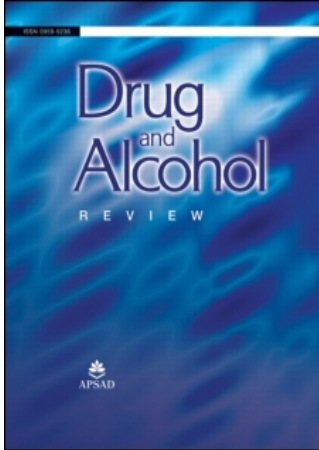


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The role of a rural sobering-up centre in managing alcohol-related harm to Aboriginal people in South Australia

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Abstract

*There is a paucity of literature on the topic of sobering-up centres (non-custodial safe overnight accommodation for the publicly intoxicated). This paper presents findings of a retrospective longitudinal case study of a sobering-up centre in regional South Australia over the ten years 1991 to 2000. There were 6,486 admissions during this period, 97.1% of which were of Aboriginal people. We collated and analysed primary data including demographic details of admissions and re-admissions, and qualitative and quantitative measures of intoxication. The findings from this case study, considered together with contextual understandings from a wider social study in this region by three of the authors, provide supporting evidence of the important role of sobering-up centres in averting the known harms of a custodial response to public drunkenness, as well as avoiding the potential harm of alcohol-related injury among vulnerable Aboriginal people. [Brady M, Nicholls R, Henderson G, Byrne J. The role of a rural sobering-up centre in managing alcohol-related harm to Aboriginal people in South Australia. *Drug Alcohol Rev* 2006;25:201–206]*

Key words: Aboriginal, harm reduction, sobering up-centre.

Introduction

Sobering-up centres have been established across Australia since the 1980s as humane forms of care for the publicly intoxicated, and as an alternative to individuals being arrested and held in police cells and watch houses. Lobbying to decriminalise public drunkenness (as well as other ‘status’ offences) began in the 1950s and gained authoritative support by the late 1960s [1]. In Australia, sobering-up centres have been integral to the decriminalisation of public intoxication. In some states laws allowed for the intoxicated to be cared for somewhere other than a police cell, but in reality few of these facilities actually existed. The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommended the establishment of more sobering-up services, and the use of imprisonment as a last resort [2]. An earlier Interim Report by Justice Muirhead recommended ‘adequately funded programs to establish and maintain facilities for the care and treatment of intoxicated persons’. He said that drunkenness should be decriminalised where it was not already [3].

Sobering-up centres do not pretend to solve the problems of alcoholism or of alcohol abuse in the community. A sobering-up centre is not a detoxification centre, nor is it geared towards long-term rehabilitation. Its role is to keep people out of police custody, to reduce alcohol-related harm and to offer practical care in a safe environment for a limited time, providing protection, shelter and food [4]. Sobering-up centres provide opportunities for brief interventions by drug and alcohol workers, referrals for further assistance, as well as respectful and humane treatment of a vulnerable population [5].

New South Wales decriminalised public drunkenness and legislated for alternative care in 1979. The Intoxicated Person’s Act (NSW) provides for locations to be identified as ‘proclaimed places’ in which people may be detained for being intoxicated in public—these include police cells and other facilities, operated by either government or non-government agencies [6]. In the Northern Territory, public intoxication was decriminalised in 1975. Alternative facilities were not

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established for another seven years, resulting in hundreds of Aboriginal people being 'apprehended' and held in police cells without charge. For example, in Tennant Creek in 1983, 94% of protective custody apprehensions were for Aboriginal people [7]. Since then, sobering-up centres have opened in Darwin (1983), Tennant Creek (1984) and Alice Springs (1986) [8]. The importance of sobering-up centres for the intoxicated was reiterated by the NT Coroner in 2003 while investigating the death of an Aboriginal man in police custody [9].

The Australian Capital Territory decriminalised public intoxication in 1983; a sobering-up centre opened in 2004. Western Australia did not decriminalise public drunkenness and open its first sobering-up centre until 1990 [10], following the RCIADIC. Tasmania and Victoria have sobering-up centres, but public intoxication remains an offence. It also remains an offence in Queensland, but after the RCIADIC, the Queensland government established 'diversionary centres' as an alternative to police watch houses for intoxicated people. South Australia decriminalised public intoxication in 1984 through its Public Intoxication Act—the culmination of many years of attempts to implement decriminalisation [11]. In 1988 the South Australian Government announced plans for two sobering-up centres (in Ceduna and Port Augusta) [12]. The move was prompted by a research paper issued by the RCIADIC that found Aboriginal males in the state were 100 times more likely to be detained for drunkenness than non-Aboriginal males, and that the majority of such apprehensions occurred in rural areas [13].

The focus of our study was the sobering-up centre located in Ceduna on the far west coast of South Australia. Ceduna is the regional centre of the West Coast Statistical Subdivision (WCSSD—35 226 km²) of South Australia. The mean total population of the WCSSD enumerated at the 1991, 1996, and 2001 Census was 6344 persons (range 6222–6446). The mean Aboriginal population of the WCSSD over the same period was 1020 people (range 902–1091), comprising 16.1% of the total population. Over the same period, the mean Aboriginal population of the Ceduna Statistical Local Area (SLA—5427 km² within the WCSSD) was 730 people (range 572–824, 20% of the total population), of whom 53.8% were aged > 18 years—similar to that of the overall Aboriginal population of the WCSSD [14,15].

The Ceduna sobering-up centre (CSUC) provides an acute service for individuals who are publicly intoxicated in Ceduna, whether residents or visitors. The CSUC opened in February 1990 with five beds and operated 24 hours per day from Tuesday to Sunday each week. For the period of our study, from 1991 to 2000, the centre was operated by Ceduna Hospital and

funded by Drug and Alcohol Services SA, but is now operated by the Ceduna/Koonibba Aboriginal Health Service (CKAHS). The centre is adjacent to the hospital and the health service, and is open to both Aboriginal and non-Aboriginal people.

Intoxicated people can access the CSUC in a number of ways, including referrals by CSUC and hospital staff, police, CKAHS staff, family members and friends, and by the Mobile Assistance Patrol (MAP)—a community pick-up bus service operated by the CKAHS.

Design and methods

This study, which had the ethical approval of five stakeholders, was part of a broader research project by the authors on reducing alcohol-related harm in Aboriginal communities in the region [15,16]. We compiled, collated and analysed primary client data from the CSUC over the period 1991–2000. This primary data included client name, date, Aboriginality, age, sex, breathalyser reading at admission, number of previous admissions and method of referral. Place of residence was not recorded by the CSUC. Staff estimated blood alcohol concentrations using a Lion Alcometer S-D2. Readings were recorded as percentage of blood alcohol concentration (eg. 0.050% is equivalent to 50 mg of alcohol per 100 ml of blood). The staff also recorded a qualitative assessment of patients' condition upon arrival (see Table 1). All primary data were recorded routinely by hand in a logbook at the centre. Admission procedures were the same throughout 1991–2000. We assessed the quality of the primary data as we entered it into a computer using range and consistency checks. Data for June and part of July 1992 were missing from the logbooks. We used a random data sample of 252 Aboriginal admissions to test the association between the condition scale and estimated blood alcohol concentration, and obtained a correlation coefficient of 0.85 that was significantly ($P < 0.001$) greater than zero.

On admission, clients were showered, dressed in clean pyjamas and put to bed. When sober, they were given a light meal and discharged by 8.00 a.m. the following morning, their clothes having been washed and dried overnight. Clients could only stay 1 night per admission. We followed a cohort of 23 Aboriginal clients from one community (known by the researchers and staff to be their normal residence) in order to investigate their pattern of admissions and re-admissions. We analysed the data (normally distributed) using STATA software (Timberlake Consultants Ltd) and statistical tests including the *Z*-test, Student's *t*-test, analysis of variance and Pearson's product-moment correlation [17].

Table 1. Scale and indicators used to determine condition upon arrival

Scale	Indicators	Estimated blood alcohol concentration range (%)
Condition 1	Presenting reasonably normal, steady on feet (balanced), reasonable coordination of eyes and limbs, clear speech, able to follow instructions, able to blow on the Alcometer, undress, shower and dress unaided. May be anxious or aggressive on occasions	000–0.100
Condition 2	Somewhat unsteady on feet (unbalanced), slurred speech, some difficulty in following instructions, may need some help in showering, not mentally alert, may be anxious or aggressive on occasions, can blow on the Alcometer but may need encouragement	0.100–0.200
Condition 3	Presenting unbalanced, difficulty talking and following instructions. Slow response time. May be sick, with strong alcohol breath. Disorientated, anxious, may be aggressive and violent, poor coordination of eyes and limbs, will need assistance in showering and going to bed, may have some breathing difficulties	0.200–0.300
Condition 4	Very unbalanced, unable to follow instructions, cannot undress, shower and dress for bed unassisted. Strong alcohol breath, difficulty breathing, drowsy, incontinent, poor condition of eyes and limbs, crying	0.300–0.400
Condition 5	Comatose. Seriously unwell. Need to transfer to hospital for care	> 0.400

Results

Over the 10-year period 1 January 1991 to 31 December 2000, there were 6486 admissions (mean 648.6 admissions/year, 95% CI 536.6–760.6), of which 6301 (97.1%) were of Aboriginal people. While there was a peak in annual admissions in 1994, coinciding with a large influx of Aboriginal visitors to Ceduna from Western Australia, overall there was no significant change in annual admissions over the 10-year period.

Of the total Aboriginal admissions, 4162 were males (mean 412.2 admissions/year, 95% CI 352.1–472.3) and 2139 were females (mean 217.9 admissions/year, 95% CI 153.5–282.3). The greater number of admissions of males compared to females was significant ($p < 0.001$). There was a small but significant ($p < 0.05$) difference in the mean age of admission for Aboriginal men (mean 42.9 years, 95% CI 41.5–44.3 years) and women (mean 40.6 years, 95% CI 39.1–42.2 years).

The mean monthly number of admissions of Aboriginal people over this period was 53.3 (95% CI 49.5–57.0). There were significantly ($p < 0.01$) more monthly admissions in the warmer and drier months between November and March (mean 59.3, 95% CI 52.6–66.0) than during the cooler and wetter months from April to October (mean 48.8, 95% CI 44.8–52.8).

Of the modes of referral of Aboriginal clients to the CSUC, 62% were by the staff of the CSUC and Ceduna Hospital, 25% by the Ceduna Police, 9% by the MAP, 3% by the CKAHS and 0.9% by other modes. There was a significant ($p < 0.001$) decline in referrals by the Ceduna Police from 1991 to 2000, and a significant ($p < 0.005$) increase in referrals by CSUC and Ceduna Hospital staff.

Table 2 shows the condition score of Aboriginal clients at the time of admission. Admissions for females and males differ for condition 1 (females 5.3% higher) and condition 3 (females 5.8% lower), but are similar for the remaining condition scores. The comparable data for non-Aboriginal admissions ($n = 185$ people) showed a higher percentage of clients with condition 1 (41.1%), a lower percentage with conditions 2 and 3 (30.3% and 22.2%) but a similar proportion with condition 4 (5.4%). No non-Aboriginal people had a condition score 5.

Over the study period there were 411 Aboriginal individuals admitted for the first time, with an annual mean of 41.1 people (95% CI 33.8–48.4). However, Table 3 shows that a large proportion of all the Aboriginal admissions (6301) were for re-admissions, with one male individual being re-admitted 423 times.

Table 4 shows the admissions of a cohort of 23 Aboriginal people (13 males and 10 females) whose normal residence was a community beyond Ceduna.

Table 2. Percentage of Aboriginal admissions over the period 1991–2000, by condition score and sex

Condition score	Females (n = 2139)	Males (n = 4162)	Total (n = 6301)
1	23.09	17.78	19.58
2	42.26	41.61	41.83
3	28.19	34.02	32.04
4	5.33	5.72	5.59
5	0.51	0.17	0.29
n.r.	0.61	0.70	0.67
Total	100%	100%	100%

n.r. = Not recorded.

Table 3. Percentage of Aboriginal admissions and re-admissions over the period 1991–2000, by sex

Number of admissions per individual*	Percent of admissions		
	Females (n = 2139)	Males (n = 4162)	Total (n = 6301)
1–9	31.45	24.87	27.11
10–49	33.55	29.15	30.65
50–99	13.60	14.68	14.32
100–149	9.16	9.30	9.25
150–199	6.63	6.15	6.31
200–249	2.80	5.65	4.68
250–299	2.15	3.32	2.92
300–449	0.33	6.44	4.36
n.r.	0.33	0.43	0.40
Total	100%	100%	100%

n.r. = Not recorded. *The intervals in column 1 are unequal in size.

Table 4. Admissions to CSUC by a cohort of 23 Aboriginal individuals over the period 1991–2000

Number of admissions per individual	Number of individuals	Number of admissions	Percent of admissions by the cohort
1–10	5	30	1.48
11–30	8	178	8.79
31–100	4	273	13.48
101–200	3	477	23.56
201–300	1	297	14.67
301–400	2	770	38.03
Total	23	2025	100%

This shows the large number of admissions to the CSUC by a small number of individuals.

Alcometer readings were obtained for 5870 Aboriginal admissions (93.2% of all Aboriginal admissions)

and for 173 non-Aboriginal admissions (93.5% of all non-Aboriginal admissions). Reasons for not obtaining a breathalyser reading included clients refusing to blow or being too intoxicated to blow. The mean estimated blood alcohol concentration of the Aboriginal admissions (mean 0.217%, 95% CI 0.215–0.219%; range of values 0.000–0.550; $n = 5870$) was significantly ($p < 0.001$) higher than that of the non-Aboriginal admissions (mean 0.159%, 95% CI 0.145–0.173%; range of values 0.000–0.550%; $n = 173$). The difference between Aboriginal and non-Aboriginal clients at admission was 0.058%. The mean estimated blood alcohol concentration of male Aboriginal admissions (mean 0.226%, 95% CI 0.223–0.229%; range of values 0.000–0.550%; $n = 3913$) was significantly ($p < 0.001$) higher than that of female Aboriginal admissions (mean 0.199%, 95% CI 0.195–0.202%; range of values 0.000–0.480%; $n = 1957$).

Discussion

The majority (97%) of people who use and benefit from the service are Aboriginal residents of Ceduna and visitors from the wider region. High usage by Aboriginal people is related to the extent of public drinking, a lack of accommodation, the role of the town as a service hub for Aboriginal people in the region and the activities of the MAP [15,16]. Large numbers of Aboriginal people travel through the area in association with periodic ceremonial activity (as shown in the Results) and as part of the normative high mobility of desert people [18,19]. It is when Aboriginal people are visiting Ceduna (for whatever reason) that they may become clients of the CSUC.

Most people accessing the CSUC are in their early to mid-40s—undoubtedly people who have been drinking for many years. Few have received any comprehensive help or the chance for a full assessment; the nearest residential treatment programmes are in Alice Springs or Murray Bridge, both over 1000 km away. Younger Aboriginal people are not accessing this facility because their drinking takes place in less public locations, such as private houses. The chief executive officer of CKAHS considers that young people in the town are polydrug users and their pattern of substance use does not expose them to the public gaze and therefore referral to the CSUC. Findings from elsewhere suggest that there is increasing polydrug use among young Aboriginal people [20,21].

The assessment of clients' condition, together with the estimated blood alcohol concentrations show that on arrival, Aboriginal people were highly intoxicated. The high levels of intoxication among females may reflect the way in which women's bodies process alcohol (the fact that they generally have less fluid and more fat in their bodies), rather than indicate that they

are consuming more alcohol. Non-Aboriginal clients were fewer in number and generally presented with lower intoxication levels. These findings support national survey data estimating that 82% of all Indigenous current drinkers consume at risky or high-risk levels compared to 28% of non-Indigenous drinkers [22]. In view of the levels of intoxication documented here, it is likely that these individuals would be at high risk of injury, abuse or death if they were not offered the humane care and safety of this facility [15].

Sobering-up centres may, however, evoke concerns about rewarding drunken behaviour while doing nothing to prevent drinking. On the contrary, when police or the MAP pick people up these interventions act to stop a drinking episode, reinforcing the message that public intoxication is socially unacceptable. When people are sober and fed, they have a chance to think about their drinking and may be amenable to further discussion and assistance [5]. Another concern sometimes expressed is that sobering-up centres function as a 'revolving door'. Our data certainly show that a large proportion of Aboriginal admissions were in fact re-admissions, with three individuals accounting for 16.9% of all Aboriginal admissions. However, over the 10-year period, almost one-third (27.1%) of the total number of admissions represented individuals who utilised the CSUC on less than ten occasions. Our analysis of the re-admissions data demonstrates the urgency of using this information to direct interventions at the local and broader public health policy levels. The high levels of intoxication raise questions about responsible service of alcohol in the region; the older age range of clients implies that little has been done to assist them earlier; and reliance on this overnight acute-care facility highlights the lack of accessible alternative treatment facilities. At the service delivery level, the regular clientele attending the CSUC present a pressing case for more targeted help to be offered by way of referrals, giving information and engaging in more intensive individualised interventions. With increased resources and training for staff, sobering-up centres such as this could greatly increase the content and range of their services.

Conclusion

The decriminalisation of public drunkenness is part of a continuum in societal responses to high-risk alcohol consumption and related harm. Like strategies such as random breath testing and the regulation of liquor licensing, decriminalisation (and the non-custodial facilities such as sobering-up centres) are examples of statutory interventions that support harm reduction.

This paper illustrates the ongoing need for these facilities as part of the armoury of harm reduction

strategies. Sobering-up centres fulfil a crucial acute-care function that diverts extremely intoxicated individuals from custodial care, protects them from accidents, self-harm and harm to others in the community and helps to avoid conflict. Given the relative lack of transport and accommodation options—particularly for those from out of town—the MAP and CSUC are important public services for Aboriginal people. In addition, sobering-up centres have widespread support from the communities they serve. Some are managed by Aboriginal people themselves, and community-based programmes such as mobile pick up services, night patrols and health services should ideally work collaboratively with them on a daily, and nightly, basis.

This case study provides an illustration of harm reduction in an area of alcohol policy and intervention that directly affects Aboriginal communities. It also reaffirms the social welfare rationale behind the provision of sobering-up centres, apart from any political, legal or philosophical rationale for their existence.

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