Seeing the Clear Light of Day:

Expert Reference Group on Decriminalising Public Drunkenness

Report to the Victorian Attorney-General

August 2020

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About this report

This report has been prepared by the Expert Reference Group appointed to advise the Victorian Government on the decriminalisation of public drunkenness and the development of an alternative health-based response.

Our report comprises two parts:

Part 1 provides background and context to the work of our Expert Reference Group, including the current Victorian context and journey to decriminalisation. It summarises the key data and evidence demonstrating the need and imperative for changes to Victorian laws, policies and services, as well as provides an examination of the experiences of decriminalisation of public drunkenness in other jurisdictions.

Part 2 outlines our Expert Reference Group's advice and recommendations on the adoption of a public health response to public drunkenness, based on the insights outlined in Part 1. It contains a detailed discussion of the various phases required to adopt a public health response, as well as key implementation considerations relating to the successful transition away from the current criminal justice response.

Glossary of key terms

The following key terms are used throughout this report:

ACCOs is a broad umbrella term that is inclusive of Aboriginal Community-Controlled Organisations including Aboriginal Community-Controlled Health Organisations (ACCHOs)

ACJP means Aboriginal Community Justice Panels, a volunteer-based community initiative that provides cultural and practical support to Aboriginal people in police custody

AHLO means Aboriginal Hospital Liaison Officer

AOD means alcohol and other drugs

CALD means culturally and linguistically diverse

DHHS means Department of Health and Human Services

DJCS means Department of Justice and Community Safety

ERG means this Expert Reference Group on public drunkenness

ESTA means the Emergency Services Telecommunications Authority

First Responder means the agency or service who has first contact with a person who is intoxicated in public and requires assistance

Heath practitioner means an individual who practises a health profession

Intoxication means affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour

LEAP means Law Enforcement Assistance Program, a Victoria Police database

LGA means Local Government Area

Medical practitioner means a person who is registered in the medical profession as set out in the Health Practitioner Regulation National Law

OPCAT means the Optional Protocol to the UN Convention against Torture

Places of safety means a place where people who are intoxicated can be safe and have their immediate health needs met to sober up. This includes private homes (where appropriate) and the various health and community services identified throughout this report.

PSOs means Protective Services Officers

Proposed Health Model means the recommended health-based model outlined by the Expert Reference Group throughout this report

RAJACs means Regional Aboriginal Justice Advisory Committees

WIES means Weighted Inlier Equivalent Separation, which is a cost weight that measures resource use in an episode of care in a hospital.

Executive Summary

There is a clear, compelling and urgent imperative to overhaul Victoria's current approach to people who are intoxicated in public. The current punitive, criminal justice led response to intoxicated people is unsafe, unnecessary and inconsistent with current community standards. A safer, sensible health-based approach is required that ensures the health and safety of all Victorians, particularly our most vulnerable.

Ever since the Royal Commission into Aboriginal Deaths in Custody, calls for the decriminalisation of public drunkenness in Victoria have been strong, sustained and spirited. Numerous reports during the past 30 years have added to the Royal Commission's clear call for decriminalisation, including the Drugs and Crime Prevention Committee's Inquiry into Public Drunkenness in 2001 and the Victorian Parliament's Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody in 2005.

While the numerous recommendations have been gathering dust, the devastating human impacts of the criminalisation of public drunkenness have continued. The death in police custody of Tanya Day – a much-loved mother, grandmother and a proud Yorta Yorta woman – has been a clarion call for change. Ms Day's story embodies the tragic human consequences of the continuing criminalisation of public drunkenness in Victoria – a punitive scheme that has widespread unjust, discriminatory and intergenerational impacts on vulnerable Victorians.

Very regrettably, Ms Day's story reflects a much larger, systemic issue across Victoria. The human impacts of the criminalisation of public drunkenness are borne out clearly in the data. What the data tells us is that the criminalisation of public drunkenness discriminates against vulnerable people, and in particular Aboriginal and/or Torres Strait Islander people, Sudanese and South Sudanese communities, people experiencing homelessness, substance abuse and people experiencing mental health.

What the data also tells us is that this reform is eminently achievable. It paints a clear picture that:

- the total numbers of incidences of public intoxication are very low, at 159 per week
- there is a significant 'low intensity' cohort of people, with the vast majority of people (84 percent) entering custody in these circumstances only once. However, there is also a small 'high intensity' cohort (6.5 percent) who are responsible for over a quarter of all public intoxication offences; and
- there are a small number of 'high demand' Local Government Areas (LGAs) where a higher number of public intoxication offences occur.

While the imperative for change is overwhelming, we are convinced that the changes required to give effect to a health-based response are not. Our work over the last year tells us that there is a clear path away from criminalisation and towards an effective health-based response to public intoxication.

Based on data, consultations with the community and experts and drawing on the salient lessons of decriminalisation in other jurisdictions, this report outlines our Proposed Health Model for the decriminalisation of public drunkenness in Victoria.

The design of a new health-based model to respond to public intoxication must begin with the fundamental premise that no one should be placed into a police cell simply because they are intoxicated in public.

In order to eliminate the use of police cells for public intoxication, there must be safe places available that are accessible and appropriate to meet the health and safety needs of people who are

intoxicated. We adopt a ‘supply and demand’ framework to identify the service system response that is required, based on current data on public drunkenness offences being the most appropriate indicator of expected demand for placements.

This report outlines the public health approach that is required to achieve this transition. Our Proposed Health Model comprises five key stages:

- First response
- Transportation to a place of safety
- Meeting the immediate health needs of an intoxicated person
- Providing health and social care pathways for high needs individuals
- Broader prevention strategies.

First response

An effective health-based approach demands a cultural shift in the characterisation of intoxication as a health rather than a law enforcement issue. The primary First Responders should be personnel from health or community services organisations, such as outreach services (including existing outreach programs associated with homelessness services), alcohol and other drugs (ADO) services and Aboriginal Community Controlled Organisations (ACCOs). While emergency services such as Victoria Police and Ambulance Victoria will play an important role, a range of health-based services must be supported to meet the levels of expected demand across the state.

Transport

The preferred and default position is that an intoxicated person organises his/her own transport or does so with the assistance of family or friends. In situations where this is not possible due to health or safety risks, a range of new transport options will be required. Victoria Police will only have a role to play in the transportation of an intoxicated person when there are no other options available. The new range of transport options, in combination, will need to be capable of responding to the expected demand based on geography, time distribution and particular individual circumstances, including health needs and cultural safety.

Places of safety

Places of safety are essential to ensuring the health and wellbeing needs of intoxicated people are addressed. Depending on the circumstances, intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to a private residence, an emergency department or urgent care centre if they require urgent medical care, or a sobering service if they require a short recovery period and cannot be cared for elsewhere.

New sobering services are integral to our Proposed Health Model. Based on the data, seven new sobering services in high demand areas will provide the capacity to meet the variances in demand across the state. In regional and rural locations where there is much lower demand, the best health response solutions should be locally devised involving engagement of health services and the communities they serve.

The expansion of the sobering services network should be combined with modular ’pop-up’ services to expand capacity in a rapid and flexible manner to respond to demand associated with specific sporting or cultural events.

Health and social care pathways and broader prevention strategies

A significant minority of people who present intoxicated in public more frequently are likely to be experiencing complex health and welfare challenges that are contributing to their drinking patterns. Increased access to follow-up or ongoing support is a key element of an effective public health approach to public intoxication. This requires improved service pathways and targeted approaches, such as filling the gaps in AOD services for Aboriginal and/or Torres Strait Islander people.

Under a public health approach, broader prevention strategies also play a valuable and effective role in reducing the impacts of high-risk drinking by addressing underlying causes.

The path forward

The major thrust of our recommendations is clear – an effective health-based service system response to public intoxication is absolutely essential for the proposed reforms to be effective. Cultural safety considerations must be at the core of both design and implementation. This requires ongoing consultation and co-design with health services and their staff and with particularly affected communities, such as Aboriginal and CALD communities, to ensure that localised responses are developed that are tailored and effective.

In light of the complexity involved in the development of the Proposed Health Model, we recommend that a phased implementation take place over a two-year transition period. This will enable the model to be trialled and statewide service infrastructure put in place before full decriminalisation takes effect.

With detailed attention given to implementation of our Proposed Health Model, we are confident that a shift from a criminal justice approach to a health-based model is both realistic and attainable.

While the journey to decriminalisation in our state has been long and painful, Victoria now has the opportunity to leapfrog other Australian states and territories and be at the forefront with the development of an innovative and transformative health-based approach to public intoxication.

Once the shackles of a criminal justice approach to public intoxication have been shed, there can be no going back. The path ahead lies in a comprehensive health-led response that recognises public intoxication for what it is – a public health issue and not one that can be addressed by a blunt and reactive criminal justice approach.

There is strong community support.

The Victorian Government's commitment is clear.

Now is the right time for this long overdue reform to begin.

Now is the time to see the clear light of Day.

List of recommendations

The ERG's recommendations for a public health response to public intoxication cover the following:

- a public health response to public intoxication
- various phases required to adopt the ERG's Proposed Health Model; and
- key implementation considerations relating to the successful transition away from the current criminal justice response.

The recommendations listed below follow the structure of this report.

The journey to decriminalisation

1. The Expert Reference Group acknowledges the Victorian Government's acceptance of the coronial findings made by the Deputy State Coroner in the Inquest into the Death of Tanya Day and strongly encourages their full implementation by the Attorney-General, Chief Commissioner of Victoria Police, CEO of V/Line and Secretary of the Department of Justice and Community Safety (DJCS).

Implementing a public health approach to public intoxication

2. The Victorian Government repeals the offence of public drunkenness in sections 13, 14 and 16 of the *Summary Offences Act 1966* to achieve the decriminalisation of public drunkenness.
3. The Victorian Government ensures no person is detained in a police cell solely for being intoxicated in public.
4. The Victorian Government should adopt a 'supply and demand' approach that identifies the current number of public drunkenness offences as the most likely indicator of the number of placements that that will be required in sobering and other health services under the Proposed Health Model.
5. The Victorian Government ensures the implementation of the Proposed Health Model takes into account the need for holistic health-based responses that are also capable of responding to drug use and experiences of mental health, including dual diagnosis, where possible.
6. The Victorian Government undertakes further consultation to ensure that the management of intoxicated people, who have committed criminal offences, and are incarcerated in police cells can be more effectively supported and comply with the mandatory terms of Victoria Police's governing policy and procedures, including proper medical supervision and access to health treatment where required.

Stage 1: First responders

Roles and functions of first responders

7. All first responders under the public health model (whether justice-based or health-based first responders) perform their respective roles and functions in such a way as to ensure the health and safety of individuals who are intoxicated in public, consistent with the principles underpinning the public health model.

First response services and agencies

8. The Victorian Government considers how the Emergency Services Telecommunications Authority (ESTA) process can change regarding determining what tasks can be referred to certain response agencies in order to promote a health-based response to incidents of public intoxication. This should include how such alternate agencies can be facilitated through such a process – having regard to the contractual arrangements ESTA has with emergency services agencies.

Consent and powers of Victoria Police

Threshold for police powers

9. The Victorian Government establishes a legislative basis for Victoria Police to detain an intoxicated individual in strictly limited circumstances, including that:
    a) the Victorian Government defines intoxication within the legislation as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour'
    b) the Victorian Government limits the threshold for police with regards to someone who is intoxicated to 'serious and imminent risk of significant harm to the intoxicated individual or other individuals'
    c) the Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Strict limits to police powers

10. The Victorian Government establishes a legislative basis for Protective Services Officers (PSOs) within Victoria Police be given the power to detain an intoxicated individual in an existing designated place and is at serious and imminent risk of significant harm to themselves or others, recognising the safeguards contained in other recommendations.
11. The Victorian Government does not extend the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others to any other cohort.
12. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
13. The Victorian Government limits the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others for no longer than 60 minutes. Any exception to this time limit required to arrange a safe placement should require the authority of a Divisional Patrol Supervisor or Inspector.
14. The Victorian Government does not establish a specific offence as a result of the establishment of police powers to detain for the purpose of making inquiries to identify a place of safety for an intoxicated person.
15. The Victorian Government implements a review process for any charges laid in relation to assault police arising from attempts to escape by a superior officer, such as an Inspector.

Conditions of detention and use of force

16. The Victorian Government takes steps to ensure that in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006*, Victoria Police exercise their powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain and the nature of restraint employed.
17. The Victorian Government ensures Victoria Police takes steps to ensure the full protection of the health of persons in their custody and in particular, shall take immediate action to secure medical attention whenever required.
18. The Victorian Government explores and consults with relevant stakeholders on how to ensure treatment during and conditions of detention of intoxicated people are consistent with relevant state and international human rights obligations and principles. This includes ensuring effective independent oversight of the detention of intoxicated people that is consistent with the Optional Protocol to the UN Convention against Torture (OPCAT).
19. Victoria Police takes steps to ensure officers use force only when strictly necessary, and the force used must be proportionate to the circumstances. The degree and nature of the force used must account for the fact that the purpose of the power to detain is to keep the person safe from harm. Thus, any use of force must be used by exception and the force used itself minimal.

Limits on police discretion

20. The Victorian Government creates comprehensive regulations, guidelines, policies and procedures on the operationalisation of the legislation, to ensure police discretion is applied appropriately and reasonably to all members of the community.
21. The Victorian Government establishes legislation to ensure police discretion in assessing whether a location is a safe place is limited, including but not limited to risk of family violence and instances where the intoxicated person is behaving or is likely to behave so violently that a responsible person would not be capable of taking care of and controlling them.

Training

22. Victoria Police provides police officers and PSO with training on the legislative amendments, regulations, guidelines, policies and procedures and be provided ongoing refresher training.
23. Victoria Police provides police officers and PSO with training on systemic racism, unconscious bias, culturally appropriate service delivery, effective communication, de-escalation and conflict resolution, and be provided ongoing refresher training.
24. Victoria Police provides police officers and PSO with training on mental health and disability and be provided with ongoing refresher training.

Record keeping obligations of police

25. Victoria Police keeps detailed records of the enquiries they make in relation to locating a safe place for the person, including any reasons for concluding that the location is not a safe place, such as risk of family violence.

Publicly available information

26. Victoria Police ensures guidelines, policies, procedures and training and other similar materials are publicly available.

27. The Victorian Government considers making disaggregated data relating to police assistance provided with consent, and police intervention without consent, publicly available. This information should include, but not be limited to, information with regards to whether people are Aboriginal and/or Torres Strait Islander, CALD status, homelessness, gender, disability and age.
28. The Victorian Government implements public reporting on the exercise of new police powers and other relevant powers that may be used more frequently subsequent to the reform (e.g. move on powers), as well as arrests for other minor offences.

Internal police oversight

29. Victoria Police ensures authorisation of any charges that arise from an incident of public intoxication should be authorised by an Inspector.

Independent oversight

30. Victorian Government, in consultation with the Victorian Aboriginal Legal Service and Victoria Police, considers the introduction of a mandatory requirement that where an intoxicated Aboriginal and/or Torres Strait Islander person is detained and/or transported for their safety by Victoria Police they be subject to sections 464AAB and 464FA of the *Justice Legislation Miscellaneous Amendment Act 2018.*
31. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms by police. This should include oversight of up-charging practices by police, and the treatment of people detained and conditions of detention during transport.

Accountability for police negligence and abuse of power

32. The Victorian Government ensures any abuse of power by police to circumvent the limitations on powers to detain an intoxicated person must be treated seriously and they should be held accountable.
33. The Victorian Government undertakes further research and consultations to establish an offence in relation to negligent conduct when detaining an individual who is intoxicated.

Stage 2: Transport to a place of safety

Guaranteeing transport coverage and availability

34. The Victorian Government supports outreach teams and sobering services to have a transport capability attached to their service or work together with separate transport teams to achieve the most effective and efficient management of demand.
35. The Victorian Government ensures that the proposed implementation phase gives local areas an opportunity to test a range of low-demand transport models, including the identification and development of local partnerships.
36. The Victorian Government ensures that the implementation phase monitors the impact on police and ambulance emergency services, including impact on response time performance measures.

Consent and powers

37. The Victorian Government establishes a legislative basis for Victoria Police to transport an intoxicated individual to a place of safety in strictly limited circumstances, including that:
    a) there be a legislative obligation that police exhaust all other avenues by which an intoxicated person could be transported to a safe place, and that police transport be a last resort
    b) the Victorian Government does not establish a specific offence as a result of the establishment of police powers to transport intoxicated individuals to a place of safety
    c) the Victorian Government ensures that all limits, thresholds and accountability measures in relation to the power to apprehend and detain, as outlined in Part 7 of this report, apply to the exercise of the limited power to transport intoxicated individuals to a place of safety.

Transport safety

38. The Victorian Government establishes a transport safety standard to ensure the safe transport of intoxicated people.

Stage 3: Places of safety

39. The Victorian Government ensures intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to one of three safe place locations to sober up, including to:
    a) their home or other private residence where it is determined that the individual is at low-risk and can be adequately and safely cared for by family or friends
    b) an emergency department or rural trauma and urgent care centre where it is determined the individual requires urgent medical assessment and/or care; or
    c) a health or sobering service where it is determined the individual does not require emergency care but still requires a short period of recovery and detoxification and/or cannot be cared for safely elsewhere.
40. The Victorian Government ensures that a home or other safe private residence remain the preferred and default safe place option to assist people with sobering needs. Wherever possible and appropriate, an intoxicated person should be safely cared for by family or friends in order to minimise the impost on health services. Additionally, people who reside alone should not by default be taken to a sobering service simply because they do not have someone to care for them.
41. The Victorian Government ensures the key elements of intake, assessment, monitoring, further assessment and intervention form the model of care for sobering services in Victoria that comprises:
    a) outreach and transport services as a key element of a model of care for sobering services in Victoria
    b) the workforce for sobering services should be multidisciplinary and at a minimum including a health practitioner, such as a registered nurse, and reflect the profile and the needs of the population and region it serves

c) a staff to client ratio between 1:6 and 1:8, which would be a reasonable starting point subject to detailed implementation planning for each location and any variations to a core model.

42. The Victorian Government considers modular health spaces as an infrastructure approach to trialling heath responses as part of the proposed implementation phase, given they are an increasingly accepted part of the health infrastructure mix, offering expanded capacity that can be deployed rapidly and flexibly to meet need.
43. The Victorian Government expands the Mental Health and Alcohol and Other Drug (ADO) Hubs model of care to enable them to provide sobering services as part of their model of care. This may require additional government investment above that initially allocated.
44. The Victorian Government supports the re-location and substantial expansion of Ngwala Willumbong Sobering Service to service Melbourne's northern region which will require additional government investment.
45. The Victorian Government considers whether the rural trauma and urgent care centres could be an effective option for provision of sobering services, and if so, infrastructure may need to be boosted to provide dedicated sobering up placements, where required.
46. The Victorian Government enhances the capability of the existing health system in areas of low demand in regional and rural Victoria to enable medically supervised sobering up placements.
47. The Victorian Government establishes both permanent and 'pop-up' sobering services in LGAs with high demand. The permanent services should operate 24-hours a day seven days a week, with capacity to scale up services at peak times.

Consent to medical treatment

48. The Victorian Government establishes a legislative basis for medical practitioners to apprehend or detain an intoxicated individual, where they do not consent to treatment, in strictly limited circumstances, including that:
    a) the Victorian Government defines intoxication within the legislation as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour'
    b) the Victorian Government ensures that limits for the threshold for medical intervention with regard to someone who is intoxicated is serious and imminent risk of significant harm to the intoxicated individual or other individuals
    c) the Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Safeguards

49. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
50. The Victorian Government ensures health practitioners are required to regularly assess the ongoing need for detention, including upon admission if detained during transport and through regular assessments of whether informed consent can be secured.

51. The Victorian Government ensures detention for the purposes of the sobering up of an intoxicated person should be a last resort and is limited by appropriate safeguards.
52. The Victorian Government considers the matters highlighted in the *Restrictive Interventions in Victorian Emergency Departments: A Review of Current Clinical Practice* commissioned by the Department of Health and Human Service must be addressed by the Victorian Government.
53. The Victorian Government ensures medical practitioners exercise their powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain and the nature of the restraint, in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006.*
54. The Victorian Government implements robust safeguards, including comprehensive legislation, regulations, and guidelines, policies and procedures on the operationalisation of the legislation. This is to ensure, for example, that medical practitioners use sedation and other chemical and mechanical restraints on intoxicated people appropriately.
55. The Victorian Government ensures that medical practitioners:
    a) maintain appropriate written records, including the reasons for the order, the period for which the person is ordered to be detained, the monitoring regime, treatment provided, restraints used and reasons, and discharge
    b) to the extent reasonably possible inform the person of the reasons for the detention and their applicable rights
    c) take reasonable steps to notify the person's nominated person, guardian or carer of their admission or detention; and
    d) provide the reasons for detainment and/or the use of restraint in writing to the person upon their discharge/release.

Independent oversight

56. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms in health service. This should include oversight of detention conditions and treatment of detained people, as well as use of mechanical and chemical restraints.
57. The Victorian Government, in accordance with OPCAT obligations, enables the National Preventive Mechanism to have oversight when intoxicated people are deprived of their liberty, including when they are detained and/or restrained in hospitals.

Stage 4: Health and social care pathways

58. The Victorian Government ensures that a comprehensive service system is capable of supporting the broader health and wellbeing needs of the high intensity cohort of people, who very often experience quite complex health and welfare challenges that contribute to their drinking patterns.

Investment in Aboriginal alcohol and other drug services

59. The Victorian Government establishes a specific adult AOD program for Aboriginal and/or Torres Strait Islander Victorians prior to the end of the implementation phase, with Wotha Daborra considered for further development as part of this process.

60. The Victorian Government ensures that all Social and Emotional Wellbeing teams include AOD expertise (a position outlined by the Royal Commission into Victoria's Mental Health System) and that the role of the teams be expanded to support the government's public intoxication reforms for Aboriginal and/or Torres Strait Islander Victorians where appropriate.

Stage 5: Broader prevention strategies

61. The Victorian Government continues to support and expand where necessary public awareness campaigns focused on primary prevention health initiatives that relate to the prevention of public intoxication, including the work of VicHealth.

Implementation considerations

Phased transition

62. The Victorian Government ensures the Proposed Health Model is phased in over a 24-month period to enable an adequate transition from the current justice-based response to public intoxication.

Trial sites

63. The Victorian Government establishes at least three trial sites during the 24-month transition period to inform the development of the statewide implementation of the ERG's Proposed Health Model.

Governance

64. The Victorian Government establishes a dedicated implementation office to operationalise the public intoxication reform agenda.
65. The Victorian Government establishes a dedicated oversight committee to oversee the overall implementation of the public health approach to public intoxication and to ensure that implementation is consistent with, and gives effect to, the intention of the proposed reforms.

Ongoing monitoring, evaluation and adaptability

66. The Victorian Government works with affected communities, including Aboriginal and/or Torres Strait Islander, Sudanese and South Sudanese communities to develop an evaluation framework including outcomes, reporting by agencies and services, provision of data to affected communities and the involvement of affected communities in the governance model.
67. The Victorian Government undertakes a statutory review of the reforms related to decriminalisation of public drunkenness.
68. The Victorian Government develops a monitoring and evaluation framework in consultation with relevant stakeholders including representatives from Aboriginal and/or Torres Strait Islander and CALD communities.
69. The Victorian Government ensures that Aboriginal Community Controlled Organisations evaluate the cultural appropriateness of the implementation and operation of the reforms.

Cultural safety framework

70. Consistent with its commitment to self-determination and co-design principles, particularly for Aboriginal and/or Torres Strait Islander people, the Victorian Government consults with

affected communities and work wherever possible with community-controlled organisations in the design, delivery and evaluation of the public health response to public intoxication.

71. The Victorian Government continues to support the implementation of a new funding and governance model across public health services to strengthen and improve approaches to delivery of culturally safe and responsive services for Aboriginal and/or Torres Strait community.
72. The Victorian Government continues to support further actions via health service statement of priority processes and funding and service agreements for funded organisations to progress Reconciliation Action Plans.
73. The Victorian Government continues to support and elevate the cultural safety planning undertaken by hospitals and the delivery of culturally safe sobering services provided in hospital settings, including:
    a) sobering services in hospitals are established in line with the identified six themes impacting cultural safety
    b) expanding the Aboriginal and/or Torres Strait Islander health workforce, including Aboriginal Health and Liaison Officers, fully utilising Weighted Inlier Equivalent Separation (WIES) loadings and other resources to adequately resource this function
    c) Aboriginal Health and Liaison Officers – or an appropriate equivalent - are available to support Aboriginal and/or Torres Strait Islander clients utilising sobering services, including access after-hours and on weekends; and
    d) undertake an audit of cultural safety in relation to both Aboriginal and/or Torres Strait Islander people and CALD communities at relevant emergency department and rural trauma and urgent care centres, and appropriate actions undertaken to address identified areas of concern.
74. The Victorian Government works in partnership with affected communities at a local level to develop culturally appropriate service responses as part of the public health response, including building on established partnerships with Aboriginal organisations and communities (e.g. Aboriginal Justice Caucus and Regional Aboriginal Justice Advisory Committees (RAJACs), and with Sudanese and South Sudanese communities under the African Community Action Plan, where appropriate.
75. The Victorian Government support comprehensive cultural safety training to be developed for all first responder agencies (in the justice and health systems), with localised input from, and delivery by, ACCOs and other affected community-controlled organisations, including training on:
    a) Aboriginal cultural awareness
    b) unconscious bias
    c) trauma-informed care
    d) mental health and disability
    e) human rights under the Victorian Charter of Human Rights.
76. The Victorian Government supports the development and delivery of cultural safety training by ACCOs and other affected communities for all staff in services in the public health model.

77. The Victorian Government ensures that training is provided to all first responders and services on localised service pathways and access for affected communities, including for ACCOs. This will be particularly important during the implementation phase.
78. The Victorian Government requires that all first responders and staff in services under the public health model undergo cultural safety training, including ongoing, localised and refresher training.
79. The Victorian Government continues to build the capacity of ACCOs and other community-controlled organisations to deliver cultural safety training in mainstream organisations, including appropriate resourcing and funding of these as professional development activities.
80. The Victorian Government ensures that culturally appropriate safeguards and service pathways are developed for Aboriginal and/or Torres Strait Islander people coming in to contact with police, including exploring options with the Aboriginal Community Justice Panels (ACJP).
81. The Victorian Government extends the role of Aboriginal Hospital Liaison Officers (AHLOs) to after-hours and/or implement an on-call model so hospital based sobering services also have access to Aboriginal support persons for relevant clients (noting this could also benefit all Aboriginal and/or Torres Strait Islander clients) ensuring any non-hospital services operate consistent with the eight cultural safety domains now in place at hospitals. This could include consideration of block grants for cultural safety to other health services with a primary direct role in public intoxication (i.e. Ambulance Victoria).
82. The Victorian Government ensures that interpreters are available across the range of service system responses identified by the ERG for the proposed reform.

Further consultation & co-design

83. The Victorian Government ensures that detailed consultation and co-design occurs as it is critical to the successful establishment and implementation of a public health model.

Local government

84. The Victorian Government undertakes a review of relevant local laws in partnership with local government. The scope of such a review might include consideration of amendments as well as operational protocols to support the reform principles underpinning decriminalisation of public drunkenness.
85. The Victorian Government analyses data relating to enforcement of local laws be monitored to track any unintended consequences associated with the enforcement of local laws.

Resourcing

86. The Victorian Government adequately resources all components of the Proposed Health Model, reflecting the interdependency between all components identified in this report.

Part 1: Background and context

1. Introduction

On 22 August 2019, the Victorian Government announced it would "decriminalise public drunkenness and replace it with a health-based response, in order to provide vulnerable Victorians with appropriate help and support".[1] This will involve the repeal of three offences relating to public drunkenness in the *Summary Offences Act 1966* and the related power of arrest.

The decision was made in the context of the coronial inquest into the death of Yorta Yorta woman Tanya Day, who died after being held in police custody in Castlemaine in December 2017 on a charge of being drunk in public.

The decriminalisation of public drunkenness is consistent with recommendations of the Royal Commission into Aboriginal Deaths in Custody made in 1991 and aligns with the findings and recommendations made by the Deputy State Coroner in April 2020 following the Inquest into the Death of Tanya Day.

1.1 Appointment of the Expert Reference Group

This ERG was established in late August 2019 to provide strategic advice and recommendations to the Victorian Government on the decriminalisation of public drunkenness and the development of an alternative health-based response.

The ERG consists of:

- **Helen Kennedy**, former Chief Operating Officer of the Victorian Aboriginal Community Controlled Health Organisation
- **Tony Nicholson**, former Executive Director of the Brotherhood of St Laurence
- **Jack Blayney**, former Assistant Commissioner and Chief Information Officer of Victoria Police
- **Nerita Waight**, Chief Executive Officer of the Victorian Aboriginal Legal Service

The Terms of Reference for the ERG identify that:

- the ERG is to ensure that its advice reflects the importance of promoting the health and safety of vulnerable Victorians and providing them with appropriate help and support, while ensuring that the safety of the community, first responders, health workers and the broader public is protected
- the ERG's advice is to be developed in consultation with the Aboriginal and/or Torres Strait Islander community, Victoria Police, health services, alcohol and other drugs experts, local government and operators of licensed premises
- the new health-based model will promote therapeutic and culturally safe pathways to assist alcohol-affected people in public places, who may be facing other challenges including homelessness, mental illness, family violence, and substance dependency; and
- a health-based approach will be particularly significant for the Aboriginal and/or Torres Strait Islander community, who are disproportionately affected by the current laws.

A copy of the full Terms of Reference for the ERG is provided in **Appendix 1**.

[1] Attorney-General, Media Release, 22 August 2019.

1.2 Methodology

Guided by the Terms of Reference, the ERG has engaged in a detailed consultation process to progress our understanding of the issues associated with adopting a public health approach to public intoxication and prepare our advice and recommendations to government. Within the time limitations provided for us to provide our report, this process has included:

- **community consultations –** a series of community forums and workshop-style consultations
- **representative forums –** meetings and workshops with key representative groups to discuss the progress of our work, including the Justice Stakeholder Forum, Aboriginal Justice Forum and Health Services and Health Partnership Implementation Committee
- **meetings with key experts –** metropolitan and regional forums, workshops and small group meetings with key experts, including peak organisations, police, ambulance, legal services, public health experts, academics and advocates. This includes experts involved in experiences in other jurisdictions, such as Aboriginal Legal Services (Ontario), National Sobering Collective (United States) and the Kununurra Sobering Up Centre (Western Australia)
- **government briefings –** presentations from government, briefing papers and responses to requests from the ERG for specific information and data
- **consultations with health services –** one-on-one, small group interviews and targeted workshops with specialist services, including health services, clinicians, and Aboriginal Community-Controlled Health Organisations (ACCHOs)
- **data and evidence review –** briefings and papers from key agencies and data sources, including the Crime Statistics Agency, Ambulance Victoria, Law Enforcement Assistance Program (LEAP) data and DHHS data
- **other key stakeholders –** one-on-one meetings with other key stakeholders, including local government and operators of licensed premises, as well as engagement with existing stakeholder forums
- **ERG meetings –** the ERG met on a regular basis to progress our work. Other stakeholders and experts attended these meetings from time to time.

1.3 Acknowledgements

We are extremely grateful to those who shared their advice and insights throughout this process and whose expertise will also be drawn upon during the implementation phase.

A list of organisations and agencies who were engaged with in the development of this report is provided at **Appendix 2**.

We are particularly indebted to the dedicated and expert staff from DJCS and DHHS for their tireless assistance and advice to support the work of the ERG. Similarly, we also want to recognise contributions provided by staff from the Victorian Aboriginal Legal Service, including Isabel Robinson and Andreea Lachsz as well as Jane Andrews from the Victorian Aboriginal Community Controlled Health Organisation We also wish to recognise the stellar contributions of our writer Ben Schokman.

Finally, we wish to acknowledge the unique challenges presented by the coronavirus (COVID-19) pandemic in the final stages of the preparation of this report, which has led to significant challenges in sourcing data and advice, drastically altered timeframes and difficulties presented for individual ERG members.

2. Vision and design principles

As we highlight in Section 3, the need and imperative for a major change to current responses to public intoxication in Victoria is clear, compelling and urgent. We outline below the vision, intended outcomes and principles that we have used to guide the design of a public health response to public intoxication. These parameters for our advice and recommendations have been developed based on the Terms of Reference and informed by the evidence and feedback received from community consultations, service providers, experts, government departments and agencies, and other key stakeholders.

2.1 Outcomes

People in Victoria who are intoxicated in public and are at risk to themselves or others will be safe, they will have access to culturally-appropriate care and support if they choose it, their contact with the criminal justice system will be minimised, and the safety of the community and responders will be assured.

2.2 Outcomes

In delivering on the ERG's terms of reference, the Victorian community should experience the following broad outcomes, including:

- reduced incarceration and deaths in custody
- decreased contact with the criminal justice system
- increased access to a culturally responsive service system that is capable of addressing both immediate short-term needs and longer-term health and social care pathways
- reduced harm from risky drinking and related behaviours by individuals
- maintenance of community safety and perceptions of community safety in relation to public intoxication.

We wish to recognise at the outset that particular communities and cohorts of people are disproportionately impacted either as a result of existing law enforcement of public drunkenness, or their experiences in the justice, health and law enforcement systems more broadly, including:

- Aboriginal and/or Torres Strait Islander people
- Sudanese and South Sudanese people
- children and young people
- people at risk of being a victim and/or perpetrator of family violence
- people with a disability
- people with a mental health issue
- people experiencing homelessness
- Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) people.

Improved outcomes for these communities have been front of mind throughout our considerations and the work that we have undertaken to design the Proposed Health Model outlined in this report.

2.3 Principles

Our advice and recommendations on the design of a public health response is guided by the following principles:

- **human-rights informed –** the new model will reflect the human rights for which Victorians have protection in the *Charter of Human Rights and Responsibilities Act 2006* – in particular freedom of movement, liberty and security, and equality before the law
- **self-determination –** Aboriginal and/or Torres Strait Islander Victorians will be empowered to make decisions about how the new model can best support Aboriginal communities
- **engagement and collaboration –** engaging and collaborating with communities, service users, service providers and researchers will help ensure the new model is fit for purpose and service responses are integrated and supported by strong relationships
- **locally tailored and consistent with overarching scheme –** while service and operational responses should vary and adapt according to local conditions, there will be fair and consistent procedures for determining an intoxicated person's risk of harm and health and safety needs. Agency roles and responsibilities will be clear, with connected referral pathways
- **scalable –** the model design can be scaled and adjusted according to changing needs, including responding to seasonal demand variation. Where appropriate, new programs and services can be trialled in one area and expanded across the state
- **safety –** cultural and psychological safety will be essential to meet the needs of Aboriginal and/or Torres Strait Islander Victorians and a range of other groups who may be at greater risk of public intoxication-related harm, including: people experiencing mental illness; harmful substance use and/or homelessness; survivors and perpetrators of family violence; young people; culturally and linguistically diverse communities; and people with disabilities
- **evidence-informed –** the new model will be informed by the best available evidence on problems, solutions and opportunities, while being adaptive and innovative
- **feasible and implementable –** make the most of all of Victoria's existing strengths – including protective factors, efforts, expertise and service infrastructure – and be adequately and sustainably resourced
- **sustainable –** funding models predictably allow services to deliver care and support in line with these principles, with consideration to changing demand levels, costs of service delivery and availability of other funding sources
- **ongoing evaluation and adaptability –** finally, given the nature of the proposed reforms, service system responses designed to implement a public health approach must be reviewed, evaluated and adapted on an ongoing basis, based on clearly identified service system parameters and quality available data.

3. The journey to decriminalisation

This section outlines the historical context leading to the Victorian Government's decision to repeal the offence of public drunkenness.

3.1 Royal Commission into Aboriginal Deaths in Custody

Nearly 30 years ago, the Royal Commission into Aboriginal Deaths in Custody investigated 99 deaths of Aboriginal and Torres Strait Islander people in custody over a nine-year period. The Royal Commission found that the disproportionate rate at which Aboriginal and Torres Strait Islander people were arrested was the major and most immediate cause of these deaths. The Royal Commission also reported on the complex, intergenerational impacts of dispossession, colonisation and institutional racism on Aboriginal and Torres Strait Islander peoples.

The Royal Commission made 339 recommendations relating to improvements in the criminal justice system and measures to reduce the number of Aboriginal and Torres Strait Islander peoples coming into contact with the criminal justice system. The key recommendations relating to responses to public intoxication are:

- abolition of the offence of public drunkenness (recommendation 79)
- establishment of non-custodial facilities for the care and treatment of intoxicated people (recommendation 80); and
- creation of a statutory duty that police must consider and use alternatives to the detention of intoxicated people in police cells (recommendation 81).

We are particularly moved by the Royal Commission's examination of the death in custody of Harrison Day – Ms Day's uncle. In re-visiting the Royal Commission's work, we are struck by the unnerving parallel between the circumstances of Mr Day's death in police custody in 1982 and his niece's death 35 years later.

Since the Royal Commission's report in 1991, the number of Aboriginal and Torres Strait Islander people who have died in custody around Australia is 438. As we discuss further below, Victoria and Queensland remain the only Australian states not to have abolished the offence of public drunkenness. As is made abundantly clear in the Royal Commission's report, there will continue to be devastating human impacts unless and until Victoria's current criminal justice approach to public intoxication is discarded and replaced with a health-based response that ensures the safety and wellbeing of individuals who require support.

3.2 A sustained case for change

We acknowledge the community groups, service providers, experts and academics who have long advocated for a change to Victoria's criminalisation of public intoxication. This includes strong, sustained and spirited advocacy by Aboriginal and Torres Strait Islander leaders, organisations and communities given the over-representation of Aboriginal and/or Torres Strait Islander people detained in police custody for public intoxication, as well as the harmful impacts of detention. For Aboriginal and Torres Strait Islander communities, experiences associated with public intoxication are inherently linked to the broader operation of the criminal justice system and the disproportionate impacts of criminal laws, policing practices and sentencing. These disproportionate impacts have enormous costs

and consequences for Aboriginal and/or Torres Strait Islander people and the broader Victorian community.

Since the Royal Commission, numerous inquiries and reports have repeated the calls for decriminalisation of public intoxication, including the Drugs and Crime Prevention Committee's 2001 *Inquiry into Public Drunkenness* and the Victorian Parliament's 2005 *Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody*. The family of Tanya Day observed that "if the Victorian Government had done what the Royal Commission into Aboriginal Deaths in custody recommended 30 years ago and abolished the offence of public drunkenness, our mum would still be alive today".[2] We echo their call that whilst the decision to decriminalise public intoxication is just the beginning and "this country has so much further to travel. For as long as Aboriginal and/or Torres Strait Islander people are targeted by police, are locked up and mistreated, and continue to die in police custody, the fight for true and complete justice for our people will be ongoing".[3]

Recently, the global impact of the Black Lives Matter movement has sharpened awareness of the overrepresentation of, and adverse outcomes experienced by, Aboriginal and Torres Strait Islander people in the justice system and the suffering of the many Aboriginal and Torres Strait Islander families whom have lost loved one to deaths in custody and continuous cycles of incarceration. The Black Lives Matter movement is also shaping community expectations of the systemic and cultural change that is required to improve health and justice outcomes for Aboriginal and Torres Strait Islander people and other vulnerable groups. We believe that everyone in our community deserves fair and equal treatment, regardless of ethnicity, socioeconomic status, or education – and that by listening and implementing reforms that heed of the calls of generations of marginalised communities we can go a long way to creating a more equal and fair society.

We recognise that the principal thrust of advocacy by community groups is the demonstrable need for a comprehensive health-based response to replace the current criminal justice approach. This requires an integrated public health approach that is capable of addressing the often multiple, intersecting challenges experienced by the high intensity cohort of people who come into contact with police when intoxicated in public. This includes culturally appropriate and tailored responses for people who are over-represented in this cohort, such as people experiencing homelessness, Aboriginal and/or Torres Strait Islander people and people with Sudanese background.

We outline more specific detail about the information received during consultations in Section 3.4 below.

We also recognise that further consultation needs to be undertaken to inform the implementation phase of the public health model addressing public intoxication (which we address in Part 2).

3.3 Inquest into the Death of Tanya Day

The Victorian Government's commitment to abolish the offence of public drunkenness was made on the eve of the coronial Inquest into the Death of Tanya Day. Ms Day died after being removed from a train and taken into police custody for being intoxicated in public. She sustained a serious head injury after falling in a police cell and died 17 days later, on 22 December 2017.

Ms Day was a much-loved mother and grandmother, and a proud Yorta Yorta woman. Her children – Belinda Stevens, Warren Stevens, Kimberly Watson and Apryl Watson – have publicly and fiercely

[2] Available at https://www.hrlc.org.au/news/2020/4/9/family-of-tanya-day-statement
[3] Available at https://www.hrlc.org.au/news/2020/4/9/family-of-tanya-day-statement

advocated for justice for their mother, as well as provided detailed submissions to the Deputy State Coroner about the need for major, systemic reform and cultural change.[4]

The Day family's submission requests that the Coroners Court of Victoria make a number of recommendations that are relevant to the approach to the decriminalisation of public intoxication and consideration of the powers of Victoria Police and other first responders. Key recommendations include:

- that the Victorian Government prohibit the placement of intoxicated people – charged solely with an offence (or offences) under the Summary Offences Act 1966 – in police cells (Recommendation 2)
- that the Victorian Government work in partnership with Aboriginal and Torres Strait Islander organisations and communities, legal and health experts, Ambulance Victoria and Victoria Police to design, resource and implement a range of non-custodial public health alternatives for the care and treatment of intoxicated persons (Recommendation 3)
- that the Chief Commissioner of Victoria Police review the adequacy of legislation, the Victoria Police Manual, Standard Operating Procedures (SOPs) and training/refresher modules regarding dealing with intoxicated persons to require that police officers:
    - consider and utilise alternatives to custody
    - consider arrest as a last resort and consider all alternatives before arresting a person, particularly for minor offences
    - undertake individual health and risk assessments to determine whether the person requires medical attention or accommodation prior to taking a person into custody
    - if the intoxicated person is an Aboriginal and/or Torres Strait Islander person, consider that they may have experience of intergenerational trauma, be more likely to have more complex health needs, and may experience being detained in custody in a particularly negative and traumatic way; and
    - provide adequate care and supervision of persons taken into custody to maintain their health, safety and wellbeing (Recommendation 18).

On 9 April 2020, the Deputy State Coroner handed down her findings and made 10 recommendations directed towards the Attorney-General, Department of Justice and Community Safety and Victoria Police. The findings included that Ms Day's death was preventable and referred Victoria Police officers for criminal investigation. These recommendations and the Victorian Government responses are provided at **Appendix 3**.

For the ERG, the Day family's submission and their long fight for truth and justice, supported by the coronial findings, has formed a strong basis for the content of this report and our recommendations.

As observed by the former Minister for Aboriginal Affairs Gavin Jennings, on 22 August 2019, "Since Tanya Day's death in 2017, her family has been committed to law reform and better support services. The courage and determination they have shown to prevent other families from experiencing their pain has been remarkable and truly inspiring."

[4] Available at https://www.hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability.

Recommendation

1. The ERG acknowledges the Victorian Government's acceptance of the coronial findings made by the Deputy State Coroner in the inquest into the death of Tanya Day and strongly encourages their full implementation by the Attorney-General, Chief Commissioner of Victoria Police, CEO of V/Line and Secretary of DJCS.

3.4 Need and imperative for change

We are acutely aware that the history and context briefly outlined above demonstrates a clear need and urgent imperative for change that is long overdue. The circumstances of Ms Day's death and the coronial inquest has become a tipping point for change in Victoria.

While this reform will bring Victoria in line with almost all other states and territories across Australia, there is a vital opportunity for Victoria to learn from the experiences of other jurisdictions. As we outline in Section 4 below, approaches to decriminalisation elsewhere have largely failed to eliminate the incarceration of people who are intoxicated. The absence of adequately resourced health-based responses has had the unintended consequence of perpetuating, and in some instances exacerbating, major issues relating to the overuse of detention and safety and wellbeing of people who are detained. In the Australian context, this failure is most clearly and dramatically highlighted by the number of continued deaths in custody, particularly of Aboriginal and Torres Strait Islander people around the country.

The advice and recommendations we provide throughout this report present a significant opportunity for Victoria to lead domestically and internationally by implementing reforms that create an ongoing legacy that promotes the safety, wellbeing and dignity of all Victorians.

3.5 Consistency with current policy priorities

The Victorian Government's commitment to decriminalise public drunkenness and adopt a public health approach is consistent with a number of current key policy priorities, including:

- delivery of the Burra Lotjpa Dunguludja - The Aboriginal Justice Agreement Phase 4
- delivery of the Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan – 2017-2027
- delivery of the Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027
- delivery of the Public Health and Wellbeing Plan 2019-23
- establishment of the DJCS Youth Justice Strategic Plan 2020-2030
- Community Crime Prevention, including the establishment of place-based interventions, new research and resources to assist in reducing crime at the local level
- DJCS's Statement of Direction outcome 'a fair and accessible justice system for Aboriginal people' and commitment to reducing over representation of Aboriginal Victorians in the justice system.

In addition, there is significant work underway on emerging reforms including:

- responses and recovery measures related to the coronavirus (COVID-19) pandemic
- amendments to the Summary Offences Act 1966

- the review of the *Liquor Control Reform Act 1998*, including consideration of current approaches to harm reduction
- upcoming recommendations of the Royal Commission into Victoria's Mental Health System
- expansion of AOD services, including residential rehabilitation services.

These priorities recognise a range of significant issues within Victoria, including the need to improve outcomes for people in contact, or at risk of contact with justice services through improved early intervention and prevention and development of service responses that meet the needs of vulnerable people and improve outcomes for rehabilitation and recidivism.

We note a Victorian Parliamentary Inquiry into Homelessness is also currently underway.

4. Victorian context

This section provides an overview of the operation of the current response to public drunkenness in Victoria. We outline the current legislative scheme and service system response. A high-level summary of the key findings from available data, stakeholder consultations and available literature is also presented.

4.1 Current Legislative Scheme

Public drunkenness in Victoria is captured by several offences contained in the *Summary Offences Act 1966*, namely:

- being found drunk in a public place (section 13)
- found drunk and disorderly in a public place (section 14)
- behaving in riotous or disorderly manner while drunk (section 16)

The mere fact that a police officer considers a person to be intoxicated is sufficient to give rise to the charge under section 13. A person does not need to be violent, disturbing the peace or at risk of harm to themselves or others to be arrested. Public intoxication offences require discretionary assessments by police about a person's intoxicated state based on their appearance and behaviour. However, alcohol levels do not necessarily correlate with the person's behaviour. People with relatively low alcohol levels can engage in behaviours that place them or others at risk. An individual may also appear intoxicated, but in fact be experiencing an underlying health condition.

4.2 Current service system responses

Under the current system, there are a number of First Responders that undertake a range of roles and functions when responding to an intoxicated person in public. These include:

- **Victoria Police –** Victoria Police have powers to maintain community safety under a range of legislation, including the current public drunkenness offences (outlined above), move on powers, banning notices and other summary offences to maintain community safety[5]
- **Ambulance Victoria –** Ambulance Victoria paramedics deliver medical care and transport to intoxicated people who need urgent medical attention. This care is mostly voluntary and is not based on any statutory power[6]
- **health services –** a range of health services respond to medical and other health needs of intoxicated people, including in particular AOD services. Support is provided where a person presents to that health service, as well as through outreach and mobile services. There are no express statutory powers for health workers to require or regulate health interventions in relation to a person's intoxication except where that intoxication requires an urgent medical response
- **welfare and community services –** a number of community organisations provide health, alcohol and other drug, and welfare services, including outreach services such as Koori Night Patrols and Ngwala Willumbong Sobering Centre and outreach services to people experiencing

[5] See general powers and functions under the *Victoria Police Act 2013*, *Crimes Act 1958*, *and Summary Offences Act 1966*.

[6] Ambulance officers do have powers under the *Mental Health Act 2014* to enable apprehension and transport to a mental health service: section 351 of the *Mental Health Act 2014*.

homelessness. These services range from professional services with medical staff to voluntary services

- **liquor licensees' –** operators of licensed premises have powers to respond to intoxication and a range of alcohol related behaviour under the *Liquor Control Reform Act 1986*. This includes refusing entry, barring and banning people from licensed venues. (The *Liquor Control Reform Act 1986* is currently under review through a separate process)
- **authorised officers –** various authorised officers enforce regulations and local laws[7] in public places and on public transport.[8] These officers may be the first to respond to a person who is intoxicated, respond to related behaviour and detect any relevant offences related to public drinking and related behaviour.

4.3 What the data told us

The ERG has received detailed data from a number of sources including police, ambulance and other health and human services data. This includes data recorded in the Victoria Police LEAP database relating to the offences of 'drunk in a public place' and 'drunk and disorderly in a public place' under the *Summary Offences Act 1966*.

Whilst the data indicates that overall numbers are quite small, it does reveal definite patterns concerning the demographics of individuals charged with public drunkenness and the time and place they were charged, all of which are critical to designing an appropriate new service response.

Based on data sourced from DJCS and DHHS, we have identified the following key findings.

Total Numbers

Total numbers are quite low. Between April 2014 and March 2019 there were a total of 41,347 alleged offences recorded in LEAP for public drunkenness. Of these, 88 percent were recorded as drunk in a public place, whilst the remaining 12 percent were drunk and disorderly in a public place. This equates to an average of 8,269 per annum or 159 per week.

Age and sex

The majority of offenders were relatively young males, with 86 percent of offences recorded against men. Further, 42 per cent of men and 34.5 percent of women were aged between 18 and 29 years. Just one percent of both males and females were aged less than 18 years.

Country of birth

Approximately 70 percent of attendances related to people who identified as born in Australia. The most common country of birth for offences relating to people born overseas was Sudan (four percent), with the next most common being the United Kingdom and Ireland (three percent), and New Zealand (two percent).

[7] Section 111 of the *Local Government Act 1989* provides that a council may make local laws for or with respect to any act, matter or thing in respect of which the Council has a function or power under this or any other Act. A local law must not be inconsistent with any Act or regulation. A local law is inoperative to the extent that it is inconsistent with any Act or regulation. The making of local laws is governed by a Ministerial Guideline that is published in the Government Gazette (see section 111A).

[8] See, for example, *Local Government Act 1986* which permits the making and enforcement of local laws; Transport (Compliance and Miscellaneous) (Conduct on Public Transport) Regulations 2015

High intensity and low intensity cohorts

The contribution by individual offenders to the total number of offences is uneven. Two distinct categories can be identified:

- **low intensity cohort*:*** During the five-year period analysed, the vast majority of people (84 percent) entered custody in these circumstances only once, with a further 9.5 percent doing so twice. Whilst this cohort represented 93.5 percent of offenders, they accounted for 74 percent of offences
- **high intensity cohort:** Whilst people entering custody on three or more occasions represented only 6.5 percent of all offenders, they were responsible for 26 percent of all offences. This cohort tend to be significantly older than those in the low intensity cohort. Almost half (47.5 percent) were aged 40 or older, compared to just over a quarter in the low intensity cohort. LEAP data matched with DHHS data indicates that they were also more likely to experience significant health and welfare difficulties. For example, in the 2017/18 financial year, 46 percent made use of homelessness services compared to 17 percent of the low cohort, 30 percent received help from AOD services compared to 12 percent in the low cohort, and 72 percent had an emergency room presentation compared to 39 percent of the low cohort.

Aboriginal and/or Torres Strait Islander people

Aboriginal and/or Torres Strait Islander people are significantly overrepresented amongst those charged with breaching public drunkenness laws. Whilst they make up 0.8 percent of the Victorian population, overall 6.5 percent of all public drunkenness offences were recorded against Aboriginal and/or Torres Strait Islander people. This may be an underestimate given that the Aboriginal and/or Torres Strait Islander status of the person offending was recorded as unknown for between 9 and 11 percent of attendances each year. In 2017, Aboriginal and/or Torres Strait Islander people were significantly overrepresented in both cohorts representing 5.3 percent of the low intensity cohort and 7.9 percent of the high intensity cohort.

People from Sudan and South Sudan

People from Sudan and South Sudan tended to be younger than others charged with public drunkenness offences and are overrepresented in the high intensity cohort. Their offending was less prone to weekend spikes and they had relatively high use of health and welfare services.

People experiencing homelessness

People who were homeless at the time of breaching public drunkenness laws contributed disproportionately to offences recorded in LEAP data. Whilst they made up only 1.9 percent of all offenders, they were responsible for 9.9 percent of all offences. Almost half were recorded as having offended four times or more. The matching of LEAP data with data held by DHHS concerning the use of health and welfare services suggested that homelessness, or the imminent risk of it, may be having a large role in the phenomenon of public drunkenness offending. For example, in 2017/2018 almost 19 percent (1,042) of the 5,545 offenders were recorded as having accessed a homelessness service.

Intersectionality with other issues

Family violence

There is a reasonably high correlation between public drunkenness offences and recorded incidents of family violence. The most significant lies with those who have been perpetrators of family violence. The data showed 28 percent of the low intensity cohort and 45 percent of the high intensity cohort had been recorded as perpetrators of family violence. Victim-survivors of family violence were also present in the data, making up 12 percent of the low intensity cohort and 16 percent of the high intensity cohort.

Presence of drugs other than alcohol

Whilst the combined presence of alcohol and other drugs was often reported during consultations the data sets available did not enable this phenomenon to be quantified.

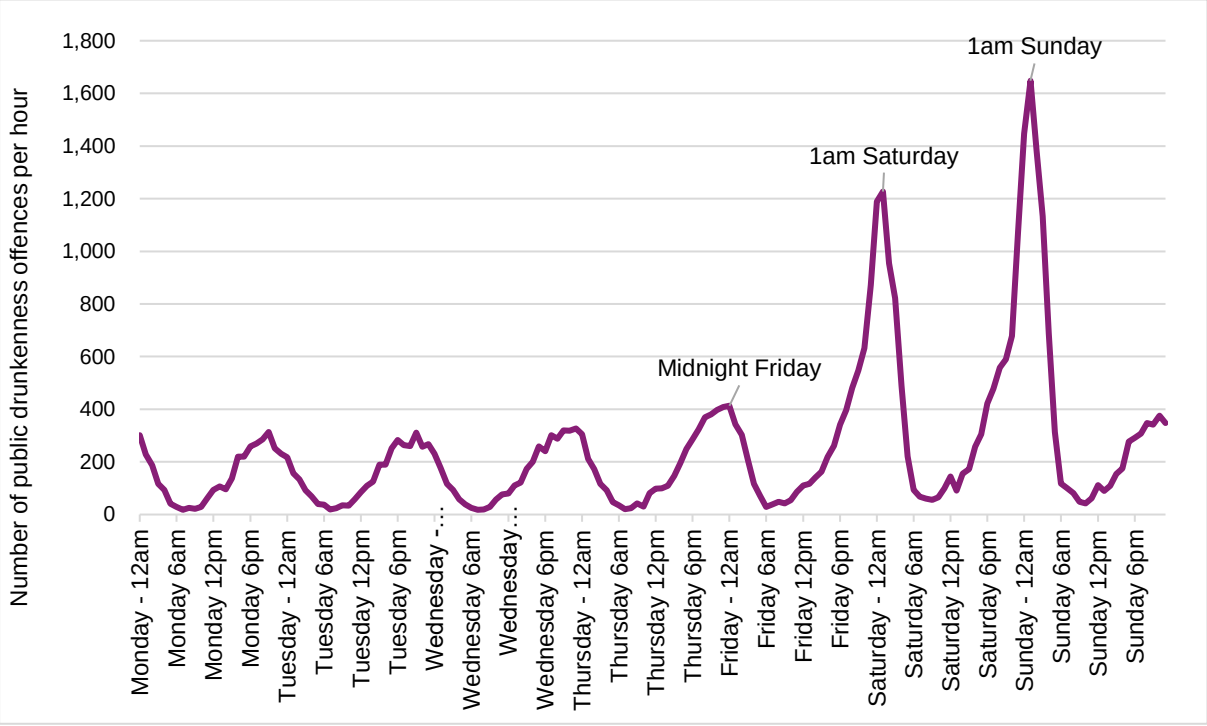
Time distribution

Public drunkenness offences take a predictable pattern across the week and the year.

Weekly pattern

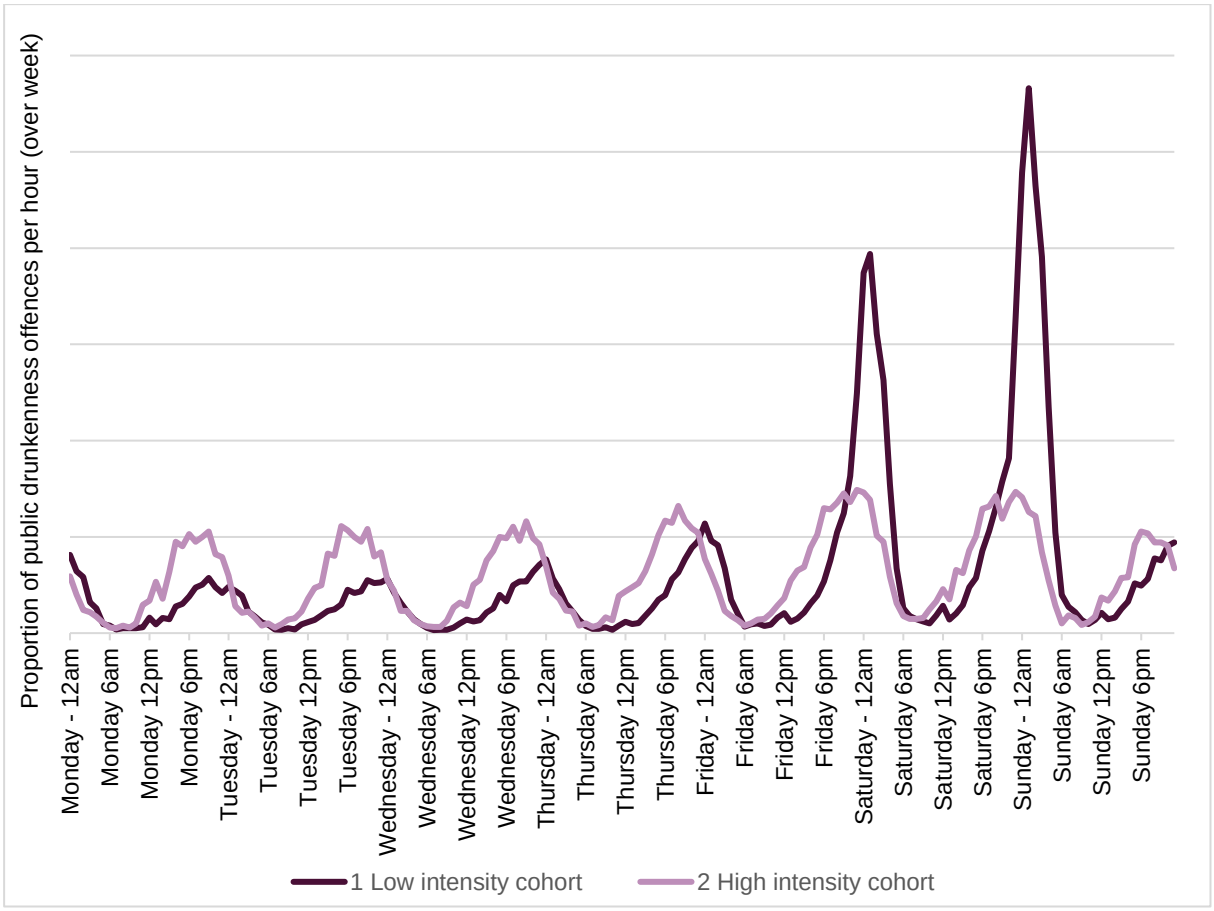
Whilst offences take place on all days of the week, major spikes occur in the early hours of Saturday and Sunday mornings.

Figure 1: Hourly number of public drunkenness offences for each day of the week



These spikes are almost exclusively caused by people from the low intensity cohort. Offences recorded by the high intensity cohort occur extremely consistently across each day of the week.

Figure 2: Hourly number of public drunkenness offences for each day of the week, by intensity cohort

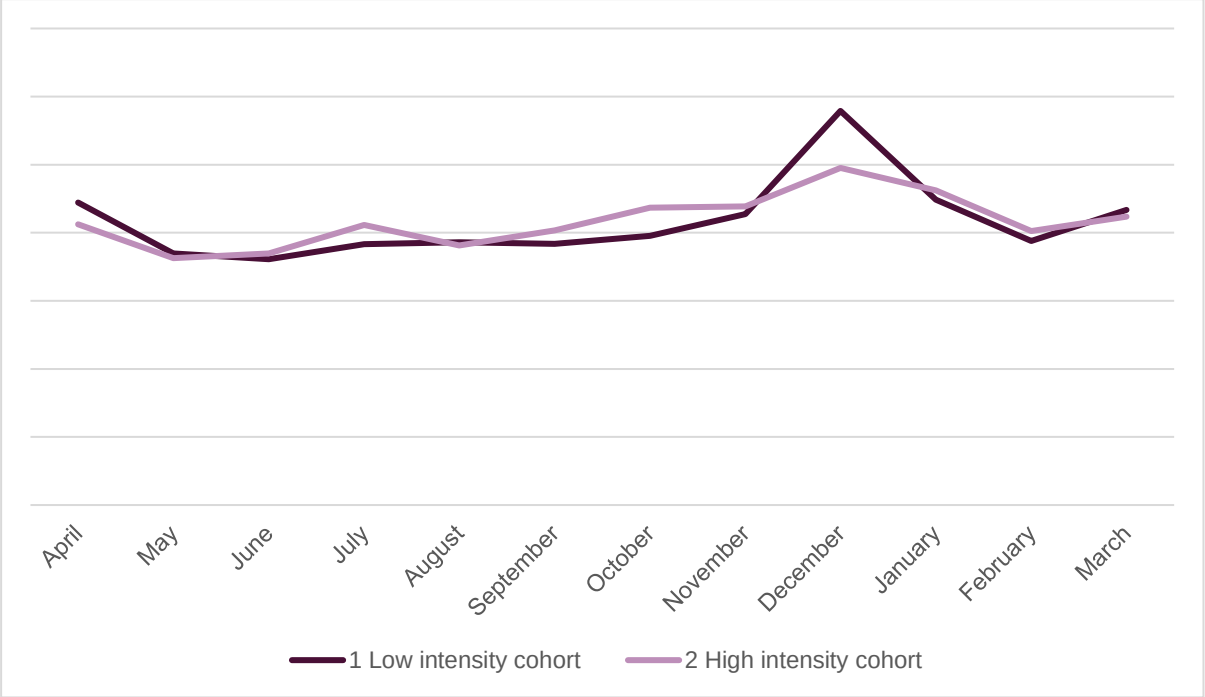


For the low intensity cohort, offences peak on Friday and Saturday nights, as well as at times of high-profile sporting and cultural events and during certain holiday periods.

Yearly pattern

A significant spike in low intensity cohort offences occurs over the summer holiday period and to a lesser extent during major sporting and cultural events. This occurs for high intensity cohort offences, but not to the same degree.

Figure 3: Distribution of public drunkenness offences over the year, by intensity cohort



Geographical distribution

There is also a very definite pattern to the geographic distribution to the recorded offences. Approximately 50 percent of all offences occur within eight local government areas (LGAs) in metropolitan Melbourne and in Greater Geelong: City of Melbourne, Greater Dandenong, Mornington Peninsula, City of Port Phillip, City of Yarra, Greater Geelong, City of Frankston and City of Stonnington. When these “high demand” LGAs are set aside, the average weekly rate of offences occurring across all the remaining seventy-one LGAs, is approximately 80.

There are several regional locations such as Mildura, Greater Bendigo, Latrobe, Ballarat and Greater Shepparton that record moderate numbers of offences, but for whom the rate of offending for their population size is disproportionately high. This is suggestive of broader problems with alcohol consumption in these communities that may not be reflected in the public drunkenness offence numbers. In many other LGAs in rural Victoria the record of offences is sparse. In as many as 33 LGAs, offences occur less than once a fortnight.

Appendix 4 contains data sourced from DHHS on the number of public drunkenness offences by Victorian local government area from 1 April 2014 to 31 March 2019, which provides the basis for the above analysis.

4.4 Feedback from consultations

Throughout the consultation process, we heard from a range of experts, agencies, service providers and community organisations. The following key themes emerged.

Model design

- Stakeholders broadly noted that a public health response is required in order to respond to immediate health and safety concerns posed by public drunkenness, and that shorter-term

interventions offer the opportunity to engage with people on any medium to longer term health needs

- Flexible responses are required as there is no one-size-fits-all approach, yet there is also a need for a consistent and equitable approach
- Any model will require a response that meets the individual needs of the person. This will depend on their immediate clinical needs and any underlying health and wellbeing issues. Social and cultural dimensions are also likely to shape both the immediate and longer-term needs
- There is no existing model than can apply across the state. Localised responses will need to be designed and implemented that are developed using agreed best practice evidence informed principles
- While the law and health elements require consideration, the social element also needs to be addressed, including stigma and discrimination
- A public health model should focus on harm minimisation approaches that consider the health and social consequences of public intoxication on both the individual and the community. This approach acknowledges that alcohol use is an inevitable part of society and occurs across a continuum ranging from occasional use to dependent use
- Self-determination principles should drive service design, planning and delivery for Aboriginal and/or Torres Strait Islander people. It's also important to remember that not all Aboriginal and/or Torres Strait Islander people want to utilise an Aboriginal service. The need to ensure a culturally responsive health, human service and justice system is paramount in this regard.

Alcohol combined with other drugs

- Intoxicated people in public places are often found to be affected by a combination of alcohol and other drugs
- Whether a person is affected by alcohol or drugs or a combination of both may not be readily identifiable to First Responders.

Places of safety

- For the majority of people who are intoxicated, all that is required is a place of safety to sober up. For many people this place of safety is with friends and family
- The hospital emergency department is the appropriate place for people with acute alcohol intoxication who require medical supervision and/or intervention. People with acute health needs who are intoxicated, including those with complex needs related to long-term alcohol and other drug use, are also likely to continue to require emergency department assistance
- For those unable to be safely transported home, or who are homeless, sobering up centres may provide an alternative service type to custody and were recommended by the Royal Commission into Aboriginal Deaths in Custody for this purpose. Sobering services can cater for chronically intoxicated people with more complex needs, for episodic and one-off binge drinkers, and can be provided by both mainstream and ACCOs
- Almost universal interest in sobering services that provide a holistic response, such as both medical and counselling services. Individuals should also be linked into the broader service system where needed, such as homelessness or mental health services

- Sobering services would not need to operate 24-hours per day, seven days per week, especially in regional areas
- There is potential to start providing brief interventions at places of safety once people have sobered up (for example, at a pop-up chill out zone or medical unit).

System capacity

- While the reform is universally supported, there is concern that demand for already stretched services will increase without a corresponding capacity increase being put in place.
- Implementing a public health response may place greater demand on already stretched services, particularly when responding to people with more complex needs. For example, safe housing is a major issue for people who are coming into contact with the justice system regularly through public drunkenness, however there is a scarcity of housing and homelessness services.
- Better to build on existing services and infrastructure rather than build new services.
- Some First Responders may need additional training in order to provide an appropriate first response for people who are intoxicated in public. This could include training in clinical assessment, triage and the provision of culturally safe services.
- Better referral pathways and connections between services need to be established and funded – not enough housing, mental health and AOD services.
- Safety for workforce – including at sobering up centres and for outreach services – needs careful planning and support.

Role of police as First Responders

- Stakeholders noted that Victoria Police's primary role is to maintain community safety, including in the context of alcohol and drug consumption. However, different views exist in relation to the functions Victoria Police should have, if any, in a public health-based response, and the powers that might support such a function (including powers for authorised officers or PSOs)
- Issues raised include the potential of the repeal of the public drunkenness offences to result in the alternative use of associated powers (such as move-on powers) and other offences relating to the maintenance of community safety, for example, obscene, indecent or threatening language or behaviour in a public place, common assault, and wilful damage of property.

Role of first responders other than police

- A number of outreach services and mobile/pop-up services run by community organisations offer First Responder options. This includes the Koori Night Patrol, field officers, AOD workforce and other Aboriginal community-controlled services
- Other key First Responders noted in discussions include paramedics, health workers, local government authorised officers and operators of licensed premises and their staff
- Occupational violence for paramedics and emergency department staff is an increasing issue associated with people who are seriously affected by alcohol. Some stakeholders stressed that a public health response must ensure occupational safety.

Legislative framework and civil detention powers

- There are varying views on whether civil apprehension and detention powers that are a feature of other jurisdictions that have decriminalised public drunkenness would be appropriate in Victoria. In other jurisdictions they are considered as 'last resort' powers where there is a threat to individual or community safety posed solely by a person's intoxication, and there is no option to release a person into safe custody
- Concerns were identified about the disproportionate use of detention powers resulting in higher number of Aboriginal and/or Torres Strait Islander people detained for public drunkenness
- Consultations have highlighted the need to carefully consider potential perverse outcomes of repealing legislation. Some other states have reported an increase in people being charged with other more serious offences following the repeal of public drunkenness laws.

Clinical issues

- Health and safety assessments on first contact are essential for triaging people into the right care pathways. However, follow up assessment once a person is sober will provide the best indication of a person's health needs
- Further education and training are required to assist First Responders and clinical staff to recognise other factors such as disability, mental health and drug use that may appear like drunkenness and/or co-exist for a person who is intoxicated
- Careful consideration needs to be given to issues of consent when people are drunk.

Cultural issues

- To ensure that a response is safe and appropriate for Aboriginal and/or Torres Strait Islander people and other CALD communities, the public health-based response needs to be developed collaboratively with those communities
- AOD services run by Aboriginal people for Aboriginal people come with their own sets of histories, values and strategies. These are all influenced by Aboriginal and/or Torres Strait Islander perspectives that are unique and continually evolving to meet the needs of the people those organisations seek to help
- Recommendations from previous work outlining best practice in Aboriginal AOD services suggests that the following key elements are critical:
    - Aboriginal community control
    - clearly defined management structures and procedures
    - trained staff and effective staff development programs
    - multi-strategy and collaborative approaches
    - adequate funding; and
    - clearly defined and realistic objectives aimed at the provision of appropriate services that address community needs.

Role of broader prevention strategies

- The problem of public intoxication also requires a broader approach, which includes community awareness, education of frontline workers and responsibility of venues that supply alcohol
- The ‘public health response’ alone cannot reduce risky drinking and underlying alcohol cultures. Government could consider strengthening its prevention response, including addressing licensing, responsible service of alcohol, promoting safe environments, education campaigns about risky drinking and alcohol advertising
- Acknowledgment that alcohol dependence is also linked to poor mental health, poverty, homelessness, intergenerational trauma and a range of interrelated issues – and that these issues also need to be addressed in order to respond effectively to public intoxication.

5. Experiences of decriminalisation in other jurisdictions

Key points

- A primary lesson we have learned is that in Australian jurisdictions that have decriminalised public drunkenness the use of police cells for such cases has continued.
- Of major concern is the significant over-representation of Aboriginal and Torres Strait Islander people still being held in police cells in jurisdictions that have decriminalised.
- Protective custody regimes adopted in other jurisdictions following the decriminalisation of public intoxication have largely failed to address the risk of death in police custody.
- A significant reason for the failure in other jurisdictions to address the risk of death in police custody has been the failure to provide an effective health-based service system response that makes places of safety available as an alternative to police cells.
- The decriminalisation of public drunkenness in Victoria is at risk of continuing to incarcerate intoxicated persons in police cells should a protective custody regime allow for this to occur and a health system response is not in place to address the care needs of such persons.

In considering the proposed health-based approach outlined in Part 2 of this report, we have examined the experience of decriminalisation of public intoxication in other jurisdictions. Public drunkenness offences have been repealed in most English-speaking countries around the world. In Australia, most states and territories have abolished public drunkenness as a criminal offence, with the exception of Victoria and Queensland.

This section outlines our assessment of the strengths and weaknesses of various responses that could inform the development of public health model for Victoria.

Continued use of police cells

The primary lesson we take from the decriminalisation of public intoxication laws in other Australian states and territories – and our major concern – is their continued use of police cells for instances of public drunkenness. Following decriminalisation, most states and territories introduced a form of protective custody legislation. While these reforms were introduced with the aim of ensuring police had powers to apprehend individuals as a last resort in order to keep them and the community safe, it is clear that decriminalisation approaches still result in large numbers of people being taken into police cells, as demonstrated in Table 1.

Table 1: Use of police cells for public drunkenness in other Australian states and territories

	Total number of people taken into custody over previous 12-month period*	Proportion of total number of people taken into custody who identify as Aboriginal or Torres Strait Islander (%)	% of general population that Aboriginal or Torres Strait Islander (2016 Census))
NSW	1802	18.1%	3.56%
SA	330	41.5%	2.52%
Tas	447	17.4%	5.84%
ACT	829	13.5%	1.9%
NT	8247	92.8%	43.56%
WA	Not available	Not available	4.09%
QLD	Not available	Not available	4.79%

* 12-month period varies slightly between jurisdictions but included data obtained from 2014 to 2019.

The continued high rates of placement of intoxicated people into police cells indicates that powers granted to police under protective custody regimes are not used as a last resort. Where the option remains to place an intoxicated person into a police cell, police continue to use the power to a significant extent. In our view, the continued use of police cells in relation to public intoxication points to a failure by governments to develop and implement effective health-based responses that are capable of providing more appropriate places of safety for people who are intoxicated and have immediate health needs.

In addition to the continued use of police cells, several issues and risks arise under the operation of protective custody regimes in other jurisdictions, including:

- disproportionate impacts on particular groups, including people experiencing homelessness, Aboriginal and/or Torres Strait Islander people, First Nations communities and particular ethnic groups9
- the failure to establish an effective health-based response through the provision of places of safety as an alternative to police cells means that intoxicated people still find themselves the subject of police scrutiny; and
- relatedly, an ineffective health-based response fails to address the underlying causes of public intoxication, leading to continued reliance on emergency services and tertiary health interventions.

Finally, and most significantly in light of the reason for the ERG's establishment, the impact of the continued use of police cells means that unacceptably high numbers of people continue to die after being taken into police custody for public intoxication, particularly Aboriginal and Torres Strait Islander people. For the Day family, this unfortunate reality has ongoing intergenerational impacts going back to the death of Ms Day's uncle, Mr Harrison Day, in 1982.

[9] See generally Pennay (2012) citing (Dyb, 2006) Brady, 2010 Galloway et al., 2007

Ultimately, while various policy responses implemented in other jurisdictions have purported to decriminalise public drunkenness, in practice the measures that have been adopted have perpetuated a punitive, criminal justice approach that conceives of people intoxicated in public as antisocial, dangerous and a risk to public safety. There has not been the requisite shift in systems and attitudes to move away from a criminal justice approach to public intoxication.

The ERG has given appropriate consideration to the above insights when developing the proposed framework for a public health response in Victoria, which we outline in Part 2 of this report.

Part 2: Implementing a Public Health Approach to Public Intoxication

We have concluded that there is an urgent need to replace the criminal justice model of dealing with public intoxication. As we outlined in Part 1, a criminal justice approach has proved to be unsafe, has led to avoidable deaths, has been ineffective in reducing the recurring public intoxication of individuals and has unnecessarily entangled people in the legal system.

In Part 2 of this report we detail our framework for implementing a public health approach to public intoxication (our ***Proposed Health Model***). The key service system responses required are outlined along with consideration of their implementation.

Implementation Themes

The following key themes provide the starting point for the development of our Proposed Health Model.

Police cells not safe or appropriate

- Our strong view is that detaining an intoxicated person in a police cell is unsafe and cannot be an option in a health-based response. No one should be placed into a police cell simply because they are intoxicated in public. The design of a new health-based model to respond to public intoxication must start from this premise.

Availability of places of safety

- In order to eliminate the use of police cells for public intoxication, there must be safe places available that are accessible and appropriate to meet the health and safety needs of people who are intoxicated (places of safety). Places of safety include going home with or to family or friends where possible and a variety of health and community-based services depending on the health needs of the intoxicated person
- In undertaking the development of our Proposed Health Model, we have used a ‘supply and demand’ approach to identify the likely number of placements that will be required in sobering and other health services following the decriminalising of public drunkenness offences. We believe that the most appropriate indicator of expected demand for placements is the current data on public drunkenness offences. Current data also provides a helpful basis on which to design the most effective and appropriate service system response under a health-based model.

Consent and voluntariness

- A consent-based model is central to an effective health response to public intoxication at all stages of possible intervention within the public health approach. This includes engagement by first responders, transport to a place of safety, admission to a health or sobering service and the provision of longer-term health and social care supports. In some extremely limited circumstances, it will be necessary to limit the principle of based, providing that appropriate safeguards in place.

Culturally responsive service system

- An appropriate and effective health-based response to public intoxication requires a service system that is capable of supporting people with diverse cultural backgrounds, including Aboriginal and Torres Strait Islander people and CALD communities. The need for tailored, appropriate solutions requires effective engagement and participation, respect for self-determination and locally developed solutions, and the implementation of a clear and comprehensive cultural safety framework.

Intersection with drug intoxication

- As identified in our Terms of Reference, we have been asked to consider how a new health-based model to public intoxication is sensitive to intersecting issues presenting in the lives of people accessing the new health-based response. While the focus of the ERG's report is drunkenness, the on-the-ground reality (confirmed in consultations) is that public intoxication very often co-occurs with drug use. For this reason, we prefer the term 'intoxication' rather than 'drunkenness'. This also reflects contemporary health-based language and is consistent with the premise that an intoxicated person should be subject to a health-based response. The considerations outlined in this report necessarily take in to account appropriate health-based responses to drug use and dependence.

Intersection with mental health

- In addition to the high interdependencies between alcohol and drug use, the data also confirms the high correlation between public intoxication and mental health. Consistent with the Terms of Reference relating to intersectional issues, this report gives appropriate consideration to how the health-based response can best respond to and support people experiencing mental illness.

Community and cultural change

- In addition to the necessary service system change, a transition to a health-based approach to public intoxication requires a shift in community and cultural attitudes about public intoxication. This involves increased awareness and understanding that fundamentally public intoxication is a public health issue that requires holistic responses that are capable of addressing the underlying causes of public intoxication.

Each of these themes is explored in further detail throughout the remainder of this report.

We consider that one related matter warrants comment at the outset. As emphasised throughout this report, our strong view is that police cells are unsafe and inappropriate for people who are intoxicated. This raises the related question of intoxicated people who are detained in a police cell on other charges and not solely due to their intoxication. The Deputy State Coroner in the Tanya Day inquest made a number of findings in relation to the management of an intoxicated person in custody, including a "culture of complacency regarding intoxicated detainees" within Victoria Police and found that there is a systemic failure to recognise the medical dangers of intoxication. The Deputy State Coroner also found that the physical checks conducted by the police on Ms Day were "illusory" and that the police officers did not take proper care of Ms Day's safety, security, health and welfare as required by the VPM and SOPs.

In our view, an appropriate health-based response to public intoxication also encompasses the health and safety needs of intoxicated people in police cells. Consistent with the findings of the Deputy State Coroner, we recommend that further consultation be undertaken to ensure how intoxicated people in

police cells can be more effectively supported, including proper medical supervision and access to health treatment when required.

Based on the implementation themes outlined above, we make the following recommendations at the outset.

Recommendation
2. The Victorian Government repeals the offence of public drunkenness in sections 13, 14 and 16 of the *Summary Offences Act 1966* to achieve the decriminalisation of public drunkenness.
3. The Victorian Government ensures no person is detained in a police cell solely for being intoxicated in public.
4. The Victorian Government should adopt a 'supply and demand' approach that identifies the current number of public drunkenness offences as the most likely indicator of the number of placements that that will be required in sobering and other health services under the Proposed Health Model.
5. The Victorian Government ensures the implementation of the Proposed Health Model takes into account the need for holistic health-based responses that are also capable of responding to drug use and experiences of mental health, including dual diagnosis, where possible.
6. The Victorian Government undertakes further consultation to ensure that the management of intoxicated people, who have committed criminal offences, and are incarcerated in police cells, can be more effectively supported and comply with the mandatory terms of Victoria Police's governing policy and procedures, including proper medical supervision and access to health treatment where required.

6. A public health response to public intoxication

Key points

- The current unsafe criminal justice-focused model of dealing with public intoxication must be replaced with an approach that comprises interventions designed to ensure the safety and wellbeing of individuals, as well as promoting access to appropriate services and supports to minimise the incidences of public intoxication in the first place
- The aim of a public health approach to public intoxication is to shift the focus away from a narrow and reactive criminal justice intervention towards a universal approach that makes sure that individuals at risk of public intoxication have the information, supports and services they need. A public health approach comprises three levels of intervention: primary/universal interventions; secondary early interventions and tertiary interventions targeted to high-risk individuals who are identified as having needs or concerns
- Our focus has been mainly focused on the tertiary element – where an incident of public intoxication has already occurred – it is also important that an effective health-based response takes a comprehensive approach.

We are convinced of the need for the development of an integrated health-based approach that is capable of responding appropriately to public intoxication. The current unsafe criminal justice-focused model of dealing with public intoxication must be replaced with an approach that comprises interventions designed to ensure the safety and wellbeing of individuals, as well as promoting access to appropriate services and supports to minimise the incidences of public intoxication in the first place.

The aim of a public health approach to public intoxication is to shift the focus away from a narrow and reactive criminal justice intervention towards a universal approach that makes sure that individuals at risk of public intoxication have the information, supports and services they need.[10] A public health approach comprises three levels of intervention:

- **primary/universal interventions**, which usually target the general public or a whole population groups to provide education and support before problems occur
- **secondary early intervention** programs and services for risk groups where there is an identified risk, in order to alleviate problems before they escalate; and
- **tertiary interventions** targeted to high-risk individuals who are identified as having needs or concerns.

While our Terms of Reference focus predominantly on the tertiary element – where an incident of public intoxication has already occurred – we consider that a continuum of strategies and responses will be necessary to reduce the number of incidences of public intoxication.

[10] The World Health Organisation (WHO) has defined a public health approach as the involvement of the entire health system and the broadest possible intersectoral and inter-institutional collaboration in developing policies and plans and executing activities that reduce the public health impact of public drunkenness on individuals, families and communities. http://www.emro.who.int/

Proposed Health Model

Applying the principles of a public health approach, Figure 4 outlines the ERG's Proposed Health Model to ensure that an immediate health and safety response by First Responders to public intoxication is integrated into a broader health and wellbeing approach.

The remainder of Part 2 of our report is structured around the five stages of the public health model identified in Figure 4.

Figure 4: ERG's Proposed Health Model to public intoxication

	Immediate response			Secondary response	Universal response
Stage	1. First response, initial screening and triage	2. Immediate transportation	3. Place of safety & initial service period	4. Assessment of longer term needs and provision of services	5. Broader prevention strategies
Purpose	Initial identification of person's health and safety needs and associated risks. Triage for appropriate response	Safely transport the individual to a place of safety	To provide a safe place where the individual can rest and recover (sober-up)	Identify health and social needs and appropriate care pathways to reduce harm and improve people's wellbeing over the longer term	Address the underlying causes to prevent problematic drinking occurring in the first place
Types of responses	Late night entertainment outreach, complex needs outreach, multidisciplinary emergency response, police / ambulance	Private transport of friends or family, Uber / taxi, outreach van, Police / ambulance van	Sobering services, fixed place sobering-up centre, after-care transport home	E-referrals, voluntary AOD services, state wide Aboriginal specific withdrawal service	Education and support services targeted towards the general public as well as specific population groups
Factors to determine appropriate response	• Health needs • Safety risk (ind, community) • Consent to receive initial assistance • Available services • Geographic location • Identity / cultural safety	• Health needs • Safety risk (ind, community) • Cooperation of individual; state of consciousness • Available services • Geographic location • Identity / cultural safety	• Health needs • Safety risk (ind, community) • Consent to be taken to place of safety • Available services • Geographic location • Identity / cultural safety	• Health needs • Consent to receive / engage with services • Available services • Broader wellbeing needs • Geographic location • Identity / cultural safety	• Broder wellbeing and health needs • Policy framework and setting • Engagement with target population groups • Local and tailored approaches • Intersection with other prevention strategies (eg AOD, homelessness)

7. Stage 1: First response

Key points

- This reform demands a cultural shift in the characterisation of intoxication as a health rather than a law enforcement issue
- The primary role of First Responders under a health-based response is to ensure the health and safety of any person found intoxicated in public. This involves assessment of both health and safety risks and the risk category will determine the response required
- Where the health risk is high, transport to a hospital or another place where health treatment is a priority. Where the health risk is low, in many cases the person may not require health or emergency services. The first consideration should be whether the intoxicated person can return to their home, or to friends or family while they sober up
- The primary First Responders should be health services personnel and/or personnel from community services organisations, such as outreach services (including existing outreach programs associated with homelessness services), alcohol and other drugs services and ACCOs
- An assessment of the safety risk will need to be made as to whether the person poses a threat to themselves or to others. In situations where an intoxicated person is a serious and imminent risk to themselves or to others, there is an appropriate role for Victoria Police to play
- Police officers and PSOs, as a last resort, should have a limited power to detain intoxicated persons to prevent harm. This power should be strictly limited with appropriate safeguards, monitoring and oversight, and should not apply to any other category of First Responder.

A public health response to public intoxication will require changes to law, policy and service delivery. Overwhelmingly, however, it demands a cultural shift in the characterisation of intoxication as a health rather than a law enforcement issue. Done effectively, this shift will be most significant in the way that First Responders support a person who is intoxicated in public.

In considering what a public health model to address public intoxication should look like, we examined a range of scenarios to test how a health model would respond to typical on-the-ground situations following the decriminalisation of public drunkenness offences. These scenarios identified a range of different factors are relevant to determining the most appropriate first response, including:

- the role and functions of First Responders
- which agencies or services should undertake the role of First Responders
- guaranteed coverage and availability of services
- consent and powers of First Responders
- tailored local responses.

Each of these issues is discussed below based on our review of the available data and evidence as well as consultations with key stakeholders.

7.1 Role and functions of First Responders

The primary role of First Responders under a health-based response is to ensure the health and safety of any person found intoxicated in public.

In responding to an intoxicated person in public, the first step should be an initial assessment as to whether health treatment is urgently required. This requires undertaking the following needs and risk assessment:

- ***health risk:*** The level of risk to an intoxicated person's health outcomes (for example, the likelihood of choking, injury)
- ***safety risk***: The risk to the safety of the intoxicated individual or others (for example, the likelihood of an accident, assault).

In different situations, each of these risks will range in severity from low to high and will require a proportionate response. The nature of the first response will often be shaped by the location of the person, what risks have been identified and what services are available to respond.

In situations where the health risk is high, transport to a hospital or another place where health treatment can be provided (for example, a sobering-up place that includes health professionals) will be necessary. Where the health risk is lower, in many cases the person may not require health or emergency services. The first consideration should be whether the intoxicated person can return to their home, or to friends or family while they sober up. Where this is possible, we consider that this should be the preferred and default position. In this instance, an assessment of the safety risk will need to be made as to whether the person poses a threat to themselves or to others if returned home or to another private residence, including any family violence threat. Where required, the intoxicated person may need the assistance of friends or family or the First Responder to identify an appropriate transport option.

Local responses, specific to some communities, will need to be developed under the new model, including Aboriginal led responses. Where a local response is available, it is expected that the First Responder would contact that service to determine whether and how they could assist. This assistance might include transport and/or placement in a safe place (each discussed in further detail under Stage 2: Transport to a place of and Stage 3: Places of).

In situations where the safety risk is assessed as high, Victoria Police may have an appropriate role to play – this is discussed further below.

Recommendation
7. All First Responders under the public health model (whether justice-based or health-based First Responders) perform their respective roles and functions in such a way as to ensure the health and safety of individuals who are intoxicated in public, consistent with the principles underpinning the public health model.

7.2 First response services and agencies

As identified in Section 4.2 above, there are currently a number of First Responders that possess a range of roles and functions when responding to an intoxicated person in public, including Victoria Police (and various authorised officers), ambulance officers, health and community services and

operators of licensed premises. A wider range of services will necessarily be required to replace the current criminal justice-led response to public intoxication with an effective health-based system.

The role and functions of First Responders under a health-based approach requires a service system response that is complementary, intersecting and overlapping. This will require a range of services and agencies with different functions and powers that are capable of providing the most appropriate first response to a person who is intoxicated in public. The nature, orientation and duration of a First Responder's engagement will depend in any given situation on the factors involved in undertaking the needs and risk assessment discussed above.

While Victoria Police will inevitably be the First Responder to public intoxication in limited situations, the effective operation of a health-based response means that police officers should not be relied on as primary First Responders. Wherever possible, First Responders should be health services personnel and/or personnel from community services organisations, such as outreach services (including existing outreach programs associated with homelessness services), AOD services and ACCOs.

With the proposed establishment of a number of sobering services (discussed further under Stage 3: Places of), particularly with transport capacity, we expect that there will be enhanced capacity amongst the cohort of outreach workers. This is a critical element of the Proposed Health Model response to ensure that, to the greatest extent possible, health-base services are the primary category of First Responder options rather than police or ambulance services.

In situations where an intoxicated person is a serious and imminent risk to themselves or to others, there is an appropriate role for Victoria Police to play based on the safety risk considerations identified above. In these cases, the role of Victoria Police within a health-based response should involve:

- engaging with the individual to make an assessment of whether immediate medical assistance is required and to call an ambulance if needed
- if the person does not need immediate medical assistance, making inquiries to identify a safe place for the person, including contacting a responsible person (family/ friend of the intoxicated person) or a sobering up centre or other similar support service; and
- where required, ensuring that there is appropriate transport to take the person to the safe place.

Powers to undertake this role effectively and appropriately within a health-based response are discussed in further detail below.

First contact

The question of how First Responders are contacted in situations of public intoxication is important in the context of ensuring a health-based response. Under the current criminal justice-based approach, Victoria Police are predominantly the default option as a result of police patrols or calls to Triple Zero (000) from members of the public or from specific groups such as operators of licensed premises.

We consider that particular attention should be given to how calls from the public can best ensure that appropriate health and community organisations are First Responders, rather than Victoria Police. For example, protocols could be established within ESTA to determine how calls from the community in relation to incidences of public intoxication are managed and directed to identified local health and community organisations in particular areas. This triaging role would serve an important function in promoting health-based responses to public intoxication rather than the dispatch of Victoria Police and a police-led response. This would also be important to ensure that the resources of emergency services are directed appropriately.

Another consideration is whether a separate contact number should be established. For example, ESTA also provides call-taking and dispatch services via a separate number (132 500) for non-life-threatening emergencies involving storm or flood. Consideration should be given to whether a separate number could be established that is dedicated to instances of public intoxication. This approach could play an especially useful role in ensuring that the most appropriate heath based First Responder is contacted to provide support and a referral pathway to an appropriate place of safety. A separate number that is not associated with emergency situations would potentially also play an important cultural change piece in promoting a change of thinking about public intoxication requiring an appropriate health-based response rather than a police-led response.

With the proposed expansion of sobering services, it is also expected that work can be done to increase awareness among operators of licensed premises of local services in the area.

Recommendation

8. The Victorian Government considers how the ESTA process can change regarding determining what tasks can be referred to certain response agencies in order to promote a health-based response to incidents of public intoxication. This should include how such alternate agencies can be facilitated through such a process – having regard to the contractual arrangements ESTA has with emergency service agencies.

7.3 Guaranteeing coverage and availability

An effective health-based response to public intoxication must be capable of meeting the levels of expected demand across the state. This requires appropriate First Responders to be available on a statewide basis 24-hours a day, seven days a week. Table 2 provides an overview of the ability of identified First Responders under a health-based response to respond to expected levels of demand.

Table 2: Summary of identified First Responders

First Responder option	Service parameters			
	Individual's health risk	Safety risk	Geographic location	Hours of operation
Ambulance Victoria	High	Med	State-wide	24/7
Victoria Police	Low	High	State-wide	24/7
Health outreach services	Medium	Low	State-wide	24/7
Foot patrols and community outreach services, including Koori Night Patrols	Low	Low	CBD, inner suburbs and regional towns	Peak, event specific
Protective Services Officers	Low	High	CBD, suburbs and regional centres	Peak
Private providers of medical/first aid services e.g. St John Ambulance	High	High	State-wide	Event specific
Liquor licensees*	Low	Low	Licensed Premises	Peak

* Operators of licensed premises are included in this table given the range of legal and regulatory obligations relating to the responsible service of alcohol and interactions with people who may be intoxicated and/or disorderly.

Under the proposed health-based model, outreach services, such as sobering and other health services, have a central role to play to ensure adequate coverage and availability of First Responders, particularly in relation to areas of high demand and during peak times. The role of these services and recommended expansion under the Proposed Health Model is discussed in further detail under Stage 2: Transport to a place of and Stage 3: Places of .

7.4 Consent and powers

As identified above, an underlying principle of our Proposed Health Model is that any intervention to assist an intoxicated person must be with the individual's informed consent and respect their right to reject treatment or assistance where they have capacity to do so.

In relation to health treatment, consent is required for medical professionals (who may also be First Responders) to provide treatment to an individual, unless the person requires emergency assistance. Anecdotal evidence highlights that most people will be willing to receive health treatment (and/or transport to a safe place), however there will be instances where an individual may refuse to consent to treatment or assistance for a variety of reasons. This can be due to the person not having capacity or being unable to comprehend the situation where they need support or treatment. There may also be situations where a person does not understand the nature of the treatment or is resistant to the First Responders.

For health services acting as First Responders, a consent-based approach is already adopted to encourage an intoxicated person to a place of safety. We consider that no discrete additional statutory powers would be required for health based First Responders to undertake their functions under the Proposed Health Model.

Where a person has capacity but refuses to consent (an informed refusal), then First Responders may consider the involvement of police where there are serious risks to the person's health. However, with the decriminalisation of the offence of public drunkenness, the role of Victoria Police (and other justice-based first providers such as PSOs) as First Responder raises important considerations in the implementation of a health-based response that require careful consideration.

Last resort powers for Victoria Police

The effect of the decriminalisation of public intoxication means that existing powers of Victoria Police to detain an individual for public intoxication are removed. The question therefore arises about what happens in situations where Victoria Police consider that an intoxicated person poses a risk to themselves or to other people. We have given very careful consideration to whether any discrete additional powers are required for First Responders to intervene to provide support and assistance to an intoxicated person. In doing so, our primary concern is to ensure that an intoxicated person who requires health treatment does not end up entangled in the justice system.

Following an extensive consultation process and detailed consideration, we recognise that Victoria Police will need an additional statutory power to support them to intervene to assist where there is a serious and imminent risk and an intoxicated person does not consent to intervention or assistance.

Before turning to a discussion of the scope and nature of this additional statutory power, we wish to make the following important observations, including that:

- the overarching purpose of this reform is to move away from a police-led response to a health-based response – proposed reforms, including the scope of any new police powers, should therefore be designed to minimise or avoid police involvement to the greatest possible extent
- with adequate resourcing of the Proposed Health Model, Victoria Police should not be relied on as a First Responder, but rather a last resort responder
- Victoria Police already possesses a range of broad powers to detain and transport people. It is vital that Victoria Police do not feel compelled to resort to more restrictive powers where they perceive that apprehension of an intoxicated person is necessary
- it is understood that the public drunkenness provisions to be repealed have been used on occasion by police as a means to resolve public order incidents, without recourse to charging people with more serious public order related offences
- in this context careful consideration has been given to striking the right balance to provide police with appropriate power to address the challenges faced in protecting the community whilst also promoting the adoption of a health-based response
- in circumstances where police powers of apprehension or detention are engaged, they must only be used where strictly necessary and in the least restrictive way; and
- effective safeguards and oversight must be in place to ensure that police powers are used as intended in only the strictest of circumstances.

In the context of these observations, we consider that under the Proposed Health Model, Victoria Police should only have the power to apprehend or detain an intoxicated individual in strictly limited circumstances.

Our views on the scope and nature of an additional statutory power are outlined below, together with a range of safeguards and oversight mechanisms.

High threshold for police intervention

The ERG considers that two high thresholds must be satisfied in order for the police exercise any power to detain an intoxicated person in public, including:

- ***significant impairment –*** firstly, 'intoxicated' should be defined as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour'. This definition is based on section 3 of the *Protective Custody Act 2000* (WA)
- ***serious and imminent risk –*** secondly, an individual who is intoxicated in public could only be detained if that individual presents a serious and imminent risk to themselves or others. Assessment of this threshold should be objective and based on the "reasonable person" test. Examples of the serious harm risks we believe would meet this threshold include a significantly impaired person walking onto a busy roadway and being at risk of being struck by a vehicle; or impaired to such an extent that they are stumbling and at risk of falling and potentially striking their head on a hard surface or otherwise seriously injuring themselves; or being unable to adequately assess risk to themselves in circumstances where they are at risk of being physically or sexually assaulted. The risk of damage to property was considered in the context of this threshold and it was determined that it should not be included.

Strict limits to statutory police powers

In addition to the high threshold discussed, there must be strict limits to the use of the police power to detain. These limits include:

- a strict requirement that the purpose of the additional statutory power must only be to:
    - detain an intoxicated person who poses a safety risk (as above) for the purposes of identifying a place of safety; and/or
    - provide transport to a place of safety (discussed below as well as under Stage 2: Transport to a place of).
- a requirement to release an individual if they no longer pose a serious and imminent risk of significant harm, acknowledging that the nature of what is ‘imminent’ can change rapidly. Detention should cease if the circumstances change and the grounds for detaining the person lo longer apply. In this context it is understood that this is a decision that involves assessment of the person’s demeanour and other related risks that may fluctuate between calmness and volatility
- PSOs often encounter intoxicated people in their patrols at designated places. They are confronted with the same challenges as police officers in terms of ensuring the safety of those people and others that may be at risk of harm. They presently have a power to arrest persons for public drunkenness and so consideration has been given to providing a limited detention power. Otherwise they will not be able to detain an intoxicated person when a serious and imminent risk of significant harm is posed, as will be the case for police officers. We consider that PSOs should also have a statutory power to detain as do police, similarly subject to the same limitations and oversight requirements but have enhanced training to address the requirements of this reform
- The ERG is also especially concerned to ensure that the creation of an additional power does not result in the creation of any new criminal offences, such as alternate offences to offending that are already addressed in law.

Detention for the purposes of transport

To ensure that Victoria Police is only a transport provider as a last resort and in the most of limited circumstances, there must be a legislative obligation that police exhaust all other avenues by which an intoxicated person could be transported to a safe place. For example, inconvenience to police, such as waiting times for other First Responders to attend, should not be a reason to default to police transport. Police must only transport an intoxicated person when other transport options have been reasonably discounted.

Conditions of detention and use of force

Under the Proposed Health Model, the use of detention and any related police powers, such as the use of force, must be consistent with the fundamental purpose of keeping the intoxicated person safe from harm, including securing immediate medical attention where required. The use of powers and detention by Victoria Police must be consistent with established human rights standards, including relevant rights enshrined in the *Charter of Human Rights and Responsibilities Act 2006*. Furthermore, any use of force should only be proportionate to the threat and be the minimal force possible to achieve the objective of addressing the threat.

Guidelines and training

To support the intended purpose of the additional police power in relation to intoxicated people, there should be comprehensive regulations, guidelines, policies and procedures on the operationalisation of the legislation, to ensure discretion is applied appropriately and reasonably to all members of the community. This should be supported by appropriate training for police officers and PSOs on the purpose and scope of the additional power.

Oversight and accountability

Given the nature of the additional power, appropriate oversight and accountability processes and mechanisms must be established. This includes:

- detailed record-keeping, particularly in relation to enquiries made to identify a place of safety and appropriate transport option
- making publicly available relevant policies, procedures and training materials
- public reporting on the use of the additional power, including disaggregated data
- internal police oversight of any charges arising from an incident of public intoxication
- independent, external oversight by a body such as the Victorian Ombudsman
- powers to conduct visits to places of detention, consistent with the principles contained in OPCAT; and
- clear accountability mechanisms for any abuse of power by a police officer to circumvent the purpose and operation of the additional power – for example, South Australian legislation makes it an offence that a ”person having the oversight, care or control of a person detained under [the Public Intoxication Act] who ill-treats or wilfully neglects that person.”

Recommendation

Threshold for police powers

9. The Victorian Government establishes a legislative basis for Victoria Police to detain an intoxicated individual in strictly limited circumstances.
    a) The Victorian Government defines intoxication within the legislation as ‘affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour.’
    b) The Victorian Government limits the threshold for police with regards to someone who is intoxicated to ’serious and imminent risk of significant harm to the intoxicated individual or other individuals’.
    c) The Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Strict limits to police powers

10. The Victorian Government establishes a legislative basis for PSOs within Victoria Police to be given the power to detain an intoxicated individual in an existing designated place and who is at serious and imminent risk of significant harm to themselves or others, recognising the safeguards contained in other recommendations.

11. The Victorian Government does not extend the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others to any other cohort.
12. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
13. The Victorian Government limits the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others for no longer than 60 minutes. Any exception to this time limit required to arrange a safe placement should require the authority of a Divisional Patrol Supervisor or Inspector.
14. The Victorian Government does not establish a specific offence as a result of the establishment of police powers to detain for the purpose of making inquiries to identify a place of safety for an intoxicated person.
15. The Victorian Government implements a review process for any charges laid in relation to assault police arising from attempts to escape by a superior officer, such as an Inspector.

Conditions of detention and use of force

16. The Victorian Government takes steps to ensure that in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006,* Victoria Police exercise its powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain and the nature of restraint employed.
17. The Victorian Government ensures Victoria Police takes steps to ensure the full protection of the health of persons in their custody and, in particular shall take immediate action to secure medical attention whenever required.
18. The Victorian Government explores and consults with relevant stakeholders on how to ensure treatment during and conditions of detention of intoxicated people are consistent with relevant state and international human rights obligations and principles. This includes ensuring effective independent oversight of the detention of intoxicated people that is consistent with the Optional Protocol to the UN Convention against Torture.
19. Victoria Police takes steps to ensure officers use force only when strictly necessary, and the force used must be proportionate to the circumstances. The degree and nature of the force used must account for the fact that the purpose of the power to detain is to keep the person safe from harm. Thus, any use of force must be used by exception and the force used itself minimal.

Limits on police discretion

20. The Victorian Government creates comprehensive regulations, guidelines, policies and procedures on the operationalisation of the legislation, to ensure police discretion is applied appropriately and reasonably to all members of the community.
21. The Victorian Government establishes legislation to ensure police discretion in assessing whether a location is a safe place is limited, including but not limited to risk of family violence and instances where the intoxicated person is behaving or is likely to behave so violently that a responsible person would not be capable of taking care of and controlling them.

Training

22. Victoria Police provides police officers and PSOs with training on the legislative amendments, regulations, guidelines, policies and procedures and be provided ongoing refresher training.
23. Victoria Police provides police officers and PSOs with training on systemic racism, unconscious bias, culturally appropriate service delivery, effective communication, de-escalation and conflict resolution, and be provided ongoing refresher training.
24. Victoria Police provides police officers and PSOs with training on mental health and disability and be provided with ongoing refresher training.

Record keeping obligations of police

25. Victoria Police keeps detailed records of the enquiries they make in relation to locating a safe place for the person, including any reasons for concluding that the location is not a safe place, such as risk of family violence.

Publicly available information

26. Victoria Police ensures guidelines, policies, procedures and training and other similar materials are publicly available.
27. The Victorian Government considers making disaggregated data relating to police assistance provided with consent, and police intervention without consent, publicly available. This information should include, but not be limited to, information with regards to whether people are Aboriginal and/or Torres Strait Islander, CALD status, homelessness, gender, disability and age.
28. The Victorian Government implements public reporting on the exercise of new police powers and other relevant powers that may be used more frequently subsequent to the reform (e.g. move on powers), as well as arrests for other minor offences.

Internal police oversight

29. Victoria Police ensures authorisation of any charges that arise from an incident of public intoxication should be authorised by an Inspector.

Independent oversight

30. Victorian Government, in consultation with the Victorian Aboriginal Legal Service and Victoria Police, considers the introduction of a mandatory requirement that where an intoxicated Aboriginal and/or Torres Strait Islander person is detained and/or transported for their safety by Victoria Police they be subject to sections 464AAB and 464FA of the *Justice Legislation Miscellaneous Amendment Act 2018* .
31. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms by police. This should include oversight of up-charging practices by police, and the treatment of people detained and conditions of detention during transport.

Accountability for police negligence and abuse of power

32. The Victorian Government ensures any abuse of power by police to circumvent the limitations on powers to detain an intoxicated person must be treated seriously and they should be held accountable.

33. The Victorian Government undertakes further research and consultations to establish an offence in relation to negligent conduct when detaining an individual who is intoxicated.

7.5 Tailored local responses

It is intended that local responses will be developed under the Proposed Health Model. This should include community-led responses by groups such as the Aboriginal community, CALD communities and the Sudanese and South Sudanese community in areas where there are populations of these groups. Where a local response is available and appears to the First Responder to be applicable to the person, it is envisaged that the First Responder would contact that service to determine whether and how they could assist. Assistance may involve a range of functions including transport or providing a place of safety.

There will be a range of First Responders under the Proposed Health Model, including potential new channels such as outreach services from sobering services, health workers and expanded night patrols. These responses should differ based on the tiered response to high and low demand areas and development of community driven solutions (existing examples include establishment of Koori Night Patrols or partnerships such as the ‘chill out zone’ established in Queensland).

It is intended that the Proposed Health Model will be responsive to individual need. At a practical level, this means that there will be a cascading response based on the circumstances and needs of an individual.

The available data suggests that people who are found intoxicated in public may require support to return to a place of safety and address any immediate health and safety issues, but that most people will not require a longer-term health response under a public health model. For the high intensity cohort, defined as people who have intersecting needs, or who may frequently be found to be intoxicated in public, the new model may provide a greater level of ongoing support beyond their immediate needs through better links with housing, community mental health services in addition alcohol and drug rehabilitation programs.

7.6 Safety of First Responders

The safety of First Responders is an important consideration and the needs and risk assessment referred to above plays an important part in the identification of appropriate First Responders and the actions they undertake. Further discussion relating to workforce safety under the Proposed Health Model is contained in Workforce requirements under Stage 3: Places of Safety.

7.7 Summary of First Responders

Table 3 provides an overview of the roles of the various First Responders under our Proposed Health Model.

Table 3: Overview of proposed First Responders

First Responder – overarching role	Functions under Proposed Health Model
Victoria Police Powers and duties to maintain community safety	• Continue to provide a statewide 24/7 service, including respond to calls from the public, or other agencies • Continue to engage with people who are drunk in public where necessary for the purpose of identifying health, safety and/or other needs of people drunk in public • Victoria Police already have powers to maintain community safety under a range of legislation and common law • No power to arrest (or charge) for public drunkenness (or being drunk and disorderly) alone • Detainment in a police cell will no longer be an option merely for being drunk in public • An additional statutory power to be created to detain people and/or transport them to a place of safety in strictly limited circumstances • The additional statutory power created for Victoria Police to detain people and/or transport them to a place of safety in strictly limited circumstances to be extended to PSOs within existing designated areas
Ambulance paramedics & non-emergency patient transport	• Will continue to attend where person has acute health needs • Statewide, 24/7 response (though more limited service capacity in rural and regional areas) • Ambulance paramedics will continue to deliver emergency care to people who are intoxicated in public, including transport to hospital emergency departments for further assessment where necessary • They may also have a role in transporting a person to an alternative safe place (such as a sobering-up centre) with the person's consent, subject to clear operational guidelines
Koori Night Patrol & community-led services	• Under the proposed model, the Koori Night Patrol and/or other Aboriginal-led services responses would be enhanced to provide greater capacity to respond in a holistic public health model

	• They would continue to have a range of flexible functions and culturally safe services, as determined by the local communities consistent with self-determination, which could include transport to a safe place
Outreach workers (incl associated with Sobering Up Centre) services Provide health and other social and outreach services	• In addition to emergency health workers (paramedics and those working in emergency departments), the model will involve a range of other outreach and health workers delivering the proposed range of services to manage non-acute health harms that cannot be managed at home or with friends and family • The primary role of outreach workers under the model will be to offer assistance to address health or other risks associated with a person's intoxication.
Operators of licensed premises Respond to intoxication and other behaviours at licensed venues	• Licensees will continue to have powers and responsibilities under the *Liquor Control Reform Act 1986* (subject to any reforms which arise from the recent governmental review). • It will be important that licensees are informed of the reforms for responding to public intoxication.
Authorised officers Enforcement of regulations and local laws in designated areas such as local council areas and public transport	• Continuation of all functions and powers as currently authorised in a particular area.

8. Stage 2: Transport to a place of safety

Key points

- Under the Proposed Health Model, whilst the preferred and default position where possible is that an intoxicated person organises their own transport or does so with the assistance of family or friends, a range of new transport options will be required. Victoria Police will only have a role to play in the transportation of an intoxicated person when there are no other options available
- The new range of transport options, in combination, will need to be capable of responding to the expected demand based on geography, time distribution and particular individual needs, including health needs and cultural safety
- To achieve the most effective and efficient management of demand for transportation, outreach teams and sobering services will need to have an associated transport capability
- Different operational models for transport should be varied across locations and should be tested during the proposed implementation phase.

A range of transport services are capable of taking people found intoxicated in public to a place of safety. Possible places of safety under the Proposed Health Model, including individuals' private homes, emergency departments and health and sobering services, are explored in further detail in the next section Stage 3: Places of .

This section discusses the role of transportation and identifies our views on the proposed transport services under a health-based model.

8.1 Role of transportation

Transporting a publicly intoxicated individual to a designated place of safety is an integral component of the Proposed Health Model. The identification of the most suitable transport option is inherently linked with the specific needs of the intoxicated person and the identification and availability of the most appropriate place of safety.

Many people who are intoxicated in public will require assistance with transport to a safe place in a range of different situations, such as:

- being separated from family/friends and needing information about local transport
- in need of a safe place because of vulnerability/state of consciousness
- at imminent risk of harm to themself or others
- in need of medical assessment and/or treatment
- after being discharged from a sobering service or emergency health service
- being homeless and having no ready access to a safe place.

Clearly, the type of transportation required will depend on the individual’s circumstances and immediate health and safety needs.

8.2 Transport options

A range of options exist to transport an intoxicated person to a place of safety. The identification of appropriate transport options depends on a number of factors, including the specific health and safety needs of the individual, the availability of an appropriate place of safety and additional relevant considerations such as cultural safety. Appropriate and adaptable transport options will need to be available in both high and low demand areas that are capable of meeting expected levels of demand.

As identified elsewhere in this report, the preferred and default position, where possible, is that people organise their own transport or do so with the assistance of family or friends. Transport options include private vehicles with family/friends or the use of public transport or taxis and ride-sharing services.

For individuals who are not in a position to arrange their own transport, there are various options for transport of an intoxicated person to a place of safety, including:

- by emergency services, such as an ambulance
- standalone transport services
- integration of transport into various outreach services
- integration of transport into health and sobering services
- private paramedic and first aid services to support major events or venues; and
- specialist taxi or rideshare services.

Following the recommendations of the Deputy State Coroner to the Tanya Day inquest, the Victorian Government's review of the ACJP model also presents an opportunity to consider and refine the role of the ACJP in the context of a public health response to public intoxication.

As discussed in relation to first response options, Victoria Police should not be a primary First Responder. Nor are police intended to be a primary transport provider under the Proposed Health Model. However, we acknowledge that there may be some circumstances, particularly in regional and rural areas, where no other transport option is available, and Victoria Police will have a role to play. The role and powers of Victoria Police with respect to transport under the Proposed Health Model are discussed in further detail under the Consent and powers section below.

8.3 Assessment of transport options

Table 4 presents an exploration of various transport options with a preliminary assessment of the suitability of each option for the range of circumstances that are likely to occur within a health-based response to public intoxication.

Table 4: Assessment of transport options

Transport option	Adaptation to health response	Advantages	Disadvantage	Suitability and assessment
Family/friends	• Suitable for cohorts who consent to this option (responder needs to assess family violence or other safety risks) • Use of family and friends is consistent with arrivals at emergency departments – only approx. 25% of emergency presentations arrive by ambulance	• Minimal or no investment. • Minimal disruption to the individual • Encourages personal responsibility	• Without careful assessment could lead to health or safety risk to both the individual and friends/family • May require time and effort to locate and short-term supervision until family/friends arrive	• Yes – subject to assessment by First Responder • Suitable in all areas unless there are significant health or safety concerns • Will not be available to all persons – family/friends may not be available or not able to offer a safe environment
Public transport (P/T)	• Suitable for low risk cohorts – people who are not violent/ agitated and reasonably capable of taking care of themselves (e.g. intoxicated and lost wallet/friends) • Could be given Myki • May not support transport to sobering service	• Reasonable availability in metro Melbourne • Encourages personal responsibility. • Minimal or no investment. • Sobering-up services staff or outreach workers can assist people to access P/T	• Potential for violence, harassment and aggression may occur on P/T when there is no police or PSO presence • Limited in outer suburban Melbourne and little or none in regional and rural areas	• Good option where available, unless there are significant health or safety concerns • Suitable in high and low demand LGAs • Less suitable for rowdy, unwell, disruptive and potentially violent people
Taxis/rideshare	• Suitable for low risk cohorts – people who are not agitated or potentially violent and reasonably capable of taking care of themselves (e.g. intoxicated and lost wallet/friends) • Could be given transport voucher/credit • Safety could be enhanced with use of family or friends to support relocation to a place of safety • Handover to sobering service may be low-quality • No additional training and often lack cultural safety/awareness	• Available in metro and regional centres • People able to use their own agency to manage the consequences of their intoxication • Minimal or no investment, unless supported by vouchers • Sobering service staff or outreach workers can assist people to access taxis/ridesharing service	• Some drivers will not be willing to transport alcohol-affected persons	• Good option where available, unless there are significant health or safety concerns • Suitable in high and low demand LGAs • Less suitable for rowdy, disruptive and potentially violent people
Event paramedics & private transport and first aid providers	• Provide a high-level clinical response to individual's health needs • Staff profile can be flexible to reflect care needs of cohort – includes paramedics, Emergency Medical Technicians or other medical staff	• Private paramedic and first aid services to support major events or venues	• Event paramedics and first aid providers may not have existing transport capability	• Potentially have a role to play particularly around seasonal events and peak periods.in areas of high demand • Cost relative to other options may be high

	• Provides existing fully equipped ambulances and experience in delivering mobile health services • Unknown interest in market for providing response and transport for intoxicated individuals • May lack cultural awareness, or experience working with vulnerable people			
Outreach and sobering services with dedicated or flexible transport	• Opportunity to create a fit for purpose model • Ensures immediate transport availability for outreach teams	• Expanding/ establishing new safe services to respond and transport people to place of safety permits local services/partnerships to draw on local resources to provide a transport solution • Evidence from other jurisdictions that it can be an effective way of organising transport for intoxicated individuals • Can transport more than one person at a time if necessary. • Potential for flexible, 'on-call' model.	• Requires two staff per van • Requires assessment capacity to ensure safety for client and staff • May require special fit outs to ensure safety	• Yes • Invest in areas of high demand • Provides flexibility to outreach /workers who can use the funds at their discretion) to provide transport options (e.g. taxi/uber vouchers as part of local solutions). • Suitable in high and low demand LGAs. May be particularly attractive in rural and regional areas • Appropriate for people with low health and safety risk
Standalone flexible transport services (no outreach or service provision)	• Opportunity to create a fit for purpose model • Separation from outreach teams provides scope for more flexibility (i.e. can link to other sobering service options such as hospitals) • Enables outreach teams to focus on first response needs	• New safe transport option	• Requires assessment of capacity to ensure safety • Costly but less expensive than transport investment options (below) • Risk of over-reliance or unnecessary transports from those able but unwilling to make their own arrangements • Reporting and monitoring may be administratively burdensome	• Yes • Most suited areas of high demand and areas with variable seasonal demand
Specialist taxi/rideshare	• Option to provide additional training and support to taxi and share ride providers to help transport intoxicated individuals	• Drivers purpose trained	• Cost and provider business model feasibility unknown	• Yes • Explore for areas of low demand or areas with variable/seasonal demand

	• Target at lower risk clients who do not have other transport options or family or friends for support • Could involve additional payments to drivers per transport above standard fees to encourage uptake of service • Will need regulation			
Ambulance Victoria	• Provides a high-level clinical response for clients requiring emergency treatment, but will provide an excessive response for low risk clients • Diversion of resources to respond to intoxication reduces capacity to respond to other emergencies • Custodial sentence applicable for violence against paramedics • Fees are payable for transportation ($1,265 for metro & $1,866 for regional; $546 for treat without transportation) or requires coverage by ambulance insurance	• Statewide, 24-hour, demand-responsive • Provides emergency clinical assessment treatment, transport for those requiring it • A safe default option when there is uncertainty about an individual's medical condition	• Increase in demand would require investment • Unnecessary transports are a significant drain on resources (particularly in rural & regional areas where ambulance services are limited)	• Last resort only or for genuine emergencies • Appropriate for people with high immediate health needs who require assessment in an emergency department • Suitable in high and low demand LGAs
Victoria Police	• Only as a last resort • Police not responsible or appropriately trained to manage health issues • Diversion of resources to respond to intoxication reduces capacity to respond to other policing work • Possible risk of escalation resulting in criminal charges	• Statewide, 24-hour, demand-responsive service • Experience in transporting intoxicated people	• Resource-intensive • Discretionary • Not always appropriate in a health-based model • Holding and detaining powers are required	• Last resort only • Suitable in high and low demand LGAs • Appropriate for people with a high safety risk but not people with high health needs

8.4 Guaranteeing transport coverage and availability

To ensure an effective health-based response on a statewide basis, appropriate transport options must be available to meet the levels of expected demand. This requires a diversity of transport options that, combined, are capable of responding to expected demand based on geography, time distribution and specific individual needs, including health needs and cultural safety.

In areas of high demand, it is clear that additional investment in specific transport options will be required. The availability of increased transport services will ensure that intoxicated people receive appropriate care and that emergency services such as ambulance and Victoria Police are only used as a last resort, leaving them free to respond to other emergencies.

It is therefore critical that outreach teams and sobering services have a transport capability attached to their service or work together with separate transport teams to achieve the most effective and efficient management of demand. We consider that different operational models for transport, whether they be attached to a sobering service, or be more flexible demand-led options, should be tested during the proposed implementation phase. Amongst these could be the use of specially trained taxi or ridesharing services for low risk cohorts.

In addition to independent transport capacity attached to sobering facilities, transport in regional areas and/or for people with complex, co-occurring presentations, will require differing and adaptable approaches outside of the scope and/or locale of a sobering services centre.

In areas where the demand for transport will be low, local solutions will need to be developed, particularly in regional and rural areas. This will need to be considered in relation to our recommendations concerning the use of hospitals and other health services to provide sobering services in key rural locations. The proposed implementation phase would give local areas an opportunity to test a range of low-demand transport models, including the identification and development of local partnerships.

The implementation phase should also monitor the impact on police and ambulance emergency services, including impact on response time performance measures.

Recommendation

34. The Victorian Government supports outreach teams and sobering services to have a transport capability attached to their service or work together with separate transport teams to achieve the most effective and efficient management of demand.
35. The Victorian Government ensures that the proposed implementation phase gives local areas an opportunity to test a range of low-demand transport models, including the identification and development of local partnerships.
36. The Victorian Government ensures that the implementation phase monitors the impact on police and ambulance emergency services, including impact on response time performance measures.

8.5 Consent and powers

Under the Proposed Health Model, consistent with the nature of consent in the context of the provision of health care, in all but a few exceptional instances consent of an intoxicated person to be

transported to a suitable place of safety is fundamental, As identified earlier, many health and community services who are First Responders already rely on the consent of an intoxicated person to be transported to an appropriate place of safety. However, we acknowledge that in some circumstances Victoria Police will be the only or last resort option to provide transport, particularly given their availability, both in terms of geography (statewide) and time (24-hours a day, seven days a week) and the fact that the availability of other transport options may vary depending on the service system in a particular area and the specific needs of the intoxicated person requiring transportation.

We acknowledge that the role Victoria Police as a transport option raises several concerns, including the potential drain on Victoria Police resources and that, in some circumstances, the involvement of police may lead to escalation of the situation.

In the limited circumstances where Victoria Police is the only available transport option and an individual does not consent to being transport, we recognise that Victoria Police will require powers that enable them to transport people to a safe place. However, police are not intended to be the primary transport provider in this model. For legal reasons, a specific power will be required for police to transport an individual to a safe space, whether consent is present or not.

Any powers given to police to transport an intoxicated person should be strictly limited to ensure that police are not the primary method of transport under the new health response. A detailed discussion in relation to the nature and scope of additional statutory powers for Victoria Police is contained in Section 7.4: Consent and powers, including our recommendations for an additional statutory power in relation to transport and associated safeguards and oversight.

Recommendation

37. The Victorian Government establishes a legislative basis for Victoria Police to transport an intoxicated individual to a place of safety in strictly limited circumstances.
    a) There be a legislative obligation that police exhaust all other avenues by which an intoxicated person could be transported to a safe place, and that police transport be a last resort
    b) The Victorian Government does not establish a specific offence as a result of the establishment of police powers to transport intoxicated individuals to a place of safety
    c) The Victorian Government ensures that all limits, thresholds and accountability measures in relation to the power to apprehend and detain as outlined in Part 7 of this report apply to the exercise of the limited power to transport intoxicated individuals to a place of safety.

8.6 Transport safety

We are very concerned to ensure the safety of an intoxicated person who is transported to a place of safety. We recommend that a transport safety standard be established to ensure the safe transport of intoxicated people.

Recommendation

38. The Victorian Government establishes a transport safety standard to ensure the safe transport of intoxicated people.

9. Stage 3: Places of safety

Key points

- Places of safety are essential to ensuring the health and wellbeing needs of intoxicated persons are addressed
- Depending upon their personal circumstances, under the Proposed Health Model intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to a private residence, an emergency department or urgent care centre if they require urgent medical care, or a sobering service if they require a short recovery period and cannot be cared for elsewhere
- New sobering services are integral to the Proposed Health Model. In effect, they will replace the current use of police cells and will have the capacity to meet the variances in demand according to location and time. This should include the capacity to respond to demand associated with cultural and sporting events through the provision of 'pop-up' services. Modular health spaces provide the opportunity to expand capacity in a rapid and flexible manner
- The workforce for sobering services needs to be multidisciplinary, at a minimum include a health practitioner, such as a registered nurse, and reflect the profile and needs of the population and region it serves
- In higher demand areas, it is recommended that sobering services be incorporated into the proposed Mental Health and AOD Hubs and that the existing Ngwala Willumbong Sobering Service be expanded. In regional and rural locations where there is much lower demand, the best health response solutions should be locally devised involving engagement of health services and the communities they serve
- Under the Proposed Health Model, provision of health services takes a consent-based approach, with strictly limited exceptions.

Under our Proposed Health Model intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to one of three safe place locations to sober up, including to:

- their home or other private residence where it is determined that the individual is at low risk and can be adequately and safely cared for by family or friends
- an emergency department or rural trauma and urgent care centre where it is determined the individual requires urgent medical care; or
- a health or sobering service where it is determined the individual does not require emergency care but still requires a short period of recovery and detoxification and/or cannot be cared for safely elsewhere.

This section outlines our views on the service system response required to provide places of safety for people who are intoxicated under a health-based model.

9.1 Home/private residences

In many instances of public intoxication, a person can be assisted by friends or family without any intervention needed from health or emergency services. An intoxicated person can be assisted to return to their home, or to friends or family while they sober up.

Wherever possible, we consider that a home, or other safe private residences, remain the preferred and default safe place option to assist people with sobering-up needs. This has the benefit of minimising the impost on health services.

This option requires a range of risk assessments to be undertaken, including whether the person:

- can be safely supervised while they sober up – for example, are there responsible people at home who can provide food and hydration?
- will pose a threat to others if returned home or to another private residence – for example, is the person at risk of perpetrating or being the victim of family violence?

If a person cannot be transported home or to friends and family, First Responders will need to undertake further consideration of what the most appropriate place of safety for the person is, having regard to a range of factors, including whether:

- the person currently at risk, or a risk to others
- they be safely supervised to sober up within a local sobering or health service
- they need a specific service response to address their needs, such as the support of an Aboriginal community organisation
- they are experiencing concurrent needs which should be addressed, such as homelessness or other vulnerabilities.

9.2 Health infrastructure overview

This section outlines the current types of health infrastructure available including their purpose, function and potential suitability to incorporate into a sobering service which utilises existing infrastructure.

In addition to these existing service types, we have considered the suitability of modular, prefabricated/pop-up infrastructure as part of the Public Health Model. Modular health spaces are an increasingly accepted part of the health infrastructure mix, offering expanded capacity that can be deployed rapidly and flexibly to meet need. It may be particularly well suited to trialling health responses and infrastructure needs as part of the proposed implementation phase.

Emergency departments

Emergency departments provide care for people who have life-threatening or other conditions that require urgent medical care. Staffing mix and operating hours make them well placed to provide an immediate medical response in cases of acute intoxication. However, emergency departments are not the best location to support intoxicated individuals with non-urgent medical care needs. Emergency resources should not be diverted towards providing lower-acuity sobering supports.

Nevertheless, hospitals with emergency departments are available 24-hours a day, seven days a week for client triaging and admission and deliver a high level of clinical governance and oversight. We consider that emergency departments have an important role to play as part of the service system response to public intoxication. We anticipate that this role will continue in regard to providing urgent

medical care for those suffering acute intoxication. We also consider that this does not require any new investment from government in respect of this reform.

Mental health and alcohol and other drug hubs

As part of the 2018-19 State Budget, the Victorian Government announced funding for six mental health and AOD responses in six public hospital emergency departments. The six public hospitals were Monash Health (Monash Medical Centre Clayton), Peninsula Health (Frankston), Western Health (Sunshine), Barwon Health (University Hospital Geelong), St Vincent's Hospital, and Melbourne Health (Royal Melbourne Hospital).

The hubs aim to enhance the emergency treatment and experience for those presenting with mental health and AOD issues. It is expected these clients will receive more timely assessment and specialist treatment, with access to a dedicated physical space and workforce that is more conducive to therapeutic interventions than a conventional emergency department.

The hubs response will operate 24-hours a day, seven days a week to provide an integrated care pathway to respond to people presenting to the emergency department with urgent physical health and mental health or alcohol and other drug needs.

The three key components of the hub response are:

- **non-admitted service** – a multidisciplinary assessment and treatment service within the emergency department. Initially this will be within existing infrastructure until capital works are completed that will deliver a dedicated space. Clients will have access to a collaborative and multidisciplinary assessment across physical, mental health and AOD domains followed by appropriate treatment, including:
    - brief (where clinically indicated) therapeutic interventions
    - peer support
    - referral to appropriate inpatient and/or community-based services with the involvement of families and carers where applicable and appropriate.
- **the short stay unit, the hub** – a 4-6 bed facility, the short-stay unit (the physical refurbishment referred to as the 'hub') within the emergency department for clients who require stabilisation and intensive support for a period of time that is clinically appropriate. Short-stay beds will be included in building works to be undertaken in line with the capital development plan for each health service. Once completed, staff will work across both the non-admitted and short stay units.
- **assertive outreach** – a 28-day post-discharge follow-up service where required. This will facilitate comprehensive assessment for clients, provide appropriate linkages and referrals in response to presenting needs and provide follow-up engagement for those discharged from the hub response into the community.

We are of the view that the hubs represent an excellent opportunity to address the sobering-up needs of clients and that consideration of extending the remit of these hubs to incorporate sobering services should occur. This proposal is particularly strengthened when the service orientation of the hubs is understood. The services intended for the hubs will complement the service requirements for a sobering service.

We consider the hubs should provide sobering services as part of their model of care. This may require additional investment above government's initial investment in the hubs.

Rural trauma and urgent care centres

Rural urgent care centres are local health services for people in small rural communities providing 24-hour care and treatment, with the option of transfer to larger services when required. Rural urgent care centres are expected to undertake initial assessments of clients and initial treatment of any type of presentation. Rural urgent care centres also receive ambulances for definitive treatment, assessment of client needs or stabilisation before transfer to a larger health service. We consider that rural trauma and urgent care centres may be an effective option for provision of sobering services, and if so, in some circumstances, infrastructure may need to be boosted to provide dedicated sobering up placements.

Public hospitals

Public hospitals provide a variety of inpatient and outpatient services, with unplanned admissions generally triaged through the emergency departments. Most hospitals have social workers available to help with personal, emotional and practical concerns relating to clients, including connecting clients to relevant community supports. Hospitals in LGAs identified as having high demand or highly complex cohorts for sobering services are generally already familiar with managing the needs of this cohort and will be well placed to establish dedicated sobering service supports.

Most hospital services are delivered during business hours, meaning that peak time periods for instances of public intoxication do not usually coincide with these hours. Additional investment and support would therefore be required for staff to be available to triage and admit clients and support escalation of care where needed, particularly in smaller rural public hospitals where there is limited or no capacity to admit clients for care outside of normal business hours.

Residential alcohol and other drug and health services

A range of existing residential services for AOD treatment operate across Victoria. They generally do not provide 24-hour accessibility. People with high needs experiencing AOD dependence and related social issues (as distinct from people who are merely intoxicated) are referred to residential treatment services through catchment-based intake services and other alcohol and other drug treatment providers.

Residential withdrawal services provide support for people to safely withdraw from alcohol and other drugs in a supervised residential or hospital facility, usually in a short-term stay. Residential rehabilitation provides a longer-term (typically three or more months), structured residential program for people who require that level of support.

We consider that the role of residential services may be better suited to integration as part of a secondary response (discussed further under Stage 4: Longer Term Needs) where a person is assessed as needing these interventions. The role of non-residential AOD services would likely be more aligned with secondary response integration.

Aboriginal-specific health and support services

There are a number of Aboriginal-specific services and initiatives, which are delivered by ACCOs as well as ACCHOs based on the principle of self-determination. ACCOs are controlled by and accountable to Aboriginal and/or Torres Strait Islander people in those areas which they operate. They deliver diverse holistic, comprehensive and culturally appropriate health and care to the community. We consider that ACCOs have a central role to play in the provision of health and sobering services as safe places for Aboriginal and/or Torres Strait Islander people who are intoxicated in public.

Implementation of an effective health-based response will require investment in ACCOs to develop new and expand existing responses to public intoxication as both First Responders and in the provision of Places of Safety. Further detail on the role of ACCOs is provided in our discussion on the expansion of Sobering services.

Community health services

Victoria has a comprehensive network of community health services that deliver a range of primary health, human services and community-based support to meet local community needs. Community health services provide universal access to services as well as targeted services for vulnerable population groups. We consider that community health services may be suited to providing sobering services given their existing focus on supporting vulnerable cohorts and experience in AOD treatment. Individuals in the highly complex cohort are likely to be already connected with these services.

However, because they are generally not open overnight and on weekends, consideration would need to be given to the additional infrastructure they would need to provide a suitable sobering service.

Homelessness support services

Homelessness services provide various forms of housing, welfare and health support for people experiencing homelessness or at imminent risk of doing so. Whilst several of the large services are accessible 24-hours a day, we consider the role of homeless services to best fit with the secondary response in a health model of responding to public intoxication.

9.3 Sobering services

The ERG is of the view that sobering services must be a core part of their recommended model. Sobering services are intended to provide a short-term recovery and detoxification response to acute alcohol or other drug intoxication.

The purpose of this section is to provide more detail on a good practice model of care and workforce and infrastructure requirements for sobering services.

It is expected that a more detailed and responsive model of care will be required for sobering services in areas of high demand or services supporting Aboriginal and/or Torres Strait Islander people or people of other cultural backgrounds. In areas of low demand, a more simplified model may be appropriate, with referral pathways in place for clients with highly complex needs.

Key issues for *new* sobering services

Scalability

The type of sobering service models should ‘fit’ with the target population and area. This can involve mobile units with outreach capacity for temporal demand associated with cultural and sporting events, and fixed site services for higher demand regions with more complex needs. Effective implementation of sobering services should consider a core model of care and workforce requirements, associated services pertaining to outreach and transport, and scalability options to ensure capacity meets the local demand.

Integrated care

Some reviews and evaluations note that sobering services may act as a ‘band aid’ to the immediate issues, resulting in the repeated use of these services by more complex clients. Sobering services are

by design a short-term solution intended to provide safety and immediate care but are often not equipped to address longer term needs, such as chronic substance use, mental health issues and homelessness.

Consequently, strong integration of sobering services with local health and human services is key to the success of long-term harm reduction. This requires a response that is co-designed across government and the community to ensure a holistic response to public intoxication. This will ensure the provision of immediate safe and health informed responses to intoxicated individuals, whilst engaging early intervention and support programs.

Establishing safety

All service elements and personnel involved in responding to public intoxication should maximise Aboriginal, cultural, linguistic, gender and sexuality safety.

This is consistent with the design principles for the public health model, and will increase the likelihood of effective engagement, trust-building, disclosure and service uptake. Local communities need to be engaged in and control the development and delivery of sobering services, and core workforce competency training should include cultural awareness and safety. This includes conforming to the six LGBTQI-inclusive practice guidelines.

Evaluation of services

Frequently highlighted in service reviews and evaluations of sobering services are the limitations due to the diversity of approaches (lack of a programmatic approach) and paucity of service and client data resulting from the absence of a data system and/or the lack of a systematic approach to data collection.[11] A systematic approach to evaluation for these services will ensure that effectiveness of the public health response can be measured and early identification of any unintended effects during the implementation phase.

History of sobering services in Victoria

In 1990, the Victorian Government funded eight ACCHOs to establish sobering-up centres to provide information, support and a crisis response for intoxicated clients. The centres were in response to the Royal Commission into Aboriginal Deaths in Custody recommendations that imprisonment should be used as a last resort, non-custodial facilities should be made available for the care and treatment of intoxicated persons, and the offence of drunkenness should be abolished. The Royal Commission supported the establishment of sobering-up centres in Victoria, South Australia, the Northern Territory and Western Australia.

In 2008, a review of Koori Community Alcohol and Drug Resource Services, which included sobering services, was undertaken to understand the program's implementation and strengthen the model of service delivery. At the time there were five sobering- services in Victoria, including four rural and one metropolitan. These comprised:

- Ngwala Willumbong Cooperative in Melbourne
- Gippsland and East Gippsland Aboriginal Cooperative interim service in Morwell
- Gippsland and East Gippsland Aboriginal Cooperative in Bairnsdale
- Rumbalara Aboriginal Cooperative in Shepparton
- Mildura Aboriginal Cooperative.

[11] Miller, P et al, 2018.

The review highlighted a range of concerns with the program, such as:

- difficulties in addressing the full range of client needs
- the need for DHHS to support locally developed strategies addressing public intoxication issues in their community
- addressing occupational health and safety issues for the staff and clients; and
- building workforce capacity.

A number of systemic issues were highlighted by stakeholders throughout the review of the services. The issues highlighted included:

- cultural competence of mainstream AOD services
- lack of coordination by services sharing common clients
- the geographical reach required, particularly in rural settings
- limited funds leading to limitations on staff available for rosters
- workforce issues including recruitment & retention of staff
- limited prevention and early intervention services in the area
- limited medical/nursing support.

Following review processes, most ACCHOs decided to move away from the then 'sobering-up service' model. This included:

- three rural ACCHOs developing local action plans to respond to the availability of new AOD rural nursing program funding and to address areas of program, clients, workforce, and collaboration and partnership. This resulted in reconfigured service responses with a stronger focus on prevention, AOD treatment, integrated service delivery, and workforce training and support
- one rural ACCHO decided to cease the operation of the sobering-up service and use the funding to employ an additional Aboriginal and/or Torres Strait Islander AOD worker
- Ngwala Willumbong Aboriginal Corporation remains the only sobering service available in Victoria, providing an on-call service at a property in Northcote and covering the metropolitan area. However, few intoxicated people are electing to be taken to the Northcote site and consequently the service is mainly focussed on providing transport support. When people have wanted to go back to the Northcote property it is often due to needing emergency accommodation.

Significant changes in the AOD service system since 2008 would place any new sobering services in a different context, which would address some of the previous operational concerns. Those changes include, the growing role of outreach and peer workers, strengthened role for ACCHOs in service delivery and partnerships with mainstream services, and a stronger authorising environment for harm minimisation approaches to AOD use. With appropriate resourcing, use of evidence-informed models of care and integrated service pathways, new sobering services could provide a catalyst to delivering culturally safe, client-centred approaches for clients with multiple and complex needs.

Sobering-up centres – other jurisdictional experiences

The ERG examined the sobering services that have operated or that are in operation today in other Australian jurisdictions. In summary, these sobering services differed significantly in service-offering, staff mix and ratio and scale. Sobering services did not provide a whole of jurisdiction solution and

were generally confined to locations of high demand. In these jurisdictions, the sobering services do not replace protective custody powers and operations whereby some intoxicated persons are incarcerated in police cells. The sobering services, particularly in the Northern Territory and Western Australia, did indicate that such services are sustainable and have experienced ongoing government support.

Models of care

Our examination of sobering services in Australia and internationally found significant variation between centres in terms of opening hours, co-location with detoxification facilities, availability of trained Aboriginal and/or Torres Strait Islander workers and the presence of security rooms for aggressive clients. Individual variation often reflects the local need of the area, as well as the philosophical, religious or cultural beliefs of the organisation that manages it. However, there are key elements that are shared by most sobering-up centres in the literature. These include:

- **intake –** referrals to sobering services are most commonly made by police or community-based patrols that deliver clients to the centre. Emergency department and self-referrals are also accepted by some services, as well as referrals by family, friends or legal representatives. Staff are skilled at engaging and winning the trust and co-operation of the intoxicated person.

  Clients of these services are not detained against their will and are free to leave at any time. If requested, a nominated contact may come collect them. Data is gathered on the individual to register their attendance, and client belongings are removed and recorded for their safe keeping.

- **assessment –** clients are assessed for their level of intoxication, using either physical assessments (e.g. walking in straight line), or a breathalyser test to determine blood alcohol concentration level. A health assessment is performed to identify any clients with medical issues that need to be attended to, and transport to hospital is arranged as necessary.

- **monitoring –** clients are observed at regular intervals in their attendance by staff trained in first aid and in the identification of withdrawal symptoms, with transport to hospital arranged as necessary. Clients with behavioural issues following intake are monitored to ensure the health and safety of personnel, with conflict resolution protocols as required for any disputes between residents.

  Basic needs attended to, including a shower, washed clothes, a clean bed, rehydration/refreshments and an appropriate meal. Clients are often recommended to ‘sleep it off’ but are not obliged to do so. Services that accept both male and female clients have separated dormitories, with a mixed gender workforce to ensure personal care can be provided in a safe environment for the client.

- **further assessment and intervention –** once the client is sober and ready to leave the service, they may be screened using tools such as the Alcohol Use Disorders Identification Test (AUDIT). AUDIT is a 10-item screening tool developed by the World Health Organisation to assess alcohol consumption, drinking behaviours and alcohol-related problems. General health and wellbeing issues are assessed, with brief interventions and referrals for further assistance provided if required. Determination of the operating hours should ensure that all clients receive assessment and intervention services upon departing the service.

  This model of care is the approach that sobering services across Australia and internationally have adopted to deliver effective immediate care for clients. It is recommended that these key elements form the model of care for sobering services in Victoria.

Outreach and transport

Some sobering services provide an ancillary service of street-based outreach teams for the purposes of locating intoxicated people and providing immediate health support. This First Responder role will often offer an associated transport service.

The model of care outlined above incorporates the elements of best practice for sobering services across Australia and internationally. It is recommended that these key elements form the model of care for sobering services in Victoria.

Workforce requirements

Staffing models vary between services, from volunteers with minimal training to multi-disciplinary teams that are led by a nurse practitioner and/or paramedic. Some services have police and/or ambulance staff on duty which may reflect emergency service involvement in the governing partnership.[12] However, all members of staff in a sobering service should as a minimum have qualifications in first aid and cultural competence[13]. Other skills, such as a caring environment with non-judgemental staff was also identified as key for building trust and rapport.[14]

Evaluations of sobering services in Australia and elsewhere highlight the need for effective workforce supports.[15] Effective workforce supports include capacity for de-briefing, formal supervision (individual and/or group) and usual staff development opportunities. Staff employed in the Northern Territory sobering services have identified that regional fora assist in building and strengthening the workforce identity, sharing of good practice and assist with skill development.[16]

The workforce for sobering services should be multidisciplinary and specific to the population and region it serves. Workers may include a mixture of AOD and mental health clinicians, medical practitioners, community and health workers with specialist AOD or social and emotional wellbeing skills, cultural support workers, peer workers and security services. The staffing profile should be considered within the specific context of the service, and with considerations for any implementation challenges, but at a minimum it should include a medical practitioner such as a registered nurse.

The *Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022*, while focused on AOD services, provides a useful framework to assess these challenges. The strategy considers availability, capabilities, diversity, worker health and safety, leadership and collaboration, and person-centred integrated care as relevant considerations.[17]

Size and capacity

The size and capacity of sobering services in other jurisdictions vary significantly. However, in establishing a new health-based response to public intoxication, Victoria has the opportunity to tailor the size and capacity of its sobering services to anticipated demand in various locations and across

[12] Moore, SC et al. pre-publication, 2020.

[13] Allen-Kelly K, McArthur M, Thomson L (2006) Evaluation of Centacare sobering up shelter. Australian Catholic University.

[14] Parliament of Victoria (2000) Inquiry into Public Drunkenness. Discussion paper. Drugs and Crime Prevention Committee, October. Available at: https://www.parliament.vic.gov.au/80-dcpc/inquiry-into-public-drunkenness

[15] Department of Human Services, *Review of Koori alcohol and drug services*, Drug Treatment Services Unit, Aged, Community and Mental Health Division, 1997; Department of Health, Victoria, 'Koori Community Alcohol and Drug Resource Service Review: Key Findings'. 2010; Department of Health, NT, 'Review of the Northern Territory Sobering Up Shelters', PwC, 2018; Ward BM, O'Sullivan B & Buykx P 'Evaluation of a local government 'shelter and van' intervention to improve safety and reduce alcohol-related harm' *BMC Public Health*, 18:1370, 2018; Miller, P. et al, 2018.

[16] Department of Health, NT, 'Review of the Northern Territory Sobering Up Shelters', PwC, 2018

[17] Department of Health and Human Services, Victoria (2018) Victoria's Alcohol and Other Drugs Workforce Strategy 2018–2022. Available at: https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022.

the days of the week. The physical size of each will need to accommodate the peak periods and the staffing regime will need to have the ability to scale up and down according to the variations in daily demand which we know to be reasonably predictable.

Critical to designing an appropriate staffing model is the establishment of staff to client ratios that ensure the quality and safety of the service. Whilst we could find no definitive staffing ratio for a sobering service, on the basis of literature and examples from other jurisdictions we recommend that a range between 1:6 and 1:8 would be reasonable starting point, subject to detailed implementation planning for each location and any variations to a core model. This assumes the presence at all times of a health practitioner such as a registered nurse.

The indicative size of the sobering up services that we recommend is addressed below in the discussion of their coverage and availability.

9.4 Assessment of options for places of safety

Table 5 provides a summary and our assessment of possible options for safe places.

Table 5: summary of health infrastructure

Leverage suitability	Option	Geographic location	Operating hours	Staffing mix
Yes*	Hospital Emergency Departments	CBD, suburbs, some regional	24/7	Doctors, nurses, social workers, AOD workers and psychologists available for consults though hours of availability vary
Yes*	Rural trauma and urgent care services (UCS)	Rural and regional	Varies, ranging from seasonal service to 24/7	Varies, the majority do not have designated nursing or medical staff, with nurses coming off the ward as needed. They may or may not have on-call medical support which are local GPs. Larger UCSs (>5000 presentations) have dedicated nurses. Phillip Island, Colac, Djerriwarrah and Portland have designated medical staff.
Yes**	MH/AOD Hubs	Future plan for 6 hubs: CBD, suburbs, Geelong	24/7	Mental health and AOD workers
Maybe	Community Health Services	CBD, suburbs, regional	Extended business hours	Broad range of workers depending on services delivered, can include both health and social worker supports.
Maybe	Public hospitals	CBD, suburbs, regional	Staffed 24/7 Admission generally 9am-5pm	Broad range of medical (including specialists), nursing and allied health staff Regional medical staff may only be available on-call
No	Residential AOD services	CBD, suburbs, regional	Staffed 24/7 Admission 9am-5pm	AOD workers and nurses. Psychologists, social workers and doctors available as required
No	Non-residential AOD services	CBD, suburbs, regional	9am-5pm, some open outside business hours	AOD workers, nurses, psychologists and social workers

Maybe	ACCOs	CBD, suburbs, regional	9am-5pm, some open outside business hours	Varied mix – including doctors, nurses, AOD workers, Aboriginal health practitioners and social workers
No	Homelessness support services	CBD, suburbs, regional	Mix of 24/7 and business hours	Housing support workers, social workers

** Subject to consultation – services/infrastructure may need to be separate from the ED or UCC.*

*** May require additional investment, to ensure capacity (especially at peak times for public intoxication).*

9.5 Differentiated service system responses

The data outlined in Part 1 of this report indicates that differentiated service responses will be required to meet the needs of people who are intoxicated. Key data, such as geographic and time distribution of public drunkenness offences, provide a useful indication of the service system responses that are necessary to meet the variability in demand for safe places.

The Proposed Health Model design should be scalable and adjusted according to changing needs, including responding to seasonal demand variation. Locally developed solutions with engagement of local area stakeholders to determine arrangements considering demographics, timing, location and trends.

As identified above, transporting a person home or to other safe private residences should remain the preferred and default option to help intoxicated people who are low risk.

It is essential that service systems are flexible, cultural appropriate and responsive to individual needs and circumstances.

We recommend the following differentiated approach to the availability and provision of safe places.

Low demand areas

In the vast majority of LGAs (85 percent), the average weekly demand is less than three placements. These low demand LGAs are found within the Melbourne metropolitan area and across regional and rural areas of the state. We propose that low demand LGAs in the Greater Melbourne area can be accommodated by sobering services proposed for neighbouring or close by LGAs.

Our strong view is that in areas of low demand in regional and rural Victoria, the capability of the existing health system can be enhanced to enable medically supervised sobering-up placements.

A new model of care will be required for regional and rural hospitals and other health services to support delivery of sobering services in areas of low demand when it is needed.

A hub-and-spoke network approach could also connect these services to a dedicated sobering service provided in an area of high demand to ensure model fidelity and quality and safety of care. Hub-and-spoke network models are often used in the health sector to increase access to high quality care. Under this approach, one organisation will act as the ’hub’ providing a central base for activity and playing a support and coordination role for the spokes. Effective corporate and clinical governance structures and communication strategies promote and support integration between the hub and spokes.

The hub-and-spoke model is often used in rural settings, where larger regional hospitals provide clinical support and leadership to smaller nearby hospitals. This model is particularly useful for services that require a degree of specialisation or where variability in demand means a hospital cannot maintain expertise in certain services.

A hub-and-spoke approach to sobering services should be considered in regional areas to ensure hospitals feel supported in managing intoxicated clients in areas of low demand.

High demand areas

In areas of high demand, there is a lack of capacity in the existing system to offer 24-hour, flexible services to meet the nature of the expected demand. New service options must therefore be developed in order to implement an appropriate health-based response.

We consider that both permanent and temporary or pop-up health services need to be available in LGAs with high demand.

For permanent facilities providing sobering services, these should operate 24-hours a day, seven days a week with capacity to scale up services at peak times. These should be supplemented by pop-up up services responding to demand associated with specific sporting or cultural events.

Tailored, community-based services

Victoria does not have a formal health service role delineation framework. This means that individual health services are relatively autonomous in respect of the services provided to their communities. This also means that a universal approach to the state is not available and a solution for one particular locality may not work in others. In this context, we are of the view that sobering service solutions, particularly for regional and rural locations need to be developed in collaboration with the relevant local health services and communities. Such local collaboration should be an integral component of an implementation approach and be aligned to the approved intent of the reform.

Further development and consultation with each local area will be required on the appropriate location and model of care, including additional infrastructure/equipment, workforce and training needs, and security issues.

There also may be a need for place-based grants for smaller and remote regional areas which cannot readily access a nearby sobering service to develop localised solutions.

9.6 Guaranteeing coverage and availability

To analyse the potential sobering service coverage and availability we utilised geo-spatial and temporal data and advice received from the Crime Statistics Agency coupled with data and advice received from DHHS regarding existing health services, the services that they provide, and their respective locations across the state. The analysis also involved separate examination of the service locations for Greater Melbourne and regional Victoria. This enabled a better appreciation of the service response opportunities and challenges, for the higher demand locations, particularly in Greater Melbourne, as distinct from the lower demand areas in some regional and rural services.

The ERG considered that an indicative benchmark should be applied to determine potential solutions for geographic location of sobering services based on demand and existing health services and related infrastructure. It was considered that a goal of a sobering service being geographically accessible within a vehicular travel time of approximately 30 minutes should be used as a guide to determine the suitability of existing service facility locations. This means that if an intoxicated person was to be transported from the public location they are in, to a sobering services facility, that trip should not exceed approximately 30 minutes. It is accepted that this should not be a hard and fast rule but should be considered as a planning guide that would demand further analysis and consideration in circumstances where the estimated travel time would be considerably more than the 30-minute guide.

We examined the range of existing and proposed health services that could have a role in providing a sobering service. For the high demand LGAs we were of the view that the proposed Mental Health and AOD Hubs represent the most suitable sobering service option. The ERG considers the proposed hubs intended for Melbourne and Geelong public hospitals present as excellent opportunities to incorporate a sobering service function under this reform. In furtherance of this consideration, the locations of these proposed hubs were examined to determine relative proximity and suitability to meet the demand arising from community locations in Greater Melbourne and Greater Geelong.

Greater Melbourne

In Greater Melbourne, hubs are proposed for hospitals in Melbourne CBD (Royal Melbourne and St Vincent's), Western, Monash and Frankston. LGAs in Greater Melbourne were mapped to these hubs on the basis of applying the 30-minute travel guide. This analysis indicated that the hubs were well placed in terms of proximity to meet the anticipated demand, with the exception of the northern metropolitan area. This area covers the north and north east of Melbourne, which includes the LGAs of Hume, Darebin, Whittlesea, Banyule and Nillumbik.

Also included are major growth corridors to the north and north-east. Here, in the absence of a hub being established in this region, we see the opportunity to substantially expand and relocate the existing Ngwala Willumbong Sobering Service into a major sobering service catering to this part of Melbourne. The ERG recommends that sobering services should be established in each of the six new Mental Health and AOD Hubs and that the Ngwala Willumbong Sobering Service be relocated and substantially expanded to service Melbourne's northern region. This would provide for a network of sobering services that would meet the anticipated service demand and proximity guide for sobering services across Greater Melbourne.

Table 6 describes the mapping of LGAs to specific hubs in Greater Melbourne and Greater Geelong. From a demand perspective the average annual, weekly and daily caseloads for LGAs are attributed to those hubs. The Melbourne CBD demand has been evenly split between the Royal Melbourne and St Vincent's hospitals. It is considered that collaborative arrangements should exist between hubs to provide relief to hubs experiencing high demand through spreading some caseload to other hubs where travel times and other circumstances suit. However, hubs should be established to be capable of meeting reasonably predictable surge demands.

As previously described, Friday and Saturday nights represent peak demand for sobering services. In the context of resourcing and demand implications, the total weekly caseload was attributed to Friday and Saturday nights, and Saturday night alone. It is not anticipated that the weekly caseload would represent the demand for a Saturday night. However, it does give insights into what may be reasonably expected as an absolute maximum demand for a hub. It is considered that attributing the weekly caseload to Friday and Saturday nights alone would be more a more reliable and insightful indicator of demand limits. On this basis, we calculate that the daily maximum service capacity will vary between 10 and 25 contemporaneous placements, according to the anticipated demand in each location.

Table 6: Mapping of LGAs to specific hubs

	Annual cases	Av weekly	Av daily	All split between Fri/Sat	All on Saturday
MONASH					
Greater Dandenong	490				
Maroondah	136				
Casey	133				
Monash	97				
Yarra Ranges	95				
Knox	90				
Cardinia	62				
Manningham	20				
Whitehorse	71				
	1194	22.9	3.27	11.48	22.96
FRANKSTON					
Mornington Peninsula	364				
Frankston	307				
Bayside	60				
Kingston	164				
	895	17.21	2.45	8.61	17.22
St VINCENTS					
Melbourne (half)	889				
Port Phillip	347				
Yarra	319				
Stonnington	264				
Glen Eira	127				
Boroondara	75				
	2021	38.87	5.54	19.43	38.86
NORTHERN					
Hume	113				
Darebin	95				
Whittlesea	45				
Banyule	51				
Nillumbik	11				
	315	6.06	0.86	3.03	6.06
ROYAL MELBOURNE					
Melbourne (half)	890				
Moonee Valley	111				
Moreland	107				
	1108	21.31	3.04	10.65	21.3
WESTERN					
Maribyrnong	140				
Brimbank	140				
Wyndham	113				
Melton	42				
Hobsons Bay	62				
	497	9.56	1.36	4.78	9.56

	Annual cases	Av weekly	Av daily	All split between Fri/Sat	All on Saturday
GEELONG					
Geelong	322				
Surf Coast	18				
Queenscliff	1				
	341	6.56	0.9	3.27	6.56

Transition arrangements discussed later in this report should include more analysis of demand with the view to refining infrastructure and resourcing decisions for broader implementation.

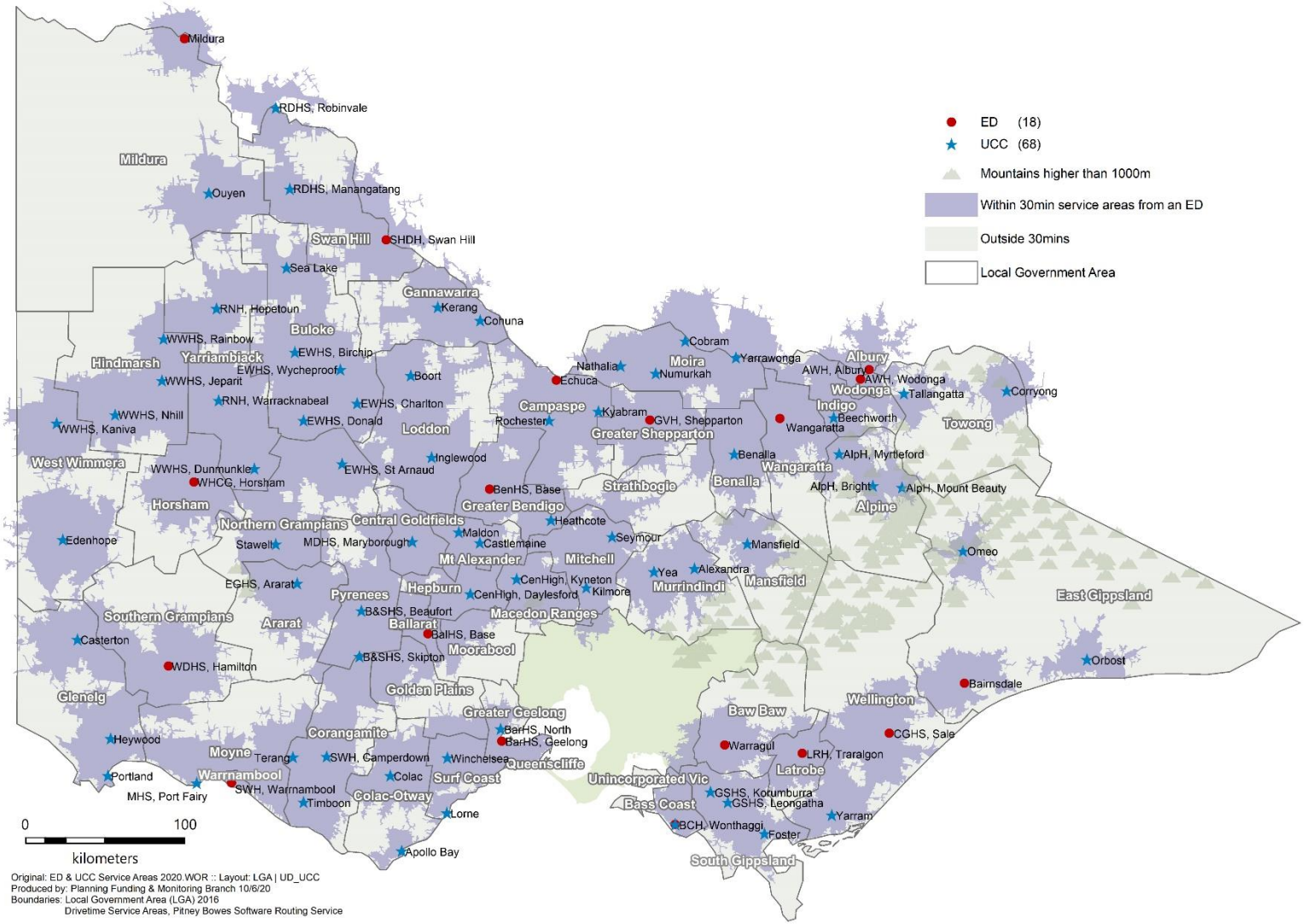
Regional and rural Victoria

It is understood that expansion of Mental Health and AOD Hubs more broadly across the state, including regional and rural locations, provide an opportunity to address sobering service needs.

We also understand from data provided to us by DHHS that many regional areas are within 30 minutes of an emergency department or urgent care centre (see Figure 5). Utilising these health networks would ensure that the vast majority of people in regional and rural Victoria would have reasonable access to a sobering service. East Gippsland and the west of Mildura are key areas that would require more localised solutions.

In summary, we believe that the Mental Health and AOD Hubs model needs to be extended to incorporate a sobering service function and that the existing Ngwala Willumbong Sobering Service be expanded to service Melbourne's northern region. This represents a solution to address the high demand locations. In time, any extension of Mental Health and AOD Hubs to regional centres should consider the incorporation of sobering services. For regional and rural locations, a range of service options exist that are achievable. The regional and rural locations are also well placed to develop sobering service solutions through collaboration between relevant local health services and communities. Such local collaboration should be an integral component of an implementation approach and be aligned to the approved intent of the reform.

Figure 5: Travel times to nearest emergency departments and urgent care centres in regional Victoria: LGA (2020)



Recommendation

39. The Victorian Government ensures intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to one of three safe place locations to sober up, including to:
    a) their home or other private residence where it is determined that the individual is at low risk and can be adequately and safely cared for by family or friends
    b) an emergency department or rural trauma and urgent care centre where it is determined the individual requires urgent medical assessment and/or care; or
    c) a health or sobering service where it is determined the individual does not require emergency care but still requires a short period of recovery and detoxification and/or cannot be cared for safely elsewhere.
40. The Victorian Government ensures that a home or other safe private residence remain the preferred and default safe place option to assist people with sobering needs. Wherever possible and appropriate, an intoxicated person should be safely cared for by family or friends in order to minimise the impost on health services. Additionally, people who reside alone should not by default be taken to a sobering service simply because they do not have someone to care for them.
41. The Victorian Government ensures the key elements of Intake, Assessment, Monitoring, Further Assessment and Intervention form the model of care for sobering services in Victoria that comprises:
    a) outreach and transport services as a key element of a model of care for sobering services in Victoria.
    b) the workforce for sobering services should be multidisciplinary and at a minimum including a health practitioner, such as a registered nurse, and reflect the profile and the needs of the population and region it serves
    c) a staff to client ratio between 1:6 and 1:8, which would be a reasonable starting point subject to detailed implementation planning for each location and any variations to a core model.
42. The Victorian Government considers modular health spaces as an infrastructure approach to trialling heath responses as part of the proposed implementation phase given that they are an increasingly accepted part of the health infrastructure mix, offering expanded capacity that can be deployed rapidly and flexibly to meet need.
43. The Victorian Government expands the Mental Health and AOD Hubs model of care to enable them to provide sobering services as part of their model of care. This may require additional government investment above that initially allocated.
44. The Victorian Government supports the re-location and substantial expansion of Ngwala Willumbong Sobering Service to service Melbourne's northern region which will require additional government investment.
45. The Victorian Government considers whether the rural trauma and urgent care centres could be an effective option for provision of sobering services, and if so, infrastructure may need to be boosted to provide dedicated sobering up placements, where required.

46. The Victorian Government enhances the capability of the existing health system in areas of low demand in regional and rural Victoria to enable medically supervised sobering up placements.
47. The Victorian Government establishes both permanent and pop-up sobering services in LGAs with high demand. The permanent services should operate 24-hours a day, seven days a week with capacity to scale up services at peak times.

9.7 Consent to medical treatment

Informed consent is considered the cornerstone of the clinical-patient relationship and a patient's right to autonomy should be respected and steps taken to ensure consent is truly informed.

The ERG has extensively considered the issue of consent in the context of receiving a service. This issue is considered above in relation to the provision of health treatment at the First Responder stage but also arises in the context of receiving a health service at the safe place options considered in this section.

Sobering services

In moving to a public health model for public intoxication, we recognise that there may be some circumstances where an individual may refuse treatment at a sobering service. This may be due to both the individual being unable to make an informed decision due to intoxication or where there is a legitimate concern expressed by the individual. For example, some Aboriginal and/or Torres Strait Islander clients may refuse to be treated at a local health facility due to distrust of mainstream services.

It is important that First Responders and sobering services establish a model of care which strongly encourages clients to use sobering services and provides a welcoming and safe environment. All necessary steps should be taken to minimise the number of individuals who may refuse treatment.

Consistent with the consent-based model we propose, our strong view is that admission to a sobering up facility should be voluntary. Providing detention powers for sobering-up centre staff may jeopardise trust and the relationship between staff and a person who needs care and treatment, including fundamentally changing the power dynamics. Furthermore, people may become apprehensive of sober-up centres where there is a possibility they will be detained against their will. Staff and management at sobering-up centres have generally expressed a reluctance to the creation of powers to detain.

Emergency departments and hospitals

Consent is required to provide medical support services to publicly intoxicated individuals unless they need emergency treatment. Health services (except in cases of emergency medical treatment) rely on an individual's voluntary engagement. Under the *Medical Treatment Planning and Decisions Act 2016*, emergency treatment is medical treatment that is necessary as a matter of urgency to:

- save the person's life
- prevent serious damage to the person's health or
- prevent the person from suffering or continuing to suffer significant pain or distress.

For individuals that continue to refuse treatment, involuntary measures may need to be taken for the safety of the person and the community. We consider that cases involving intoxicated persons refusal

of care will be rare. However, we have recommended earlier in this report that police cells will not be an option for detaining intoxicated person. Consistent with that recommendation, we are of the view that should an intoxicated person refuse treatment at a sobering service, police should not be engaged for the purpose of finding a detention solution. We are of the view that this problem should be addressed in a health setting.

We understand that the detention of involuntary people in a health context is a significant issue and will involve some level of cultural concern. We are aware that the issue of the compulsory treatment is provided for in some serious settings, for example, a provision in the *Mental Health Act 2014* that allows for detention for the purpose of treatment. Such precedents apply to the most serious circumstances and are considered a last resort option to enable critical care. We have given significant consideration to the range of risks that could exist in a sobering up setting and how they may be mitigated. We have formed the view that, if an intoxicated person does not consent to treatment and poses a serious and imminent risk to themselves or others should they leave the health setting, then a power to detain them is necessary.

We are of the view that the threshold for the power to detain should be to address a serious and imminent risk posed by intoxicated persons to their own safety or the safety of others.

As previously discussed, sobering services should be aligned to emergency departments and public hospitals under hub-and-spoke arrangements that are used in the health sector. They are particularly suited to rural locations where a comprehensive and specialised suite of health services may be less accessible. It is considered that, as a last resort, in circumstances where consent is not provided and there exists a serious and imminent risk of harm to the intoxicated person or the public, that a sobering service should be able to apply to an emergency department, public hospital or other local health service for an order permitting the detention of the intoxicated person. Such a power should be subject to strict safeguards and oversight.

Discharge

Discharge against medical advice is a small but common problem in hospitals. Clients may choose to discharge themselves if they do not agree with the treatment proposed by the hospital. Hospitals should have policies and procedures in place covering the steps that should be taken to ensure clients have adequate information regarding the risk of discharge.

In scenarios where a competent client discharges themselves and consequently suffers adverse outcomes, part of the blame for any medical negligence would be attributed to the client. The extent of this contribution would be determined based on the capacity of the client to make an informed decision at the time and documentation by the hospital of steps taken to ensure the client understood the risks.

Proposed approach

As identified above, informed consent is central to the clinical-patient relationship and to the ERG's Proposed Heath Model. Detention and the use of restraint in the context of providing health care to an intoxicated person should always occur as a last resort.

A clear framework must be developed on the use of restraint in support of the decriminalisation of public intoxication. The framework should be developed with input from clients, organisations and staff, and include a focus on continuous quality improvement to minimise its use.

The framework should consider the following elements:

- restraint is only used in line with the definition of an emergency under the *Medical Treatment Planning and Decisions Act 2016*

- hospitals require tools to ensure adequate documentation for the reason and authorisation of restraint
- clinical guidelines to support decision making for use of restraint, including guidance as to the level of intoxication which may suggest a client has lost their capacity for consent
- recognition that the client's inability to consent will be temporary, and consent may be withdrawn or change where a client has sobered to the point that they can make an informed decision
- rates of use of restriction for public intoxication are monitored and reported to appropriate oversight committees
- development of a review mechanism to assess decision making in relation to the use of restraint
- respect the rights of clients to make informed decision that may be detrimental to their health
- include proactive strategies to de-escalate aggressive situations, encourage consent for treatment or seek consent from an appropriate guardian or next of kin.

Recommendation

Consent to medical treatment

48. The Victorian Government establishes a legislative basis for medical practitioners to apprehend or detain an intoxicated individual, where they do not consent to treatment, in strictly limited circumstances.
    a) The Victorian Government defines intoxication within the legislation as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour.'
    b) The Victorian Government ensures that limits for the threshold for medical intervention with regard to someone who is intoxicated is serious and imminent risk of significant harm to the intoxicated individual or other individuals.
    c) The Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Safeguards

49. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
50. The Victorian Government ensures health practitioners are required to regularly assess the ongoing need for detention, including upon admission if detained during transport and through regular assessments of whether informed consent can be secured.
51. The Victorian Government ensures detention for the purposes of the sobering of an intoxicated person should be a last resort and is limited by appropriate safeguards.
52. The Victorian Government considers the matters highlighted in the *Restrictive Interventions in Victorian Emergency Departments: A Review of Current Clinical Practice* commissioned by the Department of Health and Human Service must be addressed.
53. The Victorian Government ensures medical practitioners exercise their powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain

and the nature of the restraint, in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006.*

54. The Victorian Government implements robust safeguards, including comprehensive legislation, regulations, guidelines, and policies and procedures on the operationalisation of the legislation. This is to ensure, for example, that medical practitioners use sedation and other chemical and mechanical restraints on intoxicated people appropriately.

55. The Victorian Government ensures that medical practitioners:

    a) maintain appropriate written records, including the reasons for the order, the period for which the person is ordered to be detained, the monitoring regime, treatment provided, restraints used and reasons, and discharge

    b) to the extent reasonably possible inform the person of the reasons for the detention and their applicable rights

    c) take reasonable steps to notify the person's nominated person, guardian or carer of their admission or detention; and

    d) provide the reasons for detainment and/or the use of restraint in writing to the person upon their discharge/release.

Independent Oversight

56. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms. This should include oversight of detention conditions and treatment of detained people, as well as use of mechanical and chemical restraints

57. The Victorian Government, in accordance with OPCAT obligations, enables the National Preventive Mechanism to have oversight when intoxicated people are deprived of their liberty, including when they are detained and/or restrained in hospitals.

9.8 Workforce requirements

Evaluations of sobering services in Australia and elsewhere highlight the need for effective workforce supports. Effective workforce supports include capacity for de-briefing, formal supervision (individual and/or group) and usual staff development opportunities. Staff employed in Northern Territory sobering services have identified that regional fora assist in building and strengthening the workforce identity, sharing of good practice and assist with skill development.

The workforce for sobering services should be multidisciplinary, at a minimum include one health practitioner such as a registered nurse and reflect the population and region it serves. Workers may include a mixture of AOD and mental health clinicians, health practitioners, community and health workers with specialist AOD or social and emotional wellbeing skills, cultural support workers, peer workers and security services. The staffing profile should be considered within the specific context of the service, with considerations for any implementation challenges.

Safety for the workforce must remain paramount, including at sobering services and during outreach, which need careful planning and support. Safe work practices for staff and volunteers are critical within sobering services, especially at night-time or in volatile situations. Most sobering services, both in Australia and internationally, do not make use of security staff. Given the nature of services, we consider that staff should have adequate training in de-escalation, cultural competency and the

general needs and behaviours of their client cohorts. Within hospital settings, existing security arrangements should be capable of meeting the needs of any “bolt on” services associated with hospitals and emergency departments.

The *Victoria’s Alcohol and Other Drugs Workforce Strategy 2018-2022,* while focused on alcohol and other drug services, provides a useful framework to assess these challenges. The strategy considers availability, capabilities, diversity, worker health and safety, leadership and collaboration, and person-centred integrated care as relevant considerations.

10. Stage 4: Health and social care pathways

Key points

- A significant minority of people who present intoxicated in public more frequently are likely to be experiencing complex health and welfare challenges that are contributing to their drinking patterns
- A key element of an effective public health approach to public intoxication is access to follow-up or ongoing support. Service pathways including AOD, mental health, Aboriginal social and emotional wellbeing, family violence, and homelessness services could be supported by 24-hour support lines, local arrangements and/or a dedicated service navigator
- Targeted approaches to support particular individuals and groups to address underlying issues that contribute to drinking patterns is a key component of a health-based approach.
- There are major gaps in AOD services for Aboriginal and Torres Strait Islander people.
- A specific adult AOD program under the Wotha Daborra model will be established providing an Aboriginal-specific adult withdrawal and rehabilitation service which aims to provide a culturally responsive, family supported, place-based response to alcohol and other drug use in other Aboriginal communities
- New Aboriginal Social and Emotional wellbeing teams being established under the Royal Commission into Mental Health include AOD expertise with team functions expanded to support the new public health reform for Aboriginal and Torres Strait Islander people where appropriate.

A key element of an effective public health approach to public intoxication is access to follow-up or ongoing support. As outlined in the data Section in Part 1, a significant minority of people who present intoxicated in public more frequently are likely to be experiencing co-occurring wellbeing or social challenges. This points to the need and imperative to support the broader health and wellbeing needs of the high intensity cohort of people experiencing public intoxication, who very often experience quite complex health and welfare challenges that are contributing to their drinking patterns.

Targeted approaches to support particular individuals and groups to address underlying issues that contribute to their drinking patterns is a vital component of a health-based approach to public intoxication that seeks to minimise the need for tertiary interventions.

We make a number of observations and recommendations designed to support individuals to access follow-up or ongoing support after they have left a place of safety following an occurrence of being found intoxicated in public, including:

- **AOD, mental health, Aboriginal social and emotional wellbeing, family violence, and homelessness services are the core potential service needs explored in this paper –** these are consistent with the government's August 2019 announcement. Other services are likely to be identified as worthwhile pathways for inclusion at the local level and through the proposed transition phase
- **safety and non-judgement will make pathways attractive –** all services and personnel involved in responding to public intoxication should maximise Aboriginal, cultural, linguistic,

gender and sexuality safety (particularly in a manner responsive to their local area)**.** This will increase the likelihood of effective engagement, trust-building, disclosure and service uptake, and is consistent with agreed design principles for the public health model.

Shame and stigma are often felt by people experiencing issues such as acute intoxication, addiction, mental health problems, family violence, homelessness or poverty. A public health model for public intoxication should recognise the real impact of these phenomena, eliminating them from service practice without assuming their effect can be nullified.

- **all core personnel and services should be able to identify and respond to need –** this includes undertaking health, safety and wellbeing assessments, and taking appropriate action. Core personnel are outreach, transport and sobering services workers, as well as Victoria Police (which has an established e-referral system) and Ambulance Victoria.

  While each geographic area should have minimum capability, at the local level, some personnel or service elements will be better placed to undertake assessment, information and referral activities. This may be for operational reasons – e.g. critical demand pressures on police or ambulance services – or because of enhanced cultural safety or practice specialisation within other elements of the service model.

  In relation to AOD needs, it is recognised that some people use alcohol with other drugs, (e.g. illegal substances or medication prescribed or otherwise). The identification of people who are intoxicated in public – and therefore in scope for the public health model – will be based on observation and engagement; it will not be possible to ascertain precisely what someone has consumed. The public health model will need to incorporate poly-substance responses into all elements, noting that this may alter health, safety or wellbeing assessments and therefore the support provided to a given client

- **engagement and trust-building is the first priority –** the potential diversity of need is significant, but clear information may be challenging to obtain while a person remains intoxicated. For a voluntary service the focus should be on maintaining safety and trust, minimising undue pressure on clients, and avoiding escalation of risk.

  This will be particularly true as Victoria's new approach to public intoxication becomes known and established in communities across the state

- **identification of need should be based on engagement, observation and handover, and may be ultra-brief –** a flexible and adaptive approach to identifying need will be required to reflect the variable service settings, personnel and duration of interactions. For example, where a person is being transported home instead of to a sobering service, only information provision (e.g. printed, text-message or online information, if safe to provide) may be feasible.

- **needs should be triaged pragmatically and collaboratively with a client, wherever possible –** a service oriented around public intoxication should not necessarily prioritise AOD or even mental health needs (unless these are acute, in which case transport to hospital may be necessary). Finding a place of safety – for example for someone who is homeless or escaping family violence – may well be a person's primary interest.

  The triaging of any support needs should ultimately be determined by the client; this may be influenced by the client's own priorities or previous experience with services, which should be respected and drive decision-making

- **service pathways could be supported by 24-hour support lines, local arrangements and/or a dedicated service navigator –**

  24-hour support lines

Public intoxication services are likely to experience the overwhelming majority of demand outside of usual business hours. Where a health, safety or wellbeing need is identified and the client agrees to some form of further action – e.g. receipt of information, passive referral, warm referral – a number of 24-hour support lines will be available, including:

- AOD: Directline: screening, intake and referral for AOD support (including Aboriginal AOD services)
- Mental health services: Psychiatric triage – mental health assessment and referral (area-based)
- Homelessness: Salvation Army Crisis Services (out-of-hours)
- Family Violence: Safe Steps Family Violence Response Centre
- Djirra: Family violence support for Aboriginal and/or Torres Strait Islander people.

Each of these services has the benefit of being a state-wide, 24-hour service with specialist expertise.

Local arrangements – outreach and sobering services

Local outreach and sobering services may prefer to establish direct connections with services at the local level. This approach may be most feasible and appropriate:

- for sobering services, which could accommodate people overnight and then, once a person has sobered up, support them to access critical services (especially homelessness and family violence, and potentially also residential withdrawal)
- for Aboriginal and/or Torres Strait Islander Victorians seeking access to specialist support via a local Aboriginal community-controlled organisation
- to help reconnect people with any existing, positive service or practitioner relationships (if volunteered by the client).

Dedicated service navigation function

Given the diversity of support needs and service pathways potentially required for higher-intensity clients, we consider a navigation service (likely telephone-based) that would work with on-the-ground services to undertake service referral and coordination functions. This could allow outreach and sobering services to focus on immediate demand (transport, safety and engagement) rather than 'back office' functions such as arranging service pathways. If recommended, this function would require effective information-sharing and coordination protocols with existing 24-hour support lines and other intake services.

A key factor in whether this kind of service is needed will be the gap between identified follow-up need and actual uptake by clients. It may be that the immediate post-intoxication period is not a valuable window of opportunity for engaging people (the experience in hospital emergency departments varies in this regard). This could be tested as part of the transition phase, with a future recommendation made about the need for a service navigation function

- **a bespoke, comprehensive workforce support package could be developed to support this model of care and ensure consistent minimum standards –** we consider that a bespoke practice and training package – including clinical, social and operational components – be developed to support both minimum and specialist capability. The training package should be adaptive, incorporating lessons identified through the proposed transition phase.

Recommendation

58. The Victorian Government ensures that a comprehensive service system is capable of supporting the broader health and wellbeing needs of the high intensity cohort of people, who very often experience quite complex health and welfare challenges that are contributing to their drinking patterns.

10.1 Investment in Aboriginal alcohol and other drug services

In moving to a public health model for public intoxication, demand for AOD services is expected to flow from new outreach teams, sobering services, and First Responders such as Victoria Police and paramedics. In the context of Ms Day's death in custody, and the over-representation of Aboriginal and/or Torres Strait Islander people in both the high and low intensity cohorts of people placed in custody for public drunkenness offences, there is high community expectation for the delivery of Aboriginal-specific sobering-up capacity and Aboriginal-specific AOD drug treatment services to support these reforms deliver improved outcomes for the community.

DHHS currently funds a range of alcohol and other drug activities for Aboriginal and/or Torres Strait Islander Victorians, including approximately 90 Aboriginal AOD workers who provide assessment, counselling, care coordination, group work including therapeutic cultural groups, health promotion, education, information, referral, advocacy and liaison services.

However, gaps in AOD services for Aboriginal and/or Torres Strait Islander Victorians remain, including the lack of a dedicated adult AOD program for Aboriginal Victorians, poor youth diversion pathways and the need to expand prevention and harm reduction approaches to drug use of primary concern to the Aboriginal community, such as alcohol and ice. A Victorian based service would enable clients to undertake rehabilitation, whereas in existing circumstances they are often prevented from doing this due to personal circumstances such as being subject to Community Corrections Order, parole, bail and involvement in the child protection system.

DHHS has provided financial support to the Koori AOD Withdrawal and Rehabilitation Consortia to establish a business case for a new and culturally informed model of care for AOD services for the Victorian Aboriginal Community, known as the Wotha Daborra model. The business case supports the development of Victoria's first Aboriginal-specific adult withdrawal and rehabilitation service which aims to provide a culturally responsive, family supported, place-based response to alcohol and other drug use in the Aboriginal community. It will offer holistic support and a wrap-around response, which includes AOD treatment, as well as access to life skills, parenting skills, health care, family therapy, education, training and employment, and housing options for individuals and families. Clients will experience improved social and emotional wellbeing by integrating cultural values, spirituality and healing with a range of evidence-based treatment interventions.

The Wotha Daborra model aligns with the upcoming expansion of multidisciplinary Social and Emotional Wellbeing teams in ACCHOs as part of recommendations from the Royal Commission into Victoria's Mental Health System.

During the next five years, social and emotional wellbeing teams will be expanded across the state and provide integrated care which addresses clients' social and emotional wellbeing. Social and Emotional Wellbeing teams are expected to include a range of specialist expertise as relevant to local community needs, including AOD workers.

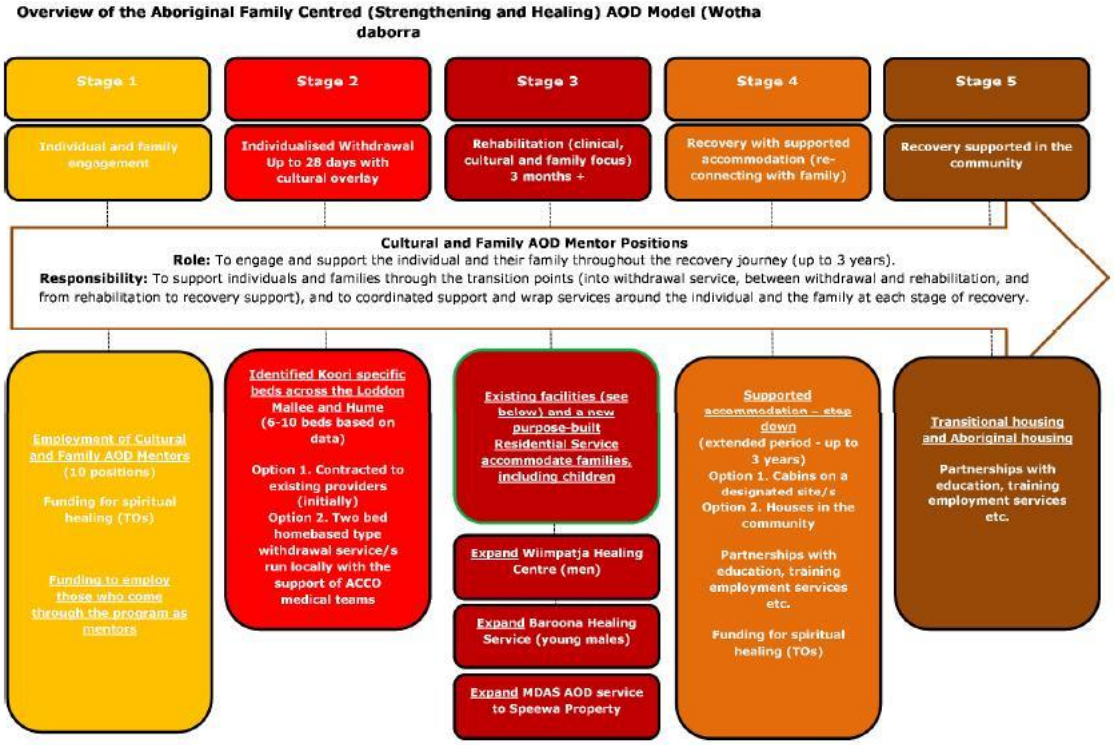
There are opportunities to leverage off the government's commitment to invest in Social and Emotional Wellbeing teams to also achieved improved outcomes for Aboriginal and/or Torres Strait

Islander Victorians engaged in public intoxication. A strong commitment to incorporating alcohol and other drug workers into the new Social and Emotional Wellbeing teams, with practices aligning to the family centred, traditional values approach in the Wotha Daborra model, will provide a high quality referral option for Aboriginal and/or Torres Strait Islander sobering service clients to address their alcohol and mental health needs.

DHHS continues to work with the consortia to develop and cost the model for government's consideration.

The ERG recognises that reforms to public intoxication also requires the development of pathways into treatment for clients who are identified as having problematic alcohol use (that is, the high intensity cohort).

Figure 6: Wotha Daborra model



Recommendation

59. The Victorian Government establishes a specific adult AOD program for Aboriginal and/or Torres Strait Islander Victorians prior to the end of the implementation phase, with Wotha Daborra considered for further development as part of this process.
60. The Victorian Government ensures that all Social and Emotional Wellbeing teams include AOD expertise (a position outlined by the Royal Commission into Victoria's Mental Health System) and that the role of the teams be expanded to support the government's public intoxication reforms for Aboriginal and/or Torres Strait Islander Victorians where appropriate.

11. Stage 5: Broader prevention strategies

Key points

- Broader prevention strategies to address the underlying causes of high-risk drinking and harm minimisation approaches form a key part of a public health approach to public intoxication
- Public awareness campaigns focused on primary prevention health initiatives that relate to the prevention of public intoxication play an important role in a public health approach
- Community strengthening programs are important to support local communities and specific groups and their leaders to develop tailored place-based solutions, particularly in high demand areas.

In addition to measures to address the longer-term needs of people experiencing problematic drinking, we consider that a range of broader prevention strategies form a key part of a public health approach to responding to public intoxication.

Victoria's *Public Health and Wellbeing Plan 2019-23* sets the direction for action across state and local government, the health and wellbeing sector and the community at large to achieve sustained improvements in the health and wellbeing of all Victorians.

The plan identifies a reduction in harmful alcohol and other drug use as one of 10 priorities for achieving the objects of the *Public Health and Wellbeing Act 2003*, and specifically targets:

- changing risky drinking cultures and delivering environments that support low-risk drinking
- better outcomes for those who access treatment, reducing harm (such as overdose, drug-related illness) and improving social outcomes (such as employment, stable housing and family reunification)
- improved capability of primary care providers to assist people to manage alcohol and other drug-related issues before treatment is required or complexity develops
- increased capability in all service systems including mental health, housing, child protection and family violence to assist people with alcohol and other drug-related issues.

We recognise that VicHealth as an independent statutory authority also plays an important role in health promotion. 'Preventing harm from alcohol' is one the five strategic imperatives in VicHealth's three-year Action Agenda for Health Promotion, with key activities including working with partners in state and local government, universities and community and sporting groups to highlight the harms of alcohol, the benefits of drinking less and the evidence for why and how. In the four years between 2019 and 2023, VicHealth's aim is to prevent harm from alcohol products with a focus on changing risky drinking cultures and enabling environments to support low-risk drinking.

This includes:

- supporting organisations and local communities to design interventions for high-risk drinking social worlds
- providing councils with tools and evidence to add value and support their efforts to reduce alcohol-fuelled harm at the local level

- providing legal policy capacity to the alcohol harm-prevention sector
- engaging the public and stakeholders to harness community support for better regulation of alcohol marketing and sales
- consulting with its advisory body, the VicHealth Alcohol Taskforce, and other stakeholders to identify priority research required to inform our future strategies and deliver this with research partners.

Clearly, many of these important initiatives play a critical role as part of a comprehensive public health approach to public intoxication, including by addressing the underlying causes of problematic drinking and minimising its potential impact in public spaces. While the focus of our work has been on public intoxication, we also wish to acknowledge the significant impact on the community of problematic drinking in private, including the role that alcohol plays in family violence as well as the broader health impacts of harmful drinking. In this respect, broader prevention strategies play an important role in minimising the dangerous consequences of both public and private intoxication.

We also make specific reference to the fact that operators of licensed premises have a range of legal and regulatory obligations relating to the responsible service of alcohol and interactions with people who may be intoxicated and/or disorderly. The ERG considers that liquor licensees' have an important role to play with respect to avoiding, as well as minimising, the risks associated with public intoxication, particularly given the majority of public intoxication occurs in entertainment precincts on weekends and during one-off events such as festivals.

In addition to specific health promotion activities, we recognise that a range of other strategies can contribute to addressing the underlying causes of public intoxication and reducing harm in high demand areas. These include:

- supporting people experiencing multiple and intersecting problems, such as homelessness, drug dependency and mental health (as discussed throughout this report, including in Stage 4: Health and social care above); and
- community strengthening programs to support local communities and specific groups and their leaders to develop tailored place-based solutions to the prevention of public intoxication, particularly in high demand areas.

Recommendation

61. The Victorian Government continues to support and expand where necessary public awareness campaigns focused on primary prevention health initiatives that relate to the prevention of public intoxication, including the work of VicHealth.

12. Implementation considerations

Key points

- To ensure that the failures that occurred when other jurisdictions decriminalised public drunkenness do not occur under these reforms, great attention will need to be given to their implementation
- In light of the complexity involved in the development of the Proposed Health Model a phased implementation over two years is appropriate. This will enable the model to be trialled and state-wide service infrastructure put in place before full decriminalisation takes effect
- Two new governance arrangements are important for effective implementation including: an implementation office to drive the operationalisation of the model and a specialist oversight committee to ensure the implementation and ongoing operation of the model reflects the intent of these reforms
- A key task during implementation will be to ensure that cultural safety considerations are at the front and centre of the design and operation of all service responses
- As highlighted throughout our report, an effective health-based response necessitates appropriate resourcing of all components of the model that reflects the essential interdependency of the Proposed Health Model.

The decriminalisation of public drunkenness is a significant reform that requires major cultural and service change to the way First Responders and health services support intoxicated people. Successful implementation of any reform is a major challenge for government.

We are especially concerned to ensure that the health-based model outlined by the ERG is implemented in a way that is consistent with the reform's intended purpose. As identified in Section 5: Experiences of decriminalisation in other of this report, experience in other Australian jurisdictions demonstrates that decriminalisation of public drunkenness without the necessary health system responses in place can and has led to unintended and significantly detrimental consequences.

This section outlines a number of key considerations relating to the effective implementation of our proposed reforms.

12.1 A phased transition

In light of the scale and complexity involved in the development of a health-led response to public intoxication, we consider that a phased implementation approach would be the most practical and effective way to transition from the current justice-based model of public intoxication. We understand that a 24-month transition period following the passage of legislation decriminalising public drunkenness would be required for the public health model outlined in this report to take full effect.

We recognise that this is a long period of time, particularly given the impacts of the existing justice-based approach and clear imperative for urgent change. However, given the complexity of the transition involved, it is essential that service system responses are capable of delivering the intended reforms. In this respect, a phased approach is designed to ensure the success of the public intoxication reforms by:

- supporting trials of sobering services in areas of high demand to test different models of care to inform a state-wide roll out
- enabling co-design to occur with the Aboriginal communities, CALD communities, local communities, organisations, workforce and people with lived experience on matters – such as where sobering services are located and the model of care they provide
- providing time to develop a detailed statewide plan for sobering services which establishes the optimal design and investment for a network of sobering services throughout Victoria, taking into account models of care, capital investment, workforce arrangements and any service gaps
- reflecting current limitations arising due to the coronavirus (COVID-19) pandemic and provide time for affected health services to consider and support the reforms. Notwithstanding the current and likely continuing impacts of coronavirus (COVID-19) on the capacity of DHHS and the health sector, the implementation of this important reform must remain an ongoing government priority
- providing time to develop any detailed legislative, regulatory or policy changes necessary to ensure the success of the reforms (i.e. identify any unintended consequences or unexpected issues)
- establish a robust quality and safety framework for the care of intoxicated individuals that covers police, ambulance and health and sobering services; and
- enabling time to develop appropriate governance, resourcing and commissioning of services.

Recommendation

62. The Victorian Government ensures the Proposed Health Model is phased in over a 24-month period to enable an adequate transition from the current justice-based response to public intoxication.

12.2 Trial sites

Under the phased implementation approach, we recommend the immediate establishment of a large, multi-site, multi-model trial of various health responses to help inform the development of the statewide scheme. Trial sites should commence in some form within six months of the passage of legislation to decriminalise public intoxication.

Under this approach, three to four areas should be selected that represent suitably varied volume and intensity of demand, geographic and social characteristics, and with a relative advanced state of readiness. For example:

- the Melbourne CBD represents high volume and both low and high intensity metropolitan needs
- Dandenong represents high volume and high intensity outer metropolitan needs; and
- Mildura represents moderate volume and high intensity rural needs with focus on support for the local Aboriginal community.

During the trial phase, trial sites should have de-facto decriminalised arrangements in place so that no person will be placed in a police cell for public intoxication. We recognise that this will require agreements to be sought with Victoria Police and other relevant services and agencies at a local level not to exercise current public intoxication powers given that Victoria Police would still retain the legal authority to take enforcement action up until decriminalisation takes effect. Local agreements should

include clear written protocols and rapid data monitoring in place to ensure ongoing assessment of the implementation of the trial sites (discussed further below under Ongoing monitoring, evaluation and adaptability).

Outside of the identified trial sites, during the transition phase Victoria Police would still be empowered to lodge people in a police cell if there were no other option available, but we strongly recommend that no fines should be issued, nor charges laid in the event that detention in a police cell is deemed absolutely necessary. Furthermore, Victoria Police should be encouraged to give effect to the intention of this reform by broadly practising aspects of the reform including working collaboratively with outreach and other alternate First Responders, utilising alternate safe places for intoxicated persons and use of police cells for incarceration only as a last resort.

As expanded on in more detail below, dedicated governance and implementation arrangements will need to be established to provide intensive oversight and accountability. This would help maximise good practice and learning.

Recommendation

63. The Victorian Government establishes at least three trial sites during the 24-month transition period to inform the development of the state-wide implementation of the ERG's Proposed Health Model.

12.3 Governance arrangements

We are especially keen to see the development of strong governance arrangements to ensure the effective coordination and oversight of the ERG's Proposed Health Model. While we assume that existing performance and governance arrangements for health and emergency services and police responses within DHHS and DJCS respectively will continue to monitor the operational aspects of the reforms, we consider that additional governance measures will be required to ensure success. This is especially the case given the importance and complexity of the proposed reforms and the fact that they span across both DJCS and DHHS. Both departments have a considerable role to play to provide the commitment, expertise, dedicated resources and collaboration required to deliver the systems and cultural change necessary to achieve the intended outcomes.

The roles of implementation and oversight are two distinct functions that should be undertaken under separate governance arrangements. Both the Royal Commission into Family Violence and the Royal Commission into Victoria's Mental Health System have highlighted that a degree of independence from the day to day operations of departments and service delivery agencies is needed to implement and embed major reforms.

We consider that two new governance mechanisms, within the existing frameworks at DHHS and DJCS, should be established to ensure successful implementation of the Proposed Health Model. In finalising the establishment details for these governance mechanisms, further consideration of the extent of independence required should occur.

Reform implementation office

A separate implementation office should be established to operationalise the public intoxication reform agenda on a day-to-day basis. Appropriate governance arrangements would need to be established

between DJCS and DHHS to ensure delivery of initiatives within each portfolio, such as a Memorandum of Understanding (MOU). The functions of the implementation office should include:

- designing, commissioning and delivering the new sobering services
- building new alliances and collaborative partnerships between key stakeholders at the local level
- early and regular data analysis, including the monitoring of any adverse consequences associated with implementation
- early and regular implementation reporting.

We consider that the implementation office could be modelled on Mental Health Reform Victoria, although the office need not necessarily be a separate administrative body. The entity should be time-limited and established over a short timeframe to cover the initial implementation phase of the reforms (approximately two to three years). This would cover:

- development and delivery of initiatives during the trial period, including supporting evaluation of the trials
- roll out of services throughout the state once decriminalisation officially commences and activities transition into standard department processes; and
- support the oversight committee (see below) and provide regular reports on implementation.

Specialist oversight committee

We consider that a dedicated oversight committee should be established to oversee the overall implementation of the decriminalisation of public intoxication and establishment of the Proposed Health Model. The primary function of the oversight committee is to ensure that implementation is consistent with and gives effect to the proposed reforms and service system models as identified in this report.

The entity should be a committee comprised of key representatives. The entity would need to include representation/partnerships with the Aboriginal community and CALD community, and adhere to the principles of self-determination.

The oversight committee role could include:

- defining the data and information needed to ensure departments and service delivery agencies can effectively account for their actions in decriminalising public drunkenness and establishing a new public health model
- maintaining regular surveillance and review over the implementation and delivery of public intoxication initiatives to ensure their success; and
- reporting regularly to government on the status of the reforms and make recommendations on future actions required to ensure the desired outcomes are achieved.

The entity should be time-limited but established over a longer timeframe to ensure the reforms are effectively embedded into standard service operations well beyond the transition period. This would cover:

- oversight of the implementation phase and assessment of the effectiveness of the two-year trial period, including making recommendations to government on additional measures required to support full roll-out; and
- oversight of the initial stages of decriminalisation and ensure reforms are successfully embedded into standard operational practice.

The entity should be independent from departments and report directly to the Attorney-General and the Minister for Health or Minister for Mental Health.

Recommendation

64. The Victorian Government establishes a dedicated implementation office to operationalise the public intoxication reform agenda.

65. The Victorian Government establishes a dedicated oversight committee to oversee the overall implementation of the public health approach to public intoxication and to ensure that implementation is consistent with, and gives effect to, the intention of the proposed reforms.

12.4 Ongoing monitoring, evaluation and adaptability

During the transition phase, we recommend that a range of data sources be collected and analysed in order to monitor the trial sites and inform the statewide roll out of the Proposed Health Model. Monitoring of the implementation of the decriminalisation of public intoxication is consistent with recommendation 85 of the Royal Commission into Aboriginal Deaths in Custody. Possible data may include recognising that further consideration and collaboration is required among relevant agencies to develop a full set of data requirements. Possible data sources include:

- any changes in demand for emergency services, including Victoria Police and emergency departments
- reporting on the use of the additional statutory power, including the frequency of its use and the characteristics of people who are detained and/or provided with transport; and
- any shift in the enforcement of more serious offences (such as offensive conduct) and exercise of other police powers (such as move on powers).

Comprehensive data analysis will be imperative to track the impact of the reforms. Monitoring and evaluation of the response should include working with DHHS, DJCS, the Crime Statistics Agency and Victoria Police.

We also consider that there should be a statutory review of the decriminalisation of public drunkenness. This could also consider Aboriginal-led data analysis to track the impact of the reforms, consistent with the *Victorian Aboriginal Affairs Framework 2018-2023*. Any such accountability measures should be accompanied by publicly accessible data, as identified earlier in this report.

Delivering a culturally safe response

Monitoring and evaluation of decriminalisation and the effectiveness of justice services in addition to the wider health response should be underpinned by the principles of self-determination and cultural recognition outlined in *Burra Lotjpa Dunguludja – The Aboriginal Justice Agreement Phase 4* (AJA4) and the *Koori Cultural Respect Framework*. AJA4 promotes progressing self-determination towards a justice system which values, promotes and requires greater involvement of Aboriginal communities in decision-making, program design and delivery which in turn results in culturally safe and appropriate initiatives. The *Koori Cultural Respect Framework* works alongside the *Koori Inclusion Action Plan - Yarrwul Loitjba Yapaneyepuk – Walk the Talk Together*. The framework was established to achieve fundamental changes to DJCS's practices, planning and policies in order to be responsive to the

cultural needs of Koori people in addition to ensuring staff have the knowledge and skills to deliver services in a culturally competent way.

A health model that is culturally safe should be developed and further evaluated in consultation with the Aboriginal Justice Caucus and other Aboriginal stakeholders.

Recommendation

66. The Victorian Government works with affected communities, including Aboriginal, Sudanese and South Sudanese communities to develop an evaluation framework including outcomes, reporting by agencies and services, provision of data to affected communities and the involvement of affected communities in the governance model.
67. The Victorian Government undertakes a statutory review of the reforms related to decriminalisation of public drunkenness.
68. The Victorian Government develops a monitoring and evaluation framework in consultation with relevant stakeholders including representatives from Aboriginal and/or Torres Strait Islander and CALD communities.
69. The Victorian Government ensures that Aboriginal Community Controlled Organisations evaluate the cultural appropriateness of the implementation and operation of the reforms.

12.5 Cultural safety framework

As identified earlier in this report, establishing an effective health-based response to public intoxication will require a cultural shift not only in the characterisation of intoxication as a public health rather than a law enforcement issue, but also in the way in which all First Responders – whether justice or health-based – support a person who is intoxicated in public.

Establishing a culturally safe and appropriate public health model is a critical aspect of an effective response. This is particularly relevant for Aboriginal and/or Torres Strait Islander people and people in the Sudanese and South Sudanese community, for whom public intoxication has a disproportionate impact.

In this section, we discuss key considerations relating to cultural safety and competence across both the health and justice systems.

Cultural safety in the health system

The DHHS Aboriginal and Torres Strait Islander cultural safety framework was developed to help DHHS and mainstream Victorian health, human and community services to create culturally safe environments, services and workplaces. The model is designed to guide DHHS and mainstream organisations as they develop strategies, policies, practices and workplace cultures that address unconscious bias, discrimination and racism

Aboriginal and Torres Strait Islander cultural safety is defined as an environment that is safe for Aboriginal and/or Torres Strait Islander people, where there is no assault, challenge or denial of their identity and experience. Cultural safety is about:

- strategic and institutional reform to remove barriers to the optimal health, wellbeing and safety of Aboriginal and/or Torres Strait Islander people

- individuals and organisations ensuring their own cultural values do not negatively impact on Aboriginal and/or Torres Strait Islander people. This includes addressing unconscious bias, racism and discrimination, and supporting Aboriginal and Torres Strait Islander self-determination
- individuals, organisations and systems ensuring self-determination for Aboriginal and/or Torres Strait Islander people. This includes sharing power (decision-making and governance) and resources with Aboriginal communities. It is especially relevant for the design, delivery and evaluation of services for Aboriginal and/or Torres Strait Islander people.

Figure 7: Cultural safety in the health system

Cultural safety in Victorian public hospitals

From 1 July 2020 Victorian public hospitals are expected to address eight domains of cultural safety. The introduction of the new governance approach to cultural safety stems from a 2016 review into Victorian hospitals' efforts to improve the cultural responsiveness and cultural safety for Aboriginal and/or Torres Strait Islander people.[18] For many Aboriginal and/or Torres Strait Islander people hospitals had been sites of trauma, they had not been "places of healing or where you got better". In providing a culturally safe environment, the review noted the following:

- **leadership and commitment –** at the Board, CEO and executive level is a necessary though not sufficient factor in enhancing culturally responsive care and cultural safety so that hospital staff and the Aboriginal community are enabled and experience change
- **relationships with ACCHOs –** are a necessary though not sufficient factor to guaranteeing culturally responsive care and cultural safety for Aboriginal community members. They provide value in hospitals accessing local cultural knowledge, supporting the AHLO and building cultural competency/safety in the hospital
- **AHLOs –** are deemed critical to enhancing culturally responsive care and ensuring the cultural safety of clients. However as critical roles within the hospital experience and as bearers of important knowledge and expertise, AHLOs mostly feel undervalued and neglected. AHLOs are the subject and object of community trauma and as such their roles are highly stressful and stress leave was common. Without sufficient support, legitimacy and acknowledgement of these roles,

[18] Social Compass (2016) Improving Cultural Responsiveness of Victorian Hospitals Final Report

culturally responsive care and cultural safety become highly vulnerable for Aboriginal and/or Torres Strait Islander clients

- **a welcoming environment –** is important and Aboriginal and/or Torres Strait Islander people place great importance on the display of flags outside the hospital and Acknowledgement of Traditional Owner plaques and local Aboriginal and/or Torres Strait Islander artwork inside hospitals. This has the effect of enabling people to feel they are still connected to land, community and culture. However, they can also feel tokenistic if the service system does not support them
- **cultural safety training –** is important, however there is no evidence of particular standards that programs need to meet, though most hospitals have a preference for local providers. The results of such training are only anecdotal as there was no evidence[19]
- **rigorous monitoring or reporting –** is not conducted at the hospital or statewide level for cultural responsiveness or cultural safety. The mechanisms for reporting that are in place are ad hoc, non-mandatory and provide an incomplete story at the sector level with regard to cultural responsiveness or cultural safety.

The role of the AHLOs is seen as key to achieving culturally safe services. Overall, the review into cultural safety at hospitals found that increasing the support and capacity of the AHLOs would have the biggest impact. While there has been considerable improvement in expanding the number of AHLOs and increasing support for their roles in organisations, problems still remain.

The 2016 review noted many AHLOs were not available due to stress leave, Sorry Business and illness. All AHLOs expressed that they found their roles deeply challenging, often feeling under-valued, under-resourced and overburdened by community need and community trauma. This was mostly due to a perceived inability to meet the demand for their services, lack of recognition of their role and expertise, and in working Monday to Friday 9am to 5pm not being present at the hospital when most clients present (after hours and on the weekend).

This latter point regarding Aboriginal and/or Torres Strait Islander hospital staff availability is critical when considering the needs of a sobering service where most demand is expected to fall after hours. The review noted the following proposals from community to address this issue including using third-party (Aboriginal community) agencies to deliver on-call AHLO equivalent services after-hours and establishing a locum AHLO pool.

Case Study: Bairnsdale regional health cultural safety initiatives

"They just make you feel welcome and have trained Aboriginal staff"

Bairnsdale Regional Health Service is located on the lands of the Gunaikurnai people. Aboriginal and/or Torres Strait Islander people make up 3.2 percent of the regional population (1,332 persons).

The hospital is seen as a leader in cultural safety and has successfully established core elements of a culturally safe service, with strong CEO leadership, integrated health services, a large Aboriginal staff and an Aboriginal employment plan.

A 2016 review into cultural responsiveness of Victorian hospitals noted the success of Bairnsdale's Aboriginal health program and community engagement, attributed to a combination of committed leadership and highly committed, community connected and capable ACHOs. The local Aboriginal

[19] Note the National Aboriginal Community Controlled Health Organisation has developed standards for cultural safety.

community itself noted that Bairnsdale had not been known for its inclusive attitudes in the past and acknowledged the work underway to change attitudes both within the hospital and more broadly in the community.

"The town has come a long way. Staff and community involvement has come a long way"

Elements supporting a culturally safe environment at Bairnsdale include:

- long standing relationship with Gippsland and East Gippsland Aboriginal Cooperative and developing relationships with other local Aboriginal health organisations
- footprints designed by a local Aboriginal artist show the way to the Aboriginal Meeting and Resource Room; and the Blue Wren (a culturally significant icon) is now a well-known and recognised symbol of the hospital
- the hospital pharmacy providing self-funded medication to all discharged Aboriginal clients
- monthly collaborative meetings with local ACCHOs
- cultural training and information for all staff
- policies and procedures to identify and support Aboriginal clients.

The allocation of resources to establish the Warrawee Room – a dedicated space for Aboriginal clients, family and AHLOs to meet in comfort – has been critical in making Aboriginal staff and clients feel welcome. Additional physical elements such as Aboriginal flags and gardens also support this.

The hospital tracks their improvement through the use of continuous quality improvement tools and holds annual meetings to monitor progress and ensure the tools is utilised through the service to assess cultural safety.

Source: Social Compass (2016) *Improving Cultural Responsiveness of Victorian Hospitals Final Report*

Funding for Aboriginal and/or Torres Strait Islander cultural safety

The Aboriginal WIES loading is a key policy lever for improving Aboriginal and/or Torres Strait Islander outcomes from hospital care. The WIES (or Casemix) funding model is the mechanism used to fund the treatment of admitted clients in public hospitals. It is an activity-based funding approach which allocates a payment to hospitals for each client treated. This model accounts for approximately 60 percent of all funding provided to public hospitals.

In 1998, a 10 percent loading per Aboriginal and/or Torres Strait Islander client was introduced, which was increased to 30 percent in 2004. The loading was meant to cover both the cultural safety costs and the excess clinical costs for Aboriginal and/or Torres Strait Islander clients which are not fully covered by the Activity Based Funding model. In 2017-18, approximately $20 million was spent on this loading.

A review of this funding in 2018 demonstrated that the WIES loading was not achieving its goal to promote and embed cultural safety in health services. Few hospitals were found to have provided all the critical cultural safety elements and many hospitals report employing few AHLOs, especially after hours (when most Aboriginal and/or Torres Strait Islander clients are admitted), or within mental health wards.

Across the past few years, the Statement of Priority process (the establishment of priority actions and deliverables with health service boards) has endorsed health services to undertake the development

of Reconciliation Action Plans as promoted via Reconciliation Australia. A Reconciliation Action Plan formerly developed should occur via partnership with the local Aboriginal community, services and Elders as an advisory body. Enhancing such partnerships as continuous improvement is required for culturally safe services.

Following the 2018 review, a range of recommended reforms were proposed to Aboriginal and/or Torres Strait Islander client funding, monitoring and cultural safety guidance, which will be fully implemented in 2020–2021. The four broad recommendations relate to funding design, funding accountability, supporting reforms and Aboriginal and Torres Strait Islander self-determination.

In 2020–2021 the 30 percent Aboriginal loading has been be split into three distinct funding streams, including:

- a reduced WIES loading closer to the national pricing adjustment of four percent to cover excess clinical costs for Aboriginal and/or Torres Strait Islander clients
- a significant proportion of the remaining loading will be redirected into annual block grants to contribute to key workforce (e.g. AHLO) costs, and other recurrent costs associated with cultural safety and supplementary programs for Aboriginal and/or Torres Strait Islander clients. The size of the block grant will vary and will be calculated using a number of criteria which may include, but not limited to, the size of the health service and the Aboriginal and/or Torres Strait Islander population within the health services catchment
- funding grants that will be available through a competitive application process to cover the costs of one-off purchases for innovative projects (including research and evaluation) designed to improve cultural safety.

These changes to the Aboriginal WIES loading approach in effect means there is a significant pool of existing funding now specifically available to hospitals to address cultural safety.

Cultural safety in emergency departments

Emergency departments are often the first entry point for clients entering the hospital system and are expected to play a key role in the triaging and admission of clients into sobering services within the hospital setting. Providing a safe and welcoming environment in the emergency department is critical to clients having a positive experience of care. However, clients seeking care for AOD related issues and/or Aboriginal and/or Torres Strait Islander clients can face stigma and discrimination in the emergency department setting.

Anecdotally, emergency departments are considered a key area where more can occur to promote cultural safety. This view is reflected in client experience surveys - in 2018-19, 71 percent of Aboriginal and/or Torres Strait Islander Victorians said they had a positive overall experience of emergency department care compared to 84 percent of non-Aboriginal Victorians.[20] This gap is wider for ambulance care with 78 percent of Aboriginal and/or Torres Strait Islander Victorians having a positive overall experience of ambulance care compared to 96 percent of non-Aboriginal Victorians. This can also be shown in the number of clients leaving treatment prematurely - in 2019-20, more than 11 percent of Aboriginal and/or Torres Strait Islander clients either decided they did not wish to wait for care or left the emergency department at their own risk after being seen by a clinician, compared to more than six percent of non-Aboriginal and/or Torres Strait Islander clients.[21]

[20] Victorian Agency for Health Information (2020) *Adult experiences of emergency care in Victoria 2018-19*
[21] VEMD data 2019-20, DHHS internal analysis

Similar findings are reflected in the international literature on the treatment of First Nations people in emergency care.

We understand that from 2020-21, Victorian hospitals are required to report formally to DHHS on their performance in providing a culturally safe service. Hospitals are working to improve cultural safety, with some notable examples of best practice (see Bairnsdale case study above).

The eight cultural safety domains are DHHS's key directives to strengthening cultural safety and provide a basis for accountability. Hospitals are also required to report on the implementation of DHHS's Aboriginal cultural safety framework through the Statement of Priorities which is an agreement between hospitals and the Minister for Health.

Cultural safety in the justice system

The justice system has significant impacts on many Aboriginal and/or Torres Strait Islander people and their communities. These impacts in the context of public intoxication have been well-documented, in particular through the Royal Commission into Aboriginal Deaths in Custody and more recently in the coronial findings and recommendation in the Tanya Day inquest.

The scope of Ms Day's inquest also included consideration of the impact of systemic racism and the Deputy State Coroner found that the V/Line conductor's decision making was influenced by unconscious bias and that his decision to call police rather than pursue other options was influenced by Ms Day's Aboriginality. The subsequent recommendations to V/Line regarding training for its staff, including input from the Aboriginal and Torres Strait Islander community about unconscious bias and a review of compatibility with human rights under the Victorian Charter of Human Rights, provide relevant context to our consideration of cultural competence for all First Responders under the public health model.

As identified in *Burra Lotjpa Dunguludja - The Aboriginal Justice Agreement Phase 4* (AJA4), a culturally-responsive system is one in which "non-Aboriginal people take responsibility to understand the importance of culture, country and community to Aboriginal health, wellbeing and safety, by working with Aboriginal communities to design and delivery culturally-responsive services". AJA4 reflects the importance of embedding self-determination and the need to reflect the current aspirations of the Aboriginal and/or Torres Strait Islander community as the core policy approach that must sit alongside efforts to address the over-representation of Aboriginal and/or Torres Strait Islander people in the criminal justice system.

It outlines a vision for Aboriginal people having access to "an equitable justice system that is shaped by self-determination, and protects and upholds their human, civil, legal and cultural rights" with key goals under four domains, including:

- strong and safe Aboriginal families and communities
- fewer Aboriginal people in the criminal justice system
- a more effective justice system with greater Aboriginal control
- greater self-determination in the justice sector.

Several explicit outcomes within these four domains are of particular relevance to the ERGs consideration of measure to ensure implementation of an effective public health response to public intoxication, including service pathways from justice system First Responders.

For example, decriminalisation of public drunkenness and the enhancement of Aboriginal community-led responses such as Koori Night Patrols contributes to the outcomes of identifying and remedying policies and legislation which either currently do, or which may in future, have a disproportionate

impact on Aboriginal people (outcomes 2.1.1 and 2.1.2). Similarly, flexible, culturally safe service pathways is consistent with the AJA4 commitment to support community policing approaches that support crime prevention initiatives and evidence based programs delivered by ACCOs for young people, in order to achieve the outcome of fewer young people becoming involved with the criminal justice system (outcome 2.2.1).

Further, under the overarching goal of safer Aboriginal communities, AJA4's strategies include empowering Aboriginal communities to identify and determine solutions to the justice and community safety issues in their local areas. Existing initiatives cited in AJA4 include Victoria Police Aboriginal Community Liaison Officers as part of community engagement and relationship building.

Good access to culturally appropriate service responses for Aboriginal people highlighted in AJA4 is critical to improve justice outcomes. Ensuring that staff in justice agencies take human rights into account when making decisions is one example of the commitments identified by AJA4 to meet the needs of Aboriginal and/or Torres Strait Islander people in the justice system more broadly. Another such example is the development of cultural safety standards for health services in both adult and youth justice systems.

Developing a culturally appropriate and safe model will require ongoing consultation with the Aboriginal community, ensuring that the wider health response is underpinned by the principles of self-determination and cultural recognition outlined in AJA4.

Cultural safety for an inclusive multicultural community

While the nature and circumstances of the ERG's work in light of the death of Ms Day warrants particular attention to be given to cultural safety for Aboriginal and/or Torres Strait Islander people, we must not ignore other communities and cohorts of people who are disproportionately impacted either as a result of existing law enforcement of public intoxication, or their experiences in the justice, health and law enforcement systems more broadly. Appropriate cultural safety frameworks must also operate to ensure that vulnerable CALD communities, including Sudanese and South Sudanese people, are able to access the health supports and services they need, as well as to avoid any disproportionate impacts of a justice-led response.

The Victorian Government's multicultural policy statement sets out a vision to enable every Victorian to participate fully in society, remain connected to their culture and ensure we all have equal rights, protections and opportunities. The Whole of Government Multicultural Affairs Outcomes Framework works across the following domains to ensure Victorians are:

- safe and secure
- healthy and well
- able to participate fully
- connected to culture and community
- have equal rights and opportunities.

Relevant to the work of the ERG, this framework articulates examples to ensure safety and security including:

- resource investment, including with Victoria Police to enhance social cohesion in partnership with vulnerable multicultural communities
- identifying over-represented cultural groups in adult and youth justice programs.

It also outlines investment in the health system including building cultural competence in health services, with extra targeted assistance for refugees and asylum seekers to address the inequalities that particular communities face.

Additional relevant Victorian Government initiatives include the *Victorian African Communities Action Plan* (VACAP), developed by and for Victoria's African communities. The VACAP covers work through several domains including:

- employment
- education
- leadership
- health and Wellbeing.

Progress on implementation of the VACAP under the health and wellbeing domain outlines initiatives relating to AOD misuse, including specialist outreach workers and education programs, the design of which is being finalised with a VACAP sub-committee together with the DHHS and the Department of Premier and Cabinet.

Recommendation

70. Consistent with its commitment to self-determination and co-design principles, particularly for Aboriginal and/or Torres Strait Islander people, the Victorian Government consults with affected communities and work wherever possible with community-controlled organisations in the design, delivery and evaluation of the public health response to public intoxication.
71. The Victorian Government continues to support the implementation of a new funding and governance model across public health services to strengthen and improve approaches to delivery of culturally safe and responsive services for Aboriginal and/or Torres Strait community.
72. The Victorian Government continues to support further actions via health service statement of priority processes and funding and service agreements for funded organisations to progress Reconciliation Action Plans.
73. The Victorian Government continues to support and elevate the cultural safety planning undertaken by hospitals and the delivery of culturally safe sobering services provided in hospital settings, including:
    a) sobering services in hospitals are established in line with the identified six themes impacting cultural safety
    b) expanding the Aboriginal and/or Torres Strait Islander health workforce, including Aboriginal Health and Liaison Officers, fully utilising WIES loadings and other resources to adequately resource this function
    c) Aboriginal Health and Liaison Officers – or an appropriate equivalent - are available to support Aboriginal and/or Torres Strait Islander clients utilising sobering services, including access after-hours and on weekends; and
    d) undertake an audit of cultural safety in relation to both Aboriginal and/or Torres Strait Islander people and CALD communities at relevant emergency department and rural trauma and urgent care centres, and appropriate actions undertaken to address identified areas of concern.

74. The Victorian Government works in partnership with affected communities at a local level to develop culturally appropriate service responses as part of the public health response, including building on established partnerships with Aboriginal organisations and communities (e.g. Aboriginal Justice Caucus and RAJACs), and with Sudanese and South Sudanese communities under the African Community Action Plan, where appropriate.
75. The Victorian Government supports comprehensive cultural safety training be developed for all First Responder agencies (in the justice and health systems), with localised input from, and delivery by, ACCOs and other affected community-controlled organisations, including training on:
    a) Aboriginal cultural awareness
    b) unconscious bias
    c) trauma-informed care
    d) mental health and disability
    e) human rights under the Victorian Charter of Human Rights.
76. The Victorian Government supports the development and delivery of cultural safety training by ACCOs and other affected communities for all staff in services in the public health model.
77. The Victorian Government ensures that training is provided to all First Responders and services on localised service pathways and access for affected communities, including for ACCOs. This will be particularly important during the implementation phase.
78. The Victorian Government requires that all First Responders and staff in services under the public health model undergo cultural safety training, including ongoing, localised and refresher training.
79. The Victorian Government continues to build the capacity of ACCOs and other community-controlled organisations to deliver cultural safety training in mainstream organisations, including appropriate resourcing and funding of these as professional development activities.
80. The Victorian Government ensures that culturally appropriate safeguards and service pathways are developed for Aboriginal and/or Torres Strait Islander people coming into contact with police, including exploring options with the Aboriginal Community Justice Panels.
81. The Victorian Government extends the role of AHLO to after-hours and/or implement an on-call model so hospital based sobering services also have access to Aboriginal and/or Torres Strait Islander support persons for relevant clients (noting this could also benefit all Aboriginal and/or Torres Strait Islander clients) ensuring any non-hospital services operate consistent with the eight cultural safety domains now in place at hospitals. This could include consideration of block grants for cultural safety to other health services with a primary direct role in public intoxication (i.e. Ambulance Victoria).
82. The Victorian Government ensures that interpreters are available across the range of service system responses identified by the ERG for the proposed reform.

12.6 Further consultation and co-design

As identified in various places throughout this report, detailed consultation and co-design will be critical to the successful establishment of a public health model to respond to public intoxication.

Consultation with and the ongoing involvement of a range of diverse stakeholders is relevant in a number of different contexts, including:

- with local stakeholders and communities to ensure that place-based arrangements respond effectively to local needs and expected demand, particularly in low demand areas where there will be reliance on existing services and transport options
- with people with lived experience to ensure services reflect the needs of the people that will use them
- with health services and their staff to ensure that appropriate health-based responses and processes are developed to respond effectively to people who are intoxicated; and
- with particularly affected communities, such as Aboriginal and CALD communities, to ensure that local responses are tailored and effective.

Effective engagement, consultation and partnership building will also be required across the service system to ensure that a comprehensive statewide model works effectively to provide a health-based response to people who are intoxicated in public. We consider that, as much as possible, implementation of the Proposed Health Model should be incorporated within relevant existing arrangements, such as rural and regional health partnerships.

Recommendation

83. The Victorian Government ensures that detailed consultation and co-design occurs as it is critical to the successful establishment and implementation of a public health model.

12.7 Local Government

The removal of offences relating to public drunkenness in legislation will not interfere with the operation of existing local laws to regulate public drinking and related behaviour by local government. We understand that this may give rise to a tension between the delivery of a public health response to public intoxication and the continued enforcement of local laws.

Where a person is intoxicated in public in an area to which a local law applies, the response may be significantly different if the First Responder is acting under the authority of a local law as opposed to the framework of the Proposed Health Model. Enforcement of local laws relating to public intoxication, particularly through prosecution, will continue to reinforce a justice-based approach to public drinking.

The Royal Commission into Aboriginal Deaths in Custody recommended negotiation between police, local government bodies and representative Aboriginal organisations and Aboriginal legal services with a view to developing an acceptable plan with respect to public consumption of alcohol.

We consider that engagement with local government will be an important component of the development of localised responses. With improved service system responses and the increased availability of places of safety under the Proposed Health Model, local government has an important role to play in promoting the adoption of health-based approaches.

Recommendation

84. The Victorian Government undertakes a review of relevant local laws in partnership with local government. The scope of such a review might including consideration of amendments as well as operational protocols to support the reform principles underpinning decriminalisation of public drunkenness.

85. The Victorian Government analyses data relating to enforcement of local laws be monitored to track any unintended consequences associated with the enforcement of local laws.

12.8 Resourcing

The provision of adequate resourcing to assure the availability and quality of the various health-based service responses identified throughout this report is essential to the success of the proposed reforms. As we have highlighted, the experiences of discrimination of public drunkenness in other jurisdictions demonstrates that the failure to put in place effective health-based service system responses means that police cells will continue to be used.

Put simply, insufficient resourcing of an effective health-based response will inevitably lead to the continuation of a justice-led response to public intoxication. This has a range of resourcing implications due to the burden placed on emergency services and in particular Victoria Police. Most significantly, it has enormous human costs including, most tragically, entirely unnecessary and avoidable deaths in custody.

Adequate resourcing must be provided for the range of components that we have identified are necessary for the effective implementation of the Proposed Health Model, including:

- guaranteeing the availability and coverage of First Responders
- guaranteeing the availability and coverage of appropriate places of safety, including the expansion of sobering services and other community and health services as discussed under Stage 3; and
- focused work on the transition phase and the resource implications required for workforce change and effective governance, monitoring and evaluation.

Resourcing cannot be dedicated to one isolated component alone as there is an essential interdependency between all components. This will be critical for effective implementation. Our Proposed Health Model requires the operation of a range of integrated components designed to complement each other and contribute to the overall effectiveness of the health-based approach.

Recommendation

86. The Victorian Government adequately resources all components of the Proposed Health Model, reflecting the interdependency between all components identified in this report.

Appendix 1: Terms of reference

Background

The Victorian Government has announced its commitment in principle to decriminalise public drunkenness and develop a new health-based response to public drinking and intoxication, in order to provide vulnerable Victorians with appropriate help and support.

This reform will implement the recommendation of the Royal Commission into Aboriginal Deaths in Custody and submissions made to the Royal Commission into Victoria's Mental Health System. The Acting State Coroner, Caitlin English, has also foreshadowed that she would recommend the repeal of public drunkenness offences in the report of the coronial investigation into the death of Ms Tanya Day.

The Government has committed to report-back to the Coroner on the progress of this reform by the end of 2019.

Expert Reference Group

Members

The Expert Reference Group consists of the following members:

- Helen Kennedy, Chief Operating Officer of the Victorian Aboriginal Community Controlled Health Organisation
- Tony Nicholson, former Executive Director of the Brotherhood of St Laurence
- Jack Blayney, former Assistant Commissioner and Chief Information Officer, Victoria Police
- Nerita Waight, Chief Executive Officer of the Victorian Aboriginal Legal Service.

Role

The Expert Reference Group will provide strategic advice to government on the decriminalisation of public drunkenness and the design and development of a new health-based response.

In performing its role, the Expert Reference Group is requested to:

- ensure that its advice reflects the importance of promoting the health and safety of vulnerable Victorians and providing them with appropriate help and support, while also ensuring that the safety of the community, first responders[22], health workers and the broader public is protected
- focus on measures to support a new health-based response that is culturally safe and appropriate, informed by clinical best practice, and sensitive to intersecting issues presenting in the lives of people accessing the new health-based response.
- have regard to approaches and experiences in other Australian and international jurisdictions.

The Expert Reference Group is not required to consider or provide advice to the government on the following matters, which are beyond the scope of this project:

[22] First responders are those who provide a rapid response at the scene and include Victoria Police, Ambulance Victoria, community response teams and other service providers.

- the specific circumstances surrounding the death of Ms Tanya Day, which will be independently examined by the Coroner through the separate coronial inquest process
- other specific cases where individuals are alleged to have committed a public drunkenness offence, particularly cases that are subject to ongoing police investigations or court processes
- the form and content of draft legislation to give effect to a repeal of public drunkenness offences, which will be a matter for the Office of the Chief Parliamentary Counsel
- the training and specific duties of police officers to implement the policing policy and priorities of the government in responding to public drinking and intoxication.[23]
- broader responses to discrimination, human rights, mental illness (which is being considered by the Royal Commission into Victoria's Mental Health System) and homelessness.

The Expert Reference Group will meet monthly and be supported by a cross-government Executive Oversight Committee and Working Group. The project governance structure is at Attachment A.

Expert Reference Group members may bring a support person to Expert Reference Group meetings.

The Expert Reference Group will consider briefings prepared by the Working Group, including briefings on consultation and engagement with stakeholders led by the Working Group.

Executive Oversight Committee

Members

The Executive Oversight Committee will include representatives of the following government departments and agencies:

- Department of Justice and Community Safety (co-chair)
- Department of Health and Human Services (co-chair)
- Victoria Police
- Department of Premier and Cabinet
- Department of Treasury and Finance.

Role

The Executive Oversight Committee will support the Expert Reference Group, including by:

- overseeing the operation of the Working Group and providing coordinated strategic direction as required
- endorsing Working Group briefings ahead of their provision to the Expert Reference Group
- overseeing advice provided to government, other than the advice provided by the Expert Reference Group.

An Executive Oversight Committee representative from both the Department of Justice and Community Safety and the Department of Health and Human Services will attend Expert Reference Group meetings.

[23] The Victoria Police Act 2013 provides that the Chief Commissioner of Police (CCP) is responsible for implementing the policing policy and priorities of the Government. Training and education within Victoria Police is a matter for the CCP and determined by Victoria Police as a Registered Training Organisation, in compliance with a national framework and informed by an Independent Advisory Board.

Working Group

Members

The Working Group will include representatives from each of the agencies represented on the Executive Oversight Committee.

Role

The Working Group will convene monthly (or more regularly, if required), and will report to the Executive Oversight Committee.

Working Group members will also attend Expert Reference Group meetings by invitation.

The Working Group will be responsible for developing draft proposals (including by undertaking research, modelling and stakeholder consultation) for consideration by the Executive Oversight Committee and the Expert Reference Group on the:

1. design and implementation of a new health-based response
2. appropriate police powers under the new health-based response required to ensure community safety.

To inform the development of the draft proposals, the Working Group will:

- undertake research, including on data, evidence and best practice responses in other jurisdictions
- undertake preliminary modelling of the cost and resourcing requirements of the proposed reforms to inform consultation, and the development of legislative reform and funding proposals
- implement the consultation plan, including collaboration with the Victorian Aboriginal Community Controlled Organisations, Victoria Police, as well as justice, health and community service providers, to promote culturally safe and best practice reform.

Design and implementation of a health-based response

The design of a new health-based response to public drinking and intoxication will consider:

1. best practice approaches to responding to public drinking and intoxication in other jurisdictions, including opportunities to learn from experiences in these jurisdictions, and the results of evaluations and reviews of these approaches
2. legal requirements and duties under relevant legislation, including the *Occupational Health and Safety Act 2004* and *Liquor Control Reform Act 1998*
3. the particular needs of different communities across Victoria (including in rural and regional Victoria), and cohorts and cultural groups within those communities
4. workforce, training, infrastructure, transport and other resourcing requirements for the successful implementation of the model.

Approach to repealing public drunkenness offences

The development of a proposed approach to repealing public drunkenness offences will consider:

1. the need for an appropriate period to prepare for the decriminalisation of public drunkenness, provide guidance and training to first responders and others on the new health-based response, and the establishment of place-based support services
2. the adequacy of existing police powers and criminal offences to protect the community and respond effectively to threats to public safety and order arising from intoxication, particularly in the context of major events where there may be significant alcohol consumption

3. the role of first responders and others under the new health-based response to assist people who are drunk in a public place, but are not otherwise committing a criminal offence
4. workforce, training, infrastructure, transport and other resourcing requirements for the successful implementation of the new health-based response.

The Working Group will collaborate closely with first responders in developing this proposal.

Consultation

The proceedings and papers of the Expert Reference Group are confidential. Requests to share materials with community and stakeholders will be considered and agreed with the Expert Reference Group as the process and advice develops, noting that final approval is required by the Department of Justice and Community Safety (as per the terms of conditions of the engagement of members of the Expert Reference Group).

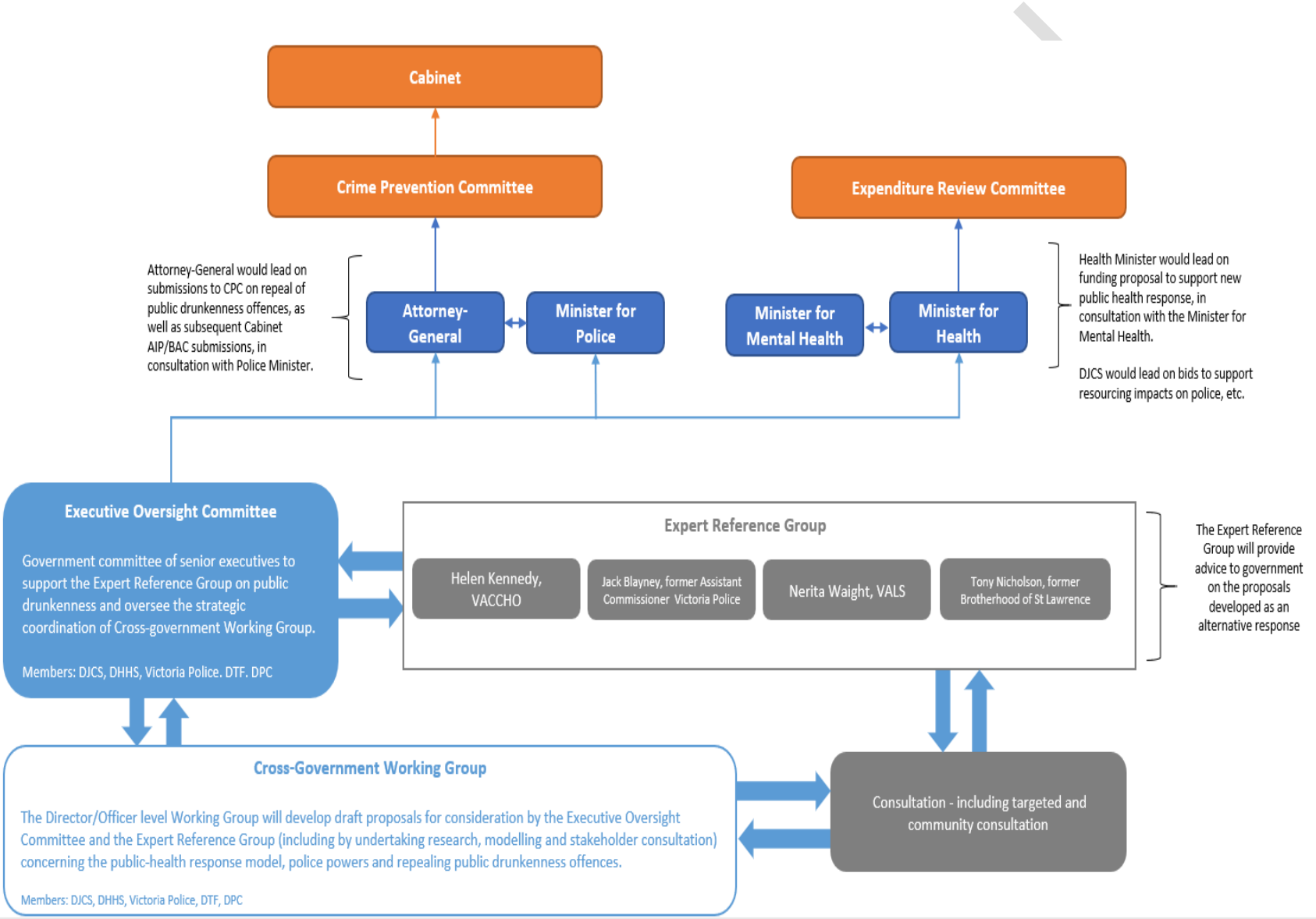
The Executive Oversight Committee and Working Group will coordinate and undertake consultation with key community groups and stakeholders to support the development of the reforms. The Expert Reference Group may attend stakeholder consultations meetings.

Report

The Expert Reference Group, supported by the cross-government Executive Oversight Committee and Working Group, will prepare a report to government with its advice and reform proposals.

The final report should be delivered to the Attorney-General and the Minister for Health by the end of **January 2020** to enable the Expert Reference Group to consider the interim report of the Royal Commission into Victoria's Mental Health System, and to allow for funding requirements arising from the implementation of the new health-based response to be considered as part of the 2020-21 Victorian Budget process.

Public Drunkenness Reform project governance



Appendix 2: Community consultation and engagement

The following table comprises the list of organisations which were invited to participate in consultations as part of the reform of public intoxication. Consultations were conducted by and large around October to December 2019 and in February 2020 as part of the process of preparing advice by DJCS and DHHS, and to support the work of the ERG.

Organisation	Organisation type
Aboriginal Justice Caucus	Aboriginal organisations
Ambulance Victoria	First Responders
Association of Participating Service Users (APSU) at the Self-Help Addiction Resource Centre (SHARC)	Consumer peak
Australian Hotels Association	Industry
Australian Medical Association, Victoria	Community peak bodies
Australian Nursing and Midwifery Federation	Unions/professional associations
Australian Security Industry Association Limited (ASIAL)	Industry
Bendigo Community Health	Community health
Bendigo Health	Health services
Bolton Clarke	Community/ health services
CAPR (Centre for Alcohol Policy Research)	Academic experts
Centre for Innovative Justice	Academic experts
Chill-out Zone, Queensland	First Responders / community organisation
City of Greater Bendigo Council	Local government
City of Greater Geelong Council	Local government
CoHealth	Community health
Commissioner for Children and Young People	Government & statutory agencies
Community Clubs Victoria	Industry
Council to Homeless Persons	Community peak bodies
Darebin City Council	Local government
Deakin University (Addiction Studies)	Academic experts
Dhelk Dja Koori Caucus	Aboriginal organisations
Djirra	Aboriginal organisations
Federation of Community of Legal Centres	Community peak bodies
Foundation for Alcohol Research and Education, ACT	Academic experts / community organisation
Goulburn Valley Health	Health services
Healing Foundation, ACT	Aboriginal organisations
Health Services Union	Unions/professional associations
Health Workers Union	Unions/professional associations
Human Rights Law Centre (HRLC)	Community peak bodies
Human Services Health Partnership Implementation Committee (HSHPIC)	Community peak bodies
Koori Youth Caucus	Aboriginal organisations
Koori Youth Council	Aboriginal organisations

Latrobe City Council	Local government
Latrobe Community Health Service	Community health
Latrobe Regional Hospital	Health services
Launch Housing	Other services
Law Council of Australia	Community peak bodies
Law Institute of Victoria (LIV)	Community peak bodies
Municipal Association of Victoria (MAV)	Local government
Melbourne City Council	Local government
Melbourne University (Alcohol research)	Academic experts
Mental Health Victoria	Community peak bodies
Mildura Base Hospital	Health services
Mildura Rural City Council	Local government
Mission Australia	Community peak bodies
Monash Health	Health services
Monash University (Law)	Academic experts
Monash University (Paramedicine)	Academic experts
National Drug Research Institute	Academic experts
Ngwala Willumbong	Aboriginal organisations
North Richmond Community Health	Community health
Penington Institute	Community peak bodies
Primary Health Network (PHN) Alliance	Community peak bodies
Port Phillip City Council	Local government
Regional Aboriginal Justice Advisory Committees (RAJAC)	Aboriginal organisations
Safer Care Victoria	Government & statutory agencies
Salvation Army	Community health
Small Business Mentoring Service Victoria	Government & statutory agencies
St John's Ambulance	First Responders
St Vincent's Hospital	Health services
Sunraysia Community Health	Community health
Turning Point	Other services
United Voice Victoria	Unions/professional associations
Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and members	Aboriginal organisations
VALiD	Community peak bodies
Victorian Council of Social Services	Community peak bodies
VicHealth	Government & statutory agencies
Victoria Legal Aid	Legal services
Victoria Police	First Responders
Victoria Police Association	Unions/professional associations
Victorian Aboriginal Health Service	Aboriginal organisations
Victorian Aboriginal Legal Service	Aboriginal Organisations
Victorian Alcohol and Drug Association (VAADA)	Community peak bodies
Victorian Ambulance Union	Unions/professional associations
Victorian Equal Opportunity and Human Rights Commission (VEOHRC)	Community peak bodies

Victorian Healthcare Association	Community peak bodies
Youth Affairs Council of Victoria (YAC Vic)	Community peak bodies
Youth Advisory Council	Community peak bodies
Youth Projects	Community health
Youth Support and Advocacy Service (YSAS)	Community health

Appendix 3: Recommendations from the Inquest into the Death of Tanya Day

The Deputy State Coroner Caitlin English handed down the findings from the Inquest into the Death of Tanya Louise Day on 9 April 2020.

The Deputy State Coroner found that an indictable offence may have been committed contributing to Ms Day's death and has referred the matter to the Director of Public Prosecutions to investigate. The Deputy State Coroner also made ten recommendations for improvements related to the circumstances of Ms Day's death. These recommendations are outlined below.

COMMENTS

Pursuant to section 67(3) of the *Coroner's Act 2008,* I make the following comment:

1. During the course of this inquest it became apparent to me that the Coroner's Court of Victoria should review the relevant recommendations from the Royal Commission into Aboriginal Deaths in Custody as they relate to coronial investigations. This review is currently underway.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroner's Act 2008*, the Deputy State Coroner made the following recommendations connected with the death:

To: The Attorney General, The Honourable Jill Hennessey

1. I Recommend that the offence of public drunkenness be decriminalised and that section 13 of the *Summary Offences Act 1966* be repealed.

   Summary of government response
   The government has committed in principle to decriminalise the offence of public drunkenness and has established an Expert Reference Group to provide advice on the development and implementation of a public health-based response.

2. I recommend legislative amendment to the *Coroners Act 2008* that the coroner in charge of coronial investigation may give a police officer direction concerning investigations to be carried out for the purpose of an inquest or investigation into a death being investigated by the coroner, thus legislatively recognising the role of the Coronial Investigator.

   I refer to both the Royal Commission into Aboriginal Deaths in Custody, Recommendation 29 and the Victorian Parliamentary Law Reform Committee Report regarding the *Coroner's Act* (1985) Recommendation 42.

   Summary of government response
   The Attorney General has instructed DJCS to undertake consultation on a legislative amendment to the *Coroners Act 2008.*

To: The Chief Commissioner, Victoria Police

3. I recommend that the Victoria Police Manual Rules and Guidelines be amended to include a falls risk assessment as part of the detainee risk assessment for each person in custody who appears to be affected by alcohol or drugs or illness.

   Summary of government response

   Victoria Police are reviewing options to include a falls risk assessment in the Victoria Police Manual and Guidelines.

4. I recommend that there be a review of training and education within Victoria Police regarding the findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody to ensure knowledge and appropriate compliance.

   Summary of government response
   Victoria Police has accepted this recommendation and will review training in the context of the Royal Commission into Aboriginal Deaths in Custody recommendations and report on specific training that has been, or is planned to be implemented, that seeks to enhance members cultural awareness.

5. I recommend training be implemented for all Victoria Police custody staff regarding the Victoria Police Manual Rules, Guidelines and local police station Standard Operating Procedures (SOP) regarding the mandatory requirements applicable for safe management of persons in police care or custody.

   Summary of government response

   Victoria Police notes the courses on the Victoria Police Learning Hub (VPLH) regarding safe management of persons in police care or custody were updated in 2019 and made compulsory to all relevant staff in April 2020. The courses provide instruction for custody staff regarding the current VPM and VPMGs and Victoria Police will continue to monitor the completion rates. SOPs provide a more localised level of detail in line with the VPM and centralised training is incompatible with this approach, however Victoria Police will ensure SOPs are updated and align with the VPM.

6. I recommend training be implemented within Victoria Police regarding the medical risks of individuals affected by alcohol.

   Summary of government response
   Victoria Police notes that all police members receive training regarding risks of individuals affected by alcohol and the Chief Commissioner notes the Custodial Health Service (CHS) provide training to Police Custody Officers (PCOs). CHS will assess the specific training needs for police based on their roles and their future responsibilities under the health model following the decriminalisation of public drunkenness responses to understand and implement training requirements.

7. I recommend Victoria Police request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 41(c) review of the compatibility of its training materials with the human rights set out in the Charter.

   Summary of government response
   Victoria Police accepts Recommendation 7 and will engage VEOHRC to conduct a review pursuant to s41(c) of the Charter to ensure training provided to Police and Police Custody Officers promotes the protection of human rights, particularly the protection of Aboriginal Cultural Rights and the right to humane treatment when deprived of liberty.

To: The Chief Executive Officer, V/Line

8. I recommend V/Line review training materials to include input from the Aboriginal and Torres Strait community about unconscious bias and to provide training to staff as to how to reduce the impact of unconscious bias in decision making.

9. I recommend V/Line request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 41(c) review of the compatibility of its training materials with the human rights set out in the Charter.

   Summary of government response
   The CEO of V/Line has accepted all recommendations.

To: The Secretary, Department of Justice and Community Safety

10. I recommend that the current volunteer model for the Aboriginal Community Justice Panel be reviewed as to is effectiveness in providing protection for Aboriginal people in custody and that this review include a clarification of the services offered by the Aboriginal Community Justice Panel with both Victoria Police and the Victorian Aboriginal Legal Service.

Summary of government response

The Secretary of DJCS has also responded accepting recommendation 10 and has commenced the process to review the Aboriginal Community Justice Panel.

Appendix 4: Public drunkenness by Local Government Area (2014-2019)

Table: Public drunkenness offences by Victorian local government area (1 April 2014 to 31 March 2019) with demand and targeted response assessments

LGA	No. of public drunkenness offences 2014-2019 (%)	Average offences per year	Demand (high/low)	Proposed cohort response
Melbourne	8,893 (21.5%)	1,779	High	Homelessness High intensity Low intensity Sudanese
Greater Dandenong	2,450 (5.9%)	490	High	Homelessness Sudanese High intensity
Mornington Peninsula	1,821 (4.4%)	364	High	Aboriginal Low intensity
Port Phillip	1,735 (4.2%)	347	High	Homelessness
Yarra	1,593 (3.9%)	319	High	Homelessness Sudanese
Greater Geelong	1,612 (3.9%)	322	High	Aboriginal Low intensity
Frankston	1,536 (3.7%)	307	High	Aboriginal High intensity
Stonnington	1,322 (3.2%)	264	High	High intensity Low intensity
Mildura	1,236 (3.0%)	247	High	Aboriginal High intensity
Greater Bendigo	1,177 (2.9%)	235	High	Aboriginal
Latrobe	1,044 (2.5%)	209	High	Aboriginal Sudanese
Kingston	818 (2.0%)	164	High	High intensity
Ballarat	765 (1.9%)	153	High	Aboriginal
Greater Shepparton	731 (1.8%)	146	High	Homelessness Aboriginal Sudanese
Maribyrnong	700 (1.7%)	140	Low	

Brimbank	698 (1.7%)	140	Low	
Maroondah	678 (1.6%)	136	Low	
Casey	666 (1.6%)	133	Low	
Glen Eira	636 (1.5%)	127	Low	
Hume	567 (1.4%)	113	Low	
Wyndham	564 (1.4%)	113	Low	
Moonee Valley	553 (1.3%)	111	Low	
Moreland	536 (1.3%)	107	Low	
East Gippsland	501 (1.2%)	100	Low	
Monash	483 (1.2%)	97	Low	
Darebin	474 (1.2%)	95	Low	
Wangaratta	474 (1.2%)	95	Low	
Yarra Ranges	473 (1.1%)	95	Low	
Knox	448 (1.1%)	90	Low	
Warrnambool	387 (<1%)	77	Low	
Boroondara	375 (<1%)	75	Low	
Whitehorse	353 (<1%)	71	Low	
Hobsons Bay	312 (<1%)	62	Low	
Cardinia	309 (<1%)	62	Low	
Bayside	301 (<1%)	60	Low	
Swan Hill	275 (<1%)	55	Low	
Wellington	267 (<1%)	53	Low	
Banyule	255 (<1%)	51	Low	
Campaspe	253 (<1%)	51	Low	
Horsham	230 (<1%)	46	Low	
Whittlesea	227 (<1%)	45	Low	
Baw Baw	216 (<1%)	43	Low	
Bass Coast	209 (<1%)	42	Low	
Melton	209 (<1%)	42	Low	
Wodonga	183 (<1%)	37	Low	
Mitchel	161 (<1%)	32	Low	

Colac-Otway	152 (<1%)	30	Low	
Moira	125 (<1%)	25	Low	
Glenelg	118 (<1%)	24	Low	
Manningham	101 (<1%)	20	Low	
Surf Coast	90 (<1%)	18	Low	
Ararat	87 (<1%)	17	Low	
Southern Grampians	86 (<1%)	17	Low	
Mount Alexander	81 (<1%)	16	Low	
Macedon Ranges	80 (<1%)	16	Low	
Northern Grampians	69 (<1%)	14	Low	
Moorabool	67 (<1%)	13	Low	
Central Goldfields	61 (<1%)	12	Low	
Nillumbik	55 (<1%)	11	Low	
South Gippsland	48 (<1%)	10	Low	
Indigo	44 (<1%)	9	Low	
Benalla	43 (<1%)	9	Low	
Murrindindi	42 (<1%)	8	Low	
Alpine	41 (<1%)	8	Low	
Moyne	34 (<1%)	7	Low	
Gannawarra	33 (<1%)	7	Low	
Corangamite	24 (<1%)	5	Low	
Mansfield	24 (<1%)	5	Low	
Yarriambiack	17 (<1%)	3	Low	
Hepburn	15 (<1%)	3	Low	
Loddon	13 (<1%)	3	Low	
Buloke	11 (<1%)	2	Low	
Pyrenees	11 (<1%)	2	Low	
Strathbogie	11 (<1%)	2	Low	
Towong	10 (<1%)	2	Low	
Queenscliffe	7 (<1%)	1	Low	
Golden Plains	4 (<1%)	1	Low	

Hindmarsh	3 (<1%)	1	Low	
West Wimmera	2 (<1%)	0	Low	
Unknown/unspecified	32 (<1%)	6	Low	