. Encouragement to consent will require repetition, possibly with different workers or agencies reinforcing the point.

Building links with various services: The outreach worker will need to be focused on encouraging the person to attend local services and become involved in other constructive activities. The main target will be engagement with alcohol services; however, it may also be important to link people into services offering support with:

- health,
- mental health,
- debt counselling &
- housing.

Outreach workers identified a number of principles that would aid engagement in services. The most obvious is to make the appointments and accompany the person (but with the aim that in the end they can do it themselves) or to find volunteers or peer mentors who can accompany them. Others include:

- Tackle client misconceptions about various services – e.g. alcohol services are not a mental health unit. This will require the worker being familiar, and building links, with the service.
- Remind clients that, in terms of alcohol treatment, abstinence is not the only option. Most community alcohol services will allow clients to explore whether they can return to controlled drinking.
- Address previous bad experience with services.
- Smooth the pathway with services by asking them to be very welcoming and encouraging if the person makes contact.
- Ask for a speedier appointment if a person is someone who is of particular concern.
- Ensure that services are asked to speedily follow-up people who disengage and report this back to the referrer.
- Follow up any referral to ensure the client makes contact with the service.
- Acknowledge to the individual that entering services can be challenging, and they will not be seen as failures if it takes time to make changes. [179]

Many hospitals now have alcohol liaison workers. If someone will not enter community services, workers should ensure that if the client enters hospital at any point they are contacted by the liaison staff.

A client entering prison should be seen as an opportunity to undertake some work with the drinker in a more stable state.

Outreach workers also need to be client advocates. At times they will have to challenge various services, including mental health services to provide a service that reflects the level of risk associated with an individual. If the services are not available, then workers need to record and report unmet need, via managers, to local commissioners.

It is important not to give the impression that the worker is condoning the street drinking lifestyle. Street drinking is not a good lifestyle choice and every drinker can achieve a better quality of life. Outreach workers can legitimately talk about the pressure the person has placed on the services e.g. ambulance costs, bed nights and the impact that has had.

Closure

Ultimately workers need to consider how to draw the engagement and support to a close. In the ideal situation this will occur with referral to a specialist alcohol service. Workers acknowledged that people can become dependent on the service and decide to move to a point where they begin to make more demands on the client e.g. coming to an office for meetings.

Workers acknowledged that some people can "try it on" in the later stages of the relationship. They may start looking for lifts, as if the workers were a taxi service. At times this contact may be viewed as a positive, but workers need to use their judgement, or seek advice from other staff. They will need to set limits that are appropriate to each person.

Even given intensive outreach over a period of time, not everyone will change their behaviour. In some cases, the service may need to pull away and focus resources on other people. However, in this case workers should:

- Discuss the decision with managers and partner agencies;
- Consider whether enforcement approaches offer an alternative;
- Explain the situation to the client;
- Record all the reasons and any contingencies.

Support material part 8
Encourage the appropriate use of legal powers

This section supports section 7.4 of the main document: **Encourage the appropriate use of legal powers**

It contains more detailed information on:

- **The evidence base for the impact of legal powers including the potential positive impact on street drinkers**

It also contains a more complete listing of the legal powers available to target street drinkers.

The main report emphasises that the use of enforcement powers should be a constructive part of a process that leads to community and individual change. This will embrace legal powers targeted at both geographical areas and identified individuals. These powers are not necessarily negative, and individual enforcement may even be therapeutic, if it pushes a drinker to engage with services.

Most of these powers are contained within the Anti-social Behaviour, Crime and Policing Act 2014. A range of other legal and quasi-legal powers impact on this group. A full list is set out below.

Enforcement powers targeting geographical areas: Geographical powers are the bedrock of the response to street drinking. They define the behaviour as a problem for a community and allow action against individuals who would otherwise be pursuing a legal behaviour which could only be challenged when disruption had reached an unacceptable level. The repeated breach of such geographical bans will be an important marker of the need for the use of individual powers.

Powers under the Anti-social Behaviour, Crime and Policing Act 2014
Public space protection orders - these orders can be used to ban public drinking in a particular area ranging from a town centre to an entire borough. These powers replaced the similar Designated Public Place Orders (DPPOs). However, the PSPO is more flexible and can ban other behaviours e.g. the use of new psychoactive substances. An order can be introduced very swiftly. Repeated breach might lead to a civil injunction.
Dispersal powers – allow a police officer (or PCSO if authorised) to require a person committing or likely to commit anti-social behaviour, crime or disorder to leave an area for up to 48 hours. The officer can also confiscate alcohol under this provision if it is likely to lead to anti-social behaviour.

These powers have been criticised for effectively increasing the social exclusion and marginalisation of an already very excluded group.[180] Others have argued that it penalises the innocent who drink in public but cause no disturbance.[181]

An academic review, published in 2012, suggested that: *"Despite recent widespread implementation of street drinking laws in urban areas, research in terms of effectiveness or community impact is limited (and)…lacked methodological rigour."* This does not mean that street drinking bans are ineffective, simply that the evidence base is poor. The same

academic study reported that bans can serve to bolster perceptions of safety and restore perceptions of moral order. In at least six of 13 locations, public perceptions of safety improved following imposition of a street drinking ban.[182]

This guidance is positive about the use of geographical powers; nonetheless, there are practical problems with their use:

- the orders can only be effective when followed by ongoing assertive police enforcement and community involvement to highlight breaches.
- the use of geographical powers can cause displacement: even to other local authorities. Drinking may be 'pushed' into areas that are more 'hidden' (and potentially dangerous) and distance individuals from support services.[183] [184] [185]
- in two areas reviewed the edges of the controlled drinking area became gathering points for drinkers.[186]
- the degree of CCTV coverage in an area will impact on the ability to enforce these powers.

Enforcement powers targeting individuals: As well as geographical powers, individual orders such as Civil Injunctions, could be targeted at street drinkers.[187] Civil Injunctions and Conditional Cautions can directly require people to engage with positive interventions such as treatment services.

Acceptable Behaviour Contracts are not a legal power, but are a voluntary agreement which if ignored can be the precursor to more assertive responses such as a Civil Injunction.
Conditional Cautions – a custody sergeant can choose not to pursue a prosecution with an arrestee if a person attends a named service. If the person does not attend, the prosecution can be pursued.[188]
Civil Injunctions and Criminal Behaviour Orders replaced the anti-social behaviour orders. They can be used to target individual drinkers with both bans and requirements for interventions; however, this will require the gathering of sufficient evidence to satisfy a court. The Civil Injunctions are likely to be the most powerful of the individual orders. NHS Protect can also apply for these injunctions for drinkers who are repeatedly disruptive in hospital. Health services in Bury have pursued this route.[189]

Practical problems also exist with the use of legal frameworks:

- The cost of a Civil Injunction will be, at least, £1,200 for an initial hearing, exclusive of the cost of staff time. Breaches will cost several hundred pounds.[190]
- Arresting someone who breaches an order can involve significant police paperwork, cell time, checks by staff, medical assessment and cleaning of the cells. The detention of drunken individuals also runs a heightened risk of death in custody.

As indicated in the main report, evidence suggests identifiable benefit to drinkers from the use of individual orders. However, there is a clear need for the development of model "requirements" for orders such as the Civil Injunctions. What should the requirements and restrictions look like on an order for someone like Angela Wrightson (who received an order that simply banned her from every licensed premises in the country)? [191] It will also require the commissioning of alcohol services that can contribute to such orders.

Other powers available to target street drinkers

Licensing Act 1902

Section 6 of the Licensing Act 1902 includes a provision to declare an offender a habitual drunkard. This is possible on conviction for a third offence under Schedule 1 of the Inebriates Act 1898 within a twelve-month period. Schedule 1 includes an offence of failing to leave licensed premises when asked to do so or attempting to enter licensed premises after being requested not to do so (s 143 Licensing Act 2003). A habitual drunkard commits an offence if, within the three-year period, he buys or obtains, or attempts to buy or obtain, alcohol on relevant premises. A person commits an offence if they knowingly sell or supply alcohol for consumption by a habitual drunkard.

The concern is that this power could be used inappropriately with someone who is dependent on alcohol, and lead to an unintended alcohol withdrawal. Its powers would best be used in conjunction with a positive requirement such as a treatment package.

Injunctions for public nuisance under S222 of the Local Government Act 1972 is a trespass injunction that can restrain perpetrators from entering locations and committing ASB or criminal offences. However, judicial rulings have indicated that this can only be used when a civil injunction can be shown not to be appropriate.[192]

Section 152-153 of the Housing Act, 1996 can be used to restrain the anti-social behaviour of drinkers where it is interfering with a housing function.

The **Vagrancy Act 1824** (5 Geo. 4. c. 83) makes it an offence to sleep rough or beg.

A **Community Protection Notice** can be issued under the 2014 Anti-Social Behaviour Act. The notice can be developed from scratch if necessary so that it is appropriate to any situation and can include any or all of the following:

- A requirement to stop doing specified things;
- A requirement to do specified things;
- A requirement to take reasonable steps to achieve specified results.

This means that not only can the relevant officer stop someone being anti-social, but they can also put steps in place to ensure the behaviour does not recur.

However, the guidance on the Act is clear that it cannot be used for: “more serious conditions, such as attendance at a drug rehabilitation course, (which) would clearly be more appropriate to a court issued order.”

The Community Protection Notice can be preceded by W**arning Letters** sent to perpetrators of anti-social behaviour (ASB) with the aim of deterring them from displaying further ASB. However, they have no legal sanctions, other than providing evidence of earlier agency action if it is decided to take more formal enforcement action.

Conditional cautioning / alcohol bail conditions Bail conditions resulting in exclusion orders are occasionally used to restrict offenders from using town centres. The idea is to ensure that the drinker is dissuaded from returning to the areas where s/he commits crime.[193] Conditional cautions guidance can be found at: http://www.cps.gov.uk/Publications/directors_guidance/adult_conditional_cautions.html

Fixed penalty notices - Police are now able to give tickets (on the spot fines) instead of arrest. It was felt unlikely street drinkers would pay the fine and would serve the alternative day in prison. [194]

Community Safety Accreditation Schemes are a means by which a Chief Constable may grant a limited range of police powers to employees of non-police organisations who contribute towards community safety e.g. neighbourhood wardens. Community Safety Accreditation Schemes were created under section 40 of the Police Reform Act 2002. Individuals who have been granted these powers are known under the Act as **Accredited Persons**.
Appointeeships - a person can be appointed to receive another's benefits on their behalf: this can be a harm reduction measure allowing the payments to be spread out over e.g. a week. However, this is not a legal power in the sense that it can be imposed and enforced without the engagement of the recipient.[195]
Mental Health Act 1983 (and subsequent revisions) – people can be assessed and possibly detained or treated if they also have a mental disorder or the suspicion exists that they have a mental disorder as defined by the Act.[196] [197]
Not adhering to treaty rights - East European street drinkers may be deported by the Border Agency for not adhering to European Economic Area treaty rights.

Support material part 9
Work in partnership with the retail trade

This section supports section 7.5 of the main document: **Work in partnership with the retail trade**

It contains more detailed information on:

- **Approaches to working with the retail trade**
- **The proposal for a CAP type approach targeting street drinkers**

Street drinkers depend on a local supply of alcohol. They tend not to buy large quantities for fear that it will be confiscated, or that they will be targeted by other drinkers. Therefore, most need to be near shops. A London School of Economics study identified the number of off-licences in an area as a sustaining factor for street drinking.[198]

Price is an important factor for street drinkers. Interviewees agreed that the cheap price of drinks such as white cider and strong lager allow higher levels of consumption. It is not possible to say that raising the price of these drinks would reduce street drinking but it is likely to reduce consumption which will have the potential to reduce harm.

The main document sets out five main forms of enforcement in the retail sector:

- The use of cumulative impact zones to control the number of licensed premises.
- The enforcement of the law on not selling to drunken individuals – particularly in off-licences.
- Reducing the strength campaigns which inhibit the sale of high strength beers and ciders favoured by street drinkers through voluntary means.
- Inhibiting the sale of single cans of high strength beers and ciders through voluntary means.
- Refusal to serve initiatives targeting locally identified problem drinkers.

Cumulative impact policy

Provisions to manage cumulative impact are part of the Licensing Act 2003. Further information is available in the statutory guidance issued under section 182 of the Licensing Act 2003: https://www.gov.uk/government/publications/explanatory-memorandum-revised-guidance-issued-under-s-182-of-licensing-act-2003

Selling to intoxicated individuals

Sales to intoxicated customers are regulated under Sections 141 and 142 of the Licensing Act 2003. Section 141 states that:

A person [. . .] commits an offence if, on relevant premises, he knowingly –
a) Sells or attempts to sell alcohol to a person who is drunk, or
b) Allows alcohol to be sold to such a person

Section 142 states that: *A person commits an offence if, on a relevant premises, he knowingly obtains or attempts to obtain alcohol for consumption on those premises by a person who is drunk.*[199]

http://www.legislation.gov.uk/ukpga/2003/17/contents

Similar regulations existed prior to the 2003 Act, but have been poorly enforced. The frequency with which street drinkers buy alcohol means that at times they will visit shops in states of obvious intoxication. As an alternative to prosecution in the courts, police constables

or other authorised officers could issue a Fixed Penalty Notice (FPN) to anyone who 'Sells or attempts to sell alcohol to a person who is drunk'. [200]

The main report highlights that, for an offence to occur, staff need to 'knowingly' serve drunk customers, creating a high evidential bar. Perhaps more importantly, a survey by the Association of Convenience Stores (ACS) found that retailers often felt intimidated, or risked physical assault, if they refused to sell to a person who was drunk.[201] [202]

A Demos report suggests a more nuanced approach to this issue. [203]

http://www.demos.co.uk/project/sobering-up/

Shops need support and advice to deal with known customers with alcohol dependency
Many retailers spoke of their responsibility to the community in which they serve and struggling to deal with known dependent drinkers. However, unlike for underage drinking, there is no clear national message for the off-trade in how to deal with excessive alcohol consumption. We found that there is a significant grey area, and much confusion, about the role of retailers in refusing to serve dependent drinkers. This leaves shop owners and those on the till to make decisions about how best to deal with potentially dependent customers. For example, we heard one was trying to wean a customer off high-strength alcohol, while another expressed uncertainty about whether keeping certain drinks artificially low in price was better for those with severe problems who may otherwise resort to crime or the black market. There is therefore space for greater partnerships between shops and charities that work to support dependent drinkers. [204]
`

Local schemes should be developed that make it possible for substance misuse workers and other support charities to work with local shops and provide guidance about how to identify and deal with dependent drinkers
Our research found little interaction between local shops and local charities that work to support dependent drinkers. Where appropriate (for example, in areas with high alcohol-related harms), local authorities should consider sending out substance misuse workers, or facilitating the involvement of local charities, to advise local shops on how to deal with those customers with dependency issues. [205]

Reducing the strength
One of the most important recent initiatives in tackling street drinking has been the roll out of "Reducing the Strength" schemes. As the main report states, Local Government Association guidance already exists on these schemes and provides a more detailed review. This can be accessed at:

http://www.local.gov.uk/documents/10180/5854661/L14-350+Reducing+the+Strength_16.pdf/bbbb642e-2bcb-47d4-8bea-2f322100b711

Single can sales
A variation on *reducing the strength* is to dissuade single can sales. *Bournemouth implemented an agreement on not selling single cans of strong ciders and lagers as part of a wider reducing the strength campaign.* It is unclear whether this has been effective. It was reported that some shops will sell multiple cans but allow the drinker to return and take cans one by one. This is not illegal.[206]

Refusal to serve initiatives: The Association of Convenience Stores suggests that where a small number of street drinkers are being targeted by reducing the strength, *"it may be more effective to focus on not serving those individuals rather than removing products for all*

customers. These initiatives are challenging, and require engagement from local groups which help street drinkers..."[207]

https://www.acs.org.uk/advice/reducing-the-strength/

Overview of retail initiatives

Retail initiatives alone are unlikely to have a significant impact on street drinking. It is also hard to rigorously demonstrate that these schemes work: too many variables influence the level of street drinking. Where *reducing the strength* schemes have been successful, they have been part of a combination of initiatives.[208]

A wider concern is whether these campaigns will push people towards other negative behaviours. One study concluded that: "Individual drinkers attempt to maintain intoxication by adapting to the intervention in different ways, including finding alternative shops, switching drinks, using drugs, or committing crimes…there were mechanisms for both positive and negative impacts on individuals' health and on the local environment."[209] Again this is an argument for these approaches being one of a set of measures.

On the positive side, these campaigns have the benefit of creating a dialogue with retailers about street drinking and the importance of responsible retailing given the impact of low price, high strength products on street drinkers. In Portsmouth and Ipswich, some of the success of the local schemes may be attributed to the time and effort put into engaging with and educating retailers. A further benefit is improved welfare among shop staff who are not having to deal with challenging individuals.

Although some retailers will sell inappropriately, others may be doing so to avoid problems for their staff or because they believe that they are helping a drinker through ensuring the person does not go into withdrawals. Efforts should be made to pick up on the Demos report proposals to create an ongoing, and possibly national, educational and supportive dialogue between those providing alcohol interventions and those selling alcohol.

Developing a Community Alcohol Partnership (CAP) style approach

A key recommendation of the main report is the need to develop a CAP type approach with the drinks industry to target street drinking. This will enable the development of training packages for shop staff as well as guidance on best practice and supportive materials such as posters and leaflets.

CAPs were developed by the Retail of Alcohol Standards Group to help communities tackle underage drinking. They are now run by an independent Community Interest Company with partnership schemes across the UK. It is supported by many of the leading alcohol retailers.[210]

A consensus emerged from the interviewees for this project that a nationally developed partnership approach to street drinking that mirrored the CAP would be of benefit. This would provide a framework for local joint working and training and build in the business and retail sector. Resources such as posters for retailers on "not selling to drunks" would be a useful part of this development.

Support material part 10
Broker agreements between mental health and substance misuse services

This section supports section 7.6 of the main document: Broker agreements between mental health and substance misuse services

It contains more detailed information on:

- **The links between mental disorders and substance misuse**
- **National guidance**

An important sub-theme in working with street drinkers is the presence of mental health problems (see data in Support material part 1 above). A significant proportion of problem drinkers will also have a mental health problem. This combination is associated with high levels of suicide, self-harm and violence to others and makes clients difficult to engage in services or treat effectively.

A National Statistics study found that 27% of people with severe and enduring mental health problems had an AUDIT score of 8 or more – that is, they were found to have a hazardous level of drinking in the year before interview, including 14% who were classified as alcohol dependent.[211]

National concern is also growing about the number of people who are suffering alcohol related dementias such as Wernicke-Korsakoff Syndrome. Post-mortem studies suggest that Wernicke-Korsakoff syndrome occurs in about 2% of the general population and 12.5% of dependent drinkers.[212]

Most areas consulted reported that it is hard to secure help from mental health services for street drinkers and people with alcohol problems generally.[213] One report called the response *stigma and exclusion*.[214] This problem may have worsened since 2013, when mental health services became the responsibility of Clinical Commissioning Groups: alcohol services are commissioned by local authority public health teams.

Client comment

- *I can't get support from mental health services; when I have been to hospitals, I have felt like I have not been treated with much respect.*

The following documents provide the framework within which that care should be provided:

- Psychosis with coexisting substance misuse – NICE Clinical Guideline 120 – 2011[215]
- Dual Diagnosis Good Practice Guide - Department of Health Policy Implementation Guide – Department of Health – 2002[216] *(This document is currently being revised).*
- A guide for the management of dual diagnosis for prisons - 2006[217]

These documents make it clear that mental health services have the lead responsibility for, at least, some of this client group. In particular, the documents make clear that requiring someone to be free of alcohol before entering mental health services is not a clinically validated response. It will place a real barrier in the way of clients accessing vital help.

- If appropriate, those working with street drinkers should seek help from mental health services and be persistent if they feel they are not receiving a response that meets the client's needs.

- Accessing help will be much easier if managers and their teams have taken time to previously build a relationship with local mental health services.
- If problems persist in securing help, staff should talk to their managers and they should talk to managers and commissioners of mental health services.
- If help cannot be secured it is vital to record unmet need and report this to commissioners.

Support material part 11
Build constructive pathways from hospitals and prisons into the community

This section supports section 7.7 of the main document: **Build constructive pathways from hospitals and prisons into the community**

It contains more detailed information on:

- **The impact of alcohol in hospitals and the prison system**
- **National guidance**

Hospital

The government's *Statistics on Alcohol, England, 2016* reported that:

- In 2014/15, 1.1 million estimated admissions had an alcohol-related disease, injury or condition as the primary or secondary reason for admission: 3% more than in 2013/14.
- In the same year, an estimated 333,000 admissions had an alcohol-related disease, injury or condition as the primary diagnosis or there was an alcohol-related external cause. This is 32% higher than 2004/05.[218]

The Department of Health estimates that 35% of A&E attendances in the UK are attributable to alcohol, increasing to 70% between midnight and 5am.[219]

Irrespective of the impact of street drinkers, alcohol misuse is a major cause of problems to hospitals and their staff. Therefore, at the very least, a clear pathway for problem drinkers ought to exist between the hospital and the community. At best, a specialist *alcohol liaison service* will exist in the hospital.

These are aspirations with clear support from Public Health England:
http://www.alcohollearningcentre.org.uk/_library/Alcohol_Care_in_Englands_Hospitals_An_opportunity_not_to_be_wasted_PHE_Nov_14.pdf *(This document describes specialist hospital alcohol services).*

http://www.alcohollearningcentre.org.uk/Topics/Browse/Hospitals/

On the basis of the PHE guidance, Police and Crime Commissioners and their partners can justifiably argue for the development of the hospital response to problem drinkers generally, and specifically to street drinkers and other high impact drinkers.

If street drinkers are attending the hospital:

- Are appropriate efforts being made to identify and engage the problem drinker in the hospital?
- Is there an alcohol liaison service?
- Is there a pathway from the hospital to alcohol services?

Prison

As with the hospital, alcohol misuse is a common problem in the prison population. Nearly two-thirds of sentenced male prisoners (63%) and 39% of female sentenced prisoners admit to hazardous drinking prior to imprisonment which carries the risk of physical or mental harm. Of these, about half have a severe alcohol dependency.[220]

Although this cannot be quantified, evidence from the interviews indicated that short prison stays are common in the street drinking population.[221] However, less national guidance exists on the pathway for problem drinkers in prison than for those in hospital.

Nonetheless, given the likelihood that street drinkers will emerge in the prison system, it will be important for PCCs and their partners to ask both prison and Community Rehabilitation Company managers whether:

- appropriate efforts are made to identify and engage high impact problem drinkers in prison?
- a pathway exists from the prison to community alcohol services on release?

Support material part 12
Encourage staff training

This section supports section 7.8 of the main document: **Encourage staff training**

It contains more detailed information on:

- **The potential content of training for those working with street drinkers.**

A key message of Alcohol Concern's *Blue Light* project has been that working with high impact drinkers is a skilled task. Staff specialising in working with street drinkers need a solid foundation of knowledge about alcohol and its effects and skills in engaging both clients and other potential sources of help. Anyone working full-time with this client group will benefit from knowledge of:

- Assessment and care planning skills.
- Alcohol and its physical effects: the management of alcohol related harm requires an understanding of how alcohol affects the body.
- The impact of nutrition on drinkers' health.
- Mental disorder and mental health legislation: many of these clients will have mental disorders. It is important to understand the range of psychiatric effects so that workers can discuss, for example, whether someone has alcohol related brain damage or psychosis.
- Guidance on safeguarding vulnerable adults: many in this group are vulnerable. Workers need to understand the risk and reality of abuse and exploitation and the vulnerable adults' framework.
- Basic counselling skills e.g. non-verbal communication and active listening skills.
- The principles of motivational interviewing: particularly that challenging and confronting people is not an effective way to motivate change. [222] [223]
- The boundaries of one to one working e.g. keeping oneself safe.
- How to keep accurate client records.
- Good communication and conflict resolution skills.[224]

Staff who simply encounter this group of clients in the course of their daily work will not necessarily need this range of skills. However, Alcohol Concern's one-day course on working with change resistant drinkers suggests generic staff should be able to:

- Identify the high impact drinkers who need to be targeted.
- Understand the rationale for attempting to intervene with this client group.
- Understand the physical and psychological effects of alcohol.
- Understand why drinkers may resist change.
- Understand the range of techniques available for use with this group including risk management, nutrition and harm reduction approaches.
- Understand the legal powers available to manage this client group including the new anti-social framework.
- Formulate a realistic intervention plan for a change resistant drinker.

Support material part 13

This section supports section 7.9 of the main document: **Ensure performance indicators are built in to any response**

It contains examples of:

- **Performance indicators**

The main report describes a number of possible indicators. This section provides two examples of local monitoring schemes.

In Lincoln, a number of measures were identified in the local street drinking strategy[225]:

Indicator	**Data set**	**Source**
Number of Street Drinker related incidents	Shop thefts, street drinking, drunk and disorderly within set time parameters	Police incident database
Number of Alcohol related ASB Incidents		Police and City Incident Database
Number of Supportive Enforcement Tools Used	Data set of ABCs, alcohol reduction seminars by alcohol service	Alcohol Service and City Council Database
Number of Restrictive Enforcement Actions by City Council	Previously ASBOs and Drink Banning Orders but now Civil Injunctions and Criminal Behaviour Orders	City Council Database
Number of identified street drinkers		Joint Team Exercise
Perception of Businesses / Local Residents		Survey / Policing Panels and Neighbourhood Boards

The table below describes the key outcomes the commissioners aimed to achieve through the Liverpool REST Centre: a wet centre targeting street drinkers (see Support Material 14):

Outcome	Measure	Source
Reduction in the use of alcohol in public places by the street drinking cohort	Reduction in arrests for begging Reduction in alcohol seizures or alcohol related interventions for street drinking offences directly attributed to the street drinking cohort. A top 20 cohort of street drinkers will be established against whom activity rates will be measured.	Merseyside Police
Reduction in crime and anti-social behaviour	Reduction in the number of Section 27 Notices	Merseyside Police

Outcome	Measure	Source
Reduction in level of threat in the surrounding area	Identify streets within catchment area on Police ASB Matrix and measure reduction in threat (and whether streets come out of ASB Matrix)	Merseyside Police
Improve the health status of the street drinker	Outcomes for the individuals: • Satisfaction for street drinkers • Reduction in alcohol consumption • A reduction in the level of recorded A&E attendance amongst the top 10/20 complex needs clients managed via Brownlow Practice • Numbers attending the REST Centre • Number of repeat visits per individual to the REST Centre • Increase in registration with GP Practice • Numbers of referrals made to health service support • Numbers of appointments attended • Perceived improvement in well-being • Safety / enforcement outcomes for street drinkers • Health outcomes achieved (wounds attended, vaccinations provided, access to vitamin substitute (thiamine) etc.	REST Centre Service A&E, Royal Liverpool University Hospital Brownlow Practice Evaluators (interviews with street drinkers, observations)
Improved accommodation for Street Drinkers	• Reduced levels of rough sleeping • Increased numbers maintain their accommodation	REST Centre Service Adult Services
Increased feelings of safety and increased satisfaction with Partnership action to tackle drink related anti-social behaviour	• BID Survey of the satisfaction of businesses • Survey of residents in the affected areas • Environmental impact (noise, litter, or other issues)	BID Evaluators (residents' survey) City centre management

Outcome	Measure	Source
To work with and involve local retailers of alcohol to support outcomes by introducing effective supply control measures.	• Number of off licence premises visited and trained in relation to street drinker needs and control measure policies • Number of premises who agree to: a. An interim 'Reduce the Strength' policy removing from sale super strength >6.5% lager and cheap ciders, or b. Supply control by only selling super strength in multiples of 4. • Reports from service facility that actions have resulted in drinkers using a less harmful product.	Alcohol and Tobacco Unit REST Centre Service

Learning lessons from serious incidents: Serious incident reviews in substance misuse services are a means of learning lessons about high-impact drinkers. Lessons may also be learned from other inquiry processes e.g. serious incidents in mental health services. The main report highlighted how street drinking featured in both domestic homicide reviews and safeguarding death reviews.

Since 2000, it has been seen as good practice for local areas to learn lessons from drug related deaths. Although this is not consistent, many areas have set up a system of drug related death reviews. Guidance on these can be found at: http://www.nta.nhs.uk/uploads/drug_related_deaths_setting_up_a_local_review_process.pdf

In some areas, e.g. Wandsworth, these schemes have also covered some alcohol related deaths. Moreover, some ostensibly drug related deaths may have alcohol as a key contributory factor. Developing alcohol and drug death review systems may provide important lessons about reducing alcohol related harm generally and street drinking specifically. Sample protocols for such a scheme (from the London Borough of Merton) are available at: www.safesociable.org.uk

Support material part 14
Other interventions

This section supports section 8 of the main document: **Other interventions**

It contains more detailed information on:

- **Environmental interventions**
- **Wet centres**
- **Toleration zones**
- **Wet activities**
- **Access to wet houses**
- **Specific medical services for street drinkers**

The nine actions explored above are not the only approaches to tackling street drinking. However, they are probably those which will have the most widespread use. Other possible approaches include:

- Environmental interventions
- Wet centres
- Toleration zones
- Wet activities
- Access to wet houses
- Specific medical services for street drinkers

These interventions are either too geographically specific (environmental approaches) or focused on the highest risk areas, for general recommendation. These are explored below.

Environmental interventions

Street drinking can be tackled by adapting the local environment to make it harder to drink in public or to reduce its impact on the community. Examples include:

- The removal or re-location of benches or other street furniture
- Alleygating to bar access to semi-covert drinking locations
- Increasing the provision of litter bins
- Making toilet facilities more available
- Reviewing street cleansing
- Changing the management of parks and open spaces
- Increasing or changing the CCTV coverage in an area.[226] [227]

- *Stafford - a bus shelter acting as a meeting point for street drinkers was removed.*
- *Bournemouth station was redesigned to discourage street drinking.*
- *Brighton - benches have been removed, in various locations, to reduce street drinking. This has been successful in some, but not all locations.*
- *Lambeth - park benches have been replaced with single seats facing in different directions.*
- *Lichfield - CCTV coverage was felt to have helped reduce street drinking.*

Environmental approaches can be effective but are dependent on the local context. Removing low walls or benches can reduce gathering places and drinking locations. However, it may also reduce amenities for local people and may push drinkers into more

hidden locations. The public may find street drinkers less intimidating on main thoroughfares than pushed into alleys and cut-throughs.

Toleration zones / designated areas

A toleration zone or designated area for street drinkers is a public or semi-public location where drinkers can gather and the laws on street drinking will not be rigorously enforced. This approach has not been extensively used in the UK.

Ipswich designated an area of waste ground as a toleration zone for about 15 months. The area was covered by CCTV, regularly patrolled and allowed a focus for welfare and rehabilitation interventions. A similar, but more short-lived, initiative was put in place in Lambeth, but this was not renewed when a change to road layouts required its closure.

Evidence for the effectiveness of toleration zones is limited. The main example was the relatively short-lived initiative in Ipswich. The partners viewed the initiative positively; however, it was not subject to any significant evaluation.[228]

Such zones may work, but would certainly impact negatively on some drinkers and some members of the public. The approach would need careful monitoring and risk assessment. Pulling drinkers together in one place could increase intimidation of passers-by. It could facilitate violence, aggression or exploitation among the drinkers. Many street drinkers will have serious health problems or impaired mobility; for these people a drunken shove could have potentially fatal consequences. This guidance cannot endorse such an approach outside of robustly monitored and evaluated pilots.

Wet day centres

An alternative to a toleration zone is a “wet” day centre where street drinkers can congregate and continue to drink, but out of the public eye in a staffed facility. Such centres aim to:

- provide support, harm reduction and treatment;
- offer alternative activities;
- build links into specialist or mainstream agencies;
- help people desist from anti-social behaviour without criminalising them.[229] [230]

A 2003 study identified that the first wet centre was established in Dundee in 1978 and, in 1991, the first was set up in England (Nottingham). In 2003, eight centres were operating in the UK including London, Leicester and Manchester. However, this appears to be the high water mark of such developments. Some have now closed and recent developments appear to be biased towards assertive outreach. The exception is the Liverpool REST centre which has operated on a temporary basis in the last two years. This has been subject to a thorough review and by Liverpool John Moores University and appears to be having a positive impact.[231] [232]

The John Moores report is available at http://www.cph.org.uk/wp-content/uploads/2016/06/Evaluation-of-the-REST-Centre-Executive-Summary.pdf

However, problems exist with this model:

- Wet centres are an expensive resource both in terms of premises costs, and staffing to a level which ensures client safety.[233]
- Local residents and businesses may object. Liverpool experienced significant problems with neighbours in attempting to set up the REST centre.[234]
- Not all street drinkers will want to spend time drinking in such a setting. Some will feel threatened by other clients; some will prefer to drink in the open air.
- A wet centre may attract drinkers to an area, especially if neighbouring areas are enforcing street drinking bans.

- At the extreme, a wet centre may harm some drinkers by facilitating them drinking more regularly. In a Scottish study, 15% of users reported their drinking increased as when attending a wet centre.[235] [236]

Wet centres can have a positive role in tackling street drinking. However, outside large urban areas it is hard to argue that wet centres should be part of the initial response to street drinking.

Wet activities - Amsterdam model

A linked approach is "wet activities". No examples were identified in the UK; however, a Dutch government supported project paid street drinkers in beer to tidy parks in Amsterdam. 20 problem drinkers worked from 09:00 until 15:00 including breaks for beer, cigarettes and a hot lunch, which were provided free of charge. This was argued to be a cost-effective way to tackle the impact of alcohol…In 12 months after the programme started, police were receiving fewer reports of stabbings and muggings in the park. Residents were happy with government support for this approach but no wider evaluation exists.[237]

Medical services

Some areas with significant street populations have established medical services targeting street communities e.g. the Bristol Wet Clinic or GP practices in inner city areas such as Liverpool which have a specialism in homeless populations.

Wet houses

The most intensive approach to street drinking is to place individual street drinkers into a long-term residential wet facility: "a wet house". In some areas specific wet houses have been set up. In others, commissioners purchase a place from an existing wet house which serves a national catchment area. This approach is appropriate, and may even be necessary, for a small group of drinkers with impaired ability to manage their own lives. However, it will be too expensive an approach to be extended to more than a small group of street drinkers. Individual placements will probably be purchased using local authority funding via the Care Act.

Wet houses are effective at what they are attempting to achieve, but are expensive options which will be limited to placements for a small number of high risk individuals or to areas with a larger population of street drinkers.

Aspinden Wood Centre

The Aspinden Wood Centre is a residential care home in South London run by Equinox, part of the Social Interest Group. It has been providing long term accommodation for change resistant drinkers since the early 1990s. The centre serves people who have been drinking for many years and have additional problems related to exclusion such as homelessness. The residents have patterns of physical and emotional damage, social instability, broken relationships and volatile behaviour. Most will have been street drinkers. The centre offers a long term home and people can stay for many years: one has been resident for 20 years.

[1] Calculated by dividing the mid-point of the range by the number of unitary and second tier local authorities.
[2] Interviewee 12
[3] Interviewee 4
[4] Interviewee 6
[5] Interviewee 11
[6] Interviewee 17
[7] Interviewee 1
[8] Interviewee 18
[9] Interviewee 3
[10] Porter K. - Bristol 'Streetwise – Street Drinkers' Evaluation –Safer Bristol – March 2013
[11] Interviewee 9
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[13] Interviewee 15
[14] The background data for this estimate is to be found at www……
[15] Anderson-Weaver, Robert – Reducing the Strength: A Good Campaign? – Portsmouth City Council February 2014
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[19] Interviewee 6
[20] Safer Guildford - Report into the death of Adult A – March 2013
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[22] Porter K. - Bristol Wet Clinic Evaluation - NHS Bristol - 2012
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[27] Interviewee 12
[28] Interviewee 4
[29] Interviewee 8
[30] Interviewee 2
[31] Interviewee 6
[32] Interviewee 17
[33] Interviewee 1
[34] Interviewee 18
[35] Interviewee 15
[36] Interviewee 19
[37] Interviewee 3
[38] Luton Drug and Alcohol Partnership - Street Drinker Project 2014/15 - Tackling Street Drinking in Luton 2015
[39] Cullen N. – Street Drinking in Hounslow – Hounslow Drug & Alcohol Action Team and the Metropolitan Police - 2005
[40] Porter K. - Bristol Wet Clinic Evaluation - NHS Bristol - 2012
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[42] Ross A. et al. - An exploration of street drinking in Drumchapel, Scotland - HEALTH EDUCATION RESEARCH: Theory & Practice Vol.20 no.3 2005 Pages 314–322
[43] Russell S. - Evaluating the Effectiveness of an Assertive Outreach Service for Street Drinkers in Liverpool – 2010?
[44] Simon Danczuk - Walk on by…Begging, street drinking and the giving age – Crisis – 2000
[45] Interviewee 6
[46] Interviewee 2
[47] Interviewee 1
[48] Interviewee 18
[49] Interviewee 19
[50] Interviewee 3
[51] Luton Drug and Alcohol Partnership - Street Drinker Project 2014/15 - Tackling Street Drinking in Luton 2015
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[69] Russell S. - Evaluating the Effectiveness of an Assertive Outreach Service for Street Drinkers in Liverpool – 2010?
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[133] The Public Interest test applies when consent cannot be obtained or has been sought and refused. Circumstances that meet the public interest test are as follows:

- Promoting the welfare of children
- Protecting children or adults from significant harm
- The prevention, detection or prosecution of serious crime.

NB The Public Safety test applies when consent should not be sought The public safety test is met when to seek consent, or delay the information sharing while consent is sought would heighten the risk of significant harm to a child or adult at risk.
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