Inquiry into the Decriminalisation of Certain Public Offences, and Health and Welfare Responses

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Submission

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ABOUT THE ALCOHOL AND DRUG FOUNDATION

The Alcohol and Drug Foundation (ADF) delivers evidence-based approaches to minimise alcohol and other drug harm. We recognise the power of strong communities and the important role they play in preventing problems occurring in the first place. A community-centric approach is at the heart of everything we do.

EXECUTIVE SUMMARY

The ADF thanks the Committee for the opportunity to contribute to this inquiry. We would like to acknowledge our expertise for this inquiry is limited to laws around public intoxication – and our submission will focus on this as such. We will also refrain from commenting on any terms of reference relating to specific legislative amendments.

In recognition of the negative impact that public intoxication laws have had on many vulnerable individuals – particularly in Aboriginal and Torres Strait Islander Communities – we strongly urge the Committee to decriminalise this outdated offence. We would also like to note that public intoxication as defined in Queensland's *Summary Offences Act 2005* can also refer to instances where the person is affected by drugs or another intoxicating substance. As such, our submission acknowledges the increasing complexity of scenarios where a person may be affected by other substances in public and in need of care and support.

Being intoxicated in public should be treated as a health issue, not a criminal one. The importance of this move is underscored by statistics showing that a significant number deaths in police cells in many western countries occur to individuals detained for public intoxication.[1]

(c) The costs and benefits of responses to public intoxication and begging in other Australian Jurisdictions

Between 1974 and 1990 – all states/territories except Queensland and Victoria decriminalised public intoxication. However, evidence has shown these laws have often been tokenistic in practice.[1] Police cells are still being used far too often[1] [2] – and this is backed up by data. From 2014-2019, the number of people taken into police cells for public drunkenness in states/territories where public intoxication is decriminalised and the data was available:

- NT – 8247
- NSW – 1802
- ACT – 829
- TAS – 447
- SA – 330[2]

For example, in South Australia, the Public Intoxication Act (1984) states that police can apprehend individuals who are intoxicated if they are unable to take proper care of themselves. Officers have the choice of either taking them home, to a sobering-up centre, to an approved place or to a police station. However, it was reported this new Act did little to change practices, as the insufficient provision of sobering-up centres meant that police mostly ended up detaining

individuals until it was safe to let them go.[1]

A second important insight from other jurisdictions was the increased use of other police discretionary powers in the absence of public intoxication laws to deal with people who were intoxicated in public. Open container laws (banning drinking in public rather than drunkenness) were introduced around the same time and are considered by some to be more oppressive due to their disproportionate impact on people who can't afford a home or can't afford to drink in a licensed premises.[3]

'Move on' powers given to police in New South Wales in the 1990s, and to Queensland Police in 2000 were also problematic. These laws allowed police to demand that an individual leave a particular public place where their presence was deemed to be 'undesirable'.[4] This legisliation focused on public safety and antisocial behaviour rather than 'welfare', as a legal obligation was placed on the intoxicated persons to remove themselves — with no requirement for the police to deliver the person into the care of a responsible person or place of safety.[4] There were also concerns raised about the removal of public intoxication laws leading to more people being charged with other public disorder offences, such as disorderly conduct or using offensive language.[4] [5]

A consequence of the lack of proper implementation of public intoxication decriminalisation has meant that many deaths in custody are still occurring where people are taken into custody for minor offences. From 1989-90 to 2020-21, there have been 129 deaths in police custody where the most serious offence committed by the person was a 'good order offence' – which encompasses a number of different minor offences, such as public drunkenness, protective custody for intoxication (in a jurisdiction where public drunkenness is not an offence), disorderly conduct, offensive behaviour etc.[6] While deaths in custody have decreased since the mid-1990s, deaths of persons in police custody remain an issue in jurisdictions where public intoxication has been decriminalised, with Aboriginal and Torres Strait Islander Australians continuing to be over-represented[7].

In Victoria, the government's recent decision to introduce legislation to decriminalise public drunkenness came following the coronial inquest investigating the death in custody of Aboriginal woman, Tanya Day, following her arrest while intoxicated. Ms. Day was asleep on a train from Melbourne to regional Victoria when she was arrested in December 2017. While in police custody at Castlemaine station, she fell and hit her head repeatedly, sustaining brain injuries and a hemorrhage. Less than three weeks later, she died at St. Vincent's Hospital in Melbourne.

The removal of public intoxication laws needs to be accompanied by investment in health and welfare services that can appropriately respond to instances of public intoxication.

(d) The health and social welfare-based responses to public intoxication and begging necessary to support legislative amendments, having regard to existing responses, such as diversion services

Any response to public intoxication should be health and welfare focused – with the key objectives being prevention of harms – and in the case of intoxication, to find the person a 'place of safety' where they can sober up and receive any required further care or support. In an ideal scenario, an intoxicated person would be assisted to return to their home, or to a friend or family's place while they sober up. This has the benefit of minimising the impact on health services.[2]

However, the reality is this option won't be available in a lot of situations as some people will be unable to be transported home, or they might be experiencing homelessness and other complex

issues. In this instance, it's important to have accessible health services where people can sober up and receive appropriate care.

A range of service models to respond to public intoxication after decriminalisation have been developed locally and internationally. These usually range from:

- **Medical models** – strong focus on treatment (sometimes compulsory) and rehabilitation
- **Social welfare models** – involves the provision of a safe space for intoxicated individuals while they sober up (no treatment expectation), can also include outreach services like Murri Watch[8] or Larrakia Nation[9].
- **Medico-social model** – combination of both, a safe space that can also offer treatment or rehabilitation options[1]

There is no strong evidence on which model is most effective[1] [10], however evidence does suggest that services with voluntary rather than mandated engagement are likely to be more effective.[1] [11]

Sobering-up centres

Sobering-up centres respond to the needs of people who drink heavily on a regular basis and may be experiencing other complex issues such as mental health, disability or homelessness. In these centres people are provided a shower, clean clothes, laundry service, food and a bed for anywhere from 2 to 24 hours. Some centres will also be able to offer pathways to longer-term health, treatment and social services if needed.[1]

Queensland currently has a number of sobering-up centres already in operation, such as MurriWatch. The ADF recommends consulting with current sobering-up services in the state to expand their capacity and gauge an understanding of best-practice service delivery.

For more information on the functioning of sobering-up services, see here: Seeing the Clear Light of Day ERG report.pdf (justice.vic.gov.au)

Alcohol Intoxication Management Services (AIMS)

AIMS services are more targeted towards people who binge drink on the weekends and are heavily intoxicated in night-time entertainment precincts.[1] These services aim to assist people who may be in distress or at risk of harm due to intoxication or violence – but do not require emergency department care or ongoing treatment or support.[12] They can be mobile services such as buses or ambulances, or a building/facility set up in a certain area. They can also be staffed by a combination of volunteers and health professionals.[12]

AIMS can provide rest and recovery spaces to receive support, supervision, first aid and reduce the risk of harm.[13] Queensland has their own form of AIMS services that the committee can consult with, known as Safe Night Precinct Support Services.

Managed Alcohol Programs – MAPS

There also other models used internationally that can be considered. In Canada, MAPS services are designed for people with alcohol dependency who are experiencing other complex needs such as housing, mental health and other substance use. MAPS can house people experiencing dependency and homelessness while providing them with regular doses of alcohol in combination with other treatment practices.[14] There are 13 of these services operating in Canada, and evaluations have shown they aim to preserve dignity and reduce the harms from drinking, while also working on the persons combined psychosocial, clinical and structural needs.[15]

Although research on these programs is in its infancy, a recent survey of homeless people experiencing an alcohol dependence in Sydney found that 76% were in support of a residential

MAP model. The authors of the study also suggested that such an approach would lead to significant cost savings for hospitals and crisis accommodation.[2] [16]

(e)The impacts of decriminalising public intoxication and begging in rural and remote communities

We know that people living in regional and remote areas of Australia are more likely to drink alcohol at risky levels and experience alcohol-related harms.[17] [18] The most recent National Drug Strategy Household Survey found that people living in these areas were 1.6 times more likely than those in major cities to consume alcohol at levels that exceeded both the lifetime risk guideline and the single occasion risk guideline.[17] We also know that people in rural and remote areas have more difficulty accessing treatment and support due to the lack of services that are available.[19]

Sobering-up services can be a way for people in rural and remote locations to access care, support and treatment. There is likely to be lower demand due to lower populations, so the best health response might be to expand on the capabilities of existing health systems and enable them to deliver sobering-up services to the community.[2] For example, the Expert Reference Group on Decriminalising Public Drunkenness in Victoria recommended that the government consider whether existing rural trauma and urgent care centres could be an effective option for delivering sobering-up services.[2]

It is worth noting that Queensland has a number of rural and remote facilities in place that could be looked at for this same purpose: Rural and remote health facilities | Queensland Health

One important consideration is the lack of transport options in rural and remote regions, including ambulances and other emergency services. Public transport is sparse, and it would be difficult to call a taxi, or access a ride share service. It may be beneficial to have sober up services that can deliver outreach and have dedicated or flexible transport.[2] Although ideally police are used as a last resort as a transport option, in rural and remote communities their involvement might be more needed due to the lack of other services that are available to transport an intoxicated individual to a place of safety.

(f)The design of health and social welfare-based responses that are culturally safe and appropriate and informed by First Nations people, including Aboriginal and Torres Strait Islander health and legal services and also representative bodies for seniors and people with a disability

Aboriginal and Torres Strait Islander people have accounted for 19% of all deaths in custody and 22% of deaths in police custody since 1979-1980 despite only making up 3.2% of the population.[6] [20]

The 1991 Royal Commission into Indigenous Deaths in Custody noted that Indigenous people were far more likely to be arrested and imprisoned than non-indigenous people, and that public intoxication laws should be immediately abolished due to the disproportionate impact they have on Aboriginal and Torres Strait Islander Communities. This still remains true today.[21]

As we demonstrated earlier, a significant number of people were still being taken into police cells for public drunkenness offenses from 2014-2019. And, the proportion of those who identified as Aboriginal or Torres Strait Islander were[2]:

- NT – 92.8% (43.56% of the population)
- NSW – 18.1% (3.56% of the population)
- ACT – 13.5% (1.9% of the population)
- TAS – 17.4% (5.84% of the population)
- SA – 41.5% (2.52% of the population)

Queensland Law Society identified that during 2019-20 – 1,009 per 100,000 Aboriginal and Torres Strait Islander People were proceeded against by Queensland police for public order offences, of which public intoxication is counted. This is compared to 87 per 100,000 non-Indigenous people who were proceeded against by the Queensland police for the same group of offences.[22]

Sobering-up centres were a recommendation by the Royal Commission in 1991 as an alternative for Indigenous people being taken into police custody for public intoxication offences. These services can be run by both mainstream and Aboriginal Community Controlled Organisations (ACCOs). MurriWatch was developed for this purpose.

The ADF recommends consulting with ACCOs and current sobering-up centres for insights on how to ensure these services can be culturally appropriate and capable of providing critical care and support.

Additionally, community-led outreach services like Murri Watch in QLD and Larrakia Nation in Darwin are examples of culturally appropriate services that respond to public intoxication in a supportive and non-punitive manner. The ADF recommends exploring models of community led psychosocial support, and how these might interface with other support options.

(g) The appropriateness of other police powers and offences to ensure community safety and public order arising from public intoxication and begging, particularly in the context of events where there may be significant alcohol consumption

Ideally, police involvement in instances of public intoxication should be as minimal as possible. The primary first responders should be health services or people from community service organisations, such as outreach services, alcohol and other drugs services and Aboriginal Community Controlled Organisations.[2]

Even for the purpose of transporting a person to a place of safety, police should only be involved if there is no other way for the person to be transported. There should also be no situation where a person is transported to a detention cell unless they are at an elevated risk of harming themselves or others and all other alternatives have been exhausted. As alluded to earlier, there also needs to be awareness around the potential for police to charge individuals with other public disorder offences such as 'open container' laws, disorderly conduct or using offensive language. This has the potential to undermine the purpose of decriminalising public intoxication and will need to be considered in the review process.

Again, the ADF recommends referring to this report for a more detailed discussion on the issues around police involvement: Seeing the Clear Light of Day ERG report.pdf (justice.vic.gov.au)

(h) How existing public messaging on the harm of alcohol and other drugs, including alcohol-related violence, can continue to be reinforced following the decriminalisation of public intoxication

Harm related to public intoxication is most effectively addressed through prevention. The National Drug Household Survey 201923 demonstrated a growing desire from the community for money to be spent on the prevention of alcohol-related harms, with respondents elected to spend $41.20 out of a hypothetical $100 on education. Research suggests that for every $1 spent on prevention, there is an estimated $18 return to the community.

Messaging that focuses on preventing and reducing risky drinking and illicit substance use in the community should be a key focus following public intoxication decriminalisation. Reducing risky drinking (four or more standard drinks on a single occasion) can reduce the chances of individuals being heavily intoxicated in public. Campaigns and strategies can be delivered at a broad community level, or through targeted campaigns for higher risk groups, for example young men.

Community level strategies

According to the 2019 National Drug Strategy Household Survey, 29% of Queenslanders aged 14 and over reported drinking five or more standard drinks on one occasion at least every month[17]. While this number has been trending downward since 2007, this level of consumption continues to put people at risk of short-term harms such as accidents or injuries.

Strategies to reduce the risky consumption of alcohol in the community include:

- Mass media campaigns, such as raising awareness about the National Health and Medical Research Council alcohol guidelines, which includes no more than four standard drinks on any one day.
- Place-based approaches that seek to prevent harms from alcohol and other drugs, and to change drinking cultures, such as in sporting clubs and other community settings, noting these approaches can also be targeted to high-risk groups.
- Increasing awareness in the community of how a person can seek treatment and support for themselves, or a family member or friend.

Our research has shown that not knowing the right questions to ask, fear of stigma, and not knowing where to go for support are the main barriers to help-seeking. That's why the ADF is currently running a new Information and Support Services program that aims to identify the evidence for what works in delivering information and support to the families and loved ones of people who use alcohol and other drugs, identify existing gaps in services, and implementing a best practice model for information and service provision.

Increasing prevention measures among certain cohorts

Evidence from the Victorian Expert Reference Group on Public Drunkenness shows there were two significant cohorts of people captured by the Victorian laws. The report outlined a 'high intensity' cohort, representing 6.5% of offenders and 26% of offences, and a 'low intensity' cohort, representing the remaining 93.5% of offenders, of whom only 84% only offended once.[2]

Clear differences existed between these cohorts, with the high intensity cohort tending to be older, and much more likely to be engaged with AOD or housing services, and more likely to be presenting to emergency rooms.[2] Additionally, as discussed elsewhere in this submission, certain community groups including Aboriginal and Torres Strait Islander people were overrepresented in the high intensity cohort. Interventions described in section (d) are targeted at both cohorts, with

an emphasis either on the short-term management of acute intoxication, or the management of intoxication while providing or linking to psychosocial supports.

With regards to the low intensity cohort, there is an opportunity to explore evidence-based prevention programs that particularly target the young men identified in this cohort. Evidence based interventions should explore the impacts of alcohol and other drugs, and the impacts of poly-substance use on public intoxication presentations. Primary prevention-based measures would remove pressure on any tertiary prevention or harm reduction services implemented, as well as reducing demand on health or emergency responders.

Liquor Licensing

Liquor licensing laws can also assist in reducing instances of public intoxication and related violence/accidents. It's imperative that high risk venues (which might be associated with high rates of public intoxication charges or ambulance call outs), are managed differently to other venues. The ADF notes that Queensland already has some laws in place for high-risk venues. And, that Queensland is one of the jurisdictions that has introduced a risk-based licensing scheme (RBL). However, evidence has demonstrated that RBL's often do not have a great preventative effect due to the weak financial penalties that are applied to venues assessed as high risk.[24] [25]

There is value in this scheme if there is stronger regulation of venues and meaningful penalties applied to venues that are non-compliant. It can also help to introduce other demonstrably effective strategies alongside RBL's, such as trading hour restrictions. [25] [26]

Drug law reform

Ideally, the decriminalisation of public intoxication would also be accompanied by the decriminalisation of drug possession. This means that anybody who is intoxicated in a public place – whether by alcohol, drugs or both – will be treated through a health and welfare model rather than one of criminalisation. It is notable that both the recent Queensland Mental Health Select Committee[27], and the Women's Safety and Justice Taskforce[28] have highlighted the negative social and health impacts of the criminalisation of possession of illegal drugs, and have recommend exploring health-based alternatives to the current system.

Providing a health response can help address the fact that at present, people's interactions with the justice system often exceed the harms that may be associated with drug use itself. In addition to the stigma and discrimination experienced by people who use drugs, to which the criminalisation of drug possession is a contributing factor, people who become entangled in the justice system can also experience long term negative impacts on their social, employment, housing, and travel opportunities.

A new approach based on a health response can help reduce these collateral harms as well as alleviate the burden being placed on the justice system. This approach can provide an equitable and proportionate response to drug use. This approach can reduce the stigma and discrimination, making it more likely that people will reach out for help with their alcohol and other drug use when they want it.

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