

WET SHELTERS: THE BENEFITS AND RISKS ASSOCIATED WITH ALCOHOL- ADMINISTERING HOMELESS SHELTERS A SCOPING REVIEW

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ABSTRACT

This Scoping Review presents the various effects of the implementation of wet shelters as a part of a harm reduction policy. This document weighs various detriments of the program against potential reductions in cost as well as the benefits accrued by the government and general populace. The impacts of the wet shelters on the clients, the government and the local citizens will constitute the majority of this paper. Studies found that wet shelters do indeed have great benefits to clients' hygiene, sleep habits and perceived happiness; wet shelters also serve as the first step towards beating an addiction formerly thought to be insurmountable. Relevant studies also found that wet shelters offer measured savings in the form of fewer police run-ins, fewer emergency room (ER) visits and better overall health. There is, however, still much resistance to the institution of wet shelters in Canada on the part of community members.

EXECUTIVE SUMMARY

The implementation of a wet shelter into a community with a high number of chronically alcoholic homeless can have several outcomes for the targeted population, the surrounding community, as well as the public service sector designated to serve them both.

The positive effects of wet shelters on individual clients, generally chronically homeless lifetime alcoholics, include:

- lower levels of consumption (up to 400%), a larger percentage of which is higher quality beverage alcohol (as opposed to non-beverage alcohol such as mouthwash)
- fewer incidents with police and fewer trips to the emergency room (ER)
- higher self-reported levels of happiness with quality of life; fewer instances of violence; improved sleep; healthier weight
- immunization and treatment of other health concerns for clients; better hygiene and improved compliance with health and medical staff
- a first step for many lifetime alcoholics to join detox programs

Unfortunately, for all the benefits of a wet shelter to the client, no measures can be taken to reverse the damage of a lifetime of rough sleeping, drug and alcohol abuse, or both. Although shelters stabilize consumption, the average change in blood-alcohol levels after admittance into a wet shelter program remains inconsequential.

Evidence shows that the implementation of wet shelters positively affects the public service sector in a number of ways, including, but not limited to:

- a tangible effort at cleaning up the streets; fewer rough sleepers
- reduced costs to police and ER services
- the ability to reach out to those normally excluded from shelters (due to alcoholism, drug use, mental illness or behaviour)

There are negative aspects to wet shelter implementation as well. The government may not recover the full operating costs of a wet shelter. Although there are cost savings in other sectors due to wet shelter's interjection, these do not always balance out. Further, wet shelters require many highly trained employees to work in an emotionally taxing environment. For this reason, finding and maintaining staff can be challenging.

The immediate community also has a vested interest in the implementation of a wet shelter. One of the main concerns of community members associated with the implementation of a wet shelter is a potential increase in perceived and/or actual levels of security resulting in feelings of insecurity and intimidation. In order to address these concerns, programs such as “litter-free parks” and other neighbourhood beautification efforts have been put in place in order to alleviate tension between the community and wet shelters.

1 INTRODUCTION

1.1 ISSUE

This document has developed in response to the growing interest in the area of wet shelter accommodations in order to address the issues of the chronically homeless.

Chronic alcoholism, mental disorders and/or other health issues all compound to create a population of homeless or underprivileged citizens who often fall through the cracks of the current social support system. Long-term alcoholism impedes the ability of some to find help, which prompts the question of how best to aid this population. Wet shelters, a program attempted in several jurisdictions (Toronto, Ottawa, U.K.), will be investigated in order to ascertain the viability and desirability of their implementation elsewhere.

The focus of this Scoping Review involves a consideration of the potential impacts on the client, the public service sector, and the surrounding community.

1.2 SCOPE

This Scoping Review focuses on the implementation of wet shelters in order to address the issue of alcohol dependency as it intersects with homelessness. A major point of discussion will be the benefits and disadvantages of administering measured dosages of alcohol or, conversely, allowing clients to drink freely under supervision of behaviour as a part of these shelters' protocols. Although methadone maintenance programs, safe injection sites, and needle exchanges maintain similar protocols, discussion of these programs will be limited. Dry shelters (those that do not admit individuals who bring alcohol on premise, or who are under the influence of drugs or alcohol) will also remain absent from the discussion.

This paper will include a literature review as well as a cross-jurisdictional analysis of six prominent wet shelter programs in Canada and the U.K. A thorough examination of any available documents found in related searches was completed. Best practices and lessons learned will be included in order to bring to light practical knowledge developed in wet shelter application that may not have any evident statistical or anecdotal backing. One should note, however, that the literature review might be somewhat limited due to a dearth in the number of documents that evaluate or discuss the merits of wet shelters.

The discussion will be refined to include mainly material concerning the wet shelters in the U.K. and Ontario, with less attention paid to jurisdictions that have considered but have not established wet shelters. Finally, the focus of this paper remains with only those wet shelters that monitor or administer alcohol. The definition for "wet shelter" is not universal and although many wet day centres, wet hostels and damp shelters do refer to themselves as "wet shelters,"

they are not considered to be wet shelters in the strict sense of the term in this document. For further clarification, see the Definitions section.

2 DEFINITIONS

Wet Centres/Wet Day Centres/Wet Shelters/Wet Hostels:

These facilities allow alcohol consumption on premises (in managed doses or in specific areas). They are meant to accommodate people who are disadvantaged and would otherwise avoid accessing a shelter or similar service, generally because they would have to relinquish their alcohol (i.e., individuals will often drink everything they have, rather than “wasting it” before entering a drop-in or overnight shelter). The terms “Wet Centres” and “Wet Shelters” refer generically to those programs that allow alcohol in their premises, whereas “Wet Day Centres” refer to those that specifically only operate during daytime hours, and “Wet Hostels” to those that operate solely overnight.

Damp Shelters:

These shelters offer similar auxiliary services to a wet shelter (health services, career development, etc.), but do not allow alcohol on the premises. Damp shelters will not pour out alcohol that clients have brought to the facility. The shelter confiscates alcohol upon entry but returns it at departure to the client. Alcoholics with no homes are the targeted population for using these centres. Many damp shelters will refer to themselves as wet shelters in practice as well as in the literature. Damp shelters may be overnight hostels or day centres.

Harm Reduction:

Harm reduction is a philosophy of public health, intended to be a progressive alternative to the prohibition of certain potentially dangerous substances and generally involves a reduction in dosage. Harm reduction, based on the premise that reducing the amount of alcohol/drugs used by individuals or changing the way in which they are used, may be a more effective strategy than the promotion of complete abstinence.

Homelessness and Dual Diagnosis (HDD):

A category of those homeless who are diagnosed both with an addiction problem as well as mental disorder. HDD refers to a social subset that makes up a significant proportion of those living on the street. Homelessness is a third diagnosis, as it complicates and amplifies the symptoms of severe mental disorders and substance abuse problems (Minkoff & Drake, 1992).

Non-Beverage Alcohol:

Non-beverage alcohol refers to items not intended for ingestion that contain varying amounts of alcohol. Street drinkers will often resort to drinking non-beverage alcohol as it is more affordable and more easily available. Popular examples include mouthwash, cleaning products, and aftershave.

Low Barrier Housing:

Low barrier housing refers to accommodations that require the fulfillment of a minimum amount of expectations in order to live there. The aim of low barrier housing is to have accommodations available to a larger number of people, improving access. Low barrier housing, considered a harm reduction measure, does not disallow illegal activities by tenants so long as they do not engage in these activities on site.

3 BACKGROUND

3.1 HOMELESSNESS AND WET SHELTERS

Homelessness has been a major issue in Canada for many years. With large numbers of Canadians sleeping on the street, in shelters, or with friends due to a lack of a home, homelessness is among the country's most pressing social issues (Cross Government Research, Policy and Practice, 2007). Although for some, homeless shelters serve as merely a stopgap measure until they can find permanent housing, for many, chronic homelessness is a condition of life. The chronically homeless represent between 10-20% of those currently occupying shelters (Minkoff & Drake, 1992). It is also among the chronically homeless that high rates of alcoholism and drug addiction prevail. Alcoholism and drug addictions force this group of homeless people to sleep rough, as dry shelters often deny them admission on these grounds.

Homelessness, most frequently coupled with, if not fuelled by chronic alcoholism, affects an estimated 53%-73% of homeless adults, a high percentage of whom are heavy alcoholics (consuming greater than 20 drinks per day). In fact, one health care centre reported that 81% of the homeless clients who sought care were alcoholics (Podymow et al., 2006). Lack of permanent housing and lack of funds turn an alcoholic street lifestyle into criminal behaviour, where police encounters become recurrent. One study reported that 70% of homeless alcoholic men had been imprisoned at least once (D'Amour et al., 2001; cf. Podymow et al., 2006). Additionally, many street alcoholics consume non-beverage alcohol because of its low cost and wide availability, which carries additional health concerns.

Many homeless people drift from shelter to shelter, staying for varied lengths of time. Most shelters, including ones set up by the Salvation Army and various other public service groups require that their guests abstain from drug and alcohol use, while also not allowing entry to those who appear to be drunk or under the influence of drugs. The wet shelter emerged in the spirit of helping those who cannot help themselves, including those whom other shelters have refused to help. Wet shelters not only allow chronic alcoholics and drug addicts into their facilities, but in many cases also prescribe a measured dosage of alcohol. The first such wet shelter, created in 1978, is in Dundee, Scotland.

Various jurisdictions have instituted different types of wet shelters based on the local resources available. Two Canadian cities – Ottawa and Toronto – have implemented wet centres. Ottawa's program, the Managed Alcohol Program (MAP), hosts 23 beds and alcohol is administered hourly (between 7:00 am and 10:00 pm) in a measured dose at the request of the client. Toronto's program operates out of the Seaton House as a part of the Annex Harm Reduction Program. It provides 150 beds in total for those unable to abstain long enough to gain entry to another shelter. Toronto's Seaton House also administers alcohol during the day and into the early evening.

Whereas the Canadian model favours an overnight shelter where clients have a bed as well as access to services, the U.K. model favours wet day centres. Wet day centres offer the same (if not similar) services to overnight shelters but do so only during their daytime hours of operation; the balance of services (place to sleep, etc.) are to be found elsewhere. Another major difference between the Canadian and U.K. models is the prescription of alcohol, another practice favoured by the Canadian model. The two Canadian wet shelters confiscate all alcohol only to serve measured doses at the request of the client. British wet shelters will limit the amount of alcohol permitted on premise, monitor the amount consumed or, as a few shelters do, act merely as a locale for whatever drinking levels the clients would like to engage in, disallowing only the negative behaviour associated with extreme drunkenness.

There is also a growing number of damp shelters emerging. While they often self-identify as wet shelters, their programs are not nearly as progressive. These shelters will allow access to intoxicated clients as long as they are not violently disruptive or actively consuming drugs or alcohol. Damp shelters fall under the same category of “harm reduction” measures as wet shelters do, and they face the same resistance.

3.2 WET SHELTERS IN CANADA AND THE U.K.

Wet shelters are still a very new and innovative program. For this reason, there are very few wet shelters. Further to this, there is also a lack of information on the wet shelters that are in operation. The following sections will outline basic information about both of the wet shelters located in Canada, and the four wet shelters in the U.K. for which there was sufficient information. The list of wet shelters below is not exhaustive; however, there is little to no information available on other programs. Even with a limited sample, this selection of wet shelters shows much variety, illustrating the dynamic and assorted nature of wet shelter implementation.

3.2.1 Canada

Seaton House, Toronto

The Seaton House in Toronto is one service offered as a part of the Annex Harm Reduction Program. The Seaton house boasts 150 beds with overnight services open to those who have difficulties gaining access to other shelters in the area due to severe drug and alcohol addictions, mental illness, and any difficult behaviour that may stem from these afflictions. While staying at the Seaton House, clients may receive a measured dose of alcohol, or may trade in their non-beverage alcohol for beverage alcohol upon request. The shelters provide measured doses of alcohol at 8 ounces per hour per client for as long as the client is able to maintain daily functioning. While eliminating binge drinking, this method also reduces alcohol consumption by approximately 400% in the typical street drinker (Wilton, 2003).

Managed Alcohol Program (MAP), Ottawa

The Managed Alcohol Program (MAP) in Ottawa consists of a 23-bed facility for those chronically addicted to alcohol and homeless (Podymow et al., 2006; James, 2007, p. 11). This harm reduction program, developed in partnership with the University of Ottawa, provides clients with the option of up to 5 ounces of wine or 3 ounces of sherry every hour on request between 7 am and 10 pm every day (Podymow et al., 2006). The MAP program offers overnight stay, health care, psychiatric evaluations, and other social services, providing help for each client in an attempt to become a more stable citizen. Length of stay in the MAP program is indefinite, but the mean average length of stay for clients participating in the evaluative study was 16 months (range: 5-24 months) (Podymow, et al., 2006).

3.2.2 United Kingdom

Anchor Centre, Leicester

The Anchor Centre, located in Leicester, is unique in that its services reach out to not only chronic alcoholics, but also to drug mis-users. This wet day centre permits patrons only a limited amount of alcohol while on site – four cans of strong beer or 2.5 litres of cider for each client. Clients are not allowed to bring alcohol into the centre in glass bottles. In a survey on the facility, zero respondents thought that the facility itself was in need of any improvements. Surveys by the Leicester police as well as outreach workers from the Anchor Centre have reported that in certain public areas in town, drinking has totally ceased during the day (Crane & Warnes, 2003).

Tollington Way, London

The Tollington Way wet day centre in North London does not administer alcohol, but offers no limit to the amount consumed by clients, so long as clients are not belligerent or violent. This day shelter has found success in recruiting clients through an outreach program, where staff solicit street drinkers to come into the shelter. Unlike many other shelters, they do not have health staff on hand, but do make referrals to general practitioners (GPs), including one in particular who has a special interest in this group and will register those who are living in his catchment area (Crane & Warnes, 2003).

Handel Street, Nottingham

The Handel Street Centre was the first wet shelter in England, established in 1991. This centre is composed of two parts: a wet day centre and a wet hostel. The Handel Street Centre permits alcohol consumption on the premises. If necessary, staff replace the clients' non-beverage alcohol with beverage alcohol and monitor intake, but they do not administer alcohol. The Handel Street Centre has gone the furthest of any of the prominent wet shelters in regards to reaching out to the community. Clients at the wet shelter take part in community restoration programs that aim to make the streets and parks in the area litter-free. Community restoration projects give clients a sense of purpose while also improving relations with the surrounding

neighbourhoods. This centre has helped to sustain a five-year reduction in rough sleeping in Nottingham.

Booth Centre, Manchester

The Booth Centre staff do not allow drinking in the facility, but they will allow clients to drink in their private garden area. The wet garden idea came about when the City of Manchester created anti-drinking bylaws that covered the area where the Booth Centre was located. As the steps outside the day centre had been the favoured drinking spot, and since staff had been administering services to clients gathered in that area, staff introduced the “wet garden” proposal. The centre enacted the plan with the help of the clients. The Booth Centre has strong social programs, including help in acquiring birth certificates, finding housing, registering with a GP, as well as many volunteer programs in which to participate.

4 LITERATURE REVIEW

Literature on wet shelters is very scarce, and in many cases, the available documents rely on the same primary resources. For this reason, in the review of wet shelter program literature, two key documents informed the basis for analysis. The first document, *Shelter-based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol* is a study based on participant interviews from the Managed Alcohol Program (MAP) in Ottawa (Podymow et al., 2006). The study included seventeen participants of varying ages and backgrounds, with a mean duration of alcoholism of 35 years. The small sample size in this particular project has come under criticism for being too small in order to make useful conclusions, although Hwang (2006) also acknowledges it as a positive start. The catalyst for this study was an inquest into the freezing deaths of several homeless men. The inquest found that a significant number of homeless people would increase their consumption immediately prior to their entry into abstinent or dry shelters so that they would be able to last the night and to avoid “wasting” alcohol.

The study on managed alcohol administration came to many conclusions on the usefulness of these programs. It found that a managed alcohol program for homeless people with chronic alcoholism stabilizes alcohol intake while significantly decreasing ER visits and police encounters. Homeless people with chronic alcoholism have long been a hard to reach population given the severity and entrenched nature of street alcoholism. This study shows ways in which those with longstanding alcohol dependency issues can stabilize and in many cases move into abstinence programs or regular housing.

The second key document on the effectiveness of wet shelter programs is *Wet Day-Shelters in the United Kingdom: A research report and manual* (Crane & Warnes, 2003), which was commissioned by the King’s Fund and Homelessness Directorate. This study looked in depth at the historical development of wet shelters in the U.K., and outlined their current situation, including services offered, staffing regiments, and client capacity, among other categories of analysis. The data from this project spawned an article by the same authors (Crane & Warnes, 2005), and a summary report from the funding agency (King’s Fund, 2003) as well as informing other jurisdictional studies (James, 2007).

Crane and Warnes’ (2003) study on U.K. wet shelters examined each of the largest centres in the U.K. individually, focussing on the aspects of each that differ from the others. This study chose shelters based not only on their size but also for the unique features that they could add to the sample. The research portion of the report ascertained the efficacy of each shelter, while the second half of the report synthesized conclusions in order to create an instructional manual for those looking to create their own wet shelter program. The manual includes best practices as well as a breakdown of the critical areas requiring attention.

Given the newness of this field of interest, there is a significant gap in the literature. This particular topic has produced few studies or evaluations; the growing amount of grey literature

found in newspaper articles, exploratory reports, and organization information pages relies heavily on the studies completed by Podymow et al. (2006) and Crane and Warnes (2003) respectively.

There is, however, a significant amount of literature that while not specifically written on wet shelters can indeed cast a light on some of the important issues surrounding them. This growing body of literature describes the effects of different auxiliary programs that wet shelters frequently institute.

Culhane et al. (2001) described the effects of supportive housing for those homeless afflicted with mental illnesses. As up to 75% of the chronically homeless alcoholic population suffer from some form of mental disorder (Metraux, Marcus, & Culhane, 2003; Podymow et al., 2006), this report can provide some important insights. Based on the New York/New York Housing Initiative, this report found many advantages to the mentally ill being placed in assistive housing. The relevance of this study is in the results, which state that low barrier housing coupled with mental health services effectively reduced the number of days per year spent in a shelter.

The newspaper articles that have been found on the topic of wet shelters have – despite differences in locale – all focussed on the more personal side of the issue, highlighting interviews with participants, administrators, and potential candidates for joining wet shelter programs. These pieces seek to apply relatable personalities to the faces of the homeless, while simultaneously highlighting the potential benefits for the people in wet shelters. Tim Dick (2005) writes from the Australian perspective, highlighting the story of José, a street drinker who has lost everything due to his drinking but maintains hope of pulling himself off the streets. The article focuses on the specific services offered by British wet centres, as well as how these services might act to increase José's quality of life if instituted in Australia. Similarly, Chamberlain (2004) focuses on the services offered at wet shelters and how these have served past participants. He cites the example of one wet shelter veteran who after 20 years of rough sleeping was able to capitalize on the housing assistance in order to secure a flat for 18 consecutive months. In addition, Dunn (1986) writes about a former chronic alcoholic homeless man who has since turned his life around such that he now helps the administration of the damp shelter in Seattle. The newspaper articles all serve the same aims of educating the public as to the purpose and methods of wet shelter initiatives while attaching it to favourable personalities such as José.

There is also a relatively large amount of newspaper articles that focus on the institution of wet shelters in various jurisdictions. However, in the vast majority of these articles what are referred to as “wet shelters” would more accurately be described as damp shelters. These shelters will provide drug addicts and alcoholics a place to eat or to stay overnight, but will not allow the consumption of alcohol or drug use. Although in many cases, the end result of lobbying on behalf of wet shelters ends with no change, these articles are useful in their use of statistical and demographic data that speaks to the homeless alcoholic population and their effect on society.

5 DISCUSSION

5.1 PRINCIPLES BEHIND THE IMPLEMENTATION OF A WET SHELTER

The central principle driving the implementation of wet shelters is harm reduction. Although abstinence is encouraged and is the ideal goal, it is not required of clients using wet shelters. Proponents believe that a reduction in consumption in the form of an administration of measured doses of alcohol (or monitored consumption), rather than requiring a total abstinence from alcohol, results in clients making more progress. Although progress would seem to be slower than if abstinence was required, harm reduction strategies target those for whom traditional methods of aid have been unsuccessful. The principle of harm reduction has an immediate appeal to those in this population, as it offers a smoother transition from the lifestyle to which they have become accustomed. The principle of harm reduction does not replace that of abstinence, but rather serves it. However, the likelihood of the chronically alcoholic subset of the homeless population to quit drinking in this manner is low. Detoxification and abstinence are the best options from a health perspective; however, psychiatric illness, poor social support, lack of stable housing, long standing addictions, and refusals of treatment all stand in the way of this goal (Podymow et al., 2006).

The administration of measured “maintenance” doses of addictive substances is emerging, with growing support, as a feasible solution to city centre homeless addict issues (NAOMI, 2008; Minkoff & Drake, 1995). By-law enforcement and area-focussed policies tend only to shift problems to different areas. By-laws do not solve the problems on the streets; tickets and charges encourage offenders to move to different areas, but do not speak to the cause of their offence (St John-Brooks & Winstanley, 1998, p. 9; cf. Crane & Warnes, 2003). In estimates of cost savings, wet shelters reduce government spending in areas such as policing and hospital stays by more than five times more than the savings associated with street drinking bans (Cranes & Warnes, 2003). Harm reduction policies are a generally inoffensive method of addressing addiction issues. As studies show that 85% of Canadians with an alcohol dependency do not seek help for it (Mann, 1997; Wells-Parker et al., 1995), the solution to street alcoholism will likely reside with active initiatives such as wet shelter programs.

5.2 BARRIERS

5.2.1 Community Reaction

In almost all cases, there is resistance by the surrounding community at the commencement of a new wet shelter (Crane & Warnes, 2003; Williams, 2004). This resistance comes from both neighbourhood citizens as well as local business owners, and is based on fears that there will be alcoholic, homeless drug users milling around their neighbourhoods.

For business owners, this represents a potential pitfall against walk-in business. Business owners in London near the Tollington Way Centre reported lower numbers of women and children using their services. Business owners thought this to be due to the number of wet shelter clients that frequented the area near the storefront (Crane & Warnes, 2003).

For citizens, wet shelters represent a potentially violent threat against themselves and their children. In the U.K., intimidation was one reason the area residents contested wet shelters. In one instance, a client chained his two Rottweilers to a fence, causing intimidation to passers-by (Crane & Warnes, 2003).

5.2.2 Staffing Issues

Maintaining an effective staff in a wet shelter stands as a challenge for two main reasons. First, it is a position that requires one to be highly trained and continually updating one's occupational qualifications. Second, it is a position that absorbs a higher than usual rate of abuse and emotional distress.

Wet shelter programs offer a plethora of services, including but not limited to: close supervision, assistance with activities of daily living, on-site health care, mental health, social services, laundry, GP registration, outdoor pursuits, health and safety checks, counselling, and skill building. These regimented services as well as other tasks that arise out of an unpredictable client base require much training in health and medical fields, as well as conflict resolution and counselling.

The *Research Report: Harm Reduction Emergency Shelter For Halifax Regional Municipality* (McNeil, 2002) as well as *Wet Day Centres in the United Kingdom: A research report and manual* (Crane and Warnes, 2003) concluded that staff need to be knowledgeable of a clear protocol in order to maintain a highly structured shelter and not descend into a "flop house" (McNeil, 2002, p. 31; Crane and Warnes, 2003). This strict adherence to guidelines means additional training requirements for staff who must remain up to date on these protocols. The required qualifications of staff limit both the potential pool of staff, as well as the usefulness of untrained volunteers.

Given the nature of the client base, aggressive actions, unpredictable behaviour and death are somewhat common. Staff are required to check on clients frequently in order to ensure safety (McNeil, 2002, p. 31). Once stabilized, clients are still susceptible to falling ill as a result of an on average 35-year alcohol addiction, of which death is often the end result (Podymow et al., 2006). Through counselling and other activities, wet shelter staff garner close relationships with clients, and death can be traumatic. Furthermore, drunkenness as well as being under the influence of illicit drugs can result in a lashing out at wet shelter workers; violent episodes can negatively affect staff. All of these potential workplace dangers add up to a taxing and emotionally wearing occupation, thus making it difficult to maintain long-term employees at wet shelters.

5.2.3 Moral Issues with Supplying Alcohol to Addicts

On the surface, providing alcohol to alcoholics may seem counter-intuitive. One outlook on this policy is that it is unhelpful and immoral to provide alcohol to someone with an alcohol dependency. Proponents of harm reduction programs however, claim that these programs are not meant to replace abstinence programs (which stand as the healthier option), but rather to complement them. Allowing consumption of alcohol in order to stabilize its intake is a means to working towards abstinence or controlled use. Critics need not think of wet shelters as condoning negative behaviour.

Harm reduction policies do not, as many critics believe, encourage heavy consumption or drug use among non- (heavy) users. As James (2007) points out, there is a complex network of factors that influence one's decision to partake in heavy drug use or alcohol consumption. Thus, merely being in proximity to other drinkers is often not a large enough influence to encourage others to drink. Furthermore, this view, as James (2007) states, ignores the large number of scientifically conducted studies that provide no evidence to the idea that harm reduction programs facilitating anti-social behaviour (drinking or drug use) actually encourage this behaviour among others.

5.3 OUTCOMES AND IMPACTS OF WET SHELTERS

5.3.1 Clients

The implementation of wet shelters most greatly affects individual clients. Their use of wet shelter facilities result in an improved quality of life in many different regards including the improvement of health, increased number of social ties, and more social behaviour. At the most general level, clients self reported that they experience higher levels of satisfaction with their life (Pavot & Diener, 2003; cf. Podymow et al., 2006). For many, a positive outlook such as this on life becomes the first step to a positive recovery. Evident here are the main advantages to wet shelters for the homeless population: a warm place to stay and an opportunity to start moving forward. Clients can “move forward” in any number of ways, many of which will be addressed in this section.

The clients' health and well-being, the main focus of wet shelter programs, is the area where the most improvements were found. In Ottawa's MAP program, drinking levels for all clients was lowered as a result of staying at the wet shelter, often by levels around 400% (Podymow et al., 2006). Additionally, the alcohol that is consumed is of much higher quality (i.e.: beverage alcohol rather than non-beverage alcohol) resulting in less bodily wear. The wet shelter programs are able to stabilize the drinking of individuals who stay in them; however, clients in wet shelters that only offer day services often take up drinking outside of facility hours (Crane & Warnes, 2003).

With the stabilization of drinking, the clients accrued further health benefits. Medical staff were able to more easily diagnose other health concerns once drinking had been controlled. Clients

were more receptive to medical staff, and would comply to a higher degree with appointments as well as with prescriptions (Podymow et al., 2006). In the case of the Seaton House, where doctors diagnosed 14 clients with tuberculosis, clients were convinced to stop, if not drastically decrease, their drinking in order to allow medication to work without causing severe liver damage (Wilton, 2003). Doctors were able to effectively cure all patients in Seaton House of tuberculosis. Further to medical diagnoses, doctors can also more easily identify mental illnesses in wet shelter clients once their drinking habits stabilize. The diagnosis of mental ailments is important, considering that 75% of homeless alcoholics are also mentally ill (Metraux, Marcus, & Culhane, 2003; Podymow et al., 2006), a condition labelled HDD or homelessness and dual diagnosis.

The immediate health benefits of wet shelters are plentiful, but additionally there are many long-term benefits from the use of wet shelters. Clients have responded well to the use of the wet shelter as a step into abstinence programs. Attempting to quit drinking can prove highly difficult for those with lengthy addictions, but the wet shelter allows clients to attempt abstinence for many reasons. Firstly, once stabilized, abstinence is far easier, meaning that clients are more likely to succeed. Stabilization means that the homeless alcoholics are not abstaining from alcohol “cold turkey,” but rather can adjust to lowered levels of consumption before moving further forward. In addition, when using the wet shelter method of lowered and controlled consumption, clients are far less likely to suffer from seizures in the process of withdrawal. As studies show, “multiple episodes of alcohol withdrawal may increase the incidence and severity of seizures during detoxification, render a person more vulnerable to brain damage, and contribute to alcohol related neuropathology and increased cognitive dysfunction” (Becker, 1998; Littleton, 1998; *cf.* Crane and Warnes, 2003, p. 8). Stabilized drinking also allows the diagnosis and treatment of other ailments that can make quitting drinking altogether far easier.

Beyond merely providing health benefits, wet shelters, along with their auxiliary services aid clients in securing housing, registering with a GP and learning job skills. These are all important tasks to complete in order to secure a re-integration into greater society. There were more than a third of the clients at Manchester’s Booth Centre that were able to secure permanent or temporary housing. Nottingham’s Handel Street Centre and Leicester’s Anchor Centre both boast only slightly lower numbers than the Booth Centre (Cranes & Warnes, 2003: R5).

While 75% of homeless in the Capital Regional District, as an example, are male (Population-at-Risk Profile, 2007), the female homeless population is under-represented in wet shelters. Although some jurisdictions maintain women’s damp shelters (McNeil, 2002; Olmstead, 2008), it is by no means the norm. As a large part of the appeal of wet shelters is in the camaraderie between clients (Crane & Warnes, 2003; Dick, 2005), this is not always a favourable environment for homeless female alcoholics looking for help. Female shelter clients stated that it was tough to be a female at a shelter filled with mostly or only men (Olmstead, 2008).

For all the benefits that wet shelter usage brings, wet shelter administrators do not presume to be able to save everyone; some clients will inevitably die while still using the centres (Podymow et

al., 2006). A lifetime of drinking harsh alcohol and sleeping rough on the streets takes its toll. Although wet shelters stabilize and house clients, many are fated to succumb to the ill effects of their lifestyle. In this regard, proponents view wet shelters as a means to improving clients' quality of life while they remain.

5.3.2 Public Service

The public service sector will find many benefits and downfalls to the institution of a wet shelter program. Financial data is limited and scattered but can provide important insights into the desirability of creating a program of this sort. The City of Victoria's report, *The High Cost of Inaction* stated that the Victoria Police department had identified 324 homeless residents (out of 1,242 Capital Regional District residents identified as homeless), who were responsible for 23,033 encounters over 40 months, with a total cost to the city of \$9.2 million (High Cost of Inaction, 2007; Population at Risk Profile, 2007). The study also noted that many of those homeless identified suffer from substance abuse issues or dual diagnoses. Further to these costs, the City of Victoria also spent \$1.4 million on costs associated with homelessness. This includes clean-up costs, needle pick-up, damage to sensitive ecosystems, security, and responses to complaints (High Cost of Inaction, 2007).

A feasibility study of a wet shelter program in Halifax calculated some of the costs associated with homelessness. Costs included \$795/day in order to stay in a hospital overnight, and \$330 every time a drunk or addict "comes to the emergency room seeking shelter" (McNeil, 2002). The government absorbs \$200 each time the police have to arrest and hold an intoxicated individual in a holding cell for up to six hours. These are all areas where the government would dramatically reduce their costs. Indeed, wet shelter clients in Ottawa's MAP program used these services far less after admission than they did before (Podymow et al, 2006).

The Managed Alcohol Program (MAP) study found that the population of homeless alcoholics, due to their lifestyle, are at much higher risk of needing to use emergency services. Intoxication, withdrawal or its complications are among the top reasons for ending up in an emergency room. Chronic illnesses are far more prevalent in the homeless population as well, making their visits to the hospital lengthier, and more costly (Podymow et al., 2006). The nature of being an alcoholic living on the street also greatly increases the chances that police will arrest them for public drunkenness or charge them for any inappropriate behaviour. Finally, homeless people have a higher mortality rate compared to those with a permanent residence. It is with these factors that we can see a direct cost savings in a wet shelter program. Podymow et al.'s (2006) study on Ottawa's MAP program shows that the wet shelter helped to improve all of these above areas.

Emergency room visits for the residents of Ottawa's MAP wet shelter dropped from a mean average of 13.5 times each month to only 8.1 times. Similarly, the average number of police encounters dropped from a substantial 18.1 times each month to only 8.8 encounters. Mirroring these trends, the use of ambulance services, hospital admissions, diagnoses of intoxication, trauma and convulsion also showed marked decrease, although not to the same extent (Podymow

et al., 2006). Podymow et al. (2006) also conducted a cost-analysis for the MAP program and Ottawa area, where they estimated that the monthly per client savings on emergency room visits was \$96, while \$150 was saved on hospital care and \$201 on police services (Podymow et al., 2006). Crane and Warnes' (2003) U.K. study cited that participants in wet shelter programs decreased their prison time, providing another substantial cost savings. An evaluation of the Anchor Centre in Leicester estimated that £248 000 would be saved every year based on cost savings on fewer arrests, tenancy failures, hospital stays, policing, casualty admissions, health care, custodial sentences, street maintenance and security (Leicester City Council, 1999; cf. Crane and Warnes, 2003).

Chronically homeless lifetime alcoholics have an incredibly hard time with detoxification programs due to the severity of their addiction. Stabilization in a wet shelter increases the likelihood that they will be successful in a detox program (Podymow et al., 2006; Crane & Warnes, 2003; Dick, 2005). There are many cost savings associated with this statistic as well; according to the Marguerite Centre in Nova Scotia, a rehabilitative care and detoxification centre, some clients have gone through detox up to 96 times, which comes at a cost of \$85-\$90/day (McNeil, 2002). Thus, fewer attempts at detox translates to dollars saved.

The City of Nottingham, home of the Handel Street Centre reported a five-year reduction in rough sleeping, partially due to the efforts of the Handel Street Centre (Crane & Warnes, 2003). This benefits the city in not only improving the overall downtown aesthetic, but also means less need for street outreach programs targeted to rough sleepers.

The cost of a wet shelter program naturally varies depending on the services offered, among other factors. The estimated costs of the MAP program out of Ottawa, was approximately \$771 per client per month (Podymow et al., 2006). The breakdown of individual costs included in this analysis was unavailable, as it did not accompany the study for which it was completed. This cost would however, be further offset by the different savings to be found in other areas of social services, as well as intangible costs such as tourist dollars that increase due to the improved street conditions.

5.3.3 Community

Community consultation stands as an important stage in the development of a wet shelter. While many would applaud the efforts to 'clean up the streets,' this sentiment fades with practical application. In Leicester, 70% of the public supported the implementation of a wet shelter in order to manage the street drinking problem (Leicester City Council, 1999). A shelter for homeless street drinkers to socialize and drink their alcohol is not something that would be welcomed to a neighbourhood, but rather something that is tolerated. Thus, the importance of community consultation cannot be stressed enough.

The presence of a wet shelter in a community has the potential to become a lightning rod for criticism. Sensitivity to the idea of a wet shelter can cause community members to lobby unfair

complaints against the facility. In Leicester, home of the Anchor Centre, area residents complained that there was an increase in litter in the form of beer cans and bottles from the facility's clients. Staff remarked that this was unfair criticism, as the majority of the bottles and cans making up the litter in the area consisted of different brands of alcohol than those consumed by the vast majority of clients (Crane & Warnes, 2003).

One method of appeasement for the community came from the Handel Street Centre, who, as a part of their rehabilitative services, provided a community beautification service. As a part of this service, wet shelter clients would pick up litter, plant and tend gardens as well as other activities that served to bridge the gap between wet shelter client and community resident. These activities also served to provide meaningful tasks to clients that could bring tangible growth to both themselves and the community.

Community members have reported feelings of anxiety and intimidation in relation to wet shelter clients. "Street drinkers, particularly in groups that commandeer prominent spaces in town centres and parks, are perceived by the public as intimidating, and businesses are aggrieved by the damage they cause to their trade" (Shimwell, 1999; Vision Twentyone, 2000; *cf.* Crane and Warnes, 2003). Evident here is the importance of actually addressing the issue rather than displacing it. A wet centre need not be merely a point of congregation for drinkers, but rather a productive space.

The release of large amounts of people at once was also a consistent cause for concern across wet shelter facilities. In one case, the closing time of the wet shelter (a day centre) coincided with the release time of the local theatre. This caused the release into the street of a large group of people from both the wet shelter and the theatre at approximately the same time. Theatregoers reported feelings of intimidation and uneasiness. Another complaint came from a school whose end bell also coincided with a wet shelter's hours of operation, making parents uncomfortable with the clash (Crane & Warnes, 2003).

5.4 LESSONS LEARNED/BEST PRACTICES

One of the most important, yet most difficult tasks of the wet shelter facility is to find and hold onto grounds that are deemed suitable by both staff, clientele and of course, the surrounding community. Forums and talking sessions with the residents, local businesses and voluntary and statutory organisations operating in the area can effectively serve to learn of and to address relevant concerns. Clear guidelines or protocol can help staff minimise the impact of the centre on the neighbourhood as well as providing a place to enact change when necessary (Crane & Warnes, 2003; Crane & Warnes, 2005).

Another crucial aspect to any wet shelter is the auxiliary services that they offer. These services, including street outreach, housing support, detoxification programs, and health services, often require the help of other agencies, which means that input from these agencies in advance of full wet shelter implementation is ideal.

There are different structures in different jurisdictions for instituting wet shelters, largely dependent on available local resources (staff, facilities, etc.). One major difference is the hours of operation, given that some wet shelters mean for clients to stay indefinitely, whereas others shut down at night, expecting clients to return in the morning. Many of the advantages accrued from a wet shelter can be seen in wet day centres (sometimes still referred to as wet shelters in the literature), as the goal of reducing or stabilizing drinking is still accomplished. However, overnight wet shelters ensure near full coverage of the clients' drinking habits, and can thus guarantee client progress to a greater degree.

Studies in Halifax and the U.K. both concluded that awareness of wet shelters by the targeted homeless population is key to a wet shelter's success. This highlights the importance of street outreach programs, as they bring people off the street as well as bringing information to those that are sleeping rough. Bringing people off the street and informing them of services offered is important, as Wells-Parker et al. (1995) cite that 85% of Canadians with alcohol dependence issues do not seek help (Wells-Parker et al., 1995). Furthermore, the *Research Report: Harm Reduction Emergency Shelter for Halifax Regional Municipality* concluded that the slow rate of time it takes homeless persons to trust a new service may have caused the initially low participation rates in Halifax (McNeil, 2002).

CONCLUSION

This Scoping Review has examined many of the outcomes from early adopters of wet shelter programs for the chronically alcoholic homeless. Currently, only Canada and the United Kingdom have instituted wet shelters, while other jurisdictions have attempted damp shelter programs. Wet shelters address a subset of the homeless population that, while requiring the most attention, are most often denied access to established shelter programs due to their addictions, mental health, or behaviour stemming from either. Administrators seem to address homelessness, mental illness and drug addiction as mutually exclusive categories. Shelters aimed at helping those who are homeless or living with mental illness will often only do so for those that abstain from drugs and alcohol. This is something that may not be feasible without some initial help. That being said, it is very difficult to abstain from drugs and alcohol without having a permanent residence or regular access to a shelter.

In an attempt to address long-standing health concerns, wet shelters actually serve to decrease alcoholic consumption while providing alcohol or monitoring intake. It is from this one benefit that so many others come forth. Once stabilized, clients had myriad psychological and medical disorders diagnosed, which were subsequently cured or managed. Furthermore, studies show that alcoholics attempting to quit or curb drinking through wet shelters are less susceptible to seizures and brain damage than those who immediately abstain or quit cold turkey.

Outside of health benefits, clients also accrued social benefits from enlisting in a wet shelter program. Clients' overall life satisfaction increased while at wet shelter facilities, due in part to the very social atmosphere. Wet shelter workers also worked to register clients with GPs, obtain birth certificates and other records in order to aid clients in finding work and housing.

The government also benefits from wet shelter implementation. Studies found cost savings in fewer ambulance rides, fewer ER visits and a decrease in police encounters on the clients' part. Wet shelters also reduced the number of times clients would check-in to abstinence programs, only to relapse and check back in, creating additional cost savings. Finally, some cities who had implemented wet shelter programs found an overall decrease in rough sleeping and a better downtown aesthetic.

Executed under prime circumstances, a wet shelter can provide excellent care to a population generally observed to be a lost cause. Wet shelters can provide helpful services to the community while those that other shelters cannot or will not accommodate can learn to help themselves with the aid of facility workers. However, without proper planning and consultation, wet shelters have the potential of fostering uneasiness in the community while ineffectively serving those that they aim to help.

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