

October 2018

## ***Department of Health (NT)***

### ***Review of the Northern Territory Sobering Up Shelters***



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# Executive summary

## Scope and Terms of Reference

Subsequent to the Alcohol Polices and Legislation Review (Riley Report) conducted in 2017, PwC's Indigenous Consulting (PIC) have been engaged to review and evaluate the nature of the services provided by Sobering Up Shelter (SUS) services in the Northern Territory and to consider how they may be enhanced and strengthened in line with the key focus areas below:

- Identify opportunities for enhancements to ensure SUS are well placed in the service system, ensuring continuum of service for clients.
- Identify if the current infrastructure including number and configuration of beds at each existing SUS are adequate to meet community standards.
- Identify a high level SUS service model considering factors that may impact on that model with regard to implementation in each geographic area such as peak demand times, staffing levels, key performance indicators and accreditation.
- Determine whether the current AUDIT (or similar) screening tool is being completed with every client, whether it is the most appropriate tool to use and identify reasons for low utilization rates in some SUS services.

## Evaluation methodology

The review was conducted using a combination of quantitative and qualitative methods. In cooperation with the Department of Health Northern Territory's Mental Health, Alcohol and Other Drugs Branch team PIC were able to engage with multiple stakeholders from each of the SUS services as well as stakeholders that have regular direct contact with the SUS services.

Initially a desktop review was performed on all relevant and pertinent information documents and data sets for each service. This was provided to PIC from the department through the AOD Treatment Systems Coordinator. PIC also undertook a desktop review of past reviews and the consultations themes arising from these. These reports included the Riley report and the Internal SUS review conducted by the Department of Health in 2013. The data identified through reviewing these sources enabled PIC to identify areas of focus for discussion when conducting the interviews with SUS services and stakeholders.

Workshops were then held in each region to meet with individual services and key stakeholders for the purpose of understanding their current service model strengths and weaknesses, and for developing future service provision models and possible enhancements. Any stakeholders that were unable to be engaged in person were consulted by email and phone.

Following documentation of the regional summaries, these were provided to each of the SUS Managers for validation.

## External parties consulted

It was important to consult with relevant external stakeholders to further understand possible enhancement opportunities to the service delivery of SUS services in each region. This was particularly important in understanding issues previously raised in relation to the operating hours of SUS services, referrals to other health service providers, BDR referrals and transport.

## Summary of recommendations and enhancements

Throughout consultations conducted with the SUS service providers and relevant stakeholders and analysis of data, it was identified that there were recommendations and enhancements that were specific to certain locations, common across multiple locations and finally across the service system as a whole.

The recommendations of this report are not presented in priority order but rather as they relate to findings of the SUS review, against the four evaluation questions.

### 1) Opportunities for enhancements to ensure continuum of service for clients.

- *MHAODB coordinate and facilitate regular regional workshops with all stakeholders to ensure a coordinated AOD service systems approach that is aligned to Service Level Agreements and consistent with the referral process contained within the current guidelines.*
- *Ensure the operating hours of the SUS services maximise client access to outreach support services to assist in the provision of information and referrals to health and other support services.*
- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures.*

### 2) Adequacy of current infrastructure to meet community standards.

- *MHAODB work with Police and the Nhulunbuy Hospital to further interrogate the client pathways to determine whether the service should be closed or relocated.*
- *Undertake formal site assessment of the SUS facilities and infrastructure in Alice Springs to identify minor works to improve client entrance space and increase the bathroom facilities.*

### 3) A high level SUS service model.

- *Ensure the appropriate engagement and communication is occurring between the SUS and other health service providers to deliver more comprehensive service provision to clients.*
- *Use the regional workshop mechanism to implement a six monthly review and planning process to assess the need for adjusting opening hours to coincide with the fluctuating seasonal demand for service by clients due to a range of factors or local decisions.*
- *Further explore alternative resources and costs for transporting clients between SUS services and other health service providers, in the instance where the police or night/day patrol cannot.*
- *Where the SUS service provider is not already accredited with an existing health standards body, they be supported by NT Health to undertake the self-assessment and accreditation process to attain the QIC Health and Community Service Standard (7<sup>th</sup> Edition).*

### 4) Use of the AUDIT (or similar) screening tool.

- *Implement the recording of AUDIT scores as a KPI and reporting requirement in all of the Sobering up Shelter service agreements to assist in accountability of referral processes.*



# Contents

Executive summary	i
1 Background – Sobering Up Shelters Review	1
1.1 Sobering Up Shelters role and function	1
1.2 Current operating model	1
1.3 Findings of the Alcohol Policies and Legislation Review	3
2 High level themes and recommendations	5
2.1 SUS role in an integrated health and AOD service system	5
2.2 A comprehensive SUS model	6
2.3 Implementing an integrated service system	9
2.4 Recommendations and possible enhancements	11
3 Site by Site Key Findings and Recommendations	12
3.1 Alice Springs	12
3.2 Tennant Creek	17
3.3 Katherine	21
3.4 Darwin	25
3.5 Nhulunbuy	29





# 1 Background – Sobering Up Shelters Review

## 1.1 Sobering Up Shelters role and function

Sobering up Shelters (SUSs) were established in 1982, funded by the Northern Territory Government (NTG), in an effort to address and minimise the harm intoxicated individuals could potentially inflict on themselves, their families and their communities<sup>1</sup>. SUSs currently operate under a philosophy of harm minimisation and are non-custodial. Clients are able to refuse to be taken to a SUS and may leave at any time subsequent to admission. Harm minimisation is an approach that aims to reduce the adverse health, social and economic consequences of drug use by minimising the harms of drug use both for the community and the individual, without necessarily eliminating use.

As well as mitigating the risks associated with being intoxicated, SUSs provide an opportunity for brief intervention and referral point to ongoing treatment and care if required. Additionally there are important linkages with police patrols and night/community patrol services in the respective regions.

Under Section 131 of the *“Police Administration Act”*, a police officer can release an intoxicated person *“into the care of a person who the member reasonably believes is a person capable of taking adequate care of that person”*. However, the intoxicated person may object to being released into the care of that person, in which case Police may need to take that person to the watch house<sup>2</sup>. Therefore, as an alternative to police custody, SUSs exist to provide a safe and caring place for intoxicated individuals to reside and remain during the sobering up process.

## 1.2 Current operating model

SUSs are currently operational in five townships and cities within the Northern Territory, locations being – Alice Springs, Tennant Creek, Katherine, Darwin and Nhulunbuy. Funding is provided through the Department of Health through grant agreements to a variety of non-government organisations. The service provider for each location are:

- Alice Springs - Drug and Alcohol Services Alice Springs (DASA);
- Tennant Creek - Barkly Region Alcohol Drug Abuse Advisory Group (BRADAAG);
- Katherine and Darwin - Mission Australia (MA); and
- Nhulunbuy - East Arnhem Regional Council (EARC)

It is important to note that although SUSs across the Northern Territory are independently managed they are governed by a set of guidelines developed by the MHAODB to ensure that a holistic and consistent approach to service delivery is being provided to patients who are presenting at a SUS in all locations. The guidelines are listed under the Standards and Quality Improvement section of the funding agreement and stipulate that SUS providers must abide by them, although it must be noted that there are some regional variances in the model of practice that will be outlined later in the report.

There are three main mechanisms of referral to a Sobering up Shelter in the Northern Territory:

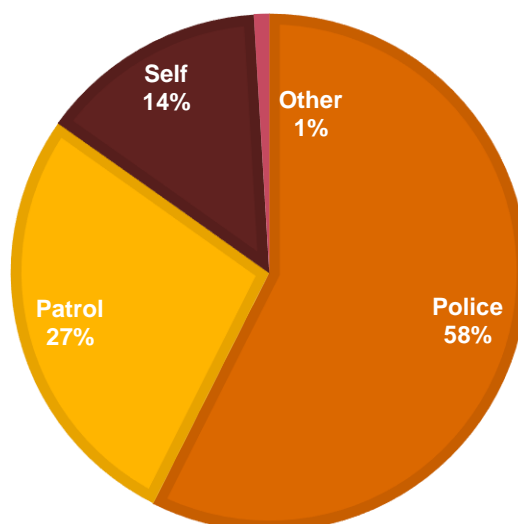
- 1) Referral and transportation to the SUS by Police,
- 2) Referral and transportation to the SUS by Night/Day patrol; and
- 3) Self-referral

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<sup>1</sup> Department of Health (NT) – Alcohol and Other Drugs Directorate, *Guideline for the establishment and Operation of a Sobering Up Shelter Service*, June 2017.

<sup>2</sup> Department of Health (NT) – Alcohol and Other Drugs Directorate, *Guidelines for the establishment and Operation of a Sobering Up Shelter Service*, June 2017

Figure 1: Referral to SUS NT Wide June 2017-May 2018



Notes: A person can be also referred via relatives or community members although this method differs from location to location and is not always identified as a source of admission. St John Ambulance policy prohibits them from referring or transporting a client to a SUS location. Data above reflects admissions from June 2017 - May 2018.

Once a client is presented to a SUS they are assessed by a care worker as to whether the SUS is an appropriate place for the individual and that there are no obvious circumstances to which further harm or risk could come to the client, workers or others within the shelter i.e. too intoxicated, high risk injuries, pre-existing medical conditions or aggressive/ abusive behaviour. This assessment generally includes testing whether a client can walk unassisted, if not they will not be accepted into the SUS. When an individual is unable to be accepted into the SUS, the referral source will be instructed to transport the individual to an alternative location such as the hospital or the watch house, depending on their condition. If the individual is transported to the hospital, the referral point will ensure the client is accepted through the triage process however does not stay for the duration. The watch house transportation is generally seen as a last resort after other options have been exhausted.

Police and night patrol services are provided with a list of SUS banned clients however will generally call the SUS location prior to arrival as the list is provided monthly. This is one process to increase efficiencies and maintain sound working relationships with external services.

Once accepted into the SUS, clients are monitored by care workers who are equipped to the equivalent level that would be expected to be provided by a reasonably informed, concerned adult in a private community context<sup>3</sup>. Clients are provided with a shower, a clean bed, washed clothes, refreshments and a nutritious snack when sober. There is no specified length of time a person is required to remain in care and clients are free to leave whenever they would like, although all are encouraged to stay the night. For the duration of the sobering up process clients are monitored and assessed regularly for any changes in their condition which would indicate any health problems requiring medical attention from another service during their stay. If this is the case an ambulance will be immediately called and the client will be transported to the hospital.

Prior to departure clients are provided with a nutritious snack to ensure that they are not leaving hungry and with an empty stomach. The SUS guidelines require that every client should be screened and interviewed using the Alcohol Use Disorder Identification Test (AUDIT) once sober enough to do so. This screening tool was developed by the World Health Organisation (WHO) and is a valid and reliable measure for identifying alcohol abuse problem behaviours<sup>4</sup>. Depending on the results of the AUDIT, further information on the health effects of

<sup>3</sup> Department of Health (NT) – Alcohol and Other Drugs Directorate, *Guidelines for the establishment and Operation of a Sobering Up Shelter Service*, June 2017

<sup>4</sup> Babor et al, World Health Organization, *The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care*, Second Edition, 2001



excessive alcohol consumption is explained to the client together with advice that assists in the option for possible referral to additional support services.

In total there are 96 SUS beds across the five locations. On any given night, an average of 32 people will be staying in a SUS across the Northern Territory. Of these, 99.1% are Indigenous and 56.9% are women and 80.7% are people who have previously stayed in a SUS. There are seasonable and regional variations in the utilisation of the SUS, with utilisation rates ranging from an average of 8.8% to 59.8%. Table 1 provides a summary of the core utilisation for the SUS services across the NT along with the percentage of admissions with a frequency greater than one.

*Table 1: Summary SUS data (June 2017 to May 2018)*

	Alice Springs	Darwin	Katherine	Nhulunbuy	Tennant Creek	NT
Total beds available a week <sup>1</sup>	96	280	90	24	112	602
Weeks of operation	52	52	52	52	52	52
Total bed nights available p.a	4,992	12,768 <sup>2</sup>	4,680	1,248	5,824	29,512
Total admissions p.a	2,983	5,009	575	110	1,403	10,080
Average utilisation p.a	59.8%	39.2%	12.3%	8.8%	24.1%	34.2%
Client frequency greater than 1 as a percentage of total admissions <sup>3</sup>	77.9%	81.4%	66.4%	50%	91.8%	80.7%

Notes:

- <sup>1</sup> Total beds available a week is determined by number of beds available per night multiplied by days of operation per week. Note that all locations are funded for a different number of days and operating days.
- <sup>2</sup> Effective 1 January 2018 Darwin increased bed capacity from 32 to 40. Therefore total nights available has been calculated using June 2017 to December 2017 with 32 beds and January 2018 to May 2018 being 40 beds.
- <sup>3</sup> This data indicates the **admissions** from individuals being presented to the SUS on more than one occasion as a percentage of **total admissions**. It does not show the percentage of **clients** who were presented to the SUS on more than one occasion as a percentage of **total clients**. For example Alice Springs had 471 of 1057 clients present more than once (44.6%), whereas the admissions from clients who attended more than once accounted for 2,066 of 2,653 admissions (77.9%). Note that the data period utilised in client frequency is from September 2017 to June 2018.

### 1.3 Findings of the Alcohol Policies and Legislation Review

The Alcohol Policies and Legislation Review (Riley report) was conducted in 2017 by an independent Expert Advisory Panel with the overarching objective of developing an integrated Alcohol Harm Reduction Strategy<sup>5</sup>.

The report made six recommendations<sup>6</sup> specific to SUS services across the Northern Territory arising, those being:

- A review of SUS services across the Northern Territory be undertaken to:
  - o Identify geographic areas of need
  - o Identify if the current beds in each existing SUS are adequate
  - o Identify the most effective service delivery and funding model for each geographic area
  - o Determine whether the current AUDIT (or similar) screening tool is being completed with every client and whether it is appropriate tool to use

<sup>5</sup> Northern Territory Government, *Alcohol Policies and Legislation Review*, October 2017

<sup>6</sup> Northern Territory Government, *Alcohol Policies and Legislation Review*, October 2017

- Examine and address the reasons for the low usage rates.
- The SUS Monitoring System be expanded to record the score generated from the use of the AUDIT (or similar) screening tool.
- Appropriate key performance indicators for SUS operations be established to measure the number of referrals to treatment services based on the score generated from the use of the AUDIT (or similar) screening tool.
- SUSs be appropriately staffed to enable assessments to be made and advice offered regarding rehabilitation and other treatment services.
- In relation to a person apprehended in Part V11 Division 4 of the Police Administration Act, Police be required to exhaust all other reasonable alternatives for the person's care and protection before detaining a person at a police station under protective custody laws, this should be monitored to ensure this is occurring.
- SUSs should have funding certainty for seven years (ten years in remote communities).

The Riley report recommendations specific to the SUS indicate that the Northern Territory needs a comprehensive, coordinated and sustained approach to reducing alcohol related harm. The approach must focus on supporting those affected by alcohol misuse, addressing social determinants (in particular housing, employment, education and access), educating the population about the detrimental effects of excessive and sustained alcohol consumption, ensuring measures are culturally responsive, targeting the supply of alcohol, and strengthening and supporting licensing and enforcement agencies and regulations.<sup>7</sup>

In the recommendations regarding sobering up shelters the reviewers also called for a review to ensure the operating hours of the shelters and community patrols reflect the demand for services and there be coordination between the two services in each location.<sup>8</sup>

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<sup>7</sup> Northern Territory Government, *Alcohol Policies and Legislation Review*, October 2017

<sup>8</sup> Northern Territory Government, *Alcohol Policies and Legislation Review*, October 2017

## ***2 High level themes and recommendations***

The review identified strengths, weaknesses and opportunities for improvement in the current operating model. This chapter summarises the high level findings of the processes and practices currently implemented within SUS services as well as a preferred more integrated model for how the SUS might operate alongside other health and community services.

Although these high level findings are generally consistent amongst all SUS services there are elements that are unique to each location, and these are further explored in section 3 “Site by Site key findings”.

### ***2.1 SUS role in an integrated health and AOD service system***

Clients accessing SUS services are generally regarded as being at the pre-contemplative stage of change. The stages of change model developed by Prochaska & DiClemente in the 1980’s, states that people who are in this stage are not thinking seriously about changing and tend to defend their current AOD use patterns. They may not see their use as a problem and the positives or benefits of the behaviour outweigh any costs or adverse consequences so they are happy to continue using<sup>9</sup>. People at this stage are often not ready to accept assistance or offers of treatment and may only accept support to meet their day to day needs.

However as the Australian Institute for Health and Welfare statement on harmful use of alcohol and other drugs recommends, a comprehensive approach to this complex, multi-causal problem is needed so that there are opportunities for people to move to the next stage of change. The components of a comprehensive approach are:

- 1) addressing the underlying social determinants;
- 2) adopting a prevention/minimisation approach to harmful use;
- 3) providing safe acute care for those intoxicated;
- 4) providing treatment for those who are dependent;
- 5) supporting those whose harmful alcohol use has left them disabled or cognitively impaired;
- 6) supporting those whose lives are affected by others harmful alcohol use<sup>10</sup>.

Through consultations held in all SUS locations it was widely considered that the SUS plays a key role in meeting the immediate safety and care needs of people who regularly abuse alcohol in a non-punitive environment while also offering a mechanism for referral to other services to enable behavioural change. All stakeholders, specifically Police and Night Patrol services reported the value of this approach as an alternative to Police protective custody or hospital (unless required for health reasons) and that the SUS was also a more cost effective use of resources.

However the level of integration between the SUS and the other parts of the health and AOD service system varies from location to location. For example, where there are differences in operating hours between SUS services and transport services such as the day/night patrols there may be missed opportunities to provide safe care. Also in

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<sup>9</sup> <http://www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front9-wk-toc~drugtreat-pubs-front9-wk-secb~drugtreat-pubs-front9-wk-secb-3~drugtreat-pubs-front9-wk-secb-3-3>

<sup>10</sup> Gray & Wilkes 2010



locations where the relationships and linkages between the SUS and health service providers are not strong, referrals may go unaddressed or there could be potential duplication of effort, which make managing and coordinating additional health support challenging. This is an issue as many of the service providers have the same client for different health requirements.

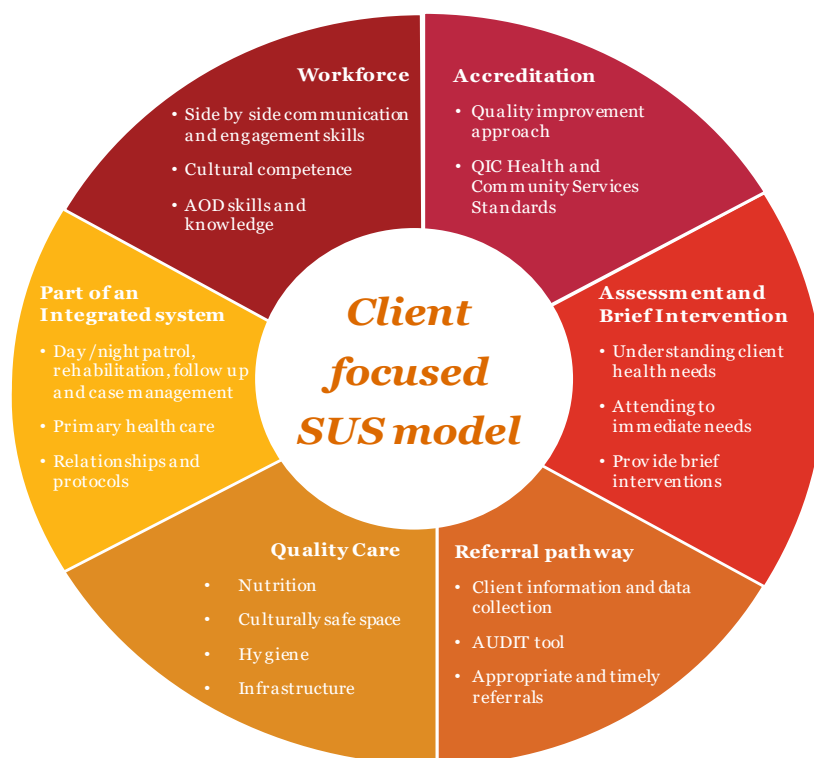
Stakeholders felt that in locations such as Darwin where the SUS is now co-located with the rehabilitation and detox services, and there are strong linkages between the day/night patrol and the Police and health services, this is a more efficient and effective model for clients and service providers. The relationships between SUS services and other service providers in each location is elaborated in Section 3 of the report.

## 2.2 A comprehensive SUS model

As outlined above, the SUS is the point of safety for many clients as well as the point of opportunity for change and connection to other services and supports. In order to maximise these benefits it appears that the SUS needs to have 6 core elements:

- Deliver safe, high quality direct care
- Capacity to undertake assessments and provide brief interventions
- Provide referrals to other services
- Operate within an integrated service system
- Have a trained and skilled workforce
- Have appropriate accreditation to ensure standards are being met

Figure 2: Comprehensive SUS model



### 2.2.1 *Quality care*

The provision of food is seen as an important part of the service delivery within the SUS. Three of the locations felt a hot meal was a necessary requirement to be provided to their clients considering the amount of alcohol consumed the night/day before and the possibility of further drinking once discharged, whereas the other two sites provided a cereal or sandwich breakfast. It was understood that in the locations that served a hot breakfast they felt that this was an influencer in maintaining clients in the SUS until the morning. Further to this it allowed an opportunity for a brief intervention and informal chat with clients that would be less likely to occur without the breakfast.

Provision of nutrition as well as hygiene services such as access to showers and clean clothes are fundamental for the client group who are often homeless or sleeping rough. It is therefore key that the infrastructure of the SUS is at an acceptable standard to ensure quality care is being provided. For many, in particular women, the SUS is also a safe place when vulnerable.

Given the majority of clients are Indigenous it is paramount that care is provided in a cultural appropriate way during their stay. If there is a lack of cultural appropriateness there is a risk of clients foregoing the option to be admitted to a SUS therefore putting themselves and/or their community at an increased risk of harm.

### 2.2.2 *Assessment and referrals*

Clients accessing the SUS are usually at the service for a period of time and ideally there could be opportunities in the morning before the client exits to offer health and wellbeing assessments and make any associated referrals to services that can meet any needs identified. Capacity for clients to access a primary health care practitioner who can undertake health assessments and provide immediate treatment for minor health matters is beneficial and can be achieved either through partnerships with health services or through use of resources within other parts of the provider organisation.

In relation to clients who are drinking to excess, the Alcohol Use Disorders Identification Test (AUDIT) is a screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviours, and alcohol-related problems. The NT SUS guidelines require that an AUDIT must be performed when discharging a client from a SUS and this is to ensure that every opportunity is taken to assess and identify issues for clients and offer brief interventions.

It was noted in the consultations that the AUDIT tool was not being utilised consistently, the exception being Tennant Creek. Further to this PIC understands that although this is stated to be completed per the SUS service agreements, the reporting of this has not been monitored.

Reporting impediments to using the AUDIT tool were that SUS staff felt they did not have the powers to hold an individual at any point during the client stay, and that the time available to administer the tool with clients when they were sober and prior to departure was too tight in most instances. This means that brief interventions are not always being offered and referrals not always made. Although unstated during most consultations, there may also be an issue in some locations about whether staff have a full appreciation of the value and use of the information gathered by the tool and the opportunity administering the tool poses for delivery of brief interventions and referrals.

### 2.2.3 *Workforce implications*

The SUS workforce across the NT varies in both size, employment type as well as the level and type of qualifications held by SUS staff. However a key enabler for implementing the comprehensive SUS model within an integrated service system is a skilled and competent workforce. Table 1 describes the key functions that are being performed within the SUS and aligns those to the type of skills and/or qualifications required.

*Table 2: Functional analysis of the SUS workforce*

Function	Tasks	Skills/Knowledge
Intake	Receive and undertake initial assessment of the intoxicated person Gather data	Communication skills Administration and data entry
Supervision	Monitor residents for OHS issues Manage disputes between residents	Communication skills First Aid Manual Handling and conflict resolution training
Direct care	Cooking Cleaning Washing and sorting clothes Driving (if transport is provided by the SUS)	Communication skills Nutrition
Assessment and intervention	Administer the AUDIT Assess health and wellbeing issues Make referrals Provide brief interventions	Communication skills AOD training Knowledge of local service system and relationship with providers

In some locations the workforce may need to be developed or refreshed over time to ensure all functions are being managed by people with the requisite skills for the roles.

#### **2.2.4 Quality improvement and accreditation**

With any organisation in the service delivery sector, quality improvement frameworks and approaches are critical. To this end, any service should strive to attain the relevant quality improvement accreditation. The importance of being recognised under the relevant accreditation model sends a strong message to the sector, the client base, stakeholders and the funding bodies. It provides an understanding that the organisation has implemented the required systems, processes and governance structures to ensure client safety, clinical practices and systems are in place to meet fluctuating demands and clearly understands the client group and can adapt to contextual changes.

One of the quality improvement frameworks that is relevant to the AOD and comprehensive primary health care sector is the Quality Improvement Council (QIC) Health and Community Services Standard (7<sup>th</sup> Edition) that covers areas such as;

- Governance
- Management systems
- Consumer and community engagement
- Diversity and cultural appropriateness; and
- Service delivery

By embedding quality improvement accreditation, the organisation will realise benefits in continuously monitoring, reviewing and implementing improvements, embed a culture of quality, workplace efficiencies of systems and improved outcomes for consumers of the service

While some of the NT SUS services are accredited, they are not all accredited to the same standards. If the whole sector were to move to the same health and community service accreditation system, there would be system wide impetus for working together to achieve system change and improved services.



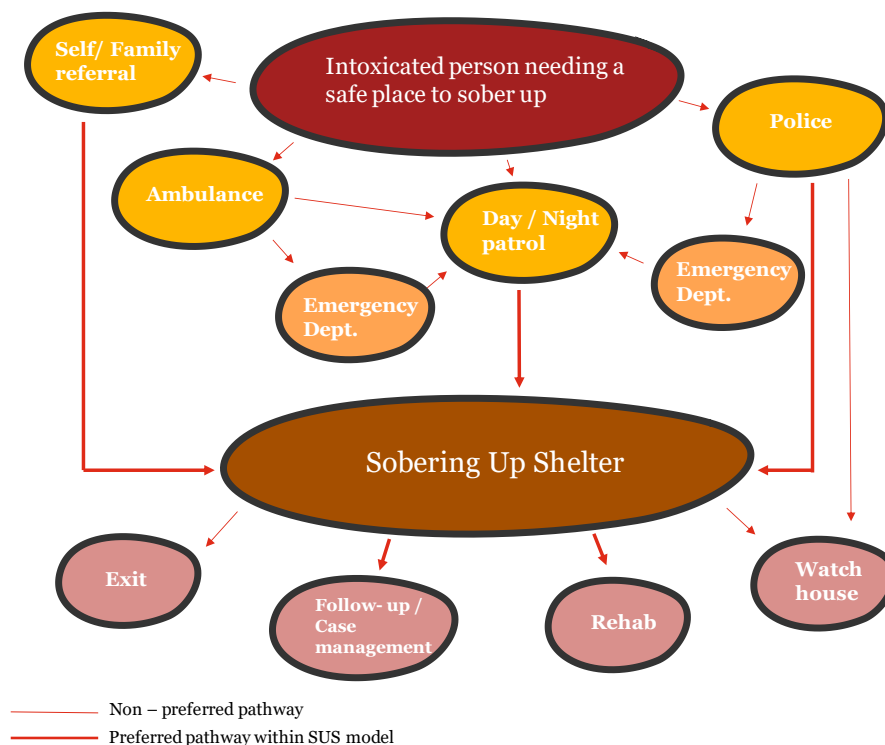
## 2.3 Implementing an integrated service system

From review of the various models in operation across the NT, stakeholders were clear that the comprehensive SUS service operates most effectively for clients when it is located within an integrated service system that delivers the following:

- Alignment of operating hours between the day/night patrol and the SUS;
- Transport capacity to move intoxicated people to and from the SUS on advice and referral from the Police, Ambulance, hospital, and other referral bodies;
- Strong relationships and agreed referral pathways between the SUS and the local Health services, in particular the Aboriginal Medical Services, other AOD services including those operating in remote communities such as the remote AOD workers;
- Strong relationships and agreed referral pathways between the SUS and the alcohol rehabilitation services;
- Strong relationships and agreed referral pathways between the SUS and after care, homelessness and outreach programs to ensure follow up care and support;
- Hours of operation at the SUS to allow time for brief interventions and referrals with clients prior to exit.

This type of integrated system would achieve the client pathway shown in figure 3 below, and would improve the likelihood of the client accessing the SUS rather than being taken to the Police watch house or the hospital unnecessarily. It also enhances appropriate and timely referrals for SUS clients as and when they are ready to take those opportunities.

Figure 3: Client pathway in a new integrated service system



Stakeholder feedback has indicated that the regional workshops that have been held in Darwin and Katherine since March 2018 have been effective in identifying barriers to effective integration of services and developing strategies to improve client access to the SUS and client through care including adjusting opening hours, improving communication systems and operational guidelines. These workshops seem to be a valuable system change implementation process that could be implemented in all locations.

### *2.3.1 Implications for transport services*

Transport was a matter that was consistently raised during consultations. Some SUS services struggled with the challenge of transportation of people from the SUS to other service locations or vice versa, for example where the hospital felt that clients were better suited for a SUS than utilising a bed unnecessarily there was usually no mechanism to transport these individuals. It was also identified that when an intoxicated person is seen by St John's Ambulance the only option for St John's is to transport the person to the hospital even if the person does not have high medical needs and would benefit from a SUS admission. In most locations, the Police and Day/Night patrol consistently expressed concern about their capacity to respond.

As outlined in the preferred service system described above, transportation both to and from the SUS and between services is critical to achieving a smooth pathways for the client. Additional transport capacity may need to be negotiated for each location in order to meet the needs of each region.

### *2.3.2 Cost implications of created integrated service systems*

If a comprehensive SUS model was to operate within an integrated service system in each region, there would need to be further exploration of the costs associated with addressing the gaps in each region.

However while there will be cost implications with addressing these gaps, there will also be cost efficiencies associated with the following:

- Reduced unnecessary presentations and/or admissions to A&E
- Reduced unnecessary admission to the Watch house

Indicative figures suggest that alcohol related hospital admissions are costing, on average up to \$806, per bed per night. Predictative modelling suggests that there could be a reduction of 4 hospital/A&E admissions per night across the NT if intoxicated people were placed in the SUS, resulting in an indicative saving of around \$700,000 per annum.

### *2.3.3 Implications for service location within an integrated system*

The location of SUSs is considered an essential factor in ensuring clients are able to access the service of the SUSs while also being in a location that enables a practical release once sober. All SUS services felt that their locations were functional and effective, with the exception being the Nhulunbuy SUS which is located next to the Datjala work camp (discussed in section 3 – Nhulunbuy).

Currently there are four SUS services which are close enough to the town/city centres allowing for easy transport by the Police, Patrol or even self-admission with the exception being Darwin which is considered quite far from the city.

### *2.3.4 Interaction with other AOD policy measures*

Since the introduction of the Banned Drinker Register (BDR), there has not been a noticeable decrease in presentations to the SUS services and there has been ongoing presentation of intoxicated people who are already on the BDR. It was consistently expressed during consultations that the reason for this was that secondary supply or black market sale and licensed venue drinking were still allowing people to access alcohol and continue to get intoxicated. It was noted however that the communities with Point of Sale Interventions (POSIs) (Alice Springs, Tennant Creek and Katherine) had seen differences in the number of intoxicated people presenting at SUS services. SUSs and stakeholders consulted, all felt that having a presence at the take-away alcohol outlets proved a deterrent for people that are identified as heavy drinkers or are on the BDR.

Stakeholders discussed whether people presenting to a SUS, particularly frequent clients, should be referred to the BDR. The model currently is that being presented to a SUS isn't an automatic trigger for referral to the BDR, although SUS managers are identified in legislation as authorised persons for the purpose of referral to the BDR Registrar.

There are mixed views on what value an automatic trigger would add to the likely outcomes for clients. The main priority for the SUS services is to provide a safe place for an intoxicated person to sober up and be referred to further treatment providers if necessary. SUS services stated that a large number of their clients are already registered on the BDR, therefore were concerned about potentially undermining the positive benefits a SUS can have on future clients by deterring them from attending. Furthermore SUS services felt that as they were not a punitive service, if attendance did become an automatic trigger for referral to the BDR, intoxicated clients that are not on the BDR would refuse utilising the service all together.

SUS services may however, be an important source of information about the effectiveness of policy measures which are being implemented to reduce the harmful consumption levels of problem drinkers. Monitoring the number of clients presenting to the SUS who are already on the BDR could provide information about the impact of secondary supply education and awareness campaigns and other supply reduction initiatives.

## **2.4 Recommendations and possible enhancements**

The analysis in this review has highlighted that to maximise the opportunities to assist problem drinkers through more comprehensive SUS services and to locate those services within integrated health and AOD service systems, some enhancements in certain locations are needed, as well as enhancements across the service sector as a whole.

- *MHAODB coordinate and facilitate regular regional workshops with all stakeholders to ensure a coordinated AOD service systems approach that is aligned to Service Level Agreements and consistent with the referral process contained within the current guidelines.*
- *Ensure the appropriate engagement and communication is occurring between the SUS and other health service providers to deliver more comprehensive service provision to clients.*
- *Where the SUS service provider is not already accredited with an existing health standards body, they be supported by NT Health to undertake the self-assessment and accreditation process to attain the QIC Health and Community Service Standard (7<sup>th</sup> Edition).*
- *Further explore alternative resources and costs for transporting clients between SUS services and other health service providers, in the instance where the police or night/day patrol cannot.*
- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures.*
- *Ensure the operating hours of the SUS services maximise client access to outreach support services to assist in the provision of information and referrals to health and other support services.*
- *Use the regional workshop mechanism to implement a six monthly review and planning process to assess the need for earlier opening hours to coincide with the fluctuating seasonal demand for service by clients due to a range of factors or local decisions.*
- *Implement the recording of AUDIT scores as a KPI and reporting requirement in all of the Sobering up Shelter service agreements to assist in accountability of referral processes.*



## 3 *Site by Site Key Findings and Recommendations*

### 3.1 *Alice Springs*

#### *Sobering Up Shelter service provider*

The service provider for the SUS in Alice Springs is the Drug and Alcohol Services Australia Alice Springs (DASA).

Other services provided by DASA:

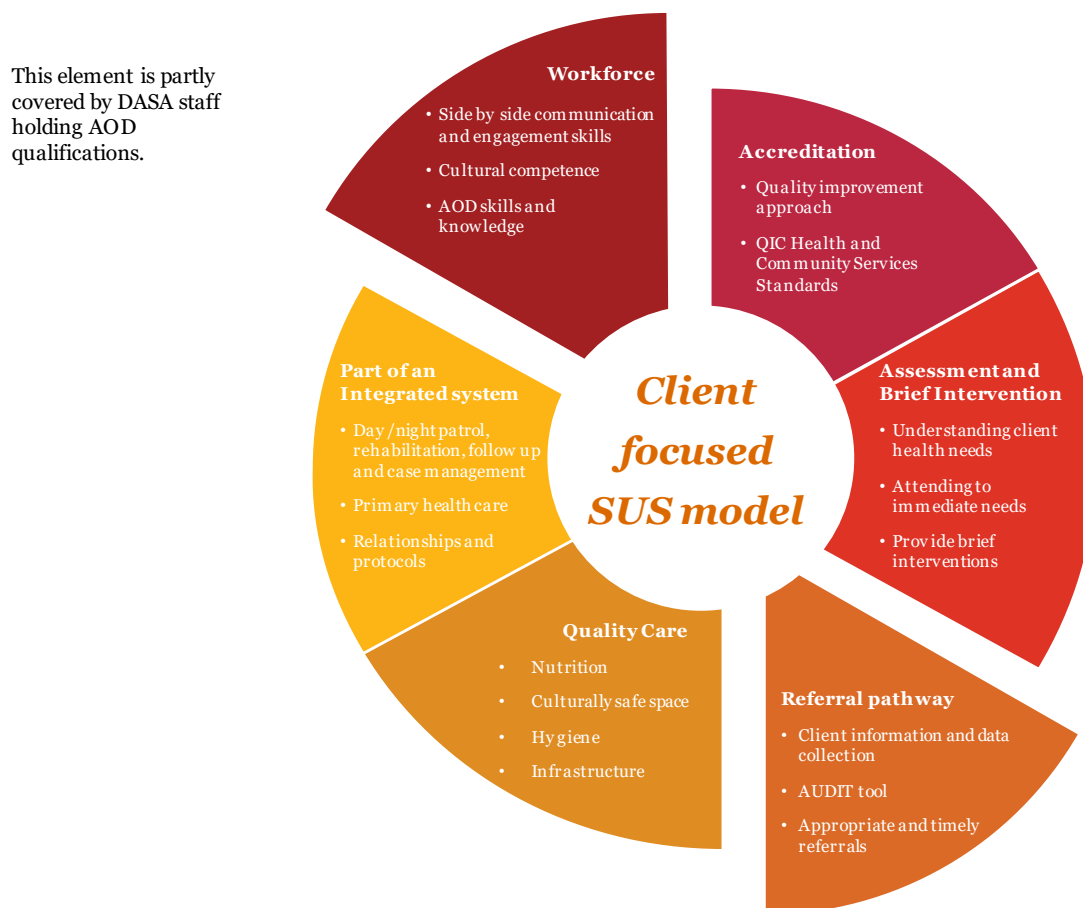
- Outreach program – This is an intervention and referral program based on the further case management of the relationships established in the Sobering-Up Shelter and other services between staff and clients. Outreach team work throughout the community with a vast range of clients, linking them with not only the services DASA has to offer, but also other appropriate services within the community. A ‘Prison In Reach’ program works with prisoners to offer AOD interventions prior to release.
- Aranda House – This program is a 20 bed residential rehabilitation facility that offers a 12 week drug and alcohol program and an 8 or 16 week program for Volatile Substance Misusers. The program is a Therapeutic Community model where residents are actively involved in their own personal recovery in a supportive and caring environment.
- Transitional After Care Unit – This program provides clients with semi- independent residential facilities in which all residents have their own bedroom, bathroom and shared common areas. Residents in this program must be working, seeking employment or engaged in study in preparation for work.
- Independent living program – This program is DASA’s final stage of rehabilitation.
- Methamphetamine outreach program – This program helps people reduce the impact of ice on their lives and to recover from addiction.
- COMMIT 2 Change – COMMIT 2 Change provides addiction-focused support for COMMIT Court bail and parole clients who are heavy drug or alcohol users.

Current funding agreement: 1/7/2017 – 30/06/2020

#### *Current operating model*

Based on the comprehensive SUS service model noted earlier, the diagram below indicates the elements that DASA provides with the workforce and health assessments partly covered through other parts of the organisation or linkages with health care providers.

Figure 4: Elements of the comprehensive model at DASA



### Location/Facilities

The SUS was built in the 1980's and was built for purpose. The leaseholder is the Department of Infrastructure, Planning and Logistics (DIPL).

Staff feel that the location is perfect as it allows for the transport and access of clients from the Police, Night/Day patrol or self-referral.

The facility currently has two toilets and two showers, one for male and one for female. There were concerns raised around the common area and space where clients are processed when being admitted

The SUS is very secure and very well monitored. There is CCTV set up throughout all of the SUS, including the entrance. An automated high strength gate is fitted as the main entry point that needs to be opened by a worker on the inside, although there is a one way exit gate that people may leave from if they do not wish to stay.

### Staffing profiles

Seven staff are employed within the SUS service. Five are full time and two are casual employees and a mix of long term and recent recruits.

DASA does not currently have any nursing staff on premises, although feel there are times when on call nursing expertise has been required. DASA believes that if a nurse were to be on call they should work across all of the DASA service lines and locations not just the SUS, as demand in the SUS would not be enough to warrant a full time nurse. Additional to this, further funding would be required to accommodate this action.

### ***Opening hours (Peaks and lows)***

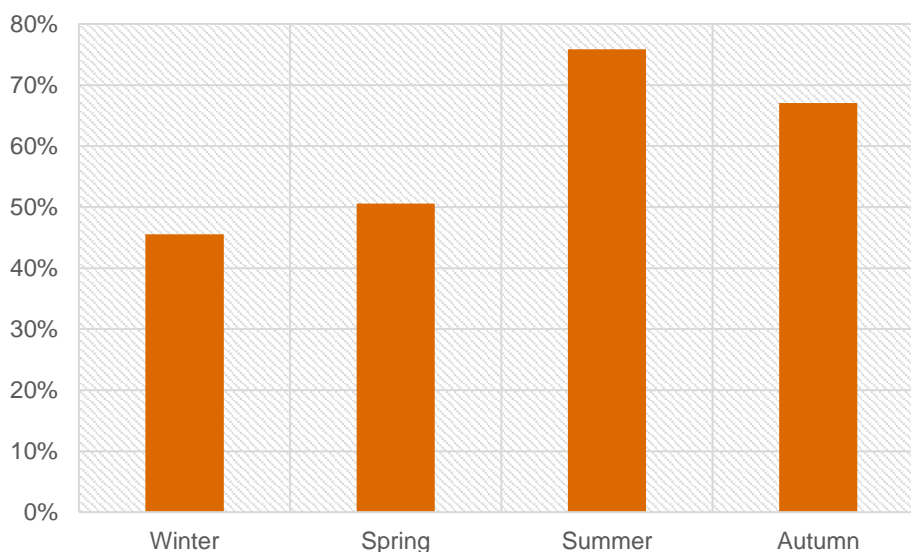
Hours of operation have been set in the Service Plan as 3:00 pm – 9:00 am six days a week (closed Sunday). DASA has determined not to accept any new clients after 3:00 am to address duty of care issues for people having enough time to sober up prior to leaving the shelter.

It was voiced that there may be some benefit in the SUS increasing its operating hours to allow it to be open from 1:00 pm. The SUS explained that Police feel that there are essentially two ‘waves’ of possible clients to be admitted to the SUS. The first wave is coming from individuals who are drinking at licensed venues prior to the take-away alcohol outlets opening at 2:00 pm Monday to Friday, 10:00 am Saturday and 12:00 pm Sunday. Whilst the second wave is considered to be the individuals intoxicated in the hours of the late afternoon and evening after obtaining alcohol from the take-away outlets.

### ***Bed capacity***

The SUS is currently funded to operate sixteen beds (eight male and eight female). It was mentioned that the SUS has a capacity for twenty-four although the provider feels that the quantity of beds currently funded is appropriate for the number of clients submitted to the SUS. It was understood that the SUS feel that the busier periods of admissions were the hotter summer months, this is consistent with data sets on admission and utilisation provided by the MHAODB team.

*Figure 5: Utilisation of beds against admission rates*

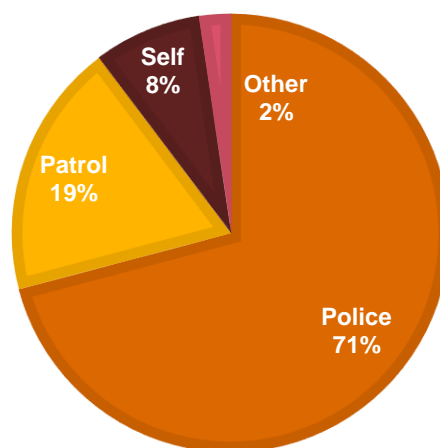


### ***Referral points***

The three main referral points to the SUS are Night patrol (Tangentyere), Police and occasionally Self-referral. This is consistent with data sets on admission and utilisation for period June 2017 to May 2018 provided by the MHAODB team.

The SUS has the capacity to refer people onto further treatment services although notes that most of the clients refuse to attend or can't make it to their recommended treatment. It was stated that there are elements out of their control and influence in ensuring clients are utilising referred treatment services. These consisted of clients not providing permission for referral and no mechanism to ensure individuals were actually attending

Figure 6: Referral Sources



### **Banned lists**

DASA maintains a 'banned list'. To be placed on the banned list a client has been abusive or violent towards staff or other clients within the SUS. And/or have pre-existing health issues which make it clinically unsafe for them to stay at the SUS. An individual can be banned from the SUS for a period between three to six months. As at the time of consultation there were 25 individuals on the DASA SUS banned list, with 18 of those due to pre-existing health issues identified from previous admissions. It was noted that although some people are on the banned list for behavioural concerns, if presented at the SUS, they are assessed on case by case basis and it is 'played by ear'.

### **Relationships**

The SUS believes relationships with other service providers and stakeholders is crucial to ensuring the quality of service provision to clients, especially considering these clients are highly likely to be clients across the other services also. It was understood that relationships with the Police and Night Patrol are considered very positive, with open communication and expectation clearly set between the parties. Relationships with the Hospital is also considered positive. It was noted that on occasion the SUS will take people from the emergency room if the hospital calls and requests it, although is dependent on availability and resourcing capacity of the police or day/night patrol to transport these individuals.

### **Accreditations**

The SUS currently holds a QIP accreditation which has recently been renewed until 2020.

### **Audit tool**

The AUDIT tool is not currently being utilised, although they are looking to implement the process. The SUS is apprehensive as the clients are looking to leave as soon as they wake up and it is deemed difficult to obtain information from them.

### **Summary of issues identified**

- Infrastructure and facilities
- Referral to other health service providers
- Operating hours
- Utilising the audit tool – Currently not being utilised



- Transport

### *Recommendations and possible enhancements*

- *Undertake formal site assessment of the SUS facilities and infrastructure in Alice Springs to identify minor works to improve client entrance space and increase the bathroom facilities.*
- *Ensure the appropriate engagement and communication is occurring between the SUS and other health service providers to deliver more comprehensive health service provision to clients.*
- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures*
- *Ensure the operating hours of the SUS's maximise client access to outreach support services to assist in the provision of information and referrals to health and other support services.*
- *Implement the recording of AUDIT scores as a KPI and reporting requirement in all of the Sobering up Shelter service agreements to assist in accountability of referral processes.*
- *Further explore alternative resources and costs for transporting clients between SUS services and other health service providers, in the instance where the police or night/day patrol cannot.*

## 3.2 Tennant Creek

### Sobering Up Shelter service provider

The service provider for the SUS in Tennant Creek is The Barkly Region Alcohol & Drug Abuse Advisory Group (BRAADAG)

Other services provided:

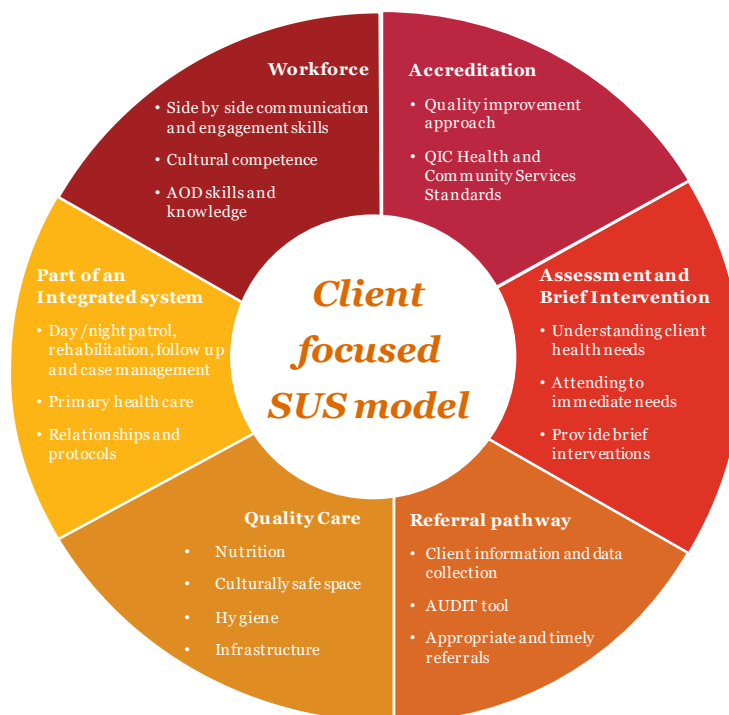
- Residential Treatment Centre –this program is an eight week program designed to assist clients in understanding their addiction, its causes, and the way behaviour needs to alter in order to combat their dependency. Length of the program can be extended if necessary.
- Transitional Aftercare/Outreach program – This service offers alcohol & other drugs education and support to residents of services, families and individuals in the township of Tennant Creek and surrounding communities.
- COMMIT 2 Change – COMMIT 2 Change provides addiction-focused support for COMMIT Court bail and parole clients who are heavy drug or alcohol users.

Current funding agreement: 1/7/2018 – 30/06/2023

### Current operating model

Based on the comprehensive SUS service model identified earlier, the diagram below indicates the elements that BRAADAG provides, albeit at different locations in Tennant Creek. In terms of the workforce, and as outlined below, BRAADAG has staff with nurse qualifications however they are not employed in the SUS.

Figure 7: Elements of the comprehensive model at BRAADAG



### ***Location/Facilities***

The service provider is very pleased with the current SUS facility arrangement. It is considered spacious and fit for purpose with the only possible enhancement to the facility being additional lights out the front of the building to ensure safety for the staff and intoxicated clients presenting themselves.

There are a total of four toilets and four showers located in the SUS which is split evenly between the men and women. This is considered functional and appropriate.

### ***Staffing profiles***

There are a total of ten staff employed within BRAADAG, four are full time staff and 6 are part time employees. Three staff members of BRAADAG hold qualifications as nurses to assess and treat minor injuries, although it should be noted that these staff work Monday to Friday during the day and are not specifically employed for the purpose of service delivery of the SUS. Nonetheless, this is considered a real asset from the point of view of the SUS as clients with minor injuries are not unnecessarily being denied admission or requiring transportation to hospital, and a client's minor health issues can be treated and/or assessed early.

### ***Opening hours (Peaks and lows)***

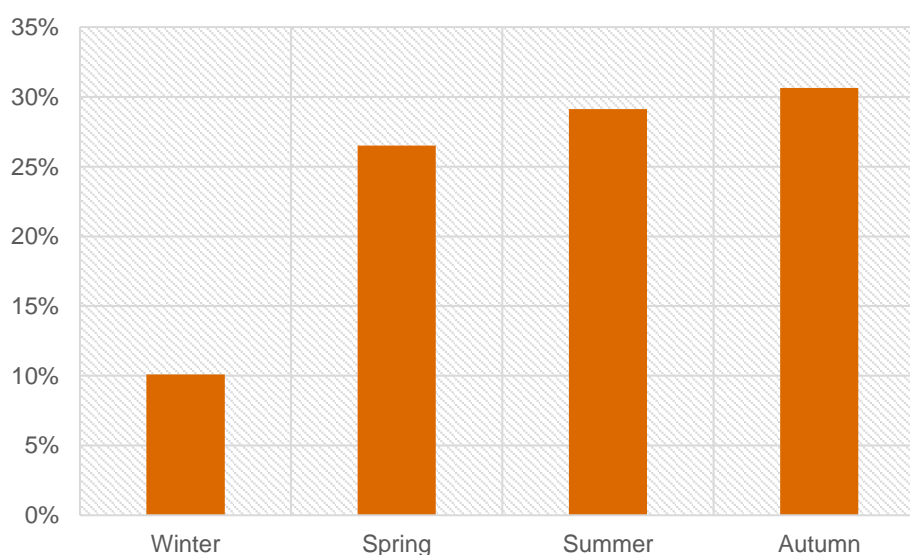
Initial funding allocation for the hours of operation were 4:00 pm to 8:00 am seven days a week. It was noted during the consultations that effective from 1 January 2019 operating days would decrease from seven to five days. This resulted from additional restrictions implemented by the NT Liquor Commission in response to community pressure which has impacted the demand by clients. At the time of this review, PIC is unaware if the additional alcohol restriction measures have been evaluated. It was understood that it needed to be determined the days to which the SUS would operate to align to the busier periods of admissions. The last admission is accepted at 2:00 am.

The take-away alcohol venues are closed on Sundays, therefore Sundays are the slowest nights.

### ***Bed capacity***

The SUS is currently funded to manage sixteen beds (eight male and eight female). It was understood that although maximum capacity was rarely met the SUS felt that the busier periods of admissions were the hotter months of the year. This is consistent with data sets on admission and utilisation for period June 2017 to May 2018 provided by the MHAODB team.

*Figure 8: Utilisation of beds against admission rates*



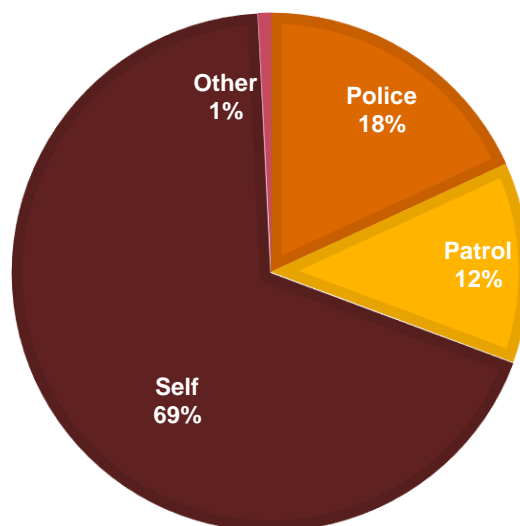
## Referrals

Unlike the other SUS services it was discussed that self-referral is the main source of admission into the SUS. This was consistent with the data sets on referral sources for the period June 2017 to May 2018 provided by the MHAODB team.

In terms of referral to further treatment options the SUS has the capability to make referrals to their other services within BRAADAG. They refer and leverage each other's services openly through their internal referral processes which enables BRAADAG to be a whole service provider in the AOD sector. It is understood that it is quite common to have clients who utilise the multiple services under BRAADAG therefore open communication is important to effective service delivery. This open and working relationship allows for follow up and case management of clients in attempting to rehabilitate from substance misuse.

If an intoxicated female presents to the Women's Refuge following a domestic violence incident, Women's Refuge will refer them to Sobering Up Shelter as Women's Refuge are unable to accept intoxicated persons.

*Figure 9: Referral sources*



It was highlighted that in Tennant Creek some of the clients are homeless and are openly engaging with the SUS as a safe space in comparison to sleeping rough or long grassing, and that this usage pattern is enabling them to meet work and other obligations while continuing to consume alcohol.

## Banned lists

There is no Banned list register held at the Tennant Creek SUS. They advised that they will never turn back an intoxicated person looking for shelter. It is worth noting that the SUS has rarely had a violent or abusive client seeking to stay, the only time they will turn someone back is if they have severe injuries or are far too intoxicated to care for, at which point they will be referred to the Hospital

## Relationships

The SUS has very efficient and open working relationships with other health services provided under the 'umbrella' of BRADAAG. It was also indicated that the relationships with Police, Night patrol, the hospital and other community providers is very positive.

The relationship that the SUS holds with community was something they voiced heavily during the consultation. It was understood that the SUS aims to be client centric and appear to have an open and unbiased approach to the care of the people in their community. They stated that there were instances where clients who had historically



come as intoxicated would come to the SUS sober and seek refuge. If the SUS was able to accommodate the admission they would do so.

### ***Accreditations***

The SUS currently is accredited under ISO 9001- 2015 with the plan to attain QIC Health and Community Services Standard accreditation by April 2019.

### ***Audit tool***

The SUS has full utilisation of the audit tool and also keeps an internal 'General Ledger' for their own tracking purposes, this recorded name, age, health and referral source. The SUS makes it clear to clients that it is a requirement to undertake an AUDIT screening prior to leaving regardless of the regularity and frequency of the client's admission to the SUS. It was mentioned that the method of undertaking the AUDIT test was achievable through having clients stay and have breakfast before their departure. This allowed an opportunity for brief intervention and discussion.

### ***Summary of Issues Identified***

- Safety concern at the street entrance of the SUS due to minimal lighting.

### ***Recommendations and possible enhancements***

- *Where the SUS service provider is not already accredited with an existing health standards body, they be supported by NT Health to undertake the self-assessment and accreditation process to attain the QIC Health and Community Service Standard (7<sup>th</sup> Edition).*
- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures*

### 3.3 Katherine

#### *Sobering Up Shelter service provider*

The service provider for Katherine SUS is Mission Australia

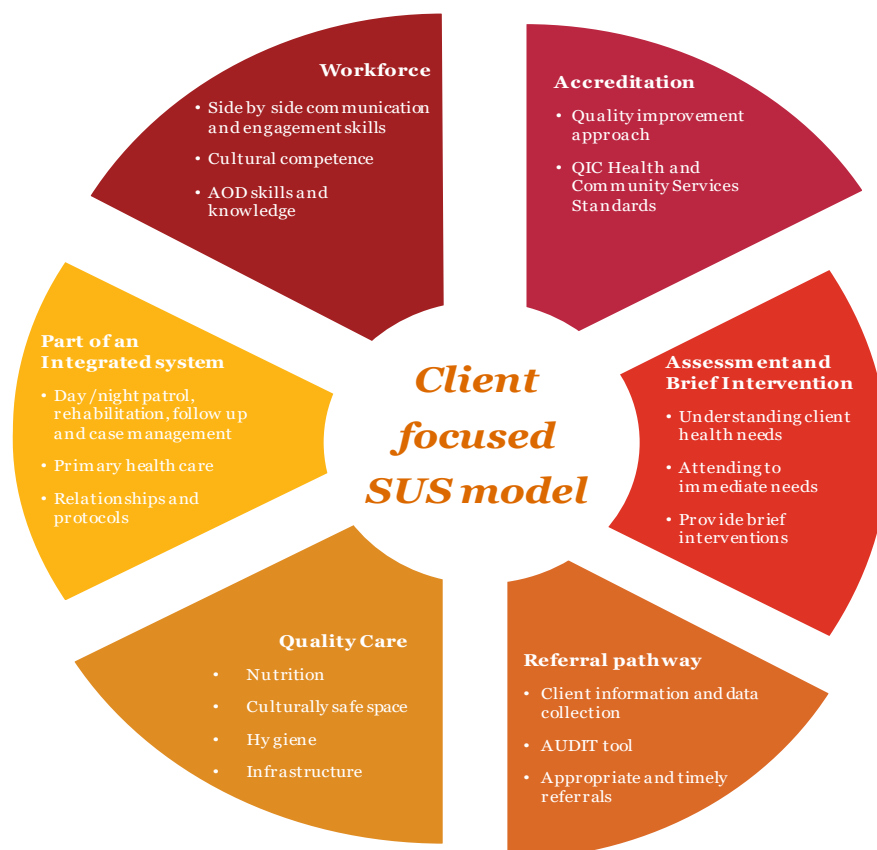
Other services: No other health service provided relevant to possible referral from the SUS. Mission is currently working with Vendale Rehabilitation Centre to streamline processes for clients to enter the rehabilitation program.

Current funding agreement: 1/7/2018 – 30/06/2020

#### *Current operating model*

Based on the comprehensive SUS service model identified earlier, the diagram below indicates the elements that Mission Australia Katherine provides. This location requires considerable work and support to implement the elements if it were to provide an integrated service model. The quality care element is the mainstay service provision of the Katherine location and should be noted as being delivered in a culturally safe environment.

*Figure 10: Elements of the comprehensive at Mission Australia – Katherine*



#### **Location/Facilities**

The SUS view the current location as being functional. The space itself is well laid out and purpose designed, there is an opportunity for the utilisation of the backyard. The SUS is very well set up in the aspect of allowing a safe set up area for workers to be in any instance of violence or abuse i.e. locked room spaces and processing area which is separate to the SUS common room and sleeping areas.

### ***Staffing profiles***

There are a total of seven staff employed with the SUS, two permanent full time and two perm part time, one casual and two are employment agency transitioning to Mission Australia. Three staff hold an AOD Certificate IV, two hold an AOD Diploma, with one currently studying AOD Certificate IV

### ***Opening hours (Peaks and lows)***

Hours of operation are 6:00 pm – 8:00 am, Monday and Tuesday then 4pm – 8am Wednesday, Thursday and Friday (closed Saturday and Sunday). Mission Australia has determined not to accept any new clients after 3:00 am to address duty of care issues for people having enough time to sober up prior to leaving the shelter.

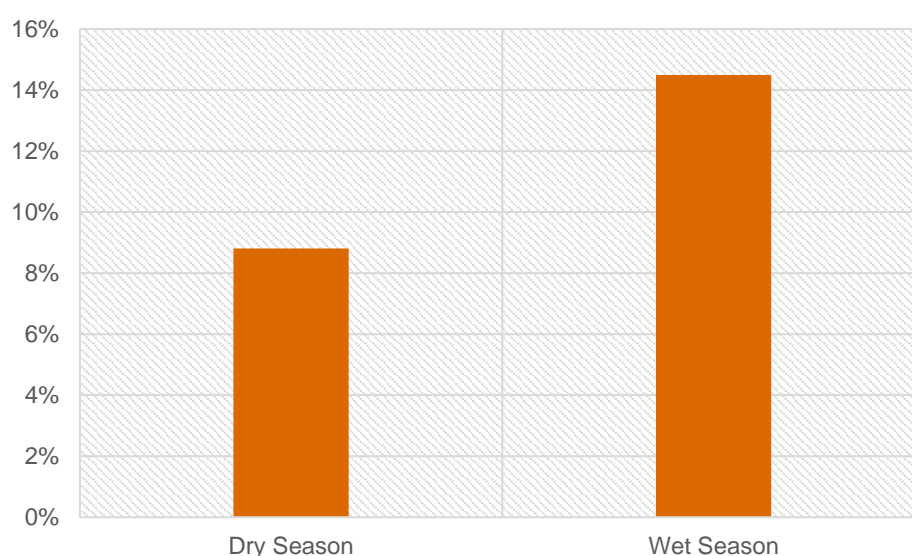
Police engaged during the review process expressed that the SUS was often closed during peak times of intoxicated people in public. It was suggested that a 12:00 pm opening time would be beneficial and effectively cater to the numbers of intoxicated individuals on the street. Mission Australia are currently assessing the feasibility of extending hours of operation with the potential of including Saturday night

The SUS indicated that for some period of time the SUS has been averaging a low frequency of clients, this is consistent with data sets on admission and utilisation for the period June 2017 to May 2018 provided by the MHAODB team.

### ***Bed capacity***

The SUS is currently funded to manage eighteen beds (twelve male and six female). The opinion of the SUS was that there have been a low frequency of clients in recent months. The provider surmised that this could be due to the Police presence at takeaway outlets resulting in people moving away from town. The drop in apparent demand is consistent with the data sets on admission and utilisation for the period June 2017 to May 2018 provided by the MHAODB team.

*Figure 11: Utilisation of beds against admission rates*



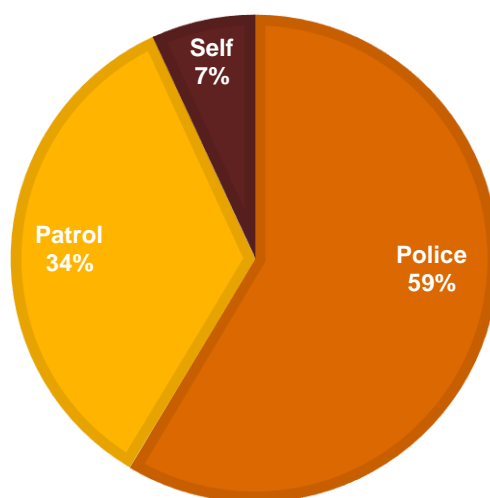
### ***Referrals***

Police and community patrol (Kalano) are the two main referral sources for people presenting at the SUS with self-referral being the least common source. This is consistent with data sets on referral sources for the period June 2017 to May 2018 provided by the MHAODB team.

Police in Katherine felt that the community patrol service is inconsistent and that only people within the Kalano community are being assisted, resulting in other intoxicated people not being transported to the SUS when needed. The Police were also concerned that the patrol currently finishes patrols by 11:00 pm, when problem drinking is at its peak, and also don't work on weekends

There appears to be limited collaboration between police and night patrol. Although this particular aspect was outside of the TOR scope, this will need to be addressed as part of any service reconfiguration. SUS stakeholder meetings may support increased collaboration between stakeholders and provide opportunity to identify suitable solutions

*Figure 12: Referral sources*



### **Banned lists**

The service provider maintains a banned list which is reviewed every three months. It is provided to Police and to the Community Patrol every three months. At the time of consultation it was stated that there are approximately nineteen people are currently on the banned list in Katherine. The individuals on this list are mainly comprised of individuals who have been violent or abusive in the past, it was noted a few were on the banned list for health reasons. Recent work has occurred with Katherine Hospital to assist SUS staff in assessing health risks and remove unnecessary transfers to hospital.

### **Relationships**

The SUS have positive working relationships with the police and the hospital. There is an open dialogue of communication and a clear understanding of the benefits of the SUS and its ability to alleviate risks associated with having intoxicated individuals in public spaces.

There are concerns expressed by multiple stakeholders about the relationship between the Community patrol (Kalano) and the SUS. It was stated that the poor working relationship is impacting the possibility of individuals who could benefit from the SUS being able to do so though lack of referrals to the SUS when required and transportation to and from the SUS. It was stated that in previous years there were two way radios used to collaborate and work together in dealing with intoxicated people, this has since changed and is no longer the case, which now means people are not able to access the SUS service which then results in lower bed utilisation and the lack of further referral or early intervention discussions with clients.

SUS stakeholder meetings can enhance the working relationships with aim of streamlining processes and improving the access to the SUS during operational times.

### **Accreditations**

The Katherine SUS holds the ISO 9001:2015 QMS accreditation that expires in September 2020.



### ***Audit tool***

Similar to other SUS locations the AUDIT tool or anything similar in nature is not currently being fully utilised, although they are looking to implement the process. The SUS is apprehensive as the clients are looking to leave as soon as they wake up and it is deemed difficult to obtain the required information from them. Where possible, the SUS does utilise a range of admission assessment, client monitoring, brief intervention questionnaire and discharge assessment tools.

### ***Summary of Issues Identified***

- Referral to other health services
- Transport to and from the SUS
- Relationship with Community Patrol requires improvement
- Audit tool is not being fully utilised
- Underutilisation of beds

### ***Recommendations and possible enhancements***

- *Ensure the appropriate engagement and communication is occurring between the SUS, patrol service and other health service providers to deliver more comprehensive health service provision to clients.*
- *Where the SUS service provider is not already accredited with an existing health standards body, they be supported by NT Health to undertake the self-assessment and accreditation process to attain the QIC Health and Community Service Standard (7<sup>th</sup> Edition).*
- *Implement the recording of AUDIT scores as a KPI and reporting requirement in all of the Sobering up Shelter service agreements to assist in accountability of referral processes.*
- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures*

## 3.4 Darwin

### *Sobering Up Shelter service provider*

The service provider for Darwin SUS is Mission Australia

Other related services:

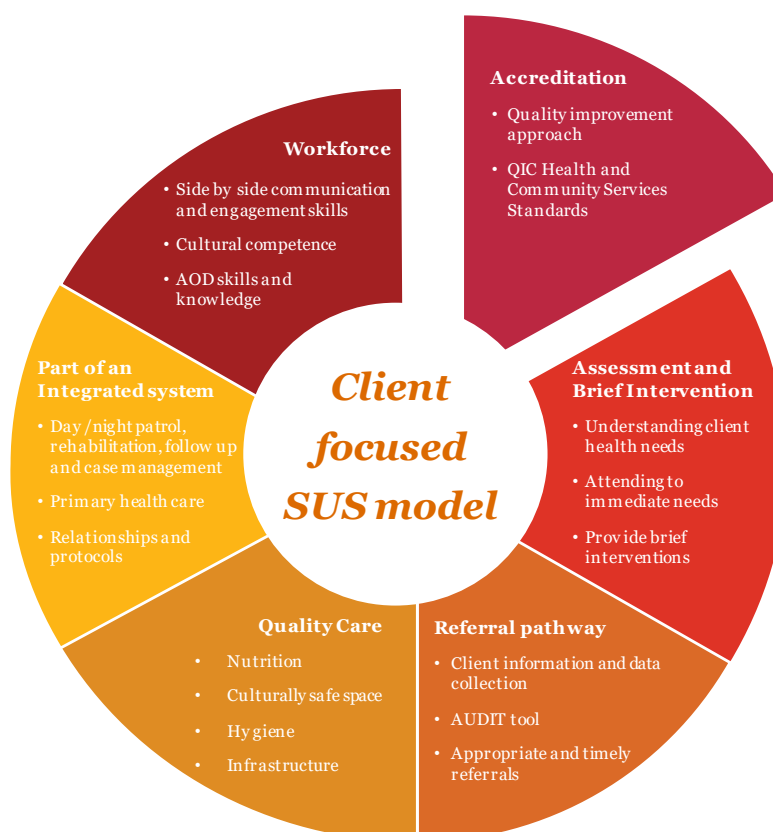
- Stringy Bark Residential Rehabilitation Treatment Service

The Top End Health Service operate the integrated withdrawal service on the same site, where clients can undergo detoxification prior to entering a rehabilitation program.

### *Current operating model*

Based on the comprehensive SUS service model identified earlier, the diagram below indicates the elements that Mission Australia Darwin provides. This co-located service could be considered the preferred model. QIC can be attained in due course with support from the relevant assessing organisation.

*Figure 13: Elements of the comprehensive model at Mission Australia – Darwin*



### **Location/ Facilities**

The Darwin SUS is situated at the old Berrimah minimum security prison on the outskirts of Darwin. The site is co-located with another service provided by Mission Australia. The facility has forty beds with separate bathrooms for male and female clients appropriately located close to the rooms. The rooms are not air conditioned which may be uncomfortable in the wet season months, however the rooms are louvered and well ventilated. Currently

## Executive summary

conversations are occurring regarding the feasibility of moving the SUS services to the Pinelands, which may have impacts on transport

There is outdoor space for people to sit and relax. The SUS offers changes of clothes, washing, food on departure, safe space, referrals to other service providers.

Mission Australia have established a visiting program with Danila Dilba Health Service and Centerlink. These visits are considered quite valuable to address a range of health factors and access to Centrelink financial services that clients may not otherwise utilise.

### **Staffing profiles**

The Darwin SUS has a total of seventeen staff: two full time and four part time, with a pool, of eleven casuals. There are six Aboriginal and Torres Strait Islander staff members.

Staff work in eight hr shifts – 4:00 pm-12:00 am, 12:00 am-8:00 am.

All staff have a minimum Cert 3 Community Services/ AOD or are currently undertaking the training.

Recruitment is underway for a Primary Healthcare Nurse to provide triage, assessment and treatment for people presenting to the SUS. It is anticipated that the SUS Nurse will act as a bridge between the SUS, other healthcare services and the Emergency Department of the Hospital.

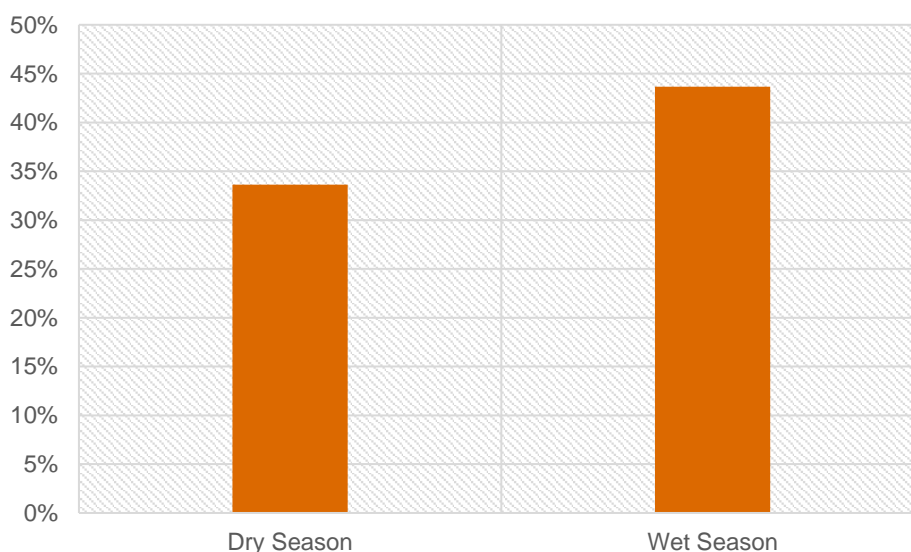
### **Opening hours (Peaks and lows)**

Initial funding allocation for the Darwin SUS operating hours was 4pm – 10am Monday to Sunday with no new clients accepted after 4am.

Normally two staff are rostered on for quiet nights (service descriptor), three for busy nights. Additional staff are available at short notice to meet an increase in demand.

Recent changes in funding will increase the operating hours of the SUS to become a 24 hour, 7 days a week service. To assist in addressing the anticipated increased demand, it is understood that Larrakia Nation day patrol service will receive additional funding to cope with the transport of clients and develop protocols.

*Figure 15: Utilisation of beds against admission rates*



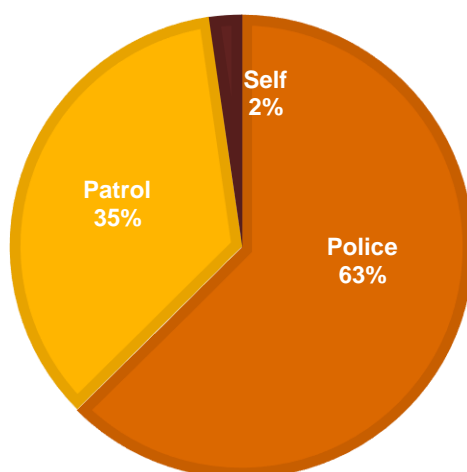
### **Bed capacity**

The bed capacity at the new Darwin SUS is forty, with the maximum usage on any one night being thirty-four people, mostly male clients. The facility has the ability to cater for both male and female clients.

### **Referral points**

Police and Larrakia Nation community patrol are the main referral sources. As the facility is located on the outskirts of Darwin, the self-referral process appears to be non-existent. While the Australian Federal Police (AFP) infrequently make direct referrals ( eg transport) to the SUS, they refer to Larrakia Nation to attend to people who are intoxicated around the Darwin Airport precinct. This is consistent with data sets on referral sources for the period June 2017 to May 2018 provided by the MHAODB team.

*Figure 16: Referral sources*



### **Banned lists**

The Darwin SUS has a banned list mostly for medical reasons. Some client are banned for behaviour with bans ranging from three months to permanent for continual violent offenders.

The banned list is sent to all stakeholders, AFP, NT Police and Larrakia Nation. This is provided monthly however Police and Larrakia Nation generally call prior to arriving at the centre to check on the banned list. Regional planning meetings have resulted in improvements and minor changes with stakeholders.

### **Relationships**

The relationships with external stakeholders indicate a sound working model. Police, Larrakia Nation and Mission Australia work closely together and share information in a coordinated manner.

Stakeholder meetings have seen an improvement with client transport from RDH ED to the SUS whilst also enhancing the working relationships between Larrakia Nation, RDH ED staff and the SUS provider. The extended hours of operation for the SUS and Larrakia Nation are a direct result of the sound work relationships developed via the stakeholder meetings.

### **Accreditations**

The Darwin SUS holds the ISO 9001:2015 QMS accreditation that expires in September 2020.



### ***Audit tool***

Audit tool is not used consistently during the SUS client visit however, the Darwin SUS does utilise, where possible an admission assessment, client monitoring, brief intervention questionnaire and discharge assessment tools.

### ***Summary of Issues Identified***

- Accreditation
- Audit Tool

### ***Recommendations and possible enhancements***

- *Where the SUS service provider is not already accredited with an existing health standards body, they be supported by NT Health to undertake the self-assessment and accreditation process to attain the QIC Health and Community Service Standard (7<sup>th</sup> Edition).*
- *Implement the recording of AUDIT scores as a KPI and reporting requirement in all of the Sobering up Shelter service agreements to assist in accountability of referral processes.*
- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures*

### 3.5 Nhulunbuy

#### *Sobering Up Shelter service provider*

The service provider for the Nhulunbuy SUS is East Arnhem Regional Council (EARC).

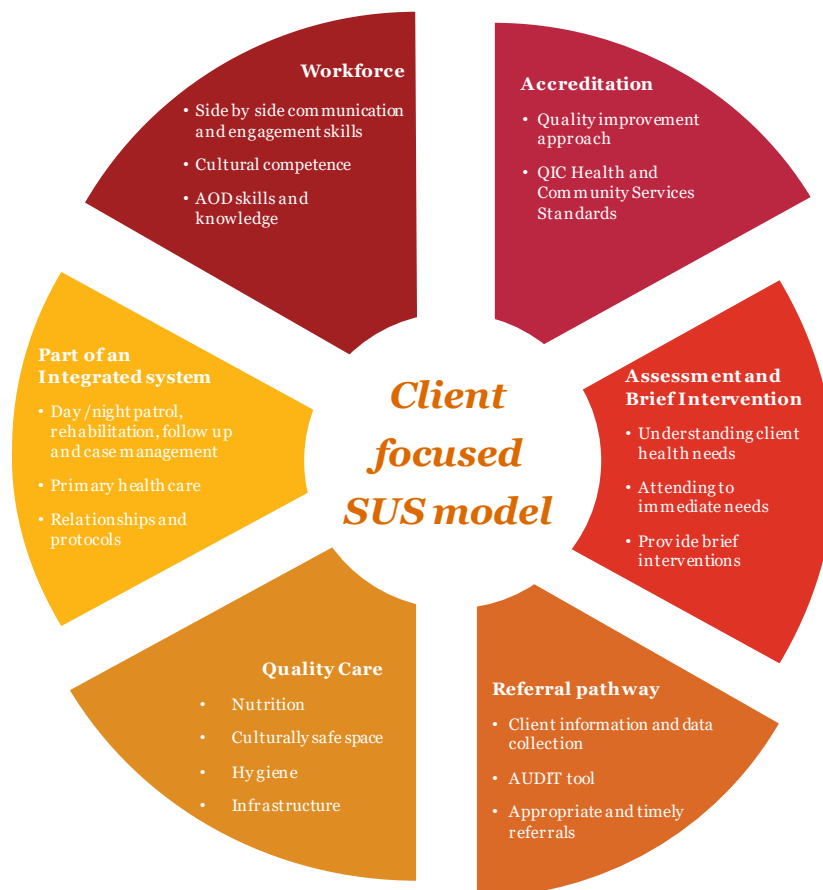
Other services provided: Community Patrol

Current funding arrangement: 1/07/2018 – 30/06/2020

#### *Current operating model*

Based the comprehensive SUS service model identified earlier, the diagram below indicates the elements that East Arnhem Regional Council provides. A core issue for this service is the location and infrastructure to adequately provide an integrated service model. Also as the diagram indicates, there are elements that need to be addressed in order to provide a form of integrated service model.

*Figure 17: Elements of the comprehensive model at EARC*



#### ***Location/Facilities***

The view of the EARC is that there are multiple issues with the SUS in relation to its location and the facilities. It is considered to be in a very poor location as it is located out of town and down a very dark road. It is also located right next to the Datjala working camp meaning clients are extremely apprehensive to spending the night at the SUS as they feel that they will wake up and be put into the prison while women clients are also concerned that the men in the prison will escape and possibly reach them.

## Executive summary

There were reasonable concerns over the facility being used as a SUS as the building is built for the purpose of a residential premises. There is only one shower and one toilet, which are located in the same space with staff and clients both sharing these facilities

### ***Staffing profiles***

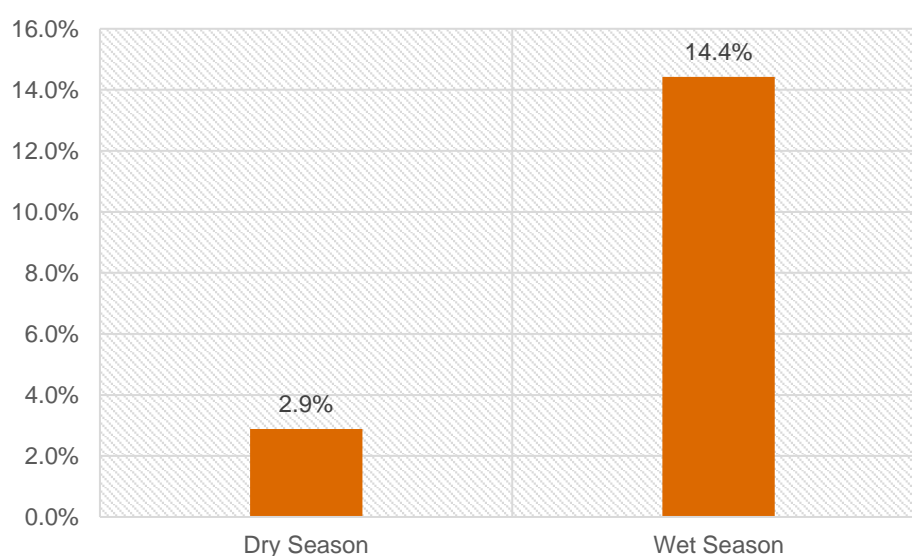
There are three staff who are employed at the SUS. One is a full time employee while the other two are part time employees.

### ***Opening hours (Peaks and lows)***

Hours of operation are 6:00 pm – 7:00 am Tuesday to Friday (closed Saturday, Sunday and Monday). EARC has determined that they will cease admissions at 12:30 am.

The SUS indicated that for some period of time the service has been averaging a low frequency of clients. It was mentioned that they can go weeks without a client. It is not known if this is due to the alcohol permit restrictions in place in Nhulunbuy or if this is related to the location and potential clients refusing to be taken to the SUS and instead requesting to be taken home or to a relative's place of residence. The low numbers portrayed in the consultations is consistent with data sets on admission and utilisation for the period June 2017 to May 2018 provided by the MHAODB team.

*Figure 18: Utilisation of beds against admission rates*



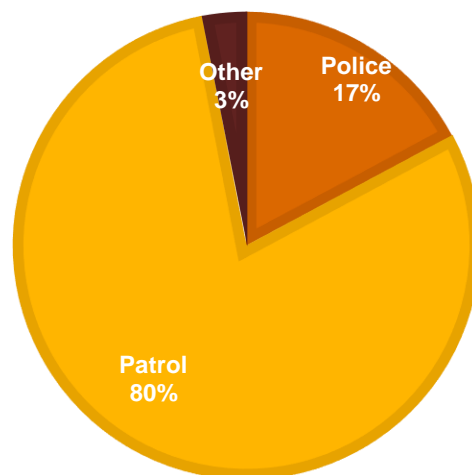
### ***Bed capacity***

The SUS is currently funded to manage six beds (three male and three female).

### ***Referral point***

Police and Night Patrol are the two main referral sources for people presenting at the SUS with self-referral being the least common source. This is consistent with data sets on referral sources for the period June 2017 to May 2018 provided by the MHAODB team.

Figure 19: Referral sources



### **Banned lists**

It was understood that the Nhulunbuy SUS hold a banned list and it currently only has one female on it due to behavioural issues.

### **Relationships**

It was mentioned during consultations that there was a great relationships with Police and other external stakeholders.

### **Accreditations**

The SUS is not accredited

### **Audit tool**


Again, similar to other SUS locations the AUDIT tool or anything similar in nature is not currently being utilised, although they are looking to implement the process. The SUS is apprehensive as the clients are looking to leave as soon as they wake up and it is deemed difficult to obtain the required information from them prior to departure.

## **Summary of Issues Identified**

- Underutilisation of beds
- Facilities and location
- Audit tool not being utilised

## **Recommendations and enhancements**

- MHAODB work with Police and the Nhulunbuy Hospital to further interrogate the client pathways to determine whether the service should be closed or relocated.
- Where the SUS service provider is not already accredited with an existing health standards body, they be supported by NT Health to undertake the self-assessment and accreditation process to attain the QIC Health and Community Service Standard (7<sup>th</sup> Edition).
- Implement the recording of AUDIT scores as a KPI and reporting requirement in all of the Sobering up Shelter service agreements to assist in accountability of referral processes.



## Executive summary

- *SUS services to collect information about how many clients are registered on the BDR and report this as part of their performance reporting to help inform ongoing review of secondary supply measures*





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