



Services that Manage the
Care Needs of Drunk and
Incapable People:
a Review of the Literature

**SERVICES THAT MANAGE THE CARE NEEDS OF
DRUNK AND INCAPABLE PEOPLE:**

A REVIEW OF THE LITERATURE

**Dawn Griesbach, Griesbach & Associates
Patricia Russell, Patricia Russell & Associates
Clare Lardner, Clarity**

Scottish Government Social Research
2009

This report is available on the Scottish Government Social Research website only www.scotland.gov.uk/socialresearch.

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

© Crown Copyright 2009

Limited extracts from the text may be produced provided the source is acknowledged. For more extensive reproduction, please contact the Queens Printers of Scotland, Admail, ADM 4058, Edinburgh EH1 1NG. Email: licensing@oqps.gov.uk

Table of Contents

1	INTRODUCTION	1
	Other review evidence	2
	Methodology.....	3
	Structure of this report.....	4
2	SOBERING-UP SERVICES IN AUSTRALIA.....	5
	Introduction and description of the evidence	5
	Background	5
	Similarities and differences between sobering-up services in Australia	7
	Prior to setting up a service	8
	Opening hours.....	8
	Staffing	9
	Referring agencies	10
	Admission criteria	10
	Service procedures	11
	Client profile	14
	Brief interventions within sobering-up services.....	16
	Links to other services	17
	Rural issues	19
	Outcomes.....	20
3	SOBERING-UP SERVICES IN NORTH AMERICA	24
	Introduction and description of the evidence	24
	Background	25
	Description of the services.....	25
	Opening hours and length of stay	26
	Staffing	26
	Referring agencies	27
	Admission, exit and safety protocols and procedures	28
	Client population	29
	Links to other services	30
	Service capacity.....	30
	Rural issues	31
	Outcomes.....	31
4	OTHER SERVICES FOR DRUNK AND INCAPABLE PEOPLE.....	32
	Introduction and description of evidence	32
	Transport services.....	32
	Providing medical support in police custody suites	34
	Temporary places of safety, mobile units and SOS buses.....	37
5	DISCUSSION	40
	Sobering-up services	40
	Transportation services and night patrols.....	42
	Provision of other types of services	42
	REFERENCES.....	44

1 INTRODUCTION

- 1.1 This report is a review of the worldwide literature on services that exist to manage the care needs of drunk and incapable people. This review was undertaken as part of a larger research study commissioned by the Scottish Government and being carried out by Griesbach & Associates. The overall study will attempt to answer four questions:
1. What do these services look like — in Scotland and elsewhere?
 2. What is considered to be good practice in providing for the needs of drunk and incapable people in Scotland and elsewhere?
 3. What need is there for services for drunk and incapable people in Scotland?
 4. What are the best options for providing such services?
- 1.2 This report partly addresses the first two of these questions. The aims of this review were:
- To identify services that exist in other countries (outside of Scotland) to manage the needs of drunk and incapable people and
 - To identify good practice in providing these services.
- 1.3 It should be noted that no literature was identified concerning services in Scotland. However, information about current services in Scotland is being collected as part of the larger research study, and was included in the final report of the study.
- 1.4 The main focus of this report is on “sobering-up services” – services which provide an overnight place of safety for people who are identified as intoxicated (either with alcohol or drugs) in a public place, and who are incapable of looking after themselves because of their intoxication. In Scotland, these types of services are often referred to as “designated places”. (In this report, the term “sobering-up services” will be used in preference to the term “designated places” as it more clearly describes the purpose of these services.)
- 1.5 So-called “designated places” were introduced in Scotland under section 5 of the Criminal Justice (Scotland) Act 1980. This legislation was part of a wider policy that decriminalised public drunkenness, following a growing awareness of a futile cycle of individuals being arrested for public intoxication, tried, fined and then sent to prison for non-payment of fines. The legislation provided for “designated places” where the police could take intoxicated people to sober up – thus diverting them from police custody.
- 1.6 In practice, the police are *still* charging people with the offence of being drunk and incapable under section 50(1) of the Civic Government (Scotland) Act 1982. This allows the police to arrest drunk and incapable people if they do not have a responsible person to take care of them.

- 1.7 Recent concerns about deaths in police custody have further highlighted the need for, and possible benefits of, a network of sobering-up services, where an individual's care needs can be closely monitored by appropriately-trained staff.
- 1.8 Although the main focus of this report will be on sobering-up services, the review also considers information about other types of interventions that are intended to meet the immediate care needs of people who drunk and incapable -- including free transportation services and the provision of medical care within police custody suites (eg, through custody nurses).

Other review evidence

- 1.9 A review of the literature on the subject of sobering-up services was undertaken for the Scottish Association of Alcohol Action Teams (SAAAT) by Macdonald towards the end of 2004.¹ This previous review found little literature which specifically evaluated sobering-up services, although it did identify sufficient material to be able to provide a general description of these services.
- 1.10 The review by Macdonald highlighted a number of issues which need to be taken into account when setting up a sobering-up service. These included:
- Potential location and opening hours of the facility
 - The need for community and stakeholder support
 - Target population and admission criteria
 - Staff qualifications and management arrangements
 - The way in which the service links to other services (either through receiving referrals, or making referrals)
 - Policies and procedures related to the operation of the service – especially in relation to client monitoring
 - The source(s) of funding.
- 1.11 This current review was initially intended as a simple update to the SAAAT review, with a focus on the literature from 2004-2008. However, in undertaking a search of the literature, a substantial number of new evaluations and other relevant reports were identified. Therefore, this report includes considerable detail about the operation of these services which would not have been available for the SAAAT review, and there is a greater focus on some of the lessons that can be learned from the implementation of sobering-up services around the world.

¹ Macdonald R (2005), Care approaches to drunk and incapable people. Designated places, drunk tanks and sobering facilities across the world. A literature review. Prepared for the Scottish Association of Alcohol Action Teams (SAAAT), January.

Methodology

- 1.12 This was a review of the international, English-language literature on the provision of sobering-up services and other similar services. The main focus was on services that aim to meet the immediate (rather than long-term) care needs of people who are identified as drunk and incapable, *and* which divert these individuals from the criminal justice system. Since there was very little literature identified on this subject, the review was expanded to include literature on the provision of medical care within police custody suites. The focus has mainly been on nurse custody schemes, but evidence was also identified on the role of forensic medical examiners in meeting the needs of alcohol-related detainees. It is important to note, however, that the provision of medical care to drunk and incapable people in police custody does *not* result in the diversion of these individuals from police custody.
- 1.13 Bibliographic databases including EMBASE, MEDLINE, PsycINFO were searched using the following search terms, among others:
- Sobering(-up) services / facilities / centres
 - Drunk tanks
 - Detoxification centres
 - Nurse + custody
 - Drunk and incapable
 - Inebriate / chronic public inebriate
- 1.14 Initially the intention was to include only literature published between 2004-2008 (to update the Macdonald review). However, when an initial search identified almost no literature in this period, the date limits were removed, and every effort was made to identify as many published papers as possible by changing search terms and searching on different combinations of search terms.
- 1.15 In addition, an internet search (using Google) was also undertaken using the same, or similar search terms. This resulted in a greater number of 'hits,' including recent evaluations and audits of sobering-up services and other types of services for drunk and incapable people. Moreover, several government reports were identified (particularly from Australia) which – while not directly related to the subject of services for drunk and incapable people – nevertheless provided detailed information about these services that was highly relevant for the purposes of this review.
- 1.16 The collected material was a combination of published journal articles, government reports, unpublished research reports, news articles and descriptions of services taken from local government or local health authority websites from around the world.
- 1.17 Most of the literature concerns the subject of sobering-up services, and the best of this literature comes from Australia. Fewer reports were identified from North America (USA and Canada), and the quality of this material was

generally poorer. The difficulty in identifying relevant literature from North America may be partly due to the names given to these services in the US and Canada. There, sobering-up facilities are often referred to as “detoxification centres” (among other things), and it would appear that some North American sobering centres are located *within* detoxification services that provide longer-term treatment for problem drug or alcohol use. However, a search of the literature for “detoxification centre” identified hundreds of articles, the vast majority of which had nothing whatsoever to do with sobering-up services.

- 1.18 Because of the differences in the quality of the literature, this report has been structured to present the data on a geographical basis, with the data from Australia presented first. Each chapter will begin with a brief description of the literature used to inform the findings in that chapter, and then will go on to present the findings themselves. The findings have been presented in a way which addresses the main issues identified by the Macdonald review undertaken in 2004.

Structure of this report

- 1.19 **Chapter 2** provides an in-depth description of sobering-up services in Australia and considers some of the outcomes of those services. This information is taken largely from published research studies, government reports and evaluations.
- 1.20 **Chapter 3** provides a description of sobering-up services in North America. The North American literature was less robust.
- 1.21 **Chapter 4** provides details of other interventions that have been used around the world to meet the immediate care needs of drunk and incapable people. These include transportation services, night patrols and the provision of medical care to detainees in police custody.
- 1.22 Finally, **Chapter 5** identifies what Scotland can learn about the provision of services for drunk and incapable people in other parts of the world, and what further issues need to be addressed in order to meet the needs of this population.

2 SOBERING-UP SERVICES IN AUSTRALIA

Introduction and description of the evidence

2.1 There was a great deal of robust information available from the literature on the provision of sobering-up services in Australia, and this literature included in-depth evaluations, government reports and other formal research studies. In addition, a formal system of monitoring and annual reporting on the use of sobering-up centres has been established in one state (Western Australia) and annual statistical reports are available. The findings presented in this chapter are taken from the following sources:

- An in-depth evaluation of an 18-month pilot of a sobering-up shelter in Canberra (Australian Capital Territory) (Allen-Kelly & McArthur, 2005 and Allen-Kelly *et al*, 2006)
- An inquiry into public drunkenness carried out by the Drugs and Crime Prevention Committee of the Parliament of Victoria. This substantial report includes an appendix (Part D) which presents a detailed discussion and case studies of sobering-up services in New South Wales and the Northern Territory (Parliament of Victoria, 2000)
- An analysis of statistics from Victoria Police on indigenous people arrested for public drunkenness (Gardiner & Mackay, 1998)
- A retrospective case study of a rural sobering-up centre in South Australia for the years 1991 – 2000 (Brady *et al*, 2006)
- A government statistical report from Western Australia presenting data on the utilisation of sobering-up centres in that state in the period 1990-2005 (Government of Western Australia, 2007)
- A Policy Directive from New South Wales Department of Health regarding the *Intoxicated Persons Amendment Act 2000 and Proclaimed Places: Protocol* (New South Wales Department of Health, 2005)
- An evaluation of a community-based intervention to reduce harm during the annual school leavers' celebrations on Rottneest Island (Queensland) (Midford *et al*, 2001)
- A review of evidence on the effectiveness of interventions to prevent substance use, risk and harm in Australia (Loxley *et al*, 2004)
- A review of alcohol, tobacco and other drug services in Tasmania (Healthcare Management Advisors Pty Ltd, 2008)
- The findings and recommendations of the Royal Commission on Aboriginal Deaths in Custody (1991)

Background

2.2 Australia has a well-established system of sobering-up services. These began to be developed in the 1980s partly as a result of the decriminalisation of public drunkenness, which took place at different times in different states, and

which led to the creation of “proclaimed places” – the equivalent of “designated places” in Scotland. There was further expansion in the number of services following publication of the findings of the Royal Commission into Aboriginal Deaths in Custody.²

2.3 The Royal Commission was set up to investigate the disproportionate number of deaths in custody of Aboriginal and Torres Strait Islander peoples. The Commission found that many of these deaths were associated with arrests for public drunkenness. The Commission made a number of wide-ranging recommendations including that:

- *In jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness (Recommendation 79)*
- *The abolition of the offence of drunkenness should be accompanied by adequately-funded programmes to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons (Recommendation 80)*
- *Legislation decriminalising public 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 (Recommendation 81).*

2.4 In general, sobering-up services in Australia have the aim of harm reduction. A review of the international literature commissioned by the National Drug Research Institute and the Centre for Adolescent Health in Australia defined a sobering-up shelter as “a temporary haven for, and supervision of, intoxicated people at risk of causing harm to themselves or others”. The additional aim of these services (particularly in light of the findings of the Royal Commission) is to divert intoxicated people from police custody.³ It should be noted that most sobering-up services in Australia accept people who are intoxicated with either alcohol or drugs.⁴

2.5 Sobering-up facilities in Australia are not detoxification services, nor do they provide long-term rehabilitation, although many are linked to treatment services in their areas. Their role is to provide an alternative to police custody, to reduce alcohol- or drug-related harm and to offer shelter, food and protection in a safe environment for a limited time. They also provide opportunities for brief interventions by drug and alcohol workers and referrals for further assistance in a manner which is respectful and humane.⁵

² Royal Commission into Aboriginal Deaths in Custody, 1991.

³ Loxley *et al*, 2004.

⁴ A comment was made in one report that the term “sobering-up centre” suggests that these facilities deal only with people intoxicated with alcohol.

⁵ Brady *et al*, 2006.

Similarities and differences between sobering-up services in Australia

- 2.6 Sobering-up services have developed in different ways in different parts of Australia, and even within states, there is considerable variation between services in relation to opening hours, client population, admission criteria and service management.
- 2.7 The common features shared by many (though not all) services include:
- Police (or community-based night patrols) deliver clients to the centre
 - Clients are showered
 - Clients belongings are removed and recorded (often for their own protection)
 - Clothing is laundered
 - Client is rehydrated with a cordial or other non-alcoholic drink
 - Client is left to 'sleep it off'
 - Client is observed at regular intervals by staff trained in first aid and in the identification of withdrawal symptoms
 - Client may be given a Vitamin B tablet
 - Where appropriate, the client is referred to treatment services
 - Clients are free to leave at any time and may not be detained against their will.
- 2.8 However, even among these shared features, there were differences between services. For example, one service in Alice Springs (Northern Territory) believed firmly that all clients must be required to shower upon their arrival at the service, whereas a service in Tennant Creek (also in the Northern Territory) was philosophically opposed to such a requirement being mandatory.⁶
- 2.9 There are many other differences between services. For example:
- Hours of operation vary
 - Some are affiliated to, or co-located with, detoxification and / or residential treatment facilities
 - Some are staffed predominantly by Aboriginal people
 - Some work alongside a night patrol or other form of transport service
 - Some accept self-referrals
 - Some take young people and some do not
 - Some offer clients a small meal in the morning before discharge

⁶ Parliament of Victoria, 2000.

- Some have security rooms, in which it is possible to place aggressive persons
- Services are operated by a variety of agencies in the public and voluntary sector. Public sector providers may include the local health authority, and voluntary sector providers can include church or other religious organisations such as the Salvation Army
- Funding comes from a variety of sources, including state and regional health budgets, the national government's Supported Accommodation Assistance Program, and state governmental bodies. (The Drug and Alcohol Office in Western Australia is an example of the latter.)

2.10 There was no information available in the Australian literature about whether people are charged for the use of sobering-up services. However, the likelihood is that they are not.

2.11 Many of these variations appear to have developed directly in response to local needs. In addition, according to one report, each centre is run to a large extent according to the philosophical, religious or cultural beliefs of the organisation that manages it.⁷

Prior to setting up a service

2.12 In setting up a sobering-up service, a number of factors were reported to play an important part in the subsequent success of the facility. The most significant of these is that key stakeholders (including the police, local health authorities, service providers and the local community) need to be involved in the planning and decision-making process involved in setting up a service. A pilot sobering-up service in Canberra found that they had few referrals until they actively engaged with the local police over concerns the police had about safety and security procedures within the shelter.⁸

Opening hours

2.13 Opening hours among Australian sobering-up facilities range from a couple of nights a week for a couple of hours each night, to full 24/7 provision. In Western Australia, 13 of the state's 14 sobering-up services operate five nights per week, while the facility in the capital city of Perth operates seven nights per week.⁹ A service in Ceduna (South Australia) operates 24 hours a day, six days a week -- from Tuesday to Sunday.¹⁰

2.14 A pilot sobering-up shelter in Canberra is open three nights per week (Thursday, Friday and Saturday) from 11pm to 11am. In this service, clients are admitted between 11pm and 6am. The remaining time (between 6am – 11am) is needed to allow clients to sober-up, have a light breakfast and

⁷ Parliament of Victoria, 2000.

⁸ Allen-Kelly *et al*, 2006.

⁹ Government of Western Australia, 2007.

¹⁰ Brady *et al*, 2005.

complete exit procedures before the shelter closes.¹¹ It is worth noting that the evaluation of this pilot service found that the limited opening times acted as a barrier to potential referrals from other agencies in the area.

- 2.15 One report made the point that when these services are closed, there is no alternative but to place people who are drunk and incapable in police cells.¹²
- 2.16 There are also examples where sobering-up services have been provided on a temporary basis for specific events or occasions. These have included:
- A limited sobering-up service in Scarborough (Western Australia), which has been provided since 2001 as part of New Year's Eve celebrations.¹³
 - A "Chill out Tent" provided to young people on Rottnest Island during "Schoolies' Week", the annual week-long school-leavers' celebrations.¹⁴

Staffing

- 2.17 There was little information in the literature about the staffing of sobering-up services in Australia, although it would seem that some services are staffed predominantly by Aboriginal and Torres Strait Islanders.¹⁵ However, one report – the evaluation of the pilot sobering-up shelter in Canberra – provided detailed information about the staffing for that service.
- 2.18 The shelter in Canberra has five beds and employs six members of staff (four of whom are employed as casual staff) on a part-time basis. Staff work on a rota system with only three people on each night. Two members of staff work from 11pm to 11am and the third person works from 11pm to 7am. A coordinator and manager (each with responsibilities for other programmes) are responsible for the management of the shelter.
- 2.19 The staff of the Canberra service had a multidisciplinary background and have experience and / or training in drug and alcohol work, mental health, homelessness, crisis intervention, counselling, risk assessment and care management. All members of staff also had qualifications in first-aid, and two were qualified registered nurses. In addition, as part of their work in the shelter, staff undertook further training in motivational interviewing, conducting (pat) searches, mandatory reporting, drugs and alcohol awareness, mental health awareness, suicide intervention and personal safety. The staff also visited other shelters in Australia to learn more about the methods used elsewhere in working with intoxicated people.¹⁶
- 2.20 While the staff of the Canberra service appeared to be very highly trained, those employed in other sobering-up facilities may be less so. For example, an independent review of alcohol, tobacco and other drug services in

¹¹ Allen-Kelly *et al*, 2006.

¹² Parliament of Victoria, 2000.

¹³ Government of Western Australia, 2007.

¹⁴ Midford *et al*, 2001.

¹⁵ Parliament of Victoria, 2000.

¹⁶ Allen-Kelly *et al*, 2006.

Tasmania identified a specific need for alcohol and drug training for staff in sobering-up services in that state.¹⁷

- 2.21 Other staff qualities are likely to be important in providing a sobering-up service too. For example, one report, citing the manager of a service in Alice Springs, indicated that a caring environment with non-threatening and non-judgemental staff was one of the keys to success in a sobering-up centre.¹⁸
- 2.22 It is perhaps worth mentioning that gender was mentioned as an issue in the staffing of sobering-up shelters in Australia. Because of the requirement to provide intimate personal care to clients who are intoxicated and vulnerable, it was seen to be important to provide both male and female staff where a shelter accepted both male and female clients.¹⁹

Referring agencies

- 2.23 Clients are generally brought to the service by the police, or by community-based night patrols (described further in Chapter 4). In some areas, the police will contact the night patrol and ask them to collect an intoxicated person from the police station.²⁰ Some facilities also received referrals from hospital Emergency Departments (as a place to discharge intoxicated people following treatment when they had no where else to go), and some accepted self-referrals.²¹
- 2.24 An evaluation of a rural sobering-up service over a 10-year period found that 62% of the shelter's referrals in that period were made by staff of the local hospital (which was located next to the shelter) or staff of the shelter itself. Only 25% of referrals came from the police, and 9% came from the local night patrol service.²² In the Canberra service, the majority of referrals overall came from the police and very few came from the hospital.²³

Admission criteria

- 2.25 The admission criteria for sobering-up services in Australia appears to vary. For example, to be admitted as a client of the Canberra sobering-up shelter, an individual must be:
- 18 years of age or over
 - Referred from within the Australian Capital Territory
 - Incapable of protecting him / herself from physical harm

¹⁷ Healthcare Management Advisors Pty Ltd, 2008.

¹⁸ Parliament of Victoria, 2000.

¹⁹ Allen-Kelly and McArthur, 2005.

²⁰ Parliament of Victoria, 2000.

²¹ The point was made in the literature that not all shelters will accept self-referrals. It is not clear how individuals who are severely intoxicated arrive at the shelter, although it is possible that some are brought there by members of the public.

²² Brady *et al*, 2006.

²³ Allen-Kelly *et al*, 2006.

- Intoxicated with drugs or alcohol
- Willing to enter the sobering-up shelter
- Conscious
- Able to walk unassisted
- Not displaying violent behaviour.²⁴

2.26 However, other services have different criteria. For example, some shelters do not admit young people below the age of 18, while others (for example, the shelters in Western Australia) have admitted children younger than 15 (although the numbers have been very small).²⁵ In addition, there appear to be a number of shelters that *only* accept indigenous Australians (Aboriginal and Torres Strait Islander people), or *only* women, or *only* young people.²⁶

2.27 In the evaluation of the Canberra service, the police suggested that the requirement that clients are “able to walk unassisted” was a barrier to use of the service, since “there are very many people who are intoxicated and incapable of protecting themselves from harm who need support to walk”.²⁷ And indeed, over a third of admissions to a shelter in Ceduna in a ten-year period were of people who presented as “unbalanced” or “very unbalanced”, and who needed assistance with activities such as showering or going to bed.²⁸ It may be worth mentioning that 20% of the 10-year admissions to this same shelter in South Australia were of people who presented as reasonably normal and steady on their feet with good co-ordination and clear speech.

Service procedures

Admission and exit procedures

2.28 The evaluation of the Canberra sobering-up service provided the only detailed description in the literature about the procedures used to manage the care of clients in sobering-up shelters. Box 1 below contains an extract from the Canberra evaluation report, describing the facility’s admission and exit procedures. These include phoning for an ambulance if a person requires medical attention.

2.29 It should be noted that in Australia, admission to all sobering-up shelters is entirely voluntary. Clients may leave at any time. In addition, one of the tasks of the shelter may be to attempt to contact a responsible person to come to the shelter to collect the intoxicated client. However, if a client is unwilling to stay in the shelter, but is assessed as being at risk of harm when he or she leaves, the police will be called and the individual will be taken to police cells.²⁹

²⁴ Allen-Kelly *et al*, 2006.

²⁵ Government of Western Australia, 2007.

²⁶ Government of Western Australia, 2007.

²⁷ Allen-Kelly *et al*, 2006, p. 53.

²⁸ Brady *et al*, 2006.

²⁹ Allen-Kelly *et al*, 2006.

Box 1: Admission and exit procedures for the Centacare Sobering-up Shelter, Canberra

Admission procedures

When a person enters the shelter, either with a police officer or on their own, the Shelter staff assume duty of care for that person and begin to monitor and assess their condition and overall wellbeing. The service is based on voluntary admission, that is, the client is free to leave at any time. However, if they are assessed to be at risk when they leave, the staff are required to notify the police.

When people arrive with the police, the police officer provides Shelter staff with an admission statement which indicates what they know about the person's name, date of birth, what time and date the person was detained by the police, a list of items which the police officer took from the person and confirmation that these articles have been returned.

The client is assessed which includes an assessment of eligibility, an assessment of their drug / alcohol use, medical conditions and current condition. The Glasgow Coma Scale³⁰ and often a breathalyser are used to assess the client's level of intoxication on entry and exit and to assess their level of risk to self or others. If first-aid is required, it is provided and if medical attention is needed, an ambulance is called.

The staff explain the procedures of the Shelter. Clients are given the opportunity to contact a responsible person, who may collect them. The procedures include recording and securing of property. Clients receive clean Shelter clothing, they are able to shower and there is a pat search procedure for safety purposes, to detect items which may cause injury to self or others. Shelter staff may launder clients' clothing overnight if required.

Carers offer a drink (usually water at night), and clients receive a clean bed and bedding. Carers monitor safety during the night ... and provide personal care, which can involve cleaning the clients and the bedding after episodes of vomiting or incontinence.

If an individual is not eligible, or not willing to stay, staff work to ensure a safe outcome for that person. A client is free to leave at any time. However, if the person is assessed as high risk and not willing to stay, the police are called.

In the morning

In the morning, staff offer clients a light breakfast and a shower. This is the period of time when the staff work with each client to establish what other needs they may have and how the Shelter can best assist them with information or connection with other services. Where possible, referral arrangements are made during this time. Clients' blood alcohol may be tested for purposes of establishing safe activities.... Staff return clothes and property, update records and offer the client satisfaction survey. Staff arrange safe transport for clients to their destination, which is predominantly provided at client cost.

Taken from Allen-Kelly K, McArthur M and Thomson L (2006) *Evaluation of Centacare sobering up shelter*. Australian Catholic University, www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1165472226&sid=

³⁰ The Glasgow Coma Scale provides an objective and reliable measure of the conscious state of a person.

- 2.30 The evaluation of the Canberra shelter found that in an 18-month period, a small proportion of the individuals who arrived at the shelter were either ineligible, or unwilling, to stay there. If the client was ineligible to stay (for example, because they were not intoxicated), the shelter attempted to provide them with other assistance to ensure a safe outcome for those individuals.
- 2.31 The evaluation of the Canberra shelter highlighted that one of the initial problems in the implementation of the service related to a question of transport to and from the shelter. This was resolved when the local health authority agreed to fund taxi fares to the shelter, by the use of a system that allowed the fares to be billed directly to the health authority. Following discharge, if the client had no means of transport and could not afford a taxi, the Shelter paid the fare and billed the health authority.³¹

Safety and security procedures

- 2.32 Since one of the main aims of a sobering-up shelter is to provide a place of safety for vulnerable people, safety procedures are clearly important.
- 2.33 The evaluation of the Canberra sobering-up service included a brief background history to the establishment of the service in December 2004. According to the report, a service had previously operated in Canberra from 1994-1996; however this service was closed following the death of a client by overdose.
- 2.34 When the new service was set up, the building was extensively modified to comply with safety and suicide prevention standards. In addition, cameras and a video surveillance system were installed throughout the shelter (apart from the sleeping areas and bathrooms), and these were monitored in the staff area. During the night, clients were checked at regular intervals in compliance with the state's *Care and Protection of Intoxicated Persons Standard 2004*. Standard 7.2 requires that:

A licensee or the manager of a licensed place shall ensure that the following requirements relating to the care of a client are complied with:

(a) where the client is awake, the breathing and level of consciousness of the client are observed at least every 15 minutes, for a minimum of 4 hours, following admission to a licensed place. Thereafter, the client will be observed every 30 minutes;

(b) where the client is asleep, the breathing of the client is observed, the level of consciousness and intoxication are assessed, and the extent to which the client is able to respond is checked, at least every 15 minutes, for a minimum of 4 hours, following admission to a licensed place. Thereafter, the client will be observed every 30 minutes.³²

³¹ Allen-Kelly and McDonald, 2005.

³² Australian Capital Territory, *Care and Protection of Intoxicated Persons Standard 2004*. See: <http://www.legislation.act.gov.au/di/2004-177/current/pdf/2004-177.pdf>. The *Standard* also sets out requirements in relation to record-keeping and staff training and qualifications.

2.35 The shelter also maintained an incident register. The Australian Capital Territory's *Care and Protection of Intoxicated Persons Standard 2004* provided the basis for the Canberra's shelter's security and safety policies and procedures. Similar standards may exist in other Australian states. This is inferred because a review of alcohol, tobacco and drug services in Tasmania highlighted concerns about client safety in the three sobering-up services in that state. The point was made that clients either had no monitoring during their stay in the shelter, or monitoring was provided via closed circuit television by staff who had many other duties to perform, and therefore were not always able to watch the screen.³³ The Tasmanian review also raised concerns about the lack of nursing or other clinical training among staff, the lack of drug and alcohol training and the lack of linkages to specialist medical input.

Violent or aggressive clients

2.36 In general, in Australia, if an intoxicated individual has committed a crime (for example, an assault), they are charged with a criminal offence and taken into police custody. In addition, if in the view of the police or the sobering-up centre staff, an individual is seen as *potentially* violent or aggressive, they are not seen as appropriate for admission to a sobering-up shelter. These individuals are instead held in police cells.

2.37 However, there are clearly exceptions. One report makes the point that diversion from custody into a sobering-up facility does not mean that charges will not be laid against an individual.³⁴ In addition, there were some examples in the literature where a sobering-up shelter had a "security room" in which to place dangerous or aggressive persons. The Albion Street Shelter in New South Wales was one such facility. However, the point was made that the staff at this shelter were not necessarily happy about this situation and had actively lobbied not to have to receive violent and dangerous persons.³⁵

Client profile

Gender

2.38 There is generally a higher proportion of males than females using sobering-up services in Australia. However, the ratio of males to females varies widely from one facility to another. For example, in Western Australia, in the 15-year period from 1990 - 2005, 68.3% of all admissions to the state's 14 sobering-up centres were males and 31.7% were females. These proportions varied from 79.7% male (20.3% female) in the city of Perth to 57.8% male (42.1% female) in the Goldfields & South East Coastal region.

2.39 One of Western Australia's sobering-up services provides services to women only, and during the period 2003 – 2005 (in which this service operated), this shelter received 1,637 admissions. However, in the Australian Capital

³³ Healthcare Management Advisors Pty Ltd, 2008.

³⁴ Gardiner & Mackay, 1998.

³⁵ Parliament of Victoria, 2000.

Territory, severely intoxicated women are often taken to women's refuges, rather than the sobering-up shelter.³⁶

Age

- 2.40 As with gender, the age structure of sobering-up centre clients varies widely from one centre to another. For example, the majority of clients attending the Wiluna shelter were males aged 20-24, while in Roebourne, most admissions were males aged 40-59.
- 2.41 In the 18-month period of its operation, the sobering-up shelter in Canberra reported admissions ranging from 18–75 years and over-70s comprised 8% of admissions in the Midland shelter (in Western Australia).³⁷
- 2.42 There are also a small number of shelters provided exclusively for young people, and in 2004 / 2005, a network of places of safety was set up in Queensland on a trial basis for young people using volatile substances.³⁸

Nature of alcohol use

- 2.43 The Australian literature suggests that sobering-up centres are largely used by people with chronic alcohol problems. Many of these individuals are also homeless. Thus, the services can be used frequently by the same people again and again. There do not appear to be any restrictions against this.
- 2.44 An evaluation of one facility in a rural part of South Australia found that, in the ten-year period between 1991 and 2000, the service had a total of 6,486 admissions. The vast majority of individuals who used the service were admitted on more than one occasion. In fact, one male had been re-admitted 423 times. This individual was one of three people who accounted for 16.9% of all admissions in that period.³⁹ Another service in the Northern Territory had 6,312 admissions in one year. Of these, 120 individuals had been in the shelter more than 20 times during that year.⁴⁰
- 2.45 Sobering-up services are also used by people as a one-off – or at least very infrequently. The evaluation of the rural facility in South Australia, mentioned above, found that, in a ten-year period, just over a quarter of admissions (27%) represented individuals who utilised the service on fewer than ten occasions.⁴¹ However, the evidence from Australia suggests that 'binge drinkers' have comprised a small minority of clients. One of the reasons for this may be that this group of drinkers may be more likely to have a network or friends and family who can be called upon to look after them.⁴²
- 2.46 One Australian evaluation found that there were significantly more monthly admissions in the warmer and drier months of the year, than during the cooler

³⁶ Allen-Kelly *et al*, 2006.

³⁷ Allen-Kelly *et al*, 2006; Government of Western Australia, 2007.

³⁸ Allen-Kelly & McDonald, 2005.

³⁹ Brady *et al*, 2006.

⁴⁰ Parliament of Victoria, 2000.

⁴¹ Allen Kelly *et al*, 2006; Brady *et al*, 2006.

⁴² Parliament of Victoria, 2000.

and wetter months. One of the reasons for this may be that people are more likely to drink indoors during the cooler, wetter months, and so do not come to the attention of the police or the community night patrols.

Housing status

2.47 Following on from the point above, it is worth noting that sobering-up shelters in Australia may be used by people who are *not* homeless, as well as those who are. However, the use of the service by chronically intoxicated homeless people can lead to multiple admissions. In recent years, a number of states in Australia have begun to address the problem of homelessness among sobering-up centre clients, and these efforts are described in further detail below.

Ethnicity

2.48 The majority of people who use sobering-up services in Australia are Aboriginal or Torres Strait Islander people rather than non-indigenous Australians. The exception is in the Australian Capital Territory, where an evaluation of the sobering-up shelter in Canberra found that only 6.5% of the clients of the service between December 2004 and 30 June 2006 were indigenous Australians. This roughly reflects the size of the indigenous population in the Australian Capital Territory overall.⁴³

2.49 However, in other states of Australia, the proportion of indigenous people using sobering-up shelters is substantially higher than the proportion of indigenous people in the general population. In some cases, between 95-100% of admissions are of Aboriginal people, although there appears to be a marked urban-rural variation in these proportions, with a larger proportion of non-indigenous people using services in metropolitan areas.⁴⁴

2.50 In the states of Queensland and Victoria, where public drunkenness has not been decriminalised, sobering-up services have been established for indigenous peoples *only* (following the recommendations of the Royal Commission on Aboriginal Deaths in Custody), and the staff in these services are primarily indigenous Australians.⁴⁵ However, an Inquiry into Public Drunkenness carried out by the Parliament of Victoria found that many people were critical of the fact that sobering-up services were *not* available to non-indigenous Australians in that state.⁴⁶

Brief interventions within sobering-up services

2.51 As mentioned above, sobering-up services are not generally intended to give people long-term support, although, as will be seen below, some states have begun to integrate sobering-up services with services for homeless people.

⁴³ Allen-Kelly *et al*, 2006.

⁴⁴ Brady *et al*, 2006; Government of Western Australia, 2007.

⁴⁵ Allen-Kelly 2005; Parliament of Victoria, 2000.

⁴⁶ Parliament of Victoria, 2000.

- 2.52 Sobering-up services are mainly used to deliver brief interventions. Details of how this can work in practice were provided in an evaluation of the pilot sobering-up service in Canberra. Staff in the service provided information to clients about the effects of binge drinking, and about housing and drug and alcohol services in the area, and can provide direct referral to those services if appropriate. They also frequently supply information to families and friends, or another “responsible person” who collects the client from the shelter:

Staff report that a big part of their work ... is assisting clients in the morning to understand what happened to them the night before, how they came to be in the shelter, and what implications this has for their lives. This [form of intervention] was supported by interviews with clients who reported that this was very helpful. From interviews with staff and clients, it appears that many of the younger people who have come to the shelter... are shocked to find themselves there, and have expressed shock when they realised the extent of intoxication they suffered the night before and their subsequent vulnerability.

Staff provide education on what causes blackouts and offer alternative behaviours to avoid that extent of intoxication in the future. They may also provide advice to the person on safety when they leave the shelter, for example, their blood alcohol may still be at too high a level to drive or to go to work, depending on their work. These brief interventions can be framed as both harm reduction and harm prevention work.⁴⁷

Links to other services

Homeless services

- 2.53 Although sobering-up shelters in Australia were initially conceived as harm reduction interventions, a number of reports expressed dissatisfaction with what had, over the years, become a ‘band-aid’ — or ‘revolving door’ — approach to harm reduction. Many of the shelters were being used night after night by the same chronically intoxicated homeless people whose real needs could not be met within the context of a sobering-up shelter:

So what is happening is that people were coming in drunk, they received an 8-hour sobering up service, and left the next day. Now a lot of these people were chronic drug-affected or alcohol-affected people, anyhow, but the reality is they had to actually get drunk again to get back in ... it was almost perpetuating their addictions.⁴⁸

- 2.54 Several Australian state governments have taken steps to address the problem by integrating sobering-up services with homeless services (and drug and alcohol services). However, the extent to which this process has happened seems to have varied from one state to another, and it is perhaps worth noting that when a decision was taken in 2001 by the Health Department of the Australian Capital Territory to re-establish a sobering-up shelter in

⁴⁷ Allen-Kelly *et al*, 2006.

⁴⁸ Parliament of Victoria, 2000.

Canberra (following the closure of the previous service in 1996), their original plan was to locate sobering-up beds within one or more existing crisis services. However, their call for tenders to provide this add-on service attracted no responses. The Canberra service was later established in 2004 as a stand-alone facility near the city centre.⁴⁹

2.55 The examples given in Box 2 below illustrate some of the models that have been used to better integrate sobering-up services with services for homeless people in Australia.

Box 2: Examples of integration of sobering-up services and homeless services in Australia

New South Wales

In the state of New South Wales, regular monitoring of admissions to sobering-up services found that the vast majority of clients of sobering-up services were homeless. This led to changes in state legislation regarding the provision of “proclaimed places” (equivalent to “designated places” in Scotland) for intoxicated persons. As part of these changes, a protocol was agreed between the Department of Community Services (responsible for managing funding for homeless services), the police and health services, and this spelled out in detail what each of these agencies would undertake to do in responding to the needs of intoxicated homeless people. The result was that “Proclaimed Places” were abolished and were replaced with Intoxicated Persons’ Units within homelessness services. This represented “a change in focus from the provision of a sobering-up service to a case management approach that attempts to address the underlying causes of both clients’ homelessness and addictions”.⁵⁰

Tasmania

In Tasmania, the sobering-up service in the city of Launceston is located within a larger crisis accommodation service, with two beds allocated for that purpose. If the police bring someone to the shelter who is intoxicated, the beds must be used for sobering-up, but if they are not needed, they may be used for crisis accommodation instead.⁵¹ It is not clear from the information provided how this arrangement works in practise, although one report suggested that a similar arrangement in New South Wales (prior to the introduction of the legislative changes described above) did not work very well, and resulted in homeless people being turned away in order that beds could be held open for people who were intoxicated.⁵²

Western Australia

In Port Hedland, individuals who attend the sobering-up centre on a regular basis are provided with intensive support and practical assistance by outreach workers employed by a homeless support service.⁵³ This particular service was cited as an example of best practice in relation to responding to the needs of the homeless Aboriginal population in the Port Hedland area.

(continued on the next page)

⁴⁹ Allen-Kelly *et al*, 2006.

⁵⁰ New South Wales Department of Health, 2005. It is not clear from the information provided what happens in New South Wales when an individual is identified as drunk and incapable, but is *not* homeless, although given the relatively small numbers of people involved, it seems likely that they are accommodated in the same facilities with those who are homeless.

⁵¹ Allen-Kelly & McArthur, 2005.

⁵² Parliament of Victoria, 2000.

⁵³ Memmott P *et al*, 2003.

⁵⁴ Parliament of Victoria, 2000.

Victoria

The Wintringham Centre for the Elderly and Homeless aims to provide comfortable and dignified accommodation and social services to Melbourne's homeless elderly in cheerful and friendly surroundings. Rather than prohibit alcohol on the premises, Wintringham allows it to be consumed even by people who may be classified as 'habitual drunks.' At the same time, they will try to provide or arrange treatment and other social services for those clients who wish to take advantage of them.⁵⁴

Substance misuse treatment services

- 2.56 As mentioned above, sobering-up services accept people who are intoxicated by alcohol or drugs. In establishing these services, there was an expectation that they would provide onward referral to detoxification and / or rehabilitation for individuals for whom that was seen as appropriate. However, the literature suggests that referrals are not routinely made, and that links between drug and alcohol services can be poor in some areas.⁵⁵
- 2.57 However, this seems to vary from one state to another, and even from one shelter to another. For example, the Darwin sobering-up service (Northern Territory) was relocated to be in the same building as the city's detox unit, and as mentioned above, services in New South Wales have been reconfigured to provide more integrated care to homeless people who have alcohol and drug problems.⁵⁶

Rural issues

- 2.58 Sobering-up shelters are as likely to be in rural areas as urban areas in Australia. For example, in Western Australia, 11 of the state's 14 sobering-up centres are in rural areas.
- 2.59 However, an inquiry into public drunkenness published by the Drugs and Crime Prevention Committee of the Parliament of Victoria noted that "it is much more difficult to deal with intoxicated people in rural areas than in Melbourne or other large cities and towns" — largely because of the lack of availability of services in rural areas. As a result, the police in rural and remote areas often have no choice but to hold intoxicated people in police cells.⁵⁷
- 2.60 The provision of free transportation services in conjunction with sobering-up centres may be particularly important in rural areas. The evaluation of a rural service in South Australia showed that the facility worked together with a mobile assistance patrol. This was a community pick-up bus service operated by a voluntary sector agency with a remit for improving aboriginal health. However, the service was available to both Aboriginal and non-Aboriginal people.⁵⁸

⁵⁵ Healthcare Management Advisors Pty Ltd, 2008; Brady *et al*, 2006.

⁵⁶ Parliament of Victoria, 2000.

⁵⁷ Parliament of Victoria, 2000.

⁵⁸ Brady *et al*, 2006.

Outcomes

- 2.61 This chapter has mainly focused on providing a detailed description of how sobering-up services in Australia operate. However, in some cases, this information has been gathered from reports of formal evaluations which have also sought to measure service outcomes. This final section will discuss some of the outcomes that have been identified in these evaluations. It will also present evidence gathered about service users' views of these services.
- 2.62 In considering the outcomes of sobering-up services, it is important to bear in mind that the two main aims of these services are:
- To give people a safe place to sober up from the effects of alcohol or drugs
 - To divert people from police custody
- 2.63 Based on these aims, the evidence from Australia indicates that sobering-up services are largely effective.

Client safety

- 2.64 The evaluation of the pilot sobering-up shelter in Canberra found evidence that the people accessing the service were receiving physical and emotional care, support and brief interventions that were tailored to their individual circumstances. Where appropriate, clients also received referral to other services. The service had no critical incidents in an 18-month period.⁵⁹
- 2.65 It is not known to what extent the Canberra shelter was typical of most sobering-up services in Australia. However, other evidence indicates that these services were clearly perceived to be much safer than holding intoxicated individuals in police custody.⁶⁰

Reduction in police detentions

- 2.66 The provision of sobering-up centres can have a dramatic impact on the number of intoxicated individuals held in police custody. A report published by the Drug and Alcohol Office of Western Australia showed that, between 1992 – 2005, the number of police detentions of intoxicated persons across the entire state declined by a massive 84% from 12,346 in 1992 to 1,972 in 2005. This report directly attributed these changes to the availability of sobering-up services.⁶¹
- 2.67 This same report (p. A-12) indicated that these services have resulted in:
- *Reductions in police time and resources previously involved in detaining and monitoring intoxicated people in lock-up*
 - *Reduced use of court time and resources*

⁵⁹ Allen-Kelly *et al*, 2006.

⁶⁰ Parliament of Victoria, 2000.

⁶¹ Government of Western Australia, 2007.

- *Reduced levels of domestic violence and other problems associated with alcohol abuse and*
- *Reduced burden on hospitals because of fewer hospitalisations for alcohol-related illnesses and accidents.*

Acceptability

2.68 A number of Australian reports indicated that sobering-up services are generally valued and well-accepted by clients and the police⁶² as well as by local communities.⁶³ However, as mentioned in paragraph 2.12 above, it is important to actively seek community involvement in the establishment of these services.

Cost-effectiveness

2.69 Sobering-up services in Australia were also perceived to be cost-effective. For example, the Drug and Alcohol Office of Western Australia has reported that, in 2005, the 14 sobering-up services in that state had a combined cost of \$3,547,190 (Australian dollars) – roughly equivalent to £1.5m, using the rate of exchange for June 2007, when the report was written. This represented an annual average cost per centre of \$253,370 (or £107,452) and an average \$183 (or £77.61) per admission.⁶⁴

2.70 This report went on to state that sobering-up services were considered to be “very cost-effective as they avoid costs that would otherwise be incurred if people had been detained or admitted to a hospital” (p. A-12).

2.71 However, a report of the evaluation of the pilot shelter in Canberra made the point that “a sobering-up facility is not a cheap option”.⁶⁵ Cost-effectiveness depends partly on the size of the facility, but it also depends on the facility being well-used.

Service users’ views

2.72 The evaluation of the pilot sobering service in Canberra, the researchers carried out telephone interviews with a small number of clients of the service following their use of the service. Some of the main findings were that:

- Most clients mentioned that the beds were comfortable and that they felt safe and cared for
- Several indicated that the staff were “professional”, “reassuring” and easy to talk to
- All clients indicated that their privacy and confidentiality were respected
- Those who mentioned that their alternative would have been police cells, were very pleased with the shelter

⁶² Loxley *et al*, 2004.

⁶³ Brady *et al*, 2006; Allen-Kelly *et al*, 2006.

⁶⁴ Government of Western Australia, 2007.

⁶⁵ Allen-Kelly *et al*, 2006.

- When asked for suggestions about improving the service, most of the clients had no suggestions, although one client suggested that the monitoring of client safety could be done through observation, rather than waking people.
- 2.73 The Canberra evaluation also reported on some of the findings from the service's own client satisfaction survey. This survey asked clients, "How would you rate the overall service provided?" (on a scale from 1 to 10). The average response among clients was 9.2, which was seen to reflect the overall positive tone of responses to the client satisfaction survey. Again, it is not clear whether the views of clients attending the Canberra facility are typical of other sobering-up service clients.
- 2.74 An evaluation of a community intervention among young people attending the annual school leavers' celebrations on Rottneest Island found that the Chill Out Tent (a sobering-station), was regarded as the highlight of the intervention by school leavers and stakeholders. Only positive comments about the Chill Out Tent were made. The young people who used the tent reportedly felt comfortable about using the facility; the volunteers who staffed it were perceived to be friendly, consistently patient and compassionate.⁶⁶

Longer-term outcomes

- 2.75 An additional aim of sobering-up services may be to offer clients (or at least signpost them to) a range of treatment and other follow-up services, but the extent to which sobering-up facilities have been integrated with other longer-term services has varied widely in Australia.
- 2.76 In a report published as part of an inquiry into public drunkenness in the state of Victoria, the point was made in discussing the effectiveness of sobering-up services:

I think you have to decide what your purpose is in order to decide whether it is successful. If your purpose is to get people off the street and out of people's way because a lot of people find it very confronting and difficult to have people drunk on the street ... and if your purpose is [to] get those people somewhere else while they sober up, then sobering up shelters and diversionary measures are very successful. They pose much less risk of self harm or deaths in custody than perhaps the alternative measures that used to exist before, of being picked up and thrown in a cell – it is much better. But in terms of dealing with the long-term problems of public drunkenness, you mop the floor endlessly but never turn off the tap.⁶⁷

- 2.77 At the same time, there is some evidence from Australia that the opening of a sobering-up service can potentially encourage the development of other services to address alcohol-related problems. For example, in Western Australia, the development and expansion of a state-wide network of these services was thought to have led to the subsequent development of a variety of outreach programmes, community patrols, homeless support programmes,

⁶⁶ Midford *et al*, 2006.

⁶⁷ Parliament of Victoria, 2000.

alcohol and other drug education programmes, as well as community support for initiatives to restrict the availability of alcohol.⁶⁸ However, it is important to note that sobering-up services in Western Australia have largely been targeted at socially excluded indigenous peoples, and therefore it seems likely that many of the services that have grown up around sobering-up services have been directed at addressing the significant social problems that have affected this population.

⁶⁸ Government of Western Australia, 2007.

3 SOBERING-UP SERVICES IN NORTH AMERICA

Introduction and description of the evidence

- 3.1 This section will describe North American sobering-up services – or sobering centres, as they are usually called. As mentioned in Chapter 1, sobering centres were also known as “detoxification centres”, and in many cases, this term appeared to refer to a sobering service located within or beside a facility for longer-term detoxification. In addition, in one state, the local sobering centre was referred to as the “Transfer Station”.⁶⁹
- 3.2 The term “drunk tank” is also occasionally used in the North American literature to refer to a facility for the overnight housing of people who are drunk and incapable. However, the precise meaning of this term and the nature of service provision is not clear. There is some limited evidence to suggest that a “drunk tank” is *not* the same as a “sobering centre”, and that the drunk tank is a facility provided by the police to individuals who are not generally charged with any offense other than being drunk in public. One report stated that a drunk tank “is simply a fancy name for a jail cell”.⁷⁰ However, individuals placed in the drunk tank are required by law – at least in California – to be checked every 15 minutes.
- 3.3 The quality of the evidence presented in this chapter is poor compared to that from Australia, and it is difficult to draw firm conclusions or make generalisations on the basis of it. The findings in this chapter are based on the following sources:
- A formal audit report concerning a service in King County, Washington. (Baugh & Sandler, 1997)
 - An evaluation of a “Pathways to Sobriety” rehabilitation programme in Anchorage, Alaska. Participants in the “Pathways to Sobriety” project were recruited from a nearby sobering centre. Analysis of admissions data for the sobering centre was carried out as part of the evaluation. (Behavioral Health Research & Services, 2004a, 2004b, 2005a, 2005b)
 - A “concept paper” published by the Vermont Department of Health in relation to substance abuse crisis services in that state (2005)
 - In-depth study on the local impact of voluntary restrictions on alcohol sales in Seattle, Washington which includes statistical analysis of call-out data for the city’s sobering unit van (City of Seattle, 2006)
 - Newsletter article on plans to create an outdoor sobering service in Fresno, California (Rhodes, 2004)
 - Descriptions of sobering centres on local government or health authority websites in Seattle, Washington; Alameda County, California; and Santa Barbara, California

⁶⁹ Behavioral Health Research & Services, 2005a.

⁷⁰ Chesky, 2000.

- On-line job advertisements for “sobering technicians” placed by the Santa Fe County Human Resources Department in April 2008 (still unfilled in August 2008) (www.santafecounty.org)
- Newspaper articles (on-line) regarding sobering centres or proposals for sobering centres in Portland, Oregon (Beaven, 2008); Santa Monica, California (Ericksen, 2005); Monterey County, California (Chesky, 2000); and Surrey, British Columbia (Bula, 2008)
- Websites of service providers (direct weblinks are given).

Background

- 3.4 Similar to Australia, sobering centres began to be developed in the United States in the 1980s in response to the decriminalisation of public drunkenness in many states.⁷¹ However, in more recent years, the impetus for establishing these services has generally been to reduce pressure on the police. Moreover, unlike in Australia, the need to reduce pressure on hospital emergency departments has also been a big driver. In the American literature, the argument in favour of establishing sobering centres was often presented in economic terms – ie, it was a poor use of financial resources for the police, or emergency departments, to have to deal with people who simply needed a place to “sleep it off”.⁷²
- 3.5 It was less common for reports to identify a public health or humanitarian impetus for these services, although one proposal for a “emergency service for substance abuse” from the state of Vermont was an exception.⁷³
- 3.6 As in Australia, the literature from North America suggests that there is considerable variation in the way sobering centres are delivered. However, the variation in North American services seemed greater than in Australia. (Further details will be given below.) Nevertheless, the aim of these services is the same: a sobering centre is a facility in which inebriated persons can sleep off their intoxication in a clean and secure environment.⁷⁴ The evidence seems to indicate that North American services usually accept people intoxicated by drugs or alcohol.

Description of the services

- 3.7 The facilities available in North American sobering centres generally appeared to be very basic. In Vancouver (Canada) and Santa Barbara (California), sobering services were described as “little more than mats on the floor”.⁷⁵ Similarly, clients of sobering centres in Portland (Oregon) and Anchorage

⁷¹ The number of states which have decriminalised public drunkenness is unknown.

⁷² Ericksen, 2005; Chesky, 2000; Rhodes, 2004; Bula, 2008.

⁷³ Vermont Department of Health, 2005.

⁷⁴ Baugh & Sandler, 1997; website of King County, Washington (www.metrokc.gov/dchs/mhd/sobering.htm).

⁷⁵ Bula, 2008; Santa Barbara County Grand Jury, 2001.

(Alaska) are placed in a large empty room (men and women in separate rooms), where they are “left to sleep it off on a concrete floor”.⁷⁶

- 3.8 In 2004, the city of Fresno (California) put forward proposals for the establishment of what was referred to in one report as an “open-air drunk tank” targeted to the city’s homeless population. This would involve providing an out-of-doors sobering service, located beneath an overpass in the city centre. City officials in Fresno reportedly referred to this as “an innovative way to save money”.⁷⁷ This service has now apparently been established, and is provided in a large marquee-style tent (40 ft²) located on property belonging to the Fresno Rescue Mission, the voluntary sector agency that delivers the service. Sleeping facilities are provided on camp beds. The tent can house up to 20 men per night and includes breakfast.⁷⁸
- 3.9 Although many American services seemed to provide spartan facilities, there were also services which appeared to be more similar in nature to those offered in Australia – where the client was offered food and a change of clothes in addition to a bed for the night.⁷⁹
- 3.10 The literature is largely silent on the question of whether these services are offered free of charge or not. Only one report, describing a service in Santa Barbara, mentioned that clients are charged \$5 per night for use of the facility.⁸⁰ However, it is not clear how common this practice is. Since the clients of sobering services in America have traditionally been homeless, unemployed people, it seems likely that most services are provided for free.

Opening hours and length of stay

- 3.11 Information about several services suggests that sobering centres are often available 24 hours a day, 7 days a week. However, the average length of client stay is short: information about three services indicated that clients stay in the facility for an average of 4-6 hours (until they are sober enough to be released).⁸¹ However, a report from a service in Seattle stated that clients may remain in the centre for a longer period of time — usually between 8 and 14 hours.⁸²

Staffing

- 3.12 An important part of the role of a sobering centre is to assess whether a client is in need of more specialised medical attention. Staff require training to recognise the common medical problems associated with alcohol and drug dependency, and must be able to provide emergency first-aid when required.

⁷⁶ Beaven, 2008; Behavioral Health Research & Services, 2004a.

⁷⁷ Rhodes, 2004.

⁷⁸ See <http://www.fresnorescuemission.org/safearea.html>.

⁷⁹ Chesky, 2000; King County Department of Health and Human Services, undated.

⁸⁰ Santa Barbara County Grand Jury, 2001.

⁸¹ Santa Barbara County Grand Jury, 2001; Beaven, 2008; Alameda County Behavioral Healthcare Services, 2008a.

⁸² King County Department of Health and Human Services, undated.

Many services employ trained (and licensed) Emergency Medical Technicians (EMTs, roughly equivalent to a paramedic in the UK).

- 3.13 It would appear that different levels of staff are employed in sobering centres. For example, an on-line job advertisement for a “Sobering Technician Senior / PRN” placed by the Santa Fe County Human Resources Department (advertised in April 2008 and still unfilled in August 2008) stipulated minimum qualification of:
- High school diploma or equivalent plus two years of experience in performing duties relevant to the post
 - Current State of New Mexico and / or National Registry EMT-Basic license – must be in good standing.
 - Possession of a valid driving license.
- 3.14 An advert for a “Sobering Technician” posted on the same website did not require an EMT license. Plans for the establishment of a service in Surrey (British Columbia, Canada) suggested that the staff in the sobering centre would be able to deal with both addiction and mental illness in their clients.⁸³
- 3.15 One service in King County, Washington was strongly criticised in an audit report for its poor practices in hiring, training and management of staff. The point was made that the staff of sobering services must not only be trained in first-aid, but also need to be able to recognise when a client needs to be referred to a more qualified medical practitioner. The audit report recommended that lead personnel in the service should be medically trained EMTs or Licensed Nurses, and that reference checks should be routinely carried out when hiring staff.⁸⁴

Referring agencies

- 3.16 In general, sobering centre clients are delivered to the facility by the police or by a specially funded transportation service. (Transportation services are described in more detail in the next chapter.) While some American sobering centres also accept self-referrals,⁸⁵ others went to some lengths to keep self-referrers out.⁸⁶
- 3.17 A proposal for a sobering centre in Vermont included provision for clients to be referred to the service by other (non-police) community services and family members, and a service in Anchorage recorded client referrals from the city’s fire brigade and from “concerned citizens”.⁸⁷

⁸³ Bula, 2008.

⁸⁴ Baugh & Sandler, 1997.

⁸⁵ Behavioral Health Research & Services, 2005a.

⁸⁶ Alameda County Behavioral Healthcare Services, 2008a.

⁸⁷ Vermont Department of Health, 2005; Behavioral Health Research & Services, 2005a.

Admission, exit and safety protocols and procedures

3.18 There was little information available from reports about admission, exit and safety procedures in North American sobering centres. The most detailed information comes from an audit in 1997 of a service in King County, Washington, which was initiated at the request of the local Council following the third fatality in the centre within a 12-month period. The audit highlighted a number of failings in the admission and client monitoring procedures used in the facility. The findings suggested that very strict protocols for client admission are generally in place in such facilities, and that these include information about when a client should be referred to a qualified medical provider:

It should be noted that experienced sobering programs have established comprehensive procedures and rigorous admission criteria (e.g., maximum breath alcohol levels, etc.) to facilitate the referral of clients at extreme levels of intoxication or with serious health conditions to appropriate medical providers rather than to the sobering facility. ... Sound Recovery Center's client monitoring practices were also inconsistent and deteriorated since the facility opened. Vital signs were taken at regularly scheduled intervals for 98.1% of clients admitted during June 1996, but for only 25.6% of clients admitted in November 1996 and May 1997.... Furthermore, the sobering staff did not have continuous visual access to clients from a central point.... Walls separated the workers' stations from the main sleeping areas, and a second sleeping area was located on another floor.⁸⁸

3.19 The audit report went on to recommend that staff in this service must have detailed policy and procedures manuals for easy reference, that breath alcohol levels and vital signs should be printed on all client intake forms, and that the monitoring of client vital signs should comprise routine staff functions.

3.20 A report of a service in Portland stated that upon admission to the facility, clients must hand over belt, shoes, wallet and other items, which are bagged and held by staff until the client leaves in the morning.⁸⁹

3.21 It is perhaps worth noting that the recording of client names can be problematic in a sobering centre. An evaluation of the "Pathways to Sobriety" rehabilitation project in Anchorage involved analysis of the client database held by the local sobering centre. The researchers in this study discovered that client names were frequently misspelled (partly due to simple typographical errors and partly due to the worker misunderstanding the client's name given verbally when a client was intoxicated). Also clients frequently used multiple names and nicknames. The researchers highlighted the importance of accurate sobering centre data in facilitating on-going needs analysis and better targeting of interventions towards this population. They recommended that staff should interview all clients prior to their exit from the service not only to check details of the client's name and date of birth recorded at admission, but

⁸⁸ Baugh & Sandler, 1997.

⁸⁹ Beaven, 2008.

also to find out their reasons for becoming intoxicated, their sources of alcohol and their living conditions.⁹⁰

Admission criteria

- 3.22 The audit report from King County, mentioned above, makes it clear that many sobering centres have admission criteria. However, there was little other information available about this, apart from a proposal for a new service in Monterey (California) which suggested that the service would only be available to “passive and healthy drunks”:

*Anyone demonstrating violence or aggression would be refused. Those with infectious diseases or lice would also be turned away.*⁹¹

- 3.23 The marquee-based service in Fresno only accepts men, and does not accept anyone who is unconscious or unable to walk.⁹²

Client population

- 3.24 As mentioned above, in general, sobering centres in North America are open to people who are intoxicated with either alcohol or drugs. Furthermore, it would appear that these services have traditionally been targeted towards people who are alcohol- or drug-dependent *and* homeless. Reports frequently refer to these individuals as “chronic public inebriates”. Mental health problems, including severe mental illness seem to be common among this group.⁹³

- 3.25 Apart from this, there was very little specific evidence about the utilisation of sobering services by gender, age or ethnicity. Only one report mentioned in passing that 90% of users of the sobering centre in Anchorage are Alaska Natives – members of the indigenous populations of Alaska.⁹⁴

- 3.26 However, media reports indicate that that, more recently, admissions to sobering centres have begun to include a greater proportion of people who could be described as “binge drinkers” – and who might describe themselves as “social drinkers”. For example, a sobering centre in Portland found that a growing number of their more recent clients had homes and jobs, as compared to their “traditional” clients. According to the Executive Director of this service: “In the early 90s, about 80% of admissions were chronically homeless addicts and alcoholics. Now it’s about 45%”.⁹⁵ The point was made that the service was set up to support homeless people, but that it was less well-designed to deal with these recent changes in its clientele.

⁹⁰ Behavioral Health Research & Services, 2004b; Behavioral Health Research & Services, 2005b.

⁹¹ Chesky, 2000.

⁹² See <http://www.fresnorescuemission.org/safearea.html>.

⁹³ Bula, 2008; Ericksen, 2005.

⁹⁴ Behavioral Health Research & Services, 2005a.

⁹⁵ Beaven, 2008.

- 3.27 One report, describing plans for a service in Monterey claimed that the “target market” for the service would be “chronic inebriates – hard-core alcoholics who desperately need rehabilitation”. However, this same report made the point that 42% of people arrested by the police in Monterey for public drunkenness in a one-year period were tourists, military personnel and college or university students. It was not clear whether this population of drinkers would also have access to the proposed centre.

Links to other services

- 3.28 American sobering centres are often co-located with longer-term detoxification facilities to facilitate referral for clients who were interested. Several were located or planned to be located near hospitals or medical centres.⁹⁶
- 3.29 Alternatively, the staffing of the centre may include workers who can provide intensive case management support (employment, housing, health care, as well as help with treatment.)⁹⁷
- 3.30 There is some evidence of punitive measures being linked to sobering services in America. For example, plans for a sobering centre in Monterey suggested that people would be offered a bed up to five nights a year. However, the sixth time, they would go to prison.⁹⁸ The same rules were in place in Santa Barbara.⁹⁹ There was also evidence of people being presented with the option of going to prison or entering a rehabilitation programme.
- 3.31 However, such restrictions did not appear to be in force in other services. For example, in a one-year period between July 2006 and June 2007, the Hooper Centre in Portland recorded that 132 clients had been admitted to the service 10 times or more.

Service capacity

- 3.32 The size of sobering up centres range from very large – over 100 beds – to very small — 4 or 5 beds. The actual capacity is dependent not only on the number of beds, but on available staffing. One report suggested that, for a service holding 123 clients, there must be a minimum staff-to-client ratio of 1:10 at all times.¹⁰⁰
- 3.33 An evaluation of the “Pathways to Sobriety” project in Anchorage found that utilisation of the sobering service varied according to season and time of the week and month. Highest levels of utilisation were in the winter months, and during the first week of each month. Highest utilisation was also during weekends and lowest on a Monday. These patterns had a cumulative effect – so that utilisation during a weekend that coincided with the first week of the

⁹⁶ Beaven, 2008; Alameda County Behavioral Healthcare Services, 2008a; Bula 2008; Ericksen, 2005.

⁹⁷ King County Department of Health and Human Services, undated; Bula, 2008.

⁹⁸ Chesky, 2000.

⁹⁹ Santa Barbara County Grand Jury, 2001.

¹⁰⁰ Behavioral Health Research & Services, 2005a.

month in winter was higher than utilisation on a weekend later in the month, or during summer time. The researchers in this study made the point that these patterns can be used in determining staff scheduling and leave arrangements.¹⁰¹

Rural issues

3.34 All the information available to this review concerns sobering-up services in urban areas. It is not known to what extent these services are available in rural areas in North America.

Outcomes

3.35 Since much of the material available to this review on American sobering centres was not based on formal evaluation, there was little specific information about the outcomes of these services.

3.36 Data gleaned from a number of reports on sobering services indicate that these services are well-used. The Dutch Shisler Sobering Centre in Seattle, which can accommodate 60 people at one time, was reported to serve an estimated 1,000 clients a year. A six-bed service in Santa Barbara was reported to have admitted 1,400 clients in a year. The Hooper Centre in Portland admitted approximately 11,000 people per year, of which 3,000 went on to enter the centre's detox programme.¹⁰²

3.37 Although there is little evidence in the literature about the impact of sobering centres on police arrests for public drunkenness, there was a great deal of evidence to indicate that there was widespread belief that sobering centres *can* and *do* provide a direct benefit to the police, in terms of reducing the amount of time the police have to spend in managing intoxicated individuals.

Service users' views

3.38 Again, there was little information available about service users' views of sobering services in North America. Only one report – the evaluation of the Anchorage “Pathways to Sobriety” project -- included interviews with a small number of clients who had experience of the sobering service (referred to as the “transfer station”) in that city:

*Although two clients acknowledged the benefits of the transfer station – namely providing enough time to sober up and refuge during cold winter months – four of the five clients expressed dislike of the facilities. Reports of thefts during their stay were made by three of the clients, one was unable to retrieve his prescription medication after his stay, and two individuals found the staff to be unfriendly. One client noted dissatisfaction with the expectation that public inebriates should lie on a concrete floor while becoming sober at the Transfer Station.*¹⁰³

¹⁰¹ Behavioral Health Research & Services, 2005a.

¹⁰² King County Department of Health and Human Services, undated; Santa Barbara County Grand Jury, 2001; Central City Concern website: http://www.centralcityconcern.org/hooper_center.htm.

¹⁰³ Behavioral Health Research & Services, 2004a.

4 OTHER SERVICES FOR DRUNK AND INCAPABLE PEOPLE

Introduction and description of evidence

- 4.1 This chapter will look briefly at other interventions which are used around the world to meet the immediate care needs of drunk and incapable people. These other interventions include transportation services and the provision of medical support within police custody suites (usually by custody nurses). It should be noted that the latter intervention does *not* divert drunk and incapable people from police cells. However, it may be argued that it does remove some of the pressure from the police in assessing the fitness of intoxicated individuals to be held in custody.
- 4.2 There was very little evidence available on these other interventions, and in the case of transportation services, this evidence has been gleaned from reports which have focused on the provision of other types of services (including sobering-up services). The mention of a dedicated free bus or van service has been mentioned almost in passing, although one study carried out for the City of Seattle provided detailed information on the use of the sobering van in that city over a five-year period.¹⁰⁴
- 4.3 Although there is little literature on the subject of providing support to alcohol-related detainees in police custody, the literature is of good quality and is based on formal research and evaluation, and published in peer-reviewed journal articles or through government research reports. This includes:
- An assessment of the Kent (England) Custody Nurse scheme undertaken for the Home Office (Gannon, 2002)
 - A comparison of nursing and medical provision (by forensic medical examiners) in police custody suites in the north of England (Bond *et al*, 2007)
 - Two investigations of the feasibility of forensic medical examiners providing brief interventions to drunken detainees in police custody in London (Deehan *et al*, 1998; and Best *et al*, 2002)
 - Abstracts of older research undertaken in Melbourne (Australia) on the evaluation of a trial forensic nursing service (Evans & McGilvray 1996; and Young *et al*, 1994)

Transport services

- 4.4 There was a great deal of evidence from North America and Australia of transportation services working in conjunction with sobering-up services. These services may, or may not, be provided by the same agency that provides the sobering service itself.

¹⁰⁴ City of Seattle, 2006.

Sobering centre transport vans in North America

- 4.5 Many sobering centres in America work in conjunction with transport vans which take clients free of charge to and from the service. There was evidence of vans operating in the cities of Seattle and Portland, and in Alameda County, California.¹⁰⁵ The transport van programme in Alameda County included several vans, all staffed with an Emergency Medical Technician (EMT) and an outreach worker.
- 4.6 In Portland, the van patrols the city streets from 7.30am to 11.30pm seven days a week. In addition, the van may also be directed to intoxicated individuals by the police. Under Oregon state law, the van staff have the power to take people into civil custody. However, they don't have police powers and generally, they allow the police to handle violent or aggressive clients.¹⁰⁶
- 4.7 The vans are well-used. The sobering up van in Seattle recorded 13,433 call-outs in 2005. This was down by 1,300 from the previous year.¹⁰⁷

Sobering service vans and night patrols in Australia

- 4.8 There was also a great deal of evidence for the use of transportation services in Australia. There was evidence of vans operating in conjunction with sobering-up services in Ceduna, Canberra and Darwin.¹⁰⁸
- 4.9 In addition, the use of night patrols is common in Australia particularly in Aboriginal communities (including rural communities) which are affected by alcohol-related violence. The night patrol is a form of community policing which is designed to deal with alcohol-related trouble before it gets to a stage of requiring police intervention.¹⁰⁹ Patrols have been operating in some areas since the mid-1980s, and in 1999/2000, there were 69 patrols operating in locations throughout Australia.¹¹⁰
- 4.10 One in-depth study of Australian night patrols reported that these interventions initially developed in response to alcohol-related violence endemic in some Aboriginal communities. The patrols use a community approach to resolve problems within the community. They work in co-operation with the police, and act as a buffer between the community and the criminal justice system.¹¹¹ In some cases, the night patrol involves people on foot, in other cases, it is a bus. Both men and women, young and old, may be members of a night patrol.
- 4.11 One report stated that on a typical night, a night patrol:

¹⁰⁵ King County Department of Health and Human Services, undated; Beaven, 2008; Alameda County Behavioral Healthcare Services, 2008b.

¹⁰⁶ Beaven, 2008.

¹⁰⁷ City of Seattle, 2006.

¹⁰⁸ Brady, 2006; Allen-Kelly *et al*, 2006; Parliament of Victoria, 2000.

¹⁰⁹ Parliament of Victoria, 2000; Curtis, 1993.

¹¹⁰ Loxley *et al*, 2004.

¹¹¹ Curtis, 1993.

*... may attend a domestic violence incident, find somebody drunk, take the drunk to the sobering-up shelter... refer people to the women's refuge, this hospital or the ... medical service.*¹¹²

- 4.12 Night patrols also provide transport for intoxicated people to be taken to a safe place (either a sobering-up shelter, or home). However, one author pointed out that the purpose of the patrol was *not* to “assist in removing intoxicated persons from the streets”, although the point was also made that there has been some misunderstanding with the police over this. The main aim of the night patrol is to reduce alcohol-related conflicts and harm -- to resolve problems in the community; to help “settle disputes when they begin and not after they have exploded”. Where the police have to be called, the patrol assists the police and the community to communicate with each other.¹¹³
- 4.13 There is variation in how these patrols operate in different areas. Some are operated entirely by volunteer members of the community working on a weekly roster system, while others are staffed by paid workers.¹¹⁴ Where a night patrol is staffed by paid workers, the available funding can put restrictions on the number of nights the service is able to operate.
- 4.14 In the city of Darwin, the night patrol was staffed predominantly by Aboriginal people. This patrol is:
- responsible for ‘scouting’ Aboriginal camps, talking to people and, with the consent of the person concerned, (they) bring that person back to the sobering up centre.*¹¹⁵
- 4.15 A report on the operation of the Darwin night patrol made the point that the requirement to get the person’s consent often requires a mixture of coercion and cajolery.
- 4.16 There have been several evaluations of night patrols in Australia. The findings clearly indicate that, where night patrols operate, people generally rated the patrols as effective in reducing alcohol-related violence and getting intoxicated people off the streets.¹¹⁶

Providing medical support in police custody suites

Background – the burden of alcohol-related arrests on police custody suites

- 4.17 In recent years, research has been carried out in the UK to analyse and quantify the burden on police custody suites of alcohol-related detentions. Two recent studies (funded by the Home Office) have investigated this issue.

¹¹² Parliament of Victoria, 2000.

¹¹³ Curtis, 1993.

¹¹⁴ Curtis D, 1993; Parliament of Victoria, 2000.

¹¹⁵ Parliament of Victoria, 2000.

¹¹⁶ Loxley *et al*, 2004.

- 4.18 One was an analysis of 1,575 custody records from three metropolitan police stations in England (carried out in February 2000).¹¹⁷ This study found that alcohol was a factor in almost a third of arrests. In analysing this data, the researchers made a distinction between *alcohol-specific offences* (such as drunkenness or drink driving) and *alcohol-related offences* (where the detainee was drunk or had been drinking prior to the arrest). Alcohol-specific offences comprised 15% of arrests and alcohol-related offences comprised 16%. Both alcohol-related and alcohol-specific offences were most likely to occur at night – particular Friday and Saturday nights.
- 4.19 Alcohol-related detainees spent *significantly longer* in custody than other detainees (average of 8.7 hours and 6.9 hours respectively) mainly because of the need to sober up before interviewing and processing. Alcohol-specific detainees spent *less* time in custody (average 4.5 hours). Many alcohol-specific detainees were held to allow them to sober up in a supervised environment and then were released without any charges being brought. (It should be noted that there were similar findings from an observational study carried out by Deehan *et al* (2002).)
- 4.20 A forensic medical examiner (FME) was called to examine about half (53%) of those arrested for alcohol-related offences and just over a third (36%) of those arrested for alcohol-specific offences. The FME recommended that custody staff closely observe about a quarter of these individuals while they were being held. Another quarter of these detainees required medical attention from the FME.
- 4.21 In addition, there was evidence from this study that police custody staff felt that dealing with drunken detainees was not a good use of police resources and resulted in unnecessary pressure on police cells. There was also some evidence that custody staff did not feel adequately trained to manage drunken detainees.
- 4.22 The researchers in this study questioned whether the custody suite was an appropriate place for *alcohol-specific* detainees – ie, those who were often held in custody simply to sober up in a supervised environment and then were released.
- 4.23 However, it was not seen to be appropriate to divert *alcohol-related* detainees from custody, since many had in fact, committed an offence. Nevertheless, individuals arrested for alcohol-related offences still posed a significant burden on the police compared with those who had not been drinking. The researchers recommended that consideration should be given to how detainees with alcohol problems, whether chronic or acute, can be effectively dealt with in the custody environment. The suggestion was that trained staff could screen detainees for alcohol problems and provide brief interventions, or refer the detainee into treatment as appropriate.

¹¹⁷ Man *et al*, 2002.

- 4.24 It is worth noting that other studies have shown that a large proportion of the work of forensic medical examiners involves intoxicated detainees, and much of this work is related to assessing individuals for their fitness to be detained. If an FME considers an arrestee fit to be detained, they usually request that custody staff make frequent checks — eg, in some cases, every 15 minutes — to ensure the well-being of the detainee.¹¹⁸
- 4.25 Traditionally, forensic and medical services to detainees in police custody have been provided on an on-call basis by medical practitioners (usually part-time GPs with special training in forensic medicine). However, in recent years, there has been a growing trend (in the UK and elsewhere) to restructure services so that initial medical contacts are made by custody nurses.

The role of forensic medical examiners and custody nurses in managing the care needs of intoxicated arrestees

- 4.26 There have been two UK studies which have specifically investigated the role of the FME in addressing alcohol-related problems of drunken detainees in police custody – through screening and brief interventions.¹¹⁹ However, neither of these studies looked specifically at the effectiveness of using FMEs to manage the care needs of drunk and incapable people in police custody.
- 4.27 Nevertheless, there were a few messages from these studies which are relevant to the aims of this review:
- First, a large part of the job of an FME involves assessing the fitness of alcohol-related detainees to be in custody.
 - Second, one of the reasons for this may be that custody sergeants feel a certain level of anxiety about this group, who represent one of the most common groups to die in police custody.
 - Third, although FMEs generally feel confident about caring for the needs of alcohol-related detainees, they question whether it should be part of their role to screen people for alcohol problems or to deliver brief interventions, and they question the effectiveness of such interventions being delivered in the context of a police cell when an individual is intoxicated.
- 4.28 Four studies were identified which examined the role of custody suite nurses. However, none of these studies concerned the specific role of nurses in meeting the needs of alcohol-related detainees. One of the studies was not relevant at all to the purposes of this review as it primarily concerned an exploration of the roles and boundaries of practice among custody nurses.¹²⁰
- 4.29 The main purpose of three of the studies (two in Melbourne, Australia and one in the north of England) was to evaluate the impact of providing nursing care in

¹¹⁸ Deehan *et al*, 2002; Best *et al*, 2002.

¹¹⁹ Deehan *et al*, 1998; Best *et al*, 2002.

¹²⁰ Gannon, 2002.

police custody suites in parallel with medical support from a forensic medical examiner.¹²¹

- 4.30 In all three studies, nurses provided the initial contact and triage assessment of police detainees. Nurses were responsible for undertaking assessments, conducting clinical procedures and carrying out on-going monitoring of detainees' health and behaviour. Referrals were made to the FME or hospital where necessary. All studies found that the use of custody nurses can improve the operational efficiency of health care services offered in police custody suites. One study found that nurses had faster response times, comparable consultation times and were perceived by custody staff as more approachable than their medical colleagues in providing handover information.¹²²
- 4.31 It is perhaps worth mentioning that this same study analysed the time nurses spent on different tasks, and similar to the studies of FMEs described above, the vast majority of the work of the nurses (approximately 90%) involved assessing an individual's fitness to be detained and / or interviewed by the police.

Temporary places of safety, mobile units and SOS buses

- 4.32 Finally, a model of service which is being used increasingly to meet the needs of drunk and incapable people in the UK, involves the use of a mobile service or a specially adapted bus.

Mobile Medical Response Unit, Cardiff

- 4.33 The Mobile Medical Response Unit (MMRU) in Cardiff is an example of the former.¹²³ This service comprises a triage vehicle staffed by a driver and paramedic, which is supported by a number of patient transportation vehicles provided by St John Ambulance Service and the Welsh Ambulance Trust. The MMRU has a police radio and can respond to 999 calls directly. On certain occasions of high demand, the service operates in conjunction with a temporary treatment centre (a first-aid post located in the Millennium Stadium), where people with minor injuries can be referred. Patients who require further treatment are referred to the local emergency department.
- 4.34 In its first year of operation (Dec 2004 – Dec 2005), the MMRU was available on 17 occasions, and the treatment centre also operated on eight of those occasions, during periods of peak demand such as during the festive season, bank holidays or sporting events. Alcohol was reported to be a factor in 96% of incidents dealt with by the service.
- 4.35 A formal evaluation of the service concluded that it provided patients with a rapid and effective means of dealing with minor injuries, while freeing up emergency resources (police, ambulance and emergency departments). It

¹²¹ Evans & McGilvray, 1996; Young *et al*, 1994; Bond *et al*, 2007.

¹²² Bond *et al*, 2007.

¹²³ John, 2006

was estimated that the service saved a total of 360 hours of emergency department time. In financial terms, this represented an estimated £14,445 in doctor costs alone. In addition, the Wales Ambulance Service Trust estimated that the triage and transport arrangements that comprised the MMRU saved the trust £25,000 in its first year of operation, largely because of the ability to retain patients geographically in the city centre. This saved on transport time, and time spent by staff having to wait at the hospital to transfer patients to the emergency department.

4.36 The costs of delivering the service were able to be kept very low because much of the cost was borne directly by the agencies involved in planning and delivering the service. For example:

- The Millennium Stadium treatment centre was provided to the partnership free of charge
- The cost of the MMRU paramedic vehicle and support vehicle was met by the Ambulance Trust, and since the MMRU relieved other ambulance vehicles of a large proportion of city centre work, this was seen as a neutral cost
- The cost of medical supplies and sustenance for volunteers and staff was met by the NHS Trust
- A donation was made to the St John Ambulance Service of £300 each time the MMRU operated, for the vehicles they provide and the three volunteers; and a further donation of £500 each time the temporary treatment centre operated, for the medical volunteers (doctors, nurse practitioners and first-aiders) that the charity provided.

4.37 In its first year, the direct costs of the service on each occasion of operation were £310.05 for the MMRU (total £5,271 for 17 occasions), and £1,044 for the treatment centre (£8,352 for eight occasions). These costs do not include the costs of nursing staff or policing, which was available on some, but not all occasions.

Other mobile services

4.38 Like the MMRU, SOS buses provide immediate assistance to people who may be intoxicated, distressed or have minor injuries.¹²⁴ They offer first-aid (including, in some cases, social and emotional first-aid), and a place of safety for people until they are able to be taken home by a family member, friend or taxi.

4.39 There are SOS buses in Norwich (since 2000), Weston-Super-Mare (since 2005), Southend-on-Sea (since 2006) and Belfast (since 2007). In every city, the bus project is a multi-agency initiative involving the local authority, police, St John Ambulance, the local community, churches and charitable agencies.

¹²⁴ All the data on SOS buses is taken from a single review carried out on behalf of Lothian & Borders Police: Symington & Robbie, 2008, pp. 24-38.

- 4.40 The service works by parking the bus in a busy, prominent, city-centre location at night. A support vehicle (a van or mini-bus) is used to transport people *to* the bus from around the city, or *from* the bus to a hospital emergency department, if necessary. In some cases, the support vehicle may also take people home. In addition, clients may present themselves or be brought along by friends. In Norwich, the bus works together with a first-aid centre (located separately in a porta-cabin some distance away).
- 4.41 The buses generally operate at the weekends, although the Belfast SOS bus is also deployed at other times during the week for educational and community project work.
- 4.42 In general, the clients are young people on a night out. In Weston-Super-Mare, steps have been taken to prevent the service being used by homeless people, by providing alternative services and shelters when the bus is on the street. There is an average 30-minute turnaround time for all clients, and the different bus projects have reported assisting between 8-9 clients (Norwich) to 400 clients (Belfast) per night.
- 4.43 Several of the bus projects are run as charitable endeavours and have received substantial donations (including donations of the bus and / or support vehicles) from the local community. Some have also been supported financially and in-kind by local businesses, nightclubs and the licensed trade.
- 4.44 Costs of the projects have varied. The Belfast bus is significantly more expensive than the others partly because the Belfast bus is larger (it is a 60-foot 'bendy bus' purchased from The Netherlands), and partly because the Belfast Bus is deployed for other activities during the day.
- Norwich: annual running costs, £43,000
 - Belfast: initial fitting-out costs, £350,000; annual running costs, £200,000.
 - Southend-on-Sea: £150,000 initial costs; annual running costs, £50,000
 - Weston-Super-Mare: £20,000 initial costs; running costs, £378/night + annual costs of £1,000 for MOT, repairs and fuel.
- 4.45 Although the primary purpose of the SOS buses has been to provide a place of safety to vulnerable people, evaluation of some of them has shown they have also been successful in diverting people who are intoxicated (and those with minor injuries) from emergency departments, ambulances and police cells.

5 DISCUSSION

- 5.1 This report has provided an analysis of the literature on services that aim to meet the immediate care needs of drunk and incapable people. One of the main findings of the review is that there is a relative paucity of evidence on this subject, and therefore, clearly a need for further research and evaluation in this area.
- 5.2 This section will look at some of the lessons that can be learned from the experience of implementing these services in other countries.

Sobering-up services

- 5.3 In considering the literature on sobering-up centres first (both Australian and North American), much of the evidence presented in this report relates to individual services delivered in specific cultural contexts. The evidence from North American sobering-up services is much less robust than that from Australia, and caution should be used in making any generalisations from this information. The evidence indicates that there is variation in services, but it does not provide sufficient information to even obtain a full and accurate description of that variation. Based on the information presented here, it would seem that North American services have a different ethos to services in Australia. The main driver for the establishment of sobering-up services in America appears to have been financial. Furthermore, the use of punitive or compulsory measures appears to be common in American services, whereas such measures were not even mentioned in the Australian literature.
- 5.4 Although there was more substantial information about the operation of sobering-up services in Australia (as compared with North America), very little of that evidence was obtained from formal evaluations. What evidence there was provides a reasonably good picture of how services in Australia work, and illustrates the variations in service delivery – but this evidence provides less information about how these services *should* work. Moreover, it is important to keep in mind that sobering-up services in Australia have largely developed in response to the needs of the indigenous Australian population. This is not to say that the lessons learned from these services could not have application in a Scottish context. They can. However, the Scottish response to drunk and incapable people will need to take into account the Scottish cultural context, and the nature of needs in Scotland.
- 5.5 Despite the caveats around the quality of the evidence, the literature seems to indicate that sobering-up services are effective in providing a safer alternative to police custody for people who are drunk and incapable in public, and that they are effective in reducing the pressure on the police – and potentially other emergency services – particularly where they operate in conjunction with a free van or bus service. However, if these services are to provide anything other than a “band-aid” approach to harm reduction, they must be integrated with longer-term services providing treatment and / or housing support.

- 5.6 The findings of this review would seem to indicate that there is no one single model of a sobering-up service which can be held up as an example of good practice. Sobering-up services around the world have been established, and have developed in an on-going way, in response to the needs of their local populations. It is worth noting that those responses have been mediated to a greater or lesser extent by available funding, and by the philosophical, religious or cultural views of the organisations providing the service. However, the important message from the literature is that a one-size-fits-all approach to planning a sobering-up service in Scotland is unlikely to be very helpful.
- 5.7 Another point worth noting is that, even after services are up and running, it will be necessary for local commissioners and service providers to remain alert to the on-going and changing needs of their local populations and to be flexible in meeting those needs.
- 5.8 On a more practical, nuts-and-bolts level, the literature suggests that good sobering-up services should have:
- A high level of training among staff – in particular, all staff must be qualified in first-aid, and at least one member of staff requires a nursing or Emergency Medical Technician-equivalent qualification. Training in drug and alcohol misuse is also needed, and mental health / suicide prevention may also be important
 - Premises that help to facilitate the safety and monitoring of clients through the night
 - Clear security and safety protocols and procedures – not only for the sake of clients, but also for the sake of staff. The extent to which the police are willing to use the service will depend on whether the police feel the service provides a safe and secure alternative to custody
 - Strong links with the police – the police should be involved in developing the admission criteria and procedures for the service
 - Strong links to local substance misuse and housing services – while it is possible for a sobering-up service to operate effectively on a purely harm reduction basis, any attempt to “turn off the tap” (see the quote in paragraph 2.76) will require that the service is able to link or refer clients efficiently and effectively to other services that can address their longer-term care needs
 - The ability to deliver brief interventions – not only to give people information and advice, but also to encourage them to reduce their level of drug or alcohol use in a professional, caring and non-judgemental way.
- 5.9 This review has provided much more detail about sobering-up services than the previous review undertaken by Macdonald (2005) described in Chapter 1 of this report. However, the issues identified in that earlier review are still relevant, namely, when setting up a service, planners need to take into account:
- The purpose and ethos of the service
 - The target group

- The potential location and opening hours of the facility
- The need for community and stakeholder support
- Admission criteria
- Staffing and management arrangements
- The way in which the service links to other services (either through receiving referrals, or making referrals)
- Policies and procedures related to the operation of the service – especially in relation to client safety and monitoring, but also in relation to admission and client discharge
- The source(s) of funding.

Transportation services and night patrols

- 5.10 The issue of transportation to and from a sobering-up service is also an area that requires consideration. Where an individual is drunk and incapable, it is unlikely that he or she will be in a position to get to a sobering-up service independently. The evidence indicates that many people are delivered to sobering-up centres by the police – there was little evidence of people arriving by ambulance. However, if one of the aims of a sobering-up service is to reduce pressure on the police, then consideration needs to be given to providing an alternative form of (free) transportation (perhaps in the form of a van or a bus) – which the police may even call upon themselves.
- 5.11 However, consideration must also be given to the question of whether the staff of these services will need certain legal powers to be able detain individuals who may be a danger to themselves or others, or whether the services will operate entirely on the basis of persuasion. In addition, it may be an option to use these services to deliver people to their homes, rather than to a sobering-up service, although it may be argued that taking a person home doesn't negate the need for that person to be monitored.
- 5.12 Based on the literature available, it would appear that night patrols are very much a response by the Aboriginal communities to the problem of alcohol-fuelled violence in their own communities. It was not clear from the available evidence to what extent night patrols operate, nor whether their methods would work, outside of Aboriginal communities in Australia. However, their methods sound similar in some respects to those used by the Street Pastor initiative currently being implemented various cities in England and Scotland.¹²⁵

Provision of other types of services

- 5.13 Evidence presented in the previous chapters on sobering-up centres in Australia and North America has suggested that sobering-up services are cost-effective – or *perceived* to be cost-effective in both countries, in that they

¹²⁵ See <http://www.streetpastors.co.uk/>. Street Pastor initiatives are currently operating in Aberdeen, Perth and Inverness, and one is planned for Glasgow in 2009.

reduce the demands made on more expensive resources such as the police or emergency departments.

- 5.14 However, a sobering centre is not an *inexpensive* intervention itself, because of the need for suitable premises and qualified staff. Therefore, the question must be asked whether there is a less expensive way of managing the care needs of drunk and incapable people.

Provision of medical care in police custody

- 5.15 The provision of medical care within the police custody suite may be one option. This approach would give police detainees access to healthcare services, without the need for large capital expenditure on a separate building.

- 5.16 However, no firm conclusions can be drawn from this review about the appropriateness or the effectiveness of delivering medical care to drunk and incapable people within police custody suites (either through a forensic medical examiner or a nurse).

- 5.17 What this literature *does* tell us is that:

- A big part of the role of the FME and custody nurse is spent in assessing alcohol-related detainees for their fitness to be held in custody
- Nurses working in co-ordination with FMEs provide a more efficient, and perhaps more accessible, service than FMEs working on their own.

- 5.18 In addition, the background literature which quantifies the level of alcohol-related detentions in police custody suggests that a useful distinction can be made between *alcohol-specific* detainees, who are generally held by the police for their own protection and then released, and *alcohol-related* detainees, who have committed an offence while under the influence of alcohol. *Alcohol-specific* detainees may be suitable for referral to a sobering-up type of service. On the other hand, *alcohol-related* detainees may have to continue to be held in police custody, while being regularly monitored for their own safety.

Temporary or mobile triage / first-aid services

- 5.19 There is evidence to suggest that the use of temporary or mobile services can be effective at reducing the burden on emergency services during periods of peak demand, particularly at weekends, or during special events. These services would also appear to be less expensive than permanent sobering-up facilities. These services provide city-centre-based first-aid service to people who have sustained minor injuries, often as a result of too much alcohol.

- 5.20 The advantage of a mobile service, in addition to its relatively lower cost, is that it is flexible and can be located where the needs are greatest. However, the fast turn-around times achieved by these services would suggest that they provide little opportunity for brief interventions, or follow-up in relation to longer-term interventions for people who are alcohol-dependent.

REFERENCES

- Alameda County Behavioral Healthcare Services (2008a) Sobering center. Safe house. Available at: www.acbhcs.org/sobering_svcs/sobering_ctr.htm.
- Alameda County Behavioral Healthcare Services (2008b) Transport van program. Available at: www.acbhcs.org/sobering_svcs/transport.htm.
- Allen-Kelly K and McArthur M (2005) *Process evaluation, sobering up shelter*. Australian Catholic University. Unpublished report received through personal correspondence with the authors. A copy of this report is available to the Scottish Government from Griesbach & Associates upon request.
- Allen-Kelly K, McArthur M and Thomson L (2006) *Evaluation of Centacare sobering up shelter*. Australian Catholic University. Available at: www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1165472226&sid=.
- Australian Bureau of Statistics (2008) *Regional Population Growth, Australia, 2006-07*. Available at: www.abs.gov.au/ausstats/abs@.nsf/mf/3218.0/.
- Australian Capital Territory, *Care and Protection of Intoxicated Persons Standard 2004*. Available at: www.legislation.act.gov.au/di/2004-177/current/pdf/2004-177.pdf.
- Baugh S and Sandler R (1997) King County Contract for Sobering Services. Report No. 97-05. Executive Summary. Available at: www.metrokc.gov/auditor/1997/alcohol.htm.
- Beaven S (2008) A more complex detox. Downtown bar patrons join the chronic drinkers and drug abusers who land at Central City Concern's sobering station. *The Oregonian*, Thursday, July 03, 2008.
- Behavioral Health Research & Services (2004a) *Consumer, staff and community providers' knowledge of and opinions about the Pathways to Sobriety Project. Pathways to Sobriety Project Program Evaluation*. University of Alaska Anchorage. Available at: www.muni.org/iceimages/healthssd/FullReport1.pdf.
- Behavioral Health Research & Services (2004b) *Pathways to Sobriety Data Report #1: Jan 1, 2002 to Jun 30, 2004*. (BHRS Pathways-related technical report 2). Univ of Alaska Anchorage. Available at: www.muni.org/iceimages/healthssd/FullReport2.pdf.
- Behavioral Health Research & Services (2005a) *Exploratory analysis of the municipality of Anchorage's community Transfer Station database*. (BHRS Pathways-related technical report no. 3). University of Alaska Anchorage. Available at: www.muni.org/iceimages/healthssd/FullReport3rev.pdf.
- Behavioral Health Research & Services (2005b) *Pathways to Sobriety Final Data Report: January 1, 2002 to June 30, 2005*. (BHRS Pathways-related technical report no. 4). University of Alaska Anchorage. Available at: www.muni.org/iceimages/healthssd/FullReport4.pdf.

Best D, Noble, Stark M and Marshall EJ (2002) The role of forensic medical examiners and their attitudes on delivering brief alcohol interventions in police custody. *Criminal Behaviour and Mental Health*, 12: 245-235.

Bond P, Kingston, P & Nevill A (2007) Operational efficiency of health care in police custody suites: comparison of nursing and medical provision. *Journal of Advanced Nursing*, 60(2): 127-134.

Brady M, Nicholls R, Henderson G & Byrne J (2006) The role of a rural sobering-up centre in managing alcohol-related harm to Aboriginal people in South Australia. *Drug and Alcohol Review*, 25 (May): 201-206.

Bula F (2008) Surrey wants a sobering centre. Facility would be unique in Lower Mainland. *Vancouver Sun*, Wednesday, February 06, 2008. Available at: www.canada.com/vancouver/news/westcoastnews/story.html?id=bb8919ac-a17f-4418-8553-d51e817587a8.

Cabinet Office (2004) Alcohol harm reduction strategy for England. Prime Minister's Strategy Unit. Available at: www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse.aspx.

Chesky L (2000) Proposed sobering center would offer arrested drunks an alternative to jail. *Monterey County Weekly*, April 20, 2000. Available at: www.montereycountyweekly.com/archives/2000/2000-Apr-20/5149/1

City of Seattle Department of Neighborhoods and Seattle Police Department (2006) *Report on voluntary compliance efforts in the central core and north alcohol impact areas and a request for mandatory restrictions*. Prepared for the Washington State Liquor Control Board. Available at: www.seattle.gov/neighborhoods/pubs/AIA%20Voluntary%20Compliance%20Evaluation%20Report%20May%202006%20-%20FINAL.pdf.

Curtis D (1993) Julalikari Council's Community Night Patrol. In S McKillop (ed), *Aboriginal Justice Issues. Proceedings of a conference held 23-25 June 1992*. Australian Institute of Criminology. Available at: www.aic.gov.au/publications/proceedings/21/Curtis.html.

Deehan A, Stark M, Marshall EJ, Hanrahan B and Strang J (1998) Drunken detainees in police custody: is brief intervention by the forensic medical examiner feasible? *Criminal Behaviour and Mental Health*, 8, pp. 214-221.

Deehan A, Marshall E and Saville E (2002) *Drunks and disorder: Processing intoxicated arrestees in two city-centre custody suites*. Home Office, Police Research Series Paper 150. Available from: www.homeoffice.gov.uk/rds/prqpdfs/prs150.pdf.

Ericksen O (2005) City set to help fund sobering center. *The LookOut*, March 21, 2005. Available at: www.surfsantamonica.com/ssm_site/the_lookout/news/News-2005/March-2005/03_21_05_City_Set_to_Help.htm.

Evans A & McGilvray L (1996) RNs trial a forensic nursing service. *Australian Journal of Advanced Nursing*, 14(2): 11-15.

Gardiner G and Mackay M (1998) Indigenous people arrested for public drunkenness. *Indigenous Law Bulletin*. Available at: www.austlii.edu.au/au/journals/ILB/1998/56.html.

Government of Western Australia (2007) *Utilisation of sobering up centres, 1990-2005*. Department of Health, Drug and Alcohol Office, Statistical Bulletin no. 36. Available at: www.dao.health.wa.gov.au/AboutDAO/StatisticalBulletins/tabid/226/Default.aspx.

Healthcare Management Advisors Pty Ltd (2008) *A review of alcohol, tobacco and other drug services in Tasmania*. Available at: www.dhhs.tas.gov.au/data/assets/pdf_file/0015/30552/HMA_Final_Report.pdf.

John T (2006) *An independent evaluation of the Mobile Medical Response Unit and Cardiff Medical Treatment Centre arrangement in Cardiff City Centre*.

King County Department of Health and Human Services (undated). The Dutch Shisler Sobering Support Center. Seattle, Washington. Available from: www.metrokc.gov/dchs/mhd/sobering.htm.

Loxley W, Toumbourou JW, Sotckwell T, Haines B, Scott K, Godfrey C, Waters E, Patton G, Fordham R, Gray D, Marshall J, Ryder D, Saggors S, Sanci L & Williams J (2004) *The prevention of substance use, risk and harm in Australia: A review of the evidence*. Australian Government Department of Health and Ageing.

Macdonald R (2005, unpublished) *Care approaches to drunk and incapable people. Designated places, drunk tanks and sobering facilities across the world. A literature review*. Prepared for the Scottish Association of Alcohol Action Teams (SAAAT), January. A copy of this report may be obtained from Alcohol Focus Scotland.

Man L-H, Best D, Marshall J, Godfrey C and Budd T (2002) *Dealing with alcohol-related detainees in the custody suite*. Home Office Research, Development and Statistics Directorate, Findings 178. Available from: <http://www.phrn.nhs.uk/CJS/Alcoholcustodysuite.pdf>.

Memmott P, Long S, Chambers C & Spring F (2003) *Categories of Indigenous 'homeless' people and good practice responses to their needs*. Melbourne: Australian Housing and Urban Research Institute, Report no. 49. Available from: http://www.ahuri.edu.au/publications/download/20168_fr.

Midford R, Farrington F & Young N (2001) Leavers on Rottnest: A glimpse of how a community managed mayhem. *CentreLines*, National Centres for Drug and Alcohol Research, Aug. Available at: <http://www.ndri.curtin.edu.au/pdfs/centrelines/ndri004.pdf>.

New South Wales Department of Health (2005) *Intoxicated Persons Amendment Act 2000 and Proclaimed Places: Protocol*. Policy Directive (PD2005_245) issued on 27 January 2005. Available at: www.health.nsw.gov.au/policies/PD/2005/PD2005_245.html.

Parliament of Victoria (2000) *Inquiry into Public Drunkenness. Discussion paper*. Drugs and Crime Prevention Committee, October. Available at: www.parliament.vic.gov.au/dcpc/Reports%20in%20PDF/Drunkenness_discussion.pdf.

Rhodes M (2004) Outdoor drunk tank established to humiliate the homeless. *Community Alliance*, June 2004, p. 3. Available at: www.fresnoalliance.com/home/magazine/2004/June2004.pdf.

Royal Commission into Aboriginal Deaths in Custody (1991) This report is in five volumes, available at: www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/. A summary is at: www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/rciadic_summary/rcsumk01.html.

Santa Barbara County Grand Jury (2001) Detention facilities and Sheriff's Department issues. Available at: www.sbcgj.org/2001/2001detfacfinal.htm.

Symington L & Robbie R (2008, unpublished) Care facilities for drunk and vulnerable people. 'Designated places' – 'Places of safety' with the UK. Available from Lothian & Borders Police, Edinburgh.

Vermont Department of Health (2005) Public Inebriate Program – Concept Paper. A report from the Public Inebriate Task Force. Available at: <http://healthvermont.gov/adap/treatment/documents/Feb05ConceptPaper.pdf>.

Young S, Wells D & Jackson G (1994) A tiered healthcare system for persons in police custody – the use of a forensic nursing service. *Journal of Clinical Forensic Medicine*, 1(1): 21-25.

ISSN 0950 2254
ISBN 978 0 7559 7700 0
(Web only publication)

www.scotland.gov.uk/socialresearch

RR Donnelley B62576 10-09

