Independent Review of Sobering-Up Centres in Western Australia

SERVICE MODEL REVIEW

Mental Health Commission

30 October 2019

nous | 20 YEARS OF INFLUENCE

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Contents

Nous Group would like to acknowledge the many committed professionals, community people and leaders in the Kimberley, Pilbara, Mid-West, Goldfields and Perth. Thank you to those who participated in the consultations and provided your time and valuable perspectives.

1 Executive summary

Sobering-Up Centres (referred to as 'SUCs' and also known as '*safe places for intoxicated people*') were established in Western Australia (WA) in 1991, as one of the key recommendations from the Royal Commission into Aboriginal Deaths in Custody. Since 2013, SUCs have been commissioned by the Mental Health Commission (MHC) following its amalgamation with the former Drug and Alcohol Office. There are currently nine SUCs operating across WA – Broome, Carnarvon, Derby, Kalgoorlie, Kununurra, Perth, Roebourne, South Hedland and Wyndham.

The demand for safe places for intoxicated people is predicted to grow. Modelling in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the *Plan*) signals that the number of beds in SUCs is due to rise from the current number of 165, to 205 beds in 2025 – an increase of 24.24%. This growth is expected to occur within the broader strategic reform program currently underway in the mental health and alcohol and other drugs (AOD) services systems. These reforms are prioritising the rebalancing of the mental health and AOD systems across the continuum of community-based care through to hospital-based care, developing more effective and integrated systems to ensure that people do not fall through the gaps, and driving collaboration and integrated service provision for co-occurring mental health and AOD problems.

It is in this context that the MHC commissioned Nous Group (Nous) to undertake an independent review of SUCs in WA. This is the first substantive external review of the SUCs in WA since their inception. To inform the review, Nous reviewed existing literature, analysed current and historical SUC data, and consulted widely across the state; meeting with more than 150 stakeholders in each community where a SUC is currently located. The stakeholders consulted include, but are not limited to, SUC service providers, police officers, emergency physicians and nurses, AOD counsellors, state and local government officials, non-government service providers, Aboriginal Elders and other community leaders. Nous has also consulted providers of similar services in the Northern Territory and South Australia to get an insight into how comparable services are commissioned in other jurisdictions.

The review has concluded that while SUCs remain critical harm-reduction services for vulnerable, intoxicated people, there are several opportunities to enhance the impact of the service on individuals and local communities and to improve value for money for government. In total, the review has identified **four key findings** underpinned by **19 discrete sub-findings**. The four key findings are:

- **Key finding 1:** For some communities, sobering-up centres are an essential harm-reduction service
- **Key finding 2:** The SUC service model as currently commissioned delivers value for money, but there are SUCs that deliver less value than others
- **Key finding 3:** There are missed opportunities to add greater value to communities through SUCs
- **Key finding 4:** The commissioning and funding approach should be adapted to realise this value.

For each key finding, this review has made one or more recommendations with a total of **15 recommendations.** The remainder of the Executive Summary steps through the four key findings and the recommendations associated with each.

1.1 Key finding 1: For some communities, sobering-up centres are an essential harm-reduction service

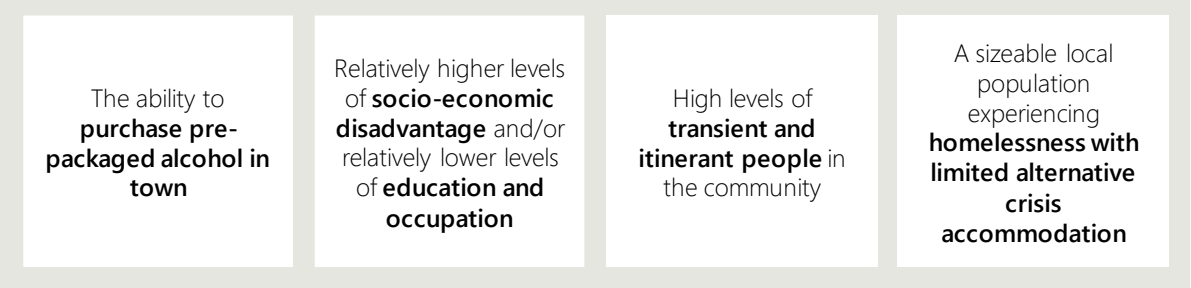
Across the communities in which they operate, SUCs seek to reduce the incidence of alcohol-related harm to both intoxicated people, and others. They do so by providing people who are intoxicated by alcohol or poly-drug use, with a safe place to sleep; where they are continually monitored, their clothes are cleaned, and they are provided a morning meal.

In undertaking the review, Nous visited all nine SUC services, speaking with the managers and staff in each, and local stakeholders across each of the nine communities. In all communities there is a near-unanimous support for the importance of the SUC within the community. The consensus is that SUCs remain crucial harm-reduction services for vulnerable people who need a safe place to spend the night, in communities where there are few, if any, alternatives.

The most common cohort of SUC clients is **older** (81.32% are aged 36+), **Aboriginal** (82.44%), **men** (70.34%). SUCs continue to meet the needs of individuals within this cohort. Whilst there is a consensus that SUCs are capable of adequately supporting other cohorts; such as younger people, non-Aboriginal people and women; there does not appear to be significant unmet demand from these other cohorts in the communities visited. As such, the service model does not need to be adapted to provide services to these cohorts.

To understand the nature of demand for a SUC, this review sought to understand the contemporary factors that impact the demand of SUCs, which in turn may inform future funding decisions. This review identified four community characteristics that are generally present in the locations where there is a SUC in high-demand, briefly set out in Figure 1.

Figure 1 | Community characteristics for SUCs in high demand



Not every community with a SUC has all four characteristics and these characteristics are not unique to just these nine communities. Demand for a SUC can change over time as local community characteristics change. When and where a community's characteristics discernibly change, the requirement for a SUC may need to be reconsidered. This has been the experience in multiple communities in WA over the last 15 years, with some previously commissioned SUCs having been decommissioned.

Furthermore. not every community requires a SUC, but where there is a continued high level of intoxicated people in public spaces and a lack of alternative services for these vulnerable people, SUCs have the potential to be a critically important service that reduces the overall incidence of alcohol-related harm on individuals and the community.

There is one recommendation in relation to key finding 1, set out in Table 1, overleaf.

Table 1 | Recommendation related to key finding 1

Recommendation 1	SUCs are a critically important service and should remain a core part of the MHC's suite of local harm-reduction strategies and its broader state-wide response to reducing the impact of alcohol-related harm.

1.2 Key finding 2: The SUC service model as currently commissioned delivers value for money, but there are SUCs that deliver less value than others

To assess value for money, this review sought to understand the direct and indirect impact of SUC services, and to compare this to the cost of funding these services.

In 2018-19, the MHC funding for the nine SUCs across WA totalled **$5,179,796**. In the same period, SUCs provided a service to 3,468 individual clients, with 15,118 total admissions at an **average cost per admission of $343.** There was a wide range of admissions across the nine SUCs, and the average cost per admission by SUC, and the number of unique clients admitted is summarised in Table 2, below.

Table 2 | SUC cost per admission and number of unique clients in 2018-19

	Roebourne	Carnarvon	Wyndham	Kalgoorlie	South Hedland	Derby	Broome	Kununurra	Perth
Cost per admission	$3,301	$1,311	$1,105	$475	$440	$375	$290	$165	$110
No. of unique clients	94	85	96	551	333	631	564	552	988

On face value, this shows that the cost per admission to the Carnarvon, Wyndham and Roebourne SUCs is significantly higher than the average cost of the other six SUCs. Furthermore, each of these three SUCs support a far smaller cohort of individuals from their communities and surrounding areas.

With a lack of quantitative outcome data, it is hard to discern whether these costs represent value for money. Therefore, this review sought to assess the value of the SUC service in comparison to alternative outcomes that an intoxicated person may experience if not able to be admitted to a SUC.

Stakeholders proposed that the SUCs provide a safe alternative to four undesirable outcomes for an individual:

- **The individual is taken to the local Emergency Department (ED).** The consensus amongst most stakeholders is that attending the ED is the most likely outcome for an intoxicated person if a SUC were not available. In 2015-16, the average cost of an ED presentation in WA, where the person was not admitted was $619 and $1,227 if they were admitted. Clinicians and public health officials noted the critical role that SUCs play both in diverting people away from hospitals who have no acute medical need.
- **The individual commits a criminal act and is taken into police custody.** An intoxicated person in police custody must be placed on 'high risk' watch, requiring two police offers to monitor each person in custody and therefore constraining the ability of police to respond to other local matters throughout the night. In many regional communities, this would compromise the police response to other, potentially criminal, situations in the community.
- **The individual is at home with the increased risk of FDV.** Many stakeholders noted that attendees of SUCs include several people that have historically committed acts of FDV. SUCs present as an

alternative place for an intoxicated person to take themselves, or to be referred by families and the community patrol.

- **The individual is 'sleeping rough'.** SUCs, at present, provide the only alternative for intoxicated people 'sleeping rough' (i.e. sleeping on the street) – most of whom are itinerant people from surrounding communities.

With the average cost of an ED presentation being at least $619, it is the conclusion of this review that with a significantly lower average cost per admission the SUCs in Perth, Kalgoorlie, Derby, Broome, Kununurra and South Hedland therefore represent value for money. In each location, a client entering the SUC would cost significantly less than that person alternatively attending the ED. It is also the conclusion, therefore, that under the right circumstances the SUC model represents value for money for the state.

The SUCs in Wyndham, Roebourne, and Carnarvon each have a higher average cost per admission than the ED and provide services to comparatively few unique clients. This does not mean they automatically are not value for money, rather that the review has therefore taken into consideration the characteristics of the local community in determining whether each is a value for money outcome:

- Wyndham has a much smaller population than all other communities with a SUC apart from Roebourne (780 people)[1]. More than 50% of this population are Aboriginal peoples, and the socio-economic outcomes are among the poorest in Australia, with high rates of family and domestic violence, alcohol-related harm, youth suicide, and anti-social behaviour. With approximately 96 unique admissions in 2018-19 and low levels of transient people in the community, the SUC therefore provides a service to approximately 10 per cent of the local population. In addition, there is only an on-call police service in Wyndham at night and only one bed in the local ED. **It is therefore the conclusion of this review that although more expensive per admission than most of the other SUCs, the Wyndham SUC is a critical community resource, supporting a significant proportion of the local community, and does represent value for money.**
- Admissions to the Roebourne SUC have significantly reduced in recent years, due to the relocation of some families to Karratha and Wickham and the completion of Homes West houses within the community. In response the MHC have reduced the number of SUC beds (from 14 beds to 8 beds from 1 July 2019), converted some of these SUC beds into low medical withdrawal beds, and funded the combined facility to be open 24/7. In doing so, the service now fulfils a dual purpose at a cost only marginally higher than a standalone SUC. **It is the conclusion of this review that the Roebourne SUC would not represent value for money for the MHC if it were a standalone SUC, but the MHC has achieved greater value for money by co-locating the service with a low medical withdrawal service**.
- Carnarvon has seen lower than expected admissions since it was established in 2014. The target level of admissions was set at 1040 admissions per annum, but since opening, the service has not exceeded 400 admissions per year. Further, in the 11 months to 30 May 2019, the SUC had only supported 78 unique clients. With a local population of over 4,400, this represents less than 2% of the local population. **It is the conclusion of this review that at current utilisation levels, the Carnarvon SUC does not represent value for money for the MHC.**

This review has made four recommendations in relation to key finding 2, set out in Table 3, overleaf.

[1] 2016 Census QuickStats, Wyndham (WA), released 23 October 2017, Australian Bureau of Statistics, Canberra, https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/SSC51639

Table 3 | Recommendations for key finding 2

Recommendation 2	The MHC to consider establishing a set of improved quantitative and qualitative KPIs that can be used to better assess value for money of SUCs into the future.
Recommendation 3	The MHC to consider evaluating the value for money of an individual SUC on a two-yearly basis. This will ensure that admission trends can be assessed without the issue of seasonal variations (see observation below).
Recommendation 4	The MHC to consider working with the provider of the Roebourne SUC and the local community of Roebourne to determine whether there is an ongoing need for the SUC or an alternative service that better meets local needs; or whether the facility should be commissioned going forward as a standalone low medical withdrawal service (noting that this service is a regional service and predominantly supports users of methamphetamine).
Recommendation 5	The MHC to consider working with the provider of the Carnarvon SUC and the local community of Carnarvon to determine whether there is a latent community need for the SUC that is not being met, and if so, how those in the community that need the SUC service can be supported to use it.

1.3 Key finding 3: There are missed opportunities to add greater value to communities through SUCs

Most SUCs exist in a silo, operating independently of the local health and community service systems. SUCs generally provide very few referrals to other services that could benefit the SUC clients; such as community alcohol and drug services, mental health services, Aboriginal health services, and/or community-based support services such as housing and employment services. In some communities, other AOD health and community service providers are unaware of the existence of the SUC and/or have a very limited understanding of its service model and purpose.

The review has concluded that the absence of more established connections between SUCs and other services represents a missed opportunity to connect clients with services and support they may require. Acknowledging there is variability between SUC services, the review has identified two fundamental issues with the service model that unless addressed will continue to inhibit the ability of individual SUCs to better connect with other local services:

- **The capability of SUC staff.** SUC care workers are widely acknowledged as dedicated and community-minded care workers. However, in general, they do not have the skills, experience and capability to manage additional responsibilities of case management and referrals to other services. Furthermore, many SUC staff have significant reservations about being given greater responsibility to connect clients to other services themselves.
- **The typical operating hours of a SUC.** The typical operating hours of SUCs are between 16:00 and 07:00 or 08:00; except for the SUCs in Perth and Roebourne, which are each funded to operate 24 hours a day. While opening at 16:00 is appropriate, the closure of SUCs at 08:00 means that most clients have vacated the SUC by 07:00 which effectively inhibits the opportunity for clients to be connected to other services in the morning. Other AOD, health and community services rarely operate before 08:30, rendering it impractical for them to provide an in-reach service to the SUC. In effect the operating hours of the SUCs creates a window of missed opportunity to directly connect SUC clients with other services.

Whilst there is an opportunity to enhance the capability of SUC staff this review does not recommend that SUC staff are given the responsibility for making referrals to other services. Rather the conclusion is that the opening hours of the SUC need to be extended to create the opportunity for specialised services to in-reach into the SUC and create connections with clients who would benefit from their support.

All the SUCs other than Perth and Roebourne operate either four and five days a week. In these communities, many stakeholders believe the biggest opportunity to enhance the SUC service is to increase the number of days that the SUC is open in line with alcohol sales within the community[2]. To these stakeholders, limiting the number of SUC operating days represents a missed opportunity to lessen the burden of intoxication and alcohol-related harm across the health, law and order, and community services. This review finds that there is no clear rationale for only operating SUCs for five days a week (other than the current levels of funding only enabling five days of operation per week).

This review provides five recommendations in relation to key finding 3, set out in Table 4, overleaf.

[2] Alcohol restrictions in some communities mean that alcohol sales are prohibited on a Sunday

Table 4 | Recommendations for key finding 3

Recommendation 6	The MHC to explore opportunities to assist SUCs in establishing internal mechanisms (i.e. case management processes and referral protocols) to identify regular clients of the SUC and create opportunities for targeted conversations between the local AOD counselling service and the client[3].
Recommendation 7	The MHC to consider the appropriate training needs of SUC care workers, that enable them to be more capable and confident of supporting clients to seek support; and consider funding SUC providers to deliver this training.
Recommendation 8	The MHC to consider increasing the level of funding provided to service providers to enable SUCs to remain open until 10:00 and provide a substantial breakfast as an incentive to SUC clients to stay in the centre after 08:00.
Recommendation 9	The MHC to consider including a requirement in the Guidelines for SUC providers to work with other appropriate local service providers to deliver in-reach services into the SUC on a regular basis.
Recommendation 10	The MHC to consider increasing the level of funding for SUCs to enable them to open between 6-7 days a week (for those SUCs showing demand, and in line with restrictions on the sale of packaged alcohol in the community).

[3] This review notes that there are client privacy challenges that make this recommendation more complex than it appears on face value; especially where different organisations operate the SUC and AOD counselling service

1.4 Key finding 4: The commissioning and funding approach should be adapted to realise this additional value

Realising the opportunity to enhance the SUC service model to create more value and achieve greater impact in local communities will require changes to the way SUC services are funded and managed.

Enhancing the SUC service model, generally, cannot occur within the existing funding envelope provided to SUCs. Any increase to operating days or opening hours will require additional funding, as will any staff development.

Much of the 'added value' potential of SUCs assumes that external services will in-reach to the SUC. This is not wholly within the control or remit of the MHC. This includes opportunities to better connect SUC clients with general health and social support services like employment, housing and FDV services.

Creating connected service systems in local communities to drive better outcomes for at-risk people requires greater collaboration between the MHC and other agencies (including the Department of Communities, Department of Health, and National Indigenous Australians Agency), and a movement toward co-commissioning. This is most critical in the case of the relationship between the SUC and the local community patrol. Where there is a good relationship between the SUC and the patrol, this has a demonstrable impact on admissions to the SUC and the minimisation of harm within the community.

There is a general absence of outcomes data related to the SUCs and SUC providers are generally left to their own devices to enhance or adapt the service to meet the needs of the local community. An enhanced mechanism for performance measurement and management of SUCs will enable more holistic performance assessments to be made in the future.

- **Measuring performance:** A balanced scorecard comprising a small number of performance measures will enable a better understanding of the effectiveness, impact and value for money of SUCs.
- **Managing performance:** A more collaborative but assertive approach to performance management, will involve greater interaction with the SUC providers and local communities; placing greater emphasis on assessing whether the SUC is having an impact on the local community, rather than whether the SUC is meeting specified admission targets.

In the last two decades, six SUCs have been decommissioned – Fitzroy Crossing, Halls Creek, Wiluna, Midland, West Perth, and Geraldton. The lesson learned from past closures is the importance of engaging in a constructive dialogue with local communities when changes in community characteristics indicate that a SUC is no longer the most appropriate mechanism for addressing alcohol-related harm. This should include the determination of whether there is another more appropriate service that could be established to address community needs, or whether demand has so substantially decreased that there is no longer a need for a targeted service.

This review provides five recommendations in relation to key finding 4, set out in Table 5, overleaf.

Table 5 | Recommendations for key finding 4

Recommendation 11	The MHC to explore opportunities to work with other agencies, including the Department of Communities, the Department of Health and the National Indigenous Australians Agency to ensure there is a 'whole of government' commissioning approach to SUCs, creating the conditions for the SUC to be better connected to other local services.
Recommendation 12	The MHC and the Department of Communities to explore opportunities to align their commissioning intentions for SUCs and community patrol; and where the services are not provided by the same organisation ensure that there is an effective relationship.
Recommendation 13	The MHC to explore opportunities to utilise the SUC facility when it is not in use; working with local communities and other government agencies to ensure these 'community assets' can be maximised to best meet local needs.
Recommendation 14	The MHC to only consider co-locating and co-commissioning dual-purpose SUC and low medical withdrawal services after appropriate community consultation, and assurance that the two services will be suitably separated, and that the social and clinical outcomes of clients are safeguarded.
Recommendation 15	Having identified that a SUC should potentially be decommissioned, the MHC should ensure there is authentic community engagement and consideration of alternate services that can better meet community needs.

2 Background and context

2.1 Background to the review

The Mental Health Commission (MHC) engaged Nous Group (Nous) to conduct an independent review of Sobering-Up Centres (SUCs) in Western Australia (WA).

SUCs exist to provide safe, supervised overnight care for intoxicated persons, thereby reducing the likelihood of them causing harm to themselves or to others in the community. The service is non-medical in nature and is not designed to offer or provide a pathway to treatment or rehabilitation. However, persons discharged from the service may be provided with information and/or referred to other services with the individual's consent.

The SUC model was introduced in WA in 1990 and since 2013 has been commissioned by the MHC following the amalgamation of the MHC with the former Drug and Alcohol Office. This is the first substantive external review of the SUCs in WA since their inception. The objective of the review was to consider the following questions:

- To what extent do SUCs meet the needs of the communities in which they operate?
- What opportunities are there to enhance or integrate the SUC service model with other alcohol and other drugs (AOD), and mental health services across WA?
- To what extent do SUCs represent value for money?
- What opportunities are there to more effectively use the funding provided to each SUC?

The review is focused specifically on the SUC service model, rather than a series of performance reviews of the nine individual SUCs. The findings and recommendations presented in this report are informed by consultations in each of the nine communities where a SUC operates, but it does not make recommendations relating to individual SUCs.

The review was conducted from June to September 2019. Nous' approach to undertaking the review is summarised in Section 3.

2.2 Strategic context

SUCs are part of the WA Government's suite of harm-reduction services – a set of long-standing community support responses for people with AOD problems. Harm-reduction services, which also include needle and syringe provision and overdose prevention, are essential public health initiatives and the MHC has signalled that they will continue to have a role in WA going forward.[4]

The demand for safe places for intoxicated people is predicted to grow. Modelling in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the *Plan*) signals that the number of beds in SUCs is due to rise from the current 165, to 205 beds in 2025 – an increase of 24.24%.[5]

In addition to the increase in community beds, there is intended to be greater investment in AOD community support services as there is currently a substantial deficit of these services.[6] Modelling of future demand shows that hours of AOD community support services will be required to increase from 17,000 (as at 30 June 2013), to 314,000 in 2025 – an increase of 1,747%.

The *Plan Update 2018*[7] met MHCs commitment to revisit the service modelling framework within a two-year period and identified a range of system-wide reform priority areas to be progressed alongside the implementation of other plan actions. This review was conducted in the context of three key strategic reform areas that remain ongoing:

1. **Balance of Services**. In rebalancing the system across the continuum of care, services need to be reconfigured so that beds and community services are better balanced in accordance with population need.
2. **Developing an Integrated System.** An effective and integrated system is essential to ensure individuals do not fall through the gaps across the service continuum and when transitioning between services. It is important that mental health and AOD services work together across the health and human service sectors in an integrated, coordinated way, to ensure service delivery is comprehensive, cohesive, accessible, responsive, and optimises the use of limited resources. In achieving an integrated system, it is important to recognise and build upon existing services and programs and identify where new services and programs may be required and/or where better linkages between services need to be created.
3. **Services for co-occurring mental health and AOD.** Mental health and AOD problems, more often than not, occur together and with other health and social issues, including trauma, physical health, and homelessness. Commissioning and service delivery requires collaborative and, where appropriate, integrated provision of treatment for mental health and AOD problems. This involves the establishment of more consistent approaches to collaboration, joint protocols, clearly defined treatment and support protocols and care pathways.

This review has therefore considered whether there are opportunities to adapt the SUC service model to improve the balance of services across the local continuum of care, enable better integration within local health and community services systems, and identify opportunities to improve the integrated provision of care for people with co-occurring mental health and AOD problems.

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[4] Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, p. 39.

[5] Updated figures for safe places for intoxicated people did not form part of Plan Update 2018, so optimal levels are as published in 2015.

[6] This includes face-to-face time between staff and consumers/carers, staff travel time, and time for other duties such as administrative requirements, training and research.

[7] Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 Plan Update 2018.

3 Approach to this review

This section sets out the scope, approach and methodology followed to inform the findings and recommendations developed. It also notes the limitations and assumptions of the review.

3.1 Scope and limitations

The objective of this review is to provide evidence-based findings and recommendations to the MHC's decision-making about the future of SUCs in WA. It seeks to: consider the ongoing validity of the SUC service model; the 'value for money' of the service provided; opportunities to adapt or enhance the service model to improve impact and value; and understand the funding and commissioning implications of realising these opportunities.

The review was conducted over the period June-September 2019. There are two key limitations to the findings and recommendations presented in this report:

- **The measurement of the outcomes of the service.** A true measurement of the impact of SUCs in local communities is not possible at the time of this review. The intended outcomes of the SUC services cannot be measured through existing data sources. The data that is collated only allows comparison of the funding, operating environment and utilisation of SUCs. Analysis of this data has been used, where appropriate to support the conclusions made following consultations with more than 150 providers and other key stakeholders.
- **The assumption that the activity data provided by SUCs is true and correct.** This review relied upon data provided by the MHC (which is submitted by each SUC on a six-monthly basis through activity reports), and ad-hoc data provided by SUC service providers where practicable. This data is collected on paper-based forms and collated for submission in the activity report. This review has assumed that all data provided by the MHC and SUC service providers is a true and correct reflection of the services provided and the clients seen.
- Further assumptions and qualifications that underpin the findings and recommendations in this review are set out in Appendix A.

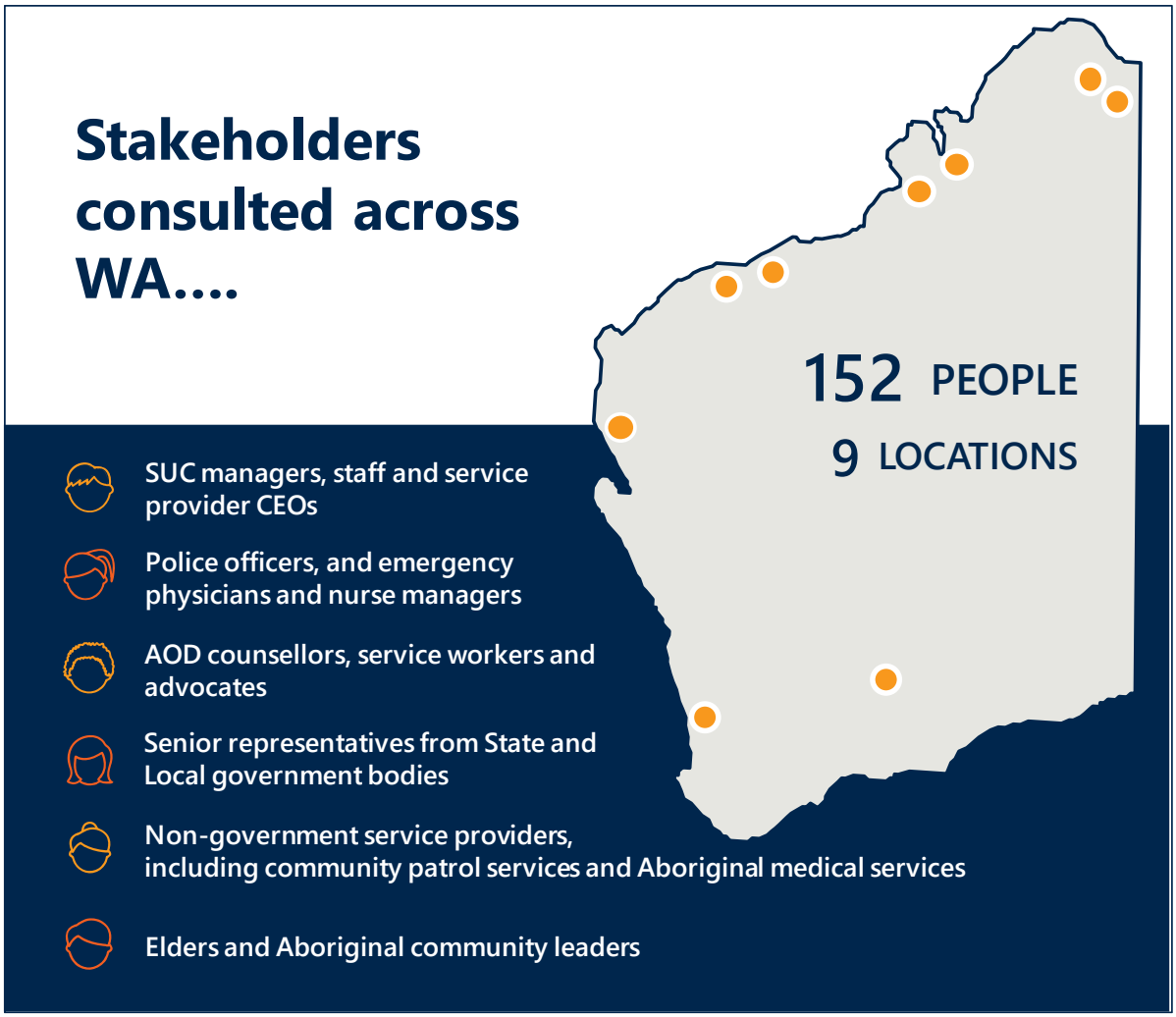
3.2 Approach and methodology

The findings and recommendations set out in this review are informed by desktop research, data analysis, and stakeholder engagement with government, service providers, local community members, and other stakeholders with an interest in providing input into the review. Specifically:

- **Desktop review:** A review of documents provided by the MHC (including the Guidelines for the Operation of Sobering-Up Centres, the *Plan* and the *Plan Update 2018*), legacy documents from the former Statewide Purchasing Authority, the former WA Alcohol and Drug Authority, and the former Drug and Alcohol Office, and other publicly available literature regarding the history of SUCs across Australia and contemporary SUC service approaches.
- **Data analysis:** Analysis of a data extract from the Sobering-Up Centre Database, including current and historical utilisation and occupancy (including admission hour, referral type, age group, Aboriginality, gender, and unique client admissions), Community Alcohol and Drug Service (CADS) data, and ad-hoc data provided by SUC service providers.
- **Structured interviews with the MHC, other government agencies, and advocacy bodies:** Interviews with MHC contract managers and prevention services, and senior Perth-based representatives from WA Police, the Department of Communities, the Department of Health, the WA Network of Alcohol Other Drug Agencies (WANADA), the Aboriginal Health Council of Western Australia and the National Drug Research Institute.
- **Interjurisdictional interviews:** Interviews with SUC service providers in Darwin and Katherine in the Northern Territory, and in Ceduna in South Australia.[8]
- **Community consultations:** The primary input into this review is the information provided by community stakeholders in each location with a SUC. Between July and September, Nous spent time in South Hedland, Roebourne, Broome, Derby, Kununurra, Wyndham, Kalgoorlie, Carnarvon and Perth and met with SUC service providers and other community stakeholders with an informed position on the SUC service. These consultations are summarised in Figure 2, overleaf.

[8] SUC service providers in Darwin, Katherine and Ceduna were consulted on the basis that each of these communities has similar demographic or community characteristics to communities across WA with a SUC (see Table 8 in Section 0). This review also approached SUC service providers in regional Queensland, but they declined to be consulted.

Figure 2 | SUC consultation summary



3.3 Glossary of terms

- **AOD:** Alcohol and other drugs. In the context of this review, alcohol is the primary drug of concern, with other drugs typically being amphetamine-type stimulants or cannabinoids.
- **Community patrol:** A local service which contributes to community safety by providing transport for at-risk community members, especially intoxicated adults or young people. The community patrol may also be referred to as 'the night patrol,' 'the street patrol,' or simply 'the patrol.' It is funded by the Department of Communities as part of its Aboriginal Community Connectors program (formerly Aboriginal Community Patrols) in 14 locations across WA, including in the nine locations in which there are SUCs.
- **Early intervention and prevention services:** Services to prevent or delay the onset of alcohol and other drug use and to protect against risk and reduce harm associated with alcohol and other drug supply and use.
- **The *Guidelines*:** The Mental Health Commission's Guidelines for the Operation of Sobering-Up Centres, revised in July 2017.
- **Harm-reduction services**: Polices, programmes and practices that aim to ensure safe, healthy and resilient communities by reducing the harm associated with the misuse of alcohol and other drugs in people unable or unwilling to stop.
- **KPI:** Key performance indicator. A measure that demonstrates how effectively a service provider is achieving key service outcomes.
- **Low medical withdrawal service:** A community bed-based detoxification service. Such a service is suitable to individuals for whom no severe or complicated withdrawal is anticipated; no medical complications requiring close observation or treatment in a hospital setting are evident; and psychiatric symptoms such as psychosis or depression can be safely managed in a community residential setting.
- **The *Plan*:** The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.
- **The *Plan Update 2018*:** The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 Plan Update 2018.
- **Social support services:** Services available in the community that serve to improve the wellbeing of individuals and families. Examples of such services include, but are not limited, to homelessness services, tenancy support, employment support, family support services, assistance and advocacy with welfare agencies or legal aid.
- **SUC:** Sobering-Up Centres, or safe places for intoxicated people.
- **Treatment services:** Treatment services is used as a collective term for **community treatment services** and **community bed-based services**. Such services may include outpatient programs, therapeutic day programs, specialised service provisions, low medical withdrawal services and residential rehabilitation services.
- **Utilisation:** A measure of whether a service is being practically and effectively used. For any single SUC, utilisation is calculated by dividing the number of annual admissions by the number of bed days (being the number of nights open multiplied by the number of available beds).

4 Service model and performance overview

This section sets out the history of SUCs in WA, a summary of the SUC service model based on the *Guidelines*, and overview of SUC performance in 2018-19.

4.1 History of SUCs in Western Australia

SUCs were established in WA in 1990 as part of the WA Government's response to the findings and recommendations from the *Royal Commission into Aboriginal Deaths in Custody (RCIADIC)*, which was conducted between 1987 and 1991. The RCIADIC was established in response to growing public concern that deaths of Aboriginal and Torres Strait Islander people in state and territory jails were too common and poorly explained. The final report made 339 recommendations across a wide range of policy areas. These included 13 recommendations specifically relating to diversion from police custody (*Recommendations 79 to 91*). Recommendations 79 – 81 specifically relate to the establishment of the SUC model:

- That, in jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness.
- That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons.
- That legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a *facility established for the care of intoxicated persons.*

In February 1989, the Australian Aboriginal Affairs Council met to discuss implementation of the recommendations contained in the Interim Report of the RCIADIC.[9] A consequent decision was that capital cost funding would be committed by the Commonwealth for the establishment of SUCs in WA and that operating cost funding would be provided by the WA Government. In June 1989, Cabinet approved the development of alternative procedures to minimise use of police cells for detaining persons found drunk in public and vested implementation of the project with the Western Australian Alcohol and Drug Authority (WAADA). Finally, public drunkenness was decriminalised in April 1990 by the *Acts Amendment (Detention of Drunken Persons) Act 1989* (WA), which repealed section 53 of the *Police Act 1892* (WA).

The first SUC in WA opened in Perth in May 1990 under the WAADA. Since 1991, a further 14 SUCs were established across WA:

- two further SUCs in the Perth metropolitan area[10] (Midland in 2002; West Perth in 2003)

[9] Richard Midford, 'A Practical Guide to the Establishment and Community Management of Sobering-Up Centres', Statewide Purchasing Authority, Perth, Western Australia, February 1995.

[10] This does not include the limited SUC that operated in the metropolitan beachside suburb of Scarborough from 2001 to 2005. This SUC operated as part of New Year's Eve celebrations to assist in the management of intoxicated persons.

- two in the Pilbara region (South Hedland in 1991; Roebourne in 1993)
- six in the Kimberley region (Halls Creek in 1992; Fitzroy Crossing in 1994; Kununurra in 1996; Derby in 1998; Broome in 1999; Wyndham in 2002)
- one in the Goldfields-Esperance region (Kalgoorlie in 1994)
- three in the Mid-West region (Wiluna in 1996; Geraldton in 2003; Carnarvon in 2014).

Since 2006, six of the 15 SUCs in WA were closed because of low demand for the service: Midland and Fitzroy Crossing in 2006, West Perth in 2009, Halls Creek and Wiluna in 2011, and Geraldton in 2017.

4.2 Overview of the SUC service model

SUCs are predominantly managed by local community organisations, providing safe supervised overnight care, with access to showers, laundry facilities and a simple meal. The model of service is set out by the MHC in the *Guidelines*. The *Guidelines* state that they are not intended to establish definitive rules and regulations that each SUC must adhere to absolutely, rather the *Guidelines* are intended to provide good principles and best practice methods for consideration in operating a SUC. It is a condition of each provider's service agreement with the MHC that the operation of the SUC is in accordance with the *Guidelines*.

Assessment and admission

Clients may be brought to the SUC by the police, community patrol, health or welfare agencies, or by other means including clients referring themselves. For a client to be admitted, they must be assessed by SUC staff to be:

- intoxicated, fully conscious, free of injuries (particularly head injuries)
- not aggressive, abusive, currently banned from the centre, or carrying any weapons
- voluntarily entering the centre, with no alcohol or other drugs on their person
- over 18 years of age.

The *Guidelines* identify a potential SUC client as a person who is intoxicated with alcohol. If a person is intoxicated with other substances, admission may be considered based on the SUC's ability to manage the client and the physiological and behavioural effects of the substances consumed.

No person should be refused admission because of the number of times that they have previously used the service. However, SUCs are not intended to provide ongoing accommodation and where it is observed that a client is attending the SUC on a regular basis, staff are encouraged to explore treatment or accommodation options with a view to engaging the client in alternative services that will better meet their needs.

Standard of care while in the SUC

Once the client has been admitted to the SUC and has agreed to stay, the person becomes a 'client' of the SUC and is 'in care'. Clients in care surrender their personal property to SUC staff, who store the items in a locked cupboard and include a written record of the items held. Clients are then required to shower, are provided with clean nightwear, are encouraged to drink water or warm drinks to avoid dehydration, and are settled in a bed.

While sleeping, clients are monitored regularly for any changes in their mental or physical state that could indicate health problems and the need for medical attention. Clients who are sleeping are checked every 30 minutes and the check noted on an observation chart.

Should a client require care for a medical complaint other than an injury on admission, or should a client receive an injury whilst in the SUC, staff are required to render First Aid. If medical assistance beyond simple First Aid is required, or if there is any doubt as to the client's condition, staff are instructed to call an ambulance. Staff do not offer medication unless instructed to under medical orders.

The MHC funds all centres to provide a simple and nutritious meal to clients before discharge. The MHC does not support the practice of providing a meal to clients on admission, due to the risk of a client vomiting whilst asleep and then asphyxiating. However, the *Guidelines* note that if SUCs choose to provide

food to clients on admission, staff should be aware that this may elevate risk for the client, and more frequent monitoring should be undertaken of clients known to have ingested food prior to going to sleep.

Discharge from the SUC

The *Guidelines* acknowledge that each SUC has its own discharge procedure, depending on resources available and local customs and practices. However, a typical discharge procedure involves:

- the client stripping the bed and remaking it with clean sheets if the mattress is not soiled
- staff returning the client's clean clothes and ensuring nightwear is handed in for washing
- encouraging the client to eat a nutritious meal and drink water or other fluids once dressed.

Upon exit, the client's personal property is returned to them in the presence of two staff members and the client signs a receipt book.

SUC staff are encouraged to raise issues related to their AOD use and, if requested, negotiate an appropriate referral for ongoing assistance and/or treatment. Such discussions should be confidential, and the client's needs should be dealt with in a manner consistent with the skills and experience of the staff member. The *Guidelines* note that while details of suitable services should be offered to the client for them to choose, staff should not place clients under pressure to discuss their problems or change their lifestyle and permission should be sought to release the client's information to other services if required. The client should also be reassured that whether they choose to attend other services or not, they are still welcome at the SUC.

4.3 Funding and performance overview for 2018-19

This sub-section presents a high-level summary of funding and activity levels for the nine SUCs in WA. A brief commentary accompanies this information, but this review has not drawn any conclusions from this information on a standalone basis.

In 2018-19, the MHC funded SUCs to the amount of **$5,179,796** (GST exclusive), for 165 beds located in the nine SUCs across WA. Figure 3 below provides an overview of SUCs across WA in 2018-19.

Figure 3 | Overview of SUCs across WA in 2018-19

SUCs are block funded with only a minor variation relative to the number of beds. There were four levels of funding in 2018-19 to operate the service for the full year:

- **$439,745** for Perth[11]
- **$526,281** for Carnarvon[12]
- **$594,250** for Derby, Kununurra, South Hedland, Roebourne[13] and Wyndham[14]
- **$621,260** for Broome and Kalgoorlie.[15]

In 2018-19, 3,468 individual clients were admitted to SUCs across the state, for a total of 15,118 total separate admissions; an average of 3.9 admissions per individual client. Figure 4 overleaf shows the summary of the total clients that accessed SUC services by SUC.

[11] See Assumption 2 in Appendix A.

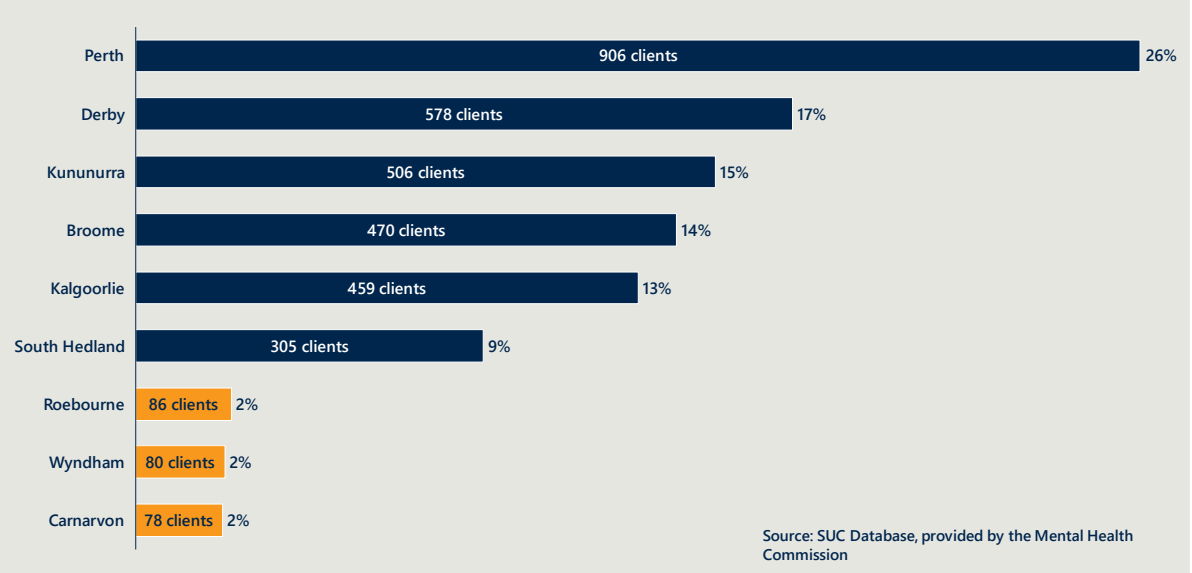
[12] Carnarvon is only open 4 days a week, compared to 5 or 7 days at the other SUCs.

[13] See Assumption 3 in Appendix A.

[14] The MHC has noted that one quarterly payment was withheld due to an underspend by the Wyndham SUC service provider in 2017-18.

[15] The MHC has noted that SUC service providers in Kalgoorlie and Broome have historically been provided with additional funding to reflect the larger capacity of the SUCs in these locations.

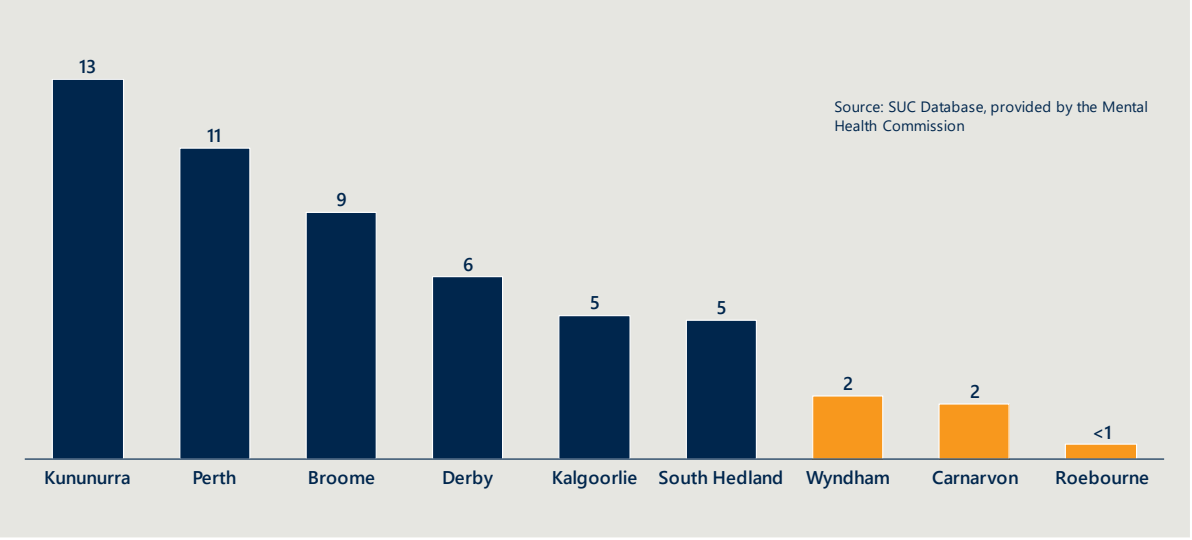
Figure 4 | Relative number of clients per SUC across WA in 2018-19



This demonstrates that the SUCs in Roebourne, Wyndham and Carnarvon see significantly fewer individual clients compared with the other six SUCs. In the case of Roebourne and Wyndham this is clearly related to the size of the local population, with the number of clients representing approximately 10% of the local population – noting that many admissions are individuals from outside the immediate community.

The lower level of clients in these three SUCs is reflected in the average number of nightly admissions for each SUC, set out in Figure 5, where Wyndham, Carnarvon and Roebourne see two or less clients per night on average. All other SUC services see 5 or more clients on average on a given night. Both Roebourne and Perth SUCs are open seven nights per week; this means that although the Perth SUC has lower average admissions per night than Kununurra, it has the highest number of total admissions.

Figure 5 | Number of clients per centre per night on average



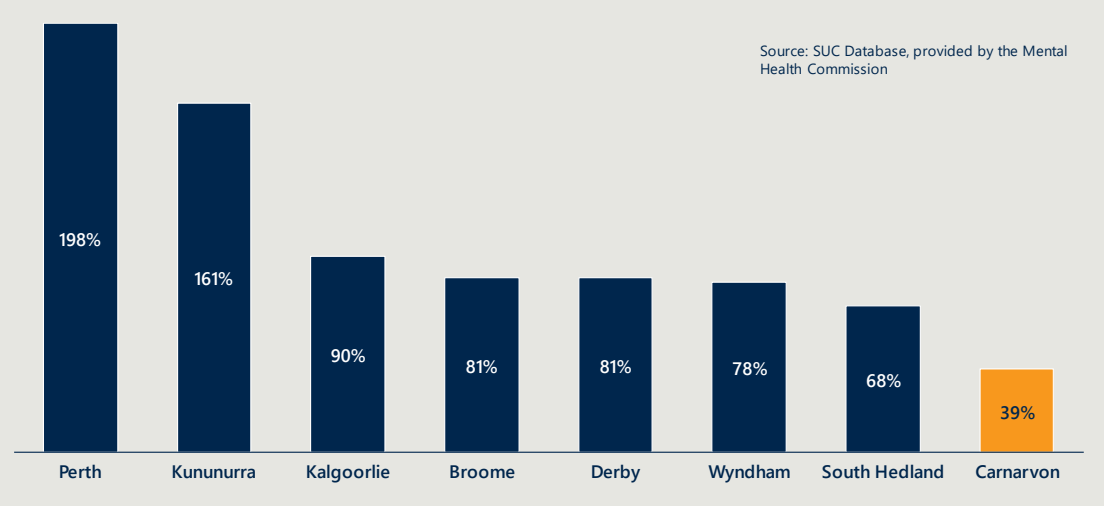
With a lower level of admissions, Roebourne, Wyndham and Carnarvon have higher costs per admission compared with the other six SUCs, as outlined in Table 6, overleaf.

Table 6 | Cost per admission per SUC across WA in 2018-19

Sobering-Up Centre	Cost per admission (pro rata)
Roebourne	**$3,301**
Carnarvon	**$1,311**
Wyndham	**$1,105**
Kalgoorlie	**$475**
South Hedland	**$440**
Derby	**$375**
Broome	**$290**
Kununurra	**$165**
Perth	**$110**

Each SUC is set a target number of admissions per year in their service agreement with the MHC. Both the Kununurra and the Perth SUCs exceed the admissions targets set out, as demonstrated in Figure 6 below. The target is not directly linked to the number of beds in the SUC, so this does not mean that the centres are operating above capacity, rather they are admitting more clients over the year than the MHC has determined to be an appropriate level.

Figure 6 | Performance against individual admissions targets for SUCs across WA in 2018-19[16]

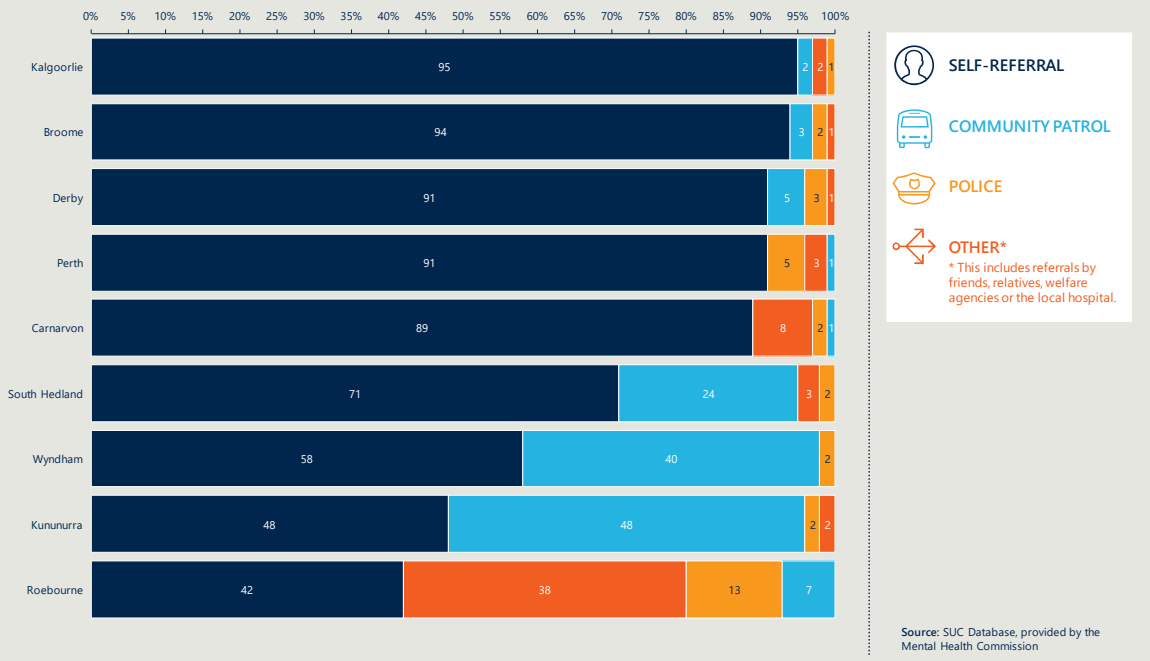


The SUCs gather a small amount of data per admission and use a paper-based record for doing so. One of the pieces of data collected is the 'admission pathway'; that being how did the client arrive at the SUC.

[16] Roebourne does not appear in Figure 5 because it did not have an annual admission target for 2018-19.

Based upon the data submitted, most admissions to SUCs across WA in 2018-19 resulted from self-referrals,[17] as indicated in Figure 7 below.

Figure 7 | Relative admission pathways per SUC across WA in 2018-19



The data indicates that Kalgoorlie had the largest percentage of admissions via self-referrals for any single SUC. This is not unexpected because the Kalgoorlie SUC is in the middle of the populated area and near to several drinking establishments. Roebourne had the smallest percentage of admissions via self-referrals, but the largest percentage of referrals through other means such as friends, relatives, welfare agencies and the local hospital. The SUCs in Kununurra, Wyndham and South Hedland collectively saw the greatest number of referrals from the community patrol. This too is expected with the community patrol run by the same organisation as the SUC and typically based at the SUC.

[17] Whilst the data would indicate that the majority of clients take themselves to the SUC compared to the patrol, this review would question whether this is an accurate reflection of reality. Having observed clients arriving at some of the SUCs during the period 4pm – 7pm, the majority were dropped off by the patrol but entered the SUC themselves as the patrol bus had already left the premises to attend to another demand. Given the level of intoxication observed in some clients, it is unlikely that 4 out of 5 clients arrive at the SUC without assistance of the patrol. This is not an issue, rather an observation about the ability to gather accurate data in the SUC on admission.

5 Findings and recommendations

The review has identified **19 findings**, which have been grouped into four higher order key findings. These key findings are:

- **Key finding 1:** For some communities, sobering-up centres are an essential harm-reduction service.
- **Key finding 2:** The SUC service model as currently commissioned delivers value for money, but there are SUCs that deliver less value than others.
- **Key finding 3:** There are missed opportunities to add greater value to communities through SUCs.
- **Key finding 4:** The commissioning and funding approach should be adapted to realise this value.

For each key finding, this review has made one or more recommendations. In total this review has made **15 recommendations.** The remainder of this section takes each key finding in turn, presents a series of sub-findings and then an overall conclusion and recommendation(s).

For some of the key findings, additional observations have been provided. These observations are not findings of the review as they are not directly related to the SUC service model or the outcomes achieved. They have been included in this report because they are closely related to the SUC services and have emerged as an important and common theme across the majority or all SUCs.

5.1 Key finding 1: For some communities, sobering-up centres are an essential harm-reduction service

SUC services provide harm-reduction services to vulnerable, intoxicated people across nine communities in WA. This review has sought to assess whether the concept of a sober-up service is still relevant and needed almost 30 years after it was introduced; and the extent to which SUCs meet the need of clients and communities in which they operate. This assessment has been made without considering whether the SUCs are delivering value for money, and whether there are enhancements needed to the model.

In conclusion, this review has determined that the concept of a sobering-up service is a critical service in some communities. In arriving at this conclusion, this review has therefore sought to identify the characteristics of a community where a SUC may be a critical service. This conclusion is based upon four sub-findings which are summarised in Table 7, below and described thereafter.

Table 7 | Sub-findings to key finding 1

Sub-finding 1.1:	A safe space for intoxicated people remains crucial in some communities.
Sub-finding 1.2:	The SUC model generally supports a cohort of people who need a safe place to sleep whilst intoxicated.
Sub-finding 1.3:	The nature of the demand on any single SUC is related to community characteristics and local needs.
Sub-finding 1.4:	Pathways into SUCs have changed substantially over time, from police to self-referrals and community patrols.

5.1.1 Sub-findings

Sub-finding 1.1: A safe space for intoxicated people remains crucial in some communities

Across the communities in which they operate, SUCs provide critical harm-reduction services, reducing the incidence of alcohol-related harm to both intoxicated people, and others. They do so by providing people who are intoxicated by alcohol or poly-drug use (where alcohol is the primary drug of concern), with a safe place to sleep; where they are continually monitored, their clothes are cleaned, and they can leave in the morning after having a meal.

In undertaking the review, Nous visited all nine SUC services, speaking with the managers and staff in each, and local stakeholders across each of the nine communities. In all communities there is near-unanimous support for the importance of the SUC in the community. The consensus among these stakeholders is that SUCs remain crucial harm-reduction services for vulnerable people who need a safe place to spend the night, in communities where there are few, if any, other alternatives.

> "It saves a lot of lives, having that bed and breakfast there in the morning."
>
> **- Aboriginal medical services worker**

People who are intoxicated, are at a high risk of causing harm to themselves or others, and across all the communities where a SUC is present – alcohol continues to be the primary drug of concern for police and health services; and alcohol-related harm remains a significant issue of concern for local communities.

> "[SUCs give us] the opportunity to remove those that are susceptible to alcohol-related harm. Without it, there'd be an increased risk of violent offences and of an enforcement response."
>
> **- Local Officer in Charge**

> "SUCs deescalate the potential for more drama. Without them, there'd be more danger, more risk, more people wandering the streets, more violence related to alcohol and more people unsafe while intoxicated."
>
> **- Emergency Department doctor**

Examples of alcohol-related harm in this context, include but are not limited to: family and domestic violence (FDV), suicide and self-harm, physical and verbal violence, injuries resulting from road accidents, falls or drownings, and other forms of anti-social behaviour.[18] In these communities, SUCs are the only bed-based service that specifically addresses this issue for an individual who is intoxicated. The only other alternatives are costly alternatives, namely a police cell or a hospital bed – neither of which are appropriate unless the individual is sick or has committed a criminal act. 'Sleeping rough' or returning to the family home are other options, however both involve inherent risks to the individual or others.

Not every community requires a SUC, but where there is a continued high demand for SUC services and a lack of alternative services for vulnerable intoxicated people, SUCs continue to be critically important services that reduce the overall incidence of alcohol-related harm on individuals and the community.

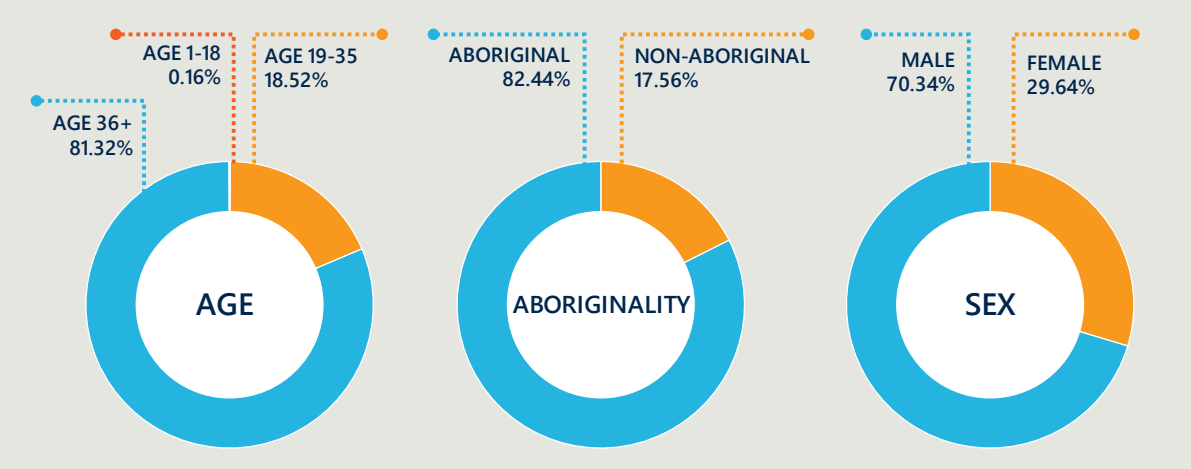
> "If we didn't have the sobering-up centre, domestic violence would skyrocket, hospitals would be overloaded, accidental deaths would increase…and it would have a catastrophic knock-on effect on all surrounding communities, who know that when they come here, there will be a safe place for them."
>
> **- SUC staff member**

[18] Western Australia Police define anti-social behaviour as behaviour that 'disturbs, annoys or interferes with someone's ability to go about their lawful business.' See: Crime Stoppers Western Australia, Anti-Social Behaviour: https://www.crimestopperswa.com.au/keeping-safe/anti-social-behaviour/.

Sub-finding 1.2: The SUC model generally supports the cohort of people who need a safe place to sleep whilst intoxicated

The demographic composition of SUC clients in 2018-19 is set out in Figure 8 below and indicates the most common cohort of clients is **older** (81.32% are over the age of 36+), **Aboriginal** (82.44%), **men** (70.34%).

Figure 8 | Demographic makeup of SUC clients across WA in 2018-19



With such a distinctive profile, it is important to understand whether there is a cohort of potential clients that are not being catered for by the current SUC model. Taking each of the factors in turn:

- **Age:** There are two hypotheses related to age. The first is that there is a stigma associated with SUCs in many communities, with the general perception that it is intended for or is primarily used by older persons. The second, and most common hypothesis, is that young people who drink and become intoxicated are far more likely to have a place to sleep, either with family or friends, and do not require a safe alternative to 'sleeping rough'. The prevailing view is that older people, particularly men, have generally experienced relationship breakdowns with family and friends, (so called 'burnt bridges') after a prolonged period of alcohol consumption. For these people, SUCs have become an important place of last resort, where they have a safe place to sleep. Nobody who was consulted believes there to be a significant cohort of people under the age of 35 who would utilise a SUC if the service environment were made more contemporary.

> "The reason the SUC only really sees older people, is because at that age, they've burnt all their bridges. Addiction has taken its toll on their family and relationships, and they have nowhere else to go."
>
> **- AOD Counsellor**

- **Aboriginality:** The high proportion of Aboriginal clients across all SUCs is influenced by the very high proportion of clients in South Hedland, Kununurra, Wyndham, Derby, Broome and Kalgoorlie who are Aboriginal (between 90 to 99% of clients in these locations are Aboriginal). It is worth noting that in each of these locations the service is provided by an Aboriginal Corporation that provides Aboriginal-specific services to the community (although that is because of the nature of demand rather than a factor that skews demand, and the fact that for many communities the SUC continues to be associated with positive outcomes of the Royal Commission into Aboriginal Deaths in Custody). In each of these communities there was no suggestion that the local non-Aboriginal community were being underserved due to the facility being run by an Aboriginal Corporation.

- **Gender:** Almost one-third of admissions were female clients. This is due to a range of factors, including the presence of women's refuges in most communities, which can be an alternative to SUCs (noting that women's refuges will not admit women who are intoxicated). Stakeholders also said that they observed higher levels of binge drinking in men.

SUCs continue to meet the needs of individuals within their primary cohort – older, Aboriginal men. There is broad consensus that SUCs are generally able to support other cohorts such as younger people, non-Aboriginal people and women; but there does not appear to be unmet demand for SUCs from this cohort. It follows that the service model does not need to be adapted to provide services to these cohorts.

Sub-finding 1.3: The nature of the demand on any single SUC is related to community characteristics and local needs

When SUCs were first established across WA, the nature of the demand was largely related to the need for safe, non-custodial facilities for individuals intoxicated in public and engaging in anti-social behaviour. As SUCs and communities have evolved over the last 30 years, the SUCs have become a well-known and understood community service, both within the community and in surrounding communities. Providers of other services, such as women's refuges and local hospitals understand when it is appropriate to send someone to the SUC and they have become a key part of the local community service system. This is highlighted by some excerpts from conversations with service providers in relation to the nature of the demand for the SUCs in their respective communities that are presented in Figure 9.

Figure 9 | Quotes from service providers relating to the nature of the demand for the SUC

> "Most of our clients come from Fitzroy Crossing, Balgo, Bidyadanga, Halls Creek and then from Broome."

> "We don't allow intoxicated women into the refuge, but we try to offer alternative safe zones, so we call the sobering up centre."

> "If people are passing through from Warralong, Jigalong or Yandeyarra, they know that when they come to town, there is a safe space for them."

> "We get people from everywhere – from up in Kalumburu to down in Turkey Creek. They've got nowhere else to go when they come here."

It is important to have a contemporary understanding of the factors that will impact the demand of SUCs, particularly to inform future funding decisions. This review has identified **four** community characteristics that are generally present in each of the locations where there is a SUC in high-demand. These factors are summarised in Table 8, below.

Table 8 | Community characteristics for SUCs in high-demand

Characteristic	Rationale
The ability to purchase pre-packaged alcohol in town	In communities such as Fitzroy Crossing and Hall's Creek, alcohol restrictions have seen the SUC close due to low levels of demand. This does not mean there is less alcohol consumption or alcohol-related harm in these communities. Rather, there are less individuals intoxicated in public, who would utilise a SUC.

Characteristic	Rationale
Relatively higher levels of socio-economic disadvantage and/or relatively lower levels of education and occupation[19]	Whilst there is a relationship between higher levels of alcohol consumption and higher levels of socioeconomic status; there is also a body of evidence that connects higher levels of alcohol-related harm such as road traffic accidents and domestic violence with lower levels of socioeconomic status.[20]
High levels of **transient and itinerant people** in the community	There are communities where the local population is regularly swelled by people visiting from surrounding communities – or further beyond - to access medical and social services, attend to cultural and family business, or access amenities only available in larger regional centres, such as shopping and entertainment.
A sizeable local population **experiencing homelessness** with limited alternative crisis accommodation	Where crisis accommodation (such as refuges or safe houses), short stay accommodation and transitional, public or community housing options are generally limited or only available to individuals who are not intoxicated, SUCs have filled a gap in services as a safe, free place to stay with a low entry threshold.

The fourth characteristic – **a sizeable local population experiencing homelessness or limited availability of crisis accommodation** – raises the question of whether the predominant reason a client chooses to attend the SUC is the need for crisis accommodation due to excessive alcohol consumption, or whether the primary driver is the client's need for accommodation. When speaking to the providers of all the SUCs, each acknowledged there are a cohort of regular users of their SUC, and in some cases these users had no alternate accommodation. In some SUCs, space has been set aside at the SUC for regular users to securely store a small set of personal belongings. The activity data provided by the SUCs indicates that there is a small cohort of clients that regularly use SUCs (summarised in Table 9, below), but in most locations, most clients are irregular users, who would use the service less than 5 times a year. It would follow that the primary drive of demand for any one SUC is the need for crisis accommodation due to the excessive alcohol consumption of clients.

Table 9 | Relative frequency of admissions per client in 2018-19

Location	Less than 5 times a year	5-20 times per year (1-2 times a month)	21-50 times a year (2-4 times a month)	More than 50 times per year (More than once a week)
Kununurra	78.3%	13.4%	5.7%	2.6%
Perth	85.9%	10.1%	2.9%	1.1%
South Hedland	81.0%	15.7%	2.6%	0.7%
Broome	83.0%	14.0%	2.6%	0.4%
Kalgoorlie	92.4%	7.2%	0.2%	0.2%

[19] For definition see Socio-Economic Indexes for Australia (SEIFA) - https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2033.0.55.001~2016~Main%20Features~SOCIO-ECONOMIC%20INDEXES%20FOR%20AREAS%20(SEIFA)%202016~1

[20] Roche et al: Evidence review: The social determinants of inequities in alcohol consumption and alcohol-related health outcomes (2015), Australian's National Research Centre on AOD Workforce Development, Flinders University

Location	Less than 5 times a year	5-20 times per year (1-2 times a month)	21-50 times a year (2-4 times a month)	More than 50 times per year (More than once a week)
Wyndham	78.8%	11.2%	10.0%	-
Carnarvon	83.3%	10.3%	6.4%	-
Derby	89.3%	9.7%	1.0%	-
Roebourne	96.5%	3.5%	-	-

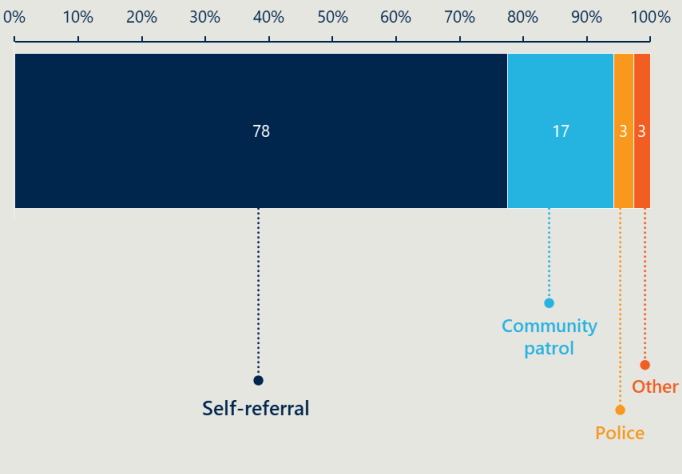
Not every community with a SUC has all four characteristics, and these four characteristics are not unique to just these nine communities; and demand for a SUC can change over time as local community characteristics change. When and where a community's characteristics discernibly change, the requirement for a SUC in any one community may need to be reconsidered. For example, anecdotal evidence suggests that the demand for the SUC in Roebourne has declined following an increase in public housing and the enforcement by police of homes designated as liquor restricted premises. In the past, the SUCs in Fitzroy Crossing, Halls Creek and Wiluna were all closed by the former Drug and Alcohol Office following the introduction of strict liquor restrictions in each town, which led to a significant reduction in demand for the service.

Sub-finding 1.4: Pathways into SUCs have changed substantially over time, from police to self-referrals and community patrols

Originally conceived as an alternative to police custody, the SUC now performs a very different role in a community. Under the *Protective Custody Act 2000* (WA), detention of an intoxicated person in a police station or lock-up should only occur in exceptional circumstances. By law, police are required to release an apprehended person into the care of another person as soon as practicable. Although SUCs provide police with a non-custodial alternative, admissions to SUCs via police have only represented an average of 3.4% of admissions to SUCs by police between 2014/15 and 2018-19.

Instead, the majority of clients arrive at a SUC either through their own volition or are taken there by the community patrol. As illustrated in Figure 10 overleaf, almost 95% of clients take themselves to the SUC or are taken there by the community patrol.

Figure 10 | Admission pathways into SUCs across WA in 2018-19



78% of admissions to SUCs occur through self-referral. The next most common form admission is via community patrols. The proportion of admissions via patrol varies based on the strength of the relationship between the patrol and the SUC.

Source: SUC Database, provided by the Mental Health Commission

In some of the communities where there is a SUC, the community patrol is considered an integral and inseparable part of the SUC model. In these communities, the patrol is highly effective, run by the same service provider and is based at the SUC premises. For example, in Hedland, Kununurra and Wyndham the percentage of total admissions by patrols to SUCs in these communities was an average of 37.4% in 2018-19; 20.7% higher than the state-wide average. Typically, patrol buses will drive around the community at night to look for people who are intoxicated and offer to transport them to the local SUC. Patrols will generally limit their service to one ride per person per night and refuse to transport individuals who are consuming alcohol. Many of the police and hospital stakeholders who were consulted confirmed they often use the patrol to transport intoxicated people to the SUC, rather than taking individuals there themselves or using an ambulance.

"The SUC is very responsive. When I need someone to be taken there, I call them up and they send their bus around to collect the person."

- Head of Emergency Department

The synergy that exists between the SUC and the patrol in communities such as Kununurra, Wyndham and South Hedland should serve as a model for other SUCs across WA. An integrated SUC and patrol service provides greater opportunities to reduce alcohol-related harm and to ease the burden on police and emergency services. Moreover, it has been observed anecdotally that there is a strong correlation between low SUC utilisation and patrols that are ineffective or that have a poor relationship with the SUC service provider. In key finding 4, this review presents a specific finding and recommendation in relation to the commissioning of SUCs and community patrols.

5.1.2 Conclusions and recommendations

Taking the four sub-findings into account, this review concludes that where unique community characteristics lead to a sustained demand for safe places for intoxicated people – SUCs continue to be a critically important harm-reduction service; a service that reduces the overall incidence of alcohol-related harm to individuals and local communities. As this finding relates to the current commissioning and provisioning of SUCs in WA there is only one recommendation relating to key finding 1, shown in Table 10, below.

"The patrol is an incredible service. Patrol workers will pop in [to the hospital] and ask if there is anyone who they can take home or to the sobering-up shelter."

- Emergency doctor

"The patrol is really needed…You see them around talking to intoxicated people. It goes hand in hand with the sobering-up centre."

- Aboriginal health services worker

"If you see a vulnerable person on the street, there's someone you can call, and you know that they'll be taken somewhere safe."

- Community member

Table 10 | Recommendation related to key finding 1

Recommendation 1	SUCs are a critically important service and should remain a core part of the MHC's suite of local harm-reduction strategies and its broader state-wide response to reducing the impact of alcohol-related harm.

5.1.3 Additional observations

There is a lack of safe spaces for non-intoxicated children and youth

Several service providers and community members consulted raised concerns that a safe space for children and young people was critical, but often lacking. Many young people in the communities visited, particularly in the Kimberley and Pilbara, spend a large proportion of time out of the family home seeking to avoid alcohol-related harm within the family home. For these young people, walking the streets late at night (they are commonly referred to as 'walkers') and committing criminal offences, sometimes so they can be taken into custody, is a common occurrence. Such safe spaces fall outside of the remit of this review, but their absence is noted to be a causal factor in the consumption of alcohol and other drugs by the youth of these communities.

"These are the kids that will be SUC customers in the years to come if we don't intervene now."

- Local government representative

5.2 Key finding 2: The SUC service model as currently commissioned delivers value for money, but there are SUCs that deliver less value than others

As detailed in section 5.1, SUCs have a positive impact for clients and the local communities where they are located. However, measuring the value for money of the SUC service model and individual SUCs is difficult. At its most basic, value for money for a government funded service is an assessment of whether the outcomes achieved by a service are worth the funding allocated. The amount of funding provided by the MHC is a known quantity, but there are very few established and tangible measures relating to SUC performance and no measures that assess the outcomes for clients and communities.

To assess value for money, this review has sought to understand the direct and indirect impact of SUC services, and to compare this to the cost of funding these services. The conclusion is that generally SUCs deliver value for money, but some deliver less value than others This assessment is broken down into four sub-findings which are presented in Table 11, and described thereafter.

Table 11 | Sub-findings to key finding 2

Sub-finding 2.1:	Assessing service outcomes is challenging.
Sub-finding 2.2:	Admissions data alone does not have enough nuance to fully assess value for money.
Sub-finding 2.3:	SUCs provide significant social and economic cost avoidance.
Sub-finding 2.4:	A SUC with a high cost per admission may represent value for money when taking into account broader community factors.

5.2.1 Sub-findings

Sub-finding 2.1: Assessing service outcomes is challenging

It is difficult to assess the direct service outcomes of SUCs, particularly in relation to reducing alcohol-related harm in the community. The current level of data that is recorded and reported makes it almost impossible to make a quantifiable assessment of performance and value. Service providers are assessed against nine KPIs aligned to four service outcomes, set out in Table 12, below.

Table 12 | The standard service outcomes and KPIs

Service and Contract Outcomes	KPIs / Measures
Reduction of the impact of intoxication on families and the community.	a. Number of intoxicated persons who are provided with service per annum.
Intoxicated people are provided with an accessible, safe, supervised, care oriented environment.	b. Number of beds in the SUC available for use by intoxicated people each night. c. Number of nights that the facility is open per annum. d. Number of unplanned closures. e. Percentage of staff with the required first aid training. f. Percentage of staff have appropriate Police clearances.
Intoxicated people have access to information and those seeking additional support have access to appropriate referrals.	g. Staff are trained and aware of information and referral procedures.
Effective relationships and referral pathways exist with key services including, but not limited to: the Police, Community Patrol, Hospital and Community Drug Service Team.	h. Maintain effective relationships with other services. i. Develop appropriate referral processes.

These KPIs effectively fall into three categories:[21]

1. **Demand and supply:** KPIs (a) to (d) measure demand and supply at each SUC. Measuring the number of people who use the service – KPI (a) – is a useful measure and informs a value for money assessment, but as noted in Sub-finding 2.2 (below) in its own right does not have sufficient nuance to fully inform a value for money assessment. The other three KPIs – (b), (c) and (d) –help inform the MHC whether the service provider is performing but have no relevance to value for money.
2. **Contractual compliance:** KPIs (e), (f) and (g) will inform the MHC whether the service provider is complying with its contract but will not inform a value for money assessment.
3. **Supplier engagement capability:** KPIs (h) and (i) help paint a picture of the local environment, but providers are required to produce a qualitative statement for each and as such these KPIs cannot be used to assess value for money.

This means there is only one quantifiable measure that can be used to inform a value for money assessment, and this measure is a demand measure rather than an outcome measure. When asked,

[21] These categories have been proposed by this review. They are not determined by the MHC.

stakeholders found it difficult to quantify the SUCs impact on reducing alcohol-related harm in the community, other than an assumption that if an individual is in the SUC there is a lower chance that they or others in their community will come to harm. As such, the assessment in this review of impact and outcomes – and therefore value for money – has considered three factors:

1. What one set of quantitative data (admissions) can feasibly tell us – see sub-finding 2.2.
2. Whether the cost of admitting a client to a SUC avoids a higher cost to another service – see sub-finding 2.3.
3. What the community consultations have proposed is the qualitative value of the SUC to their community – see sub-finding 2.4.

Sub-finding 2.2: Admissions data alone does not have enough nuance to fully assess value for money

In 2018-19, the MHC spent **$5,179,796** on the nine SUCs across WA. This represents 6.2% of the $86,597,000 in total funding for all AOD services commissioned by the MHC in 2018-19. As summarised in Section 4, there were broadly four levels of SUC funding in 2018-19 to operate the service for the full year:

- **$439,745** for Perth[22]
- **$526,281** for Carnarvon
- **$594,250** for Derby, Kununurra, South Hedland, Roebourne and Wyndham
- **$621,260** for Broome and Kalgoorlie.

This funding is intended to cover the cost of managing and staffing the facility, general maintenance (including replacement of linen and other items for wear and tear) and any other reasonable costs for the performance of the service agreement.

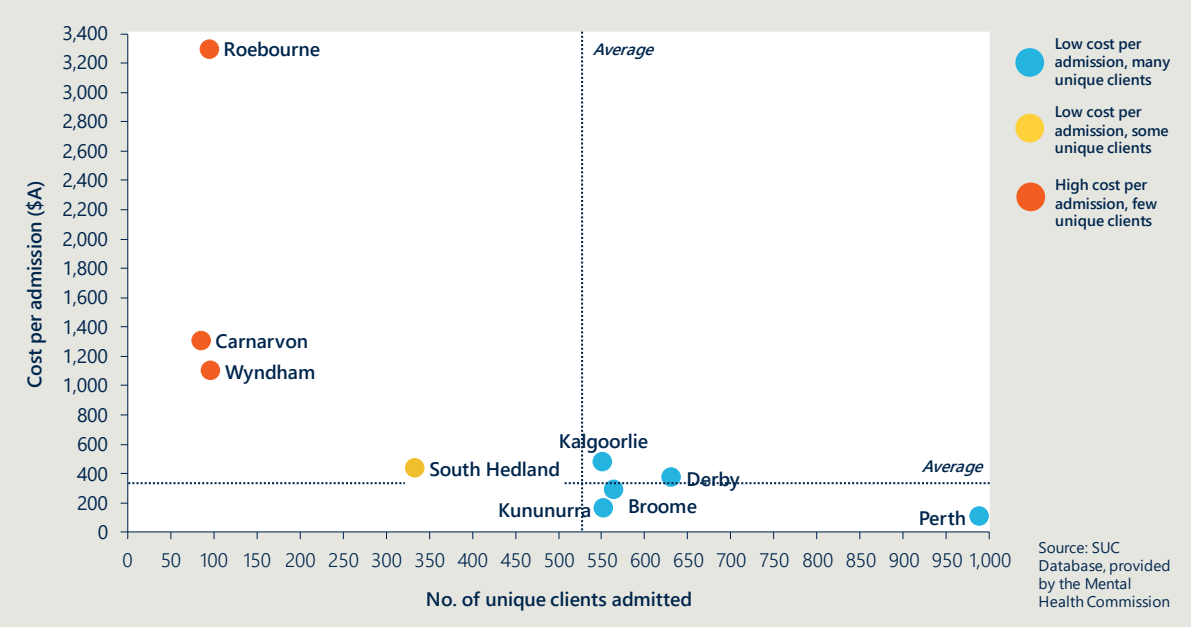
During 2018-19, SUCs provided a service to 3,468 individual clients, with 15,118 total admissions provided across WA. **The average cost per admission to a SUC in 2018-19 was therefore $343.** Knowing the cost per admission at any individual SUC is useful to know for the purposes of comparison between the SUCs, but in its own right does not enable a value for money judgement.

The admissions data provided to the MHC by the SUC providers has a secondary benefit when considering value for money in that it also provides a breakdown of the number of discrete individuals who utilise the service and the frequency of their use.[23] In total 3,468 unique clients were admitted to a SUC in 2018-19, equating to an average of approximately 385 unique clients per SUC. This is helpful information, because it demonstrates the breadth of impact that any one SUC has on its community and the likelihood that a SUC is being used as a *de facto* place of residence for a cohort of local community members.

Understanding the cost per admission and the number of unique clients supported enables a better comparison between SUCs and helps inform an assessment of value for money. In Figure 11 overleaf, each SUC is plotted against the average cost of admission in 2018-19 and the number of unique clients admitted in the same period.

[22] See assumption 3 in Appendix A.
[23] See assumption 2 in Appendix A.

Figure 11 | Average cost per admission and number of unique clients admitted, per SUC



On face value, this shows that the cost per admission to the Roebourne, Carnarvon and Wyndham SUCs is much higher than the average cost, whilst the average cost for the five other regional SUCs is two-three times lower in comparison. Furthermore, each of these three SUCs support a far smaller cohort of individuals from their communities and surrounding areas.

This comparison is useful, but in isolation does not provide sufficient nuance to determine whether any one SUC is demonstrating value for money. As summarised above, each SUC is similarly funded. This is because there is a high fixed cost required to provide and maintain a safe service in any SUC, regardless of location and regardless of demand. It is therefore expected that SUCs that support larger populations are likely to have higher numbers of admissions and consequently a lower cost per admission. Lower population communities such as Roebourne and Wyndham would not reasonably be expected to see the average number of unique clients, nor have the demand to drive a low cost per admission.

However, from a quantitative perspective, the admissions data shows that if solely considering demand, then the SUCs in **Perth, Kalgoorlie, Derby, Broome, Kununurra** and **South Hedland** potentially **each achieve value for money,** providing many intoxicated people with a safe place to sleep, at a significantly lower cost per admission in comparison to the other three SUCs.

What this analysis cannot tell us is whether a cost per admission in the $150-500 per admission range is an acceptable cost to bear. To test this, the review has therefore considered the opportunity cost to government and local communities if the SUCs were no longer commissioned.

Sub-finding 2.3: SUCs provide significant social and economic cost avoidance

The value and associated impact of SUCs can be assessed in terms of the social and economic cost avoidance resulting from their provision. From its origins as an alternative to police custody, SUCs have evolved to lessen the burden of intoxication and alcohol-related harm to health services, law and order, and communities. This review has heard from many stakeholders in each community and there was broad agreement that SUCs present an alternative to four undesirable outcomes for an individual:

- **The individual commits a criminal act and is taken into police custody.** 29 years after the Royal Commission into Aboriginal Deaths in Custody, SUCs continue to provide local police with a safe alternative place to take vulnerable, intoxicated persons that is not a police cell. With the decriminalisation of public drunkenness in 1990, many of the individuals who use the SUC are not committing a criminal act, so policy custody is not an option; but even if it were, taking intoxicated persons into custody is seen as an option of last resort. An intoxicated person in police custody must be placed on 'high risk' watch, requiring two police offers to monitor each person in custody and therefore constraining the ability of police to respond to other local matters throughout the night. In many regional communities, this would compromise the police response to other, potentially criminal, situations in the community.

> "This community, without the SUC, would be devastating. Vulnerable people would be in cells to keep them safe, which means that police officers would be taken off the street to watch intoxicated people on 'high risk watch'. It would be a massive impost."
>
> **- Local Officer in Charge**

> "If the SUC was to close, it would be a nightmare for us. There is nowhere and nothing else. There is a reason that it is here. The SUC routinely comes to our rescue."
>
> **- Local Officer in Charge**

- **The individual is taken to the local Emergency Department (ED).** Clinicians and public health officials in each community noted the critical role that SUCs play both in diverting people away from hospitals who have no acute medical need, and as a discharge option for the ED where an individual is clinically fit for discharge but still intoxicated – thereby reducing the prevalence of social admissions.[24] The importance of SUCs in some regional towns is exacerbated due to the small number of inpatient and ED beds available in small regional hospitals. For example, Wyndham Hospital only has four inpatient beds, and one emergency bay. With 17 beds at the Wyndham SUC, the capacity of the SUC to safely support intoxicated individuals is much higher than that of the local hospital.

> "If the SUC was closed, the ED would feel it [the impact]. It would result in a significant increase in social admissions, which cost us more than ED beds. We would need more doctors and nurses. There is a massive cost avoidance because the SUC is here."
>
> **- Senior clinician**

> "We are opposite the main area where people congregate and drink for most of the day. When the SUC is closed every Saturday we really notice it in the ED."
>
> **- Head of Emergency Department**

[24] A social admission refers to a patient with no acute medical needs that is brought to, and remains in hospital because there are no safe discharge arrangements at the time of presentation.

- **The individual is at home with the increased risk of FDV.** Stakeholders from many of the communities visited noted that attendees of SUCs include several people that have historically committed acts of FDV. SUCs provide a place for intoxicated person to take themselves, or to be referred by families and the community patrol. The same stakeholders noted that alcohol-related family violence is a significant concern in Broome, Derby, Kununurra, Wyndham and Roebourne. SUCs also provide a safe space for victims of FDV. This review heard from providers of women's refuges who work with the SUC to get short term support for women who are victims of FDV but are themselves intoxicated. The SUC provides a safe place to sober up before the victim can enter the refuge.

> "We had one regular client who came to us because he was about to hit his wife. Someone told him about the SUC, and he knows when he's had too much to drink it is better to come here than go home."
>
> **- SUC Service Provider**

- **The individual is 'sleeping rough'.** SUCs provide a safe place to sleep for intoxicated individuals that would otherwise most likely be sleeping on the street. This review has heard from stakeholders, particularly community patrol workers, local government, and police, who noted that the prevalence of intoxicated people 'sleeping rough' in the Kimberley and Pilbara is significant. SUCs, at present, provide the only alternative for those individuals – some of whom are itinerant peoples travelling from surrounding communities

> "If the shelter closed, you'd just have more unnecessary deaths. People will get run over by cars. I've seen many people just walking down the middle of the road when they get drunk"
>
> **- Community patrol staff**

> "It sounds like an urban myth, but a couple of years ago we had a local lady, who often used the SUC, fall asleep by the side of the creek one night when the SUC was closed, she was attacked by a croc."
>
> **- Local Officer in Charge**

Of these four outcomes, the only one with data for comparison is the cost of avoiding a presentation and admission at the ED.[25] In 2015-16, the average cost of an ED presentation in WA, where the person was not admitted was $619 and when the person is admitted was $1,227.[26] Whilst this review accepts that not every client in a SUC would otherwise have attended an ED if a SUC bed were not available, there was broad consensus from the consultations that the ED was the only other safe space within the community for an individual who was intoxicated.

It is therefore the conclusion of this review that with an average cost per admission of less than $619 the SUCs in Perth, Kalgoorlie, Derby, Broome, Kununurra and South Hedland do represent value for money. In each location a client entering the SUC would cost significantly less than that person alternatively attending the ED.

With six of the nine SUCs demonstrably lower cost than one of the primary alternatives, it is therefore also the conclusion of this review that the SUC model, more broadly and as currently commissioned, can represent value for money where there is sufficient demand for the service.

[25] Report on Government Services 2018; Tables 12A.58 and 12A.60.

[26] The WA Emergency Access Target requires that 90% of individuals presenting at an ED should be either discharged or admitted within four hours. It is likely that if an intoxicated person were to attend an ED and the SUC was not available then the individual would most likely need to be a 'social admission' and incur a cost nearer the higher of the two costs presented.

Sub-finding 2.4: A SUC with a high cost per admission may represent value for money when taking into account broader community factors

In concluding that the SUC model can represent value for money, and that six of the nine SUCs do, this does not in turn mean that the other three SUCs do not represent value for money. It is important to recognise that local community factors may still mean that an individual SUC represents value for money for the MHC, even when the average cost per admission is relatively high.

A SUC's value for money may also change over time. A *substantive change* in local factors, which leads to a *prolonged reduction* in admissions to a SUC, may mean that the service no longer represents value for money for the MHC. This has been seen in communities such as Fitzroy Crossing and Hall's Creek where alcohol restrictions (the *substantive change*) led to a *prolonged reduction* in admissions, and ultimately the decommissioning of the SUC.

It would be impossible to develop an exhaustive list of factors that should be considered, but the following factors have all been proposed during the consultations:

- The availability of alcohol in the community changes, whether that is a consequence of local restrictions or the closure of local alcohol outlets.
- A change in the availability of local housing and the consequent reduction in homelessness.
- The number and profile of 'dry houses' in the community where the police are able to enforce house by house liquor restrictions.
- The attitude of police towards drinking in public.
- The level of employment within the community.

The SUCs in **Wyndham, Roebourne** and **Carnarvon**, each have relatively higher costs per admission and provide services to comparatively few unique clients. However, any value for money assessment should be qualified by the unique circumstances in each location:

- **Wyndham** has a much smaller population than all other communities with a SUC (780 people) with the exception of Roebourne (981 people).[27] More than 50% of this population are Aboriginal peoples, and the socio-economic outcomes are among the poorest in Australia, with high rates of family and domestic violence, alcohol-related harm, youth suicide, and anti-social behaviour. With approximately 96 unique admissions in 2018-19 and low levels of transient population in the community, it is a reasonable assumption that the SUC has admitted approximately 10% of local population during the period.
- The SUC in **Wyndham** is one of only a small number of community services provided locally – many of the services are provided from Kununurra, and the local hospital only has four inpatient beds and one emergency bay. Although the Wyndham SUC only has an average of two admissions per night, this is effectively above the capacity of the local ED. Furthermore. the local police only operate an 'on call' service over night and detaining somebody overnight is only feasible where there has been evidence of criminal behaviour.

  It is therefore the conclusion of this review that although more expensive per admission than most of the other SUCs, the Wyndham SUC is a critical community resource, supporting a significant proportion of the local community, and does represent value for money.

[27] 2016 Census QuickStats, Wyndham (WA), released 23 October 2017, Australian Bureau of Statistics, Canberra, https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/SSC51639

- Admissions to the **Roebourne** SUC have significantly reduced in recent years (there were approximately 180 admissions in 2018-19), due to several factors, notably the closure of the local hotel (the only alcohol outlet in the community), the relocation of some families to Karratha and Wickham and the completion of Homes West houses within the community. In response the MHC has reduced the number of SUC beds (from 14 to 8 beds), converted other SUC beds into low medical withdrawal beds, and opened the facility 24/7. These low medical withdrawal beds predominantly support clients withdrawing from use of methamphetamine and see admissions from across the Pilbara and the Kimberley. In 2018-19 the low medical withdrawal beds supported 47 clients for a total of 599 bed days.

  Anecdotally, the facility is predominantly now viewed by the community as a 'detox' centre rather than a SUC, with some local stakeholders not realising that the facility still offers a Sobering-Up service. Some stakeholders hypothesised that the fall in admissions was possibly related to this lack of awareness – although it should be noted that the same organisation operates the community patrol service which in other communities conveys a number of people to the local SUC. Some community members questioned whether Roebourne still needed a SUC following the changes in local factors over the last 4-5 years.

  It is the conclusion of this review that the Roebourne SUC would not represent value for money for the MHC if it were a standalone SUC.

- **Carnarvon** has seen lower than expected admissions since it was established in 2014. Carnarvon's target level of admissions was set at 1,040 admissions per annum, but since opening, the service has not exceeded 400 admissions per year. Further, in the 11 months to 30 May 2019, the Carnarvon SUC had only supported 78 unique clients. With a local population of over 4,400 the SUC has admitted less than 2% of the local population. It is noted that the service has been operating for a significantly shorter period than any other SUC and it should be expected that it will take time to build awareness of the service – although the number of admissions in 2018-19 has not shown substantive growth compared to the prior year. Further, the MHC's 10-year plan has identified the need for 28 SUC beds in the Midwest-Gascoyne by 2025; substantially more than are currently provided in Carnarvon. Anecdotal feedback from consultations suggests there may be several factors that are influencing the level of admissions, including:

  - a lack of understanding and awareness of the service in the community
  - high turnover of staff within other local services who in other communities work closely with the SUC – such as the police and local hospital
  - the SUC provider's approach to promoting the service and building relationships with key stakeholders
  - a disconnected relationship between the SUC and the community patrol service.

  It is the conclusion of this review that at current utilisation levels the Carnarvon SUC does not represent value for money for the MHC.

5.2.2 Conclusions and recommendations

In summary, taking all these sub-findings into account this review has concluded that:

- the SUC service model, as currently commissioned, does represent value for money for the MHC
- there is the potential for any one individual SUC service to no longer represent value for money if community characteristics change
- of the nine current SUCs, there are two – Carnarvon and Roebourne – where the MHC need to work with the local provider to determine how and if value for money can be realised into the future.

In relation to key finding 2, this review has four recommendations, set out in Table 13, below.

Table 13 | Recommendations

Recommendation 2	The MHC to consider establishing a set of improved quantitative and qualitative KPIs that can be used to better assess value for money of SUCs into the future.
Recommendation 3	The MHC to consider evaluating the value for money of an individual SUC on a two-yearly basis. This will ensure that admission trends can be assessed without the issue of seasonal variations (see observation below).
Recommendation 4	The MHC to consider working with the provider of the Roebourne SUC and the local community of Roebourne to determine whether there is an ongoing need for the SUC or an alternative service that better meets local needs; or whether the facility should be commissioned going forward as a standalone low medical withdrawal service (noting that this service is a regional service and predominantly supports users of methamphetamine).
Recommendation 5	The MHC to consider working with the provider of the Carnarvon SUC and the local community of Carnarvon to determine whether there is a latent community need for the SUC that is not being met, and if so, how those in the community that need the SUC service can be supported to use it.

5.2.3 Additional observations

There are external factors that influence the level of admissions to a SUC

It is important to note that some SUCs see significant seasonal fluctuations in demand over a 12-month period, so when assessing whether there has been a *prolonged reduction* in admissions to a SUC, then this would need to be over a period of greater than 12 months. During the consultations, some SUC service providers observed that the nature of the demand on any single SUC can fluctuate based on changes in the weather, large community events such as funerals and major sporting events. In these instances, large numbers of people can travel from outlying communities and get 'stranded' in the community for a period that can extend to weeks and months. For example, the demand for the SUC in Kununurra is greater during the wet season, and this is reported to be connected to 'long-grassers' – people who typically rest and sleep in the tall spear grass that grows nearby – coming to the town for a safe and dry place to stay. In some communities, it is not unusual to see an increase or decrease in utilisation over a 6-month period.

The ability to create a culturally safe environment in the SUC will influence demand

- During the consultation there were observations from some SUC providers that potential users from the local Aboriginal population were not using the SUC due to not feeling culturally safe. There were two different circumstances noted:
- Where there are few or no Aboriginal staff working in the SUC there has been a perceptible reduction in admissions.
- Where there are cultural barriers between two or more Aboriginal groups within a community and there is a perception that the SUC is provided for one group, then there are few admissions from the other group(s).

5.3 Key finding 3: There are missed opportunities to add greater value to communities through SUCs

This review has concluded that as currently commissioned, the SUC service model provides a valuable service to some communities and generally represents value for money to the MHC. This review has also concluded that there is an opportunity to increase the value achieved and improve outcomes for individuals and communities.

The *Guidelines* effectively set up SUCs to operate as a standalone service, but with the expectation that there are mechanisms in place to refer clients to other AOD services. In reality this is impractical and whilst some of the SUC providers have developed processes to improve connections, **this review has identified opportunities to increase the value to individuals and communities through enhancements to the SUC service model.** This conclusion is underpinned by five sub-findings which are presented in Table 14, below and described in detail thereafter.

Table 14 | Sub-findings to key finding 3

Sub-finding 3.1:	Some SUCs are disconnected from AOD, health and other community services.
Sub-finding 3.2:	There is strong support for the SUC service model to be better connected to AOD, health and other social support services.
Sub-finding 3.3:	SUC care workers are generally not equipped to better connect SUC clients to other services.
Sub-finding 3.4:	The typical operating hours of SUCs limits the ability to connect vulnerable clients with other services.
Sub-finding 3.5:	Limiting the number of operating days per week potentially places a burden on other local services when the SUC is not open.

5.3.1 Sub-findings

Sub-finding 3.1: Some SUCs are disconnected from AOD, health and other community services

Some SUCs exist in a 'silo', operating independently of the local health and community service systems within their communities. SUCs generally provide very few referrals to other services, such as CADS, state health services provided by WA Country Health Service (WACHS), community mental health services, Aboriginal health services, and/or community-based support services such as housing and employment services. In the consultations it became apparent that in some communities, other AOD, health and community service providers are either unaware of the existence of the SUC, or have a very limited understanding of its service model and purpose; and have little interaction with the SUC.

"I don't know how the SUC works and I don't have much to do with it."

- Emergency clinician

"The SUC operates in isolation."

- Mental health and drug worker

"We have limited knowledge about the SUC... We lack an understanding of what they do and how we can better work with them."

- Officer in Charge, WA Police

"SUCs that are not connected to other services. It doesn't really operate on any continuum of care."

- Health service leader

The standard service agreement between the MHC and SUC service providers states the following as a service outcome: "effective relationships and referral pathways exist with key services including but not limited to the Police, Community Patrol, Hospital and Community Drug Service Team" and that this is measured by "Maintaining effective relationships with other services" and "Developing appropriate referral processes". SUC providers deliver a qualitative response to this in their half-yearly performance report, but these statements are often brief, and largely superficial in nature, and do not require any substantive evidence or objective measurement.

There is also no evidence that the MHC proactively validates actual performance against this outcome, or seeks a qualitative evidence base from other services in the community. This is in contrast to the Northern Territory (NT) where the NT Department of Health, which funds Sobering-Up Shelters (SUSs), coordinates a quarterly meeting between SUSs and other services to build relationships, joint protocols, and care pathways.

"At the moment, integration is a country handshake at best. Someone can spit the dummy at any time and it's over."

- Mental health and drug worker

SUCs that are disconnected from the broader health and social support service systems may be missing opportunities for greater impact. Other local service providers commented that there were missed opportunities to better support vulnerable people in the SUC because their staff lacked an understanding of the SUC service model, and how to facilitate access to clients of the service or to refer clients to the SUC.

This is most critical for EDs, in some communities there is a close working relationship with the SUC, in others there is little interaction. In all communities the review team visited, hospital staff noted that a very high proportion of presentations to their ED are alcohol-related. In many communities the staff noted that they didn't often refer patients to the SUC - either because they are unaware how the SUC operated or are sceptical of the standard of care provided in SUC services. This is not the case in all communities. In

Kununurra for example, the lead ED clinician commented that the SUC had a strong relationship with the ED and engaged with the SUC and community patrol almost every night to take individuals to the SUC from the ED when the patient was medically fit for discharge.

With regards to referrals from SUCs to other services, the review found that where there are close working relationships between the SUC and other community services, this is typically where the same provider runs both the SUC and the other service. For example, in South Hedland, Bloodwood Tree run the SUC and some local AOD counselling services. The SUC has established a process whereby if a client attends the SUC on five or more occasions in a 30-day period then the client is contacted by a Bloodwood Tree case worker to discuss whether there is additional support that the individual would like to be referred to.

"Everyone's service has a limitation, but there's no reason why we can't be better connected."

- Aboriginal health services worker

Sub-finding 3.2: There is strong support for the SUC service model to be better connected to AOD, health and other social support services

With the exception of the ED, the police and the community patrols, SUCs plausibly engage with the greatest number of vulnerable, at-risk people on any given night. This means there is the potential for SUCs to facilitate the provision of more holistic health and social support services to people who would otherwise "fall through the gaps".

It is well-understood by the SUC providers, the staff and other stakeholders that the long-term effects of alcohol consumption are complex and significant. Some of these effects are set out in Table 15, below.

Table 15 | Long-term effects of alcohol consumption[28]

Health problems	Social and financial problems
• Mental health issues, including suicidal ideations and an increase risk of suicide • Increased incidence of diabetes and obesity • Cancers, including stomach cancer, bowel cancer, breast cancer, mouth cancer, throat cancer and liver cancer • Brain damage and other cognitive impairments • Heart issues, including high blood pressure, heart damage and heart attacks • Cirrhosis of the liver and liver failure	• Increased risk of criminal behaviour • Increase risk of violent or aggressive acts, including FDV • Breakdown in relationships • Long-term unemployment • Financial difficulty

As such, many staff and other stakeholders expressed a genuine regret that the SUC service model did not better facilitate access to early intervention and prevention services and is not better integrated with local health and social services systems. Examples of this feedback are presented in Figure 12 overleaf.

This was most profoundly expressed by the staff on shift in one of the SUCs (who asked to remain anonymous). The review team were invited to spend time at the SUC from 18:00-19:30, to witness the first wave of admissions and to spend time with the staff. The staff – all of whom had worked at the SUC for more than five years – wanted to ask just one thing: *Can this review lead to helping clients out of a cycle of chronic alcohol consumption.*

[28] What are the effects of Alcohol?, updated 27 August 2019, Australian Government, Canberra, https://www.health.gov.au/health-topics/alcohol/about-alcohol/what-are-the-effects-of-alcohol

Figure 12 | Excerpts from conversations with cross-community stakeholders regarding the need to enhance the SUC service

This review acknowledges that many SUC clients are, generally, pre-contemplative,[29] and may not be receptive to conversations relating to changing their behaviour; but it has also heard feedback that some SUC clients *do* express an interest in changing their behaviour, creating a critical opportunity to start a conversation and support the individual to a better outcome, whether that is a path to rehabilitation, housing, employment or addressing a health/mental health issue (for example).

The review has concluded that the absence of more established connections between SUCs and other services represents a missed opportunity to connect clients with services and supports they may require. In arriving at this conclusion, the review has considered whether it is individual SUC provider performance, the SUC service model, the *Guidelines* and/or funding that has inhibited better connections between the SUC and other service systems. Whilst the review has heard there is variability between SUC providers in terms of their success in engaging with local stakeholders, the review has identified two fundamental issues with the service model that unless addressed will continue to inhibit the ability of individual SUCs to better connect with other local services, these are the:

> "I've had grown men literally crying to me, begging me for help."
>
> **- SUC worker**

1. overall capability of SUC staff
2. typical operating hours of a SUC.

These issues are discussed in sub-findings 3.3 and 3.4 respectively.

[29] The 'Stages of Change' Model was developed by James Prochaska and Carlo DiClemente in the late 1970s as a way to explain the process of change in the context of substance use and dependence. The model recognises that different people are in different stages of readiness for change. 'Precontemplation' is the first stage in the model and refers to a state where people are not thinking seriously about changing and tend to defend their current AOD use patterns, and may not see their use as a problem.

It is important that any adaption or enhancement of the SUC service model should complement, not diminish its core purpose. As the AOD service system across WA continues to mature, and moves increasingly toward early intervention and prevention services, the importance of harm-reduction services should not be lost. First and foremost, SUCs should be a safe space for intoxicated people (as concluded in Finding 1). Any enhancement to the SUC service model in response to this review must not compromise this core purpose, and still needs to retain flexibility for local adaptation to best meet local needs and mitigate local constraints.

"Claiming that harm minimisation services are no longer relevant is contrary to all the evidence and the strategies we employ."

- Professor Steve Allsop, National Drug Research Institute

"It is important that they [SUCs] do not move away from their central purpose – harm-reduction."

- AOD policy advocate

Sub-finding 3.3: SUC care workers are generally not equipped to better connect SUC clients to other services

SUC care workers are widely acknowledged as dedicated and community-minded care workers. In general, they do not have the skills, experience and capability to manage additional responsibilities of case management and referrals to other services.

"Staff lack confidence, and any external experience. The only experience they've ever known is at the sobering-up centre."

- Aboriginal medical service

In conversations with SUC care workers across the Kimberley and Pilbara, SUC staff have significant reservations about the opportunity to adapt the SUC service model. This is not because they do not see the importance of enhancing the service, but because they felt uncomfortable with the responsibility of providing additional services themselves.

There is also little to no capability of SUC care workers to meet the needs of people where there is co-occurring mental health and AOD problems. The MHC's ten-year plan has placed an emphasis on building the capability of staff and organisations to meet the needs of people with co-occurring mental health and AOD problems, but for the typical staff member in a SUC the capability to address mental health and AOD co-morbidity does not currently exist. One SUC care worker described an interaction with a client with suicidal ideations and noted that they had a lack of understanding as to how to manage the interaction.

"SUC services don't really employ people with the skills to do anything other than provide basic are. That can't provide mental health counselling, or address co-occurring mental health and AOD issues."

- AOD advocate

Further, as the consumption of methamphetamine rises in regional communities,[30] SUCs are not prepared to manage the additional challenges that will come with clients presenting with poly-drug use. Many SUC services currently maintain a risk-averse approach to 'high risk' clients, implementing short-term and permanent bans for any client that poses a risk to the health and wellbeing of staff and other clients. While this approach is understood by most community stakeholders, there are others – including the police and community patrols – that expressed concern about the threshold for the SUC model being raised to a point where it places a burden on other local services.

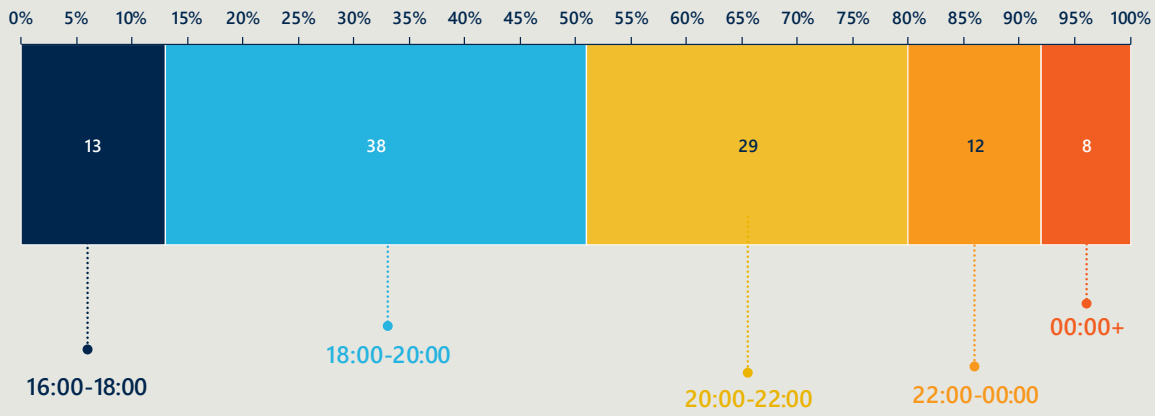
This review has concluded that it would be unrealistic to expect SUC care workers to significantly increase their capability, but there is an opportunity for modest investment in their capability so they can start the conversation with clients about opportunities to connect to other services. The Bega Garnbirringu Health Service – who run the Kalgoorlie SUC – have provided their SUC staff with some training to raise their capability. This training has required funding, but Bega has seen a significant improvement in staff retention since introducing the training and an anecdotal increase in SUC clients connecting with other Bega services. Adapting the *Guidelines* and funding to require staff to receive training that: (i) improves the conversations they have with clients and (ii) helps identify the types of support the client would benefit from; has the potential to create more opportunities where clients become receptive to further support.

[30] According to data provided by Community Alcohol and Other Drug Services, there has been a 7% rise in the consumption of methamphetamines as the 'primary drug of concern' in the last five years.

Sub-finding 3.4: The typical operating hours of SUCs limit the ability to connect vulnerable clients with other services

The typical operating hours of SUCs are between 16:00 and 07:00 or 08:00; except for the SUCs in Perth and Roebourne, which are each funded to operate 24 hours a day. The hours of operation of SUCs are determined by service providers, in consultation with the MHC, and reflect the period during which demand for the service is the greatest. In 2018-19, 80% of SUC clients across WA were admitted between the hours of 16:00 and 22:00, as illustrated in Figure 13 below. This indicates that opening at 16:00 is appropriate and delaying opening could impact the utilisation of the SUC service.

Figure 13 | Frequency of admission hours into SUCs across WA in 2018-19



Source: SUC Database, provided by the Mental Health Commission

Whilst opening at 16:00 is appropriate, this effectively inhibits the opportunity for clients to be engaged the following morning; when they have 'sobered up' and may be more receptive to an appropriate discussion about their current AOD consumption and habits. SUCs receive sufficient funding to operate two eight-hour shifts per day. By necessity this means the first shift is 16:00-00:00, handing over to the second shift, where staff work from 00:00-08:00. So that the SUC can be cleaned and closed by 08:00, clients are generally woken up at about 06:00 to 06:30 so that they have enough time to get dressed and eat a simple breakfast before leaving. This means that, generally, SUC clients are tired, hungover or possibly still intoxicated by the time they leave the SUC by 07:30 at the latest.

"Right now, it's not the sobering-up shelter - it's the hangover shelter."

- Officer in Charge, Police

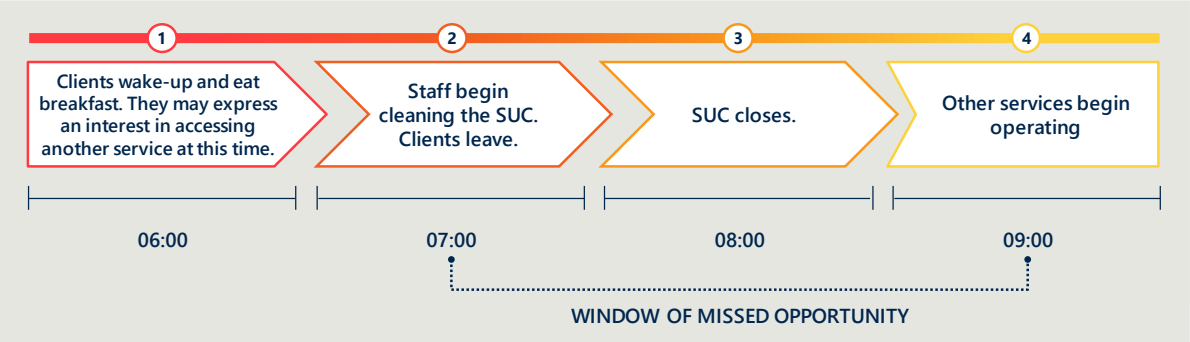
"It's called a sober-up shelter for a reason. If you're waking them up, then you're defeating the purpose."

- SUC Service provider, Ceduna, South Australia

Not only are clients less likely to be receptive to discussions about their AOD problems or referrals to other services at 06:00-07:00, but other AOD, health and community services rarely start services until 08:30, rendering it impractical for them to provide an in-reach service to the SUC. The review heard from multiple stakeholders that creating a connection between SUC clients and other services needs to be in the moment for it to be effective. Where staff have successfully made an appointment for a client – the likelihood of the client following up and *actually* attending the appointment is, anecdotally, very low.

Therefore, in effect the **typical operating hours creates a window of missed opportunity** to directly connect SUC clients with other services. This window is the 90 minutes between the time clients typically leave the SUC (approximately 07:00) and the time that other services begin operating (approximately 08:30), as illustrated in Figure 14 below.

Figure 14 | Window of missed opportunity for SUC clients to access other services



One illustration of this missed opportunity is in Carnarvon, where the SUC is co-located with the base for the Midwest Community Alcohol and Drug Service (CADS) in the 'Carnarvon Dual Purpose Alcohol and Drug Centre'. Despite this co-location, there is little to no interaction between the service, with very few SUC clients accessing CADS services due to no overlap between the services.

"When we're finishing work, they [SUC] start work, so there is no overlap."

- CADS staff

"Because other agencies start after 8, by the time people are done with their breakfast you just miss them."

- Community patrol staff

"I tried to arrange for a health worker to come in and do health checks, but they won't come in that early."

- SUC service provider

"We start at 8am, by which time they're gone."

- CADS staff

However, this review has heard from the SUC in Ceduna, South Australia, that trying to make this connection at 06:00-07:30 may be problematic. They reported they had tried employing an "*assertive support worker*" and AOD counsellor to start at the centre at 06:00 and speak with clients. However, such an assertive approach so early in the morning deterred clients attending the SUC or saw some clients chose to leave the centre before 06:00 to avoid the counsellor. The review heard from SUC staff in WA that many SUC clients often leave the SUC soon after being woken citing several reasons, including:

- routine or habit
- no incentive to stay at the SUC any longer
- being encouraged to leave by SUC staff seeking to close the centre by 08:00
- the need or desire to reach another destination by a certain time or before the day gets hot
- feelings of shame
- the onset of alcohol withdrawal symptoms, where clients *need* to 'find their next drink' before withdrawal symptoms like 'the shakes' set in.

If a client needs to be somewhere else or is not in the mindset to engage in a conversation, then there is little that can be done to connect them to another service. However, some SUCs take an alternative approach to connecting clients to other services by providing them with an incentive to stay at the centre longer. Bloodwood Tree Association (South Hedland SUC) and Bega Garnbirringu Health Services (Kalgoorlie SUC), have changed the way they operate on some days to incentivise some clients to stay at the SUC beyond 08:00. Through a combination of other funding sources and donations, both provide a substantial cooked breakfast on some mornings that is free to all SUC clients – and in the case of South Hedland for others in the community – and keep the SUC open past 08:00. The experience from both SUCs is that some clients choose to stay at the SUC beyond 08:00, creating time for other services to in-reach into the SUC and engage with SUC clients. For example, in the Kalgoorlie SUC, one of the smaller rooms on site has been repurposed as a medical consultation room and a nurse from the Bega Garnbirringu Health Service regularly performs health checks on SUC clients.

"You can't get people to do anything at 5:30am when they're hungover."

- SUC service provider

"People have breakfast at 6am at the latest, and they're gone."

- SUC service provider

Whilst it is inevitable that some clients will leave the centre before 08:00, enabling the SUC to extend its opening hours beyond 08:00 and provide an incentive – in the form of a substantial cooked meal – for clients to stay has shown to be an effective mechanism to create an opportunity for connections between SUC clients and other services that can assist the client with health, AOD and other social factors.

Sub-finding 3.5: Limiting the number of operating days per week potentially places a burden on other local services when the SUC is not open

At present, the operating days of SUC services differ across the state, and are:

- **seven days a week:** Perth and Roebourne (due to co-location with a 24/7 low medical withdrawal service)
- **five days a week:** Kununurra, Wyndham, Broome, Derby, South Hedland, Kalgoorlie
- **four days a week:** Carnarvon.

Across the communities in which SUCs *do not* operate every day of the week, several stakeholders noted that the biggest opportunity to enhance the service was to increase the number of days that the SUC is open. To these stakeholders, limiting the number of SUC operating days represents a missed opportunity to lessen the burden of intoxication and alcohol-related harm across the health, law and order, and community services systems.

For some of the communities, alcohol is available for purchase six days a week, but not on a Sunday. Stakeholders, including the SUC provider, observed that there would probably be little demand for the SUC on the Sunday evening if there is no availability of pre-packaged alcohol on a Sunday.

"It would be good for the SUC to be open on weekends. The demand doesn't end just because the SUC is shut."

- Officer in Charge, WA Police

"It's too restrictive…there is absolutely no reason it shouldn't be open on Saturdays. It's a safe place where people can go. When it's closed on a Saturday people just congregate outside Liquorland."

- Community Elder

Some stakeholders did observe that opening seven days a week could be problematic, even if alcohol was sold seven days a week in the community, because that would increase the chance that for some clients the SUC can become *de facto* place of residence. This review heard that there are SUC clients who are homeless and generally consider the SUC to be their place of residence on days on which it is open and simply 'sleep rough' on days on which it is not, although the data presented in the SUC activity reports would suggest that there are only a small number of clients who are admitted to the SUC more than 50 nights a year.[31]

"It's harder to get people to leave the ED on a Saturday [when the SUC is closed]. I'll tell the patient they can go, and they'll say "ok, where am I going to go and how am I going to get there?"

- Senior emergency department clinician

"[When nothing else is open] the Police become everything to everyone – the SUC, child protection, hospital, family counselling, and mental health."

- Officer in Charge, WA Police

Although the *Guidelines* give service providers the flexibility to change SUC operating days to be open on any five days a week – to best reflect local demand – the funding level is not linked to days of operation and SUCs would be more expensive to operate on Saturdays because of penalty rates.

[31] This review has no basis to question the validity of the activity reports, but the general impression from the consultations with SUC staff was that there are a small number of daily users of the SUC – higher than the activity reports would indicate.

There is a practical staffing issue if a SUC is open more than five days a week, because a five-day roster is significantly easier to deliver with a complement of full-time staff. A six- or seven-day roster is more complicated and may require part-time workers or overtime to deliver.

This review finds that there is no clear rationale for only operating SUCs for five days a week (other than because current levels of funding can only support five days of operation per week). The finding that SUCs represent value for money is unlikely to change if SUCs were open (and funded) for seven days a week of operation, given the cost of ED presentations. While there is a small risk that some clients may use the SUC as a *de facto* place of residence, this does not represent a good enough reason to not increase the operating days of SUCs to meet community needs.

5.3.2 Conclusions and recommendations

Taking all the sub-findings into account and in summary, this review has concluded that:

- the SUC service model needs to be adapted in order to create the opportunity to connect some SUC clients to other services that can help them with their AOD use, health issues and other social needs
- the two main adaptations of the service model that will support better connections with other services are:
    - modest levels of training for SUC staff to enable them to be better informed and have better conversations with SUC clients about the range of supports available to them
    - enabling operating hours to be extended beyond 08:00 so that other services can in-reach into the SUC and engage with SUC clients
- there is a case to be made for also increasing funding to enable the SUC to operate 6-7 days a week (depending on local alcohol restrictions).

In relation to key finding 3, this review has five recommendations as outlined in Table 16, below:

Table 16 | Recommendations

Recommendation 6	The MHC should explore opportunities to assist SUCs in establishing internal mechanisms (i.e. case management processes and referral protocols) to identify regular clients of the SUC and create opportunities for targeted conversations between the local AOD counselling service and the client.[32]
Recommendation 7	The MHC to consider the appropriate training needs of SUC care workers, that enable them to be more capable and confident of supporting clients to seek support; and consider funding SUC providers to deliver this training.
Recommendation 8	The MHC to consider increasing the level of funding provided to service providers to enable SUCs to remain open until 10:00 and provide a substantial breakfast as an incentive to SUC clients to stay in the centre after 08:00.
Recommendation 9	The MHC to consider including a requirement in the *Guidelines* for SUC providers to work with other appropriate local service providers to provide in-reach services into the SUC on a regular basis.
Recommendation 10	The MHC to consider increasing the level of funding for SUCs to enable them to open between 6-7 days a week (for those SUCs showing demand, and in line with restrictions on the sale of packaged alcohol in the community).

[32] This review notes that there are client privacy challenges that make this recommendation more complex than it appears on face value; especially where different organisations operate the SUC and AOD counselling service.

5.3.3 Additional observations

There is not a direct pathway from SUCs to low medical withdrawal services

There are two low medical withdrawal (detox) services connected with a SUC service – Perth and Roebourne. Some stakeholders observed that they would support an increase in such arrangements to enable clients to easily move from the SUC to the detox facility. To those outside of the AOD service system, it seems there is a logical pathway from the SUC to detox; but SUC service providers and others working in AOD services confirmed that there are a number of steps in the pathway from the SUC to detox, and even though the services are co-located, there are not many clients in detox who have previously used the SUC; in fact, in Roebourne the majority of clients being admitted to the detox facility are withdrawing from methamphetamine and are not from the local community.[33]

SUC and AOD staff identified that that are a small number of steps that SUC clients must go through before detox is an option, including a medical assessment, and that it can be a matter of weeks from nominating to go to detox before the individual enters detox. SUC and AOD staff proposed that it would be more beneficial for SUCs to provide education and information to clients and connect them with an AOD counselling service rather than trying to create a direct pathway to detox.

"It is not necessarily possible or even advisable to enter detox straight from a SUC. First, there is an educational component around learning concepts of responsibility, consequences and dependency. Second, people need to get their affairs in order before moving into a 24/7 facility. Only then are they ready for admission."

- SUC and detox provider

It is the conclusion of this review that whilst there may be an efficiency gain from co-locating a SUC and low medical withdrawal service (see Finding 4 for more specific detail on this), there is no merit in enhancing the SUC service model to create a direct pathway from SUC to detox.

On a related point, many community and SUC stakeholders commented that they felt there was a lack of provision of low medical withdrawal services across the Kimberley, Pilbara and Mid-West. It was observed that the need to travel significant distances away from their community discouraged clients who have indicated they wish to detox – especially Aboriginal peoples with a close connection to a specific community.

[33] The Roebourne detox facility supports clients from across the Pilbara and Kimberley in detoxing from methamphetamine use.

5.4 Key finding 4: The commissioning and funding approach should be adapted to realise greater value

This review has identified opportunities to enhance the SUC service model to create more value and achieve greater impact in local communities. Realising these opportunities will require changes to the way SUC services are funded, and broader adaptions to the way the MHC works with other government agencies and local service providers to commission the SUCs and other services in regional communities.

These findings reflect the direct SUC service model enhancements as set out in Section 5.3 and acknowledge that the impact of the SUCs does not wholly sit with the SUC service providers. The MHC has a significant role – alongside other agencies and providers – in enabling the success of SUC services and maintaining value for money. This review has identified six sub-findings that underpin key finding 4, which are presented in Table 17, below and described thereafter.

Table 17 | Sub-findings to key finding 4

Sub-finding 4.1:	Realising the potential for added value presented by SUCs will require additional funding and a 'whole-of-government' approach to commissioning.
Sub-finding 4.2:	The critical link between SUCs and community patrol needs to be reinforced through a collaborative commissioning approach.
Sub-finding 4.3:	There may opportunities for SUC facilities to be used for other purposes during the day and on non-operating days.
Sub-finding 4.4:	While co-locating SUC and low medical withdrawal services has created value for money for the MHC, there are associated issues that have only recently been mitigated.
Sub-finding 4.5:	The MHC needs to establish a new approach to assessing and managing performance.
Sub-finding 4.6:	The process of decommissioning a SUC has been less contentious when there has been a demonstrable shift in need and authentic community engagement.

5.4.1 Sub-findings

Sub-finding 4.1: Realising the potential for added value presented by SUCs will require additional funding and a 'whole-of-government' approach to commissioning

Section 5.3 summarised opportunities to enhance the value and impact of SUC services. These opportunities include:

- increasing the operating times of SUC services to create in-reach opportunities
- increasing the number of days that SUCs operate to lessen the burden on other services
- modest investment in the development of SUC staff capability.

These opportunities cannot be realised within the existing funding envelope provided to SUCs. Current funding for SUCs (not including Perth and Roebourne) enables the services to support clients four-five days a week, for 16 hours per day; and to fund general wear and tear of the facility and equipment used by the facility. **Any increase to operating days or opening hours will require additional funding. Staff development will also require additional funding.**

Creating connections with other mental health, health and community services to provide more holistic services to clients cannot be affected by the MHC alone and will require a whole-of-government approach to commissioning AOD and community services in local communities.

Much of the 'added value' potential described in Section 5.3 assumes that external services will in-reach to the SUC. This includes opportunities to better connect SUC clients with mental health, general health and social support services like employment, housing and FDV services. The agencies that fund and commission many of these services include, but are not limited to:

- **Department of Communities** (community patrols, men's and women's refuges, housing and unemployment services and FDV services)
- **Department of Health** (Hospital and Aboriginal medical services)
- **National Indigenous Australians Agency** (employment services, and residential rehabilitation services in the Kimberley and Pilbara)
- **Mental Health Commission**[34] (mental health services).

This review has observed that where one service provider is currently commissioned to deliver other health and community services within the community, in addition to the SUC, providers have realised economies of scale that have enabled staff from other services to 'in reach' to the SUC to connect with clients. Bloodwood Tree Association (South Hedland) and Bega Garnbirringu Health Service (Kalgoorlie) are two clear examples of where this approach has anecdotally succeeded.[35]

- In **South Hedland**, Bloodwood operates a SUC, AOD and mental health counselling, homelessness support services, and employment and training services, amongst other services. As previously described in key finding 3, Bloodwood has created the opportunity to connect its SUC clients with other services by operating a community breakfast on some mornings and keeping the SUC open beyond 08:00. Bloodwood's AOD counsellors and mental health worker visit the SUC to casually meet

[34] Noting that integrated AOD and mental health commissioned by the MHC is maturing.
[35] The review has taken it on face value that this approach has increased connections; providers have not captured any data to demonstrate this impact.

with SUC clients over the extended breakfast. As stated earlier in the report, information sharing within the organisation has also enabled the Bloodwood AOD counselling service to follow up with clients who have attended the SUC more than five times in a 30-day period.

- In **Kalgoorlie**, the SUC provider Bega Garnbirringu Health Service is the local Aboriginal medical service, operating the health clinic (including GP service, dental service, and maternal child service), social support services (including the local 'rough sleeper' program), and social emotional wellbeing services. Bega has converted a small room in the SUC into a clinical consulting room and provides a substantial breakfast twice a week to encourage SUC clients to stay until 10:00. This provides their AOD counsellors, nurses and staff from other services with the opportunity to meet with clients and provide support, particularly to rough sleepers, who are supported to access housing and accommodation. Bega Garnbirringu Health Service believes that in the four years since they began providing in-reach services into the SUC, several 'regular' clients have now found sustainable housing and completed residential rehabilitation programs.

Creating connected service systems in local communities to drive better outcomes for at-risk people requires stronger cooperation between these agencies, and a push toward co-commissioning. Specific opportunities have been identified later in this section, but more broadly, the SUCs will need support from many parts of government to fully realise the potential of the enhanced service model.

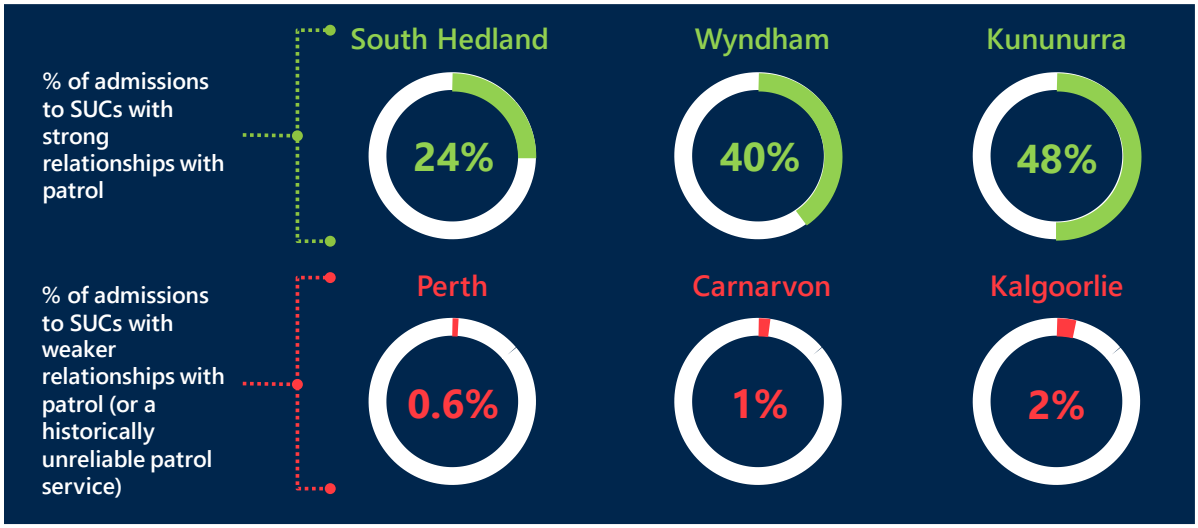
This review acknowledges that non-government community and health services operate within contestable service systems, and it is not a recommendation that government collaborates to commission these services from a single provider. Rather, it is the conclusion of this review that the MHC should work with other agencies at a local level to set 'whole of government' commissioning expectations for services that need to effectively connect with the SUC.

Sub-finding 4.2: The critical link between SUCs and community patrol needs to be reinforced through a collaborative commissioning approach

There is a critical link between SUCs and community patrols in communities where both services operate. Where there are strong partnerships and cooperation between the two services this has a direct and positive impact to admissions to the SUC, and consequently a greater positive impact on the community.

Conversely, where the relationship between a patrol and SUC is weaker, or the community patrol is considered by community members to be 'unreliable', admissions to SUCs are impacted. Figure 15 below provides a comparison of the proportion of referrals to SUCs by the community patrol in six locations – three in locations where the SUC and patrol are operated by the same provider, and three where they are operated by different providers.

Figure 15 | Comparison of referrals to SUCs by the community patrol in select communities



In the locations where the proportion of referrals from the patrol to the SUC are relatively high, there is a strong relationship between the community patrol and SUC (typically because they are run by the same organisation and the patrol is based at the SUC). Conversely, where the operational relationship between the patrol and SUC are weaker, this is reflected by relatively low referral numbers.

"[The patrol] don't patrol around the Perth CBD as frequently anymore, because the City of Perth is the only council in the area that won't contribute to their funding."

- SUC service provider

Where the community patrol is considered an integral part of the SUC service, patrol staff help build the connection between the community and the SUC. For example, in South Hedland, the patrol and SUC work together to operate a self-funded 'night kitchen' where Aboriginal peoples from across South Hedland are picked up from public places between 16:00-18:00 and driven to the SUC where they are provided with a hot meal. Some of these individuals are not admitted to the SUC but are often taken home by the patrol thereby diverting that individual from the environments where they were drinking and would be susceptible to continued alcohol consumption.

This review spoke with the SUC service provider in Katherine, Northern Territory, who reflected the importance of the community patrol as an access pathway to the SUC. The relationship between the SUC

and the patrol has diminished over time and has seen the patrol refuse to take people to the SUC on occasion. Admissions to the SUC have consequently reduced.

This does not mean that the SUC and community patrol must be provided by the same provider. With community patrols funded in many more communities than SUCs are located, this would be impractical. Rather, it is the conclusion of this review that the MHC and the Department of Communities should align their commissioning intentions for the SUCs and community patrol respectively, and mandate close collaboration as part of the respective service agreements.

This review was made aware that the Department of Communities is currently undertaking a review of the community patrol service, so the SUC review team met with the Department of Communities review team. This review notes that the Department of Communities is keen to work more closely with the MHC to ensure that SUC and patrol services can effectively collaborate, regardless of whether the services are delivered by different providers.

Related to this sub-finding is that in general, the community patrols are only operated until 22:00/23:00. Several stakeholders noted a frustration that the patrol finished 'early' and was not available to take people to the SUC after this time. In most cases, it was commented that it would not be necessary to operate the patrol beyond midnight. Furthermore, several SUC staff observed that the patrol bus could be utilised by the SUC in the morning to help connect clients to other community services that were not able to in-reach into the SUC.

"The patrol just sits there, parked during the day. The SUC could do so much more if they used the patrol bus for other purposes."

- SUC service provider

Sub-finding 4.3: There may be opportunities for SUC facilities to be used for other purposes during the day and on non-operating days

Where a SUC service only operates during the night and early morning,[36] there may be an opportunity for government agencies and local service providers to consider how the facility could be used for other purposes during the day.

Many stakeholders expressed their desire to see the SUC facility, a community asset, used for other purposes during the day. The most common suggestion was for the potential of the SUC to operate as a 'drop-in' centre, where vulnerable people could access a safe place with reasonable domestic facilities (including a kitchen, showers and laundry). This could follow a similar model to homeless drop-in centres in Perth (for example, the Ruah centre), where vulnerable people can access a safe location from 10:00 until 15:00, meet some basic needs, be fed and be connected to social services that could provide additional support. This review notes that this type of service is not one that the MHC would commission, so it would require the MHC to work with the local community and other government agencies to establish the appropriate commissioning and funding arrangements. As noted in the following sub-finding, the co-location of the SUC and detox facility in Roebourne has created greater value for money; which may be a tangential benefit of utilising the asset during the day time.

SUCs would not be suitable for a broad range of community services. They are relatively basic facilities, most of which are only in a reasonable state of repair, or have been specifically configured to be a SUC.

> "We have a beautiful facility. It should absolutely be used for another purpose during the day"
>
> **- SUC staff (Carnarvon)**

It is important to continue promoting the facility as a SUC service **first**, and other services **second**. Roebourne serves as a caution in this context. As noted earlier in this report, following the co-location and co-commissioning of a SUC and low medical withdrawal service, many clients and community members now believe that the services is only a 'detox' service, and not a SUC.

Where there are unmet community needs the MHC should explore opportunities to utilise the SUC facilities during the day. These opportunities should be identified and assessed in consultation with local communities and other government agencies.

[36] Noting the Roebourne and Perth SUCs operate 24 hours a day, 7 days a week.

Sub-finding 4.4: While co-locating SUC and low medical withdrawal services has created value for money for the MHC, there are practical co-location issues that need to be taken into account

As concluded in key finding 2, the decision to co-locate and co-commission a SUC and four low-medical withdrawal beds in Roebourne has created value for money for the MHC and gone some way to addressing gaps in low medical withdrawal beds in the Pilbara and Kimberley. This value for money has been created because the low-medical withdrawal service operates 24/7, and at a marginal cost of extending the SUC service from 80 hours per week, to 144 hours per week.

Data provided by Yaandina, the SUC service provider in Roebourne (that also provides a residential rehabilitation program, Turner River, in South Hedland), indicates that 47 clients were provided with low medical withdrawal services in 2018-19, with approximately 600 bed days in that period. Stakeholders in Roebourne emphasised the importance of the low medical withdrawal service, both in the Pilbara, and in the broader North West, as being a critical stage in a client's rehabilitation journey.

However, stakeholders identified some practical concerns with co-locating a SUC and low-medical withdrawal service that have only recently been mitigated in Roebourne.

The review heard from multiple clinicians and local stakeholders who felt that the co-location arrangements can compromise the outcomes of people undergoing substance withdrawal when there is the potential for sobering-up clients and withdrawal clients to utilise common areas of the facility. In the case of Roebourne, the converted SUC facility had limited physical division between SUC and low medical withdrawal clients.

> "Having people detox in a sobering-up environment is ludicrous. You can't have people detoxing in the same place that you have people smelling of alcohol."
>
> **- AOD counsellor**

> "It really plays on the minds of those detoxing when they are around people that are drunk or intoxicated."
>
> **- Clinician, ED**

In October 2019, the SUC and low medical withdrawal service in Roebourne was scheduled to relocate to a new facility, funded through a LotteryWest grant, with the balance self-funded by the service provider. The new facility has separate areas for SUC and detox clients, which largely mitigates the likelihood that SUC clients and detox clients will interact.

However, it is important to note that the reason for the relocation to the new premises is not to mitigate the issue outlined above, rather it is a consequence of the condemnation of the old SUC facility due to the presence of asbestos.

It is not the conclusion of this review that the MHC no longer co-commission SUCs and low medical withdrawal services in a dual-purpose facility. Rather, it is the conclusion of this review that MHC should only consider co-locating and co-commissioning dual-purpose SUC and low medical withdrawal services where the facility is suitable to ensure clients using the two services can be kept separate and that the outcomes of clients withdrawing from alcohol or other drugs is safeguarded.

Sub-finding 4.5: The MHC needs to establish a new approach to assessing and managing performance

As noted earlier in this report, there are no outcome measures for the SUC and the primary mechanism through which the MHC monitors the '*reduction of the impact of intoxication on families and the community*' is through monitoring the level of admissions to the SUC relative to a target that the MHC establishes as part of the service agreement.[37]

Interviews with service providers, hospital staff and police reflected that the utilisation of a SUC can fluctuate substantially, particularly in regional communities. A change in utilisation does not mean that the need for the SUC has also changed or that the SUC provider is under-performing. There are several factors that may influence the utilisation of a SUC, and which are outside the control of the SUC provider. Examples include community events like funerals and sporting events, an ineffective or unreliable community patrol service, and staff turnover in other community services, where lack of knowledge of the SUC limits referrals.

Assessing the performance of the SUC service provider and the ongoing need for a SUC within a community will require the MHC to establish a new mechanism for how it **measures** and **manages** the performance of SUC services.

Measuring performance

The MHC should establish a balanced scorecard to better understand the effectiveness, impact and value for money of SUCs. There is much research into the adaptation of the balanced scorecard approach in health and mental health services. An example of this is the 2008 study: *Adapting the Balanced Scorecard for Mental Health and Addictions (Lin and Durbin): Government of Ontario and the Ontario Hospital Association*.[38] This paper proposes using four broad domains of measurement (adapted to suit the context of the SUC):

- utilisation and client outcomes
- system integration
- client perception
- financial performance.

This review does not propose that there should be a large number of KPIs established, acknowledging that data is captured on paper at each SUC and it is not the intent to create a costly or bureaucratic performance management system. To illustrate this point, the review has developed a small number of KPIs per domain in Table 18, below. It is not intended that these KPIs are adopted by the MHC, rather that they be used as an example to inform the type of KPIs to be established.

Table 18 | Indicative balanced scorecard for the SUC service

Domain	Indicative KPI	Why this may be useful?
Utilisation and client outcomes	Average number of clients admitted per day.	To understand the use of the facility.
	Percentage of clients admitted to the SUC more than once per week, on average.	To understand the proportion of clients regularly using the SUC.

[37] For the purposes of brevity, the use of the word 'utilisation' is used, rather than performance against the target level of admissions.
[38] 2008, Adapting the Balanced Scorecard for Mental Health and Addictions: An Inpatient Example, Healthcare Policy 3(4): e160–e174 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645157/.

Domain	Indicative KPI	Why this may be useful?
	Average number of clients per week who attend a follow-up service – outside of the SUC – after an interaction at the SUC (to be gathered from the provider of the in-reach service).	To measure potential outcomes of the SUC service being commissioned (not a performance measure of the SUC provider).
	Level of alcohol-related harm occurring in public places in the community (reflected through qualitative feedback from the local police).	To assess whether the SUC is reducing alcohol-related harm in the community that it can directly impact (i.e. not in the home alcohol consumption).
System integration	Number of in-reach services that attend the SUC per week.	To understand how effective the provider is in creating an opportunity for other services to in-reach to the SUC.
	Perception of the SUC in other services in the community.	To understand how effective the SUC is in engaging with other services.
	Average number of clients per week who engage with an in-reach service in the SUC (to be validated with in-reach provider).	To assess how effective the SUC is in creating an environment where the clients can engage with other services.
Client perception	Client perception of the service.	To understand whether the SUC is meeting the needs of clients.
	Client perception of the service's support in connecting to other services.	To understand whether the SUC is helping clients to engage with other services.
Financial performance	Average cost per admission.	To support a balanced assessment of value for money.

Managing performance

The Service Priority Review (2017)[39] identified that "Contractual relationships between government and the not-for-profit sector are yet to reach maturity and there remains much to be learned by both sides."

With regards to SUCs, the MHC should take a more collaborative but assertive approach to performance management, informed by the balanced scorecard of performance measures. This will involve greater interaction with the SUC providers, other local stakeholders and local communities. When managing performance, the MHC should place greater emphasis on assessing whether the SUC is having an impact on the local community, rather than whether the SUC is meeting specified performance targets.

The MHC has a role in maximising the impact that each individual SUC has on the community, this will require a greater investment of time from the MHC in managing both the performance of the SUC provider, but also engaging with local communities and other government agencies to create the conditions for each SUC to thrive.

[39] 2019, Service Priority Review, WA Government, https://www.wa.gov.au/organisation/public-sector-reform/service-priority-review.

Sub-finding 4.6: The process of decommissioning a SUC has been less contentious when there has been a demonstrable shift in need and authentic community engagement

In the last two decades, six SUCs have been decommissioned by the MHC or its predecessor, the Drug and Alcohol Office, in Fitzroy Crossing, Halls Creek, Wiluna, Midland, West Perth and Geraldton. This review has not assessed whether the past decommissioning of SUCs was appropriate but based on feedback provided by stakeholders across the state, there is an important lesson to be learned.

On 1 July 2006, the Fitzroy Crossing Sobering-Up Centre was closed. The decision to close the centre was made with the agreement of community stakeholders including WA Police, WACHS, the local Aboriginal medical services, and operator of the sobering-up centre. This followed a significant reduction in demand for the service after the enforcement of strict liquor restrictions in the town. In its place, new alcohol and other drug treatment and prevention services now operate from the old sobering-up centre building using the funding that had previously been applied to the sobering-up service.[40] The closure of Halls Creek in 2011 closely mirrored the closure of Fitzroy Crossing, where the enforcement of strict liquor restrictions in town saw an 80% reduction in numbers admitted to the SUC.

> "In Halls Creek and Fitzroy Crossing, it was a long process, with sustained modifications to other services to carry the burden after the SUC closed."
>
> **- AOD advocate**

The Midland SUC (closed 28 February 2006) and the West Perth SUC (closed 29 August 2009) were also closed due to very low demand of the services and following consultations with local stakeholders. The funding of each was redirected to either residential treatment beds for Aboriginal peoples (Midland), or related AOD support services (West Perth).

The Geraldton SUC was closed following the MHC's 2017-18 budget review process, with sustained low levels of demand meaning that the cost per admission was relatively high compared to other SUCs. Based on stakeholder feedback, there were missed opportunities to provide input into the process of decommissioning the service, and to understand how the funding provided to the SUC would be directed to other AOD services for the community,[41]

As summarised in key findings 1 and 2, demand for a SUC will be impacted by local characteristics. It is appropriate that the MHC decommission a SUC where there is a sustained decrease in demand and the service no longer represents value for money.

The lesson learned from past closures is the importance of engaging in a constructive dialogue with local communities when changes in community characteristics indicate that a SUC is no longer the most appropriate mechanism for addressing alcohol-related harm. Part of this dialogue should include whether there is another more appropriate service that could be established to address community needs, or whether demand has so substantially decreased that there is no longer a need for a targeted service.

[40] Parliamentary Questions, asked in the Legislative Assembly of the Parliament of Western Australia on 14 June 2011, http://www.parliament.wa.gov.au/parliament/pquest.nsf/3f9c0f35f2b504544825718e001105c9/741db9db167f95ef482578aa0016c760?OpenDocument.

[41] The former Geraldton SUC is being repurposed to provide a new 10-bed community mental health step up/step down service, which is anticipated to open in 2021.

5.4.2 Conclusions and recommendations

Taking all the sub-findings into account and in summary, this review has concluded that:

- to realise the added value that SUCs can present to clients and communities (as summarised in key finding 3), the MHC will need to provide additional funding and should take a 'whole of government' approach to commissioning the SUC
- this includes a particular focus on ensuring there is a strong and positive relationship between the SUC and the community patrol
- there may be opportunities to use the current SUC facilities for alternate purposes, but these should be targeted at meeting a local need and reflective of the inherent constraints of the facility
- the MHC should change its approach to the measurement and management of SUCs and ensure that when decommissioning a SUC, it does so following authentic engagement with the local community.

In relation to key finding 4, this review has five recommendations as outlined in Table 19, below:

Table 19 | Recommendations

Recommendation 11	The MHC should explore opportunities to work with other agencies, including the Department of Communities, the Department of Health and the National Indigenous Australians Agency to ensure there is a 'whole of government' commissioning approach to SUCs, creating the conditions for the SUC to be better connected to other local services.
Recommendation 12	The MHC and the Department of Communities should explore opportunities to align their commissioning intentions for SUCs and community patrol; and where the services are not provided by the same organisation ensure that there is an effective relationship.
Recommendation 13	The MHC should explore opportunities to utilise the SUC facility when it is not in use; working with local communities and other government agencies to ensure these 'community assets' can be maximised to best meet local needs.
Recommendation 14	The MHC should only consider co-locating and co-commissioning dual-purpose SUC and low medical withdrawal services after appropriate community consultation, and assurance that the two services will be suitable separated, and that the social and clinical outcomes of clients are safeguarded.
Recommendation 15	Having identified that a SUC should potentially be decommissioned, the MHC should ensure there is authentic community engagement and consideration of alternate services that can better meet community needs.

5.4.3 Additional observations

There are no additional observations relating to the commissioning and funding of SUCs.

Appendix A Assumptions and qualifications

To finalise the findings and recommendations for the review the following assumptions and qualifications have been made:

1. **Completeness of 2018-19 SUC data**. The SUC activity data provided *does not* include the full year of activity for 2018-19. For Perth, Kununurra, Derby, South Hedland, Roebourne and Carnarvon, admissions data *does not* include activity that occurred in June 2019. For the Broome, Kalgoorlie and Wyndham SUCs, admissions data *does not* include activity that occurred in May and June 2019. Data for this period relating to the number of nights open or the number of unplanned closures was not available. **Full year admissions data has been based on a pro-rating of the 10/11 months data available. 2017-18 data for nights open and unplanned closures has been used as a proxy.**

2. **SUC client count may be overestimated.** SUC service providers are required to maintain hardcopy admission records and forward copies of these records to the MHC within ten business days of each calendar month. The MHC inputs the information collected into a database and autogenerates unique but anonymised client identification ('ClientID') numbers. It is believed by the MHC that this is not a wholly accurate practice and as such the number of unique clients admitted to each SUC is overestimated. Additionally, it is assumed that any one individual is only admitted to one SUC in any given year. It is acknowledged that it may be possible for any one individual to be admitted to multiple SUCs over any 12-month period, but the data does not provide this level of detail. **As such any data or analysis related to the number of individual SUC clients that is presented in this report should be used with this qualification in mind.**

3. **There is a different funding and contracting structure for the Perth SUC.** The Salvation Army (Western Australia) is block funded under a single service agreement to provide a SUC, low medical withdrawal service and non-residential services (individual and family AOD counselling) in Perth. As per the service agreement, the funding provided by the MHC equates to 74% of the total funding for these services, with the Salvation Army self-funding the balance. In 2018-19, the MHC provided a total of $1,002,134 in funding to the Salvation Army for the provision of these services. For the purposes of this review, it has been estimated that the funding for the Perth SUC service alone amounts to 74% of the baseline funding of a SUC with a similar number of beds ($592,250), so this review assumes that the funding provided by the MHC in 2018-19 was $439,745.

4. **As of July 2019, the funding and contracting structure of the Roebourne SUC has changed.** Prior to July 2019, Yaandina Community Services were funded $595,250 in 2018-19 to provide 14 SUC beds from the Roebourne SUC facility. Separately, Yaandina were funded out of the Western Australian Methamphetamine Action Plan to provide 2 low medical withdrawal beds out of the same facility. As of July 2019, the two service agreements have been varied to form a Master Agreement, under which Yaandina is block funded to provide 8 SUC beds and 4 low medical withdrawal beds out of the same facility which is open 24/7 (unlike the other seven regional facilities). In 2019-20, the estimated value of this block funding for the SUC part of the service is $565,059 – lower than other SUCs due to management efficiencies of running the two services in the same facility.

Appendix B Stakeholder Consultation List

Between July and September 2019, Nous spent time in each of the nine locations with a SUC to meet face-to-face with stakeholders who made themselves available to contribute to the review. Nous also conducted a series of teleconference interviews with stakeholders who were unable to meet in person or who were located interstate. Table 20, below, provides a location-by-location list of the organisations consulted and the total number of people consulted.

Table 20 | Organisations consulted as part of this review

Location	Organisations Consulted	Total number of people consulted
Broome	Aboriginal Health Council of Western Australia (AHCWA) Broome Health Campus Broome Police Department of Communities Kimberley Aboriginal Medical Services Kimberley Mental Health and Drug Service Mamabulanjin Aboriginal Corporation (Kullarri Patrol Services) Men's Outreach Service Aboriginal Corporation Milliya Rumurra Aboriginal Corporation	13
Carnarvon	Carnarvon Family Support Service Carnarvon Health Campus Midwest Alcohol and Drug Services	6
Derby	Derby Aboriginal Health Service Derby Hospital Derby Police Garl Garl Walbu Association Aboriginal Corporation Shire of Derby-West Kimberley	15
Kalgoorlie	Bega Garnbirringu Health Service Hope Community Services Goldfields Rehabilitation Services Kalgoorlie Police	6
Kununurra	East Kimberley District Leadership Group Gawooleng Yawoodeng Aboriginal Corporation (Kununurra Crisis Accommodation Centre) Kimberley Mental Health and Drug Service Kununurra District Hospital Kununurra Police Kununurra Waringarri Aboriginal Corporation MG Corporation Ord Valley Aboriginal Health Service Shire of Wyndham-East Kimberley	39

Location	Organisations Consulted	Total number of people consulted
Perth	Department of Communities Mental Health Commission National Drug Research Institute Nyoongar Outreach Services Royal Perth Hospital The Salvation Army WA Police Western Australian Network of Alcohol and other Drug Agencies (WANADA)	34
Roebourne	City of Karratha Mawarnkarra Health Service Roebourne District Hospital Roebourne Police Yaandina Community Services	8
South Hedland	Bloodwood Tree Association Department of Communities Hedland Health Campus Julyardi Aboriginal Corporation Mission Australia (Drug and Alcohol Treatment Service) South Hedland Police Town of Port Hedland	15
Wyndham	Ngnowar Aerwah Aboriginal Corporation Wyndham District Hospital Wyndham Police	11
Other	Ceduna Koonibba Aboriginal Health Service (South Australia) Mission Australia (Northern Territory)	5

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