COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:
Ms CP McMillan MP—Chair
Mr SA Bennett MP (virtual)
Mr MC Berkman MP
Ms AB King MP (virtual)
Mr JP Lister MP (virtual)
Mr RCJ Skelton MP

Staff present:
Ms L Pretty—Acting Committee Secretary
Ms R Mills—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE DECRIMINALISATION OF CERTAIN PUBLIC OFFENCES AND THE HEALTH AND WELFARE RESPONSES

TRANSCRIPT OF PROCEEDINGS

TUESDAY 12 JULY 2022

Brisbane

TUESDAY, 12 JULY 2022

The committee met at 10.31 am.

CHAIR: Good morning, everyone. Thank you very much for being here this morning. I declare open this public briefing. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands, winds and waters we all share.

My name is Corrine McMillan. I am the member for Mansfield and chair of the committee. With me here today are Mr Michael Berkman MP, member for Maiwar; Mr Rob Skelton MP, member for Nicklin; Mr Stephen Bennett, the member for Burnett and deputy chair, via teleconference; Mr James Lister MP, member for Southern Downs, who is substituting for Dr Mark Robinson, the member for Oodgeroo, via teleconference; and Ms Ali King, member for Pumicestone, who is substituting for Ms Cynthia Lui, the member for Cook, via teleconference.

The briefing is a proceeding of the Queensland parliament and is subject to the rules of parliament. The proceedings are recorded by Hansard and broadcast live on the parliament's website. Media may also be present and are subject to my direction at all times. The media rules endorsed by the committee are available from the committee staff if required. All those present today should note that it is possible you might be filmed or photographed during the proceedings by media and images may appear on the parliament's website or social media pages. I ask everyone present to turn mobile phones off or to silent mode. Only the committee and invited officers may participate in the proceedings. As parliamentary proceedings, under the standing orders, any person may be excluded from the briefing at the discretion of the chair or by order of the committee.

The purpose of today's briefing is to assist the committee with its inquiry into the decriminalisation of certain public offences and the health and welfare responses that accompany that. I ask that responses to questions taken on notice today are provided to my committee by 5 pm on Friday, 29 July 2022. The program for today has been published on the committee's webpage and is available to the public. Hard copies are available from committee staff. I also welcome all of those members of the public who are watching online this morning.

BROWN, Mr Anthony, Director, Legislation Branch, Policy and Performance Division, Queensland Police Service

GOLLSCHEWSKI, Deputy Commissioner Steve, Deputy Commissioner (Southern Queensland), Queensland Police Service

TAYLOR, Deputy Commissioner Paul, Deputy Commissioner (Regional Queensland), Queensland Police Service

CHAIR: This morning it gives me great pleasure to welcome and acknowledge representatives from the Queensland Police Service. First is Deputy Commissioner Steve Gollschewski, who is known to all of us. Thank you for your great work during COVID, leading the response on behalf of the Queensland police. You did an outstanding job, and the committee acknowledges and appreciates your ongoing commitment to public service here in Queensland. Deputy Commissioner Paul Taylor from Regional Queensland: your contribution is going to be significant today, given your knowledge of regional Queensland, so thank you for being here today. I also acknowledge Mr Anthony Brown, Legislation Branch, Policy and Performance Division. It is great to have you here similarly. Good morning to each of you. Thank you again for your service to Queensland and to Queenslanders. Thank you for appearing before the committee today and assisting us with our inquiries. I invite you, Deputy Commissioner Gollschewski, to make a brief opening statement, after which the committee members, I am sure, will have very many and important questions for you.

Deputy Commissioner Gollschewski: Thank you, Chair, and good morning to you and the committee. Thank you for the opportunity to brief the committee about the decriminalisation of certain public order offences under the Summary Offences Act 2005. Firstly, I pass on Commissioner Carroll's apologies to the committee. Unfortunately, she has a prior commitment preventing her being

here today. However, I can assure you that this inquiry has the commissioner's full support. I was speaking to her this morning about it and she is taking a very keen interest on its outcome. I am Steve Gollschewski, as you know. I am the Deputy Commissioner for Southern Queensland and I am joined today by Deputy Commissioner Paul Taylor for Regional Queensland and Anthony Brown, who is the Director of our QPS Legislation Branch.

The QPS has provided a written briefing for the committee addressing the terms of reference for the inquiry insofar as they relate to the functions of the Queensland Police Service. I will not restate the information already provided in our written briefing, but there are some important observations that can be drawn from it that I would like to highlight.

Firstly, the numbers of people charged by police for public urination, public begging and public intoxication are low. In 2021, 182 persons were charged with public urination. That equates to less than four people per week. During the same period, police issued 602 infringement notices for public urination, or about 12 per week. For public begging, 44 persons were charged during 2021 and only 18 infringement notices were issued. With respect to public intoxication, the story is similar: in 2021, the police charged 1,256 people with public intoxication. That is roughly 24 persons per week of whom approximately half would typically identify as Indigenous. By comparison, between April 2014 and March 2019, Victoria recorded an average of 8,269 public drunkenness offences per year, or 159 per week. Our police in Queensland do their utmost to ensure that people do not end up in a police cell to sober up, but that is not always possible. This is either because of a lack of alternative places of safety or because of their aggressive behaviour.

In addition to the statistics provided, we have also looked at records for public intoxication offences during the first quarter of 2022. This has provided a better understanding of what is occurring on the ground. Those records indicate that the public intoxication offence is being used by police as a low-impact way of intervening to prevent other offences being committed or the offenders coming to serious harm and/or to prevent the escalation of their behaviour to more serious offending. For example, an offender would not leave the Fortitude Valley safe night precinct after being given a banning notice; the offender was intoxicated and unable to understand the direction; the offender was arrested and taken into custody for his own safety and to prevent further offending.

In Aurukun, our police attended an incident involving a highly intoxicated person who was using a broomstick during a fight. Police detained the person for both his safety and that of others.

In Mackay, an offender with a cut to her head was attended to by the QAS, who assessed her but declined to transfer her to hospital for further treatment. The woman could not provide an appropriate address to police to divert her to and she told them she planned to sleep on the rocks next to the river. The woman was arrested and transported to the Mackay watch house for her own safety.

Gold Coast police observed a man walking down the middle of Surfers Paradise Boulevard. Police assisted the offender off the road and onto the footpath. The police advised the person to stay on the footpath and off the road. However, he continued to argue with the police and physically resisted them. He was arrested and conveyed to the Southport watch house for his safety, where he continued his noncompliant behaviour.

In Townsville, our police located a man arguing with another person in the vicinity of licensed premises. Police directed the offender to leave, but he failed to do so. Police arrested the offender and attempted to divert him to a diversion centre; however, the centre would not accept him. Police spoke to a relative, who also told police they would not accept him.

Innisfail police had previously taken an intoxicated person to hospital; however, a call was later received from the hospital advising that that person was not listening to directions and was being disruptive. Police were compelled to return to the hospital and arrested the person for public intoxication to prevent further offences being committed and repeated calls for service from the hospital.

Finally, as an example, in Toowoomba an intoxicated person in a shopping centre was removed by centre security staff but repeatedly attempted to re-enter whilst intoxicated. Police arrested and transported the person to Toowoomba Hospital and then attempted to place him with a family member; however, no-one would take responsibility for him. The police were left with no option but to transfer the person to the Toowoomba watch house as a place of safety.

These incidents I have briefly recounted to the committee are typical of the more than 100 incidents recorded in the first three months of this year. I can also advise the committee that in the vast majority of these 100-plus incidents the conduct of the offenders involved could have resulted in

charges with more serious consequences. Had officers not chosen to exercise their discretion, some offenders may well have been charged with offences such as public nuisance, failure to leave licensed premises, consuming liquor in a public place, creating a disturbance or nuisance in or on passenger vehicle, wilful exposure, wilful damage, affray, trespass, pedestrians causing traffic hazards or obstructions, stealing and going armed so as to cause fear. The QPS is very pleased to be here today to assist the committee with its inquiry, and we will do our best to answer questions the members may have about our QPS responses to public urination, public begging and public intoxication. Thank you.

CHAIR: Thank you very much, Deputy Commissioner. I assume, Deputy Commissioner Taylor and Mr Brown, you do not have anything to add at this stage?

Deputy Commissioner Taylor: No, Chair.

Mr Brown: Nothing, thank you.

CHAIR: I am sure you will adequately respond to the questions we have.

Mr BENNETT: Being a regional member, my question is to Deputy Commissioner Paul Taylor. What has just been outlined for me raises some concerns. Particularly in the regional jurisdictions where public intoxication and particularly urinating in public places has been identified, what are the alternatives? I know that we will talk about diversionary centres but, with that parked for a minute, what other options, if something like this was decriminalised or made legal, would the police officers have at their disposal to deal with particularly public safety?

Deputy Commissioner Taylor: Firstly, they need to have the capacity to take people into custody for their safety and the safety of others. With regard to opportunities to divert, first and foremost in most locations they look at a place of safety, which invariably could be the person's address, in particular if there are people at that address—friends, family—who are able to suitably look after the person in question. Secondly, if that is not available, there is the opportunity to refer to a place of health. A lot of these things depend on the behaviour of the individual. On occasions, on presentation to a health service, apart from the fact that the health services may be challenged in that particular area, the person's behaviour may prevent that from being successful. Thirdly, in those locations where there is a capacity for a diversionary centre and that centre is suitably staffed, that is predominantly where the police take the person to. The issue there is that they are contracted arrangements and, where they are familiar with a lot of the clients that the police divert there, they refuse to take those clients who have had a previous position around violence with staff members at those centres. There are frequent occasions where the police, whilst trying to divert to suitable places, are unable to secure those, so they go to the watch house on those occasions. From a watch house perspective, in conversations with the watch house staff, no-one wants a person in custody who is intoxicated. They are aware of the ongoing health issues. I hope that answers your question.

Mr BENNETT: Deputy Commissioner Taylor, I was just trying to flesh this out. If public intoxication becomes legal, do police officers have other mechanisms to direct, coerce or help intoxicated persons or to ensure public safety if these people are playing up? Will this impede police officers' capacity to do just as you outlined with all of those opportunities or potential scenarios?

Deputy Commissioner Taylor: I think you can decriminalise it, but you need to have a capacity for police to respond to an incident and take persons into custody for their safety and the safety of others and look at those diversionary opportunities. A very similar situation happened with volatile substance issues where opportunities to divert were looked at. In that situation, if there was no place of diversion, I think custody comes to an end if you are unable to place them elsewhere. The problem for us if that was to occur with someone who was intoxicated, for example, is that it leaves us in a very vulnerable position. Given it was a police response, it could subject the police involved to scrutiny, particularly if someone becomes injured after police have released them with no suitable person to look after their welfare. If they were injured or, indeed, if as a consequence of their activities they died, the matter would be subject to a coronial review and possibly could be considered as an injury in custody or a death in custody or police operations, so there needs to be that ability.

I think the statistics clearly show that police do not want to take people who are intoxicated to watch houses. They go out of their way not to. From my experience, there have been a number of occasions where there have been partnership arrangements, and by that I mean there have been entities that have been funded, agencies that recognise particular issues, where they have collaborated with police. There has been the use of First Nations police liaison officers to try and resolve issues in public spaces and move that person to a place of safety. They have been ad hoc arrangements.

In those areas—for example, Cairns and Townsville—where there are economic centres that thrive on tourism and night-life, they are the same places where predominantly people gravitate, so there needs to be a capacity there for police to respond to calls for service in a way that balances the safety of the individual and those around them but also recognises those individuals' human rights. We need that mechanism. If you decriminalise it, you could still have that mechanism there. The other point I should have mentioned is that, with regard to diversion centres, there is an issue around juveniles. My understanding is that any person under 18 will not be accepted at a diversion centre.

CHAIR: Out of the figures that you provided, can you give some indication of, firstly, the number of First Nations people involved and, secondly, known illnesses or conditions that generally could be considered to require a social welfare response rather than a criminal response? We know, for example, that individuals with diabetes have urinary tract and urinary control issues. There are also First Nations people who are known to have issues with alcohol et cetera. What sorts of figures are we talking about in terms of the number of people who have been arrested who are First Nations people with a health condition who would benefit from a health or welfare response rather than a criminal response?

Deputy Commissioner Gollschewski: Can I just start by giving some context. These offences are really nuanced. Generally speaking, when police are investigating offending behaviour they are trying to address offending behaviour, so with that comes the consequence of an arrest and a charge or a notice to appear and then consequences for that behaviour. The nuance with this is that it is not about addressing offending behaviour; it is about minimising risk of harm to individuals and the community. They are using a system that, whilst it carries an offence, is not about the offence; it is about trying to mitigate that risk and harm. It is a very important nuance, but without the ability to do that our police are not able to address potential harm to the individuals involved.

With respect to your question, as per attachment 1, 47 per cent of all people charged for urinating in a public place identified as being Indigenous, 46 per cent of all people charged for public intoxication identified as being Indigenous, and 64 per cent of all persons charged with begging identified as being Indigenous, so there is a significant over-representation of Indigenous people for these offences. With respect to your other question around health issues, we will probably have to take that on notice. Whilst there is some health data collected by our watch houses, we will have to look at the availability of that very specific information and come back with that.

CHAIR: What comes to my mind is that generally people do not choose to engage in that behaviour publicly, so I am interested to know the health context and the relationship to Indigeneity and socio-economic status et cetera.

Deputy Commissioner Taylor: I would just add that from a Far North Queensland perspective there are very complex underlying health issues which are not apparent. Whether they be physical health issues such as diabetes, mental health issues or a combination of many, they are difficult for police to understand because they are not apparent. Obviously there are privacy issues around an individual's health information, so it is difficult. That is why there are proactive strategies around vulnerable people with predetermined health conditions who, when you add alcohol to it, become quite volatile. I think there are opportunities there from that perspective to minimise our interaction.

Mr BERKMAN: I appreciate your time today. Thank you for the written briefing; it is a very helpful starting point. Deputy Commissioner Gollschewski, in your opening statement you listed a number of alternative offences that might be used instead of public drunkenness. I did not catch them all. They will obviously be in *Hansard*. I am keen to understand whether that is the full suite of offences. Are there others? I did wonder specifically about offensive language offences, given they were also mentioned in the Royal Commission into Aboriginal Deaths in Custody. Is there a complete suite of alternative offences that you could provide us with and give an indication of how likely it is that they would be used as an alternative to public drunkenness?

Deputy Commissioner Gollschewski: I think offensive language would be covered by the disorderly conduct offence under the Summary Offences Act. I think there were a number of previous offences under the old Vagrants, Gaming and Other Offences Act that all got pulled down into that catch-all, if you like. Our point is that our police are left with the situation where they have to address this harm issue. When people are at risk one way or another, not only the offender but also potentially other members of the community—if there is not this softer approach where they can take people into custody and divert them to a place of safety—they are going to have to resort to other offences that may be at their disposal, and some of them are much more serious. That is not an exhaustive list. It would depend on the circumstances of the behaviour involved. If there is a serious criminal offence committed, that will still have to be dealt with anyway under current circumstances. Intoxication, of course, is not a defence necessarily. That is there. We can certainly revisit that list. I do not know

whether Mr Brown might be able to assist with this. There are probably offences that were taken from some of those examples that would have been otherwise done by the police if they did not have the ability to take people in custody.

Mr Brown: That is correct. Probably the most likely offence that police would turn to would be public nuisance, which captures those sorts of things like offensive language and disorderly conduct. Once the threshold of behaviour goes beyond just simply being drunk in public, then you start to deal with more serious criminal offences and take action for those things. As Deputy Commissioner Gollschewski said, it is no longer a matter of being drunk in public; you have done something more serious than that which needs to be dealt with.

Mr BERKMAN: I expect this is something that would need to be taken on notice, but are you able to provide the committee with information on, for example, the list of offences you mentioned before and the comparative penalties that are available, just so we can understand the relative seriousness of them?

Deputy Commissioner Gollschewski: Yes.

Mr BERKMAN: Is sleeping in cars an offence at a state level or is that something that falls within local government?

Deputy Commissioner Gollschewski: I think that would be covered by local government by-laws.

Deputy Commissioner Taylor: Yes. The problem is: if they are intoxicated and they are in charge of the car, it takes it to another level, because they can still be technically charged with being in charge of a car, which carries the same penalty as 'did drive'. They have to actually take manifest steps to show they were not going to drive; for example, they have got rid of the keys or given the keys to somebody else. There are local government issues particularly around locations where people congregate, so you would have to have a look right across the board at which local governments it would impact. I know that some governments have put up 'no parking' and 'no standing' signs at locations people congregate to try to mitigate the risk.

Mr BERKMAN: Yes, those beachfront parking lots are a classic example. You did mention in passing before that juveniles cannot be accommodated in those diversionary centres. I just wanted to check the figures that you have provided in the attachments. Do they include charges laid against juveniles?

Deputy Commissioner Gollschewski: They are all offences.

Deputy Commissioner Taylor: So that would include them, yes.

Mr BERKMAN: Is it possible to get a breakdown? In the same way we have a breakdown of Indigenous and non-Indigenous charges, could we get a list of under-18s and potentially even under-14s?

Deputy Commissioner Gollschewski: Yes.

CHAIR: I think that is really important information to request, particularly for those young people who obviously would require a different social welfare response to the diversionary programs that you mentioned.

Mr SKELTON: I am going to ask about the begging side of things and the difficulties in maintaining public safety, individual safety and the law. It happens a lot more in the tourist areas. Are you aware of any data regarding begging and fraud, for example, and beggars being part of organised begging rings to fraudulently cash in on public sympathy?

Deputy Commissioner Gollschewski: I think you are right about the locations.

Mr Brown: In attachment 1 to the written briefing there are some statistics on begging.

Deputy Commissioner Gollschewski: That data breaks it down into regions, if you like—Brisbane, South Brisbane, North Brisbane, Central. Then it gives you the actual figures of numbers per year. You can see that it tends to be more congregated in the larger areas but also to some degree in Northern region. I am certainly not aware of any evidence or intelligence of organised begging rings, per se, but that is something we can certainly follow up to see whether we have any—

Mr SKELTON: It is just a random type of thing? What I am touching on is probably different from how after disasters you have the scamming type of thing.

Deputy Commissioner Gollschewski: Yes, I am familiar with what you are talking about.

Mr SKELTON: It is not like what occurs in the Third World either, where they organise things.

Deputy Commissioner Gollschewski: These are low numbers annually. We are talking about very low numbers in that offence.

Mr SKELTON: Thank you.

Deputy Commissioner Gollschewski: I am not aware of any charges. There are the three offences. It is begging and soliciting but not using the children. I do not think we have seen that charge at all in recent times.

Mr SKELTON: Thank you.

Mr LISTER: In the case of antisocial offences such as urination in public, obscene language and so forth, what proportion of charges are the result of a public complaint as opposed to police detecting it themselves or witnessing it themselves?

Deputy Commissioner Gollschewski: We do not have that figure with us in this data, but we will follow up on that and see whether we can break that down. That will come back to our QPRIME data as to how the complaint was received in the first place—whether it was police detected or a complaint of the public. We will follow up on that.

Ms KING: Is there any data available as to what proportion of people charged with all three of this suite of offences are experiencing homelessness?

Deputy Commissioner Gollschewski: That may be a difficult one. It will come down to the identifiers that go into our system. Whilst we can identify First Nations clearly, in terms of homelessness we will follow up to see whether we can and come back.

CHAIR: Deputy Commissioner Taylor, do you have any comments in relation to that from your firsthand observations—without quoting figures, of course? Can you give a general sense of the degree of homelessness amongst those charges or arrests?

Deputy Commissioner Taylor: With regard to the northern part of the state, predominantly a lot of these offences are what I would call itinerant. The itinerant group is a broad range of people. It could be people who are homeless; it could be people whose houses are some distance away and they have come to a city for a range of services. The councils that I have seen over recent years have really increased access to public toilets. Some time ago, the doors of a lot of public toilets were closed after hours. In fact, in some cases councils have instigated, particularly in safe night precincts and where there is a high volume of tourists and other people, public toilets being available 24/7. In the places where some of these offences occurred, no doubt that has taken a bit of pressure off. Whilst the statistics do not show a dramatic decrease, there has not been a massive increase in the statistics.

CHAIR: This is probably more a question for the Department of Health, but I am interested. One of the findings from the inquiry into social isolation and loneliness that this committee led concerned the limited number of toilets and showers available in some council parks throughout Queensland. This hindered some of this access for homeless people, itinerant people and some of our First Nations community. In your eyes, would it be beneficial to include showering facilities as well as toilets in some of those regional areas? I am thinking about those people in particular who suffer health issues such as diabetes where adding alcohol to a health condition like that can cause some discomfort and embarrassment to individuals. Would that be useful?

Deputy Commissioner Taylor: Perhaps I can comment again from my observations in the north and the far north in particular. In my view, councils have expanded the availability of toilets. I know that in locations where they have expanded both toilet facilities and showering facilities it creates opportunities. Backpackers is a huge movement. You tend to get a lot of backpackers gravitating to the parking areas. It is a situation of trying to get that balance right.

The diversion centres, apart from being diversion centres for places of safety for those who are intoxicated, have a number of beds for homeless and itinerant people. Again, unfortunately, because of the behaviour of some clients, they get 'do not come again' on the door. There are opportunities, I think, to talk to councils about those issues. Some councils employ rangers who actually police activity so that people are not excessively using those facilities. Perhaps there are avenues there.

CHAIR: As I mentioned, your experience in the Far North and regional Queensland is of great benefit to the committee.

Mr BENNETT: I would like your thoughts on urinating in public spaces. I know of the toilet issue. As the chair mentioned, we held an inquiry and noted that that has to happen. In the meantime, with the reality of this offensive behaviour carrying on, what else do you see? How else would a person get arrested for urinating in a public place? Is that public nuisance? Is it an offence or is it just downright disgusting?

Deputy Commissioner Gollschewski: There are other offences. There is public nuisance. There is also wilful exposure. That carries other implications. Even though it is a Summary Offences Act offence—I think it carries only a couple of penalty units—it has other connotations if it is on someone's criminal history. There is that sexually offensive type connotation about it. For someone who is simply urinating in public because of circumstance, it is not the sort of place we would want to go even though it is available. There are some difficulties with those.

I think it is really important to understand the demographics that sit with some of these statistics. If you look at begging, urination and intoxication, it flips from the south-eastern region, which is the Gold Coast. The numbers are very much non-Indigenous. You have demographics at play here. If you go to the north of Queensland, it goes completely the other way. My suspicion is that—we will do some work about whether we can identify this—homelessness on the Gold Coast, for instance, would be quite low, whereas in Brisbane, where we see some numbers around begging, homelessness would probably come into play fairly significantly. When you look at the figures across our report and across the different areas, you can see what local issues come into play with how the offences are playing out. I just wanted to make that point.

CHAIR: It is a complex issue and we appreciate your analysis of that.

Mr BERKMAN: I appreciate that in the written briefing you have identified that public intoxication offending is more widespread across the state. You have listed specific districts including the Far North district, Townsville, Mackay, Mount Isa, Darling Downs and Capricornia. Can you give the committee any more specific guidance around which regional centres we might most usefully visit to see the state of play of the diversion centres and whether there are particular gaps or needs in terms of those social support and health responses should this be decriminalised?

Deputy Commissioner Gollschewski: Paul might want to comment on the north. We see this very much tied to certain areas such as tourism areas in Cairns. I think there are some challenges in that area. We have identified in our brief, too, that in some instances, even though there are diversionary centres, they are not as effective as we would like to see. I think that is probably where we should focus on what is happening on the ground.

The issue for us in the absence of those sorts of services is that we are reverting to the watch house approach, which is an increased risk, obviously, as Paul has already identified. There is a list here within the brief where we have identified those areas. It has identified the numbers of persons charged in 2021. You can see that on the Gold Coast, for instance, there were 347 but there is no available diversionary centre. As I said, the demographics there are probably quite different from what you would see in places such as Townsville and Cairns. As a starting point, I think some of those places with diversionary centres would be the place to start.

Deputy Commissioner Taylor: If you look at the statistics and if you look at the representation from First Nations, Cairns is a location where you see predominantly First Nations. If you have a look at the statistics that have been provided you will see that there are 317 offences but only 258 persons. Within that, you have people who have been taken into custody multiple times. Compare that to the non-Indigenous. Sometimes the indicators for First Nations and non-Indigenous are not as clear. If persons do not readily identify or do not identify through questioning, they are shown as non-Indigenous, so it could be higher than the statistics show. It will give you a good idea particularly of the interaction between the services that are on the ground and what the friction points are between police responding and the opportunities for diversion. Perhaps in a different context but still First Nations is Mount Isa. Predominantly, the issue for Mount Isa is not Mount Isa residents and potentially not Queensland residents; they are from the Northern Territory. The issue there is actually an issue for First Nations. The Kalkadoon people in Mount Isa are quite affronted as well because of the issues that are created by people from the Northern Territory. It gives a different complexity around the issue and how it is there. As Deputy Commissioner Gollschewski mentioned, it is the reverse where you have those safe night precincts in particular, where a high volume of patrons go to the nightclubs. In terms of urination and intoxication, you probably see a majority of them being non-First Nations people.

Mr BERKMAN: A field trip to Surfers then, Chair?

CHAIR: Thank you, member for Maiwar. At your levels of leadership, is there work being done across departments to capture the status of homelessness or the nature of living arrangements for those people arrested? Is that captured by other government departments perhaps, or is there some collegial work around that? I just concerned, within those statistics, about the consideration around the number of people who may be at risk of homelessness.

Deputy Commissioner Taylor: There have been a number of ad hoc activities in terms of collaboration. Predominantly they have been because of relationships built between key stakeholders where there is a recognition that collaboration is going to deliver a better outcome. Certainly, in my view, there is scope to better understand the issue. For example, there is a program in Cairns called Return to Country, where police and other agencies work with individuals to try to see them reinstated into their community. Sometimes that involves mediation between that individual and others in the community around points of friction which may have existed in the past but may not exist now or if they do to try to resolve those issues. There are those activities which take pressure off the system, but they are all ad hoc processes. Like many complex issues that police deal with—whether it be youth justice, DV or a range of other issues—that collaboration is key to try to get a successful outcome.

CHAIR: Thank you, Deputy Commissioner Taylor. That is very worthwhile information. The time has expired for our conversation with the Queensland Police Service. To my knowledge, there have been five questions taken on notice. The committee would appreciate if the answers to those questions could be provided by 5 pm on Friday, 29 July 2022. Given the complexity of those questions, if you require any support or additional information or require extra time—whatever is needed—please reach out to either me as chair or the committee secretariat and we will be able to support you in those endeavours.

On behalf of the committee, thanks again for your great service to Queensland and for your insight into some complex issues that are very different across the state, whether it be regionally or rurally or in the south-east. It is very pleasing to hear your understanding of that complexity and the insight that you provide. Thank you very much for your leadership. We wish you a good day.

ALLAN, Associate Professor John, Executive Director, Mental Health and Alcohol and Other Drugs Branch, Clinical Excellence Queensland, Queensland Health (via teleconference)

GROGAN, Ms Haylene, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Aboriginal and Torres Strait Islander Health Division, Queensland Health

POWELL, Ms Emma, Senior Project Officer, Governance, Aboriginal and Torres Strait Islander Health Division, Queensland Health

CHAIR: Welcome. I wish each of you a good morning and thank you for appearing before the committee today. On behalf of the committee, I acknowledge your great work as members of Queensland Health as we have continued to navigate the global pandemic. We appreciate your efforts and the work that you have carried out on behalf of the government and on behalf of Queenslanders. We thank you for your great service.

We also thank you for appearing before the committee today. We have a very exciting inquiry in front of us as a committee. It is a complex issue. Today is about assisting the committee to understand the complexity of the issue and for us to understand the issues that exist in all pockets of Queensland—not just in the most privileged part of Queensland, that being the south-east. Professor Allan, I invite you to make a brief opening statement, after which committee members will have many important questions for you, I am sure.

Prof. Allan: I acknowledge the traditional owners of the land upon which we meet today and pay my respects to elders past, present and emerging. I also acknowledge my colleague Haylene Grogan, who will have a particular First Nations perspective for us.

Queensland Health obviously welcomes the committee's inquiry and supports the approach to ensure that people who experience intoxication from alcohol and other drugs in public, along with those engaged in less safe behaviour, have access to appropriate supports. Obviously we feel that proportionate responses and limiting unnecessary contact with the criminal justice system can further reduce harms for people experiencing other vulnerabilities.

We have already put in a submission so I will speak briefly to that. It highlights that we recognise the over-representation of Aboriginal and Torres Strait Islander people in the criminal justice system. First Nations people and people who are particularly vulnerable, such as the homeless and those people with serious mental illnesses, are also more likely to end up with these offences.

From the Queensland Health point of view, health and welfare responses are delivered with our current models and resources. They need to match the person's level of need. Obviously there is the frontline emergency and medical care which we would deliver through the Ambulance Service or the emergency departments of hospitals. Then care and treatment may be required because of injuries sustained or because of the urgent health risks associated with a person's level of intoxication. For example, some of the mental health crises that people would see as also associated with intoxication can be a permissive factor in people presenting with suicidal ideas as well.

From our point of view, about two-thirds of the ambulance services for drug and alcohol are really about alcohol. It may be also that a person with these offences already has some existing drug and alcohol problems or other physical problems that we are treating. It is always a complicated matter for us to determine where the best thing is. Obviously, there are also people who do not have a health problem but who need some sort of diversion for sobering up and so on. I am sure you are going to talk about that so I will not go into that.

Haylene can speak about the First Nations experience, but I particularly note that we work with a number of First Nations health organisations, and in particular QAIHC—the Queensland Aboriginal and Islander Health Council. They have a number of education programs and so on about drug and alcohol use—they are very useful for young people in the communities—that we would sponsor. There are other leaders and other health agencies that I am sure you are going to speak to.

I will say a bit about specialised alcohol and other drug services. From our point of view, we try to attract people into treatment. When a person maybe presents through this system or some other way, we try to engage them with treatment. Obviously when a person is intoxicated it can be difficult to engage the treatment. From our point of view—I think I put this in the submission—about 36 per cent of our treatment episodes relate to alcohol in particular. We have people in emergency departments who do drug and alcohol and brief intervention work. We try to work with people who

present with drug and alcohol problems in emergency departments. For example, we try to engage them to do something but it is often difficult when the patient is intoxicated. It is a much broader thing than just those thoughts.

I will stop there because it is a bit hard on the phone, but I am happy to take any questions on notice or provide further information. I will give a chance to Haylene if she wants to add anything.

CHAIR: Thank you, Professor Allan. Deputy Director-General, do you have a contribution you would like to make or would you like us to move to questions?

Ms Grogan: I have a statement. I acknowledge my colleague online for his longstanding leadership in Queensland Health and an important one. Firstly, I acknowledge the traditional and cultural custodians of the country we are on today—the Turrbal and Jagera peoples—and where you are as well, John. I would like to pay my respects to elders past and present. In particular, I always take this opportunity to acknowledge my elders who afforded me the opportunities I have had. If it was not for their efforts, I would not be here.

My name is Haylene Grogan. I am Queensland Health's first Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General of the Aboriginal and Torres Strait Islander Health Division. I stand on the shoulders of my ancestors and elders who came before me. I take the responsibility as Queensland's inaugural Chief Aboriginal and Torres Strait Islander Health Officer very seriously. As a proud Yalanji and Tagalaka woman, with Italian heritage, I am honoured to appear for Queensland Health today to offer our opinion on the decriminalisation of public health intoxication and begging offences, and specifically what this might mean for First Nations people. Being a First Nations woman, I also bring some of my own lived experience.

The current punitive criminal justice led approach to public intoxication is not only unsafe and unnecessary but also inconsistent with current community standards. A safe, pragmatic, health based approach is required—one that ensures the safety of all Queenslanders, particularly vulnerable First Nations people. To understand what I mean I will try to set the scene and describe the realities of the current system and practice from the perspective of First Nations peoples.

To do this, it is vital to start at the beginning to understand the fundamental importance of both adequate health care and sufficient nutritional intake during pregnancy and up to the first two years of life. An iodine deficiency, for example, can lead to mental health issues such as depression and cognitive impairment. Without this care, First Nations children are disadvantaged from birth and less equipped to take advantage of opportunities even when these exist. Trying to catch up later in life is very difficult yet a reality that has constantly plagued First Nations people—playing catch-up, and not just catch-up in terms of practical health and wellbeing outcomes for First Nations people but catch-up in terms of recovering from trauma caused by systemic disruption and disconnect from a way of life that has impeded the passing of cultural knowledge so critical to its survival.

Here we are more than 200 years later, in 2022, and First Nations people continue to be left behind, experiencing disparities and inequities in accessing basic health services which inevitably translate to poor health outcomes. Not surprisingly, the most prevalent of these poor health outcomes for First Nations people is a harmful legacy to their social and emotional wellbeing. Is it any wonder when we combine a healthcare system not always accessible with the stigma that gives to shadow social and emotional wellbeing that First Nations people turn to alcohol to self-medicate. What we have is a large proportion of disadvantaged, traumatised and vulnerable First Nations people using alcohol as a panacea, which subsequently increases their risk of exposure to the criminal justice system for public intoxication.

Our criminal justice system, like other government agencies, has institutional and systemic racism and bias towards First Nations people. In fact, I understand that data from the Queensland police demonstrates that the most disadvantaged and vulnerable members of society, including First Nations people, are most likely to be prosecuted under the Summary Offences Act 2005—a prosecution that often creates a cycle of contact with the criminal justice system that is difficult to break. I am sure the Queensland Police Service highlighted that.

I take this opportunity to highlight two reports that have been highlighted to me and that I understand capture what I am talking about. The first report is titled *Kids in court: the sentencing of children in Queensland* and the second is titled *Connecting the dots: the sentencing of Aboriginal and Torres Strait Islander peoples in Queensland*. I have been advised that the *Connecting the dots* report found that more than two-thirds of First Nations people sentenced over a 14-year period to 2019 were repeat offenders.

From here the story is familiar and well documented. The Pathways to Justice report, for instance, I have been advised, found that certain public orders like public drunkenness and begging were a significant factor in the over-representation of First Nations people in the criminal justice system. In fact, it is incredible to be reminded that the Royal Commission into Aboriginal Deaths in Custody in 1987—that is 35 years ago—found that the high number of First Nations deaths in custody stemmed from disproportionate detention rates primarily due to arrests for public drunkenness.

It goes without saying that the need for change is clear and evidence based. We need to find solutions to public drunkenness outside the criminal justice system. We need to tackle the underlying social and emotional wellbeing issues driving this vicious cycle. A significant part of the solution is health equity. Health equity is not about enticing or forcing First Nations people to fit the system; it is about ensuring the system reflects the needs of First Nations people. For a significant, substantive, lasting, meaningful change to occur it has to be achieved through genuine co-design with my mob from the outset.

Health equity demands we listen to, understand and represent the First Nations people it is intended to help. These voices and lived experience from a range of urban, regional and remote communities must be heard. After all, this is their future. Though it may sound simplistic, the wide-reaching benefits of health equity extend well beyond the health portfolio. Health equity is a powerful enabler with a multiplier effect. I will try to explain what I mean.

Health equity should ensure a First Nations mother has access to medical care and sufficient nutrition during pregnancy, providing her child with the best start to life. This start, along with the sustained access to nutritious food, allows a child to develop physically and mentally and take full advantage of the benefits of education. While health equity does not educate the child, without it the child will never be able to attain the same level of academic achievement. Health equity should allow school-age children to learn and to learn at school, and allow school leavers and graduates to get a job and reach their potential, bettering themselves, their families, their communities and Australian society as a whole.

Health equity can be the means to transform the cycle described above in a virtuous cycle that I just tried to describe, with fewer First Nations people having social and emotional wellbeing issues, and those who do it better are able to cope with them and access culturally appropriate support. This leads to less self-medicating with alcohol, less public drunkenness and less need to criminalise this behaviour. It also enables a more tailored and considered model of care for those who fall through the net. These are the outcomes that a public health response should deliver.

I am pleased and proud to say that health equity is imminently achievable and we are on our way to realising it in Queensland. Queensland Health, in partnership with the Aboriginal and Torres Strait Islander community controlled health sector, and as Professor Allan just alluded to, the Queensland Aboriginal and Torres Strait Islander Health Council, QAIHC, as the peak body, have developed and commenced implementation of the historic, Australia-first health equity regulation. Do you want me to explain that simply? I have not written it in my statement. I am about to finish.

CHAIR: If you could briefly explain, that would be good.

Ms Grogan: In its simplest form, the amendments to—I do not know whether you understand. We have a Department of Health in the centre, but every hospital and health service has a piece of legislation that is governed by a board that requires the HHSs, as we often refer to them as, to deliver health services and be responsible for the health outcomes in that backyard. The amendments to the legislation from the hospital and health board were that all HHSs required at least one Aboriginal and Torres Strait Islander member on their boards and all HHSs were required to develop First Nations health equity strategies that are co-designed, co-developed and co-delivered with Aboriginal and Torres Strait Islander people.

Importantly, the regulation in April last year was passed and it prescribes the requirements of those equity strategies, and that is to improve Aboriginal and Torres Strait Islander health outcomes, to provide culturally appropriate care, to intersect with social determinants of health, to ensure that every HHS has a First Nations workforce proportionate to the First Nations population they serve across every category and every level, and to eliminate racism. That is written in the regulation.

This regulation legislates the principles of health equity I have discussed above—that is, First Nations people be involved in the design, decision-making and delivery of healthcare service in Queensland. What it translates to in practice can be summed up in a simple equation that I talk about a lot: it is our people in the system—it is our voice in the system—which equals a better coordinated and culturally capable system. I will repeat that: it is our people in the system; it is our voice in the system; it is having a better coordinated system. This is why I am here before you, offering to assist

as a conduit between you and the First Nations community when considering a public health response. Their message is clear to us: 'nothing about us without us'. Considering First Nations first puts this into practice.

Thank you for the opportunity to attend today. We look forward to working with the committee going forward. Thank you for the opportunity to make that statement. I can provide that in written form as well.

CHAIR: Thank you, Deputy Director-General. I would appreciate if you could provide that statement in writing and also make available to the committee the two reports that you referred to. I also say that, irrespective of their political persuasion, members of this committee are all incredibly committed to our First Nations people and their plight for health equity. Deputy Chair, I am sure you would agree that our committee is very committed to that.

Mr BENNETT: Thank you both for your contributions. I do not want to sound argumentative, but my question is about the fact that statistically we are not making improvements. Whether they are punitive or not, the numbers are consistently high—unacceptably high. I acknowledge that. What do we have to do in the public health space before we decriminalise some of these activities? For me, you still have to have a mechanism, regardless of whether it is First Nations or other Australians, whereby we have a public safety outcome. What other public health issues do we need to implement to make sure we can move these very important issues of public safety and, more importantly, help the people who suffer unfortunately through intoxication and end up doing these unfortunate things that they get arrested for?

Ms Grogan: I do not have Professor Allan in the room.

Prof. Allan: Sorry, do you want me to answer?

Ms Grogan: Yes, you go first.

Mr BENNETT: Was I clear enough, Professor? I am asking what you would like to see in the public health space if we had a crystal ball and a perfect world.

Prof. Allan: That would be great.

Mr BENNETT: Indeed.

Prof. Allan: There are a couple of good facts to point out. One is that the rate of alcohol use in younger people has been decreasing decade by decade, and I am sure you are aware of that. The peak of alcohol use is no longer the young people but the middle-aged people and moving to the slightly older, particularly amongst women. Also, the rate of what we used to call binge drinking—one-time, large-loading drinking—has actually decreased, despite the troubles that we see in some of the safe night precincts. I was listening to the police giving evidence on that. As a general rate, that has decreased. That does mean that preventive health measure about the seriousness of drinking, intoxication and the harm that you can do yourself is taking effect in younger people. It has not necessarily taken effect in older people just yet. That is a good thing. Obviously, there are still groups of people who do not get that message, and we always have known that. As has been pointed out, we really learn that message from very early on—from before birth, really—about those levels of drinking and, of course, that relates to how families drink and how families behave and the pressures they are under. We know, for example, that the increase in drinking at home with COVID is probably likely to have modelling behaviour for people later on. There are a whole lot of public health education and various restrictions that we have had around that drinking and what would happen.

If you ask me what would be the ideal public health measure, I would say to raise the drinking age because we behove the vulnerability of young brains, and 18 is not actually a really safe place to be absorbing that amount of alcohol that people are doing. We know also that young people are more likely to voluntarily delay that age of first drinking because of the education they have been given. Obviously a lot more of that is required. That is No. 1.

No. 2—and I think Haylene has touched on this—there are multiple social factors involved in those behaviours. A high proportion of the people who get arrested—as the police pointed out, there are a couple of different cohorts—are usually unhappy and have other problems in their lives that need to be looked at. There is that multi-issue, complex part of it. I do believe that the easiest step would be around the drinking age, information that goes to young people, what parents teach or show and give young people, and a more concerted effort around education would be important, before we even get to the effects that we are talking about.

CHAIR: Deputy Director-General, your comments around health equity have resonated with me. I understand it is pertinent to First Nations peoples, absolutely, but I am interested in your thoughts around the concept of health equity and socio-economic status and the issues we are talking about today. I am interested in a hypothesis that health equity, socio-economic status and engagement in these offences are linked.

Ms Grogan: This is probably a very personal perception and perhaps not an authoritative answer, but I think it is about access to services that our mob do or do not get, and often it is lack of access to all of the above, the circumstances that they are born into and what that might look like. I think it is really exciting, the journey that we are about to embark on in Queensland Health with the community controlled health sector in particular, to try to get it right in health, and the requirement for us to intersect with the social determinants is really exciting as well. What that looks like on the ground, with each HHS developing their equity strategies to try to articulate what they can do to meet the requirements of the regulation, is really important—and the local application and leadership is incredible in this space, but we have to do some system reform to support that as well. We have the perfect agenda through Closing the Gap. The Queensland government is embarking on treaty, Local Thriving Communities and other big agendas that are going to support what we are trying to do. I am going off answering your direct question, but the opportunity for us to get the environment right across the portfolios, I think, is here.

Going back to your question and also that of the deputy chair, sometimes I think it is as simple as our mob being involved in the criminal justice system. I truly believe those three things I talk about you could apply to any portfolio anywhere, from a sporting organisation to a football club to anything—First Nations people in the system, a voice in the system, a better coordinated system. If we have more of our people in the system, and particularly it is already proven in the police, we can have a better relationship with our mob that are going to experience what we experience and then avoid a lot of the punitive responses that the criminal justice system might have on offer. A relationship with our mob on the streets can make a huge difference. I do not think we have enough of our people in the system, on the health side and/or the criminal justice side, including in the police, but it is really important to have relationships that can be built and useful by having our people in the system.

I know it is a simple thing to say, but I am actually talking about a health system from gardeners to surgeons. I have been saying it for a decade. It is just as important to have gardeners in our hospital grounds as it is to have the surgeons doing the surgery. We are a big system and we can make a big difference. We can work better with our counterparts in the other portfolios.

Sorry, I can talk a fair bit, and thank you for acknowledging our work in COVID, but I think we showed how we can work very quickly and, particularly our First Nations community, work very well with police. If it was not for the leadership and the coordination through the state disaster management committees and the role the police had when we introduced—I do not know how much you know, but we had the biosecurity arrangements in the discrete communities that were locked down. My point is that we had a really good relationship with the police, with the local leadership in those communities, and we made it work and we protected those communities. The nature of having a relationship between our portfolios and our community is a key success factor to addressing inequity.

Mr LISTER: Is it the case that there are some examples where offences have been detected by police or dealt with by police and the offender has, through that process, had access to or has taken up the sort of help that they need to deal with some of the issues that gave rise to the offence—alcoholism, domestic violence, those sorts of things?

Prof. Allan: I am assuming that there are. We probably do not collect that data. The police can bring people to health services without arresting them, obviously. They have powers under the Police Powers and Responsibilities Act to bring people to a place of safety for treatment and care. There are powers under the Public Health Act that deal with the emergency examination authority to do that. It used to be under the Mental Health Act but it has changed. They can always bring people to our health system without an arrest. I do not have data on arrests versus alternative help, but obviously the more times you can offer someone help the better is the chance of them taking it up.

Mr BERKMAN: I really do appreciate your time today. I am interested in better understanding the really pointy end, the kind of immediate response to incidents of public drunkenness specifically. The police described to us before—and it is addressed in your written submission as well—how they are not focusing so much on the offending behaviour in these incidences but about minimising risk, and taking people to an emergency department or a diversion centre are two of the avenues that are open to them. I do not know if it is something that you can answer, given the diversity of circumstances

and resources in the different HHSs and their individual responsibility to develop those health equity strategies, but what additional resourcing do HHSs need to ensure they can deal with that real crunch point if they are seeing police present with intoxicated people who need support?

Prof. Allan: I think it is a good question, because the key point is: does that person need additional medical help at the time or do they just need some supervision and sobering up? It is unfair to ask the police to try to make that diagnosis. That is not their job. They cannot make that diagnosis. Obviously some people have such a level of intoxication that they are at serious risk of alcohol poisoning and so on. Of course, the level of alcohol is not always indicative of a person's response, given habituation of drinking and so on. That is important. Then, of course, there may be other injuries or other circumstances that do require medical attention. I think that would really help, though, and this comes again to the heart of the matter about resources. When there is nowhere else for that person to go, if they do not need any care and they have to take up a hospital bed as part of the sobering up process, that is stress and strain on the resources—and I will not go into the ramping and all of those things. That puts a strain on resources and obviously, if you think about that in a logical way, there can be resentments, and the deputy director-general has really spoken about those as well—some of the attitudes that can develop. I think the issue would be, if they were there, a rapid assessment, a really good plan and then the opportunity to divert them somewhere that is safe but is not necessarily in a hospital would be important. Of course, it is always best to go home with somebody who can actually care for them as well. Once again, it is probably families and friends or others who have responsibility, it is not just for the government to supply. Is that what you are asking?

Mr BERKMAN: Yes, that is a really helpful answer. I suppose a related question is: what relationships exist or would need to be built between the health professionals involved in those presentations and the diversion centres or the other kinds of social supports that sit just outside the health system? Do those communication channels exist when someone is in police custody, for example? Does it fall to the police to move them from a health setting to another social service setting or do the hospitals themselves have capacity to do that?

Prof. Allan: The hospitals would like to not have so many people present, but there are relationships obviously between the hospitals, the police, and particularly the Indigenous police as well, and the sober-up centres. The deputy director might talk a bit more about that. I think there are those relationships. I think the issue is of capacity. They are not everywhere. There is not always that opportunity. If they do take that opportunity and are welcome, there are often issues around transport—about who is going to actually take the person from one place to another as well. There can be delays in all that because the police are busy, the ambulance are busy, the liaison officers are doing something else as well. There are sometimes practical issues that are there and, as you say, it does rely upon the relationship. I might just hand over to my colleague.

Ms Grogan: I will try to answer in a way both questions. We can always have more resources—absolutely. The support to the person and the way it is happening, whether it is police or health, would be happening in various ways across the state. I think it is the one thing that we have to get right, and this is where our community controlled sector can play a big role, whether it is Health or other parts of the community controlled sector. They are doing it well in parts of the state, including down in South-East Queensland—connecting the care when someone comes out of hospital, because obviously at the discharge point for whatever they have been hospitalised for, but in this instance from intoxication, there are some parts of the state where they are providing very good wraparound support and making sure that person gets access to a house somewhere safe or gets transport that they need to go somewhere for any other follow-up issues or social support that they need. Some of our community controlled health services are doing that very well. I will call out to the Institute for Urban Indigenous Health, which actually has a program that proved very successful, again during COVID but even before and beyond COVID. I cannot stress how important, how critical and how useful it is for our mob who enter the health system for whatever reason to have that support to help navigate where they need to go next. It would be happening in varying degrees across the state. I really think an investment into our community controlled sector would be an answer.

The other question about funding is that health equity is also about access to equitable funding. We are making some major reforms in Queensland Health—I hope I do not say the wrong thing here—and the hospital and health services are giving a fair bit of flexibility and agility with their funding to ensure that we deliver on health outcomes, but we are increasing accountability to make sure we can measure what those health outcomes are. I am hoping that we are able to reform the way resources are allocated, whether it is human or financial, to ensure that we achieve health equity, which is also funding reforms. That is a bit of a high-level response to something where you are trying to get at the pointy end about how you make it happen.

Mr BERKMAN: That is very helpful anyway.

Ms Grogan: We have a lot of community controlled organisations that do it very well in terms of supporting our people.

Ms KING: Professor Allan, having just been part of the Mental Health Select Committee, which looked in particular at the work across the state and in other jurisdictions around safe spaces, I wonder whether there is a view about the appropriateness of some of those safe spaces for use as a place of safety for people who are intoxicated. What might be the problems or benefits of co-use of those spaces?

Prof. Allan: That is a really interesting question and one that is being played out in HHSs at the moment. I would probably like to say that I do not think the safe spaces we are developing for people in suicidal crisis are necessarily a sobering-up place, because they have different staffing. They have peer support workers who are really trying to get into a conversation with the person, and maybe that comes a bit later for that person who is intoxicated. I think in general they are probably not, but obviously there are people who present with problems who have some level of intoxication. Obviously, people who are out-and-out asleep intoxicated just need to be monitored in the proper way, rather than expecting to be talked to. I think that is the issue: when do you monitor and keep them safe and when do you talk? I think Haylene was talking about the wraparound service, that you follow through the safety with the further talk. I think they are a bit different. All emergency departments are always thinking about where they can accommodate people who need that kind of supervision for a range of other things without doing that. It is a point of discussion. I cannot see your face so I am not sure if that helps or not. I am happy to follow up.

Ms KING: Thank you, Professor. It does.

CHAIR: Did you have anything to add, Deputy Director-General?

Ms Grogan: No, I would probably say ditto for what Professor Allan said. I think whether or not we structure safe spaces as multi-use, it would require human resourcing that would probably be costly. I think we have to have a range of options for people, and that is where the community controlled sector relationship with people who are coming out of hospitals can facilitate them back to home, which is one of the safe places, rather than structured safe spaces that are resourced by other people. I do not know whether I answered your question adequately. I think we have to have a range of options. I want to stress that the relationship between the community controlled sector and government services is the critical answer here.

Mr BENNETT: Can I ask a general question—without repeating myself, Ms Grogan—around the facilities and services? I was specifically thinking about First Nations people in dealing with the three offences that we are talking about with the committee today. Would you like to add anything more about the facilities and services you would consider necessary?

Ms Grogan: More of them and more appropriate to cater for our mob.

Mr BENNETT: For the committee to understand what that is, are you able to elaborate a little bit? The demographic of Queensland means that we have a tale of woe from one end to the other, but if we are, as you said in your introduction, seeing a higher proportion of representation from First Nations people, and we are talking about public urination, intoxication and begging, I am just wondering whether you would like to add anything further for the committee's consideration particularly around those areas.

Ms Grogan: I would still advocate what I have been saying, which is resourcing the community controlled sector—and I am not talking just in health; I am talking in the justice sector as well—to support our mob. They have a good relationship with our mob mostly and/or know our mob, I think it is really important that they are resourced. That is probably where the gap is. I do not know the stats. I do not know what it looks like across the state properly, but I do know that the community controlled sector can play a big and most critical part in what we are trying to do.

CHAIR: Thank you. Professor Allan, I want to come back to the hypothesis I raised earlier around the social determinants of health, health equity and, regardless of Indigeneity or not, the number of arrests and its link to socio-economic status. I wanted your academic perspective around those who are being arrested or have been arrested. From the data we know that 50 to 60 per cent of them are First Nations people. That means 40 to 50 per cent are non-Indigenous. Can you provide your thoughts around that issue and its link to socio-economic status, health outcomes, health equity and social determinants of health?

Prof. Allan: I think it is a very complex question. To put it simply, we know in all aspects of health, social outcomes, educational outcomes, employment and so on that the more of those so-called ACEs, the adverse events in early life, you have the more likely you are to have a bad outcome. I think what we are seeing is the perfect storm of those things—people who have had

significant adverse circumstances in their early lives. That might be coming from a broken family, abuse, early drug use and so on. I think that is a very complex issue, but it is quite clear that this is just another example of that work. It is really important to note that by the time a person gets arrested the damage is done in terms of their life. It happens from quite early on in their childhood.

At every opportunity when something happens to a person, we have an opportunity to intervene. It was put to me this way: you can have a terrible life at home but when you first go to school you might meet some people who behave differently and take you under their wing and change things for you. There are opportunities like that in public health clinics, kindergartens, schools and sporting clubs. In all sorts of places we have opportunities to intervene in some of those terrible outcomes. There is a government responsibility, there is a community responsibility and there is obviously what we can do as individuals to help people. I think I would stress that these things happen early on. By the time we get to this problem it is often very fixed, but people can still turn their life around with the right supports and changes. We just have to intervene in all of those levels. That is the issue, I think.

CHAIR: Thank you. I am conscious that we have run out of time with you. It is time for us to move on. There were no questions taken on notice. You were able to respond to the committee's questions in their entirety so thank you. I do recall that you are happy to provide those two reports that you alluded to. I would appreciate that. I am sure the committee would appreciate that reading. That concludes our session. I thank you, Associate Professor Allan, for your time this morning. Deputy Director-General, it is always a pleasure and thank you for your great work. Ms Powell, thank you for being here today. On behalf of the committee we thank you, as the leaders of our state health system, for the remarkable work that you do. Thank you very much

HOWARD, Ms Louise, Acting Deputy Director-General, Communities, Department of Communities, Housing and Digital Economy

McCOY, Mr Brad, Executive Director, Community Services, Department of Communities, Housing and Digital Economy

CHAIR: The committee welcomes both of you to our committee hearing this morning. It is a very exciting inquiry that we have been given by the Queensland parliament. We ask that you make a brief opening statement, after which our committee will have many pertinent questions for you.

Ms Howard: I would like to start by acknowledging the traditional owners and custodians of the land on which we meet today and pay my respects to elders past, present and emerging. Thank you for the opportunity to talk to the committee today.

The Queensland government provides funding for a range of community services through the Department of Communities, Housing and Digital Economy. Community services support communities to thrive through investing in quality community services that can connect and support the social and economic inclusion and wellbeing of people of all ages, abilities and backgrounds.

In 2021-22, $18.7 million was provided through community services for public intoxication and diversion services. Public intoxication and diversion services deliver a range of supports to provide immediate and ongoing assistance for Aboriginal and Torres Strait Islander men and women who are at risk of harm or being taken into police custody for intoxication in public spaces or for those who are already in custody for related offences.

There are five types of public intoxication and diversion services representing a continuum of service responses. These range from addressing immediate safety needs and longer term individual support for goal setting to responses that involve group work, connecting people with each other to address issues. The five initiative service model components are: cell visitor services, providing support to people while they are in custody; diversion centres, which provide a safe place for people to sober up and get support; and community patrols, which provide outreach services and transport to a safe place for people who are intoxicated in public spaces and at risk of being held in police custody for related offences. Linking and connection services, also known as the Managing Public Intoxication Program, provide personal support through assertive outreach and case management to assist people to engage with support services, change harmful drinking behaviours and reduce the recurrence of incarceration. We have Reducing Demand services, where we provide culturally appropriate activities and support for people to change behaviour, build skills and reduce their harmful consumption of alcohol.

It is important to note that our public intoxication and diversion services are not withdrawal or rehabilitation programs and our diversion service staff do not undertake the duties of medical officers or nurses. Public intoxication and diversion services seek to take appropriate care of service users and work towards inclusive ways to engage and provide support aimed at minimising and reducing harm. The department is also working with other government agencies to provide initiatives that aim to reduce alcohol related violence and harm in entertainment precincts, drive cultural change around drinking behaviours, and balance a reduction in harm with the interest of patrons and the hospitality industry.

In 2021-22 the department provided $3.5 million in funding for the delivery of one of these initiatives: Safe Night Precinct Support Services. Safe Night Precinct Support Services contribute to creating a safer night-time environment for Queenslanders by assisting vulnerable people who are at risk of harm or violence in late-night entertainment precincts. Since 1 July 2016 Safe Night Precinct Support Services have operated in 15 precinct locations across Queensland: Airlie Beach, Brisbane CBD, Brisbane inner west, Broadbeach, Bundaberg, Cairns, Fortitude Valley, Gladstone, Ipswich, Mackay, Rockhampton, Sunshine Coast, Surfers Paradise, Toowoomba and Townsville. We are happy to take any questions from the committee.

Mr BENNETT: Good afternoon; thank you for coming. Over a period of time the committee has been looking at social isolation and loneliness and the issue of homelessness in that space. We are also doing an inquiry into public community housing, and the issue of homelessness continues to be raised. If the offences we are talking about in this inquiry were decriminalised, do you see any correlation or association with homelessness within the areas the department administers?

Mr McCoy: We do see certainly overlap, as Professor Allan was saying earlier, among a number of risk factors or adverse life events for people. That includes problem alcohol consumption, obviously, and mental health and homelessness are key among them. I would have to refer you to the police in terms of statistics around arrests and the circumstances of people being arrested. I can

tell you that in our diversion centres, which Louise has just spoken about, we do see people who are homeless. It is known that the service users of our diversion centres overlap a lot with service users of homelessness services as well as mental health services. We have a piece of work ongoing at the moment through the Queensland Housing Strategy.

Last year the Housing and Homelessness Action Plan 2021-2025 was released. It included an action to look at the operation of public intoxication diversion centres as well as mental health services and homelessness services, particularly in Cairns, Mount Isa and Townsville, where we know there is quite an overlap among service users. There is certainly an overlap among those issues and the service users of the relevant service types.

Mr SKELTON: Can you describe the more successful programs the department has implemented in response to public intoxication and begging?

Mr McCoy: As Louise explained, there are five different service types that we have under the Management of Public Intoxication Program. I do not know that I would be able to comment on whether one is more successful than another. They serve different purposes. They are all relevant to this inquiry, but obviously where people are held in custody is of direct relevance to the issue around people being arrested for public intoxication. The cell visitor program is certainly an important program in terms of visiting people who are being held in custody, ensuring their safety, checking on them and providing support and information—I missed the police part of the hearing, unfortunately, so they may have spoken about this—but also connecting with police and working through options to support people collaboratively.

We also have services that operate more publicly. Our community patrol program has been highly effective in terms of visiting areas where it is known that people tend to congregate and engage in problematic alcohol consumption. That model means that people are being supported often before there is even police contact. That has been a very effective model in terms of diverting people from arrest and custody and also providing people with the support they need for their health and wellbeing.

Diversion centres as well, of course, are absolutely crucial. I am sure the police would have talked at length about the importance of having safe places where people who are intoxicated can be taken or attend of their own accord to receive the services they need and also to have a place to sober up. I would say that we have some models which we call linking and referral, or the MPIP program, which is about providing medium to longer term case management support for people. We know that in our cell visitor program and diversionary services we do tend to see people reappearing over time. The benefit of having some services that provide case management support is that people are being provided the support they need to break the cycle of continuing with their problem with alcohol consumption.

We have had case studies recently where those services have been doing fantastic work in terms of reconnecting people with culture, reconnecting people with country where appropriate and getting them access to other services through referral and collaboration. They have been highly successful. I did hear one of the witnesses from the police talk about itinerant populations. Those services have been highly successful in returning people to country where that is appropriate and suitable for them. We have heard, for example, case studies of people who are in Cairns accessing services through diversion centres. They are then referred on to linking and referral services, who connect them with family and community. It might be in the Torres Strait or other areas. They arrange travel and accommodation for them and connect with other service providers to see them returned home. They are not just returned home; obviously they are linked with the support services they need at home as well.

Mr LISTER: Thank you very much for coming today. I do not have any questions.

Mr BERKMAN: I appreciate your time this afternoon. There is a table in the written briefing that shows 25 public intoxication program services across the eight locations. First of all, is that an exhaustive list of those programs as delivered?

Mr McCoy: Yes, it is.

Mr BERKMAN: It says in the subsequent paragraph that funding is provided to 10 NGOs, six of them being Aboriginal and Torres Strait Islander service providers. Again just so I am clear, are those 10 NGOs responsible for the delivery of all 25 of those services across the locations?

Mr McCoy: That is correct, yes. Typically what we have in each location is one service provider providing that span of services—not in every case, but that is typically what we have.

Mr BERKMAN: Given there are just those eight locations and some of the services are not available in some of those locations, is there a forward-looking program for the delivery of more services either in more locations or additional services in those same locations?

Mr McCoy: 'Yes' is the short answer. There is no forward program that is funded currently. The funding that is available is what we have funded and contracted out in those eight locations. We are, though, embarking on a review of the program and the five services within it. Obviously that will now be well informed by the work of this committee's inquiry. The program was established in 1995—that is in the submission we made—based on the inquiry into deaths in custody. What you see in terms of the service types in each location are the initial services that were delivered in each location, and then there have been additions over time. The patchwork of services is somewhat historical. We are keen to explore, as part of our review and working with our stakeholders on this, the right service mix, not only in the public intoxication program but also in terms of associated service programs. As I said earlier, we will be looking in Cairns, Mount Isa and Townsville around the connection with mental health services and homelessness services, because these services do not operate in a vacuum. They are very closely integrated with other services in their locations. As part of that review, we would obviously then be looking at what is the right mix in each location.

Mr BERKMAN: Without trying to get you to show your hand for funding that does not yet exist, if there is any information you can give us about additional priority locations, that would be helpful for the committee just to target where we might take this inquiry. The further question I did want to ask was around engagement with QAIHC. You would have heard the representatives of the health department talking about the importance as they see it of the Aboriginal and Torres Strait Islander community controlled organisations. Is there a direct and ongoing engagement between this service provision and QAIHC and the members of QAIHC?

Mr McCoy: Yes. Our engagement with QAIHC is via Health. We work with Haylene Grogan and her team and the Mental Health Alcohol and Other Drugs Branch in our work on public intoxication as it relates to the health system. That is our chief engagement, around that health intersection. Many of the services that we fund to provide the public intoxication program are quite closely connected with QAIHC. As part of that community and health sector, there is good partnership and collaboration across those organisations.

Mr BENNETT: It might seem a little bit out there, but one of the things we have heard over the last year or so involving the role that all levels of government have, particularly around these issues of public intoxication and urination, was working with local councils in relation to providing additional services. Do any of the officers work with local councils in relation to how we might improve facilities such as public toilets and other things that might help in this space?

Mr McCoy: Yes. We work collaboratively with our colleagues in the Department of State Development, Infrastructure, Local Government and Planning around these sorts of issues. On the basis of the work of this committee in relation to social isolation and loneliness we have been working with our colleagues there around recommendations made on the importance of public spaces. We have been having conversations about that and progressing work in relation to that. We also work with local councils across a number of our programs, probably most notably—as I am sure the committee would be aware—in relation to neighbourhood and community centres. We have quite a partnership with councils around how those services are funded and also the premises that many of them operate from.

I cannot say that we have had specific conversations around public amenities in relation to the delivery of public intoxication services, although that is certainly something that we are keen to explore. Part of our review of this work is to be working with our colleagues in DSDILGP and also local councils around the intersection between the effectiveness of these services, the work of police and Health and others and the sorts of amenities that are available via council.

CHAIR: This issue was raised with diligence by the member for Pumicestone earlier in the session. If we look at the data around arrests—whether we take the last financial year or earlier sections in time—how is homelessness and the itinerant nature of living circumstances linked to the data? Does your department have any information around that issue?

Mr McCoy: We receive output data from the services that we fund for public intoxication program services. The information collected by those services about service users varies and we do not have specific counts of, for example, people who are homeless, so I cannot tell you the circumstances of the number of people they see. As people are attending the five quite different services under the public intoxication program, there are very different circumstances which might include homelessness. Within that, obviously there might be people who are sleeping rough as opposed to people who are couch surfing or homeless in other senses as opposed to people who are travelling or might be considered itinerant who would not consider themselves homeless but are visiting friends or family or might be travelling through locations. One of the police witnesses spoke

about people from the Territory travelling to Mount Isa and vice versa. There would be a range of circumstances of people accessing these services. It would be very difficult to have some sort of a breakdown around that.

Mr BERKMAN: Since we have the time, I will return to the 25 services we were talking about before. Is the pool of services on offer continually expanding? Has it grown and shrunk over time, or was it just a one-way trajectory?

Mr McCoy: I am not aware of any expansion in recent times. I have been in this role since October. The most recent would be, I believe, as a result of a 2020 government election commitment. The government committed to expand the diversion centre in Cairns, so that is currently undergoing a significant redevelopment to the premises to expand the capacity of that service.

Mr BERKMAN: Those diversion centres are the only brick-and-mortar infrastructure amongst the programs?

Mr McCoy: That is correct, yes.

Mr BERKMAN: I am also really interested in the MPIP program that you touched on before. It strikes me that all of the coordination amongst the various needs of folks involved in that program happens under MPIP and will necessarily branch out into all of the mental health spaces you were talking about, homelessness and employment services. I am curious to understand the extent of that crossover and how much that links in to the youth justice space as well. Is that part of the work that MPIP does?

Mr McCoy: No. Typically, our public intoxication program is for adults, particularly obviously diversionary centres where there is a safety issue. Our community patrols will come into contact with young people as they are doing their work in their locations, but the service model and the service intent is to be providing services to adults; therefore, there will not be much of a connection with the youth justice system.

The MPIP program as well as the Reducing Demand program, which are both case management models, do connect on a local basis with a wide range of services—obviously, as you said, mental health and local emergency relief providers, services that are able to offer practical assistance in the way of clothes and access to accommodation. It might be linking with the formal housing system, through our department or through housing providers, or assisting people to access accommodation in other ways. On a local basis, there is a very wide range of services that they are connecting with, as well as the Return to Country program, which I heard police talk about earlier, which has been very successful with returning people to country and reconnecting them with culture.

Mr BERKMAN: I do not mean to put you on the spot, but the committee is anticipating doing some regional travel in light of the terms of reference and that focus of these issues in regional centres. If you were to list a handful of the next highest priority centres that do not have these services available, are you able to suggest some of those? Is that a question better taken on notice?

Mr McCoy: I think it would be difficult for us to name a location. There is a level of analysis required. I see that police have provided some statistics around arrests in different locations. That is obviously one metric to look at. Obviously there is a lot of other information to look at in terms of those arrests—who is being arrested and why—but also looking from location to location at what other services are available. It would be worth looking at the types of services in each of the eight locations. What is available would be a good starting point. Certainly Cairns, Mount Isa and Townsville are our biggest diversionary centres and there is a strong demand for those service, so I think they are very well located. If you want to see centres that are seeing a higher number of clients and a diverse group of people, that is probably a good starting point as well.

Mr BERKMAN: Do you have any suggestions for us in terms of how we might best assess the locations where there is the most unmet need? Perhaps that is the other way of approaching that question of where we might go.

Mr McCoy: I suspect there would be quite a bit of health data around these issues. Certainly the arrest data would be of interest as well. If your starting point is the public intoxication program and its original intent as diverting people from being held in custody, you want to be looking at locations where we need to be diverting people from being held in custody, noting obviously that this committee is looking at options to potentially change those circumstances. In terms of areas where we might see high numbers of people who have a constellation of adverse life circumstances, I suggest that the eight locations we have are well located. It would probably be a matter of looking at the health data and police data around where the demand would be.

Mr BENNETT: Considering the issues we are talking about today, can you enlighten the committee on safe night precincts, which have been a great success I must say? In the budget there were some issues around the continuation of the safe night precinct in Townsville. Would you like to comment on that?

Mr McCoy: I am not aware of budget deliberations around the program. Funding for the Safe Night Precinct Support Services Program is administered by our department as part of a broader program that is led by the Department of Justice and Attorney-General. We do have ongoing funding for the safe night precinct support service component of that into the current financial year. I am not aware of any issues in relation to the ongoing funding for that.

Mr BENNETT: Thank you for that feedback.

CHAIR: Thank you sincerely for what you have brought to this inquiry and certainly for your written briefing, which was very thorough. We as a committee certainly look forward to working with you on this important inquiry going into the future. We thank you both for your significant time this morning. We appreciate your great support of the work of the committee and also your work as a member of the Public Service in delivering for Queenslanders. Thank you very much. That concludes our public briefing. I now declare this public briefing closed.

The committee adjourned at 12.31 pm.