“Shelter From the Storm”: Identifying the needs of rough sleepers with alcohol problems.

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EXECUTIVE SUMMARY

This report describes the findings of a small qualitative study undertaken in Exeter, Devon in collaboration with St Petrock's, an established and highly regarded charity supporting people who are homeless or inadequately housed. Findings are based upon individual interviews with a number of people who have entrenched alcohol problems and with a current or recent history of rough sleeping.

1. Links between alcohol use and rough sleeping

* There is a comparatively small but persistent group of alcohol using rough sleepers who maintain very high levels of alcohol use, and who have long histories of homelessness and rough sleeping.

* As established in previous studies, the links between dependent alcohol use and rough sleeping are complex. In our sample we found that a significant alcohol problem had mainly pre-dated the transition to homelessness and that another crisis, often involving a significant relationship breakdown, triggered a precipitation to a pattern of rough sleeping and drinking. Most respondents described their use of alcohol as a way of managing pain over long periods of time and a number linked the onset of alcohol dependence to early family difficulties.

* Alcohol use, and the need to maintain this throughout the day, remained for most a 'central organising principle'. In other words, there was a conscious awareness, throughout the day, of where and how the next drink would be obtained. This routine was linked around other regular daily activities.

* Respondents described various levels of willingness or capacity to change either their drinking or rough sleeping. Most struggled to really explain to us or themselves exactly why they continued to live their lives in this way and why such a difficult lifestyle continued year after year, given their descriptions of risks and of the negative consequences when weighed against what appeared the relatively small advantages. When asked about the possibility of change, there was very

strong sense, in a number of interviews, of being unable to get past the presenting reasons for alcohol use. This appeared to link in some way to the role that alcohol continued to play as a 'holding mechanism' allowing feelings to be blocked and as a form of self medication in terms of physical and mental health as well a providing a form of social networking and routine .

* Respondents described detailed and highly routinised days from rising in the morning to settling down to sleep. This routine was influenced by a number of contingences. These included sleeping arrangements; avoidance of risk from attack or insult; the maintenance and supply of alcohol (availability, proximity to off licence; social contact in parks) and Day Centre and other support activities .

2. Motivation to change

* Some respondents expressed a strong sense of ennui – a complete lack of capacity to envisage change, or a feeling that they had been on the streets so long they could not move into accommodation. Those that did express a need for change were often older and felt that they were going to have change because of the deterioration in their health and the toll on their bodies (particularly in winter) as they got older.

3. Rough sleepers' views of services

* Whilst 'first line' support services for alcohol problems were seen as good, there appeared to be a problem with many in this group moving on from entrenched dependence and rough sleeping.

* The availability of good support systems appeared to offer not only respite and some protection against risk but also a potential oasis where there was the potential to identify opportunities and motivation to change. Respondents were very positive about basic support services (except for provision of emergency shelter) and the attitude and response of professionals. Other opportunities in relation to fostering motivation particularly regarding outreach services were identified. Support, provision for and systems to move out of and from dependent alcohol use and break established patterns were identified as far more problematic.

4. Rough Sleepers' Suggestions for Changes to Services

Many respondents had ideas for either additional services or suggestions for the way in which additional services could be developed or changed. A number suggested the need for some kind of night shelter. Several people felt there needed to be more support offered on discharge from hospital in terms of accommodation.

Others felt that there should be better co-ordination in terms of gaining accommodation. There was a also a view that street drinkers would benefit from, and perhaps be more motivated by, more regular outreach contact, particularly in the evenings and when engagement and motivation to change may be more productive. Designated drinking or wet areas, if developed, may help prove a potential point of contact for other services to link to street drinkers. In fact, in terms of basic support services the most consistently observed omission was a night shelter or wet or dry provision. This highlights the need to maximize times or geographical spaces where workers might have more success in building motivation to change.

5. Professional views on the challenges and responses needed

* Professionals recognised a significant barrier to engagement with this group in terms of lack of motivation to change based on a complex relationship with alcohol alongside the daily struggle of survival when coping with the extreme realities of rough sleeping. These factors meant the group was often entrenched in this lifestyle and resistant to more formal approaches to support.

* It was felt that a series of small, low key interventions were particularly effective with this group, in terms of developing trust and forming the basis for future support. It was recognized that the local Homeless Resource Centre (HRA) was well placed to provide the backdrop to these interventions as it was an environment which the target group was regularly accessing and in which they appeared to feel comfortable and relaxed. These interventions needed to be

consistent and a model of intervention based on a stepped care approach could be accessed through a locally run training programme.

6. Responding to Issues of Risk

* The issue of risk was strongly highlighted by rough sleepers and professionals. These included internal risks due to mental and physical health problems and alcohol related conditions and external risks which took the form of threats, intimidation and possible violence, especially at night. This was a consistent theme across the interviews.

* Risks in relation to withdrawal, hypothermia etc were seen to be problematic particularly in winter months. Professionals expressed concern about providing direct advice about drinking when they were unaware of the exact nature of the drinking habits of this group. There was a clear identification of the risks around problematic and long term alcohol users suddenly abstaining from use without the overview of a medically based specialist and prescribing agency. A harm reduction model was therefore seen as most effective approach with this group at an early stage of engagement.

7. Change and accommodation

There were many identified difficulties in terms of being able to move out of a cycle of homelessness and alcohol use. As we have seen, for the majority of those interviewed, there appeared to be a slow but progressive immersion into a lifestyle that indicated that significant change was going to be problematic. There was also a strong seasonal element in the maintenance of this way of living, with many suggesting that, in the summer months, there was no motivation to seek accommodation although there was a need to seek respite in the harsher months.

* Moving on to accommodation did not appear to be a successful transition for a number of respondents who had been through this process. Many respondents had had experiences of hostels and detox. These had not always been positive and at least two respondents felt that a local hostel provided unsuitable accommodation, combining unnecessary restrictions

with open drug use, making for an unsafe environment, and one that few people were likely to choose over the risks but freedoms of street life.

* Accounts suggested that many felt little motivation to access what was on offer, in terms of the next stage of sorting out their alcohol problems and establishing a more settled way of life. This seemed to highlight a gap in the pattern of service provision that could theoretically provide a real opportunity to move out of the rough sleeper/drinking culture.

* The '*Winter Pressures Scheme'* and the recently piloted '*Individual Budget Scheme'* allowed a more flexible approach in which accommodation was easily and readily available and in the later, longer term support packages could be tailored to meet the specific needs of individuals.

* This in effect provided much needed respite and opened the way for contemplation of longer-term accommodation and a fundamental change in lifestyle. The group felt that this initiative could be built on, if a direct access hostel existed targeted specifically at alcohol users. It was noted that at present this group did not consider the local hostel to be an option as it was seen as dominated by heroin users.

8. Inter Agency Working

* Inter-agency working was seen as largely positive and in particular the range of drop-ins provided at St Petrock's allowed this group access to services in-situ. However there could be improvement in the lines of communication between more specialist alcohol and mental health services and front line services, allowing a more co-ordinated approach with this group. It was felt this could be achieved by inviting these more specialist services to visit the relevant agencies in order to facilitate an improved understanding and allow a development of professional relationships. It was also noted that future forums based on the model for this focus group were a useful contribution to inter agency working, the group felt allowing individuals the time and space to reflect on their practice and explore a range of dilemmas and concerns.

FINAL RESEARCH REPORT – "Shelter From The Storm"

Introduction

This report describes the findings of a small qualitative study undertaken in collaboration with St Petrock's, an established and highly regarded charity supporting people who are homeless or inadequately housed. Its aim was to gain a better understanding of the link between dependent (hazardous) drinking and rough sleeping, in order to improve interventions and outcomes for this group.

The specific aims of the research were:

* To gain a more detailed understanding of the characteristics of this group, the links between hazardous and dependent drinking and rough sleeping and whether there have been critical events or turning points in people's life histories which have led to these outcomes.

* To establish whether different types of professional intervention have helped, hindered or influenced trajectories of drinking and rough sleeping and to explore clients' experiences of services/intervention in relation to tackling alcohol use as well as what motivates change.

* An exploration of the practice dilemmas and challenges of working with this group, as identified by the main provider and its partner agencies.

* To establish what additional resources, knowledge, understanding and/or skills might be needed to respond more purposefully and effectively to this group.

Background

Against the background of Government initiatives to reduce the problem of street homelessness, St Petrock's staff, over the last 8 years, have identified alcohol misusing rough sleepers as a group that present very significant challenges that go beyond the more simplistic central and local initiatives to merely move these people on to obtain accommodation. Local policy has reflected national initiatives for this group, with attempts to incorporate two 'driving aims' of reducing rough

sleeping down to as close to zero as possible, and of improving the opportunities and outcomes for former rough sleepers" (Exeter City Council Homelessness Strategy 2008-2013).

Experience suggests that a significant number in this group have complex needs. St Petrock's estimates that approximately 45% of this group are alcohol dependent, a figure comparable with data from other cities. For example Fountain et al (2003), in their survey in London in 2003, found that 37% were found to be alcohol dependent - slightly lower, as they point out, than previous estimates of the 50% of some government estimates.

In their experience, as the lead agency tackling homelessness in the city, St Petrock's found that this client group resist or find change hard and, consequently, it is seen that support to this group is variable. As a result, the organisation has identified an urgent need to improve the effectiveness of responses and approaches to this group due to what have been seen as the difficulties of helping them achieve change and the often high risks related to their lifestyles. This is underlined by the number of health problems and deaths that have occurred in the last two years. The problems experienced by this group and the perceived difficulties presented may be seen to represent a microcosm of the issues and challenges of working with this group more widely. Whilst, therefore, there are regional variations and this project cannot be seen to be representative, learning may be usefully transferred to similar settings across the country.

There has been significant growth in the research into homelessness particularly from the 1990's onwards. This has included research into what has been defined as 'absolute' homelessness i.e. having no shelter at all or 'rough sleeping' (McNaughton 2008 (a), p.4). The focus of such research has included the contested and complex nature of such a definition (Fitzpatrick and Kennedy 2000) and the link with other marginalised social problems (Anderson and Tulloch 2000). Alongside this, research studies have examined the complex links between both homelessness and rough sleeping and alcohol and drug problems, including the key factors which may lead to or exacerbate this link (Orwin *et al*. 2005). Despite this, some recent commentators have suggested that there is a comparative paucity of theoretical knowledge about the interaction between these

factors, particularly those that might be translatable into specific practice outcomes (McNaughton 2008).

St Petrock's practice experience with this group has also been reflected in recent research, identifying the problems, barriers and limited aspirations of those experiencing dual pressures of homelessness and alcohol use. The relevant research from the addiction field, in this regard, includes the psychological and sociological reasons for attachment to alcohol (and drugs), and the difficulties of relinquishing such attachments when they are influenced by family trauma, social problems and stigma (Kroll and Taylor 2003; Etherington 2008; Orford 2001; Warnes and Crane 2006; Velleman and Orford 1999; Dench, Gavron and Young 2006; McNaughton 2008(b). This has interesting links with emerging studies from the housing field concerning the social and psychological factors contributing to repeat homelessness ('multiple exclusion') in particular, and the part that social identity can play, in terms of internalisation and resistance to change (Fitzpatrick 2006).

The need for more research into individual pathways to rough sleeping and alcohol use, re-enforcing cycles of exclusion and marginalisation, and ways to help people manage a transition out of such situations have been emphasised by both researchers and funding organisations (Carter 2007). Consequently, this study hopes to both build on and add to emerging research in this field, with a particular emphasis on practice development.

Ethics

Throughout the period of the study, the research team has worked closely with Pam de Clive-Lowe from the local Research Governance Management Unit. The principles of informed consent the production of interview schedules and other procedures have been discussed and approved. All names used in this are pseudonyms.

Methods

Mixed qualitative data-collection methods were employed. This involved 11 interviews with 'rough sleepers' who had a significant problem with alcohol use and a focus group with key professionals who provide interventions for this group.

(i) Individual interviews

Eleven in depth interviews were undertaken. This is a potentially 'hidden group' and access was gained via the respondents' use of St Petrock's day centre where the interviews were conducted. An 'interview as conversation' schedule was used based around the core themes of the research, although a central aim was to allow for an in depth discussion with the opportunity for respondents to talk about their own individual experiences at some length. Interviews lasted from 50-90 minutes. All interviews were taped, by consent, and transcribed verbatim.

(ii) Focus Group

Key professionals from within the locality who had regular and ongoing contact with this client group were identified and invited to the focus group. A focus group schedule based on challenges, dilemmas and issues presented by this group was developed. The professionals who attended the group included workers from St Petrock's, the local street homeless team, and representatives from local alcohol and drug services. The discussion was taped and transcribed verbatim.

FINDINGS

Here we summarise the key findings from our study. In order to place this in context, as well as bring alive some of the stark realities of life on the streets for people with alcohol problems, we will first describe some of the characteristics of the people to whom we spoke. This will then be followed by 'A Life in the Day' of one respondent who we will call 'Jake', before we move on to a more thematic analysis of the individual interviews. All those interviewed were asked if they would be happy to be quoted in this report and any subsequent publications. All

were happy for their exact words to be used. To ensure respondent confidentiality, all have been provided with pseudonyms. Part (d) of this section will present the findings of the professional focus group.

(a) Characteristics

The eleven men interviewed were all white and aged between 23 and 74. Ten were British and one was Hungarian. Just under half the sample (n=5) were aged between 40 and 52. Analysis of rough sleeping data in London shows that 88% are male, 77% are white and that they predominantly fall into the 25-55 years age bracket. The characteristics of our sample reflect this picture although there seems to be a slightly older age group within our sample than perhaps was expected.

The fact that they were an ageing population was also significant from a general health and welfare perspective. In many cases, chronological age and 'physical' age were c. 25 years adrift, with a man of 40 having health problems consistent with someone in their 60s.

We were also struck by the fact that all those in the sample had been homeless for a considerable period of time and were therefore well immersed in the rough sleeping/drinking subculture. This seemed to suggest that change would be harder to achieve and maintain. Alongside this, accounts suggest that although there seemed to be robust support at a basic level, more sophisticated, targeted and structured services were needed. In other words, looking at this from a 'Cycle of Change' (Prochaska and DiClemente 1984) perspective, although there was support for maintaining their lifestyle (pre-contemplation) and reducing further deterioration - no small feat with this group who had experienced multiple deprivation and multi-problems - together with a little help with 'ambivalence', 'motivation to change' was not being tackled at any real level.

Although there were variations in the level and pattern of alcohol use, all of those in the sample reported long histories of dependent alcohol misuse and, for all but one or two, they remained dependent, continuing to consume large amounts of alcohol throughout the day. The most common forms of alcohol consumed were

cider, lager and sherry although a common theme was the sharing of alcohol amongst drinkers and selection was largely determined by cost and availability.

(b) A Life in the Day: Jake's Story

Jake is in his 50s and has been a rough sleeper on and off for the past 25 years. The following is based on an interview with Jake and gives an insight into a typical day for him.

5-6am: Woke up. Only slept 3-4 hours last night. Didn't choose best spot. Should have seen if there was space behind the local offices. I'll try there tonight. Need to find a dry, sheltered spot. Don't fancy a spot in the town centre. Got a right good kicking last weekend from a bunch of pissed army, weekend warriors. Even got pissed on once. Shame they didn't throw any coins at me that time. Could have saved them and bought some more cider.

6am: Packed up all my gear, sleeping blanket and extra layers of clothes. I carry everything on my back and never risk leaving it anywhere. If my rucksack went I would be in real trouble ! I used to have a little radio but that got soaked. Shame really. Found an open public toilet so I could have a quick wash. Next stop – off licence.

7am: Off licence just opened. Bought my usual – white cider, cheap and strong. Had enough money for a few litres. If I'm short, I have a few mates who'll lend me a bit.

7-9am: Walking, waiting and drinking time. Also time to think…It's been a while since I was last in hospital. Had quite a bad fit due to severe alcohol withdrawal so back on the cider now. I find it difficult to remember a time when I wasn't drinking. It really started in my 20s, once I had finished my apprenticeship. My wife had divorced me and drinking just blocked out the rejection I felt. Also had a lot more money then. Have been on my own ever since.

9am: St. Petrock's opens its doors! …here Monday to Friday. Breakfast first. Only costs 50p. Well worth it. Read the paper, did the crossword and had a chat with some friends. Felt really relaxed. Could have spoken to a worker if I wanted to, but didn't need to today.

12pm: Lunchtime. St Petrock's cook is a real star. 50p for roast beef and all the trimmings followed by bakewell tart and custard.

1pm: St. Petrock's closes. Dry and warm weather today – perfect. Tend to go to the library if it's cold or wet. A good place to shelter and reading can be a good way to pass the time. Went to a local park to drink with friends. One of my mates, who is in a local hostel at the moment, needed some money so a few of us helped him out. I still have enough of my benefit money left but it will soon run out. Have sold The Big Issue in the past. Have even turned my hand to shoplifting but wasn't very good at it thank goodness. That's not what I'm about.

7-8pm: Soup runs. These can be chaotic, but it's free food. Need to keep my wits about me in the evenings and make sure I can get back to my spot safely. Not a good idea to pass out in the open. Have known lots of people who've done this and not made it through the night. Headed back to my spot outside town near the college buildings to skipper down for the night. The security guards there know me and are ok. I never leave a mess or cause a problem. Don't like to spend too many nights in the same spot though. Am used to being on the move. Had to fend for myself since a teenager after all.

Settled in my spot. Will be gone at first light tomorrow. More drinking then. Have managed to save some for the morning. Can't really remember a time without drinking. Just seems to be one day at a time.

(c) Emerging themes from individual interviews

- Level and type of alcohol use
- Routes into alcohol use
- Routes to rough sleeping
- The risks of living on the streets
- Experiences of services

Each one of these emergent themes will be discussed briefly and individually below.

1. **Level and Type of Alcohol Use**

'It's dominated my life' ('Henry', 52)

'Always been a binge drinker…..(at one stage) I was drinking 9-12 litres of cider a day' ('Robert', 45)

'(I) drink spirits, sherry, wine, beer – virtually anything with alcohol in it….to get out of your head as quickly as possible'('Simon', 53)

The majority of those interviewed described what amounted to dependent drinking that had continued for many years. Many described themselves as 'alcoholics' and talked about drinking for most of the day, aside from times when they were at a day centre in the morning. Some, however, struggled to maintain enough sobriety to manage this.

Two respondents, however, saw themselves as having more control of their use, with one describing himself as a 'social drinker' who did not drink to get drunk.

This, though, was exceptional; the majority described being drunk for at least part of the daytime with alcohol use as both constant and a priority. Most were also physically as well as psychologically dependent, to the extent that they would experience withdrawal symptoms if alcohol levels were not maintained.

Respondents mainly drank cider, lager, sherry and, less frequently, beer. A number of respondents also described use of high strength lagers and ciders (white cider), as well as vodka. There was a strong consensus, however, that choice was largely decided by cost, strength and availability. Availability was also strongly linked to what others in the social group had managed to obtain, as there was a clear sense of sharing alcohol throughout the day. Given that alcohol was seen as either a 'coping mechanism' or a 'relaxant'- "something to break up that day and pass the time" ('Wilf') as well as a way of blocking out feelings, choice of alcohol was very linked to the effects. What was important was that there was a constant supply (and ensuring this was available was seen as a priority) that would then need to be 'rationed' throughout the day (and night) to stave off withdrawal symptoms, particularly in the morning. It was crucial to have alcohol available, on waking, and to ensure a source of supply nearby.

2. Routes into Alcohol Use

"My problem is not from the streets but goes a long way back (' John', 44)

"Alcohol made me feel ten feet tall" ('Jazzer', 47)

"It's social and (a way) to meet and chat with people' ('Theo', 74)

"I started to drink to forget and block things out" ('Baz', 46)

Most of those interviewed talked about having a problem with alcohol, which pre-dated their homelessness. Some were more willing to discuss their pasts than others and, in line with other similar studies (Ravenhill 2008), some were more willing to give more details of what they considered the reasons for their dependence. The ages at which these men began drinking also varied. Three started very young ('Baz' now 46, was 9, 'Jazzer' was 11 and 'Jamie' was 'a kid'). Adolescence was the trigger for several, linked to feelings of insecurity and peer group pressure, whilst for others, it was in response to relationship breakdowns in

their 20s and 30s that alcohol took hold. For 'Antal', however, the only non British respondent and initially a social drinker, the onset of his drinking problems was linked to racist bullying while working in a highly pressurised environment and then developed as part of his pattern of living on the streets.

At least six of those interviewed talked about their upbringing as a significant factor. 'Simon' recalled his father's drink problem, his absences due to working away from home, and the pressure on his mother of coping alone with three sons and the resultant lack of parental control *("I ran wild…... my problem stems from my drinking family").* He started drinking very heavily in his early 20's, and spent a significant amount of his life as a new age traveller - a lifestyle where he described drinking and cannabis as central components. Significantly, he also talked about the attraction of getting drunk - *"it gets you out of your head as quickly as possible" - which* was in line with other respondents' comments about their reason for drinking.

'Tom' was much younger than others in the sample and also different in that he described a heroin addiction in addition to his use of alcohol. He was in foster care at the age of 2 and describes his dependencies (and homelessness) against a background of changing placements and accommodation. Having started drinking at the age of 14, he describes himself as an alcoholic by the age of 16, using amphetamines at 15 and heroin at 19 and, for a short period, using both alcohol and heroin together. He linked his drinking to his lifestyle and peer group.

Whilst 'Robert' was less explicit about the reasons for the onset of his drinking *("I have always been a bit of a binge drinker"),* he considered that the breakdown of his relationship precipitated intensity in his drinking behaviour - *" I was drinking more heavily to relieve the pain*". He also talked about his mother dying of alcohol misuse but did not link this event to his own drinking and it was not clear when this event occurred or started to impact.

'Henry' described a similar pattern of established drinking intensifying as a result of a major relationship breakdown. He talked about drink dominating his life, with serious drinking starting from his early twenties, as he had more money available. Whilst drinking impacted on the relationship itself, the ending precipitated a crisis

and a significant increase in the use of alcohol to stop the feelings – *"I saw the divorce as being rejected….. that hurt me.. my drinking was a way of (initially) blanking that out".* At the same time, he also made a link between this recent traumatic event and previous hurts linked to feelings in late childhood, including having to fend for himself at any early age, and being put in a hostel by his parents.

'Simon' also talked about the significance of the breakdown of his relationship with his wife, and the temptations created by coming into money at the same time. In his case he stresses that this led to travelling and eventual homelessness and rough sleeping which then led to an increased dependence on alcohol – "*Even if teetotal you would soon start drinking on the streets*". He went on to explain that, out of about 30 people he knew, he was only aware of one that did not drink, and she happened to be female. For the others there was already a dependency on drink that had been intensified by a crisis, leading to homelessness.

'John', quoted at the start of this section, felt that his route to drinking was linked more to social and peer group pressure from a young age, keeping up with those older than him. Peer influence was also significant in 'Jamie's' account; he said he had been drinking *since he was "a kid".* Having more money, in his case increased his consumption but he described his divorce as a catalyst for the decline when "alcohol took control". 'Wilf' explained that he had used alcohol as a coping mechanism to deal with past relationship breakdowns and loss of work.

In all these examples, the respondents' significant alcohol problems pre-dated problems with homelessness. For most of these, a more recent problem (usually a relationship breakdown) had precipitated heavier drinking leading to homelessness, although in the case of 'Simon' drinking and travelling seemed to occur more in tandem.

3. Routes to Rough Sleeping

'It was my choice. I wasn't abused as a child' ('Simon', 53)

'I had nowhere to go at the time, was starting to hit the drink even harder…a lot of friends didn't know because, to me it would be embarrassing to tell anyone…. they (services in home area) could not help me - "not vulnerable" was their sort of words' ('Robert', 45)

What, then, were the routes into more permanent and entrenched rough sleeping? Again, there was a range of explanations for this. These included a sudden precipitation into homelessness, triggered by a crisis, a lifestyle choice - an extension of a restless, travelling, 'on the road' existence - and the impact of pre-existing alcohol and/ or drug problems on security of employment and accommodation. Relationship problems, as seen in the previous section, and an apparent lack of any emotional scaffolding with which to manage these, also played their part, with respondents describing the way in which "things got out of control quickly….the drinking will take over….with history repeating itself" ('Jazzer').

For 'Baz' and 'Antal' there was a "just up and left without a plan or anywhere to stay" moment ('Baz') where, due to various pressures, this seemed the solution to an unbearable situation. Both, however, described the experience of finding themselves on the streets as "a serious shock", highlighting their lack of understanding of how rough sleeping 'worked' as well as the *extreme* and dangerous situations they encountered.

For others such as 'Henry' and 'Theo' it seemed almost to be a lifestyle choice. 'Henry' described a period of twenty years of rough sleeping combined with short periods of temporary accommodation. Changes were related to the conditions in summer and winter in that he preferred rough sleeping when it was dry and temperate but sought respite in the winter months. Like other respondents, this was described as a kind of a choice - "I would not say I was happy but that was the pattern...in the summer months I had no motivation to gain accommodation at all and was more than happy to

stay outside". This seemed a lifestyle that he had settled into, rather than making a positive decision to either accept or change. However, also like others within this age group, he described more anxiety about remaining on the streets, as he got older, as this was taking an increasing toll. The summer months also provided a period to recharge batteries, seen as increasingly important as time went on. This was a sentiment expressed by several others interviewed. 'Henry', at least in hindsight, felt that alcohol had *"dominated my life*", being the main cause of the breakdown of the relationship with his wife. At this point, he saw the social nature of his drinking changing from an activity involving friends and acquaintances in the village to a point where he would drink with anyone and this appeared to represent a transition point to sleeping rough, as previous ties were lost. In terms of drinking patterns, this would link to the stage of 'narrowing of repertoire' in the alcohol dependence syndrome model.

'John' had also been on the streets for a long time, and for the last three years had been living at the back of an old eye hospital, where he described some of his 'friends' as living for the last twenty years. He described his 'route' to rough sleeping emerging from an itinerant lifestyle that appeared to have its origins in an escape via travelling, initially abroad and then in England, following the breakdown of a relationship after 13 years – *"I wanted to get away".* As in the case of 'Henry', initially it seems quite difficult to see how this had developed into such a sustained way of life over such a long period of time. He talked, however, about the way that drinking on the streets gradually increased, due to it being part and parcel of the lifestyle –"*Basically, you drink to forget...you wake up in the morning and drink to forget that day....I started just drinking at the weekend and now, well basically I have a bottle in my bag now".* A similar process was described by 'Jamie', who talked about the impact of his divorce and who could trace clearly a pattern of increased drinking, lack of employment and unsettled or short-term accommodation within the last seven years. This slow decline and 'immersion' in a heavy drinking lifestyle appeared to be a significant sign, echoed by others in a similar way. It seemed to be a possible factor in the difficulty often experienced in moving entrenched rough sleepers off the streets, as their

experiences of accommodation or 'home' were framed by or contaminated by memories of negative or traumatic experiences.

'Robert' had temporarily gained accommodation due to the cold weather but had been street homeless for three of the last five years. He would generally sleep on the streets in a small tent or tarpaulin down by the river, fearful of sleeping on his own in the town centre. As in the case of 'John', drinking did not appear, in itself, to lead to homelessness and rough sleeping, but acted as a conduit to this. 'Robert' was drinking prior to his relationship ending, but he then described drinking more '*as a way of relieving the pain'*, moving from being a weekend binge drinker to drinking more regularly. The end of the relationship led to accommodation problems and a move away from his hometown. This breaking of ties led to less support in a new town, accompanied by heavier drinking. As in the case of 'John', once on the streets, 'Robert's' alcohol use then became more entrenched - *"When you are out it's a comfort and helps you sleep as well. It takes quite a grip and by at the end you can't get out of that kind of grip, it's quite frightening sometimes actually thinking of it".*

'Tom, 'Wilf' and 'Jamie' all had pre-existing drug and/or alcohol problems leading to difficulties with employment and accommodation which resulted in unsettled lifestyles, 'sofa surfing' and increased alcohol use. For 'Tom', who, at 23, was by far the youngest respondent, alcohol and drug use resulted in losing different types of accommodation leading to him becoming street homeless at the age 16. He had been rough sleeping for some 7 years, estimating that he had been on the streets for about 5 of these. In foster care from the age of 2, he described his drinking and use of amphetamines starting when someone else in his supported housing was drinking heavily. He progressed from drinking with friends at the weekend to drinking cider all the time. He described himself as an 'alcoholic' at the age of 16 – *"I was drinking all the time ... every place I had I was getting kicked out of".*

Although he talked about it being hard on the streets at first, after a while he become used to it, mainly sleeping in car parks and sometimes staying with friends. Despite help from his social worker in accessing supported housing, his drinking and drug taking led to the loss of a number of placements. He said that he had not 'chosen' to live on the streets but provided an account of a gradual transition to a life of alcohol, drug use and imprisonment. At one stage, both he and his partner were on the streets and he described a period in and out of prison when he "was shoplifting for about four habits". Like others, he described a process akin to a type of 'immersion' into this way of life and commented that he had met some people that have been on the streets for so long that they preferred to be there and had little motivation to gain accommodation.

'Simon', who combined living under some railway arches in the week with sleeping near some bushes near the river at the weekend, had spent most of his life moving around the country, spending a considerable time with various new age travellers. He described both a travelling lifestyle, a tendency to drink and a love of getting drunk as significant aspects of his life. Whilst problematic drinking was a significant factor in his family, he describes his own motivation as the search for a freer type of life – *" I wasn't abused as a child.. I grew up with a merchant navy family, grew up with them telling me stories of where they had been and what they had seen and it got into my blood. At the age of 17 I felt that I had to and see some of that and It became a lifestyle".*

At the same time, he discussed drinking as a major factor – "*I think the problem stems from a drinking family… Mother did not drink but father did".* He describes the desire to drink in order to get drunk – "*I enjoy the buzz.. It's just like having a hit I suppose".* The initial choice of lifestyle had involved the attractions of drinking, freedom and sociability. Rough sleeping appeared to him not dissimilar, with drinking playing a central part and linked to socialising (with the added bonus of blocking out the cold). However, he clearly saw the positives diminish, as he got older, but definitely viewed

rough sleeping and his use of alcohol as intertwined – "*It works both ways - I lose accommodation because of my drinking and vice-versa".*

4. Risks of being on the streets

'*You sleep but you don't sleep…you have always gotta keep an eye open because you don't know what is around the corner ('John', 44)*

'In relation to alcohol, the risks are all of it because it's drinking not eating, it's the amount….' ('Robert', 45)

'In colder weather survival becomes the priority so I don't wash or take care of myself' ('Wilf', 42)

'(I) often feel frightened or vulnerable…..Many of the people I have met with alcohol problems are very vulnerable' ('Henry',52)

'My body is starting to cave in' ('Simon', 53)

'You can get a good kicking in the town centre' ('Theo', 74)

Risks identified could be broadly characterized into three main types - personal risks and fears of others, due to the vulnerability of being out on the streets, physical health risks resulting from the alcohol and rough sleeping lifestyle and risks to mental wellbeing (depression, suicidal thoughts and suicide attempts).

Many described the greater risk of being in the town centre rather than outside the city, especially at weekends. Here they were more likely to experience verbal abuse, stones or coins being thrown and, in some cases, physical attacks. The most common perpetrators tended to be those described as 'weekend warriors' – intoxicated people coming out of clubs at the weekend in the early hours of the morning. This group posed a real and significant threat to those in our sample, and all felt extremely vulnerable if alone. 'Tom', 23, described "*people coming up to me to piss on me, spit on me"* and 'Theo' remarked *"you can get a good kicking in the town centre*". Most described feelings of vulnerability at the hands of what one described as "*idiot piss-heads at night"* particularly if alone and there was a general feeling that it was important for them to support one another – *"If I see someone (alone) I ask them to come with me" ('Tom').* They would also consciously choose to group together if in town at night, or avoid sleeping there at the weekend. 'Wilf' said that he often felt '*vulnerable'*. 'Tom,' who had been on the streets at 16 talked about how at first his friends protected him and that now he would always make sure he was not on his own.

As illustrated most vividly in the 'Life in the Day' example, respondents described a lifestyle in which their daily routines centered around the need to accommodate their drinking, meet their basic needs and mitigate, as far as possible, the inherent dangers in their lifestyle. Choices about where to 'pitch' and with whom were key factors.

All of the respondents identified either actual or potential health risks for themselves or others due to drinking and or drug taking and rough sleeping 'Harry' summarized the problems as follows: *"Many of the people I have met with alcohol problems are very vulnerable… can't get themselves together in the morning, they are subject to breathing problems, bronchitis, pneumonia, many of them smoke…they have problems with withdrawals in the morning, throwing up*". Risk of alcohol withdrawals also included the risks of seizures, as well as the general health problems connected to such a lifestyle such as constant colds and chest infections.

Risks were particularly linked to the harsher lifestyle in the winter, and many highlighted the risk of hypothermia at night – "*You're drunk...You bed down at 9 o'clock… there is a drop in temperature in the morning, you're asleep, comatose…I mean you have drunk so much...It's never happened to me but you can sleep through it and not wake up in the morning"* ('John'). 'Simon' talked about his own fear of hypothermia due to having previously collapsed on a beach when drunk, not being found until the morning and then ending up in hospital for a long period. There was a strong sense of being at the mercy of the elements in the winter and the sense of vulnerability that this induced.

Physical health problems related to a history of alcohol use or the toll taken by a rough sleeping lifestyle were prevalent throughout the accounts. Many in this sample had maintained heavy drinking and rough sleeping over a long period. 'Simon', for example talked about the *'grinding'* effect over years, the health problems, including asthma, and the mental as well as the physical toll it took – *"My body is starting to cave in.. the physical toll is affecting me mentally in ways I never thought or wanted to think before… about settling down…getting somewhere* warm and dry". Others talked about the combined effects of heavy drinking, and poor eating habits. 'Robert', who at one time describes drinking 9-12 litres of white cider a day and having been diagnosed with liver damage, talked about the attraction of alcohol over food: *'"In relation to alcohol (the risks) are all of it because its*

drinking and not eating…half the time drinking is for comfort…or to get to sleep for a bit". 'Tom', although still only in his twenties, had been warned about the effects on his liver and had seen a number of friends die on the streets (both drinkers and drug users).

A significant theme in the data was the risk to mental well being. This is often given less attention than the physical risks of street living but, for many of our respondents, this was a pressing issue. 'Wilf', 'Jazzer' and 'Antal' eloquently described their struggles with depression and suicidal thoughts. 'Jazzer' talked of having made at least 6 previous suicide attempts linked to feelings of lack of confidence, and self worth, lack of hygiene, and things *'spiraling'* out of control, exacerbated by his increase in alcohol use. He also described the support needs necessary to help him address this (see below). 'Antal' described similar feelings, particularly in cold and wet weather, adding that he had once asked the police to "*please shoot me"* and was disappointed not to be arrested for shoplifting, at a time when he sought some sanctuary from the streets. The impact of the cold had a similar effect on 'Wilf' whose self-care skills also deteriorated and who was overcome by "*hopelessness, feeling I'll never be able to change"* and fearing he would be trapped forever in the rough sleeper lifestyle. 'John' felt that the lifestyle itself would lead to depression and described an endless cycle of waking up, getting drunk, getting bored, going to sleep - with even the social life of the streets become part and parcel of this – *"It's the same shit, just a different day. I mean it goes on 7 days a week… if that's not going to get you depressed…"*

In coping with this variety of risks on the streets what also emerged were the skills, knowledge and strategies that respondents developed as a way of surviving these experiences and particularly in finding suitable sleeping places and staying dry and warm. These included communication skills and the ability to develop relationships with authority figures such as the police, security guards, and caretakers. *("the security guards gave me a fiver for breakfast"*, 'Antal)'. An identified theme, particularly among the more

experienced and entrenched but less chaotic group, was an overarching awareness of the issues around avoiding making a mess or causing a disturbance. At the same time, certain risks at night might be exacerbated by a 'taboo' within this sub culture of reporting incidents to the police when it may bring unwanted attention to their lifestyle. This may result in crimes of this type becoming more 'hidden' due to lack of reporting and leading to lack of attention on this problem by the authorities.

5. Experience of Services

'If you go hungry in this town it's your own fault…you get fed, watered, there is nothing you actually need you can't get for free' ('Henry', 62)

'St Petrock's is fantastic…open every day of the week (except weekends)…if you want to do maths, English classes, get your breakfast, dinner, change of clothes…It's fantastic ('John', 44)

'The Clocktower service is a very useful service... because they deal with people on the streets, they know all your symptoms basically' ('John', 44)

'The hostel was not a good place…it was full of smack heads hitting up in the kitchens and leaving needles around' ('Baz', 46)

'What would you need to break the cycle? – Something like a hospital... locked away...kept away…I didn't like it but it was necessary because of the temptation to buy alcohol' ('Simon', 53)

'You do need a reason to stop drinking' ('Wilf', 42)

'Many people have been on the streets so long, they don't want accommodation', ('Tom', 23)

'If I stick it out, can I end up with my own place? It's not so much the physical side it's the mental side, changing my mindset…It's this idea of

years and years of total freedom… walls closing in…it's like towing lines…I don't need that…in places like that (hostel). I have to adhere to the rules, jump through hoops' ('Simon', 53)

To place this theme in context, it is important to say a little about the services in Exeter that serve the city centre's small rough sleeper community (c. 18-25 people, mainly men. figure based on an average of SHOT/STP count for this period). These largely fall into the following groupings :

1. Front line basic survival services. St Petrock's and a range of church based soup runs and food providers.
2. Outreach services where workers take the initiative in making contact, such as the SHOT team. To some degree, the Police (largely seen as sympathetic and supportive) fell into this category.
3. Health services including a dedicated G.P surgery with mental health support.
4. Drug and alcohol services.
5. Education/training/life skill providers often in situ at St Petrock's /MOP.
6. Supported accommodation providers.

Alongside consideration of service provision, it seems timely to reiterate a few key characteristics of our group which shed light on the task to be addressed and some of the obstacles to be overcome. First, what many described was the 'all or nothing' grip of alcohol dependence for them. Henry's comment about there being "*no middle way*" with alcohol was typical in this regard. Almost all agreed that mixing with fellow drinkers, whilst offering considerable support in relation to risks/support, also made giving up that much more difficult - "*I could not stop…not whilst being on the streets…I have cut down but the drink is always there. I don't know anyone who doesn't drink on the streets"* ('John'). Second, all respondents had long histories of alcohol use and many had made previous unsuccessful attempts to tackle their dependency and gain permanent accommodation. They also

described high levels of current use with many also having long-term health problems. As a consequence, services had multiple and complex entrenched, longstanding problems to tackle.

6. Accessing Services: Setting the scene

The majority of respondents tended to incorporate services into their regular, daily routine or 'orbit', as the day in the life and other accounts above have suggested. These included St. Petrock's, (and the services available within it such as Addaction), the Clocktower surgery, the Street Homeless Outreach Team (SHOT), and other basic support services such as soup runs. *These include 'Crosslines' and other services organized by local churches.* This 'routine', then, seemed to be part of the pattern of longstanding, entrenched homelessness for many, whose journey to this point had been long, crisis driven and characterized by multiple losses (of partners, accommodation, employment, security, health etc.). Such services provided oases in their rather routine and bleak journeys through the day.

For two of those interviewed, 'Theo' and 'Antal' however, whilst they accessed basic survival services, they said they managed their experiences fairly independently of other support and felt little need for it. This suggests that, for them, rough sleeping was more a choice than an inevitable result of dependent drinking.

<u>Core and Outreach Services</u>

These 'first line' services were generally seen very positively, with staff viewed as respectful, professional, empathic, responsive, understanding and supportive. The fact that other key services were on site at St. Petrock's was seen as very important. Many commented on the fact that St Petrock's offered many aspects of a 'one stop shop' that would encourage the use of other service providers. 'Jazzer', comparing the experience in London of 'Crisis at Christmas', felt that this could be extended further, in that Exeter would benefit from a more comprehensive 'hub' system where all services would be in one place, including places to go later in the day.

Activities were seen as purposeful. Almost universally St Petrock's was praised as providing respite from the demands and pattern of daily street drinking – *"A life saver… it keeps me out of trouble" ('Tom').*

This also seemed a key aspect for respondents because they knew that there would be at least one period in the day when they would get a break from drinking. This provided not only physical restoration but also a mental break, giving a more purposeful structure to the daily routine. St Petrock's therefore provided a crucial point of contact for this group given the high and often chaotic level of drinking throughout the day. Equally significant was the fact that staff members were seen to be understanding and to strike a fair balance between not excluding on the grounds of any alcohol use but not allowing those in who might be drunk or disruptive.

Other services that enabled people to maintain their day-to-day lifestyle included the street homeless team, the Clocktower surgery, which provided primary care services including access to a G.P, nurse and CPN. Respondents who had accessed the Clocktower service on a regular basis commented on the fact that they could always obtain appointments with a Doctor –"*they are helpful when you need them"* - and a number had been given advice about health problems caused by alcohol use, mainly liver damage. 'Tom' had been warned about the effects on his liver and, as mentioned previously, had seen a number of friends die on the streets (both drinkers and drug users).

Many of those interviewed talked about the need to fill afternoons and evenings when there were fewer services available. The local library, which was seen generally to have a tolerant attitude towards rough sleepers, was one place identified as a sanctuary in this regard. Most of the recipients identified particular parks where they would meet with others and drink in the afternoon (e.g. Belmont, Northenhay, Rougement) although they are all technically within the city centre, where alcohol is prohibited *or at least tolerated*.

The Street Homeless Outreach Team Service (SHOT) included outreach workers one of whose roles was to visit rough sleepers first thing in the morning. Both

'Robert' and "Henry' commented on the value of such contact first thing, although 'Jamie' felt they had been *"a little lax"* as he had been disappointed by lack of promised follow-up contact.

Relations with the police varied from person to person but on the whole were seen mainly positively. With some exceptions there appeared to an apparent de-facto agreement about where and where not to drink in public.

Specialist Services

In relation to accessing more specialist alcohol provision, respondents tended to be more equivocal about how these might have helped them tackle their alcohol problem. Many of the respondents were self-deprecating about their own willingness or capacity to use these purposively or sustain changes – *"it's the situation you put yourself in!"* ('John').

'Tom', who had particular problems with heroin as well as alcohol, described the main problem as being the wait for a script (8 months). He said he got quicker access in prison, following his shoplifting offence , than a friend had done, who was still waiting for script, when 'Tom' came out of prison –"*if they did it quicker it would end helping a lot more people" (*'Tom').

Another respondent talked about a similar problem in relation to awaiting a detox for his alcohol problem. Whilst accepting the problem of limited resources, he discussed the difficulties of remaining motivated when waiting for a place. This was made more difficult due to the timing of his alcohol dependent partner's treatment. This also highlights the fact that motivation to change can be significantly affected by where partners/ friends might be in their progress towards tackling their drinking problems.

There were many identified difficulties in terms of being able to move out of a cycle of homelessness and alcohol use. As we have seen, for the majority of those interviewed, there appeared to be a slow but progressive immersion into a lifestyle that indicated that significant change was going to be problematic. There was also a strong seasonal element in the maintenance

of this way of living, with many suggesting that, in the summer months, there was no motivation to seek accommodation –"I *would not say I was happy…. but this was a pattern" (*'Henry') although there was a need to seek respite in the harsher months. However, many of those interviewed also commented that their perception of such a pattern continuing was undermined and threatened by age as alcohol related health problems intensified, and took their toll. Many recognised that their bodies could not continue to take such punishment – "*My body is starting to cave in… the physical toll is affecting me mentally in ways that I have never thought or wanted to think before...about settling down...getting somewhere warm and dry"* ('Simon').

Many respondents had had experiences of hostels and detox. These had not always been positive and at least two respondents felt that a local hostel provided unsuitable accommodation, combining unnecessary restrictions with open drug use, making for an unsafe environment, and one that few people were likely to choose it over the risks but freedoms of street life.

These accounts suggested that many felt little motivation to access what was on offer, in terms of the next stage of sorting out their alcohol problems and establishing a more settled way of life. This seemed to highlight a gap in the pattern of service provision that could theoretically provide a real opportunity to move out of the rough sleeper/drinking culture.

<u>Suggestions for Changes to Services</u>

Many respondents had ideas for either additional services or suggestions for the way in which additional services could be developed or changed. Like others in the sample, 'Tom' suggested the need for some kind of night shelter *"especially for older people… I have known about 6 people in the last few years who have died and they have all been quite old".* Several people who accessed the Clocktower surgery and the local hospital for medical support for help with withdrawal felt there was no support offered on discharge from hospital in terms of accommodation. They felt there should

be better co-ordination in terms of gaining accommodation and "*more chasing up of accommodation referrals could have been done by the Shot team".* 'Wilf's' view was that street drinkers would benefit and perhaps be more motivated by more regular SHOT outreach contact, particularly in the evenings ('*when you need it more')* and when engagement and motivation to change may be more productive. 'Baz' suggested that designated drinking or wet areas, if developed, may help prove a potential point of contact for SHOT and other services to link to street drinkers. This highlights the need to maximize times or geographical spaces where workers might have more success in building motivation to change. In terms of basic support services the most consistently observed omission was a night shelter or wet or dry provision.

d) Emerging themes from professionals' focus group

Introduction:

The focus group consisted of professionals who regularly work with problematic alcohol users who are also rough sleeping .The purpose of this meeting and discussion was to explore the practice dilemmas and challenges of working with this particular group and highlight potential improvements in terms of training, practice and overall professional development.

The discussion was facilitated by the researchers. The group met in the months after a particularly severe winter and the extensive use of a national *winter pressures scheme* (Exeter City Council Homelessness Strategy 2008 - 2013) in which local authorities had a legal duty to accommodate individuals when the temperature dropped below freezing for three consecutive nights. In addition an *Individual Budget Pilot* Scheme was in operation. (Pritchard, 2010).

The following are the professionals who attended the meeting. Workers from the local male and female hostels were invited but unable to attend. Unfortunately the nurses at the local dedicated homeless G.P surgery were also unable to attend.

George is a project worker at the local homeless resource centre (St Petrock's) which provides a basic survival service to homeless individuals including cheap or

free food, laundry and washing facilities, access to medical services as well as a chiropodist. The centre also provides clients with a comprehensive assessment of need leading to an agreed action plan and access to a key worker. In addition the centre offers educational support including an art group and basic numeracy and literacy groups.

Becky is a housing officer in a local prison. Her role involves offering an in-reach service to prisoners who will be homeless on release from custody and includes referrals into various forms of accommodation including supported accommodation for problematic alcohol users.

Adrian and **Sophie** are based in the **Street Homeless Outreach Team**. (SHOT).Their roles involve providing an early morning outreach service to rough sleepers, signposting to relevant services and agreeing appointments for later referrals. This allows a record of the number of rough sleepers to be regularly up-dated.

Zoe works for an **alcohol support agency** which offers advice to problematic drinkers around harm reduction and addressing their longer term use. Kate and a colleague also provide a weekly drop in at the local homeless resource centre

The themes emerging from the Focus Groups are discussed individually below.

1. Barriers to engagement:

Overall there was agreement that the entrenched group being discussed were typified by low levels of motivation and often deep-seated resistance to change and a reliance on alcohol in terms of physical and emotional need. There was also recognition that alcohol played a significant role in terms of providing a daily routine among the group as well as the context for social contact. There was also reluctance amongst the group to make any financial commitment towards their accommodation which posed a problem when considering most of the supported accommodation providers required residents to make a contribution to the cost of their accommodation and support. This system is referred to as a "top-up" and can range from approx £10 to £40 per week. The experience of all the workers and, in particular, George who is based at St Petrock's who would encourage

individuals to budget as part of key working responsibilities, was that any available income (usually from benefits) would be seen as money to be almost exclusively spent on alcohol.

There was recognition that an expectation for individuals to actively contemplate change while coping with the often extreme lifestyle associated with rough sleeping and problematic alcohol use were unrealistic as were expectations of keeping to regular appointments. This had an impact on the likelihood of completing potential accommodation referrals and/or risk assessments and other pieces of work normally associated with periods of service user engagement. As a result, the group was often labelled as "stuck" in this "daily struggle for survival" without any likelihood of meaningful engagement. However there was a strong motivation to "reach" this group and explore a variety of approaches to facilitate a more productive working relationship.

Discussion followed around the social nature of alcohol use among the group, in terms of socialising and company, who saw it as "a way of avoiding boredom and being alone" (George). It also provided a daily structure and ''a daily routine" and, in effect, an "identity". This was illustrated by the practice among the group of pooling resources and buying each other alcohol and providing a steady supply. Adrian and Sophie from the outreach team commented these ties were so strong it would continue well after individuals have gone into accommodation both supported and independent. It was noted that this was a common reason for eviction, exceeding the number of permitted consecutive nights out from the local hostel (3) or rent arrears. Therefore some members of this group were actively choosing to rough sleep when accommodation was available.

The group felt a major factor in engaging and moving this group forward was replacing the social side of alcohol use. This in effect was seen to provide a significant barrier to change and engagement. George's role as Project worker at St Petrock's meant he observed and worked with members of this group during the morning open access session. This period would often constitute the only waking period when the group were not actively consuming alcohol and demonstrated individuals' ability to interact, socialise and experience an

alternative to alcohol use-if only for limited periods. The initial attraction to the centre for those individuals was accessing the basic survival service.

In light of these barriers a discussion followed about approaches that were seen as more effective.

2. Effective Interventions

There was agreement within the group that providing brief low key interventions was a successful approach with this group, described as a process of "chipping away" and "sowing the seeds of change". The worker based in HMP (Becky) gave the example of a prisoner who had received 14 sentences for alcohol related offences and, after a number of brief contacts moved from total non-engagement and resistance to a point of moving into supported accommodation on his last discharge. Some of these contacts were- in the early stages- no more than "hello" and "how are you?" It was felt this allowed trust to be established and a relationship to develop. In effect, these initial contacts were crucial in establishing the basis for future engagement.

This was a theme echoed by the rest of group who felt the homeless resource centre was ideally suited to provide the backdrop for these interventions often informally over coffee and provided a potential "springboard for change" (George). In particular the alcohol agency felt there was scope to develop these contacts with clients and identify the early stages of motivation to address alcohol use and to do some initial work around education and information. This would allow individuals immediate access to basic advice from project workers based in St Petrock's around their alcohol use. There would also be an opportunity to refer individuals directly to the alcohol agency for an assessment and possible treatment plan or signpost them to their weekly drop-in held at the centre itself.

Zoe from the alcohol agency, felt a joint and consistent approach, based on a 'stepped care' model **(**Sobell, et al 2003) and aimed at supporting individuals to help themselves and providing the lowest intensity of engagement necessary, was crucial when working with this group. She felt some initial training would be of benefit, in this respect, as there had not always been a consistent approach in the past. This was seen as a priority and it was noted that a training package was

easily accessible and already running on a regular basis. This highlighted an opportunity for agencies and workers to access training based on a brief intervention or solution focused model tailored to this group, as well as the opportunity to "roll out" a co-ordinated approach with the potential of improved outcomes.

3. Harm reduction

It was felt the risk around heavily dependent alcohol users withdrawing from alcohol was a significant issue when engaging with this group. Zoe outlined the alcohol team's approach of advising safe strategies for reducing drinking, based on a *harm reduction model* rather than sudden and total abstinence. She felt it would be dangerous to advise a complete halt to drinking without contact with a prescribing or specialist agency or local G.P. There was some agreement on this point, with concerns about lack of information sharing from the alcohol prescribing agencies hindering a more consistent approach in this area.

Similarly, in terms of advising on levels of alcohol use, there was a little confusion about which agency would co-ordinate the support or 'hold the case'. The group felt there were complications in relation to confidentiality and restrictions in terms of consent to share information when ,for instance ,sharing information about how much an individual was currently drinking. The group felt a more integrated approach involving input from the local alcohol prescribing or specialist agency, in particular, may improve service provision, allowing a more co-ordinated approach. This issue was explored in more depth when considering the effectiveness of inter-agency working.

Zoe, the alcohol worker, felt that, in light of the risks associated with sudden abstinence from alcohol, the sometimes 'observed' police tactics of throwing away alcohol taken from street drinkers was a risky strategy possibly highlighting a lack of awareness around this issue. There was general agreement with this point and recognition that the risks had not been fully appreciated. Becky relayed the standard practice in HMP where dependent drinkers would be placed on arrival in custody directly into the hospital wing for a managed alcohol 'de-tox' due to the risks to health associated with a sudden withdrawal from alcohol. This

highlighted a potential to open a dialogue with them and there was some debate around the feasibility of opening up meaningful communication with the police around this issue possibly through an invitation to a community officer to attend a future forum or meeting.

The group moved on to discuss wider social attitudes to alcohol use and its impact on delivering a harm reduction model. The group discussed how it was seen as "morally acceptable" reflected in its legal status and "part of the fabric of society" (George) and actively and aggressively promoted i.e. "2 for 1" deals in supermarkets as well as in the wider advertising industry. It was felt this contributed to a situation where the boundary between social and problematic drinking became blurred. In particular Zoe felt her work towards safe drinking and harm reduction was being undermined by the abundance of cheap alcohol and in particular 'deals' which would financially penalise those buying less alcohol in terms of strength and volume. This was seen as largely a political issue and it was noted that current national policies appeared to indicate the beginnings of a recognition that society's relationship and attitude to alcohol impacted on wider issues of problematic alcohol use.

4. Access to accommodation

The *Winter Pressures* scheme (Exeter City Council Homelessness Strategy 2008 - 2013) in which local authorities have the legal duty to accommodate all rough sleepers when the temperature fall to freezing or below for three consecutive nights was regarded as having a significant impact on the lives of this group. This immediate access to accommodation was seen by the focus group as being a key initiative since it by-passed the need for a lengthy referral process and the need for regular appointments which have been recognised as barriers to effective interventions. It was also recognized that this approach was free of any financial commitment for individuals towards the accommodation which had already been identified as a significant barrier to engagement with this group. This, combined with the severe weather, meant a group who had resisted any accommodation were quickly "indoors" and experiencing it often for "the first time in years" (Becky). This was seen as a hugely significant development, allowing a springboard for future change and engagement.

The group commented on the type of accommodation on offer under the scheme which ranged from the "floor of a hostel" to an en-suite bed and breakfast room. This point reflected the view among some of the target group about the local hostel which was seen as chaotic, violent and used mostly by heroin users. As a result some would not stay and opted to rough sleep, despite the weather. According to George (HRC), this possibly illustrated an historic division between alcohol and heroin users, in which both groups have considered themselves to be separate and having their own identifies and view each other with mistrust and even hostility. The focus group agreed that for this group who already had reservations about hostels this experience was counterproductive. However bed and breakfast accommodation was a positive introduction and allowed a shift of mindset among the group. The benefits of this were seen through increased engagement and movement towards more long term accommodation options.

The group discussed the absence of a local direct access night shelter providing a permanent opportunity to access respite through immediate access to short term accommodation. It was however recognised that any mixing of alcohol and (primarily) heroin users may be problematic within this environment. It was then suggested that a possible solution to this dilemma would be a targeted direct access 'wet' hostel. This would allow a group of entrenched rough sleeping 'drinkers' an easy 'first step' into accommodation, with access to support based on a brief intervention model and strategies for safe or safer drinking (Kate). It was felt that this was, however, potentially politically unpopular, although the benefits for this group would be considerable.

The group moved on to discuss the recent *Individual Budget Pilot Scheme*. The overall aim of this scheme was to 'reach out' to identified entrenched rough sleepers with multi complex needs and establish a personal relationship; to assist clients take greater control over their lives in order that they might be encouraged into accommodation (Pritchard, 2010).The pilot, one of four personal budget pilots for rough sleepers being tested, began in October 2009, was independently evaluated in March 2010 and ended in July 2010.

Individuals were offered a designated care co-ordinator of their choice who would ask what they needed to help them off the streets. This could be a mobile phone

to keep in contact with friends or family, a spare set of clothes or beauty treatment. The budgets in Devon averaged £2,500, though this figure depended on the client's needs. Each was given multi-agency support and a care co-ordinator to manage a budget to buy in services to help them into accommodation. The scheme has been co-led by Exeter and North Devon councils and the local NHS. It was funded by the Department of Communities and Local Government and Supporting People. The overall results also suggested a need for more flexible floating support and outreach services to cater for this client group and for community-based mental health services to provide greater priority to them. (Pritchard, 2010).

The feedback from of the group was overwhelmingly positive in relation to this scheme, and confirmed that, with long term rough sleepers, a more individualised approach was indeed necessary. It was agreed that this initiative provided the basis for a positive and productive change in approach allowing, in effect, accommodation 'packages' to be tailored to the individual's need. This was seen as providing a model of engagement with the potential for a significant improvement in future practice and the group were in broad agreement with the scheme's evaluation (Pritchard, 2010).

5. Interagency working

The group agreed this was largely positive commenting on the effectiveness of the series of drop-ins at the local HRC. This allowed easy access to a range of services including nurses, a chiropodist, outreach workers, alcohol workers, a job club and crucially, in an environment where individuals felt comfortable and received a basic survival service. This approach mirrored the overarching ethos at the HRC in its approach to engaging with homeless service users who, by regularly accessing the service to meet their basic survival needs were more likely to engage with services in situ. Becky, from HMP, felt another positive development was that a range of agencies now had a presence in both the community and prison, allowing support packages or plans to follow the individual through custody and on release. This was particularly relevant with those considered as prolific offenders and living a chaotic lifestyle.

The role of the local G.P surgery was seen as significant as it was set up to meet the specific health needs of the homeless community and as such its medical team was skilled and experienced with working with the group being discussed. In effect they provided an expert service in response to the group's mental and physical health needs and crucially offered easy and quick access to medical support. It was again noted that the nurses provided a much valued drop in service at the HRC particularly for those who may not be accessing other services and therefore defined as hard to reach and having complex needs.

Those present felt their agencies worked well together and there was an awareness of the importance of keeping open recognised lines of communication and the avoidance of becoming overly "territorial" in terms of "client or service user work". It was agreed that this continued good practice relied on the attitude and approach of individual workers and a commitment to a client centered approach.

Less clarity existed around the role of mental health services (outside the local G.P surgery) and in particular thresholds for support and referrals. An example was the question of what constituted a genuine 'crisis' for the crisis team? Similarly it was felt an improvement with information sharing between the prescribing alcohol agency and more front line workers would facilitate a more co-ordinated approach especially around advising how to reduce alcohol use safely. This was seen as an area of possible development and an opportunity to invite outside agencies to come and give training in relation to their service with the possibility of incorporating a question and answer session allowing relationships to be developed and specific questions answered in order to clear up any ambiguities.

Summary of Focus group findings

* The entrenched group being discussed were typified by low levels of motivation and often deep-seated resistance to change and a reliance on alcohol, in terms of physical and emotional need.

* Brief low key interventions was seen as a successful approach with this group and the local homeless resource centre was ideally suited to provide the backdrop for these interventions.

*The risks around heavily dependent alcohol users withdrawing from alcohol was viewed as a significant issue when engaging with this group and therefore a harm reduction model was favoured, rather than sudden and total abstinence.

* The experiences of the Winter Pressures Scheme as well as the Individual Budget Pilot were seen as key interventions with this group, allowing a more effective, individualised approach and avoiding some of the traditional barriers to engagement.

* The effectiveness of the drop-ins at St Petrock's was noted, allowing easy access to a range of vital services for this group as was the role of the Clock-tower surgery. However, there was scope for improved communication with more specialist mental health and alcohol services.

Conclusion

A number of key findings emerged from both the individual interviews and the professional focus group.

* There is a comparatively small but persistent group of alcohol using rough sleepers who maintain very high levels of alcohol use, and who have long histories of homelessness and rough sleeping.

* As established in previous studies, the links between dependent alcohol use and rough sleeping are complex. In our sample we found that a significant alcohol problem had mainly pre-dated the transition to homelessness and that another crisis, often involving a significant relationship breakdown triggered a precipitation to a pattern of rough sleeping and drinking.

* Respondents described various levels of willingness or capacity to change either their drinking or rough sleeping. Most struggled to really explain to us or themselves exactly why they continued to live their lives in this way and why such

a difficult lifestyle continued year after year, given their descriptions of risks and of the negative consequences when weighed against what appeared the relatively small advantages. However, most respondents described their use of alcohol as a way of managing pain over long periods of time and a number linked the onset of alcohol dependence to early family difficulties. When asked about the possibility of change, there was very strong sense, in a number of interviews, of being unable to get past the presenting reasons for alcohol use. This appeared to link in some way to the role that alcohol continued to play as a 'holding mechanism' allowing feelings to be blocked and as a form of self medication in terms of physical and mental health as well a providing a form of social networking and routine

* Some respondents expressed a strong sense of ennui – a complete lack of capacity to envisage change, or a feeling that they had been on the streets so long they could not move into accommodation

* Those that did express a need for change were often older and felt that they were going to have change because of the deterioration in their health and the toll on their bodies (particularly in winter) as they got older.

* Alcohol use and the need to maintain this throughout the day remained for most a 'central organising principle'. In other words, there was a conscious awareness throughout the day of where and how the next drink would be obtained. The routine of this was linked around other regular daily activities.

* Respondents described detailed and highly routinised days from rising in the morning to settling down to sleep. This routine was influenced by a number of contingences

- Sleeping arrangements/ avoidance of risk from attack or insult
- Ways of keeping a supply of alcohol (availability, proximity to off licence, social contact in parks)
- Day Centre and other support activities
- Social Contact

* Professionals recognised a significant barrier to engagement with this group in terms of lack of motivation to change based on a complex relationship with alcohol alongside the daily struggle of survival when coping with the extreme realities of rough sleeping. Barriers to engagement revolved around the view that this group lacked motivation to change, and in many ways, had become entrenched in a lifestyle based on a daily struggle for survival, which made it difficult to attend appointments and complete applications etc. This situation was exacerbated by a relationship with alcohol that provided a daily routine and companionship. However , it was felt that the open access session at St Petrock's provided an example of how this group could interact and spend time 'not drinking' and provide an opportunity to build therapeutic relationships.

* Following on from this an approach that was considered effective with this group was a series of often informal, small low-key interventions, which could lead onto more meaningful engagement, based on a brief intervention model. This was particularly relevant to the alcohol team who felt these contacts were perfect for assessing levels of motivation and an opportunity to provide basic information. This could eventually signpost them to more formal support direct from the alcohol agency, based on a stepped approach, involving attending regular one to one key working sessions with a professional alcohol worker. This would involve a series of meetings with a number of agreed targets and outcomes. However, an area for development was a consistent approach among individual workers. It was agreed that a training programme that was provided regularly by a local agency and could be easily accessed would meet this need and provide an evidence based approach that relevant workers could adopt and implement.

* Internal risks due to mental and physical health problems and alcohol related conditions were strongly highlighted. External risks in terms of threats, intimidation and possible violence, especially at night, were a consistent theme across the interviews. Risks in relation to withdrawal, hypothermia etc were seen to be problematic particularly in winter months.

* In terms of harm reduction it was noted that very real risks existed if dependent or heavy drinkers were to suddenly stop without medical support and therefore a 'safe drinking' model should be adopted. This approach could be improved with

better lines of communication between either the prescribing agency or G.P or a 'lead worker' who would co-ordinate the approach and hold the case. It was noted that cheap, heavily promoted alcohol made a harm reduction model more problematic.

* Whilst 'first line' support services for alcohol problems were seen as good, there appeared to be a problem with many in this group moving on from entrenched dependence and rough sleeping.

* The availability of good support systems appeared to offer not only respite and some protection against risk but also a potential oasis where there was the potential to identify opportunities and motivation to change. Respondents were very positive about basic support services (except for provision of emergency shelter) and the attitude and response of professionals. Other opportunities in relation to fostering motivation particularly regarding outreach services were identified. Support, provision for and systems to move out of and from dependent alcohol use and break established patterns were identified as far more problematic.

* Moving on to accommodation did not appear to be a successful transition for a number of respondents who had been through this process. The *Winter Pressures scheme* and the recently piloted *Individual Budget Scheme* were seen as particularly relevant to this group as it allowed a more flexible approach in which accommodation was more easily and readily available and in the later longer term support packages could be tailored to meet the specific needs of individuals. This flexibility and freedom to think outside the box in terms of offering support was seen as an important and significant development with this group in effect facilitating important breakthroughs. A point supported by the evaluation of the pilot scheme carried out by Pritchard, (2010)

*Interagency working was largely considered positive with St Petrock's providing a range of drop-ins accessed by a group which had been largely regarded as 'hard to reach'. However, gaps did exist particularly around mental health and tier one alcohol services in terms of thresholds for support and information sharing. It was felt that this could be addressed by organising a number of agency visits

and, ideally, a more formalised approach to the way in which support is co-ordinated with improved lines of communication. Ideally this would take the form of a regular multi-agency meeting.

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