THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by Professor Kate Dolan 2014 Churchill Fellow

To study Managed Alcohol Programs

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24 August 2015

Signed Dated

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Introduction

Many homeless people are plagued by alcoholism. They place a high burden on hospitals and police and are assaulted when drinking on the street. They are unable to control their drinking.

Managed Alcohol Programs (MAPs) provide homeless chronic alcohol dependents with a regulated amount of alcohol and housing to stabilise their drinking. They provide a range of services. MAPs require a high level of co-ordination between key agencies. According to staff, the MAP transforms many clients with dramatic changes in appearance, outlook on life and behaviour.

Acknowledgments

I wish to acknowledge the assistance of the following people; Matt Petrie and Scott, from Manchester, Greg Lambert, Simon Gibbons and Julie Prendergast from Liverpool, Ray MacQuatt, Wendy Muckle and her staff from Ottawa and Julie McGuiness and Kailin See from Vancouver. I also benefited from discussions with Professor Tim Stockwell and Dr Bernie Pauly from the University of Victoria, Canada.

I am also grateful to have been able to talk to MAP residents and clients about their lives.

Managed Alcohol Programs

Executive Summary

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Many homeless people are plagued by alcoholism. This group consumes over 20 standard drinks a day; often non-beverage alcohol (mouthwash) and drinks until unconscious. They place a high burden on hospitals and police and are subjected to assaults when drinking on the street. While abstinence from alcohol is preferred, it is unrealistic for a minority of chronic drinkers.

Managed Alcohol Programs (MAPs) provide homeless chronic alcohol dependents with a regulated amount of alcohol and housing in order to stabilise their drinking. MAPS take drinkers off the street and provide them with a range of services. I investigated the benefits of Managed Alcohol Programs to determine if this service would be a useful addition in Australia's alcohol treatment field. I visited programs in Liverpool and Manchester in the UK and in Ottawa and Vancouver in Canada. I met with Police, council workers and staff from the housing sector and health services. I also met a number of residents in the Programs. It was interesting to observe staff having meaningful engagement with a group that it is shunned by most other services. I was particularly impressed with the Oaks program in Ottawa, as it seemed to be the most developed and had the most residents, 55 persons. The Drug Users Resource Centre stood out as well in terms of the range of services and the heavy involvement of the client group.

The underlying philosophy of Managed Alcohol Programs is harm reduction, which aims to reduce adverse health, social and economic consequences of substance use without requiring abstinence. Managed Alcohol programs reduce alcohol consumption and improve residents' health. They also reduce the burden on police and hospitals by providing a meaningful response to a community problem.

Successful MAPs had a high level of co-ordination between key agencies, offered a range of services and activities for residents, accepted that residents will continue to drink and allowed residents to participate in the running of the Centre. According to staff, the MAP transforms many clients with dramatic changes in appearance, outlook on life and behaviour.

This Report will be launched at the UNSW, posted on its website and distributed to key stakeholders in Sydney to promote discussion on whether Sydney needs a Managed Alcohol Program, as they do not currently exist in Australia.

Programme

Date	Organisation	Contact
29/6	Booth Centre Edward Holt House Pimblett Street Manchester M3 1FU	Matt Petrie matt@boothcentre.org.uk Www.boothcentre.org.uk
30/6	Doherty House MAP Great Western St Manchester	
1/7	Wet Centre Bolton Street Liverpool L3 5LX	Simon Gibbons, Centre Manager Julie Prendergast Council White Chapel Centre
7/7 8/7 3/8	Police Merseyside	Greg Lambert Merseyside Police
	University of Victoria Email discussions about research into MAPs	Bernadette Pauly Tim Stockwell
15/7	Health and Community Services Ottawa	Wendy Muckle wmuckle@uottawa.ca Sophie wheeler swheeler@ottawainnercityhealth.ca
16/7	Shepherds of Good Hope TED MAP program	Caroline
17/7	The OAKS 233 Murray st Ottawa ON K1N 5M9 www. shepherdsofgoodhope.com	Ray MacQuatt Manager
19/7	PHS Community Services Society 20 Hastings Street W Vancouver, BC V6B 1G6	Julie McGuinness
20/7	Drug Users Resource Centre DURC 412 East Cordova St Vancouver	Kailin See

Lessons learnt

Consumption of non-beverage alcohol is wide spread among street drinkers

There were reports of alcohol based hand sanitizers being stolen from hospitals. This prompted one housing service to issue a warning of the dangers to clients. These gels are sought after for their high strength of alcohol content despite being poisonous and extremely dangerous when consumed. Non-beverage alcohol includes rubbing alcohol, hand sanitizer and Listerine.

The Police have a role to play in addressing street drinkers

In the summer of 2010 and 2011 in Liverpool, residents and businesses were complaining about the anti-social behaviour of street drinkers in the city centre. The police grew tired of dealing with street drinkers, they would pour out their alcohol and move them on. This response was actively contributing to increased reports of begging as seizing the alcohol from individuals simply created the need for them to beg to buy more.

The Police also arrested the street drinkers, repeatedly, but this seemed fruitless as they would appear before the court, which was costly. Furthermore, it did not address the underlying cause. The Police realised it was costing a small fortune in staff costs and associated criminal justice costs which was not only unsustainable but inefficient.

Most Managed Alcohol Programs started as a pilot project.

The Police in Liverpool lobbied for a pilot project to provide a place, a wet centre, for homeless persons to drink off the street and to be in contact with health services. After that pilot, another was conducted over the summer of 2015. The police are regular visitors; so much that staff has asked they reduce their visits so as not to deter clients visiting. The police were in attendance the day I visited.

The inclement weather in Canada saw numerous homeless persons die from exposure during winter. Similar discussions about street drinkers were being held in Ottawa. A group of business associates, police and social services came together to work out how to deal with the homeless problem. This new co-operation meant that services would share their resources, fill any gaps in service delivery and introduce a new management structure, the Matrix model. When agency workers in Ottawa were discussing the homeless problem, the idea of a Managed Alcohol Program was not even on the agenda.

Wet Centres and Managed Alcohol Programs are different

Manchester's Booth Centre operates a Wet Centre, which means clients can bring alcohol into the Centre and drink it inside and off the street. Managed Alcohol Program are different as workers distribute a regulated amount of alcohol to clients at set times. The philosophy of the Wet Centre is to meet their clients where they are at in their lives. Originally, the clientele was the 'old tramp in the doorway' but now street drinkers include young people and women.

In Liverpool, local bottle shops were contacted by the council and asked not to sell very strong beer during the pilot and they were asked to mention the Wet Centre to the street drinkers (see appendix A).

Managed Alcohol Programs (MAPs) are a pragmatic response to street drinking

Managed Alcohol Programs are usually a residential service. Residents need to be assessed in order to join the Program. They are provided with one unit of alcohol from 7.30am to 9.30pm, an average of 15 drinks a day. Some Centres allow residents to have two units at the beginning of the day and then one every hour after. The service is a low or no threshold service, meaning that there are few barriers to entering or remaining in the service.

<u>Examples of Wet Centres and MAPs</u>

The Wet Centre in Liverpool was a very basic outdoor space. The grounds were an empty block of land that had two shelters similar to bus shelters for clients to sit in and drink and two demountable cabins for staff. Toilets were Portaloos. There was no sign on the gate and it was difficult to find. Clients have to bring their own alcohol and they can drink there most of the day. Health staff were available to assist with medical problems and other support workers assist with other issues. The nurse thought there should be hand-washing facilities at the Centre, especially if infections are to be prevented. The Centre was across the road for the main train station. This was the second pilot of a Wet Centre in Liverpool and was under evaluation by researchers from the John Moores University in Liverpool.

The Booth Centre in Manchester is also a Wet centre as clients can bring alcohol to consume there but the Centre does not provide it. The Centre offers an array of services and the Wet Centre aspect seemed peripheral to the overall service.

In Manchester, the Heavy Drinkers' project is a residential Managed Alcohol Program. There is one core house with 15 outlying houses. The core house has seven bedsits and seven one-bedroom flats. Support staff are available 24 hours a day at the core house. Residents in the outlying houses can call the office for assistance but the idea is they

are to live independently as far as possible including monitoring their own alcohol intake.

Canada has five managed alcohol programs. In Ottawa, the Targeted Engagement and Diversion program (TED) has 12 beds for men and 2 for women. TED is placed within a larger housing complex where other residents include families with children. The rationale behind having a MAP incorporated into a regular housing building was that families drink alcohol at home and children are exposed to that. Some residents are in Opioid Substitution Treatment (OST) as well. There are 80 other residents at TED who are not in the MAP.

Also in Ottawa, the OAKS opened in 2010 and has 55 beds of which 10 are for the mentally ill. Some 15-20 residents still live there since it opened. The Oaks Residence is a supported housing care facility operated in partnership between the Shepherds of Good Hope, Ottawa Inner City Health and the Canadian Mental Health Association. The Oaks is situated in a residential area and there was much opposition to its location. There are many services on offer at the Oaks, but some, such as the gym, are never used by clients.

The Drug Users Resource Centre in Vancouver opened in 2003 and provides a safe, supportive and welcoming space for drug users, including alcohol dependents. Their MAP is a day service where clients are provided with alcohol but they do not live on the premises. Over 200 clients visit each day. Services include a methadone clinic, primary health care and culturally specific programs for clients. There are work and volunteer opportunities, an arts and cultural program and housing support. Nearly all staff are peers and peers have the major say in the operation of the Centre, through the Advisory Board.

There are strict criteria for joining a Managed Alcohol Program

Eligibility criteria include homelessness or at risk of it and struggling with long-term alcohol dependence. Before coming into a MAP, many can be consuming 30 units of non-beverage alcohol a day. They are not interested or able to attain abstinence. They have a high frequency of visits to hospital and regular contact with the police.

In Ottawa, clients for the MAP are identified through TED, the targeted engagement and diversion program. At the Drug Users Resource Centre, potential clients join a drinkers' lounge every Friday for a few weeks where they are assessed for suitability to enter the MAP.

There is a sense of community where residents learn to bond and to manage conflict. They lose the chip on their shoulder and open up. If they are really drunk they go to bed. MAP is an intervention to stabilise alcohol consumption.

A range of staff work in MAPs

Staff members include mental health workers, social workers, in-house support workers, nurses and doctors. One Centre had a barber visit to cut residents hair. Many Centres employ clients or residents as workers.

Finding a suitable location of a MAP can be difficult

Most MAPs were located in light industrial areas and near main train stations as these were places where the target population congregated. It was necessary to spend a considerable amount of time negotiating with the local Council, businesses and home owners to resolve this problem. There was opposition in terms of NIMBYism so it essential to engage with the community to move the project forward.

Residents are long-term alcohol dependents with a history of trauma

Many residents report drinking non-beverage alcohol such as Listerine, rubbing alcohol or hand sanitizer, which have a high alcohol content but are poisonous. Residents can trade in non-beverage alcohol if it is sealed for alcohol.

Street drinkers are not just the old style "tramp in the doorway," now they include younger males, females, non-Anglo persons, Inuit, Aboriginal and persons with acquired brain damage, Foetal Alcohol Syndrome or PTSD. Canada has a terrible history of childhood assault in boarding schools and many residents were traumatised there. Every single client has experienced some sort of trauma. The MAP is an intervention to stabilise residents' drinking who are then in a position to deal with other issues.

Cognitive impairment can differ among individuals for example one person may be able to shower but fails to remember to eat. Once alcohol consumption has stabilised, life skills training can focus on carrying out daily chores. MAPs are seen as a part of a continuum of care.

Many residents have concurrent disorders; alcohol dependence and mental illness. Very heavy drinkers, who consume over 400 units of alcohol per week, have problems that require social and medical solutions rather than a policing one. Therefore, it made sense to co-opt people in those areas to help drinkers to stop drinking on the street. Many residents are disabled and have the cognitive ability of an eight year old.

Peer workers, current residents who are doing well, show others that change in possible. These workers are given some responsibility and enjoy being useful and valued.

Dispensing alcohol

In Ottawa, a doctor determines the level of dosing which usually ranges from 5 to 7 oz. of alcohol an hour. Residents receive 12 units a day and they can have beer, wine or Vodka. Once the resident selects a particular type of alcohol, they must stay with it for the day, although they can change the type of alcohol the next day. A record is kept of the amount and time alcohol can be dispensed to each resident.

Clients and residents I met

Workers at each Centre allowed me to meet a number of their clients or residents. I was able to talk to them in private about their lives. The overwhelming message from these people was that they had been given a chance to rejoin society, to be valued and were happy that someone still cared for them. Most had spent many years in a downward spiral where they had endured some pretty tough times. All had been subjected to violence while on the street, most had been rejected by their families and many felt a sense of failure from being heavily dependent on alcohol. When asked about the programs and staff, everyone I spoke to was full of praise for the work of the Centre staff. All accepted the rules and supported the staff whenever possible.

The views of staff challenged some of mine

Without exception all staff were completely dedicated to their jobs. They had many stories to share about how different clients had improved, rebuilt relationships with their families and friends. One confronting revelation was that some staff saw the MAP as palliative care and that some clients would never move on, rather this would make their final years more bearable than otherwise. I found this position hard to accept as my inclination would be for clients to graduate from the MAP to be living on their own and perhaps to become alcohol free.

I was touched by the effort the staff dedicated to clients and residents who had passed away. There was a wall of photos of deceased clients and pages within newsletters remembering those who had died.

Case studies from the housing sector

1. “Emma” comes to the Booth Centre in order to avoid committing crime, she used to rob shops, now she gardens, helps in the kitchen and cleans at the Centre. She has completed a number of courses such as a First Aid Course and a woodwork course. She used to drink at the Booth Centre but not anymore. She was a binge drinker, as was her aunt, mum, cousin and her uncle. She began drinking in her teens. She is aiming to find paid work.

2. Declan, an elderly Irish gentleman, was drinking 260 units of alcohol a week before entering the program and now drinks 125 a week in the program; less than half. He has a support plan which is outcome driven and reviewed every three months. Declan has psoriasis on his hands and feet and is waiting until he can go six weeks without alcohol in order to have the laser treatment. The alcohol management plan is about controlling the amount of alcohol he drinks with a view to reducing it completely so he can undergo treatment. He also has a financial plan, which allows him to save a little money. His daughter and a worker go to the bottle shop each week and buy his alcohol and cigarettes.

Case study from the Police

3. The male offends predominately in Liverpool city centre and on the Wirral. In 2011, he was arrested for theft once, drunk and disorderly twelve times, breach of bail twice, court warrants for failing to attend court five times and breaching a dispersal order once. He was given an interim Anti-Social Behaviour Order in April 2011 for street drinking and arrested for breaching this three times. This was ratified to a full Anti-Social Behaviour Order and he has been arrested for breaching this 22 times. It was estimated that 500 police staff hours have been spent dealing with this individual.

MAPS have good relationships with the police and ambulance services

All Centres reported that it was essential to work closely with the Police to operate MAPs. Staff at the Heavy Drinkers' House has a good relationship with the police who visit often. They also work closely with a health centre to facilitate health care, which means it is rare for the ambulance to be called and visits to the Accident and Emergency Department are genuine as staff filter the use of these services. The Police in Liverpool often visit the Wet Centre to check on how the Service is going, as they were the main instigators of the Centre. The Mancunian Booth Centre worked closely with the Police to refer potential clients to them.

In Ottawa, the TED Centre accepts patients from Paramedics who go into their observation room rather than being admitted to hospital. They are observed for 24 hours. This approach has saved $2m in averted hospital costs. However, when MAP residents are transferred to hospital they still need to be maintained on alcohol, otherwise they will leave hospital. Several MAPs had an arrangement with the local hospital, which allowed workers to bring their doses of alcohol into them.

Rules vary across Programs

Interestingly different Programs had different rules around where residents could drink. The Heavy Drinkers' project restricted drinking and smoking to residents'

rooms, while the TED allowed residents to drink in communal areas but not in their rooms. Residents are allowed to drink outside the Centre but they would rather stay inside.

At two Centres, residents decided the rules and staff enforce them. For residents, normal eviction rules apply; such as being behind in one's rent or being violent. Among the residents at the Oaks, there is a Mayor who is elected by other residents to present their views to management.

Most Centres have strict rules about residents having physical contact with staff. At one Centre residents are banned for a year if they touch a worker. The Liverpool Centre, which was a pilot, was developing its rules on this, while the DURC doesn't ban anyone otherwise they will have nowhere to go as the DURC takes on clients who no one else will.

MAPs do more than just provide alcohol

Centres provide a range of services to their clients such as assisting clients to obtain Identification or birth certificates. Centres provide free food, laundry facilities, toiletries, snacks, coffee, local and long distance phone calls and computer access. The Canadian services provided acupuncture, which was very popular for the treatment of stress, trauma and addiction. These agencies also provided traditional food for indigenous clients such as seal, whale and moose. Activities include a walking group, cooking, gardening and a coffee morning. Other Centres provided a table tennis, a drama group, gardening and art classes. One Centre had a performance space available for clients to put on their own shows.

Other services include a foot care and a wound care clinic. Staff monitor clients' liver function. At a MAP it can be the first visit to the doctor and dentist for many clients for some time. Also they are assisted to reconnect with family and friends. Centres had ramps or lifts as well as stairs as many clients have limited mobility.

Workers provide residents with work and volunteer opportunities and a daily job draw, which is paid. Residents can earn money by collecting bottles for recycling. The vast array of activities occupy the residents' time and helps them reducing their focus on drinking and alcohol consumption.

Residents and clients are encouraged to have their family and friends visit and to engage in positive social interactions. Several Centres allowed residents, clients and even staff to bring dogs onto the premises.

MAPs brewed their own alcohol

Several Centres had decided to brew their own alcohol. This decision was reached due to the amount of alcohol that MAPS dispense each week. One Centre in Ottawa was

spending $1,500 on alcohol every fortnight, or $39,000 per year. Given home brewing is labour intensive, it made sense to cajole residents in to assist in the process.

The Oaks residents brew their own alcohol and dispense 810 gallons every 5 weeks for 55 people. It costs $5,000 a brewing kit, which is made up in 45-gallon drums. As the City of Ottawa supports the project they don't need a licence to serve alcohol. They brewed a California white wine. At the Drug Users Resource Centre, residents who assisted with the brewing were rewarded with bus tickets.

Residents can progress from a MAP

Most Centres operate MAPs at two levels; providing 24-hour supervision in the main house and less supervision in outlying houses. At the main house, their alcohol consumption is managed very closely, with it being dispensed every hour during the day. At the outlying houses, residents live independently with off-site support and manage their own alcohol consumption. Staff work with people over a long period so they are able to manage their own alcohol consumption.

MAPS are controversial

The notion of providing alcohol to 'alcoholics' is controversial. It is unsurprising that there would be community opposition to the placement of a MAP in their area. Managers of MAPs spoke of prolonged community consultation in order to establish the service and to counter resistance. For example in Liverpool, the local taxi-cab office objected strongly to the Wet Centre being near them in Liverpool.

People improve when they join a Managed Alcohol Program

When residents arrive at a MAP, they are self-centred. "It is all about me, myself and I". As they progress, they are able to welcome others and are able to consider other people. They lose the chip on their shoulder and open up. There is a sense of community where residents learn to bond and to manage conflict, without violence. One woman was very aggressive with staff from all sorts of services but once she entered the MAP she stopped being aggressive.

Peer workers, residents who have progressed enough to carry out some duties at the Centres, are employed at MAPs. This serves to illustrate that change is possible and among people exactly like themselves.

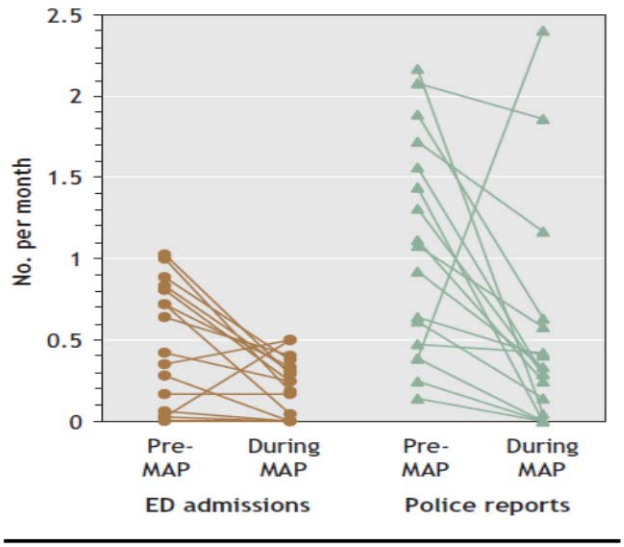
Experience suggests that it takes three to five years to see any improvement in clients' brain function. A study on executive functioning found that clients had good

verbal skills but responded poorly to stimuli and operated at the level of an eight year old.
Some people behaviour badly on illicit alcohol; they get into fights, are violent and create chaos around them. After joining a MAP, many modify their behaviour and exhibit normal behaviour again. One person had 15 visits to a hospital over a one-month period and many interactions with the police. After joining the MAP, the person has had no hospital visits and very few interactions with the police.

MAPs are an effective intervention

An World café evaluation found most residents wanted a regulated, a normal life. The female clients wanted to have friends and be able to eat a meal with others. A study of 17 adults in a MAP with an average age of 51 years had been dependent alcohol for an average of 35 years. After 16 months in the Program, their mean monthly visits to accident and emergency departments decreased from 13.5 to 8 (p=0.004) while Police encounters decreased from 18.1 to 8.8 (p=0.018) (See graph below). All participants reported less alcohol consumption. Staff noticed that residents had improved hygiene and compliance with health care (Podymow, 2006).

Graph Number of A & E and Police contacts pre and during the MAP



Currently, a three-year research project is focusing on five sites in Thunder Bay, Ottawa and Vancouver under the supervision of Professor Tim Stockwell.

MAPs are cost effective

According to the London School of Economics, each instance of anti-social behaviour

costs the Police £500 in their time. In the six months before the pilot of Liverpool's Wet Centre, 117 street drinking related Anti-Social Behaviour incidents cost £585,000 in Police time. The Police estimated that Liverpudlian Wet Centre saved the Police £124,806, which more than covered the cost of the Wet Centre which operates from May until September 2015.

However, the Home Office report "Tackling Anti Social Behaviour" from 2006 identified a baseline cost for each breach of ASBO prosecution to the Police, local authority and court to be £1500, three times the Police estimate.

In Canada, Government housing benefits covers most of the costs for clients, who receive $619 per month, of which $519 goes to the agency and they keep $100. The estimated daily cost per bed in a MAP was approximately $90 across three different Centres in Canada. The Targeted Engagement and Diversion Program has saved $2 million in averted hospital costs.

Organisational structure

Two MAPs were managed by a Church, which meant they had considerable freedom in what they can do. Other Centres were managed by the Health or Housing Departments but still had reasonable autonomy.

A range of resources has been developed for MAPs

Centres have developed a number of forms and scales to assess and monitor their clients' health and activity. Intake forms measured client characteristics and some included cognitive tests to assess if there was any brain damage or other impairments.

The Liverpool Wet Centre had a Triage Form to record interventions, referrals and attendance. It used a Tracking Form to record clients' demographic characteristics and locations where they drank in the city. They had Facility Hourly Litter and Area Check Sheet to ensure the space is kept tidy and no one has passed out without being noticed. They had an Incidence Form to record all incidents of aggression, what were the triggers and how individuals responded or intervened. Finally, they used an Entry and Exit Procedure Form to ensure staff attended to all the duties in the running of the Wet Centre. Staff at the Ottawa MAP has developed an excel program to measure alcohol consumption among clients.

Conclusions and Recommendations

Homeless people have high rates of chronic illness, long hospital stays, increased mortality and contact with the police. These people who are homeless and drink heavily are stuck and unable to move out of their predicament. They need a comprehensive intervention to address mental health issues, alcohol and drug dependency issues, primary health care and their homelessness. Managed Alcohol Programs (MAP) are a novel service for homeless with severe and intractable alcohol dependence. MAP clients receive a regulated amount of alcohol at set times. MAPs operate in the UK and Canada and have led to reduced alcohol consumption, binge drinking, convulsions, visits to emergency departments and encounters with police.

Managed Alcohol Programs tend to be located in a light industrial area near a main train station, which are areas that most of the target population would frequent. Managed Alcohol Programs work well when there is a high level of co-ordination between services such as the police, health and housing.

Many clients are chronically ill and are dying from alcoholism. MAP improves their quality of life and while some take a break from drinking, few quit. MAP lessens the blow of alcohol on this group. If a resident goes into hospital, they continued to be maintained on alcohol otherwise they will leave hospital without completing their treatment.

MAPs provide an opportunity for people who are struggling with out of control alcohol addiction to stabilise through regulated and supervised administration of alcohol. This approach has proven effective for both those wanting short-term intervention and those wanting a future which includes access to stable alcohol management. As a low barrier program, the MAP aims to include individuals who are at greatest risk of harm from excessive alcohol consumption. According to staff, the MAP transforms many clients with dramatic changes in appearance, outlook on life and behaviour.

The main recommendation of this report is that there is sufficient evidence that a Managed Alcohol Program should be trialled in Sydney.

Dissemination of information

This Report will be launched at the UNSW and a press release will be issued drawing the media's attention to it. The Report will be posted on the website of the National Drug and Alcohol Research Centre, UNSW.

A copy of the Report will be sent to the NSW Health Ministry, St Vincent's Hospital, the NSW Police Force and the NSW Ambulance Service.

I will make a presentation on Managed Alcohol Programs at the 24th International Harm Reduction Conference in Kuala Lumpur in October 2015. I will continue to submit abstracts on my Report to other conferences. I will also make a presentation to my colleagues at the National Drug and Alcohol Research Centre in our monthly seminar series.

What could you do to bring about improvements in Australia

Sydney has at least 350 alcohol dependent homeless persons, but no Managed Alcohol Programs. About 30% of homeless persons admitted to St Vincent's Hospital present for an alcohol or drug problem. Efforts to establish a MAP in Sydney have been hampered by a lack of evidence.

I intend to organise a half-day forum where interested stakeholders can come together to discuss the role a Managed Alcohol Program could have in Sydney.

What other improvements should be made in Australia

A closer relationship between the Housing Sector and the Alcohol Treatment Sector is likely to be an essential first step in the development of a Managed Alcohol Program in Sydney. The target group for this Program is not well served by either sector as they present problems that are difficult for each Sector to solve on their own.

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Appendix A Flyer for Liverpool Wet Centre

The Whitechapel Centre

The Basement Advisory Centre

R.E.S.T Centre for Street Drinkers

The R.E.S.T (Rehabilitation, Education, Support & Treatment) Centre aims to tackle the crime and anti-social behaviour related to street drinking in Liverpool while at the same time offering support and treatment to those attending.

The Citysafe initiative is a 4 month pilot from 1 June to 30 September 2015, and is being independently evaluated by researchers from Liverpool John Moores University to see what impact (positive or negative) the Centre has on street drinkers and the local community.

The Centre will be located on waste ground at Bolton Street L3 5LX. Opening times are from 12 noon to 8 PM daily. The Centre is jointly staffed by The Whitechapel Centre and The Basement, and as well as offering a safe space for drinking it will provide support to address substance use, health issues and accommodation problems. Activities will take place to provide diversionary options and health professionals will be on site 16 hours per week.

Local off-licences have agreed to take part in the 'Reduce The Strength' Initiative, which means they will not sell super strength alcohol which causes the most harm. Merseyside Police will be taking a zero tolerance approach to street drinking outside of the R.E.S.T. Centre.

There is no formal referral process to the Centre. Clients who street drink can simply turn up. You can contact staff on site by ringing 07798 518254 during opening hours.

ANY QUESTIONS?

If you would like any further information about the REST Centre please ring 0151 207 7617 or email info@whitechapelcentre.co.uk

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www.liverpool.gov.uk/citysafe