

PUBLIC INTOXICATION REFORM

JUSTICE EVALUATION
FINAL REPORT
DECEMBER 2025

THROUGH A DIFFERENT LENS

BY KYLLIE CRIPPS

They say:
“Decriminalise. Divert. Reform.”
As if change is simple,
as if care is the norm.

But this fight is decades deep —
from royal commissions,
and lives cut short.
Decriminalisation was never soft.
It was survival.
It was justice.
It was life.

Because public intoxication
wears many faces.
It's the roar of the footy crowd,
the concert,
the race —
nights of celebration
that spiral, and spill into the public.

And it's also the silence —
the bottle clutched
to quiet the grief,
to numb the ache,
to turn pain into habit,
and habits into chains.

So reform must answer both.
Not just the night out gone too far,
but the years of sorrow
that can also sit beneath.

It must be care that stays,
care that listens,
care that asks first.

Not cold services.
Not ticked boxes.
But trust,
time,
and space.

Systems must shift.
Silos must break.
Care must flow
like steady streams —
culture held,
not crushed by schemes.

Our lens does not flinch.
It names the harm,
it calls for truth.
It is culture.
It is kin.
It is time.

Quick fixes fade.
Trust is slow.
We are still here,
walking this road.

There are gaps that still remain.
Committed we must be
to future-proof what we have
started —
be bold,
yet clear:
this reform is here to stay.
Its work is not yet done.
With continued refining,
reflection,
deep listening —
change will be ours,
setting the example
for others to follow.

Because this work lives
in all of us now —
in families,
in services,
in streets and towns.
In the quiet care
that keeps people safe,
in the hands that reach
before harm takes place.

And when our children ask
how this began,
we'll tell them:
we chose care over fear,
community over control.

We built something lasting —
not perfect,
but possible —
so they could stand
on solid ground.

And together,
we walk forward —
strong,
steady,
determined,
in care,
in safety.

Professor Kyllie Cripps, a Palawa woman, is one of Australia's leading experts on violence against First Nations women. Her research redefines how Indigenous family violence, sexual assault, and child abuse are understood—centring Indigenous voices and driving systemic change. Through community-led, interdisciplinary work, she champions culturally grounded solutions and safer futures for Indigenous women and children. Kyllie is co-lead Investigator for the Public Intoxication Reform Evaluation.

ACKNOWLEDGEMENT

Recognising the significance of the grassroots initiative led by the Day Family and the Dhadjowa Foundation to honour the life and legacy of Aunty Tanya Day, this report incorporates the colour pink throughout as a mark of respect. Featured in key sections, including the recommendations, pink serves as a visual reminder that this work is part of an ongoing collective effort to uphold her legacy and to continue the call for justice and reform.

CONTENTS

List of Tables	4	Data Analysis	25
List of Figures	4	A Living, Adaptive Evaluation	25
Acronyms	5	Findings	26
Notes on terminology	5	The Complex Context of PIR Implementation	26
Acknowledgments	6	Victoria Police and the PIR	34
Evaluation Governance	7	Ongoing Criminalisation (Use of police powers)	36
Ethics	7	Implementation-related insights	42
Executive Summary	8	Service provision and related limitations	47
Introduction	10	Ngwala Case Study: Implementing PIR	50
Context of the reform	10	Geographic disparities in PIR implementation	55
Goals of the reform	11	Insights from the South Sudanese Australian community	57
Purpose of this Evaluation	11	Police Responses	60
Research questions	12	Custody reduction	65
Evaluation Framework	13	Use of Outreach	69
Reform Theory of Change (RToC)	13	Policing and marginalised communities	81
Methodology	18	Lived Experience and Difficult Truths	82
Our Approach and Indigenous Research Methodologies	18	Awareness of PIR	85
Evaluation Governance and Design	19	Reflexive Practice and Reform Monitoring	90
The Four Pillars in Practice	19	Partnerships	93
Research Methods	20	Discussion	95
IBAC, VALS and Ngwala case studies	20	Recommendations Table	98
Situation analysis, incorporating Literature Synthesis and Policy Documentation Analysis	21	References	107
Descriptive and trend analysis	21	Appendices	108
PDR App Incident Data	23	Appendix 1: Chief Commissioner's Instruction: Persons drunk in public	108
CAD Data	23	Appendix 2a: Human Rights Analysis	124
Qualitative data, and related thematic and narrative analysis	24	Appendix 2b: Comprehensive Duty of Care Analysis	135
Case study: South Sudanese Australian community	24	Appendix 3: Additional Ngwala Case Studies	138
Human Rights Analysis	25	Appendix 4: Insights from South Sudanese Australian community members - Case Study	140

LIST OF TABLES

Table 1: Alignment of RQs with RE-AIM and RToC frameworks	15
Table 2: Public Intoxication Reform Evaluation Logic (includes RToC and RE-AIM dimensions)	16
Table 3: Overview of the multiple methods collected for the current evaluation	20
Table 4: VSIIDR data sources	21
Table 5: Current PIR-related services in Victoria (as at Sept 2025; Source: Victorian Department of Health)	44
Table 6: Police attendance outcomes, November 2023–March 2025 (n=3,191)	65
Table 7: Outreach requests by key characteristics	70
Table 8: Relative share of Incidents and Outreach requests	70
Table 9: Outreach requests that were attended	72
Table 10: Ambulance requests that were attended	73
Table 11: Use of health services	77

LIST OF FIGURES

Figure 1: Key elements of the Reform Theory of Change (RToC; HMCTS, 2021)	13
Figure 2: An outline of the Reform Theory of Change (HMCTS, 2021) and its implementation for the current evaluation	14
Figure 3: The characteristics of Indigenous research methodologies (National Indigenous Research and Knowledges Network, 2024)	18
Figure 4: The Four Pillars of Indigenous Research Methodologies	19
Figure 5: Victoria Police Regions, with evaluation sites marked	22
Figure 6.1: Average number of alternative public order offences per month by type, October 2021–March 2025	37
Figure 6.2: Average number of alternative public order offences per month by type, Indigenous people, October 2021–March 2025	37
Figure 6.3: Average number of alternative public order offences per month by type, Sudan/South Sudan born people, October 2021–March 2025	37
Figure 7: Distribution of incidents (number), November 2023–March 2025	42

Figure 8: Distribution of incidents (number, %), November 2023–March 2025	42
Figure 9: Source of CAD calls: November 2023–March 2025	45
Figure 10: Reason for CAD calls: November 2023–March 2025	46
Figure 11: Source of and reason for CAD calls: November 2023–March 2025	46
Figure 12.1: Transportation by police, by ethnicity	61
Figure 12.2: Transportation by police, by homelessness status	61
Figure 12.3: Transportation by police, by reason	61
Figure 12.4: Transportation by police, by police region	61
Figure 13.1: Distribution of outcomes by ethnicity	66
Figure 13.2: Distribution of outcomes by age	66
Figure 13.3: Distribution of outcomes by homelessness	67
Figure 13.4: Distribution of outcomes by criminal offence	67
Figure 13.5: Distribution of outcomes by police region	68
Figure 14: Outreach services requested or not requested	69
Figure 15.1: Reasons for NOT requesting services by ethnicity	71
Figure 15.2: Reasons for NOT requesting services by homelessness status	71
Figure 15.3: Reasons for NOT requesting services by police region	71
Figure 16.1: Ambulance and hospital requests by ethnicity	72
Figure 16.2: Ambulance and hospital requests by age	73
Figure 16.3: Ambulance and hospital requests by homelessness status	73
Figure 16.4: Ambulance and hospital requests by police region	73
Figure 17: Contacts with health and social services	76
Figure 18: Contact with health services for alcohol and drug related diagnosis	76
Figure 19: VALS CLE workshop Ballarat	88
Figure 20: Street posters	89

ACRONYMS

ACJP	Aboriginal Community Justice Panels	LEAP	Law Enforcement Assistance Program (Victoria Police database)
AOD	Alcohol and Other Drugs	PD	Public Drunkenness (term used by Victoria Police and CSA)
CCI	Chief Commissioner's Instructions	PDR	Public Drunkenness Reform (term used by Victoria Police and CSA)
CSA	Crime Statistics Agency	PDR App	Public Drunkenness Reform App (Victoria Police database)
CLAS	Community, Legal and Advocacy Services	PIR	Public Intoxication Reform
DH	Department of Health	PIRE	Public Intoxication Reform Evaluation
DJCS	Department of Justice and Community Safety	RAJAC	Regional Aboriginal Justice Advisory Committee ²
ERG	Expert Reference Group on public intoxication	RCIADIC	Royal Commission into Aboriginal Deaths in Custody (1987-1991)
HRLC	Human Rights Law Centre	VALS	Victorian Aboriginal Legal Services
IBAC	Independent Broad-based Anti-Corruption Commission	VAHS	Victorian Aboriginal Health Services
LSEC	Local Site Executive Committees ¹		

NOTES ON TERMINOLOGY

1. This report uses the terms 'intoxicated' and 'intoxication' to refer to being affected or apparently affected by alcohol or other substances. The term 'public drunkenness' is primarily used when referencing Victoria Police data, pre-reform laws, Crime Statistics Agency data, or historical articles and policies. While contemporary practice favours the term 'intoxication', we have maintained original phrasing when citing or discussing historical documents to ensure accuracy and maintain consistency with source materials.
2. Throughout the report, the term 'South Sudanese Australian' is used to refer to people of South Sudanese ancestry who live in Australia. This terminology reflects how many community members choose to identify, as it recognises both their South Sudanese heritage and their belonging within the broader Australian context.
3. The evaluation relates to the South Sudanese Australian community. However, the quantitative datasets available, including those analysed by CSA, use the umbrella label 'African' and cannot be disaggregated further. We recognise that the African Australian community is not a single community and that this term masks broad multilingual and multicultural experiences. Because the data are reported only at the 'African' category level, the number of South Sudanese Australians represented in those figures cannot be determined with certainty. Where possible, we supplement these figures with qualitative insights specific to the South Sudanese Australian community.

1. Local Site Executive Committees (LSECs) are local governance bodies that enable cross portfolio strategic decision-making, direction setting and collective leadership, adopting a place-based approach that enables flexibility to respond to issues and priorities within their local context. Membership can include Victorian Government departments, Aboriginal organisations, and sector organisations.
2. Regional Aboriginal Justice Advisory Committees (RAJACs) operate throughout Victoria to develop and implement regional justice plans. RAJACs advocate for improved justice outcomes, develop and implement Regional Justice Action Plans and monitor Aboriginal contact with the justice system and aid the successful delivery of Aboriginal programs under the Victorian Aboriginal Justice Agreement (*Burra Lotipa Dungaludja*).

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And finally, to those who shared their stories with us in interviews and focus groups—**thank you**. Your experiences, frustrations, hopes and ideas give this work its meaning. You are the reason this reform matters. This evaluation is, at its heart, a reflection of the stories you entrusted to us, and we hold that responsibility with deep respect.

EVALUATION

GOVERNANCE

The Evaluation is guided and overseen by a Community, Legal, and Advocacy Services (CLAS) Advisory Committee comprised of representatives from the following organisations:

- > Dhadjowa Foundation
- > Aboriginal Justice Caucus
- > Aboriginal Community Justice Panel
- > Victorian Aboriginal Legal Service
- > Human Rights Law Centre
- > Djirra
- > Ngwala Willumbong Aboriginal Corporation
- > Victorian Aboriginal Health Service
- > South Sudanese Australian Community representative
- > Cohealth
- > Victorian Alcohol and Other Drugs Association
- > Self Help Addiction Resource Centre
- > Youth Affairs Council
- > Melbourne City Mission

Other key stakeholders providing support and oversight include the Department of Justice and Community Safety, Crime Statistics Agency, Victoria Police, Department of Health, Triple Zero Victoria, and Ambulance Victoria.

ETHICS

Ethics approvals for this evaluation were obtained from the Monash University Human Research Ethics Committee (Project ID: 41883) and the Justice Human Research Ethics Committee (Project ID: CF/24/13621).

EXECUTIVE SUMMARY

On 7 November 2023, public intoxication was decriminalised in Victoria—marking a landmark shift away from punitive justice responses towards a health-based, culturally grounded model of care. The Public Intoxication Reform (PIR) were introduced in recognition of the historical harms caused by criminalisation, the disproportionate impacts borne by Victoria's most marginalised communities, and the decades of advocacy—particularly by Aboriginal leaders, families and organisations—that called for a fundamentally different approach.

This evaluation, led by Monash University, assesses the justice impact of the first 22 months of PIR implementation. It examines changes to policing practice, legal outcomes, community experience and system behaviour, with a focus on Aboriginal and Torres Strait Islander communities and other groups who have long faced disproportionate police attention. Guided by the Reform Theory of Change and supported by the RE-AIM framework, the evaluation tests fidelity, outcomes, adaptations and sustainability across the reform landscape.

Critically, the evaluation was grounded in a robust Indigenous research methodology, supported by governance structures essential to achieve credibility and trustworthiness. The governance established for PIR—including the CLAS Advisory Committee and the involvement of Aboriginal and Torres Strait Islander researchers—provided the authority, accountability and cultural integrity required to undertake work of this sensitivity. Drawing on four interconnected pillars of Indigenous research methodologies, the evaluation was designed and overseen through community-led decision-making about priorities, tools, language and interpretation. This governance was not symbolic; it operated as a living framework that ensured the evaluation remained responsive, respectful and aligned with principles of self-determination. It enabled an evaluation process that was collaborative and adaptive, capable of surfacing real-time challenges while strengthening trust among the communities most affected. In doing so, the governance model not only safeguarded rigour and integrity, but actively supported reform delivery—modelling the culturally grounded, community-led systems of accountability and care that the reform itself aims to achieve.

The rigour of this evaluation is further demonstrated through its comprehensive research methods and the breadth of engagement across all stakeholder groups. Guided by Indigenous Research Methodologies, the evaluation employed a mixed-methods design integrating quantitative analysis of Crime Statistics Agency (CSA) datasets, custody and charge trends, and police interactions recorded through the PDR App with rich qualitative evidence generated through Yarning Circles, community focus groups, stakeholder interviews, co-design workshops, and media and policy analysis. Community-led thematic analysis, cross-case comparisons, and case study synthesis drawing on IBAC and VALS matters provided a layered, system-wide understanding of how PIR is operating in diverse contexts. All qualitative work was undertaken using community- and stakeholder-engaged ethical processes, ensuring cultural safety and lived-experience insight, while quantitative data were analysed with the same level of rigour. Together, this breadth and depth of evidence ensure the evaluation's findings are robust, culturally grounded, and reflective of both systemic shifts and lived experience.

The reforms have unequivocally met their core intent: no person has died in police custody or been placed in a police cell solely for being intoxicated in public since PIR commenced. Victoria remains the only jurisdiction that has not introduced a replacement police power such as protective custody—recognising, as outlined in *Seeing the Clear Light of Day*, the significant harms associated with such powers. This decision alone represents a progressive and principled commitment to a genuine health-led response, rather than a rebranded form of criminalisation.

Available data* shows that Victoria Police broadly met reform objectives. Arrests for low-level offences during intoxication-related events were uncommon, occurring in approximately 5% of matters. However, Aboriginal people were comparatively twice as likely to be arrested (9%) to the general population—evidence of both the progress achieved and the deep structural inequities that persist. Custody was used infrequently overall, signalling a cultural and operational shift away from enforcement and towards care-oriented responses.

The evaluation highlights the important role of outreach services, sobering facilities, and the centralised intake and dispatch line as key diversionary pathways. Leaving a person in situ emerged as a common and often appropriate outcome. While stakeholders noted its benefits, they also identified safety and wellbeing risks—particularly for those without support networks, experiencing homelessness, or in unsafe environments. This feedback reinforces the need for guidance, visibility and investment that reflect the real-world complexity of intoxication in public spaces.

Most importantly, this evaluation is grounded in the stories, insights and lived experiences that illuminate the realities behind the data. Story reveals how people encounter the system—where trust is strengthened or eroded, where harm is reproduced, and where the reform's promise becomes tangible. It shows how historical and contemporary experiences shape whether an interaction is understood as care, surveillance or risk.

The evaluation also acknowledges the central and ongoing role of Aboriginal community-controlled organisations, RAJACs, the Aboriginal Justice Caucus and other Aboriginal governance structures. Their leadership, cultural authority and advocacy have shaped the reform from inception through implementation, and they remain essential partners in ensuring its future integrity and effectiveness. PIR also extends beyond Aboriginal communities to address the experiences of other marginalised groups—including Sudanese and South Sudanese Australian communities and young people—who face distinct but interconnected forms of over-policing and mistrust.

Reform does not occur in a vacuum. The success of PIR depends on strong partnerships, cultural accountability, adequate resourcing, and a shared commitment to resisting the pull back towards criminalisation. It also depends on deliberate, ongoing reflexive practice—recognising unintended consequences early and responding with system strengthening, not system retreat.

WHERE TO FROM HERE?

The path ahead requires consolidating the gains achieved and building the next phase of a health-led, community-governed system. The recommendations in this report set out a clear forward agenda across government, health, police and community sectors.

Standardising legislative terminology, aligning public-facing materials, and strengthening police policy, training and reporting systems will help embed consistency and transparency across agencies. Enhanced oversight—including monitoring compliance with the PDR App (and future enterprise system), validating data with the CSA, and integrating body-worn camera evidence consistent with existing Chief Commissioner's Instructions (CCI) directives—will safeguard against any drift back to enforcement-led approaches.

The expansion and long-term sustainability of the health response is central to the future of PIR. This includes maintaining and enhancing current services, increasing coverage across metropolitan Melbourne (particularly the South-East), expanding services in regional areas based on demand, and building surge capacity during major events. Investment in a statewide Public Intoxication Reform Hub, specialised nodes of expertise, and community-governed models for Aboriginal communities and for South Sudanese Australian young people will deepen cultural safety and improve pathways into care and aftercare.

Strengthening referral pathways, improving visibility of the Victorian Aboriginal Health Service triage line, reducing reliance on Triple Zero and police, and addressing transport gaps—especially in regional areas—will improve accessibility and reduce unnecessary justice involvement. Public education, rights-based campaigns, and youth-focused initiatives, co-led with Aboriginal and South Sudanese Australian communities, will further embed understanding of the reform and support safe, informed decision-making.

A statewide PIR Monitoring and Reporting Framework, supported by regular independent evaluations across justice and health, will provide the transparency, accountability and reflexivity needed to sustain reform. These mechanisms will track system performance, identify emerging risks, and ensure continuous improvement over time.

Ultimately, the future of the Public Intoxication Reform requires ongoing courage: a commitment to deepening community partnerships, embedding cultural safety, maintaining a clear prohibition on expanding police powers, and investing in a system capable of keeping people safe without criminalisation. PIR has set a new benchmark for how jurisdictions can respond to public intoxication. The task now is to strengthen, expand and future-proof this approach so that every person who becomes intoxicated in public is met with care, dignity and a system that understands and responds to their needs.

INTRODUCTION

The decriminalisation of public intoxication in Victoria on November 7, 2023 marked a significant shift in formal mechanisms used to address instances of alcohol intoxication in public spaces. Public Intoxication Reform (PIR) aims to reduce contact with police and the criminal justice system for people found intoxicated in public. Central to the reform was a shift in the response from a criminal justice system-reliant approach to a health-focused response, which attends to the personal and cultural safety and wellbeing of the intoxicated person.

The characterisation of this approach as ‘health-led’ contrasts it with a ‘justice-led approach’ that treats a person’s drunkenness as an offence in and of itself. The health-led approach encourages police to separate a person’s actions from the fact of their intoxication when assessing the need to exercise power, and to treat the intoxication itself as a health issue. Notably, Victoria is the only jurisdiction to date that has not supplemented police powers in response to public drunkenness decriminalisation. The absence of replacement powers is intended to prevent criminalisation by other means, such as the use of public order, move on, or other offences as proxy mechanisms to detain intoxicated people.

For Aboriginal and Torres Strait Islander Peoples, PIR cannot be separated from a long record of over-policing, disproportionate criminalisation, and profound harms, including deaths in custody. Despite sustained recommendations from the Royal Commission into Aboriginal Deaths in Custody, these harms continued, brought into sharp focus by the death of Aunty Tanya Day. The Yoorrook Justice Commission (Yoorrook) has reiterated the need for decriminalisation, independent oversight, and the meaningful inclusion of First Peoples’ voices in reform. Crucially, this shift reflects decades of advocacy led by Aboriginal organisations—such as the Aboriginal Justice Caucus—and sustained grassroots activism by Aboriginal Community-Controlled Organisations (ACCOs). Through community campaigns, coronial advocacy, policy submissions, and on-the-ground service leadership, these bodies have kept public intoxication on the reform agenda and insisted that responses prioritise cultural safety, self-determination, and accountability.

In October 2023, Monash University was appointed to evaluate the justice impact of the first 22 months of PIR. This final evaluation report details the insights gained from key government and non-government stakeholders and members of marginalised (at-risk) community groups throughout the evaluation, and identifies opportunities for future refinements of the PIR implementation.

CONTEXT OF THE REFORM

Victoria’s Public Intoxication Reform responds directly to recommendations made in the 2020 *Seeing the Clear Light of Day: Expert Reference Group (ERG) on Decriminalising Public Drunkenness* report. These recommendations comprised four pillars, with the first three focused on those who are intoxicated in public. Specifically, the ERG report strongly recommended that those intoxicated in public and at risk to themselves or others should:

- > Be **safe**;
- > Have access to **culturally appropriate care**; and
- > Have **minimal contact with the criminal justice system**.

The fourth pillar attended to first responders (including members of Victoria Police) and the community, recommending that their **safety** be protected. A key aim of the model is to reduce incarceration, prevent deaths in custody, and to provide culturally-appropriate care grounded in principles of public health.

The ERG report was released following family, supporter and community advocacy calling for reform after the 2017 death in police custody of Aunty Tanya Day. While the report provided the catalyst for change in public intoxication laws and practices, the PIR also followed over 30 years of advocacy by First Nations communities and allies, having been first recommended in the April 1991 final report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).

Victoria, the second last Australian jurisdiction to decriminalise public intoxication and the second to do so since the RCIADIC final report (Alcohol and Drug Foundation, 2023), had a unique opportunity to draw on nearly 50 years of reform experience across other states and territories (Milford, 1991). Unlike elsewhere, Victoria has removed public intoxication offences without maintaining related police powers such as ‘protective custody’, which allow police to detain intoxicated individuals for safety reasons—powers associated with ongoing risks of deaths in custody (VALS, 2023).

Victoria's approach is further distinguished by its PIR model, which positions responses entirely within a public health framework (Human Rights Legal Centre, 2023). This approach is particularly significant given recent ministerial discussions about reversing decriminalisation in other jurisdictions, such as Queensland (The Guardian, 2025).

GOALS OF THE REFORM

The Public Intoxication Reform aims to ensure the safety of people intoxicated in public and provide them with culturally appropriate care while minimising their engagement with the criminal justice system. PIR hinges on a state-wide health response model which bridges medical (which treats clinical aspects of intoxication, including addiction-related elements) and social welfare (which focus on safety and wellbeing) approaches to best ensure the safety and wellbeing of intoxicated people. In so doing, PIR seeks to achieve its overarching goal of diminishing incarceration rates and preventing deaths in custody.

The PIR relies upon effective interaction between health services, Ambulance Victoria, Triple Zero Victoria, and Victoria Police to address community safety risks and ensure compassionate and health-centred interventions for people intoxicated in public. Key elements of the multi-agency response are:

- > **On-demand outreach services and transportation.** Outreach services will undertake screening for health and safety needs, and provide support and referral to other services (as needed) for general and at-risk populations in metropolitan and regional areas of the state. The focus on safety also means that the response will include the identification of safe locations and ensuring transportation to those places;
- > **Sobering centres and places of safety** will be set up in metropolitan and regional areas, with specific centres (metropolitan) or specific services (regional) established for Aboriginal Peoples. These centres will be supervised by properly trained clinical staff; and
- > **Centralised intake, referral and dispatch supports,** in which calls for referral to PIR health services are received and prioritised, and a clinical staff-operated helpline is provided to support outreach teams engaging with intoxicated people.

While the reform represents a significant change to community policing and policing operations, police continue to have an integral role under this model, including in addressing community safety concerns (with intoxication no longer the threshold for intervention). Where no community safety risks exist, police play a role in de-escalation and providing support and consent-based referrals to appropriate health services, including to Ambulance Victoria for serious or emergency health risks. This approach allows the response to balance public safety with compassionate and health-centric interventions for people intoxicated in public.

PURPOSE OF THIS EVALUATION

This evaluation focuses on the justice system impacts of PIR, giving specific attention to the subsequent changes to policing practices, legal outcomes, and justice-related consequences following the repeal of public drunkenness as an offence. It draws upon the Reform Theory of Change (RToC; HMCTS, 2021) and the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance; Glasgow et al., 1999) framework to assess the effectiveness of transitioning from a justice-based response to public intoxication to a health-based approach, whether this transition achieved its intended outcomes, and document any challenges experienced or encountered by diverse key stakeholders in the reform process.

Led by Monash University, the evaluation is informed by partnerships with key government, service, and community stakeholders. Furthermore, it was guided by the Community, Legal and Advocacy Services (CLAS) Advisory Committee, which met 3-monthly over the course of the evaluation period, ensuring that the evaluation remained faithful to the ERG report and community priority.

The evaluation aims to:

- > Assess the fidelity and outcomes of PIR implementation across police and justice processes;
- > Examine unintended consequences or system adaptations that may undermine reform intent;
- > Centre the experiences of Aboriginal and Torres Strait Islander Peoples, South Sudanese and other marginalised groups; and
- > Support reflexive practice and continuous improvement.

This report incorporates insights gained through 'process, impact and community impact' evaluations to inform government recommendations on how to support and strengthen the PIR into the future. Specifically, the evaluation focuses on the role of PIR in reducing engagement with the justice system and mitigating a spectrum of associated harms including death in custody and other forms of harm.

RESEARCH QUESTIONS

The evaluation was guided by ten research questions (RQs), which draw upon those initially developed by the Department of Justice and Community Safety (DJCS; see Appendix A) and later reframed through co-design workshops with Victoria Police, DJCS, the Aboriginal Justice Caucus (AJC), the Victorian Aboriginal Legal

Service (VALS), Yoorrook Justice Commission, Regional Aboriginal Justice Advisory Committees (RAJACs), the Implementation and Monitoring Oversight Group (IMOG), the Department of Health, Ambulance Victoria, and Triple Zero Victoria. These RQs were endorsed by the CLAS Advisory Group and seek to explicitly connect the goals of the evaluation (outlined above) with the practical work of data collection and analysis.

Each research question was designed to address one or more evaluation aims, and to support a structured, mixed-methods approach that integrates qualitative and quantitative evidence (see below for detailed information on research methods). Together, these RQs reflect the evaluation focus on justice system impacts, system integration, cultural safety, and equity:

- 1. Implementation fidelity:** How has the PIR been implemented as planned and in accordance with its intended purpose? If not, how are any challenges being addressed? How has implementation of PIR differed across the regions? Are there geographic disparities in how PIR is being experienced?
- 2. Police responses:** What operational and structural responses have been employed by Victoria Police for responding to people who are intoxicated in public? Have these aligned with the PIR objectives? If not, what are the barriers for Victoria Police? To what extent has there been a culture change within Victoria Police and other services when responding to PIR incidents? Has this been informed by training and guidelines?
- 3. Custody reduction:** Has PIR been effective in reducing the police custody of people who are intoxicated in public, particularly for disproportionately affected cohorts?
- 4. Use of outreach:** What factors have influenced the effectiveness of outreach services in responding to public intoxication and reducing justice system involvement, including through a) referrals from police and b) diversionary referrals that avoid police involvement (e.g., from liquor licensees, local councils, or transport providers)?
- 5. Police contact:** To what extent has PIR decreased contact between Victoria Police and people intoxicated in public, especially Aboriginal and Torres Strait Islander Peoples and other disproportionately affected community groups? What are the communities' insights on the cultural safety/appropriateness of any contact that has occurred?
- 6. Use of power:** To what extent has police power been exercised in interactions with people who are intoxicated in public? What factors affect whether power is used in these interactions? Are there indications of ongoing criminalisation through the use of police powers, including arrests for alternative low-level offences?
- 7. Human Rights alignment:** How aligned has the justice and legal infrastructure supporting the implementation of PIR in practice been with the Victorian Charter of Human Rights and Responsibilities Act 2006?
- 8. Unintended consequences:** What have been the unintended justice outcomes of the PIR?
- 9. Reflexivity:** How has reflexive practice been used to monitor and address known risks identified at the outset of the PIR (e.g., service gaps, role clarity, or access issues)? What changes have been made to policies or procedures in response to emerging risks or unintended consequences?
- 10. Partnerships:** What partnerships have been actively engaged as a result of the PIR?

These RQs also provide the basis for the structure of the report findings (on the following page).

EVALUATION FRAMEWORK

To respond to the RQs, the evaluation draws upon two established frameworks for exploring policy and program change: the Reform Theory of Change (RToC; HMCTS, 2021) and the RE-AIM framework (Glasgow et al., 1999). Both are outlined below.

REFORM THEORY OF CHANGE (RTOC)

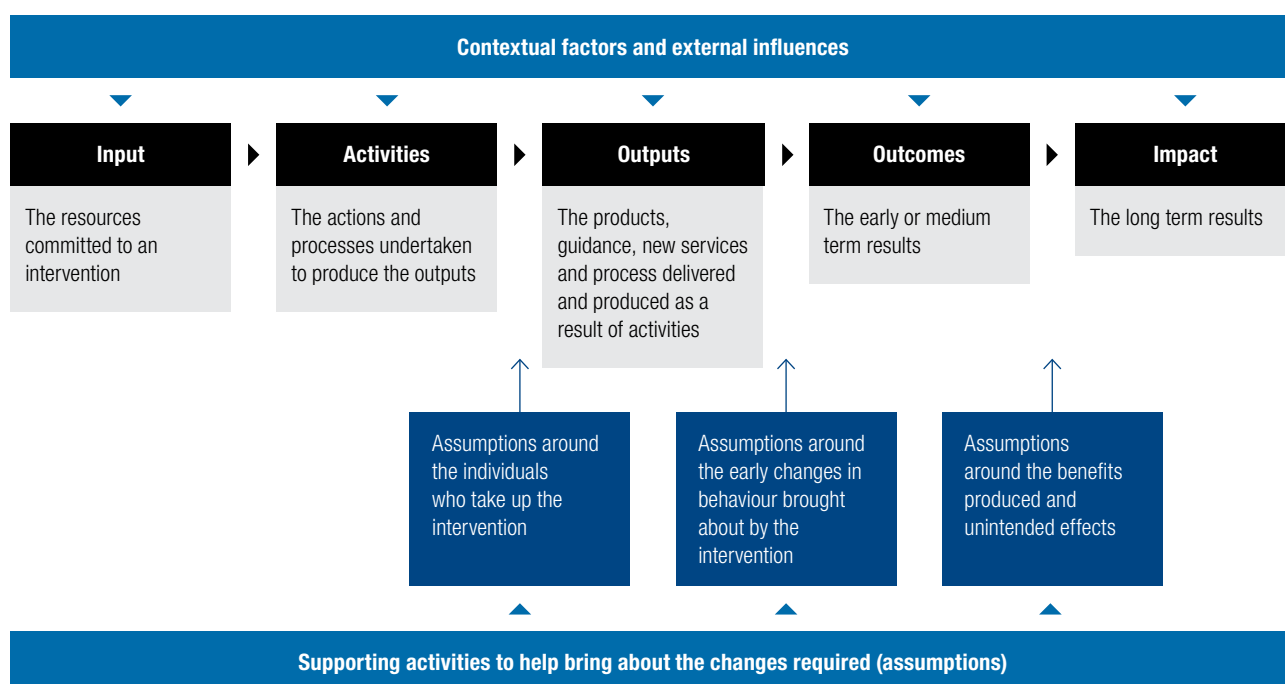
This project employs an adapted version of the Reform Theory of Change (RToC) framework developed by the United Kingdom's Ministry of Justice in 2021 (HMCTS, 2021). It applies the 'theory of change' model to judicial reform and seeks to encapsulate both the 'process of reform' and the 'impact'. Of particular relevance to the current evaluation, the RToC also seeks to capture non-linear transformations that contribute to processes of change (law reform). The team employed the RToC approach to: a) guide the evaluation scope and methodological plan to determine the extent to which the reform-specific objectives are achieved and b) to explain 'how' reform activities contribute to the changes that produce the final impacts (HMCTS, 2021). The key elements of the RToC are shown in Figure 1.

The RToC acts as a living record of implementation and evaluation, and is updated across the evaluation timeline. As shown in Figure 1, *Inputs* include the various personnel, financial, time, social (including social capital – the resources that are embedded within relationships) and political resources that have been committed by the Victorian Government to implement the intervention. 'Outputs' are defined as the tangible (e.g., procedures) and intangible (e.g., individual policing practice) products that are produced through the PIR. 'Outcomes,' in contrast, are the short-and-medium-term results of the intervention.

The complexity of the RToC is useful for the current evaluation as the PIR involves multidirectional and complex pathways across multiple agencies and jurisdictions. In addition to identifying the inputs, constraints and enablers in achieving the evaluation goals, the RToC also articulates any assumptions that shaped the evaluation. For the current evaluation, these assumptions are:

- > Decriminalisation will reduce avoidable contact with the justice system;
- > Police responses will shift from enforcement to care-oriented referrals;
- > Outreach and sobering services will provide safe alternatives to custody; and
- > Trust, cultural safety, and human rights compliance will improve.

FIGURE 1:
Key elements of the Reform Theory of Change (RToC; HMCTS, 2021)

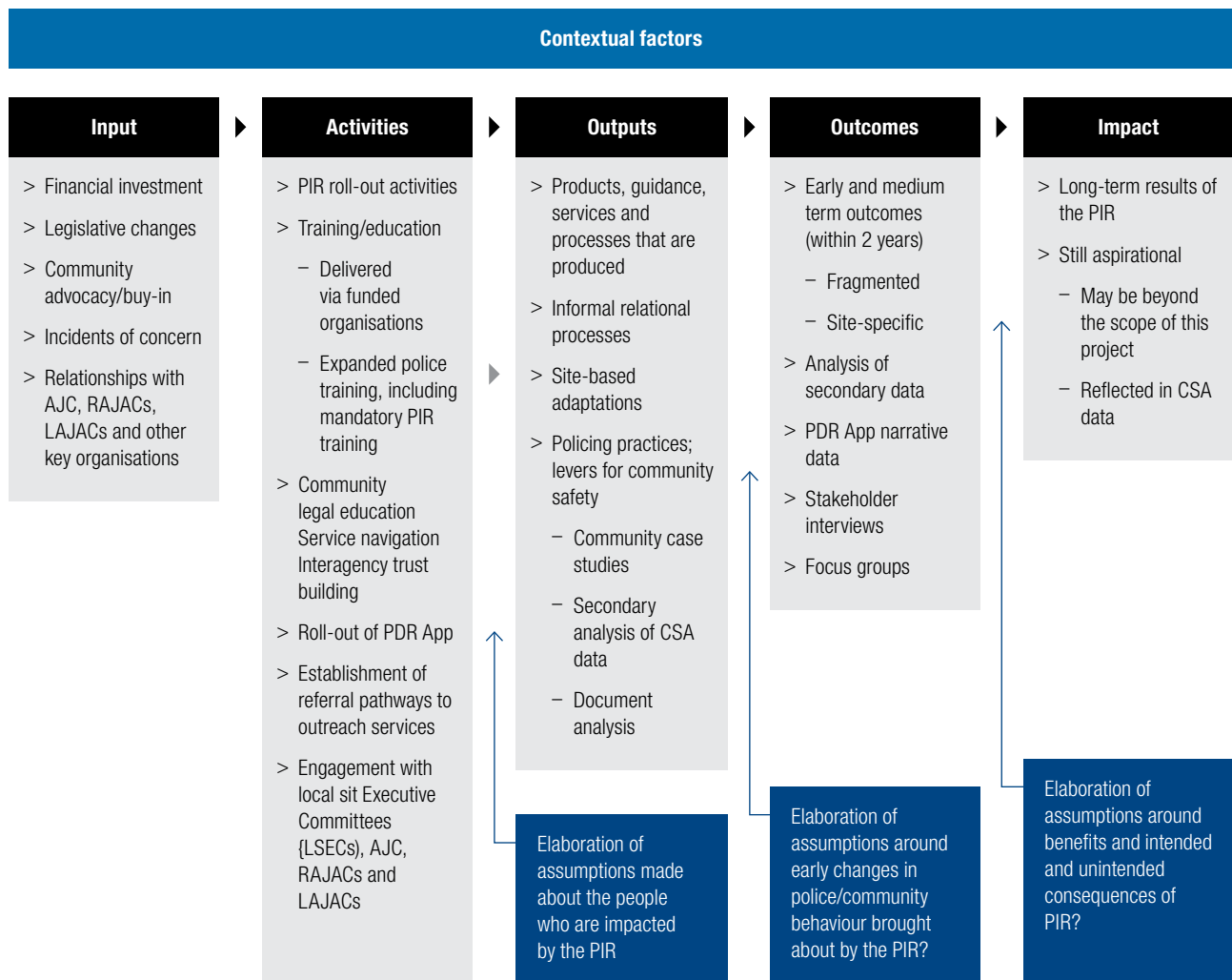


The evaluation tests these assumptions against actual implementation and observed outcomes, by incorporating feedback loops to recognise how operational drift, role confusion, or service failure may produce unintended harms. Thus, by tracking the *context* of the PIR along with its process and the tools employed, the generated theory of change identifies ‘what’ has contributed to (or hinders this) reform success and ‘how’ this occurred—that is, it provides a way to visualise and understand the

mechanisms and causal pathways involved in achieving the reform’s outputs, outcomes and goals. It also offers a tool to understand the process involved in applying **activities** generated by the PIR. Figure 2 (below) identifies: inputs, activities, the outputs created, the outcomes (intermediate and end of evaluation) that result from changes, higher-level impacts, impact pathways, and barriers that impede attainment of each of these.

FIGURE 2:

An outline of the Reform Theory of Change (HMCTS, 2021) and its implementation for the current evaluation



The RToC was applied alongside the RE-AIM framework (Glasgow et al., 1999), which will determine the **R**each (which captures the key evaluation questions related to appropriateness), **E**ffectiveness, **A**doption, **I**mplementation (which includes efficiency) and **M**aintenance (sustainability) of PIR-related initiatives and activities. Bridging the RToC with the RE-AIM framework also allowed the elucidation

of the individual and system-level factors that support or impede the translation of initiatives into the anticipated outcomes (Holtrop et al., 2021; Glasgow et al., 2019; Kwan et al., 2019). As shown in Table 1, the integration of these two frameworks allowed the application of a single and simple framework to simultaneously conduct both process and impact evaluations.

TABLE 1:
Alignment of RQs with RE-AIM and RToC frameworks

EVALUATION RQ	RE-AIM DIMENSION(S)	RTOC COMPONENT(S)	EVALUATION TYPE
RQ1: Implementation fidelity	> Adoption > Implementation	> Input > Activities > Outputs	> Process
RQ2: Police responses	> Effectiveness > Implementation	> Input > Activities > Outputs	> Process > Impact
RQ3: Custody reduction	> Reach > Effectiveness	> Outcomes > Activities	> Impact > Community Impact
RQ4: Use of outreach	> Adoption > Implementation	> Input > Activities > Outputs	> Process
RQ5: Police contact	> Reach	> Outcomes	> Process > Community Impact
RQ6: Use of power	> Effectiveness	> Activities	> Process
RQ7: Human rights alignment	> Reach > Implementation	> Outcomes	> Process > Impact
RQ8: Unintended consequences	> Implementation	> Outcomes	> Process > Community Impact
RQ9: Reflexivity	> Maintenance	> Output > Outcomes	> Process > Impact > Community Impact
RQ10: Partnerships	> Adoption	> Input	> Process

The central components of our two evaluation frameworks—inputs, activities, outcomes and contexts—are embedded in the Program Logic (see Table 2, below).

TABLE 2:
Public Intoxication Reform Evaluation Logic (includes RToC and RE-AIM dimensions)

CONTEXTS		
Social and Political	Cultural	Geographic
> Community encounters with Victoria Police under the PIR model > Patterns of discretionary policing and public contact > Political/Ministerial commitment and approaches	> Service-specific cultural protocols and trust dynamics > Cross-agency relationships and informal escalation practices	> Regional variation in service coverage and access > Local implementation practices (metro vs rural) > Local government/police culture
INPUTS (METHODS AND PARTICIPANTS OF THIS EVALUATION)		
Stakeholders involved in PIR	Stakeholders impacted by PIR	Disproportionately affected cohort groups
> Victoria Police (frontline + exec) > DJCS, DH > VAHS and outreach and sobering services	> Aboriginal and Torres Strait Islander communities > South Sudanese Australian community > Service providers across sites	> Aboriginal people > South Sudanese people > People with unstable housing, co-occurring AOD or MH
Justice system data	Policy and documentation	Literature and context
> PDR App data (quant and narrative) > Triple Zero CAD data > Custody data > CSA LEAP-based offence data (incl. repealed offences and public order offences)	> PIR Health Model Framework > PIR Service Framework > Chief Commissioner's Instruction > Training content	> Academic and grey literature on public intoxication, discretion, policing and decriminalisation > ERG and Yoorrook reports
Community and stakeholder insights	Additional sources	
> Yarning circles > South Sudanese Australian focus groups > Service provider interviews > VicPol member interviews	> Incidents of concern corpus	

ACTIVITIES		
Policy and implementation analysis	Fieldwork and stakeholder engagement	Cross-system analysis
> Mapping of PIR implementation fidelity > Policy document review > Comparative literature review	> Interviews (VicPol, services) > Yarning circles > South Sudanese Australian community engagement	> PDR App analysis (quant + narratives) Trend analysis of custody and charges Incident typologies (IBAC, notifiable incidents) > Analysis of VAHS referral call data
Analysis of police discretion and power	Community-grounded interpretation	Reflexive practice tracking
> Narrative analysis of power use > Mapping substitution effects (e.g. new offences) > Regional and demographic comparisons	> Community-led thematic coding > Aboriginal and culturally specific interpretation of policing patterns	> Mapping adaptive responses by VicPol and services > Evidence of learning loops (complaints, briefings, internal review)
OUTCOMES		
Justice system impacts	Equity and harm reduction	System learning and transformation
> Reduction in use of police custody for intoxication > Reduction in use of coercive powers for intoxicated individuals > Diversion away from criminal charges or arrest pathways	> Fewer adverse outcomes for First Nations people > Reduced custodial responses for disproportionately affected cohorts > Increased community trust in alternative responses	> Identification of unintended consequences > Clarification of discretionary decision points > Evidence of improved police/community relationships > Clearer delineation of roles between justice and health
Community-level outcomes	Institutional/systemic outcomes	
> Greater awareness of decriminalisation > Stronger access to culturally safe alternatives > Improved sense of safety and dignity	> Clear referral pathways and decision protocols > Increased alignment with Charter obligations > Institutional capacity for ongoing monitoring and adaptation	

METHODOLOGY

OUR APPROACH AND INDIGENOUS RESEARCH METHODOLOGIES

Given the significance of these reforms to Aboriginal and Torres Strait Islander communities, the evaluation is guided by Indigenous research methodologies (Figure 3). The Indigenous leadership and governance of the evaluation respects the political expression and need for Aboriginal and Torres Strait Islander Peoples to determine how, and by whom, narratives are constructed to ensure that they reflect Indigenous cultural values and lived experiences, including in institutional contexts such as the justice system. The methodological approach reflects the right of Aboriginal and Torres Strait Islander Peoples to be involved in research that concerns them, placing importance on fostering relationships and genuine decision-making powers. This approach is detailed further in the following section.

At its core, evaluating PIR is not only about measuring policy outcomes but about recognising the rights, dignity, and self-determination of the communities most affected. The reform was introduced to address the harms of criminalisation, particularly the disproportionate impact on Aboriginal and Torres Strait Islander peoples, yet its success cannot be captured solely in figures about reduced custody or diversion. True impact—particularly community impact (one of the three types of evaluations employed in this project)—lies in how reforms are felt: whether they strengthen trust, respect the authority of community knowledge, and support pathways that are culturally safe and responsive. Central to this is self-determination.

Evaluating PIR requires an approach that does not speak for communities but listens to them, honours their authority, and acknowledges their role in shaping both care and accountability. Indigenous research methodologies guide this process, allowing the evaluation to privilege collective

narratives and relational ways of knowing alongside system-level data. They recognise that public intoxication is not an isolated event but one that intersects with histories of dispossession, systemic inequality, and community resilience. In this way, the current evaluation is more than a technical exercise—it became a practice of deep listening and respect, led by relationships rather than imposed frameworks. Being responsive to relationships also means recognising that reform is not enacted uniformly. Consent, cultural safety, and duty of care are negotiated differently in urban centres, rural regions, and across diverse communities. Police, service providers, and community organisations all interpret and carry responsibilities differently; these differences shape how safe or unsafe, supported or unsupported, individuals feel within the PIR framework. An evaluation grounded in relationships can trace these variations, showing where the reform is lived as genuine care, and where gaps risk reproducing control or marginalisation.

When advocacy, self-determination, and relational accountability come together, the evaluation evolves into a shared project of truth-telling and transformation. For communities, it ensures their stories and authority remain central. For policymakers, it offers insight into the conditions that allow reform to succeed or falter. In both respects, it strengthens a vision of justice that is not only about reducing harms in the present but about reshaping the system toward one that is culturally grounded, people-centred, and sustainable across generations.

The justice evaluation of Victoria's PIR was designed from the outset to be more than a measurement exercise. It is both a mirror and a driver of reform, modelling the very principles it seeks to assess. By shifting responses away from criminalisation, centring Aboriginal leadership, embedding cultural safety, and ensuring outcomes are meaningful for the communities most affected, the evaluation itself enacts the aims of PIR.

FIGURE 3:

The characteristics of Indigenous research methodologies (National Indigenous Research and Knowledges Network, 2024)



Recognition of Indigenous worldviews, knowledges, and realities as distinctive and vital to their existence and survival.



Honouring social protocols (mores) through which the Indigenous Communities can live, learn and situate themselves on their lands, and the lands of others.



Emphasising social, historical, and political contexts which shape their experiences, lives, positions and futures.



Indigenous research methods will privilege Indigenous voices, peoples, and lands.



Identifies and addresses issues of importance to Indigenous Peoples and Communities.

EVALUATION GOVERNANCE AND DESIGN

This evaluation had to be undertaken with great care. Public intoxication has been a historically and politically contentious issue, entangled with the legacy of Aboriginal deaths in custody and fraught public debate. To be credible, the evaluation needed to set new standards—not only in measuring reform, but in ensuring integrity and strengthening trust among the communities most directly impacted.

Guided by the governance structures established for PIR—including the Community, Legal, and Advocacy Services (CLAS) Advisory Committee and the strong involvement of Aboriginal and Torres Strait Islander researchers—the evaluation has been conducted as a collaborative, adaptive process. Its design rests on four interconnected pillars (Figure 4), adapted from Indigenous research methodologies, which have been fundamental to holding this work to the highest standard. They safeguard the integrity of the process and ensure the evaluation actively contributes to reform delivery while building community trust.

FIGURE 4:

The Four Pillars of Indigenous Research Methodologies



**INDIGENOUS
LEADERSHIP
& GOVERNANCE**



**RELATIONSHIPS
FIRST**



**MATERIAL
EQUITY**



**COMMUNITY
BENEFIT**

THE FOUR PILLARS IN PRACTICE

1. Indigenous Leadership and Governance

Aboriginal voices lead both design and process. Aboriginal researchers are embedded across all stages of the evaluation, shaping methodology, data collection, and interpretation. Governance is operational, not symbolic: decisions about priorities, tools, language and reporting are community-led. The CLAS Advisory Committee—with representation from the Victorian Aboriginal Legal Service, Djirra, VAHS, Dhadjowa, and South Sudanese Australian community members—provides oversight and ensures accountability, self-determination, and alignment with Yoorrook recommendations.

2. Relationships First

Relationships First means evaluation is built on respect, reciprocity, accountability and trust. Engagement is iterative, with findings shared back in real time to allow practice adjustments. Crucially, this principle acknowledges the daily labour of communities and organisations implementing health- and community-led responses on the ground. Being respectful of our ‘ask’—mindful of shifting conditions and contexts and avoiding unnecessary burdens—honours and supports frontline practice. This careful approach has surfaced tensions such as police uncertainty about powers, challenges around consent, and service gaps between urban and regional sites. These are addressed collaboratively, showing how respectful relationships make evaluation a tool for improvement, not intrusion.

3. Material Equity

Material Equity ensures that participation is possible and meaningful for all. Evaluation tools are accessible and culturally appropriate, drawing on culturally responsive methods like Yarning to allow participants to share in ways that feel safe and familiar. Policymakers, police, community workers, and community members all engage on equal footing. Resources are directed to remove barriers, embedding equity into priorities, processes and outcomes.

4. Community Benefit

Community benefit requires that the evaluation deliver tangible improvements, not just reporting. Beyond tracking custody rates or offence statistics, it asks whether communities feel safer, more culturally supported, and less exposed to criminal justice contact. Benefits include strengthened referral pathways, culturally safe practices via bespoke support and services, improved community trust, and better health-led responses. For Aboriginal and Torres Strait Islander peoples and South Sudanese Australian communities disproportionately affected by the old laws, this is the measure of reform success.

RESEARCH METHODS

To best capture the perspectives of all stakeholders involved in PIR, and in line with Indigenous Research Methodologies, the evaluation employed a mixed-methods study design (Table 3) which captured both systemic shifts and lived experiences. Quantitative data included CSA datasets and police interactions recorded through the PDR App, while qualitative evidence—Yarning Circles, community focus groups, stakeholder interviews, co-design workshops, and analysis of policy and media discourses—provided depth and context. Together, they offered a layered account of how PIR is working across diverse settings.

In addition to these methods, the project was also informed by insights from co-design workshops (undertaken between 2023 and 2025) and the CLAS Advisory Group meetings (2024-2025). All qualitative work was grounded in community- and stakeholder-engaged ethics and methodology, while the quantitative analysis consisted of secondary analysis of data provided by Victoria Police and CSA.

IBAC, VALS AND NGWALA CASE STUDIES

As part of the qualitative data, the evaluation drew on de-identified case studies provided by IBAC, VALS and Ngwala. These appear throughout the report to illustrate key issues. Both IBAC and VALS hold important accountability roles in the reform; Ngwala plays a key role in delivering the health response. The case studies were supplied to Monash solely for the PIR justice evaluation and must not be used for any other purpose; IBAC matters relate to complaints received and some may remain under investigation.

IBAC is Victoria's agency for preventing and exposing public sector corruption and police misconduct across state and local government, police, parliament, and the judiciary. It receives complaints and notifications, investigates serious matters, and promotes prevention through education to strengthen integrity and accountability.

VALS' Custody Notification Service, established under section 464FA of the *Crimes Act 1958*, provides timely legal and welfare support to Aboriginal detainees, helping prevent mistreatment and deaths in custody. While IBAC and VALS have different core mandates, their case studies in the context of PIR point to the need for strong oversight and culturally safe legal protections within Victoria's justice system.

The Ngwala Willumbong Public Intoxication Response Model provides a culturally safe, health-based state-wide response to instances of public intoxication. Their model of care is detailed further in this report (p.50). The case studies provided by Ngwala offer more detailed insights into the on-the-ground experience of public intoxication responses. Each of these case studies highlights the complexities encountered by First Nations Victorians, outreach workers and Victoria Police members in ascertaining the most appropriate responses.

TABLE 3:
Overview of the multiple methods collected for the current evaluation

METHOD	APPLIED TO DATA SOURCES
Document and policy analysis	Government documents and legislation (2024-2025)
Literature synthesis	Academic literature and public reports (2023-2025)
Descriptive and trend analysis	PDR App quantitative data (2025), CAD and CSA data, custody and charge data (2024-2025)
Thematic and narrative analysis	PDR App narratives (2025), interviews with VicPol and service providers (2024-2025), media analyses (2025)
Human rights analysis	PDR App narratives (2025)
Cross-case analysis	Service provider interviews (2024-2025), regional patterns (via CSA; 2024-2025)
Community-led thematic analysis	Yarning circles and focus groups with Aboriginal and South Sudanese Australian community members (2024-2025)
Case study synthesis and typology development	IBAC, VALS and Ngwala cases, notifiable incidents, incidents of concern corpus

SITUATION ANALYSIS, INCORPORATING LITERATURE SYNTHESIS AND POLICY DOCUMENTATION ANALYSIS

Analysis of relevant policy documents and grey literature was undertaken as part of a situation analysis exercise. This included data and reports on the PIR trial, and facilitated a comprehensive examination of the current context, factors, and trends relevant to the reform, with the aim of achieving a clear understanding of the environment in which the reform has operated (and continues to operate). In addition, an analysis of media reports was undertaken to identify other influences on the context of reform. Overall, the situation analysis assisted in identifying key stakeholders, assessing strengths and weaknesses, opportunities and threats, and understanding any existing challenges or barriers.

DESCRIPTIVE AND TREND ANALYSIS

CSA conducted linked data analysis using Victorian Social Investment Integrated Data Resource (VSIIDR) data to examine health and social service contacts for 2 cohorts of people who have been intoxicated in public and recorded by police. The VSIIDR comprises linked administrative data capturing how Victorians use selected government health, human services, education and justice services. Linked administrative data can be used to examine generalised and de-identified client pathways through service systems to inform practical decisions about service and policy design and show the impacts and outcomes of contact with services. The data sources in Table 4, via VSIIDR, were used for this analysis.

TABLE 4:
VSIIDR data sources

SOURCE	COMPONENT OF ANALYSIS/CONTACTS COUNTED	DATE RANGE
VicPol – Law Enforcement Assistance Program	People linked to a police-recorded public intoxication related offence.	Oct-2021 to Nov-2023
VicPol – Public Drunkenness Reform Application	People with a recorded public intoxication interaction with police.	Nov-2023 to Dec-2024
DGS – Victorian Death Index	Study cohort with a recorded death date during the study period.	Oct-2021 to Dec-2024
DH – Emergency Department (VEMD)	Study cohort with an Emergency Department presentation and whether a drug and alcohol diagnosis was recorded during the study period.	Oct-2021 to Dec-2024
DH – Alcohol & Drug Services (VADC)	Study cohort with an Alcohol & Drug Service contact and service event, and the treatment end reason during the study period.	Oct-2021 to Dec-2024
DH – Mental Health Community Services (CMIODS)	Study cohort with a Mental Health Service contact and service event, and whether that contact was linked to an alcohol and drug service location during the study period.	Oct-2021 to Dec-2024
DH – Admitted Episodes (VAED)	Study cohort with an Admitted Episode, and whether the episode had an alcohol and drug diagnosis, care type or referral recorded during the study period.	Oct-2021 to Dec-2024
DFFH – Homelessness Services	Study cohort with a Homelessness Service contact and/or accommodation start date, and whether that contact had a reason for assistance related to alcohol and drugs recorded during the study period.	Oct-2021 to Dec-2024
DH – Non-Admitted Episodes (VINAH)	Study cohort with a Non-Admitted Health Service contact and/or episode, and whether the episode had a health condition related to alcohol and drugs recorded during the study period.	Oct-2021 to Dec-2024

The study period ran from 1 October 2021 to 31 December 2024. VSIIDR data was used to identify unique people linked to police recorded instances of public intoxication through two Victoria Police datasets:

- > Pre-reform: through police-recorded public intoxication offences in Law Enforcement Assistance Program (LEAP) incident data; and
- > Post reform: through police-recorded public intoxication-related interactions in the Public Drunkenness Reform Application (PDR App).

The first incident per person within each cohort was classified as the *index public intoxication interaction* for this analysis. The study cohorts for this analysis include people with at least 12 months between their index public intoxication interaction and 31 December 2024, and includes:

- > 4,049 people in the pre-reform cohort
- > 491 people in the post-reform cohort.

Demographic analysis of the study cohorts is determined by information obtained through VSIIDR. A small proportion of each cohort, 8% (n= 318) of the pre-reform cohort and 5% (n= 26) of the post-reform cohort had no demographic information recorded.

Indigenous status was the most commonly recorded indigenous status in VSIIDR, and is recorded in VSIIDR as either Indigenous, Not Indigenous or Not Stated. The age of the study cohort was determined by age at index public intoxication interaction and grouped as under 25, 25 and over, or Unknown/Not recorded.

It is important to note that country of birth refers to a person's recorded birth country and does not necessarily indicate ethnicity. For this analysis, country of birth was grouped into Australia, Sudan or South Sudan, and Other. Where country of birth is classified as Unknown/Not stated, this means that country of birth is either not recorded in VSIIDR, or is recorded as Inadequately Described, Not Stated or Unknown.

The study cohorts were linked to VSIIDR health and social services data to determine contact with Victorian health and social services within the 12-month study period from their index public intoxication interaction. Keyword searches of the below variables were conducted to determine whether the contact was related to alcohol or drugs:

- > Emergency Department presentation primary diagnosis;
- > Mental Health Service contact service location;
- > Admitted Episodes diagnosis;
- > Homelessness Service reason for assistance; and
- > Non-Admitted Episodes health condition.

The analysis of this data has been explicitly endorsed by the CSA³ to be included in this Report, and is supplemented by additional explanatory aids, developed by the Monash University team, to assist readability. As provided by CSA, data are delimited by police region, rather than by the sites selected via evaluation co-design workshops. Figure 5 overlays evaluation sites with police regions.

FIGURE 5:
Victoria Police Regions, with evaluation sites marked



Source: [Victoria Police Corporate Plan 2024-2025: About Victoria Police](#)

The CSA analysis is based on recorded interactions between Victoria Police and people who were publicly intoxicated between 7 November 2023, the start of the post-reform period, and 31 March 2024, a span of approximately five months. In the reporting below, findings are broken down for four key marginalised groups: Aboriginal and Torres Strait Islander people, people of African backgrounds, young people (aged under 25), and those experiencing homelessness (no fixed address).

Caution is needed when interpreting data for several reasons. First, a significant number of incidents involved people whose Aboriginal status was marked as missing or unknown. This is partly because Victoria Police members only asked about Aboriginal status in some interactions, such as before a PIR referral or during arrests, but not as a standard practice when a person was referred to Ambulance Victoria or left in place. Another contributing factor is that a person being apprehended by police may not identify as Aboriginal even when asked in order to protect themselves from potential discrimination—this is discussed further in the section entitled, *Service provision and related limitations* (p.47). Second, arrest data reflects arrests for offences committed by people who were intoxicated, not arrests for intoxication itself, as public drunkenness is no longer an offence. Finally, all numbers and percentages refer to the count of incidents, not individuals. Since people can have multiple interactions with police, the total number of incidents far exceeds the number of unique individuals.

3. Data provided by the CSA were validated prior to providing them. CSA representatives have also validated the data and interpretation as presented in this report.

Limitations

This analysis includes health and social service contacts recorded in datasets available in VSIIDR. This may not capture all health and social service contacts a person may have for a range of reasons:

- > Contacts with private health or related treatment providers will not be included in this analysis (for example, private rehabilitation supports);
- > Any Commonwealth funded or subsidised health and social service contacts (for example, Medicare subsidised GP or other health practitioner visits);
- > There may be limitations where service contacts were not accurately recorded in VSIIDR due to data entry errors;
- > There may be limitations to data linkage methods where a service could not accurately be linked at the person level due to inconsistencies in personal information recorded in different databases (for example, spelling of names, date of birth typographic errors); or
- > It is possible that other terms related to alcohol and drug related contact have not been identified here due to the choice of search terms used in this analysis (drug, alcohol, intoxic*, overdose).

PDR APP INCIDENT DATA

The PDR App-based incident data was made available for the first 17 months of the post-reform period, from 7 November 2023 to March 2025. However, the recorded number of incidents declined drastically after the first two months. The number of incidents peaked in the first two months of the post-reform period, and has since been on a downward trend, reaching around 100 each in the first three months of 2025. The number of recorded incidents for the most recent period was only about a quarter of the number recorded for the first two months. This may be partly due to Industrial Action (see note).⁴ While this Industrial Action was resolved by late 2024, usage of the PDR App did not return to pre-Action levels. This has implications for the capacity of this report to address two key RQs—implementation fidelity or police responses—in full.

This trend in the recorded number of incidents indicates that the PDR App has not been widely used after the initial few months, particularly since January 2024, the third month of the post-reform period. This raises questions about the value of the data to draw inferences about the time trend in intoxication incidents; for this reason and to enhance the utility of the analysis, data are reported as percentages rather than as numbers.

Given this context and the absence of a pre-decriminalisation baseline for PDR App data,⁵ we decided to focus on the first five months—in each of these months, at least 200 incidents were recorded and this allows inferences about only patterns and not change over time.

The analysis was conducted for four marginalised groups: Aboriginal, African, young (aged under 25 years) and homeless (no fixed permanent address) people. Aboriginality data should be interpreted with caution as a significant number of incidents related to individuals whose Aboriginal and/or Torres Strait Islander status was recorded as missing or unknown. Within the context of a public intoxication event and in line with Victoria Police policy,⁶ police are only enabled to ask a question around a person's Aboriginal and/or Torres Strait Islander status either a) when that person consents to be referred to a health service or b) if that person is arrested. This is so that the correct service (or other supports) can be arranged, where required. In addition, a person interacting with police or Protective Service Officers (PSO) is not obliged to identify themselves as Aboriginal or Torres Strait Islander and, importantly, a person who is Aboriginal or Torres Strait Islander may intentionally choose not to identify themselves as such in police presence if they feel unsafe or fear discrimination. Where the question is not able to be asked, or where an individual elects not to answer this question, police and PSO are unable to verify or record a person's status.

Arrest data represents the number of arrests for offending by people who were also intoxicated. Arrests were not and could not be based on intoxication alone (due to the PIR).

As with the linked data (outlined in the previous section), the numbers and percentages used in the report refer to the count of incidents, not individuals. As individuals can interact with police multiple times, the number of incidents far exceeded the number of unique individuals.

CAD DATA

Computer aided dispatch (CAD) data is information collected throughout the call-taking process and is generated when a person calls 000. This data, provided by Victoria Police, has information on a limited number of items for a subset of intoxication incidents recorded in the PDR App. Only two pieces of information from this data set were analysed: call source and event type. All of the limitations that apply to PDR App data apply to this data set as well.

4. Members of Victoria Police were undertaking Protected Industrial Action during the period of this evaluation. This meant that there were indefinite or periodic bans on the collection of data, recording of daily industrial action instances and provision of information to Victoria Police and the Victoria State Government. During this action, Members were directed not to collect, compile, collate or provide data for the purpose of audits or statistics relating to protected industrial action for internal use or for the Victorian State Government (Advised by Victoria Police to DJCS via memo, October 2024).
5. This is because it was only a requirement for members to collect PDR App data state-wide following decriminalisation.
6. Including Chief Commissioners Instruction (CCI) on *Persons drunk in public*.

QUALITATIVE DATA, AND RELATED THEMATIC AND NARRATIVE ANALYSIS

Qualitative data were collected through five main techniques: Focus groups, yarning circles, interviews, a cohort focus group discussion, and co-design workshops.

Focus groups provide a space for communal knowledge to be recorded informally and conversationally (Liamputtong, 2011), and were employed to capture the perspectives of key stakeholders involved in and/or impacted by the PIR. These focus groups were complemented by semi-structured interviews with marginalised community members impacted by PIR and those who were disproportionately impacted by historic public intoxication laws. Twenty-eight focus groups were undertaken, with each comprising between 6 to over 20 people, and 32 semi-structured interviews took place.

Focus groups lasted a minimum of 60 minutes, ranging in duration from 60-120 minutes. Group discussions were facilitated by a minimum of two researchers: one initiated and moderated the discussion, while the other took notes and provided additional (often technical) assistance. All focus groups were audio-recorded and transcribed.

Focus group questions were developed to capture each of the RE-AIM elements (shown in Table 1, p.15). The question guide was broadly semi-structured and flexible, and the specific direction of each discussion followed iterative principles. This meant that the focus group revolved around the direction the discussion took as it occurred on the day: elements raised by participants in a specific group were followed up in detail and further questions were asked. In addition, the question guide included prompts for participants to discuss their experiences with PIR including implementation, opportunities, and challenges. Additional follow-up questions were asked to obtain deeper insights into participants' responses and gain further information on the specific issues encountered by each of the participant groups.

Participant recruitment for **semi-structured interviews** was extremely challenging, whereas we had a great deal of interest in the focus group discussions—presumably as PIR was seen as a community issue, rather than an individual concern. While these numbers reflect a disparity from the project plan, insights were obtained from a larger number of people than anticipated. In addition, analysis of the interview data indicated that the point of 'data saturation' had been achieved—this is the point at which no new insights are generated (that is, new participants are telling us information that had already been shared), and is a recognised indicator of a rigorous sample size (Guest et al., 2006). The number of focus groups well exceeded the minimum number required to generate high quality insights (Guest et al., 2017).

A focus group discussion and member-checking process—which we term the '**cohort focus group discussion**'—took place at the final CLAS meeting and was aimed at ensuring our findings reflected the perspectives of people from the at-risk cohorts: Aboriginal and Torres Strait Islander and South Sudanese communities, and youth justice, mental health, homelessness and other groups disproportionately impacted by historic public intoxication laws.

Eleven **co-design workshops** were undertaken with key stakeholders and aided in establishing the goals and informing the research methods used. In addition, a co-design workshop with DJCS focused on reviewing findings and developing practical recommendations.

CASE STUDY: SOUTH SUDANESE AUSTRALIAN COMMUNITY

Engagement with the South Sudanese Australian community in both regional and urban settings in Victoria has been significant. We conducted three focus groups in Shepparton, five in Dandenong and one in Werribee, giving a total of 9 focus group discussions. We also conducted five individual interviews with young people across West Melbourne, and one interview with a community leader in Dandenong. In total, approximately 60 South Sudanese Australia community members directly contributed to this consultation. A key limitation of our findings is the relatively small number of young people involved. Despite substantial efforts to recruit young participants—including engaging youth community researchers in regional and urban Victoria—we were only able to speak with eight young people in Melbourne.

Of particular focus in this report is the data obtained from the focus groups conducted with South Sudanese Australian members of the Nuer community. Four of these focus groups were conducted in Nuer with the support of a community interpreter. Across these sessions, we engaged with approximately 40 participants, including several respected community Elders who hold significant influence and play an active role in decision-making within the community. Although the focus groups were held in a particular metropolitan area, participants travelled from across metropolitan Melbourne and from regional areas to share their perspectives on the reform.

HUMAN RIGHTS ANALYSIS

A human rights analysis of the reforms was undertaken in light of relevant rights set out in the Charter, including the use of police powers and the risk of up-charging. This includes an evaluation of PIR-related operational documents such as Victoria Police guidelines and operating procedures. In terms of the particular effect of the reforms on Aboriginal and Torres Strait Islander Peoples, the human rights team examined the data and reform material in light of relevant domestic and international human rights obligations, employing the United Nations Declaration on the Rights of Indigenous Peoples as a crucial tool in guiding this analysis.

DATA ANALYSIS

Focus group, interview, cohort focus group and co-design workshop transcripts and notes were analysed using NVivo, a qualitative data management software. Data were initially coded by members of the qualitative research team, with support from a research assistant. From this, a coding framework, complete with definitions, was generated based on the RQs as well as the topics discussed during the qualitative data collection (Saldaña, 2021). Thematic analyses emphasise the identification and description of both implicit and explicit concepts present within the data, commonly referred to as themes (Guest et al., 2011). Thus, the thematic analysis allowed us to identify key themes within and across the different forms of qualitative data collection (Guest et al., 2011), which supported us to address the RQs and aims.

A LIVING, ADAPTIVE EVALUATION

This evaluation is deliberately adaptive. By embedding Indigenous leadership, privileging relationships, resourcing participation equitably, and ensuring community benefit, it models the justice, equity, and respect at the heart of the reform. Interim findings have been shared quickly, allowing refinements in real time: we have termed this approach 'community-led thematic analysis' (Table 3, p.20). Challenges are treated as opportunities for collective problem-solving, rather than unresolved tensions.

The evaluation also leaves a legacy. Its governance structures and principles provide a model for how reforms in other domains can be evaluated with integrity, cultural safety, and trust at the centre. In this way, evaluation itself becomes a site of reform, not just its measurement.

FINDINGS

Due to the complexity of this evaluation, involving the inclusion of multiple data sets, stakeholders and methods, the findings are organised by the ten key research question thematic areas. This means that each section includes insights from multiple research methods, although it should be noted that some findings have application for multiple research questions. The findings are later synthesised in terms of the RToC and RE-AIM frameworks in the discussion section of this report.

First, however, is a detailed overview of the complex context—including the policing and intersectional, community-based challenges—that have informed and shaped the PIR and its implementation fidelity. This includes a detailed consideration of the terminology used between jurisdictions.

THE COMPLEX CONTEXT OF PIR IMPLEMENTATION

Language matters, especially when considering the specialised terminology of Public Intoxication Reform and how this is employed between government agencies. The language used to describe social realities shapes and is, in turn, shaped by public perception, social attitudes and prevailing cultural norms, media and (importantly in the case of public intoxication), public policy and legislation. One of the central tensions in the implementation of PIR has been around how the reforms themselves are described—specifically whether the term ‘public intoxication’ should take precedence over the term ‘public drunkenness.’

The DJCS and Department of Health (DH) use the name ‘Public Intoxication Reform’—which embeds the term ‘intoxication’—with most, if not all, of their public-facing information and publications, including those generated by community health and legal services, employing the term ‘intoxication.’ In contrast, Victoria Police uses the word ‘drunkenness’ exclusively in all its policies, training and communications. While there is little debate that ‘intoxication’ is a more inclusive and less stigmatising term than ‘drunkenness’, there are also legal implications of the terminology. The continued use of ‘drunkenness’ by Victoria Police is intentional, reflecting the role of the organisation in responding to the specific cohort of people who fall under the legal definition of ‘drunkenness.’

Inconsistency in terminology, and the interchangeable use of these terms, including the global application of ‘intoxication’ to refer to both alcohol and other drug use, has resulted in both operational and communication difficulties across the system. It is undermining the success of the reform and its embeddedness into the community consciousness (see section on *Awareness*, p.85). As a result of the inconsistency, emergency services, health providers, and liquor licensees each interpret and apply the reform in a slightly different way. As one licensee noted:

“An interesting question that was asked at the Liquor Accord meeting that I last went to, which was run by Liquor Control Victoria, was ‘why do you think that licensed venues aren’t using this number?’ And there was just silence on the Zoom. And I put my hand up and I said, “Well, how can you ring a sober centre saying someone’s drunk if you’re not legally allowed to have a drunk person on your premises?” **(Licensee)**

As evident in this quote, terminology also impacts the actions perceived as possible by licensees, in turn impacting the uptake of referral and support services.

Terminology needs to be consistent and streamlined; however, in order to do this, there is an underlying imperative for widespread clarification of reform scope and close examination of how legislative terminology plays out in the operational (including policing and liquor licensing) environment. The following quote from a policy stakeholder further articulates the importance of resolving these issues to enhance PIR success:

“There are two specific infringements that can be issued to the licensee in relation to this reform. One is a licensee is not permitted to have a drunk person on premises, but a licensee is permitted to have an intoxicated person on premises, as long as they do not serve them alcohol. So one of the challenges with the reform when it was rolled out is that it referred to intoxication... Like, I understand the reasons why it was intoxication, not drunk, right? But I think that may have caused confusion amongst the licensees.” **(Stakeholder)**

Legislative aspects

In order to navigate terminology-related tension, it is essential to consider how legislation distinguishes between the two terms. The historical offence that was repealed is ‘public drunkenness’ (not ‘public intoxication’). This is a meaningful distinction and signifies that, from a strictly legal standpoint, the term ‘drunkenness’ is the correct terminology. Using the term ‘intoxication’ in this context misinterprets the legal intent behind decriminalisation and fails to recognise that the terms ‘drunkenness’ and ‘intoxication’ mean two different things in legislation. ‘Intoxication’ encompasses a spectrum of responses from mild to severe, whereas ‘drunkenness’ has a specific threshold limit. Broadly, drunkenness means being at or above a certain point of intoxication. Employing the term ‘intoxication’ when referring specifically to the legislative offence that has been repealed is technically incorrect.

A further complication is the interchangeable use of the term ‘intoxication’ in describing a person affected only by alcohol as well as a person affected by both alcohol and drugs. The *Liquor Control Reform Act 1998* (section 3AB) clearly defines ‘intoxication’ as being the result of the consumption of alcohol only. However, the term ‘public intoxication’ is commonly used across the health sector as a broad descriptor that encompasses both alcohol and other drug (AOD) use. A shift away from ‘drunkenness’ to ‘intoxication’ without a corresponding change in legal terminology would wrap a much larger group of people into a possible police response and is contrary to the intent of the reform.

Sociocultural aspects

Language, however, is not just about legislative accuracy. The shift in terminology from ‘drunkenness’ to ‘intoxication’ reflects more than just a language change—it symbolises a move away from moral and legal judgment toward a contemporary understanding of alcohol use as a health issue. Moreover, it marks a cultural and social transition from a punitive justice response to one grounded in public health, recognising that intoxication often stems from complex social, cultural, and health-related factors and should be addressed through care and support rather than criminalisation.

The community, and in particular Aboriginal stakeholders have been explicit in their view that the term ‘drunkenness’ should be removed from the reform lexicon completely and replaced with ‘intoxication.’ Importantly, Aboriginal stakeholders view the term ‘intoxication’ as carrying less stigma than ‘drunkenness’, emphasising that ‘drunkenness’ has long been associated with negative stereotypes about Aboriginal people, and that the alternative framing of ‘intoxication’ is less discriminatory and more reflective of the reform’s intended shift toward a health-based approach.

Implementation aspects

Outreach and health services reported that they were initially trained and resourced to provide support for the narrow legal scope (only) of ‘public drunkenness’ but were later required to rapidly adjust their models of care to reflect the expanded scope implied by intoxication, including the potential to support people affected by substances other than alcohol:

“This [terminology issue] played out really early on too in the program [when] we thought it was a service to public drunkenness. The funder started using different language that then incorporated a whole range of other potential intoxications and my understanding from the ACCOs is they all pushed back and said, ‘nope, we didn’t sign up for that.’” (Stakeholder)

“All of the language was about public drunkenness, alcohol intoxication. There was no wording in the service guidelines about anything other than that. We’re all aware that there’s poly-substance use out there, but it was very clear that it was public drunkenness. So a lot of these service providers actually developed their models on dealing with people who are alcohol-affected... I think when people started talking about public intoxication, I don’t think it’s that the service providers are against that. It’s that they didn’t actually develop their models to cater for that. And if they did, they need the resources to actually have services available to do that.” (Stakeholder)

Venue operators similarly highlighted the practical impact of the terminological inconsistency. One licensee observed that in the liquor licensing context, ‘intoxication’ is defined and enforceable, whereas ‘drunk’ is not. This distinction affects compliance obligations—venues are legally required not to have ‘drunk’ patrons on premises yet are simultaneously expected to contact services about people who may be ‘intoxicated’. As the licensee noted in the quote above, intoxication as a legislative term holds a lower threshold than drunkenness, and the absence of a clear, shared definition risks exposing staff to liability while creating uncertainty about when and how services should be called.

Terminology also shapes what decisions are made in terms of seeking support. Community members more broadly expressed uncertainty as a result of the inconsistency in terminology. They reported confusion about when it is appropriate to call PIR-related services, particularly in cases where a person is affected by drugs other than alcohol.

Recommendations 1 to 3 recognise the (often-contrasting) goals and purposes of terminology as related to all agencies with vested interests in PIR. Each is agency-specific and responds to the sociolegal complexities in advocating for clarity to enhance implementation and awareness.

Recommendation 1

Victorian Government, supported by the **Department of Justice and Community Safety** to:

- A. Review all alcohol-related legislation with a view to standardising the definition of 'intoxication' for the purposes of consistency and clarity under Public Intoxication Reform.

Note – this recommendation refers to standardising language only; it is not recommending an adjustment to reform scope or intent

Recommendation 2

Department of Health to:

- A. Update all public-facing material to incorporate standardised legislative terminology.

Recommendation 3

Victoria Police to:

- A. Align all policy, training, IT and communications material with standardised legislative terminology; and
- B. Design, develop and implement training for police and protective services officers that explains standardised legislative terminology and acknowledges the historical harm and stigma of the term 'drunkenness.'

Recognising Different Patterns of Intoxication

Evidence from local service providers, licensees, and health and legal stakeholders points to two distinct patterns of intoxication in the community: event-based and chronic. These patterns require different operational strategies under the PIR, as the drivers, frequency, and appropriate responses vary significantly.

"The key factors in the local response really was the difference between chronic public intoxication—so those individuals that we know sort of frequent a lot of the services within the smaller towns or bigger regional towns—and then the event-based kind of being public, being intoxicated in public." (Stakeholder)

"The drunkenness that you're seeing out of licensed premises is possibly not the same level of drunkenness you're seeing on the street where someone's been drinking since the morning, for example." (Stakeholder)

Event-based intoxication often spikes during festivals, sporting events, and other large gatherings. Stakeholders observed that these peaks can overwhelm existing services if not anticipated. In such cases, locally tailored responses, such as temporarily extending service hours and deploying additional outreach capacity can reduce strain and improve responsiveness. One stakeholder also noted that a lot of intoxication occurring on licensed premises is linked to such events. They note that while they can identify and refuse service to those known to have chronic alcohol dependency, event-based intoxication presents a more transient and unpredictable challenge.

Chronic intoxication, in contrast, reflects sustained dependence on alcohol. Stakeholders emphasised that dependency is not a matter of choice or timing, with one stating that: '*a dependent person doesn't choose what day of the week they drink.*' Health services report seeing the same people repeatedly accessing sobering services. These repeat presentations signal underlying health and social needs that cannot be resolved through a single overnight stay.

From a justice perspective, legal services note that people with chronic alcohol or other drug dependencies are more likely to have repeated interactions with Victoria Police, and may feel profiled or harassed as a result. This reinforces the need for a health-led approach that addresses dependency as a complex health issue rather than primarily a policing matter, underscoring the importance of the PIR health-based approach. It also attends to the impact of marginalisation on those who are most impacted by the reform, as we consider in the following section.

Individual Journeys and Intersectionality

From the outset, this evaluation has examined PIR through two complementary lenses. The first has been to view PIR as a broad ecosystem, that is, as an interconnected network of policies, services, referral pathways, and collaborations. The second has been to consider PIR through the experiences of an intoxicated person moving through the system, recognising that the reform only becomes real through these individual encounters. In doing so, we have recognised that no two people experience PIR in the same way, as each person's journey is shaped by their unique circumstances and needs.

A central part of our approach has been to employ an intersectional lens. Intersectionality refers to the way multiple aspects of a person's identity and circumstances—such as gender, race, culture, socioeconomic status, disability, or experiences of trauma—combine to shape both the opportunities they access and the barriers they face (Crenshaw, 1989). Importantly, these factors do not operate in isolation; when they overlap, they can intensify experiences of disadvantage or marginalisation. Reviewing PIR findings through an intersectional lens is critical, because it highlights not only whether responses to both justice and health services are effective in general, but also whether they are equitable and responsive to the needs of those whose lives are most affected by overlapping forms of vulnerability.

Implementation of PIR has already shown how intoxication is rarely a stand-alone issue. Instead, it intersects with broader challenges linked to mental ill health, homelessness, substance dependence, and family violence. These overlapping factors create compounding risks when individuals encounter police, referral systems or services. This is further evident among particular groups, such as Aboriginal people, South Sudanese people, and for young people in residential care, whose experiences are shaped by systemic inequities and historical patterns of marginalisation.

The criminalisation of public intoxication in Australia has long had disproportionate consequences for Aboriginal and other racialised communities. From the earliest colonial statutes, laws regulating alcohol consumption in public spaces were often enforced in ways that specifically targeted Aboriginal people, embedding policing as a mechanism of racial control. Over time, these laws came to symbolise broader forms of marginalisation, contributing to the over-representation of Aboriginal people in the justice system and, tragically, to deaths in custody. South Sudanese Australian communities, while more recently established in Victoria, have similarly been subject to disproportionate policing of public space, particularly where alcohol use is involved. Racial profiling, heightened police attention in areas where South Sudanese Australian youth gather, and negative media coverage have combined to entrench a perception, and a lived reality, of over-policing. Against this backdrop, the decriminalisation of public drunkenness was viewed as a long overdue response to systemic injustice.

For Aboriginal communities, the PIR reform represented the culmination of sustained advocacy that both predated and continued after the Royal Commission into Aboriginal Deaths in Custody (1991), whose key recommendation to decriminalise public drunkenness gave visibility and urgency to this issue. The reform was therefore seen as a critical opportunity to shift away from punitive responses towards care and support. Yet, as discussed in this report, and as Aboriginal stakeholders have emphasised, the risk of ongoing criminalisation significantly undermines the potential of the reform to redress past injustices.

Attending to marginalisation

By applying an intersectional lens, we see more clearly that a health-led approach to intoxication will only succeed if it is designed to respond holistically. That means recognising and addressing the intersecting justice, health, social, and cultural realities of people who were disproportionately harmed under the former public drunkenness laws. Without this awareness, PIR risks reinforcing unequal outcomes; with it, the reform has the potential to open up more meaningful, fair, and supportive pathways for those most at risk. For example, while children and young people are particularly exposed when intoxicated in public spaces, many are already navigating disadvantage, family violence, or systemic harms. Their immediate circumstances—missing a transport stop, being unfamiliar with their surroundings, or lacking a safe home environment—further shape these risks. One stakeholder noted, *'the kids that are going to be out in public drinking are going to be from particular cohorts... it's because they've not got a safe space to be.'* A further complication is that alcohol use by those under 18 remains an offence, so they need tailored health and justice responses that operate both within the reform and alongside it.

These stories—interwoven through this report—highlight why PIR must respond to intersecting vulnerabilities, not rely on criminal justice frameworks that compound harm.

The experiences of Aboriginal and South Sudanese Australian young people, in particular, show why intersectionality must be central to PIR design and monitoring. Their stories reveal how race, culture, trauma, and systemic bias intersect to shape vulnerability. Stakeholders emphasised that *'culturally safe, trauma-informed approaches must be core—not peripheral—for effective reform.'* Without dedicated engagement strategies, young people risk remaining at the margins of reform, unseen in outcomes and unsupported in practice. In the following section, we explore the implications of intersectionality for PIR implementation and for partners involved in its delivery.

Alcohol and Other Drugs

Stakeholders highlighted the strong intersection between alcohol use and other forms of drug dependence, noting that polysubstance use is the norm rather than the exception among many clients. They emphasised that individuals frequently combine alcohol with other substances, creating heightened risks of acute harm, long-term health complications, and unpredictable behavioural outcomes. Clinically, this complexity makes accurate assessment and effective referral more difficult, as it is often unclear whether a presentation is driven by alcohol, another drug, or their interaction.

For frontline police, these dynamics carry significant operational implications. Current practice often relies heavily on the detection of alcohol, with the smell on a person's breath serving as the main prompt for intervention. While operationally simple, this approach risks underestimating or overlooking the role of other substances. Such reliance creates blind spots in policing responses, which may inadvertently narrow the focus to alcohol while missing the fuller picture of polysubstance impairment. Additionally, police intervention based on smell alone may lead to escalation when the person refuses to engage with police, as demonstrated in VALS Case Study 1.⁷

VALS Case Study 1

A person took the train from Melbourne back to their home in regional Victoria and was walking home when they were approached by police who stopped them and remarked that they could smell alcohol on their breath. The person explained that they had a few beers but were managing well. When the person confirmed that they had been drinking, one officer immediately called for backup. The person tried to continue walking, pointing out that they were not under arrest and were asserting their rights. Police blocked their path and then placed them under arrest, turning them around and handcuffing them. Two additional police cars arrived, and the person was searched. Police then gave them a move-on direction. The person became frustrated and agitated. They were restrained again for not complying with the move-on order, handcuffed a second time, and transported home in a Divisional van. They later received fines for refusing to comply with a move-on direction and for verbal abuse.

This misalignment is also evident in the design of PIR services, which were conceived around managing 'public drunkenness' rather than broader (other non-alcohol drug) intoxication. In practice, sobering services are increasingly expected to respond to presentations involving multiple substances. The current model, shaped narrowly by an alcohol lens, risks being structurally mismatched with the realities of community presentations over time. As stakeholders stressed, the justice and health responses need to strategically align service models with patterns of real-world harm, ensuring that interventions move beyond an alcohol-only frame if presentations are skewed more in this direction, to effectively address the broader spectrum of intoxication. This requires further data monitoring and analysis to consider whether changes are required to the PIR service design.

Mental Health

People with mental health issues were identified as a key marginalised cohort as part of the Public Intoxication Reform process. The intersection between intoxication and mental health is complex and has a bi-directional relationship, with both police and PIR services frequently encountering people whose intoxication is complicated by underlying or co-occurring mental health issues. This overlap creates additional complexities for the police response, as well as barriers for access to and delivery of public intoxication services.

At the outset, the nexus between the legislative context for mental health and the policing response, and its alignment with the intent of PIR, needs consideration. Amongst the chief provisions of the *Mental Health and Wellbeing Act 2022* is the establishment of a framework that facilitates a health-led response to mental health crises, including principles specifying that powers must be led or informed by health professionals and exercised in the least restrictive way possible (as far as is practicable with regard to individual circumstances).⁸ The intent of the *Act* therefore mirrors the purpose behind decriminalisation of public intoxication legislation, that is, to shift the response to mental health from being primarily justice-based to being primarily health-based.

It is noteworthy then to consider that the central 'care and control' power under the *Act* (that is, the power to take someone into care if they appear to have a mental illness and are at risk of seriously hurting themselves or another person) is only able to be exercised by police. It is further relevant that Victoria Police has seen a 26.5% increase in mental health crisis responses between 2017-18 and 2023-24. This equates to a callout every 10 minutes in 2023-24 as opposed to every 12 minutes in 2017-18 (as detailed in the April 2025 financial and performance report of the Public Accounts and Estimations Committee).⁹

7. Shared for evaluation purposes by the Victorian Aboriginal Legal Service (VALS); as such, case studies are required to be used as provided.

8. *Mental Health and Wellbeing Act 2022 Handbook* | health.vic.gov.au.

9. <https://www.parliament.vic.gov.au/4a5dc0/globalassets/taled-paper-documents/taled-paper-9092/paec-60-11-2023-24-financial-and-performance-outcomes.pdf>.

Mental health has, unsurprisingly, emerged as a persistent theme in Victoria Police's data on public intoxication. Unlike PIR, the *Mental Health Act* incorporates a range of powers (including the Care and Control power) for Victoria Police to employ (see the section on 'use of police powers' p.36). Up to 15% of narratives in the PDR App feature suicidal ideation, self-harm, post-hospital discharge or psychiatric crisis. Further, many incidents involve repeat callers who are facing both substance abuse and chronic mental ill-health. Concurrently, the CSA's linked data analysis suggests that overall community contacts with mental health services saw a decline post-PIR implementation (detailed further on p.79).

Mental health has also been a central factor in a number of cases where an intoxicated person engaging with police and/or PIR services later died or was injured. The Independent Broad Based Anti-Corruption Commission (IBAC) has provided the three case study examples.¹⁰

IBAC Case Study 1

IBAC received a notification from Victoria Police regarding an investigation of an allegation of duty failure. Members attended a situation where an individual was threatening to walk in front of a train and at risk of self-harm. The individual was intoxicated and suffering a mental health episode. On this occasion, members did not intervene to apprehend the individual to commence a mental health examination under section 351 of the *Mental Health Act 2014*. A short time later the individual was found deceased after a collision with a train.

Note – Legislation in place at the time of this incident was the *Mental Health Act 2014*; this legislation has since been repealed and was replaced by the *Mental Health and Wellbeing Act 2022*.

IBAC Case Study 2

IBAC received a notification relating to the death of a community member. Victoria Police had responded to multiple calls reporting that a man was lying on the road. Police members attended and were advised by witnesses that the man had been lying on the road, was heavily intoxicated and threatening to commit suicide. Members attended the person's house and spoke to him in his residence and where he told them was suicidal and that he wanted to go to a sobering up centre.

Members contacted the service providers and told him that someone would come and collect him. The service provider phoned the members back saying they could not accommodate the request due to having no male staff.

Members left him and waited around the corner for a further 10 minutes to ensure he did not return to the road, before leaving. Less than half an hour later, he returned to the road and was driven over and dragged by a car. Ambulance Victoria attended and declared him deceased.

IBAC Case Study 3

IBAC received a notification from Victoria Police regarding a death associated with police contact. Victoria Police Members conducted a welfare check of a woman following a call to Triple Zero. When police attended, the woman appeared severely alcohol affected and expressed a desire to self-harm. The woman declined an ambulance and refused intervention or assistance. The woman advised police that she had been trying to contact mental health services, but they were not answering her calls. Police determined that the woman did not meet the criteria to be taken into care and control under section 232 of the *Mental Health and Wellbeing Act 2022*, as she did not pose an imminent risk of self-harm or suicide.

The next day, the woman was found deceased by her daughter.

10. Note: IBAC has disclosed this information to DJCS and Monash University under section 41(1)(d) of the *Independent Broad-based Anti-Corruption Commission Act 2011 (Vic)* to support the evaluation of the decriminalisation of public intoxication. These cases have been reported in the media. As a result, individuals may be identifiable. The evaluation team is unable to amend the information provided by IBAC under the Act.

It is key here to note the threshold for exercising care and control is high, and limits police to only taking a person into care and control to *prevent imminent and serious harm to the person or to another person* (section 232, *Mental Health and Wellbeing Act 2022*). Community stakeholders broadly support the high threshold for invoking the care and control and related powers under the *Mental Health and Wellbeing Act 2022*.

There is a clear imperative arising from these case studies and articulated by stakeholders (in particular legal organisations) for more transparent, consistent and specific training for police that takes into account the intersectional nature of many public intoxication encounters, and acknowledges that multiple factors, including mental health, may contribute to a person's behaviour.

When considering PIR services, stakeholders have also been explicit that the current service model for public intoxication fails to consistently integrate mental health support into delivery pathways. While some services have access to on-call mental health staff or have established partnerships with mental health services, others operate without any of these supports, limiting their capacity to respond appropriately. This creates an unequal care situation and a constant 'loop' back towards police and/or emergency departments – again, a concern for the fidelity of the PIR implementation.

Mental illness has significant negative connotations associated with its labels and expressions. Community representatives raised concerns that people with mental health conditions may avoid engagement with PIR services due to stigma, fear of police involvement, or previous negative experiences in institutional settings. This can reduce the effectiveness of the consent-based model if people decline referral even when support is available, and is detailed in the 'Use of Outreach' section (p.69) of this report.

It is clear that integrated and interconnected pathways between PIR and mental health services are required. This includes training PIR staff in recognising and responding to psychiatric symptoms, ensuring clear referral channels to crisis mental health teams, and developing joint protocols that balance safety with the rights of intoxicated people.

Further, the question of why there is a central police presence in a space that is intended to be health-based must also be raised. Regardless of Victoria Police's performance around mental health, there is an opportunity here, via the interconnectedness of mental health and public intoxication, to advocate for a situation that positions police as peripheral to the mental health response. Victoria Police have been world leaders in trialling programs for collaborative police and mental health responses (for example, through the PACER program; Evangelista et al., 2016),¹¹ indicating that the tools to better address mental health are within reach.

Homelessness and housing instability

Homelessness and public intoxication intersect in ways that amplify risk and system contact. Without private space, drinking occurs in public, making intoxication more visible to police, bystanders, and services and increasing the likelihood of intervention. As a stakeholder who works regularly with people experiencing homelessness noted:

"I know a lot of young people and older people, especially street-based homelessness... who are obviously using [AOD] for safety reasons for themselves, to stay awake, and also just to manage the trauma."

(Stakeholder)

This intersection is reflected in the PIR incident data. The data showed that homelessness strongly shaped outcomes (elaborated in Figures 11 and 12.3). Overall, people without a fixed permanent address were more often handed over to Ambulance Victoria or hospitals (21%) and referred to PIR services (12%) than those with a fixed address (13% and 6%, respectively). Outreach was also sought more frequently: 19% of incidents involving homeless people prompted an outreach request, compared with 9% for others.

The issue of homelessness was also woven throughout the PDR App narratives, representing up to 20% of incidents. Homeless people were routinely engaged by police and PSO. These contacts were overwhelmingly welfare-oriented: officers attempt to rouse individuals, offer crisis accommodation, or refer to outreach and medical services. The frequency of engagement reflects not selective enforcement, but the vulnerability and visibility of those without stable housing. Examples abounded of officers supplying food, sleeping bags, or facilitating connections to support; arrests occurred only when criminal behaviour, not homelessness, was the precipitating factor. This reflects concerns raised by Victoria Police members about the lack of safe referral options available to them when dealing with intoxicated homeless people, particularly as restrictions excluding people who are intoxicated from shelters and crisis accommodation means there is no viable option. Health-based referral services, meanwhile, may be unavailable due to limited hours of operation or lack of capacity. This leaves Victoria Police members with few alternatives beyond leaving the person in a potentially unsafe environment or relying on hospital emergency departments. When help was refused or unavailable, system gaps were laid bare and officers, unless immediate danger exists, leave individuals in situ.

11. Evangelista, E., Lee, S., Gallagher, A., et al. (2016) Crisis averted: How consumers experienced a police and clinical early response (PACER) unit responding to a mental health crisis. *International Journal of Mental Health Nursing*, 25(4): 367-376. <https://doi.org/10.1111/inm.12218>.

Homelessness presents a fundamental barrier to accessing health-led responses under PIR. Stakeholders repeatedly noted that people experiencing homelessness are among the most likely to come into contact with PIR services, yet their circumstances make effective referral and follow-up particularly difficult. Health providers, outreach staff, and organisations working with homeless people reported that the nature of homelessness compounds both the vulnerability and health risks of intoxicated people. Intoxicated people without safe housing face elevated risks of harm due to exposure to violence, extreme weather, and the ongoing stress of displacement. In addition, unstable housing makes it harder to coordinate ongoing care, whether through general practitioners, AOD programs, or community health services. The absence of stable accommodation also places additional burdens on PIR staff, who may be reluctant to release a person back into unsafe environments late at night or in extreme weather conditions.

One regional legal service representative stakeholder observed:

“Until they [people experiencing housing instability or homelessness] know where they’re sleeping every night and they can keep their personal possessions safe, they can’t connect with medical treatment.” **(Stakeholder)**

This statement highlights how the instability of daily survival—finding shelter, safeguarding belongings, and managing basic needs—can take precedence over engagement with health or social support. Without a secure base, people experiencing homelessness often struggled to remain engaged with treatment pathways which can lead to them cycling repeatedly through police custody, sobering services, and emergency departments, as another stakeholder noted:

“It’s a roundabout... Housing first is needed.”
(Stakeholder)

Sobering centres and outreach services were reported as sometimes being used as a ‘stop-gap’ form of shelter:

“Even sobering centres are becoming homelessness shelters, yeah, when they’re not intended [to be].”
(Stakeholder)

One member of Victoria Police observed that some people experiencing homelessness deliberately consume alcohol in order to access a bed through PIR services. This pattern reflects not only gaps in housing provision but also the wider strain on the social services system. In effect, health-based responses intended to support intoxicated people are being repurposed as emergency accommodation.

Because homelessness intersects with other systemic disadvantages, including family violence and poverty, a purely short-term sobering response is often insufficient, a point repeatedly emphasised by community representatives and health service providers. Instead, they suggested that PIR should be linked more explicitly to housing and homelessness services, allowing for warm referrals rather than discharges back onto the streets. Some recommended co-location of sobering facilities with crisis accommodation or drop-in centres to create more sustainable care pathways.

Family Violence

Intoxication is frequently a contributing factor in domestic and family violence incidents, and its presence complicates how police respond when both issues intersect. When intoxication and family violence occur together, police’s response is to prioritise the safety and the protection of victim-survivors, even when it may conflict with approaches that might otherwise prioritise health intervention or diversion for the intoxicated person.

An estimated 8% of encounters recorded in the PDR App narratives were marked by family violence, with police and ambulance responses straddling both welfare and criminal processes. While women suffering visible injuries were assisted and, in some cases, offenders arrested, these narratives spoke to the broader theme of interlaced social harm requiring far more than law enforcement. The two case studies below (provided by IBAC) provide insight into how tensions in the best approach to handling these situations play out practically in police decision-making.

IBAC Case Study 4

IBAC received a notification from Victoria Police of a complaint relating to alleged duty failure. Victoria Police members attended a family violence incident. The affected family member was suffering from injuries that required hospital treatment, and the respondent was present with the children, but alcohol affected.

Attending police were not satisfied with advice of a senior officer to take no action, and arrested the respondent rather than leave him intoxicated with his children.

IBAC Case Study 4 specifically reflects the ethical weight borne by frontline police, who must sometimes challenge internal directions to act in the best interests of community safety. It demonstrates the live tension between duty of care, chain-of-command pressures, and officer's own responsibility to intervene in circumstances of significant risk. In comparison, IBAC Case Study 5 highlights the dangers of failing to adhere to established procedures for managing intoxicated persons and illustrates how, however well-intentioned in the moment, procedural lapses can have severe consequences for all of those involved. This can put at risk the integrity of the policing standards and impact community trust.

The PDR App narrative data also provides a unique insight into the frontline decision making and the following case study is provided to again demonstrate the complexities of these situations.

PDR App Case Study 1

Police received reports of an intoxicated male walking west along [location], with several near misses involving vehicles. He was located on the roadside and stated he had argued with his partner and was walking to his grandmother's house. He refused to provide his partner's details or elaborate further, but disclosed he had pushed his partner's father during the dispute. The male appeared intoxicated, agitated, and expressed indifference to being struck by a vehicle, though denied suicidal intent, he did not meet the criteria under section 232 (*Mental Health and Wellbeing Act 2022*).¹² He declined all offers of assistance, including transport, medical aid, or contact with family. When cautioned for unlawful assault and wilful damage, he became aggressive toward police, adopting a fighting stance and making verbal threats. Due to his aggression, he was unsuitable for transport or placement at a sobering-up facility. He was left in situ and continued walking. Follow-up will be conducted regarding the disclosed family violence incident.

Together, these case studies underscore the intersectional nature of intoxication. The incidents described in the boxes are not merely matters of criminal behaviour or alcohol misuse, but are complex events occurring at the crossroads of social harm. In these examples, intoxication intersects with family dynamics, gendered violence, policing practices, child safety, health concerns but also systemic accountability. Decisions made in such contexts cannot be reduced to single-issue responses; they require integrated frameworks of policing, health responses and social services to provide immediate safety, follow-up and longer-term interventions.

VICTORIA POLICE AND THE PIR

The *Victoria Police Act 2013* (the *Act*) is the primary legislative framework governing the operations of Victoria Police and defining the roles, responsibilities and powers of police and protective services officers. The role of Victoria Police under the *Act* is to serve the Victorian community and uphold the law so as to promote a safe, secure and orderly society (*Part 2, Division 1, section 8*)¹³ and its corresponding functions are listed as being preserving the peace, protecting life and property, preventing the commission of offences, detecting and apprehending offenders and helping those in need of assistance (*Part 2, Division 1, section 9*).¹⁴

Notwithstanding the requirement under the *Act* to assist those who need help, Victoria Police's primary role is centred around ensuring the safety of the Victorian community. There is an inherent tension therefore between this legislated role and the requirement for police and protective services officers (PSO) to provide what amounts to a preliminary 'health check' and subsequent 'health response' to members of the community that are intoxicated in a public place.

Chief Commissioner's Instruction: Persons drunk in public

The primary policy direction for police and PSO is provided in the *Chief Commissioner's Instruction: Persons drunk in public* (CCI—see Appendix 1). The terms 'drunk' and 'drunkenness' used in the CCI mirror the *Summary Offences Amendment (Decriminalisation of Public Drunkenness) Act 2021*.¹⁵

Under the CCI, police and PSO have two roles:

1. To only attend public drunkenness incidents involving risks to community safety.
2. To continue providing general support and assistance in a community policing capacity to members of the public that are drunk in public and in need of assistance when members are on patrol or alerted to a person in need of assistance while on duty.

12. *Mental Health and Wellbeing Act 2022*.

13. content.legislation.vic.gov.au/sites/default/files/2020-04/13-81aa031 authorised.pdf.

14. *Victoria Police Act 2013*.

15. *Summary Offences Amendment (Decriminalisation of Public Drunkenness) Act 2021*.

The CCI is clear that these roles do not alter existing duties and functions. Police and PSO are directed to act in accordance with legislation and Victoria Police policies in executing their duties, exercising powers and complying with obligations under the *Charter of Human Rights and Responsibilities Act 2006*.

The CCI places particular emphasis on human rights, as is appropriate within the context of a human-rights centred reform, but is also plain in its direction to police and PSO that the policy does not constrain or limit the use of the full spectrum of available powers. There is thus an implicit requirement of police and PSO to balance the dual and often competing priorities of human rights with community safety.

As outlined in the CCI, where a person who is intoxicated in public is experiencing a health emergency, police and PSO must contact Ambulance Victoria. Outside of this, the CCI gives police and PSO a range of health-based options to deploy when responding to a person who is intoxicated in public, including: a) placing a person into the care of family or friends, b) referring a person to a local outreach or sobering service, or c) leaving a person where they are (referred to as leaving 'in situ').

The CCI makes a deliberate distinction between risks to a person's *health* (for example, from excessive alcohol consumption or from the risk of hypothermia on a cold night) versus a risk to a person's *safety* (for example, a person walking onto a roadway or being a victim of crime). This is particularly relevant when considering the high threshold for transportation in a police vehicle, which is permitted in the CCI *only* when there is an imminent risk to a person's *health* (not their safety). Further, transportation can only be undertaken when the person has consented to the transport, when there is no outreach service or sobering centre available, *and* when a supervisor has approved the transport.

In the CCI, all activity in response to a person intoxicated in public (except for the exercising of powers or health emergencies) is predicated on the person both participating voluntarily in the process and giving explicit consent to any response options provided by police and PSO. The capacity of police to obtain valid consent from an intoxicated individual is inherently problematic in practice and, due to the potential cognitive and decision-making impairments caused by intoxication, it is difficult to ensure that any consent provided is fully informed and freely given.

The CCI responds to this issue with a suite of criteria that police and PSO can use to determine whether consent has been obtained. These criteria are judgement-based and rely on police and PSO making an informed decision about whether or not they have obtained the free and full consent of the person.

Police discretion

A continuous thread through the CCI is the role of police discretion in mediating the exercise of police powers and the fulfilment of police responsibilities. Discretion is framed in the CCI as the fulcrum that balances two critical principles—the protection of human rights and the lawful use of police powers. The CCI defines discretion as *'the choice made by a member on whether the law, having regard to all the circumstances, should be enforced'* (p.11). It specifically clarifies that any enforcement action needs to be the result of balanced decision-making, taking into account the need to:

- > Enforce the law to its full extent;
- > Take appropriate action (or no action) in relation to the person that recognises their individual circumstances and the circumstances of the offence; and
- > Choose the least severe action that achieves the purposes of taking that action against that person.

The CCI identifies breach of peace and move on powers as possible options to facilitate an outcome to instances of public intoxication, and gives criteria for the appropriate application of these powers. Move On powers are legitimate and are able to be used where there are grounds to do so under section 6 of the *Summary Offences Act 1966*. However, the CCI explicitly states that these powers are not intended to serve as de facto replacements for the repealed public drunkenness offences. This point speaks to a widely-held concern in the lead-up to the implementation of PIR was that police may continue to rely on existing powers (including breach of peace and move-on directions) to manage intoxicated individuals, essentially using other powers as 'stand-ins' for the prior offence of public drunkenness. This risk is discussed later in this evaluation report via the broader lens of 'ongoing criminalisation' and is anchored by a critical examination of how discretion, judgement and operational decision making are applied in practice in the context of public intoxication.

The following sections are organised thematically, considering the evaluation findings in relation to the guiding RQs. While they are presented as part of a single theme, many findings are not exclusive to any one question but rather cut across the RQs and question themes, and should therefore be read in this context.

ONGOING CRIMINALISATION (USE OF POLICE POWERS)

While the reform removes public intoxication as an offence, the risk of ‘ongoing criminalisation’ remains when other existing powers are used as stand-ins. Yoorrook warned of the risk that public order offences, move-on powers, and breach-type charges can operate as proxy mechanisms to detain or penalise intoxicated people, effectively re-creating the pathway for criminalisation. This dynamic is not hypothetical; discretionary tools have historically been applied unevenly, particularly where intoxication intersects with poverty, visibility in public space, and racialisation.

These risks fall heaviest on communities that already experience racialised policing. Aboriginal and Torres Strait Islander people and Sudanese and South Sudanese Australians have long reported disproportionate surveillance and the use of broad public order powers to manage behaviour coded as ‘risky’ or ‘disruptive.’ In these contexts, intoxication can become the pretext rather than the problem: a marker that justifies intervention even when the reform calls for health-led responses.

On a local level, council by-laws add another layer of potential criminalisation. Although public intoxication is no longer an offence, open-container rules and related local regulations can function as back-door criminalisation of drinking in public. For people with little or no access to private space, especially those sleeping rough, any alcohol use is, by definition, ‘in public.’ Enforcement then targets the most visible and least resourced, entrenching a pattern in which homelessness is managed through infringement, fines, and police contact rather than housing and health support.

Broadly, the reform’s intent is to interrupt this cycle. To realise this intent, practices must safeguard against the use of alternative powers and prioritise health-led responses. In this section, we examine how potential ongoing criminalisation can manifest in the reform, and explore the use of discretionary powers as well as the need for ongoing oversight and accountability to mitigate the risk of re-criminalisation.

Public Order Offence Data

Any decline in public drunkenness offences in the post-trial implementation period may reflect a real decline, increase in other offences or a combination of both. To examine this, it is worth examining the time trends in potential alternative public order offences. For this purpose, we consider five relevant types of public order offences: common assault, criminal damage, resist or hinder officer, assault police, emergency services or other authorised officer and offensive conduct.

The data for these offences is provided for the 24-month pre-reform (October 2021 to September 2023) and 17-month post reform (November 2023 to March 2025) periods. As is clear from Figure 6.1, common assault and criminal damage were the most common offences, accounting for about 80 per cent of the alternative public order offences. The third largest offence was resisting or hindering an officer, followed by assaulting an officer and then offensive conduct. It is also clear that the number of offences changed little between the pre-reform and most of the post-reform period. However, the first three months of 2025 has seen a small downward trend in the total number of public order offences, driven largely by declines in common assault and criminal damage.

The alternative public order offence patterns for the Aboriginal and Sudan-born peoples are similar to that for the entire population (Figures 6.2 and 6.3). As with the trend for the total population, the Aboriginal population also experienced a small decline in the average number of offences per month in the January-March 2025 period, again driven by decline in common assault and criminal damage offences. The pattern for Sudan-born people is similar.

FIGURE 6.1:

Average number of alternative public order offences per month by type, October 2021–March 2025

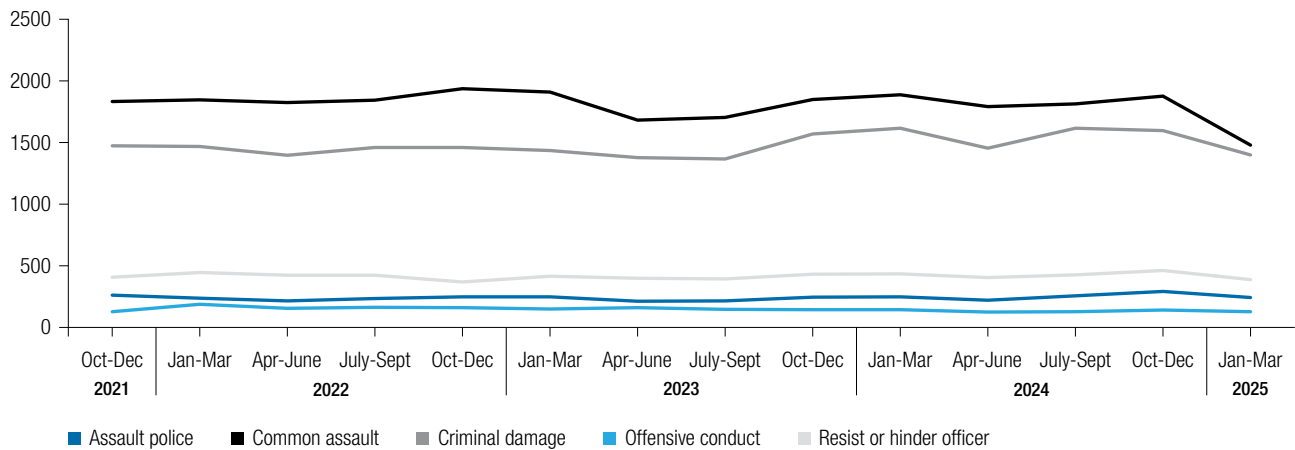


FIGURE 6.2:

Average number of alternative public order offences per month by type, Indigenous people, October 2021–March 2025

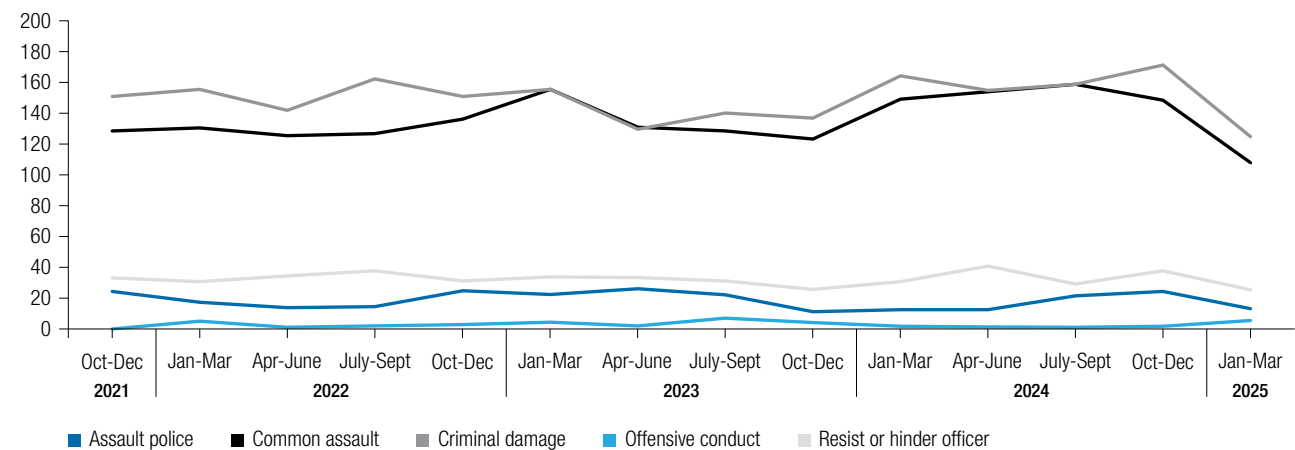
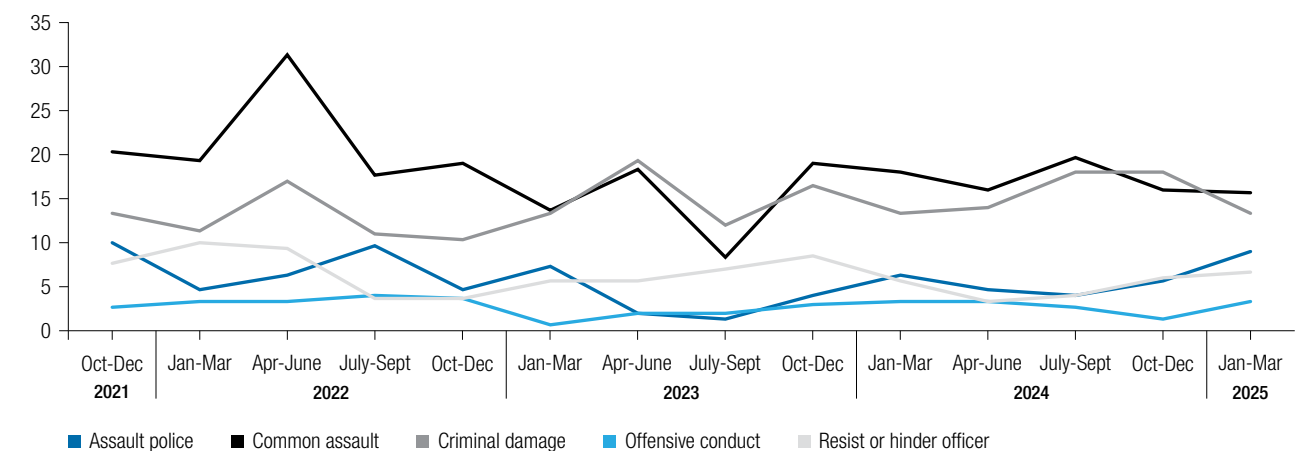


FIGURE 6.3:

Average number of alternative public order offences per month by type, Sudan/South Sudan born people, October 2021–March 2025



Discretion, Judgment, and Decision-Making

Police and PSO operate in an environment that is both highly nuanced and deeply consequential. Their ability to balance public safety, individual rights, and community expectations hinges on the use of discretion—a central feature of contemporary policing. Yet, as Yoorrook emphasised, discretion is never neutral: it is exercised within a context of entrenched institutional practices, systemic racism, and historically unequal power relations.

The Independent Broad-based Anti-Corruption Commission (IBAC) is the Victorian agency responsible for overseeing police conduct in Victoria and serves as a key mechanism for ensuring police accountability and mitigating the risks associated with unchecked police discretion. As the State's oversight body, IBAC investigates serious and systemic police misconduct including excessive-use-of-force, discrimination, misuse of police powers and human rights breaches. IBAC also reviews internal police investigations to ensure procedural fairness and accountability and can elect to conduct its own investigations, hold public hearings and issue recommendations to enhance police practice.

Discretion enables police and PSO to tailor their responses in complex and often ambiguous situations. However, it also carries inherent risks. Without strong accountability, discretion can manifest as inconsistency, subjectivity, or escalation—particularly for Aboriginal communities who have long borne the brunt of over-policing. Yoorrook documented multiple examples where discretionary powers, including move-on directions and resisting arrest charges, were used in ways that undermined the protective intent of reforms. The Commission was clear: genuine reform requires not only the repeal of offences but vigilant safeguards to prevent substitution through alternative charges.

The following case study illustrates how discretionary escalation may occur even when the original grounds for intervention have been resolved.

VALS Case Study 2

A person who had been drinking at a pub was approached by police after leaving the venue and being directed to move on. Although they complied with the request to leave the pub, they remained in the vicinity, and officers engaged with them despite there being no further issues at hand. Police body-worn cameras showed police members discussing how they could work around public intoxication decriminalisation and bring the person to the station/arrest the person for another issue. Members were recorded noting that they knew they couldn't arrest the person for intoxication and discussing what they could instead do to bring them to the station.

This example illustrates how discretion can be deployed *not* to uphold the intent of PIR, but to search for legal substitutes to maintain control, effectively undermining reform.

The Problem of Ongoing Criminalisation

The PIR framework is designed to shift responses to intoxication away from criminalisation and towards health-based care. However, as Yoorrook highlighted in their *Yoorrook for Transformation* reports, Recommendation 30a,¹⁶ the risk of 'technical' rather than substantive decriminalisation is real. In jurisdictions such as New South Wales, the repeal of public drunkenness was offset by new detention powers, effectively preserving punitive outcomes. The Commission warned that Victoria must not repeat this pattern. Evidence already demonstrates points of concern, as shown in the following IBAC case studies.

IBAC Case Study 6

IBAC received a notification from Victoria Police of a complaint of unlawful assault. The complaint alleges that police had contact with members of the public outside a licensed premises, reportedly intoxicated and walking in traffic. Police handcuffed and told the complainant that they were under arrest for drunk and disorderly conduct. They were released after their identity was confirmed but re-arrested for failing to comply with move-on directions. Rather than be taken to the police station, the complainant was taken to a street not far from their residential address. The complainant has alleged to have initially refused to leave the police van, but was eventually removed and had their handcuffs removed. The complainant has then allegedly spat on the police vehicle and was subsequently OC sprayed. They were later released into the custody of a friend.

Here, the use of multiple discretionary powers—arrest, move-on, re-arrest, and use of force—demonstrates how individuals remain vulnerable to criminalisation and escalation even after the repeal of the offence.

16. Yoorrook for Transformation Summary Report.

Similarly, community casework reveals patterns of discretionary policing that shift the ground but not the outcomes:

VALS Case Study 3

A young person, who was homeless, attended a hospital while intoxicated seeking medical attention. The hospital assessed them as too intoxicated to safely access their service, but also not unwell enough for their presentation to be considered urgent. Staff contacted police to remove them, as they were reportedly causing disruption. At the time of the incident, there was a PIR health service available at the location. However, police did not refer the person to the service, instead issuing them with a couple of move-on directions, which they didn't comply with. They were then arrested and charged with trespass and behaving in a riotous manner. Those charges were later withdrawn.

This case highlights how discretionary powers can be stacked—first through stop and search, then through move-on orders, then through escalation to arrest—culminating in fines and criminal sanctions contrary to PIR's health-based intent.

Human Rights Analysis

As detailed in Appendix 2 (Human Rights Analysis), the available evidence indicates that the application of move-on and alternative offences limits a number of rights set out in the Victorian Charter.

First, the discretionary police powers engage the *right to equality and enjoyment of rights without discrimination* (section 8) due to the disproportionate impact they are having on certain groups in the Victorian community, namely Aboriginal and Torres Strait Islander Peoples and migrant and refugee groups. If such powers are being used to protect public safety, then consideration should be given as to whether the use of these mechanisms are reasonable and demonstrably justified, and whether there are less restrictive and reasonably available ways to achieve the protection of public safety. This will require greater resourcing of the health response component of the PIR so that police are more readily able to utilise the health response in situations of public safety concerns.

Second, evidence about the use of move-on powers and alternative offences by police also may engage the right to freedom of movement (section 12) and the right to liberty and security of person (section 21). In light of available evidence, it appears that the application of move-on and alternative offences against intoxicated persons may be being used in a way to limit the right to freedom of movement and right to liberty under the Charter.

Further work (including training) should be carried out to ensure that move-on powers and alternative offences are not being used to temporarily hold intoxicated persons in the absence of an intoxication offence.

If intoxicated persons continue to be arrested and placed in detention when they should in fact receive a health-response, then section 22 of the Charter requiring humane treatment of those deprived of liberty will also be engaged (in addition to the prohibition of inhuman or degrading treatment under section 10 as discussed above). We note that Victorian Charter case law has established that public authorities are required to take positive measures to ensure that detained people are treated with dignity and humanity and that the protection of human dignity encompasses measures such as ensuring adequate conditions of accommodation, food and personal hygiene, clothing and bedding standards and access to medical services.¹⁷

Oversight, Transparency, and Accountability

Both Yoorrook and the Victoria Police Chief Commissioner have acknowledged the dangers of 'up-charging' and reliance on substitute offences. The Chief Commissioner's Instruction is unambiguous: discretion must not be used to replicate repealed offences. Yet, the Commission also observed that policy intent does not automatically translate into frontline practice—oversight, monitoring, and cultural change are critical. The following case demonstrates how these risks are particularly acute for vulnerable individuals.

VALS Case Study 4

A young person, who was homeless, attended a hospital while intoxicated seeking medical attention. The hospital assessed them as too intoxicated to safely access their service, but also not unwell enough for their presentation to be considered urgent. Staff contacted police to remove them, as they were reportedly causing disruption. At the time of the incident, there was a PIR health service available at the location. However, police did not refer the person to the service, instead issuing them with a couple of move-on directions, which they didn't comply with. They were then arrested and charged with trespass and behaving in a riotous manner. Those charges were later withdrawn.

This case underscores the stakes of discretion when health-based pathways are overlooked. Failure to engage the PIR service and reliance instead on police powers not only undermined the reform but also left the young person further criminalised before eventual withdrawal of charges.

17. *Castles* at [94], [100], [106]–[108], [113]; *Haigh v Ryan* [2018] VSC 474 at [85], cited in Finding into Death with Inquest of Veronica Nelson (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023) at [96].

It is not disputed that IBAC plays a critical role in overseeing police conduct in Victoria. However, the problematic picture of ongoing criminalisation revealed during this evaluation makes it clear that a further layer of independent oversight—that is PIR-specific and that is separate to IBAC—is essential. In its *Yoorrook For Justice* Report, the Yoorrook Justice Commission was unambiguous in its recommendation that ‘*Victoria Police conduct be closely monitored to ensure police members do not use existing powers to unnecessarily take intoxicated people into custody, for example by ‘up-charging’.*’¹⁸ This evaluation affirms the Yoorrook recommendation and suggests that, without clear monitoring and an explicit expectation of transparency and accountability, police discretionary powers risk becoming a hidden channel through which punitive practices persist. Recommendation 4 seeks to build on the Yoorrook recommendation and address these risks.

Recommendation 4

Victoria Police to:

- A.** Make publicly available (via the CSA) the use of the following offences under the *Summary Offences Act 1966 (SOA)* where they are used in conjunction with incidents of public drunkenness as legally defined:
 1. Direction to move on (s 6 SOA)
 2. Assaulting, resisting or obstructing an emergency worker (s 51 SOA).
 3. Assault police
 4. Common assault
 5. Criminal damage
 6. Offensive conduct
 7. Resist or hinder officer
- B.** Make publicly available (via the CSA) the use of local laws prohibiting the possession or consumption of liquor in a public place, where they are used in conjunction with incidents of public drunkenness as legally defined.
- C.** Make publicly available (via the CSA) rates of individuals who are arrested for an offence and placed in custody in a Victoria Police-owned and operated premise and who are also drunk as legally defined.
- D.** Make publicly available (via the CSA) all incidents where a person who is legally defined as drunk in public is charged with an offence, and where the charge is subsequently dropped.

Recommendation 5

Victorian Government to make an explicit public commitment that there will be no re-expansion of police powers under Public Intoxication Reform, including an explicit commitment to prohibiting new or alternative police powers.

Recommendation 6

Department of Justice and Community Safety to:

- A.** Establish an independent oversight process/body separate to IBAC that:
 1. Provides continuous monitoring and oversight of police use of the following powers where they occur in conjunction with incidents of public intoxication.
 2. Provides an independent complaints pathway for members of the public to use in order to report issues arising from police contact as a result of being intoxicated in public.
 3. Requires Victoria Police to report all instances of duty failure, death, injury or other adverse outcomes that are usually investigated internally and/or via the Independent Broad Based Anti-Corruption Commission that are related to public intoxication.

Community Trust and the Test of Legitimacy

For Aboriginal and culturally diverse communities, the measure of PIR’s success will not be found in legislative text but in lived experience. As Yoorrook underscored, mistrust of police is grounded in generations of harmful encounters and reinforced by ongoing experiences of discriminatory enforcement. Substantive decriminalisation will only be realised if communities perceive and experience policing as different in practice: guided by fairness, empathy, harm minimisation, and accountability.

The task, then, is twofold. Reform must ensure that discretion is exercised with integrity, underpinned by clear training and guidance, while also embedding structural oversight to prevent circumvention. Only through this dual focus can PIR deliver the health-based outcomes intended and meet the standard of justice that Aboriginal communities, Yoorrook, and the broader public have demanded.

18. [Yoorrook-for-justice-report.pdf](#).

Police Practice: Use of excessive or unwarranted force

Use of excessive or unwarranted force has not been commonly reported to the evaluation, but incidents have been raised by community members and legal organisations, with some matters referred to IBAC (see cases below). Allegations typically concern physical handling perceived as disproportionate to the risk presented by an intoxicated person, or force used after a person has declined assistance but is otherwise not offending. Even when infrequent, these incidents carry significant weight because they shape community perceptions of the reform and influence people's willingness to consent to health-based support.

Excessive force can trigger escalation. What begins as a health-led encounter may quickly become confrontational, prompting defensive or agitated behaviour by the intoxicated person. This, in turn, increases the likelihood of additional charges, such as resist or hinder police, assault emergency worker, offensive language, or breach of the peace, being laid. In effect, the use of force can convert a situation that PIR intends to manage through care and consent into a justice response, functioning as a form of ongoing criminalisation.

Community and legal professionals repeatedly emphasised the need for consistent de-escalation practices and trauma-informed police training. The evaluation's Human Rights Analysis has pointed to the importance of further training and education to understand and reduce stigmatising responses. It was noted that an intoxicated person's behaviour may escalate on contact with police not simply because of intoxication, but because prior experiences—fear, shame, stigma, or earlier negative encounters—are being re-triggered in the moment. Training should therefore equip members to recognise trauma cues, slow interactions down, use consent-based communication, and avoid language or positioning that can be perceived as coercive, as one stakeholder noted:

“What training do they get around just working with someone who's got significant trauma, you know? And who uses alcohol to deal with self-medicating and other things? And then police being a trigger... What training do they get to kind of navigate that, and actually, do they acknowledge it themselves?” (Stakeholder)

This point was raised particularly by many Aboriginal stakeholders, who stressed that the history of trauma from past encounters with police is always present when an Aboriginal person is approached, as is noted in the following case studies:

IBAC Case Study 7

IBAC received a notification from Victoria Police of a complaint of alleged assault by a Victoria Police member. Victoria Police members responded to a report of persons 'causing trouble' outside a licensed premises. No offences were alleged, although several were reported to be heavily intoxicated and 'unruly'. During the interaction, a police member is alleged to have sprayed a community member with Oleoresin Capsicum (OC) Spray.

IBAC Case Study 8

IBAC received a notification from Victoria Police regarding an investigation of an allegation of excessive use of force. It is alleged that during the removal of an intoxicated person from a stationary tram, a police officer pushed the intoxicated person in the back/shoulder, causing him to fall down the steps and strike his head on the road surface. Police were called as the intoxicated person was asked to leave the tram by the driver as the tram was going to the depot. The intoxicated person delayed cooperating with this request but was not posing a threat to the driver.

IMPLEMENTATION-RELATED INSIGHTS

Recording of Insights

CSA data indicates a sharp decline in the number of recorded incidents was noted after the initial two months post-reform (i.e., post-November 7, 2023). As shown in Figure 7, incident numbers peaked in the first two months of the reform but then steadily decreased, reaching around 100 per month in the first quarter of 2025.

In effect, incident counts in the most recent months are only about one-quarter of those recorded at the start of the post-reform period.

Figure 8 shows that nearly half of all incidents recorded over the entire 17-month period occurred within these first five months.

FIGURE 7:

Distribution of incidents (number), November 2023–March 2025

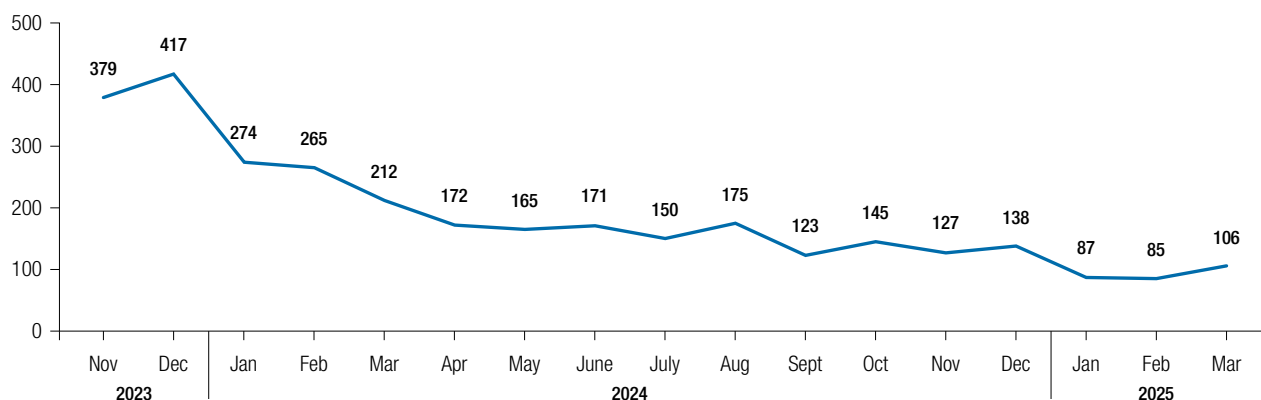
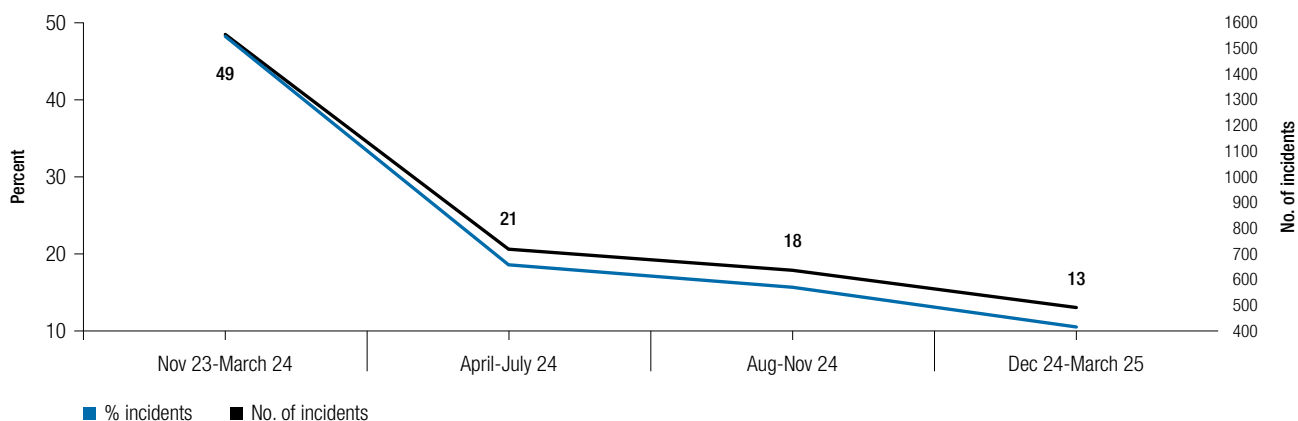


FIGURE 8:

Distribution of incidents (number, %), November 2023–March 2025



The decline in recorded incidents suggests that PDR App usage dropped significantly after the initial rollout, especially from January 2024 (the third month of the post-reform period). This decline limits the reliability of the dataset for identifying trends over time in intoxication-related incidents. As a result, the analysis focuses only on the first five months, each of which recorded at least 200 incidents. This approach allows us to examine general patterns but not long-term changes. At the same time, the limited use of the PDR App has implications for implementation fidelity: recording of encounters is an essential mechanism through which DJCS and Victoria Police can monitor PIR implementation in the future.

Partly explaining these changes in reporting, Victoria Police informed DJCS in October 2024 that the significant reduction in PDR App data collection was directly linked to ongoing protected industrial action.¹⁹ As part of this action, members implemented indefinite and periodic bans on recording data, including instances of industrial action and other information that could be used for audits or reporting. Victoria Police explained:

“Members of Victoria Police are currently undertaking Protected Industrial Action where we have an indefinite or periodic bans on the collection of data, recording of daily industrial action instances and provision of information to Victoria Police and the Victoria State Government regarding protected industrial actions. As such Members are not to collect, compile, collate or provide data for the purpose of audits or statistics relating to protected industrial action for internal use or for the Victorian State Government.” **(Victoria Police)**

The stated purpose of suspending data collection was to prevent this information from being used to meet government reporting requirements, defend enterprise bargaining negotiations at the Fair Work Commission, or dock the pay of participating members. However, as noted above, there has been no increase in PDR App data following the cessation of industrial action in February 2025. This informs our Recommendation 7, outlined as follows.

Recommendation 7

Victoria Police, in line with Chief Commissioner’s Instruction Persons drunk in public, to:

- A.** Initiate an organisation-wide process that explicitly monitors police and protective services officer consistency in completing the PDR App (enterprise solution) for every instance of public drunkenness at a station, police service area and regional level.
- B.** Working with the Department of Justice and Community Safety, develop a report that is submitted internally to the Chief Commissioner and is part of the PIR Statewide Public Intoxication Monitoring and Reporting Framework that enables identification of areas in the organisation that are consistently neglecting to use the PDR App (enterprise solution) to record public drunkenness incidents.
- C.** Establish clear disciplinary process for police and PSO who consistently neglect to utilise PDR App (enterprise solution) to record public intoxication incidents.
- D.** Initiate regular validity audits with CSA to test the completeness, accuracy and reliability of all data collected via the PDR App (enterprise solution).
- E.** Ensure that all data currently collected via the PDR App continues to be collected via the enterprise solution and that data points are not otherwise reduced, constrained or removed when transition from the PDR App to the enterprise solution occurs.
- F.** Make data collected via the PDR App (enterprise solution) available as part of the PIR State-wide Monitoring and Reporting Framework.

At the broadest level, available data indicates that Victoria Police met the objectives of PIR. Since implementation, there has been a steady increase in referrals to health services from police and PSO and concurrently, the level of arrests as a result of offending behaviour where individuals are also intoxicated in public has decreased (see the section on ‘Custody Reduction’, p.65). Police and PSO have consistently endorsed the health-based approach and expressed broad appreciation for PIR services. Nonetheless, a recurring and major concern has been the limited availability of these services, which constrains the capacity of police and PSO to provide the health response at the centre of PIR. This is aligned with community feedback and is viewed as particularly acute in regional and rural locations. We outline service provision and associated challenges in the following sub-section.

19. It should be noted that the Protected Industrial Action commenced in August 2024 and was resolved in February 2025. However, the reductions in usage of the PDR App extended beyond the conclusion of this.

Service provision

As part of the health-led approach, a range of new services in metropolitan Melbourne and regional Victoria have been established, including outreach programs and sobering centres. Services have been intentionally established in two distinct streams, with the first stream providing support for the general community and the second stream, delivered solely by Aboriginal organisations, providing culturally safe and appropriate support specifically to Aboriginal and Torres Strait Islander Communities.

In metropolitan Melbourne, these services are provided by Cohealth, which provides services to the general community, and Ngwala Willumbong Aboriginal Corporation ('Ngwala'), which delivers support specifically for Aboriginal people. In addition, Aboriginal-specific outreach services and safe spaces have been developed in eight regional locations: Shepparton, Ballarat, Geelong, Swan Reach, Mildura, Bendigo, Swan Hill, and Morwell. Table 5 provides an overview of the available services as at September 2025.

TABLE 5:
Current PIR-related services in Victoria (as at Sept 2025; Source: Victorian Department of Health)

REGION	TYPE OF SERVICE	TARGET POPULATION	LEAD PROVIDER
State-wide	> Centralised service: – Intake (24/7) – Referral – Dispatch	General population (Aboriginal and non-Aboriginal People)	Victorian Aboriginal Health Service (VAHS)
Metropolitan Melbourne	> Sobering centre > Outreach services	General population	Cohealth
Metropolitan Melbourne	> Sobering centre > Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala
Wyndham	> Sobering centre > Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala
Frankston	> Sobering centre > Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala
Shepparton	> Outreach services > Places of safety	Aboriginal and Torres Strait Islander Peoples	Rumbalara Aboriginal Cooperative
Bendigo	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Bendigo & District Aboriginal Cooperative
Geelong	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Wathaurong Aboriginal Cooperative
Ballarat	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Ballarat & District Aboriginal Cooperative
Mildura	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala, with Mildura Base Hospital
East Gippsland	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala
Latrobe	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala
Swan Hill	> Outreach services	Aboriginal and Torres Strait Islander Peoples	Ngwala

Referral processes and pathways

The Department of Health established a PIR Centralised Service phone line (03 7043 9175) to facilitate referrals to PIR health services from across Victoria. The Victorian Aboriginal Health Service (VAHS) acts as the central dispatch service for PIR across all of Victoria. It operates and oversees the Centralised Service phone line managing referrals for both Aboriginal and non-Aboriginal clients, coordinating all phone calls requesting PIR health services and dispatching outreach teams where available. VAHS also provides 24/7 support through AOD advice. The advice line connects callers such as first responders, outreach services, health services and members of the public with qualified AOD clinicians. These clinicians can offer clinical assistance, help determine if someone requires emergency support, provide information about other AOD services in the area, help manage risk factors associated with intoxication and provide general guidance.

Currently, there are several referral pathways to VAHS:

- > Direct referrals from emergency responders including Victoria Police and Ambulance Victoria (for example Police officers encountering an intoxicated person in public while on patrol can directly contact VAHS to request referral).
- > Direct referrals from hospitals and health/social services, licensed premises, public transport operators, VALS and justice service centres in metropolitan Melbourne (for example, liquor licensed venue operators may call VAHS when an intoxicated patron has left their premises and requires support).
- > Direct referrals from select regional community stakeholders including supermarkets, security guards and neighbourhood houses.
- > Direct referrals from the public (members of the public have recently been able to contact VAHS directly, although the phone number is not yet widely distributed).

The Centralised Service line was rolled out in phases to allow time for PIR service providers, particularly those in regional areas, to scale up their service capacity and to enable service eligibility criteria to be communicated. Groups to receive access at the commencement of implementation (7th November 2023) were those that have traditionally had the highest level of contact with people who are intoxicated in public. These were emergency responders (Victoria Police, Ambulance Victoria and Triple Zero Victoria), local governments, liquor licensees, and transport operators.

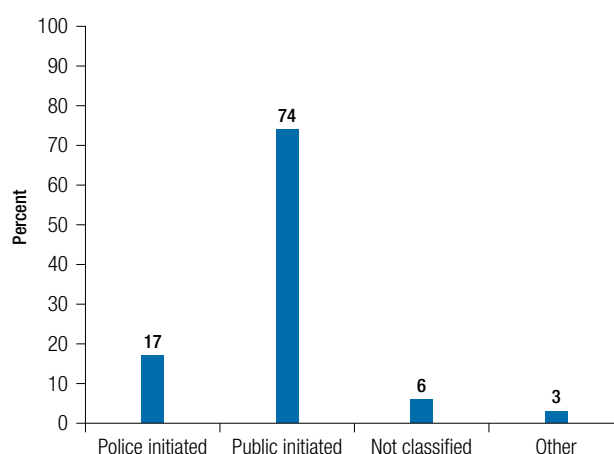
In August 2024, the line was also shared with ACCOs, hospitals and social/health services (including hospital emergency departments, crisis centres and community health centres) and justice service centres in metropolitan Melbourne. In July 2025, and after consultation with service providers the phone line was shared with stakeholders in regional Victoria, including security guards, neighbourhood houses and local supermarkets. The Department of Health has indicated that the gradual expansion of the line has yielded positive results in referrals and that there has been an increase in referrals particularly from hospitals, Emergency Departments, and community health services.

The role of VAHS is to coordinate and deploy outreach teams, but this is only possible if the intoxicated person is located within a 45-minute radius of a PIR health service. This limitation means that outreach responses are not available in all areas, especially in more remote or regional locations.

A more common pathway is through 000 (Triple Zero Victoria (TZV)). Calls to 000 are generally made by the public either out of concern for the intoxicated person's health and wellbeing (sometimes resulting in Ambulance Victoria being dispatched) or for safety concerns (sometimes leading to police being dispatched). When Ambulance Victoria or Victoria Police attend and determine that there is no immediate risk to the person or others, they can contact VAHS to arrange a PIR outreach team. There is currently no arrangement in place for VAHS to be contacted directly by TZV operators.

CAD data supplied to this evaluation gives a good sense of the origin point and type of event police respond to, and which ultimately results in a public intoxication outcome. The data indicates that out of a total of 1189 incidents (occurring between 7 November 2023 and 31 March 2025) the majority of calls (74%; n=880) were initiated by the public, with less than one in five (17%; n=202) calls by the police (Figure 9).

FIGURE 9:
Source of CAD calls: November 2023–March 2025



Overall (see Figure 10), the majority of calls (35% or about 1 in 3 callers) were to request a welfare check. Calls about people ‘causing trouble’ were also common (21% or about 1 in 5 callers).

A further examination (see Figure 11) of who is reporting what types of events indicates that, while police-initiated calls are likely to be classified as ‘field events’ (55%; n=111) or ‘subject stopped’ (42%; n=85), the overwhelming majority of calls from the public are likely to be classified as ‘welfare checks’ (40%; n=352) followed by people ‘causing trouble’ (26%; n=229).

These data points are critical as they point to two major considerations. First, it is clear that most CAD calls resulting in a public intoxication outcome originate from members of the public rather than police. Second, the majority of calls resulting in a public intoxication outcome are initially categorised as welfare events. There is clearly a strong link therefore between welfare events and public intoxication and the importance of considering the two in tandem cannot be underestimated. As reporting of these welfare (and eventual public intoxication) events is driven by the community there is a need to reinforce understanding and awareness within the community of how to respond to a person who is intoxicated and needs help. Further, as responses to these calls are driven through Triple Zero Victoria, it is crucial to consider the opportunities that may be available to disrupt the call’s journey before it reaches police and divert to an intoxication response earlier in the call-taking process.

FIGURE 10:
Reason for CAD calls: November 2023–March 2025

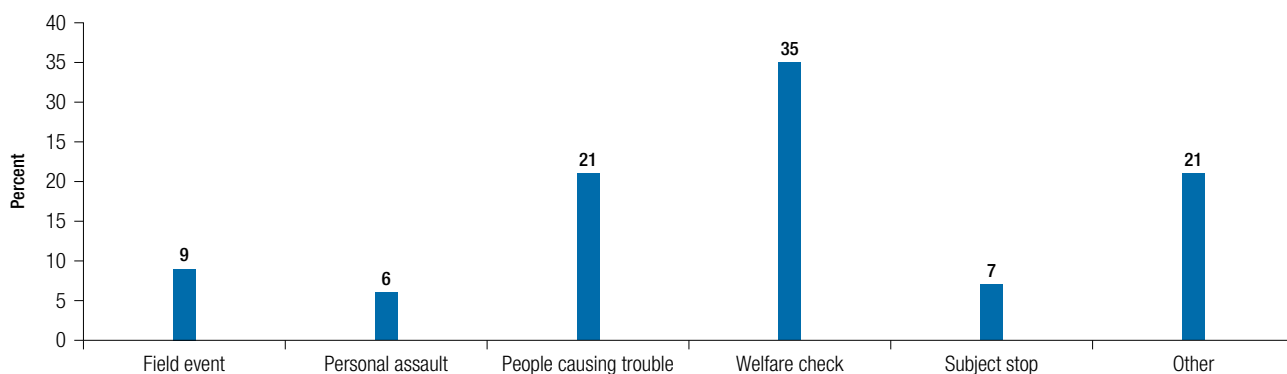
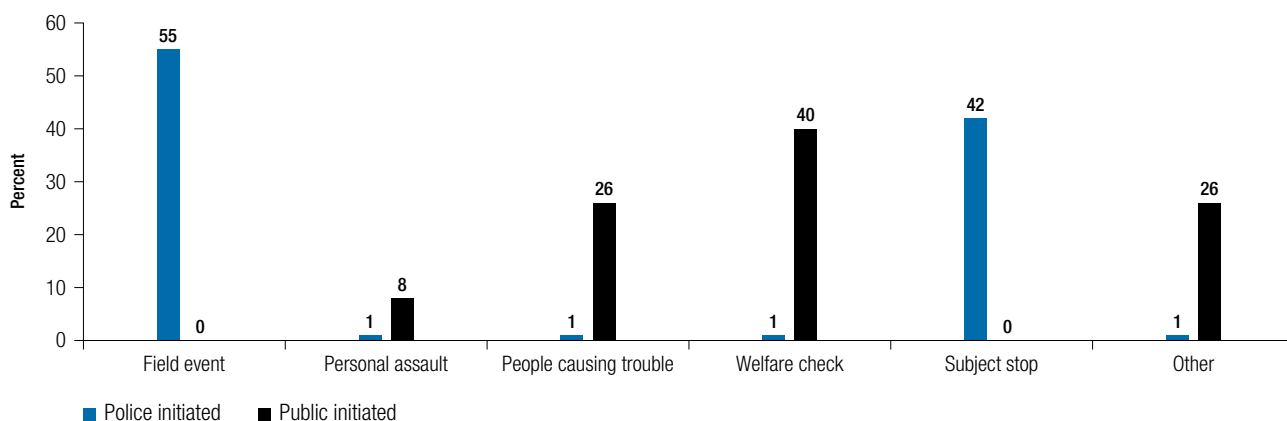


FIGURE 11:
Source of and reason for CAD calls: November 2023–March 2025



It should be noted that referrals away from emergency services are not part of Triple Zero Victoria's core remit and, further, that this is currently a function of Police Communication Liaison Officers situated within Triple Zero Victoria call centres. However, current processes do not provide sufficient reason to disregard the compelling need to review and potentially integrate a referral function from Triple Zero Victoria to VAHS in order to decrease the footprint of police in public intoxication events.

Recommendation 8

Department of Health to:

- A. Significantly enhance public visibility of the Victorian Aboriginal Health Service triage line to ensure widespread public and community service providers and partners' awareness and reduce reliance on Triple Zero Victoria and Victoria Police.

Recommendation 9

Triple Zero Victoria, in consultation with **Victoria Police**, to review the call-taking pathway for events which may involve public intoxication to:

- A. Identify where these events can be diverted away from police towards a health response; and
- B. Identify if and how a direct referral function to the Victorian Aboriginal Health Service (VAHS) Centralised Service phone line can be integrated within the triple-zero call-taking and dispatch process.

SERVICE PROVISION AND RELATED LIMITATIONS

Service gaps remain a significant issue for the reform. From a justice perspective, the limited and uneven availability of services in regional areas restricts the options available to police when responding to public intoxication. Disparities in service availability and integration across regional locations were a recurrent theme in stakeholder discussions. Many participants observed that, even after the roll-out of PIR, places of safety and sobering-up facilities were still lacking in some regional areas. Factors constraining service availability are discussed below.

Service availability within a 45-minutes radius

One of the key factors affecting service access is the maximum travel time policy of 45 minutes. This parameter was adopted to ensure that people could be reached within a practical timeframe, reducing the period during which police, emergency services, or referrers are required to remain with them. It also aimed to avoid relocating people too far from the location of intoxication, which could separate them from their home or support networks.

However, stakeholders noted several limitations with this model. The 45-minute radius is highly variable, depending on the time of day and traffic conditions, resulting in areas that are only intermittently covered.

"I think when you look at the service map, the locations, there's a whole lot of Victoria that don't have supports."

(Stakeholder)

For example, Frankston and Werribee were described as being within range at some times but outside it at others. Other locations, such as the Grampians and the South West regions, have no available services. Similarly, in Echuca, there is no coverage at all, despite nearby services in Bendigo and Shepparton. As one stakeholder observed:

"Auntie Tanya Day's family was from Echuca. You've got Bendigo and you've got Shepparton, and you've got in between, and neither service will go to Echuca because it's outside of the 45-minute catchment. We're talking about a family who strongly advocated for this program to be off the ground, and their own community doesn't have service. So that's a gap, and it's a big one."

(Stakeholder)

The stakeholder also noted that Echuca is a distinct community in its own right and would benefit from a dedicated service. Similarly, a focus group with the South Sudanese Australian community in Werribee expressed concerns about being on the outer edge of the catchment area and the associated risk of *'falling through the cracks.'* resulting in unintended harm due to inability to access health services.

Licensees also highlighted the limitations of the 45-minute rule. They pointed out that transporting a person such a distance can remove them from their support network and suggested that smaller, distributed sobering options (such as six-bed hubs across the north, south, east, west, and major nightlife areas) would provide more appropriate coverage.

Service providers reported that applying the 45-minute rule has created operational challenges, explaining that it was necessary to design a detailed coverage map and allocate resources accordingly. They emphasised that discretion is often used in cases where a person is located on the edge of the defined service zone.

Service eligibility requirements

Eligibility for services under the PIR model has been constrained, particularly in relation to non-Aboriginal and Torres Strait Islander people. Currently, all services within the state cater for Aboriginal and/or Torres Strait Islander communities, but metropolitan Melbourne is the only service available for the general community. Stakeholders queried whether this lessened the potential community benefit of the PIR, as the following quote illustrates:

“My question has to be then: why, in St Kilda, is that centre for Aboriginal people only? You know, if you want it to work properly, then it should be for everyone. Yep, you know, because otherwise, you’re really limiting the options for people that are drunk.” **(Stakeholder)**

This issue was raised most frequently in regional areas, where Aboriginal-specific services reported being under pressure to support members of the broader community. While these services often did so informally to avoid leaving people without assistance, they emphasised that they were not funded to provide this level of coverage. For example, services located in East Gippsland, Latrobe Valley, Mildura and Swan Hill will assist if required, however they prioritise Aboriginal Peoples first.

Eligibility issues could also contribute to intra-community tensions. Aboriginal-dedicated health services expressed concern about potential community backlash or frustration from police and other organisations referring to PIR services. This concern has influenced their willingness to promote their services more broadly. As one provider explained, advertising widely could generate calls from the mainstream community, which would place them in a difficult position if they were unable to accept those referrals.

They noted that this could create perceptions of unfairness or favouritism, undermining community trust in the service, as one provider stakeholder noted:

“We’ve certainly had our reservations about advertising. Yeah. Because we’re, you know, obviously because we’re just servicing Aboriginal community. Yeah, yeah. And so if we advertise broadly, and then we’re getting phone calls from mainstream community. We’re going to look silly. And you know, look like we’re favouring...” **(Stakeholder)**

Questions also emerged around how Aboriginal status is ascertained. One regional health service reported an incident where police mistakenly brought a person of African descent to their facility, assuming he was Aboriginal. Although Victoria Police receive training to ask people whether they identify as Aboriginal or Torres Strait Islander—partly because they are required to notify Aboriginal legal services—records of PIR incidents suggest that this question is not consistently asked in practice. Stakeholders acknowledged that operational pressures may play a role but noted that this inconsistency makes it difficult to monitor how eligibility is being applied.

Stakeholders also observed that some Aboriginal people may be reluctant to disclose their status to police or emergency services. Historical experiences of harm in these interactions contribute to hesitancy, reinforcing the need for community education to explain why such questions are asked and how they link to dedicated health supports. As a regional PIR service staff member noted:

“I guess that’s also a police practice question too, isn’t it? About how they frame their reason for asking. If it’s framed in terms of ‘we’re asking this because there could be pathways for you for appropriate support’, maybe people would identify more often.” **(Stakeholder)**

Not all referrers felt comfortable asking about Aboriginal identity. For example, one licensee stated that they would ‘*never ask such a question*,’ describing it as racialized:

“Everyone’s the same. We don’t want to be asking what your nationality or your race is, or how you identify, or whether it be culturally or sexually or anything. We’re sort of probably trained just to treat people as equals.” **(Licensee)**

Instead, the licensee suggested that sobering centres should cater for the wider community while including a specific wing for Aboriginal people, staffed by culturally-responsive workers. In their view, this model would allow licensees to make referrals without raising questions of identity directly, while outreach services could confirm status once the person was admitted.

Inconsistent service operating hours

The availability of PIR services varies significantly across locations (Table 5, p.44). In metropolitan Melbourne, centralised intake and dispatch services (VAHS), Cohealth (general population), and Ngwala (Aboriginal services) operate on a 24/7 basis. In contrast, regional services operate on restricted schedules:

- > Ballarat and Geelong provide 24/7 coverage.
- > East Gippsland operates Thursday 3pm to Monday 11pm.
- > Latrobe Valley and Mildura/Swan Hill operate Friday 3pm to Monday 10am.
- > Shepparton operates Thursday 4pm to Monday 8am.
- > Bendigo operates Monday to Thursday 9am to 5pm then Friday 9am to Sunday 9am.

These schedules were designed to align with peak demand periods, particularly weekends. However, stakeholders consistently identified the limited operating hours as a gap in service provision. They noted that vulnerable groups, particularly people with chronic patterns of alcohol use, may require support outside of these designated periods. One stakeholder explained:

“The regional services, a lot of the hours are limited, you know, we get a lot of calls Monday, Tuesday and Wednesday. And to me, people who are dependent on substance don’t choose a day of the week to drink.”

(Stakeholder)

This uneven coverage highlights the ongoing challenges of meeting the needs of both event-based and chronic patterns of intoxication under the current model.

The inconsistent availability of PIR services also has direct operational consequences for Victoria Police, as they are sometimes required to respond differently to the same circumstances depending on the day of the week or the service hours in a given location. For example, a person who may be eligible and willing to be transported to a PIR service on a Friday night may not have the same option available on a Tuesday morning. This variability undermines consistency in practice and can generate confusion and frustration among police (as well as in the community). Stakeholders raised this issue during a meeting, noting that such inconsistencies risk reducing police confidence in the system and may discourage them from contacting dispatch services in the first place.

This sentiment was echoed by members of Victoria Police who, while expressing appreciation for the availability of sobering centres and outreach services and noting that when these supports are accessible, the outcomes are often positive, also identified major gaps in service coverage. This was particularly the case outside metropolitan areas.

Members also pointed to challenges when outreach or sobering services refuse to accept certain clients, including well-known community members who may present safety risks. While such refusals are understandable as a way of protecting staff, members described this as creating a form of ‘risk shifting,’ where responsibility defaults back onto police, leaving them to manage situations with few viable options.

Limited and inconsistent capacity to manage intersecting health considerations

Another key service gap relates to the limited and inconsistent ability of PIR health services to respond to complex health presentations, particularly where alcohol intersects with other drugs or behavioural risks. While some facilities have on-site nursing staff and clinical capacity to manage AOD clients, others do not. This means that even when a referral occurs within operating hours, the capacity of a service to accept and safely manage an intoxicated person can vary.

Stakeholders reported inconsistency in decision-making, where a service might accept a person who had consumed multiple substances on one day, but refuse a similar case the next. As one Aboriginal health service explained:

“One day a service will take someone that’s had other substances, and the next day they go, ‘Oh, no, sorry, we’re not going to take them today.’” **(Health worker)**

This inconsistency is partly a result of the shift in terminology and scope from ‘public drunkenness’ to ‘public intoxication.’ Services that were originally designed to manage alcohol intoxication alone have, in practice, become responsible for clients experiencing a broader range of AOD-related harms. Without the corresponding investment in workforce training, clinical protocols, and risk management frameworks, services have found themselves navigating new responsibilities beyond their initial remit. As one health worker noted:

“There’s a whole heap of different risk issues involved, different scope of practice, different staff skills that you need... Would it be a helpful service? Absolutely. It’s just not what we set out into safely.” **(Health worker)**

In addition, services highlighted safety concerns when managing people who may present with violent behaviour. These concerns are particularly acute in facilities staffed primarily by women, where there may be insufficient security or protocols in place to de-escalate situations and ensure the wellbeing of both staff and clients.

Overall, these issues point to a structural gap between the intent of the reform to respond holistically to public intoxication and the current resourcing and training available to frontline emergency responders (Recommendation 10).

Recommendation 10

Department of Health to:

- A. Establish a referral feedback loop that enables the Department to track the outcome of all public intoxication referrals (including via the Victorian Aboriginal Health Service line and Victoria Police referrals), and which is fed into the PIR Statewide Monitoring Framework.

NGWALA CASE STUDY: IMPLEMENTING PIR

The Ngwala Willumbong Public Intoxication Response Model provides a culturally safe, health-based alternative to criminalisation by offering a 48-hour brief intervention, follow-up, and support framework for Aboriginal and Torres Strait Islander community members. The model is grounded in harm reduction, cultural connectedness and community-led care. This section outlines the implementation model designed by Ngwala and uses diverse case studies to highlight some of the complexities encountered by organisations delivering the PIR response. This section reproduces advice provided to the evaluation team by Ngwala.

The Ngwala model

Multiple entry pathways ensure the model is responsive and accessible. Intake may occur through the centralised VAHS dispatch line, which receives referrals from police, PSO, paramedics, hospitals, publicans, security staff, businesses, community members and local services. Intake may also occur through Ngwala's assertive outreach teams, who proactively engage community across Melbourne, Wyndham, Frankston, Latrobe, Gippsland, Swan Hill and Mildura. Outreach teams target known hotspots—including gathering areas, nightlife districts, rough-sleeping locations and places where community members may be vulnerable—to ensure people most at risk receive timely support.

Once contact is made, nurses, Aboriginal health workers or assertive outreach staff conduct an initial assessment. Immediate assistance may include basic first aid, material aid, or transport home or to a Sobering Up Centre. At the Sobering Up Centre, individuals receive a further health assessment alongside access to food, clothing, showers, a safe place to rest and close monitoring. Where health concerns escalate, staff coordinate hospital transfer or ambulance support.

Following a period of rest, workers identify any chronic health needs, crisis issues or referral requirements and support individuals into appropriate pathways of care. People may be transported to treatment services, supported home, or assisted to another safe location. Over the following 48 hours, Ngwala staff conduct welfare checks to ensure safety, wellbeing and engagement with referrals. Regular service users may also be supported through care-team coordination to strengthen information sharing and continuity of care. For individuals placed in emergency accommodation, staff provide ongoing welfare checks while case management teams explore longer-term housing or detox options.

The model is further enhanced through community engagement activities, including the Ngwala coffee vans and the Veg Out community lunches at St Kilda's Peanut Farm. These initiatives build awareness of the program, foster trust and strengthen ongoing relationships with community members who may use the service.

Culturally safe design

Ngwala's Public Intoxication Response Program operates as a community-based, non-clinical model that prioritises environmental and cultural safety. The centre is intentionally designed to feel homelike while providing dedicated, safe and private spaces that respond to the needs of men, women, young people and LGBTQIA+ community members. A youth-specific rest area and lounge can be sectioned off from adult spaces to ensure safety and comfort. Community members also have access to secure outdoor areas and on-site staff who are readily available for yarning, support and connection. The presence of an Elder in Residence provides additional cultural grounding, offering guidance, mentoring and support to both community members and staff.

The broader suite of Ngwala services strengthens the model and ensures community members can access longer-term supports where needed. Comprehensive Intake and Assessment services help identify immediate risks, needs and priority pathways. Alcohol and Other Drug (AOD) case management provides culturally informed, structured support for individuals seeking ongoing assistance, including goal setting, relapse prevention and treatment planning. Community members can also access a wide range of treatment options, including residential programs, day programs and community-based interventions.

For people experiencing or at risk of homelessness, Ngwala's entry point provides homelessness and housing support that includes crisis responses, advocacy, referrals and help navigating short-and-long-term accommodation. Holistic wellbeing is supported through counselling and family therapy, which offer culturally safe spaces to explore trauma, strengthen relationships and support healing. Additional social and emotional wellbeing programs—such as dedicated men's, women's and youth groups—promote cultural identity, empowerment and community connection.

Together, these services form a strong, integrated network of culturally grounded supports that complement the Public Intoxication Response Program, ensuring community members receive timely assistance, ongoing care and pathways toward long-term wellbeing.

The following (anonymised) account highlights the often-unseen work undertaken by outreach and health staff as part of this model, and highlights an instance when the boundary between a health and a justice response could become blurred.

Ngwala Case Study 1 ²⁰

Late one evening, a service provider in a regional area received a call from Victoria Police requesting assistance for a man who was reportedly 'Aboriginal, presenting as intoxicated, and causing a disruption in a quiet neighbourhood by walking into yards and knocking on doors.' Police advised that they had received several complaints over a period of time and believed it would be more appropriate for a service provider to attend. No police officers attended the scene to conduct a risk assessment.

An assertive outreach worker and a health worker responded and located the man. Due to the remote location, the time of night, and minimal lighting, workers were unable to complete a thorough health assessment. After gaining consent for support, they identified that he was presenting as significantly unwell and likely required urgent medical attention. Workers transported him to the local hospital by car.

Upon arriving at the emergency department, staff noticed blood on the back of the man's clothing. They helped him lie down, as he was unsteady on his feet, and alerted hospital staff immediately. It was then discovered that he had been involved in a physical altercation and had sustained a stab wound to his upper torso near his back.

The community member was urgently assessed and airlifted to the Alfred Hospital in Melbourne for surgery due to the severity of his injuries. He spent several weeks in ICU. During this time, the service provider supported his family by arranging transport and accommodation so they could be with him in Melbourne. They continued to provide regular check-ins and welfare support to both the individual and his family throughout his hospitalisation and following his return to community several weeks later.

The community member has experienced long-term health impacts as a result of the incident.

20. These case studies were provided by Ngwala to the evaluation team for use in this report; accordingly, they are reproduced verbatim.

Case study 2 illustrates how the vulnerability experienced by many Aboriginal people can extend beyond the immediate intoxication event and an appropriate response can be made more challenging by existing health and life circumstances.

This case highlights the complex balance between respecting a community member's autonomy, responding to cultural and historical trauma, and managing significant health and safety risks within the constraints of current policy and mandated-care thresholds.

Ngwala Case Study 2

Late one evening, an Assertive Outreach team received a call regarding an elderly Aboriginal woman who is well-known to the service. On arrival, workers located her in a public area. She was heavily intoxicated but alert, and she consented only to being taken home. The woman is known to be a significant fall risk, and while the team's preference was to transport her to the local sobering-up centre for monitoring, she refused and continued to insist on returning to her residence.

After completing a safety assessment, the team determined that it was safe to transport her home. They drove her approximately 5–7 kilometres to her property. Upon arrival, it became clear she had lost her house keys. The woman refused to leave the premises, insisting on waiting outside her home. Given the cold weather, her level of intoxication, and her vulnerability as an Elder, the team did not consider it safe to leave her alone. They contacted management for support in gaining access to the property, but no emergency locksmiths were available at that time.

Workers continued to monitor and support her while she remained outside her home. Several hours later, a neighbour noticed the situation and was able to assist in gaining access to the property. The team supported the woman inside and helped her settle into a comfortable chair. Once indoors, she attempted to stand and usher the workers out, but she stumbled and fell, striking her head on a doorframe.

An ambulance was called immediately. When paramedics arrived, the woman initially resisted assessment but eventually consented. Despite her injuries, level of intoxication, and high fall-risk profile, she refused to attend hospital. Paramedics advised that she did not meet the threshold for a mandated transport response and provided monitoring recommendations to the outreach team.

As the paramedics exited with the workers, a loud thud was heard from inside the house. They re-entered to find the woman on the floor, having fallen again and struck her head on a bench, resulting in a visible bleed. She was reassessed, but once again refused transport to hospital. Paramedics reiterated that the threshold for mandated care was not met and advised continued close observation.

The service provider remained with the woman for approximately six hours, conducting regular observations and monitoring her condition in line with paramedic recommendations. They remained on site until her level of intoxication had reduced, her presentation had stabilised, and they were confident she could safely remain at home.

Case study 3 reinforces the value of Ngwala's model in centring cultural safety through all responses.

Ngwala Case Study 3

Ngwala Willumbong's Public Intoxication Response Program received a referral via the centralised dispatch line from Victoria Police regarding a woman reportedly intoxicated in Melbourne's CBD. Police indicated that the woman appeared heavily affected by alcohol and was having difficulty communicating.

An Assertive Outreach Worker and a Registered Nurse were deployed to the call-out. On arrival, they located a woman in her early thirties who reported she had been out with friends for the evening. The team conducted an assessment, determining that she was significantly intoxicated but medically stable and suitable for non-clinical support through the Sobering Up Centre.

The woman was transported safely to the centre, where she was provided with food, hydration, and a culturally safe, calm environment to rest. Staff monitored her closely over several hours while she slept.

Upon waking, the woman appeared confused and disoriented. The team provided gentle reassurance, explained the events leading to her arrival, and ensured she felt safe and supported. Once she regained orientation and confidence, she opted to leave the centre but accepted the offer of transport home.

A few hours later, the woman returned to the Sobering Up Centre to thank staff. She expressed embarrassment about the situation but explained that she was a nurse herself and lived with a mild disability that sometimes affects her speech, particularly when fatigued or intoxicated.

She shared that she had consumed alcohol after attending the gym earlier in the day and having had very little to eat. She recalled interacting with police but felt they were becoming frustrated with her speech difficulties and level of intoxication. She was relieved that Ngwala's team had been contacted, stating she had not been aware that such a culturally safe, health-based service existed.

The woman thanked the Outreach staff for their compassionate response, saying she did not know what might have happened had Ngwala not been called. Her appreciation highlighted the program's value not only in reducing harm, but in providing culturally responsive, non-judgmental support during vulnerable moments.

The Ngwala model extends beyond the sobering up centres and includes community-based engagement and wellbeing activities. While these may appear to be unrelated to the PIR response, the following case study highlights the opportunities for providing public health-based support through these seemingly-unrelated

activities, illustrating the possibilities of a creative approach. This case study also highlights the value of an intersectional approach.

Appendix 3 includes three further case studies provided by Ngwala for this evaluation report.

Ngwala Case Study 4

Ngwala Willumbong's coffee van—staffed by assertive outreach workers—was operating its regular community engagement activities in an inner/outer Melbourne location known to have a significant rough-sleeping community. The van provides a safe, informal way for community members to connect with workers, access basic needs, and learn about available supports.

While being served coffee, a community member began asking staff about the types of support Ngwala offers. During the conversation, they disclosed that they themselves were rough sleeping and that a woman had recently come to stay at their camp. They expressed concern for her safety, sharing that she had escaped domestic violence and had been appearing increasingly distressed. Recognising the potential risk, the outreach staff followed the community member to meet the woman.

The woman, in her mid-30s, disclosed that she had been brought to Melbourne by her partner before fleeing following a series of violent incidents. With no local supports, no money, and no phone, she had been relying on strangers for safety. She reported feeling extremely vulnerable and frightened living on the street and did not know where to go for help.

Ngwala staff provided immediate emotional support, explained the services available, and ensured she felt safe and in control of decisions about her next steps. The coffee van team contacted Ngwala's Assertive Outreach Program and requested additional support at the site. Upon their arrival, the woman consented to being transported to Ngwala's Sobering Up Centre, where she could receive a health assessment, food, rest, and a safe environment away from harm.

From the centre, staff contacted an emergency accommodation provider, advocating for immediate crisis housing. A temporary placement was secured that evening, ensuring the woman had access to a safe bed, privacy, and the opportunity to stabilise. Over the following day, Ngwala's Assertive Outreach and the crisis support provider worked collaboratively to:

- > Support the woman to contact her family interstate;
- > Explore her options for returning to New South Wales;
- > Seek funding to cover the cost of safe travel;
- > Ensure she remained connected to crisis accommodation until travel could be arranged; and
- > Maintain cultural safety, trauma-informed care, and empowerment throughout decision-making.

Her family expressed relief and welcomed her return. Ngwala's staff were able to coordinate safe transport, ensuring she could travel home directly to family support.

GEOGRAPHIC DISPARITIES IN PIR IMPLEMENTATION

The rollout of PIR has highlighted stark inequities between metropolitan and regional Victoria. In Melbourne, the model was designed to operate alongside well-established infrastructure: multiple sobering centres and outreach teams, 24/7 service availability, and a variety of safe transport options including taxis, rideshare, and frequent public transport. In contrast, regional communities operate in a vastly different context. Services are fewer and often only available during limited hours, with some towns and remote areas having no outreach or sobering services at all. Public transport is sparse, rideshare services do not operate in many locations, and community members are often known personally to local taxi drivers or service providers, which has at times led to service refusal.

“There’s also the sort of tyranny of distance in the regional communities, the lack of public transport to get people home safely, and then no after-hours response.”
(Stakeholder)

Regional stakeholders frequently described PIR as metro-centric—a policy built around the infrastructure and service systems of Melbourne, without sufficient consideration of the realities of regional areas. The lack of comparable infrastructure means that the health-led model, while effective in metropolitan areas, is much harder to deliver outside major cities. These gaps often leave intoxicated people with no safe place to go, increasing the risk of harm, escalation, and reliance on police to manage situations.

Some Local Site Executive Committees (LSECs)²¹ in regional areas consistently called for proportional funding rather than no funding, arguing that current investment patterns reinforce a sense of neglect and undervalue regional needs:

“I think, you know, the recommendation would be that it [should be] proportional funding, not no funding. No funding sends a really bad message, particularly to Aboriginal communities.” (Stakeholder)

They highlighted that the absence of funding and service infrastructure not only limits access to health-led support but also sends a poor message to regional communities about their importance in statewide reform efforts.

Stakeholders emphasised that regional service responses should not be viewed as optional or secondary; rather, they require dedicated investment and innovative approaches, such as reviving night patrols and community-led sobering centres, to address gaps without starting entirely from scratch.

The evaluation found a clear consensus that equitable implementation requires PIR to move beyond a one-size-fits-all model. Services must be adapted to local context, resourced adequately, and designed in collaboration with regional communities, many of whom expressed frustration that policy decisions rarely reflected their realities.

Impact on policing

Victoria Police members described how the inconsistency of promised health services has left them without the alternatives needed to support intoxicated people under a health-led model. One member commented:

“[The health service availability] was promised to us, it was promised as part of our... training... This was the plan but there’s nothing there...” (Victoria Police member)

This sentiment reflects the frustration of frontline police who were trained and briefed on a model that assumed health services would be available as a response pathway. Officers noted that service unavailability not only undermines their ability to deliver on the PIR as planned, but also exposes them to community criticism when health-based responses cannot be accessed. This particular concern was reflected in a PDR App entry made by a police member:

“Belligerent and obnoxious drunk. Threatening to damage property and assault people. Told to move on. Repeatedly returned to scene. Couldn’t be moved on as unsafe in country area. **No services available.** No family available. Verbally aggressive towards police and hotel staff. Public angry at police lack of action and drunk reform.” (Victoria Police member)

This case shows a key tension encountered by members of Victoria Police: police were unable to charge the man because he had not committed an offence, yet without any health service referral options, they were left to manage the situation alone and with few available options. The outcome not only exposed officers to community anger but also undermined confidence in the PIR model.

21. LSECs have been established in 17 areas across Victoria, and are an important strategy through which equitable justice outcomes for Aboriginal Peoples are sought. LSECs ‘provide a forum for government and sector leaders to come together to find shared ways to solve local problems and improve the way services are delivered.’ (Support Aboriginal decision-making | Aboriginal Justice).

Community organisations filling the gaps

In the absence of funded health services, many communities have had to rely on local organisations and volunteer-run programs to bridge the service gaps. Night patrols, youth outreach services, and community-led initiatives often step into this space, offering critical on-the-ground support despite lacking the resources or formal recognition to do so. These efforts, while invaluable, are often undertaken voluntarily and without sustained funding, a situation that was described by stakeholders as both unfair and unsustainable. Volunteers themselves face mounting pressures from the rising cost of living, family responsibilities, and the demands of juggling other employment. As one lawyer observed:

“It’s just not a space that is easily stepped into by community because of all the barriers that we all know about, and so they struggle to, there are often vacancies that they will fill them, but they’ll have gaps when people leave and take up other roles and opportunities... that often those services in the past were run voluntarily.” **(Lawyer)**

Stakeholders also repeatedly raised concerns about the lack of government action in supporting or formalising these community-led responses:

“I think building on the strengths of those communities, things like sporting groups and local service groups, you know, Rotary, Lions Club, those sorts of things. Community members are involved in those and they were seen as sort of opportunities to be able to engage other members of the community.” **(Stakeholder)**

They noted that when the community suggests ways to build on existing community services in non-PIR areas, these suggestions are rarely taken up by government. This pattern contributes to a sense of frustration, particularly in regional Victoria, where the absence of dedicated funding was seen as a strong signal that government places greater value on metropolitan areas. Community representatives argued that regions should not be left without support entirely, calling instead for proportional funding that reflects local need.

Some stakeholders emphasised that funding could provide a practical pathway to resourcing existing organisations and reviving community programs that had proven effective in the past. They noted that services, such as night patrols and community-led sobering centres (which were defunded some years ago), could have been restructured and integrated into the PIR, rather than requiring new services to be built from scratch. Their absence has meant lost opportunities to draw on trusted, culturally grounded models already embedded in communities. A stakeholder from regional Victoria noted:

“We had that sobering service for 20 odd years, and then snap of fingers, it’s gone. And yet, here we are again, having to establish something from scratch again.” **(Stakeholder)**

One Victoria Police member reflected that many of the alternative pathways that once supported both communities and police, such as community-controlled transport services for intoxicated people, are no longer in place. The disappearance of these options has reduced the range of non-police responses available, leaving police with fewer supportive avenues to draw upon.

Beyond immediate referral and care, stakeholders highlighted the importance of resourcing organisations to engage with clients after they leave sobering services, ensuring continuity and wraparound support. While there is currently no dedicated PIR funding stream for follow-up, Aboriginal community-controlled organisations noted that they continue to provide this support for Aboriginal clients as part of their community obligations. Extending similar funding to other organisations would strengthen outcomes and help ensure that the health-led response does not end once a person leaves the sobering centre. These insights are summarised in Recommendation 8.

Recommendation 11

The **Victorian Government**, supported by the **Department of Health** to:

Forward agenda

- A. Identify and clearly define the forward agenda of Public Intoxication Reform, with an emphasis on future expansion—including adequate resourcing—to support sustainability.

Funding and resourcing

- B. Ensure that existing funding and resourcing for current PIR services is maintained.

Service expansion: Metropolitan

- C. Expand service coverage across Metropolitan Melbourne that:
 - 1. Prioritises coverage in the South-East metropolitan area.
 - 2. Establishes more services for the Aboriginal community and general public in those metropolitan areas that are beyond the 45-minute radius of existing services (Cohealth and Ngwala).

Service expansion: Regional

- D. Use available data (including Victorian Aboriginal Health Service, Victoria Police and the Victorian Social Investment Integrated Data Resource) and community consultation to identify areas of unmet demand and establish more services in regional Victoria.
- E. Use available data (including Victorian Aboriginal Health Service, Victoria Police data and the Victorian Social Investment Integrated Data Resource) to align PIR service hours to demand in both regional and metropolitan areas (including extending 24/7 coverage in large regional hubs and extending metropolitan and regional hours to include peak demand periods).

Service expansion: Major events

- F. Build capacity for surge in demand during major events (including consideration of casual staffing pools, on-call capacity and flexible operating arrangements) and ensure responsivity to diverse stakeholder groups (including the Aboriginal community).

INSIGHTS FROM THE SOUTH SUDANESE AUSTRALIAN COMMUNITY

Information on cultural and migration-related factors further complicated the PIR and service needs for members of the South Sudanese Australian community, one of the key marginalised groups targeted by the reform. These participants stressed that cultural context must be understood and incorporated into responses, starting with basic considerations around greeting customs, religious sensitivities, norms around eye contact and interpersonal communication, and a broader understanding that unmarried individuals typically live with family, meaning next of kin should be contacted immediately.

Younger participants, in particular, emphasised the need for a non-aggressive approach, as aggression often escalates tensions. Importantly, because alcohol use is closely associated with shame in the South Sudanese Australian community, any response must be handled with care, cultural sensitivity and confidentiality. These elements are unpacked below and further elaborated in Appendix 4.

The influence of cultural norms around alcohol use

Alcohol use and intoxication—terms often used interchangeably within the community—are commonly associated with shame by older community members, many of whom have never consumed alcohol themselves. Alcohol is typically not available in the home, and as it is generally considered a substance that should be consumed privately, is rarely discussed in public settings. As a result, parents and children lack important education and information about alcohol, and young people are likely to turn to their peers to learn drinking norms. While older members of the community are conservative and typically inexperienced with alcohol, there is acknowledgment that first-generation young people will inevitably have their first encounters with alcohol once they arrive in Australia. Despite this, some older community members described young people who are publicly intoxicated as bringing ‘shame to the community.’ One noted, *‘Because most people, we know them. Especially our children and some adult people.’*

The shame associated with intoxication, combined with limited alcohol or alcohol-related education within the home, is closely linked to public drinking among South Sudanese Australian youth. Young people are highly unlikely to consume alcohol at home or to contact their parents if they become intoxicated in public, and the youth participants emphasised that any drinking or intoxication is generally kept secret from their parents:

“There’s definitely a big, you know, taboo in terms of, like, you’re not supposed to drink, and, and I think that puts a lot of pressure on young people and, it steers them away from telling their parents, that they do drink, and, yeah, so then they pretty much just do it without any supervision, without anybody knowing.”

(South Sudanese Australian youth participant)

This secrecy contrasts sharply with the experiences of their Australian peers. In highlighting the difference, one youth participant identified the risks that young South Sudanese Australian people faced:

“I grew up with a lot of young people in my year level that did drink, but their parents knew, you know, so it was a lot different in terms of how they perceived alcohol but with us, a lot of it is, unsupervised. So, you know, they [South Sudanese Australian youth] would be getting highly intoxicated.”

(South Sudanese Australian youth participant)

These generational and cultural differences in alcohol use, combined with the absence of parental guidance or support to manage intoxication, significantly increase the likelihood of South Sudanese Australian youth encountering the criminal justice system. As one youth leader reflected:

“We’ve been taught predominantly to never drink alcohol, and now we’re drinking alcohol. So where’s the education around that? Like, I remember I was in year 10, and, you know, the [non-South Sudanese Australian] kids were getting their little pieces of paper and getting it signed by their parents to drink at their friend’s party. It’s like, it’s normal, you know, but it’s like, there’s so much protection in place for that young person. If they get drunk, mum and dad will pick them up. But because in our community, we don’t have that system in place, these kids aren’t calling their parents. These kids aren’t calling whoever they need to call to, to help them out in that situation. And unfortunately, the only other people who are gonna be on the other side [available to call] is usually Victoria Police.” **(Youth leader)**

This insight highlights a critical gap: while protective frameworks and parental supervision are normative for many Australian youth, South Sudanese Australian youth often lack these supports. The combination of shame, secrecy, and disrupted parent/child relationships lead to a lack of education places young people at higher risk of public intoxication incidents escalating into encounters with the criminal justice system, demonstrating how cultural and familial factors intersect with structural systems to shape these outcomes.

Youth, mental health and intoxication

Youth participants highlighted the strong links between alcohol use (and abuse) and the persistent mental health challenges experienced across the South Sudanese Australian community in Victoria. In several instances, it was evident that youth participants found it difficult to discuss alcohol, as doing so meant confronting the hardships and emotional burdens they are currently enduring. One youth participant articulated this struggle, stating:

“Especially in our community, like there’s been a lot of a lot of deaths as well. And a lot of people in our community feel like it’s not being spoken much about. So, what we do, like my youth, we, we’re just drinking all the time. That’s literally, the only way you see us coping and it’s not like a really good way to go about it.”

(South Sudanese Australian youth participant)

This quote reflects the deep connection between alcohol use and coping mechanisms among young people, highlighting that drinking is often used as a way to manage grief, trauma, and broader community stressors.

Community leaders reinforced these concerns, highlighting the range of challenges currently faced by young people in their community. They identified high unemployment, limited educational opportunities, and social marginalisation as key factors contributing to higher rates of intoxication among youth. Community Elders also emphasised that the racism and discrimination young people experience at school plays a significant role in their disengagement. They stressed the need for greater collaboration between parents, schools, and support services to help young people avoid antisocial behaviour, alcohol use, and contact with police. One community leader described the cumulative effect of these pressures, explaining that when young people feel overwhelmed by their circumstances, they may ‘give up.’ This has further impacts: *‘When they give up, then they will be wandering around and they go to prison.’*

These perspectives together illustrate a troubling cycle: systemic challenges and community stressors can contribute to alcohol abuse among youth. Drinking is often used as a coping mechanism, which increases the likelihood of young people being intoxicated in public spaces. This, in turn, can lead to greater visibility to authorities and higher rates of police engagement, compounding the risks they face and potentially drawing them into the criminal justice system. Implementation of the PIR—if it is to adequately address the needs for this particular marginalised community—should therefore recognise these particular considerations. The recommendations related to these particular findings are included under ‘Partnerships’ (p.93).

Confusion about PIR service purpose and referral pathways

Community members expressed confusion about when PIR services should be used. Uncertainty remains about what constitutes a referral-worthy situation, including whether the services were for instances where someone was publicly intoxicated but not harmful, or only for when a person is unconscious or visibly unwell. There is also concern that PIR health services cannot be contacted directly by members of the public and that police must still act as gatekeepers to access care, an approach many want to avoid. This concern reflects the fact that, while the contact details for VAHS have recently been made publicly available, there remains very low public awareness of when and how to request outreach services for intoxicated people.

Summary

Overall, the aim of the Public Intoxication Reform is clear. It is to facilitate a health rather than a justice-led approach to public intoxication, thereby reducing and minimising the interactions between people intoxicated in public and the criminal justice system, including police and protective services officers. While initial efforts from the first 2 years of PIR roll-out are promising, there remains opportunities to further address community and stakeholder concerns. Recommendation 8 speaks to the need for an integrated, multi-sectoral response.

There is some inevitability within the reform space around Victoria Police becoming somewhat of a default provider of a crisis health response to public intoxication, due to its ubiquitous nature. The organisation operates state-wide, twenty-four hours a day and seven days a week and its members are trained to provide a response to a wide variety of events and situations. However, the question needs to be raised that, just because Victoria Police is available and is able to respond, should it be one of the primary (and sometimes the only) pathway to response to someone who is intoxicated in public? This question is considered in more detail in the following section.

Recommendation 12

Department of Health to:

- A.** Establish a centrally integrated statewide Public Intoxication Reform Hub that:
 - 1.** Enables real time assessment of individuals and provides seamless, warm referrals to existing health and social services, via expedited pathways.
 - 2.** Includes integrated 'nodes of expertise' (including homelessness, mental health, LGBTQIA, drugs, children and young people and multicultural services) and embeds culturally safe and trauma-informed expertise.
 - 3.** Includes a bespoke 'node of expertise' staffed by Aboriginal community members.
- B.** Establish a community-governed and culturally safe service for South Sudanese Australian young people, co-designed with community leaders and integrating alcohol and other drugs, mental health, family support, education and employment pathways and case navigation.

POLICE RESPONSES

PIR does not explicitly address the practice of transportation of an intoxicated person in a police vehicle. However, Victoria Police has intentionally established a very high threshold for police transport. The CCI sets out the following four criteria, all of which must be met before transport can occur:

- > The person is capable of providing informed consent and agrees to being transported;
- > A local outreach or sobering service is not available to attend within a reasonable time;
- > Transport is necessary to mitigate and/or eliminate an immediate or imminent serious risk to the person's health; and
- > The duty officer has approved this action.

This threshold reflects a deliberate risk mitigation effort on the part of Victoria Police, which has been put in place for good reasons. Police vehicles essentially function as mobile holding environments, but without the safeguards present in formal custody settings, such as access to medical personnel (custody nurses) and regular monitoring and oversight by police supervisors. Transporting an intoxicated person in such conditions, even with their explicit consent, exposes them to a high-risk environment with minimal monitoring during an extremely vulnerable period. Specifically, both community stakeholders and Victoria Police members pointed out that visibility of a person in a police vehicle (especially in a divisional van) is low, and there is a high risk of falls and injuries when an intoxicated person is unsecured and unable to remain seated.

It is reasonable to look at the balance of risk between transporting a person a short distance to a safe place versus other options, such as leaving a vulnerable person in situ and there are certainly situations where transportation would be less risky than other available alternatives. Police have called out the stark absence of the police vehicle transport option, particularly in situations where the transport is short (for example the person lives 'around the corner'), where there are gaps in service delivery and where the only alternative has been to leave a person in situ.

As a stakeholder explained, these dilemmas can be magnified in regional areas and small communities where police members are often well known to the community, and potentially to the intoxicated person themselves, and therefore feel more visible and scrutinised in their response.

"Where the police often live within the community... and they're small communities that they only have one local policeman living in town, they have a completely different way of surviving by becoming part of the community and doing those things that wouldn't happen in bigger locations to keep the community safe, but [also] to make themselves fit into the community."

(Stakeholder)

Outside of the risk component, police have also expressed that they frequently face ethical dilemmas in situations where they view actions taken in line with policy—such as leaving someone in situ without a response—as being at odds with their broader ethical duty of care and their fundamental commitment to protect the community, as a stakeholder explained:

"[There has been] a real shift in a mindset where our members had to take away their own bias and whether that they were empathetic or concerned or had care for someone... that was removed. So that was a real challenge." **(Stakeholder)**

An example that is frequently raised is the leaked scenario from mandatory police training of a vulnerable young woman left in situ by officers, which left many members feeling uncomfortable about the limitations of PIR and parameters around their ability to assist. This scenario and the broader legal and ethical duty of care implications for police that arise as a result of PIR are discussed more fully on page 64.

Patterns of police transportation

When looking at the PDR App²² data on police transportation, some patterns are evident. Figure 12.1 shows that police were more likely to transport Aboriginal people following an arrest (10%, n=11) than for health risk reasons (5%, n=6). For people of Caucasian background, the pattern was reversed, with a higher likelihood of transport for health risk (7%, n=57) than for arrest (4%, n=33). There was little difference between younger and older people, who were transported at similar rates for both arrest and health-related reasons. People with a fixed permanent address were more often transported for health risk than arrest, while homeless individuals were equally likely to be transported for either reason (Figure 12.2).

Individuals charged with criminal offences were far more likely to be transported for arrest (32%, n=18) than for health-related reasons (7%, n=4). In contrast, people who were simply drunk in public, although the overall numbers were low, were more often transported for health reasons (5%, n=59) than for arrest (1%, n=17). This is shown in Figure 12.3 below.

Across most police regions, there were no significant differences in transportation reasons, except in the Western region. Here, people were twice as likely to be transported for health-related concerns (8%, n=28) as for arrest (4%, n=13). No similar trends were observed in other regions (see Figure 12.4).

FIGURE 12.1:

Transportation by police, by ethnicity

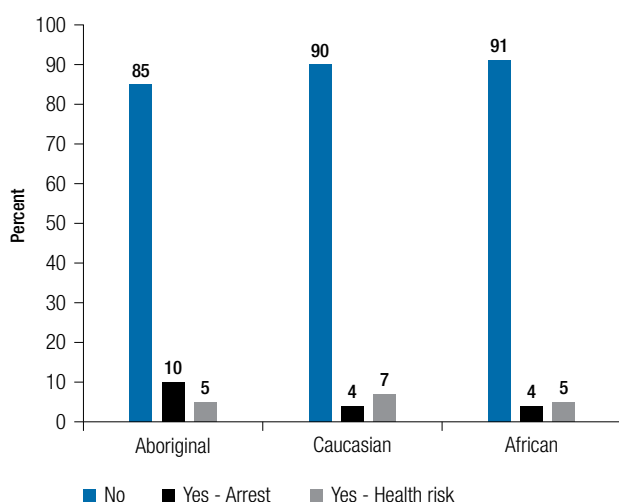


FIGURE 12.3:

Transportation by police, by reason

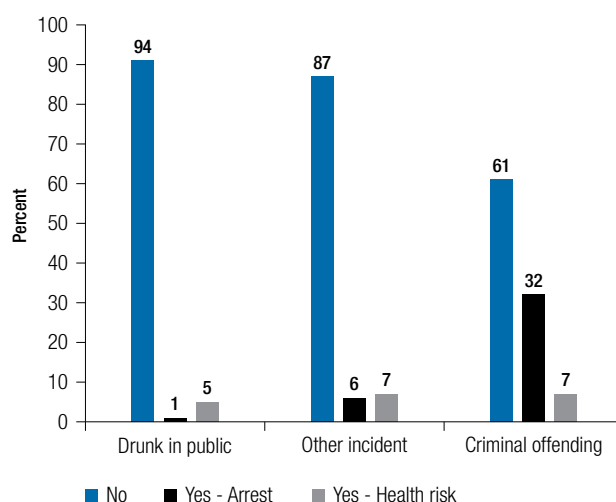


FIGURE 12.2:

Transportation by police, by homelessness status²³

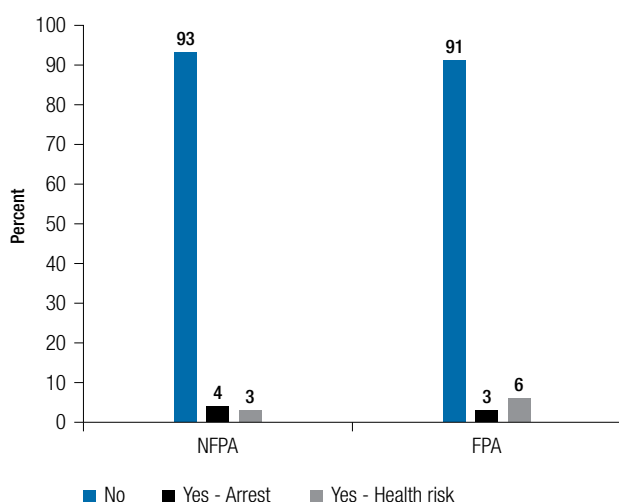
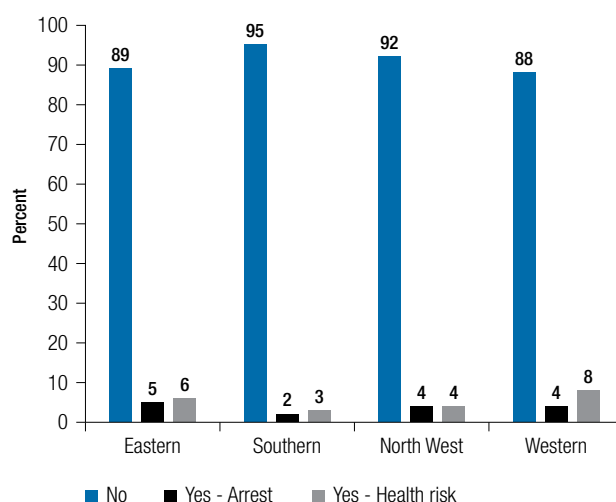


FIGURE 12.4:

Transportation by police, by police region



22. As noted above, usage of the PDR App dropped significantly across the evaluation period. For this reason, data are reported as percentages, rather than numerically, as this gives more useful insights into the impact of the Public Intoxication Reform.

23. NFPA refers to 'no fixed permanent address', while FPA indicates 'fixed permanent address'.

It is reasonable to anticipate then that—particularly in the absence of viable alternatives—police may continue to transport individuals outside of formal policy parameters in order to uphold their ethical duty of care to the community. Narratives from the PDR App support this assertion and indicate that police are transporting individuals outside of policy settings. This transportation is always framed in duty of care terms and as a measure to ensure the person's *safety*.

However, in the strictest sense, this is a policy breach as the CCI is clear that the only conditions under which a person should be transported are where there is a serious and imminent risk to *health*. This is a subtle but important distinction for police when considering whether or not to transport a person but is sufficient to prompt reports of duty failure, as highlighted by IBAC who provided the following case study:

IBAC Case Study 9

IBAC received a notification from Victoria Police regarding an investigation of an allegation of duty failure. It is alleged a person was transported home while intoxicated, in breach of the Chief Commissioner's instructions regarding the management of intoxicated persons.

There is no doubt that there is situational merit to transport, particularly when the alternative is leaving a vulnerable person alone in an unsafe environment. However, the overarching risk remains substantial. Police, despite acting in good faith, are not trained health professionals, and the transport of intoxicated individuals in uncontrolled settings introduces considerable safety and health concerns. Both police and community members interviewed for the evaluation acknowledged the reasoning behind this policy and there has been broad support for the retention of this threshold, with stakeholders stressing that any gaps in response should not be addressed by shifting additional responsibility to police.

Fundamentally then, the solution to transport is not to water down policy limitations on transport by police, but to enhance outreach service availability, particularly in regional areas where public transport and private options such as taxis and ride share services are scarce and/or completely unavailable. There is a significant need to invest in outreach teams and health-led transport solutions across all regions. Where specific health infrastructure is not feasible, this gap could be filled by community-based, community-controlled services. Options that were discussed during stakeholder consultations include funding and establishing (and, in many cases, re-establishing) local night patrols, culturally appropriate transport initiatives (one police officer, for example, noted that night buses had previously been available for the local Aboriginal community) and alternative models proposed by local communities.

Furthermore, any reduction in the current threshold for police transport risks undermining the health-based framework of the response and incrementally shifts responsibility for public intoxication back towards police. This would constitute a regressive step for PIR and—it is suggested—not resolve the core problem of limitations in service provision. There thus remains a need to establish multiple transport options to eliminate the police transportation issue (Recommendation 13).

Recommendation 13

Department of Health, supported by the **Department of Justice and Community Safety** and in consultation with local communities (focusing on regional Victoria, Aboriginal community and South Sudanese Australian communities) to:

- A.** Identify current transport service gaps across the State;
- B.** Identify previously successful community-based transport solutions (e.g., night buses and community designated drivers);
- C.** Fund and implement local transport solutions in service gap areas; and
- D.** Fund peer-led community education and communication to facilitate understanding of local transport options, including why these are preferable to police transport.

Liability, Duty of Care and Immunity

The intersection between duty of care, liability and immunity is complex and the concepts, although distinct, are very closely related. For police, 'duty of care' refers to their responsibility to take reasonable steps to avoid causing foreseeable harm to others, while *liability* refers to the legal responsibility police hold for breaching this duty of care. In turn, 'immunity' refers to legal protections (exemptions) that police are granted in specific situations and that protect them from legal consequence. Taken together, these concepts require careful balancing and the concurrent consideration of police obligations, accountability and protections.

With these concepts in mind, it is reasonable to suggest that the response options available to police under PIR represents a challenging legal space. The response of leaving a person 'in situ', a common option for Victoria Police both before and after the reform, is arguably the most powerful example of this challenge. On one hand, it is a beneficial solution that avoids unwarranted custody. Conversely, it can leave an intoxicated person in a vulnerable position, particularly where health services or community support are not available. Ahead of the reform's implementation, police raised concerns about potential legal risk when dealing with intoxicated people in public, noting that the shift to a health-led response reduces detention powers and can leave members without tools to manage people who fall through service gaps, especially if the person must then be left in situ.

Victoria Police's CCI Persons Drunk in Public policy outlines specific circumstances in which police are instructed to stay with a person or leave them unattended ('in situ'), stating that:

'a person may be left in situ where one of the following applies:

- > The person does not or cannot consent to receiving assistance;
- > The person does not require, or no longer requires assistance;
- > Assistance has been provided and the person is awaiting the arrival of:
 - a nominated person;
 - private transportation (such as taxi or rideshare);
 - a local outreach or sobering service; and
- > An alternative local support service assistance has been provided and no nominated person and/or relevant local support service is willing or available to attend' (Victoria Police 2023a, section 46, p.10).

The CCI also places strict limits on transporting a person who is intoxicated but not under arrest, even with their consent. It states:

'Transport of a person in a police vehicle who is drunk and not under arrest can only be considered when all of the following apply:

- > The person is capable of providing informed consent (refer to sections 21-27 of this policy), and agrees to being transported;
- > A local outreach or sobering service is not available to attend within a reasonable time;
- > Transport is necessary to mitigate and/or eliminate an immediate or imminent serious risk to the person's health; and
- > The duty officer [senior supervisor] has approved this action' (Victoria Police 2023a, section 46, p.10).

Notably, the CCI defines a risk to health as:

"a risk to physical or mental health, including from alcohol consumption, but extending to other risks, such as the risk of suffering hypothermia on a very cold night. It does not extend to safety risks, such as a person walking onto a roadway or being a victim of a crime."

(Victoria Police 2023a, p.3).

These thresholds narrow the circumstances for police transport, aligning with the reform's health-led intent but in the process creating operational challenges where outreach coverage is fragmented or delayed. This is particularly the case when there are no other available options of care including handing over to family and friends. These strict instructions create a challenging environment for members, who must balance minimal intervention with the risk of harm. Underlying this concern is an unspoken fear of civil or even criminal liability if harm occurs, whether due to inaction, negligence, or decisions made in difficult circumstances.

It is important to note that legal precedent in Australia, the UK, and elsewhere show that police are rarely found liable for omissions or failure to act. Courts traditionally avoid imposing liability for non-intervention, reflecting the absence of a general legal duty to rescue and concerns that constant litigation could undermine effective policing. Cases like *Hill v Chief Constable of West Yorkshire* [1989] 1 AC 53(UK) and *Stuart and Another v Kirkland-Veenstra* [2009] 237 CLR 215 (AUS) reaffirm that police are not usually held responsible for harm they did not directly cause or control.

It is far more likely that police in Victoria will face liability for taking action (the concept of 'positive' actions) than for omissions or failures to act. Members may be held responsible for false imprisonment or wrongful deaths in custody, and survival of actions legislation allows estates and dependants to pursue claims. Liability may be more likely to occur where police actions actively increase risk to an intoxicated person.

The *Victoria Police Act 2013* also provides a balancing mechanism around liability. section 74 of the Act provides for broad personal immunity to individual police members for duty of care breaches (both in actions taken and omissions or failures to act) in the absence of serious and wilful misconduct by an individual police officer. In these cases, the State takes on liability and compensation responsibility. This is an important insight and further underscores that police are unlikely to be held personally liable for—essentially—acting in good faith.

The Expert Reference Group suggested that the Victorian Government explore creating a new offence for negligent conduct when detaining an intoxicated person. This would focus on actions that create or increase risk while someone is in police custody. Importantly, this offence would only apply to what police do while detaining a person, not to decisions about whether or not to detain them.

These legal settings underscore why police remain cautious under PIR. Police members are aware that leaving an intoxicated person without support at times carries risks, but intervening inappropriately can create liability and compromise people's safety. The challenge for PIR is ensuring that members are not left as the default responders in situations where no safe, funded, or culturally appropriate health response exists, both to protect public safety and to reduce exposure to legal risk.

Beyond legal interpretation, the concept of ‘duty of care’ was often discussed in broader ethical terms by stakeholders and community members during the evaluation. Many consider it as an ethical obligation toward people who are in vulnerable situations, regardless of whether they have declined assistance. This relational sense of responsibility emphasises preventing future harm, not just addressing immediate health risks.

These concerns were echoed by some politicians, Victoria Police members, and emergency services. For example, when a leaked Victoria Police training video aired on Channel 7 showing officers leaving an intoxicated young woman unattended on a park bench after she had declined assistance, then-Police Shadow Minister Brad Battin MP publicly criticised the scenario as unacceptable, stating:

“As not just a parent but also a former police officer, it is an absolute disgrace that the state government [is] going to put vulnerable people in a position of pure danger.”²⁴ (**Police Shadow Minister Brad Battin MP**)

This sense of professional duty is also sometimes borne out in police and PSO operating outside of training (and policy) parameters and allowances and can include transporting people to a safe place and remaining with people for considerable periods of time, either when waiting for outreach services and where a decision is eventually made to leave a person in situ.

In practice, while it appears that being left in situ was a common outcome for many intoxicated people (around one in five) without issue, there have also been instances where a person left in situ has later suffered significant harm, including death and serious injury (see IBAC case below).

IBAC Case Study 10

IBAC received a notification from Victoria Police regarding a death associated with police contact. PSOs approached a man at a train station who was using offensive language and appeared alcohol affected. As no offences or welfare concerns were identified, the PSOs did not ask the man for his name and address and left him with the group of people he was talking to. Three hours later, police were called to attend a bus pedestrian fatality near the train station. It is believed that the bus left the station and travelled a short distance before hitting the man who was possibly lying on the road or gutter at the time.

Overall, it is a difficult balance for police trying to interfere as little as possible while still protecting an intoxicated community member from foreseeable harm. The reform narrows detention and transport options and places real weight on consent, yet in many locations service coverage, transport alternatives, and after-hours support remain uneven. In that context, leaving a person in situ can be the least coercive option and consistent with policy, but it also carries residual risk if the setting is unsafe, supports such as PIR services or family/friends are delayed, or the person’s condition changes once police depart.

The evaluation points to several practical options that can ease this tension. First, reliable outreach and transport coverage reduces the need to default to in-situ outcomes. Where standing services are not feasible, community-controlled options (for example, night patrols or local transport arrangements) can provide a safer bridge. Second, clearer joint protocols between police, Ambulance Victoria, VAHS and local providers, covering risk assessment, handover, and follow-up, help align decisions with both the letter and spirit of the reform. Finally, a shared monitoring approach is needed so that ‘leave in situ’ does not become ‘leave unsupported.’ That includes basic data capture on in situ outcomes, rapid review of adverse events, and feedback loops into training and service design. With these elements in place, service availability, coherent protocols, practical training, and oversight, members are better positioned to comply with policy while meeting the broader ethical expectation of care.

It is important to note that data collected from community stakeholders presents a more complex and, at times, contrasting picture to that from Victoria Police, indicating that members of the community—particularly those from marginalised groups—continue to experience disproportionate levels of police contact, including escalation, charges, and arrests, which appear to be indirectly linked to public intoxication. Further, while uncommon, some evidence of excessive or unwarranted force has also been reported. These factors are elucidated further in the following sections.

Summary

While the high threshold set in the CCI for transporting individuals in police vehicles lays bare the lack of viable alternative transport options as part of PIR services. There is broad community support for this high threshold and the evaluation is clear that this policy setting should not change. However, it is also clear that this is another gap in the health response that constrains police and PSO capacity to respond proactively to individuals who are intoxicated, particularly in areas with limited service infrastructure and coverage.

24. [Public Drunkenness laws put police and vulnerable at risk. - Brad Battin MP - Member for Berwick.](#)

CUSTODY REDUCTION

The evaluation analysed PIR incidents by outcome to provide insight into how the reform is functioning in practice and whether it is achieving its intended goals. Arrests due to offending where the individual was also intoxicated are a key area of focus, as these data points are critical to assessing whether ongoing criminalisation is occurring despite the decriminalisation of public intoxication. Tracking referrals to PIR health services was equally important, as this represents the core objective of the reform to connect intoxicated individuals with health-based responses rather than punitive measures.

In terms of outcomes, arrests were relatively uncommon, occurring in only 5% (n=72) of incidents. This is unpacked further in this section, which shows that Aboriginal people were twice as likely to be arrested (9%, n=10) as the general population. Around 20% (n=23) of incidents involving Aboriginal people resulted in referral to PIR services. Young people were more often handed over to family and friends, while homeless individuals were more likely to be referred to PIR services or ambulance/hospital care.

The analysis of outcome data also focused on the proportion of people who were left in situ as both Victoria Police and community stakeholders have raised concerns throughout the evaluation about the safety and wellbeing of intoxicated individuals in these situations. This is particularly relevant when considering questions of duty of care (discussed above), especially in contexts where service availability is limited, and police have few alternative options for managing intoxicated people safely.

Table 6 summarises incident outcomes by period. In the first post-reform period (November 2023 to March 2024), around one in five incidents resulted in individuals being left in situ, while approximately 15% (n=240) were placed in the care of family or friends, and 14% (n=217) were handed over to Ambulance Victoria. About one in twenty (5%; n=77) of incidents involved arrests (due to offending and where public intoxication was also present), and a slightly higher proportion (7%; n=108) resulted in referrals to PIR services.

Notably, over the full 17-month period, the percentage of referrals to PIR services more than doubled, rising from 6.5% to 15.4%. Although this trend suggests that the reform may be shifting outcomes towards health services as intended, confidence in this conclusion is limited. The sharp reduction in recorded incidents in later months (from 1,547 incidents early in the period to only 416 in the most recent period) makes the data incomplete and less reliable for assessing longer-term trends. For example, the recorded absolute number of referrals suggests a decline over the period, from 101 referrals to 64 referrals, which contradicts the trends reported in the data.

TABLE 6:
Police attendance outcomes, November 2023–March 2025 (n=3,191)

OUTCOMES	NOV 23-MAR 24	APR 24-JUL 24	AUG 24-NOV 24	DEC 24-MAR 25	TOTAL (%)
Referral to PIR service	7	12	14	15	10
Arrest	5	5	6	1	5
Hand-over to Ambulance Victoria	14	13	11	13	13
Left in situ	20	14	14	17	17
Care of family/friends	15	17	25	12	15
Other	40	40	40	40	40
All	100 (n=1,547)	100 (n=658)	100 (n=570)	100 (n=416)	100 (n=3,191)

Significant differences in outcomes were observed across certain cohorts (Figure 13.1). While the overall arrest rate for an offence where the person was also intoxicated was around one in twenty incidents, this figure was nearly double for Aboriginal people (9%, n=10), compared with approximately 5% for people of Caucasian (n=44) and African (n=7) backgrounds. Aboriginal people were also referred to PIR services at a much higher rate (20%, n=23) than either of the other two groups (6%, n=54 for Caucasian, n=9 for African).

By contrast, people of African background were more often provided with alternative transport options such as public transport, rideshare, or taxis (21%, n=31) compared to

Aboriginal people (8%, n=9). They were also less frequently handed over to family, friends, or carers (9%, n=13) than Aboriginal people (13%, n=15).

Looking at age differences, there were significant differences for two outcomes. A much larger proportion of young people (under 25 years) were handed over to family, friends, or carers (31%, n=64) compared to older individuals (12%, n=124). In contrast, younger people were less likely to be referred to PIR services (4%, n=8) than their older counterparts (8%, n=78). For other outcomes, differences between age groups were minimal (see Figure 13.2).

FIGURE 13.1:
Distribution of outcomes by ethnicity

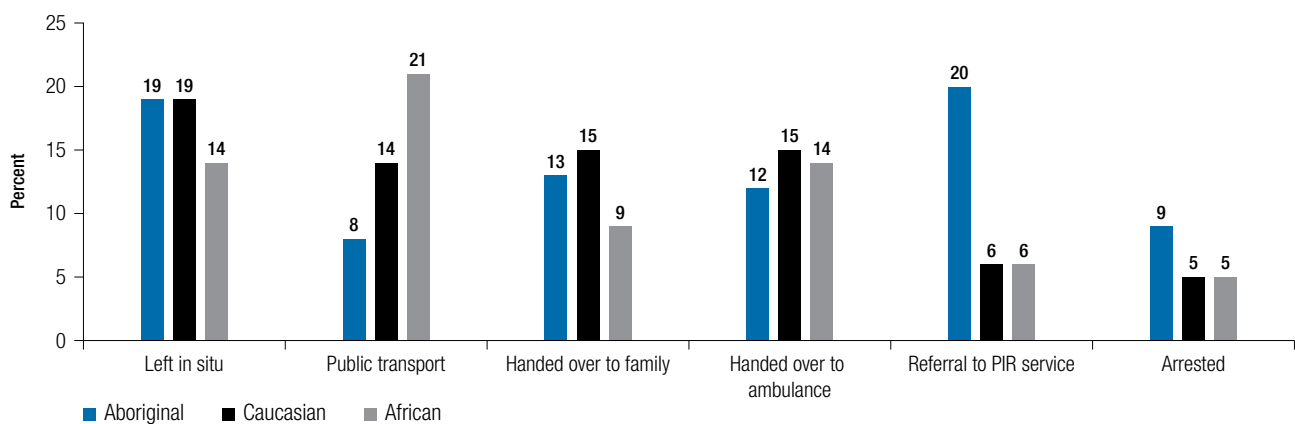
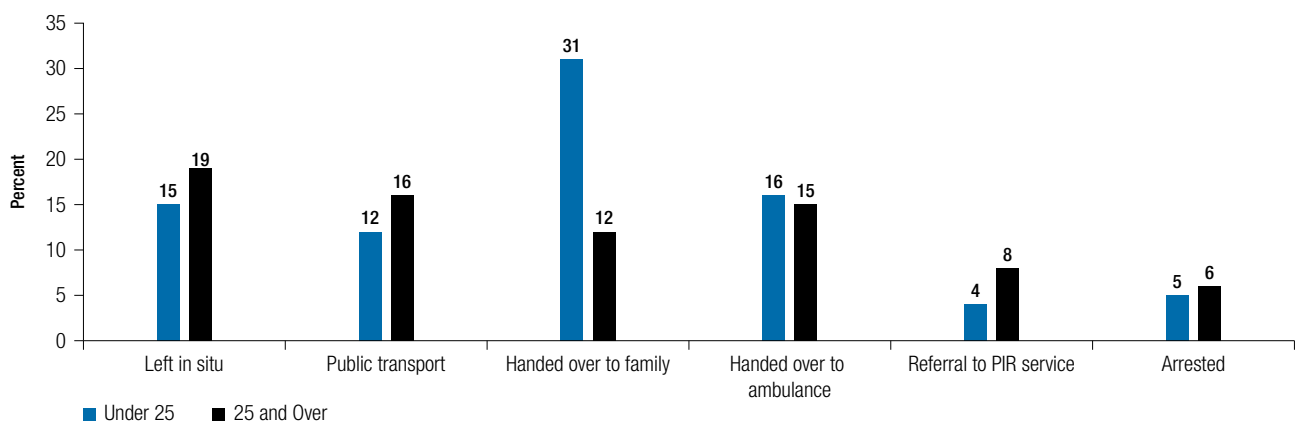


FIGURE 13.2:
Distribution of outcomes by age



Homelessness strongly influenced outcomes (see Figure 13.3). People without a fixed permanent address were more often taken into the care of Ambulance Victoria or hospitals (21%, n=35) or referred to PIR services (12%, n=20), compared to those with a fixed address (13%, n=182 and 6%, n=81, respectively).

As expected, incidents involving criminal offending most often resulted in arrests (42%, n=25), with far fewer cases leading to referrals to PIR services (3%, n=2), being left in situ (3%, n=2), or being handed over to Ambulance Victoria (7%, n=4). These figures should be interpreted with caution, as only 4% of recorded incidents (n=59) involved criminal offending. Notably, not all arrests were tied to

criminal offences: only 35% of all arrests (n=72) were linked to criminal offending. About 40% (n=29) of those were connected to other incidents requiring police attendance, including roughly 25% (n=18) as a result of attendance by police relating to public intoxication (see Figure 13.4).

FIGURE 13.3:
Distribution of outcomes by homelessness

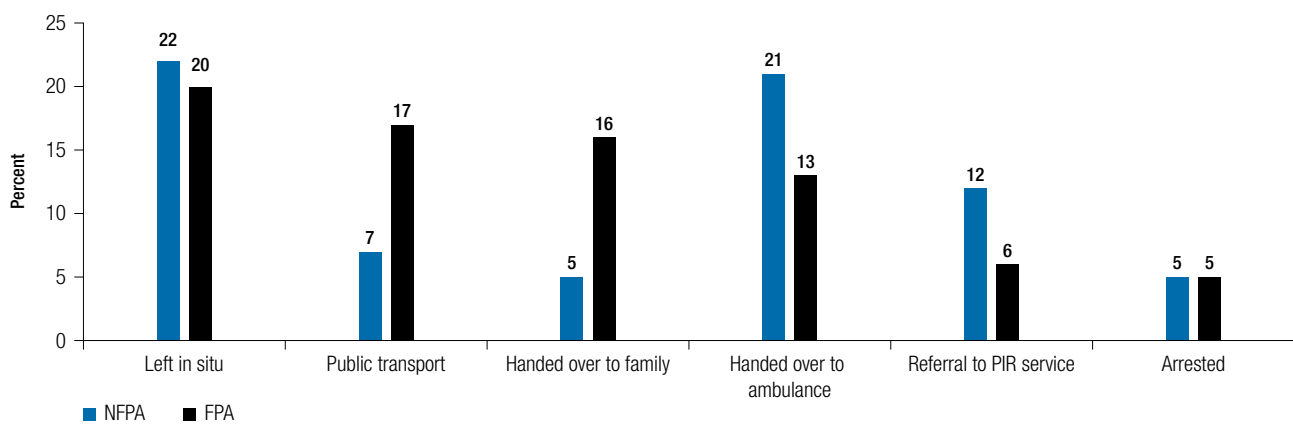
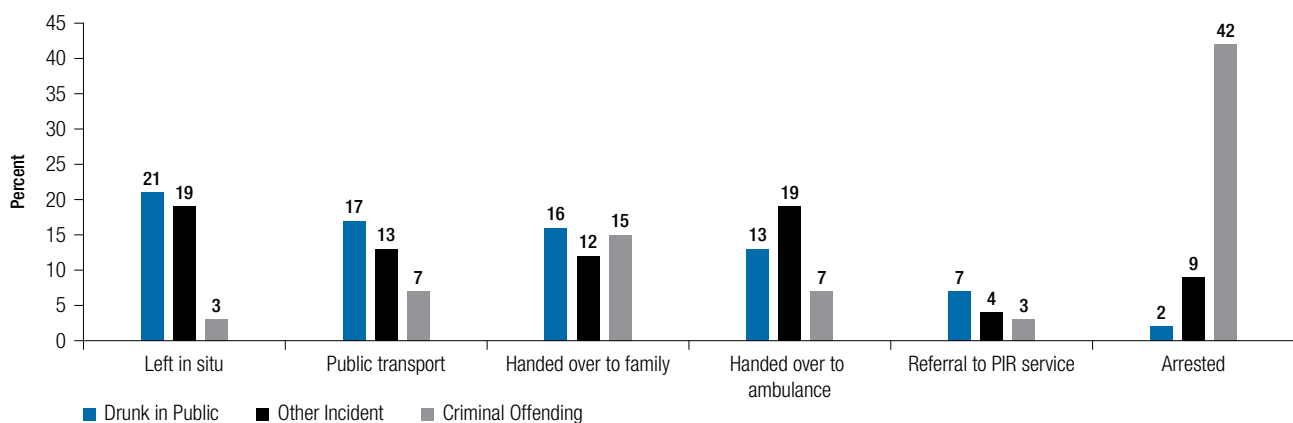


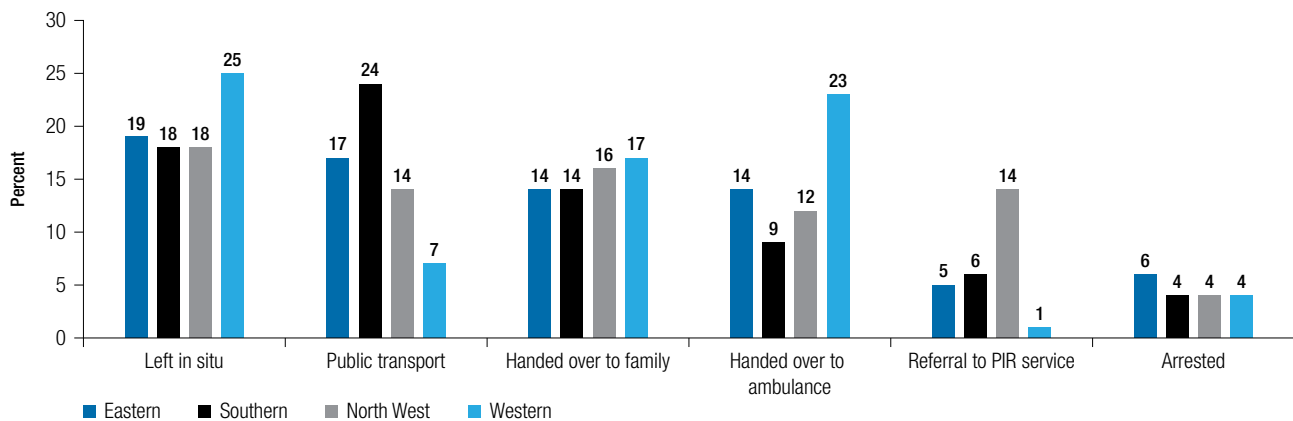
FIGURE 13.4:
Distribution of outcomes by criminal offence



Analysis of outcomes by police region revealed clear regional differences across three key categories. The Western region exhibited a unique pattern, with just 1% (n=3) of cases referred to PIR services but 23% (n=80) involving handovers to Ambulance Victoria or hospitals. In contrast, the North-West region recorded the highest number of referrals to PIR services (14%, n=53) and a comparatively low rate of handovers to Ambulance Victoria (12%, n=44). The Western region also reported a high proportion of people left in situ (25%, n=86). Meanwhile, the Southern region showed a relatively high rate of public transport use (24%, n=106) compared to other regions, while Southern and Eastern regions were otherwise broadly similar. Overall, the Western and North-West regions stand out for their contrasting referral and handover practices.

Overall, arrests for offending where the person was also intoxicated in public were relatively uncommon, occurring in about one in twenty incidents. This rate doubled for Aboriginal people (9%, n=10). Referrals to PIR services were also rare overall but were far more common for Aboriginal people, with around one in five incidents resulting in referral, over three times the rate for people from African or Caucasian backgrounds. Young people were less likely to be referred to PIR services but more often handed over to family and friends. People experiencing homelessness were twice as likely as others to be referred to PIR services (12%, n=20 vs 6%, n=81) and about 50% more likely to be handed over to Ambulance Victoria (21%, n=35 vs 13%, n=182). In general, people were more often handed over to Ambulance Victoria or hospitals (14%, n=217) than referred to PIR services (7%, n=101).

FIGURE 13.5:
Distribution of outcomes by police region



Shifts in responses and perceptions

Stakeholders identified a welcome shift away from the criminalisation that once dominated police responses. Before PIR, young people often experienced policing as punitive, contributing to mistrust and disengagement. Yet the shift is not simple. Entrenched perceptions remain: *'so many children, young people, do not see police as a protective body.'* This tension is further complicated by overlapping frameworks—youth justice laws, human rights obligations, child protection, and diversionary policies—that prioritise welfare but can also expose young people to increased surveillance and pathways to criminalisation. For those already involved in child protection or juvenile justice, PIR interactions risk reinforcing rather than disrupting cycles of harm. The case study below highlights how police are navigating these tensions in practice.

PDR App Case Study 2

During patrol at the Railway Station, PSOs observed a known underage youth with a history of alcohol-related concerns. The individual was initially seen walking around the station in the company of friends. Over time, the youth became increasingly unwell and eventually fell asleep on the floor near the PSO pod. The youth was woken by friends and escorted to the designated waiting area. PSOs made contact with the individual's mother, who agreed to attend the station. Upon arrival, she safely transported her child home. A check of LEAP records confirmed there were no active family violence matters involving the individual. The case manager was notified by email to ensure continuation of support services.

This example demonstrates how police navigated welfare-first practice, reinforcing PIR's principles while still operating within broader statutory frameworks. Of course, any data on reductions in the use of custody cannot sit alone, but rely on the availability of other supports, including those that comprise the health-based response. This is the focus of the following section.

USE OF OUTREACH

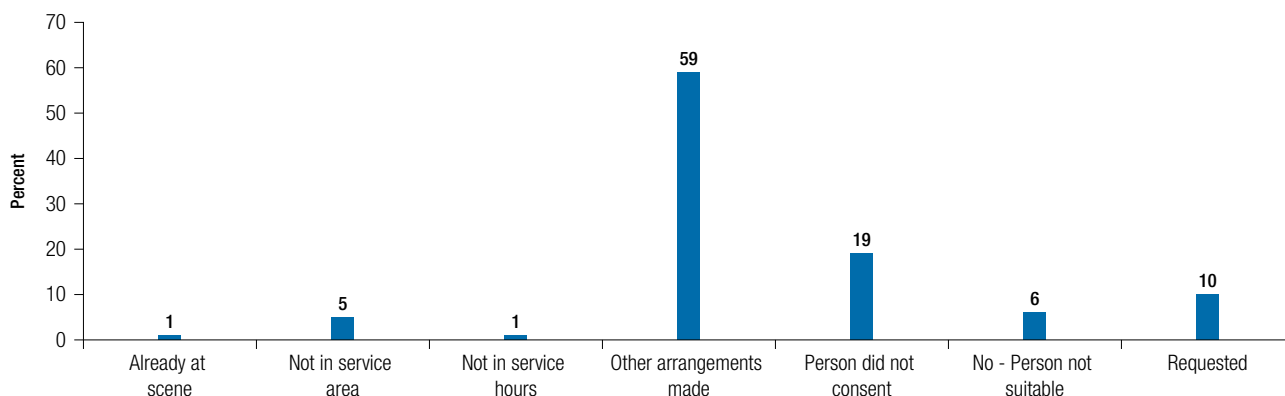
Examining how, and how often, outreach services were requested was a critical part of the evaluation because the core aim of the reform is to replace a justice-led response to public intoxication with a health-based model. Tracking these requests provides insight into whether this cultural and operational shift is taking hold, particularly within Victoria Police, who have historically been the first point of contact for intoxicated individuals.

Prior to implementation, Victoria Police developed and delivered training to its members emphasising the importance of contacting VAHS as the central coordination point for PIR services. Internal communications also consistently reinforced this requirement, positioning outreach referrals as a key step in achieving the reform's objectives. Analysing these patterns allows the evaluation to assess not only the uptake of health-based pathways but also whether training and communications have successfully translated into operational practice.

Tracking outreach requests

Of the 1,547 incidents recorded for the period Nov 23-March 24, only 154 (10%) prompted outreach requests (Figure 14). For the majority of incidents (59%; n=913), alternative arrangements were made. Services were not requested for one in twenty incidents as they occurred in non-service areas, while in 19% (n=294) of cases, outreach services were not requested because the intoxicated person did not consent. Outreach services could not be requested for about 1% (n=15) of the incidents as they occurred in non-service hours.

FIGURE 14:
Outreach services requested or not requested



Outreach requests were more common for Aboriginal and homeless people, as well as those in the North West police region (Table 7). Aboriginal people were more than twice as likely (27%, n=30) to be considered for outreach services compared to people of Caucasian (10%, n=88) or African (8%, n=12) backgrounds. The relatively low request rate for African-background people stands out, given that the number of incidents involving this group (n=146, or 9%) was slightly higher than those involving Aboriginal people (n=112, or 7%) (see Table 8). Further investigation is warranted to understand the factors behind higher request rates for Aboriginal people and lower rates for African-background people.

TABLE 7:
Outreach requests by key characteristics

	REQUESTED	NOT REQUESTED
Police Region		
> Eastern	8%	92%
> Southern	8%	92%
> Northwest	19%	81%
> Western	5%	95%
> Victoria	10%	90%
Ethnicity		
> Aboriginal	27%	73%
> Caucasian	10%	90%
> African	8%	92%
Age		
> Under 25	8%	92%
> 25 and over	12%	88%
Homelessness		
> Yes	19%	81%
> No	9%	91%

Requests for services were notably higher for homeless people (19%, n=31) compared to others (9%, n=123). Regional differences were also significant. The North West region recorded the highest proportion of service requests (19%, n=70), while the Western region had the lowest (5%, n=17) (Table 7). Despite both regions accounting for a similar share of total incidents (24%, n=365 in North West and 23%, n=355 in Western), nearly half of all requests (45%, n=70 of 154) were made in the North West, whereas only 11% (n=17 of 154) came from the Western region. This disparity suggests that unique factors in the Western region may be influencing the relatively low number of outreach service requests there.

TABLE 8:
Relative share of Incidents and Outreach requests

	INCIDENTS	REQUESTS
Police Region		
> Eastern	24%	19%
> Southern	29%	24%
> Northwest	24%	45%
> Western	23%	11%
Ethnicity		
> Aboriginal	7%	19%
> Caucasian	55%	57%
> African	7%	8%
Age		
> Under 25	13%	10%
> 25 and over	65%	75%
Homelessness		
> Yes	11%	20%
> No	89%	80%

Figures 15.1 to 15.3 break down the reasons for not requesting outreach services by ethnicity, homelessness status, and police region. No major differences were found by age, so these results are not shown. People of African background were more likely to not give consent for a service request (25%, n=37) compared to other groups, while Aboriginal people were the least likely to do so (13%, n=15). The potential drivers for this discrepancy are discussed in the Consent section (p.82) of this report. Only 1% (n=15) of all incidents could not have outreach services requested because they occurred outside service hours, but this figure was higher for Aboriginal people (4%, n=5) compared to Caucasian (1%, n=8) and African groups (0%).

Being outside a service area was reported as a barrier only for Caucasian individuals, not for Aboriginal or African groups.

Across police regions, incidents in Eastern (10%, n=37) and Western (9%, n=31) regions were more likely to have no outreach request because they occurred in non-service areas. In contrast, this issue was much less common in Southern (2%, n=9) and North West (1%, n=2) regions. There was no notable regional difference in the proportion of incidents occurring outside of service hours. Notably, refusal of consent was reported less frequently in the Western region (14%, n=49) compared to Southern (21%, n=95) and North West regions (21%, n=78).

FIGURE 15.1:
Reasons for NOT requesting services by ethnicity

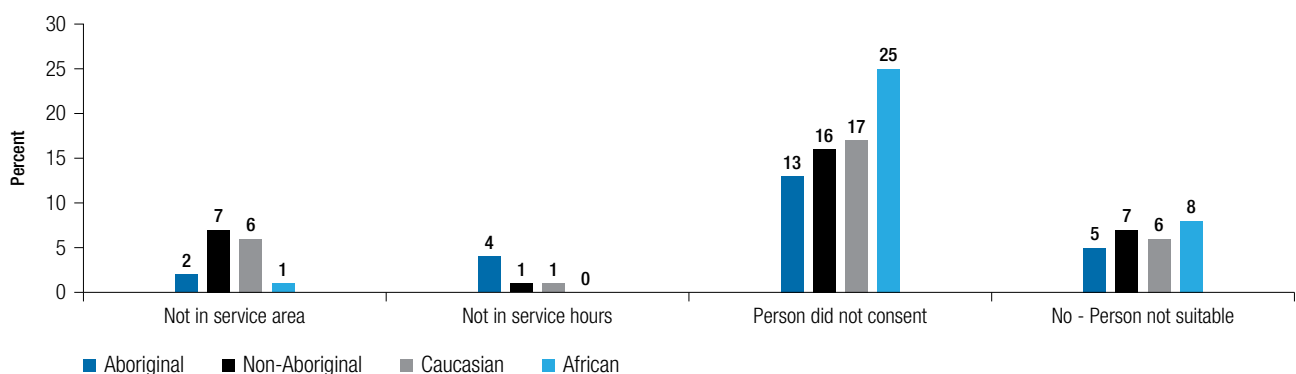


FIGURE 15.2:
Reasons for NOT requesting services by homelessness status

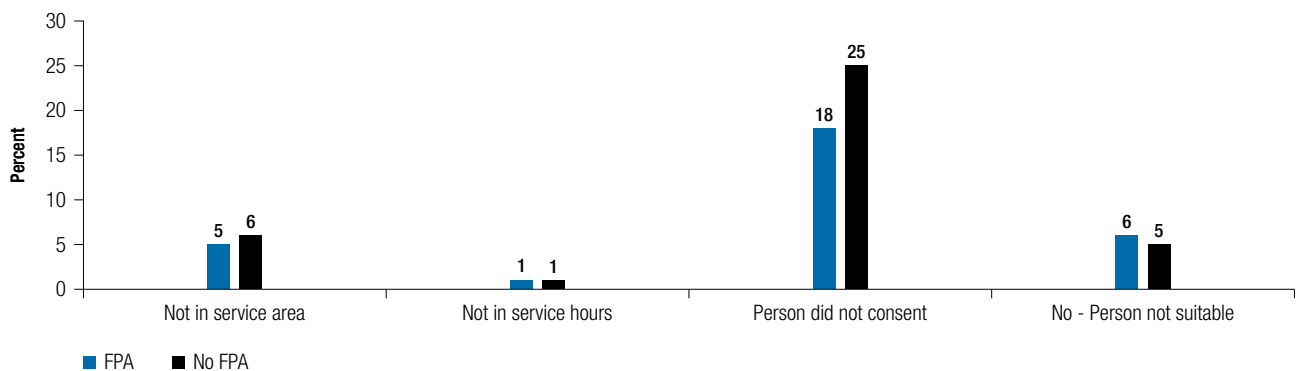


FIGURE 15.3:
Reasons for NOT requesting services by police region

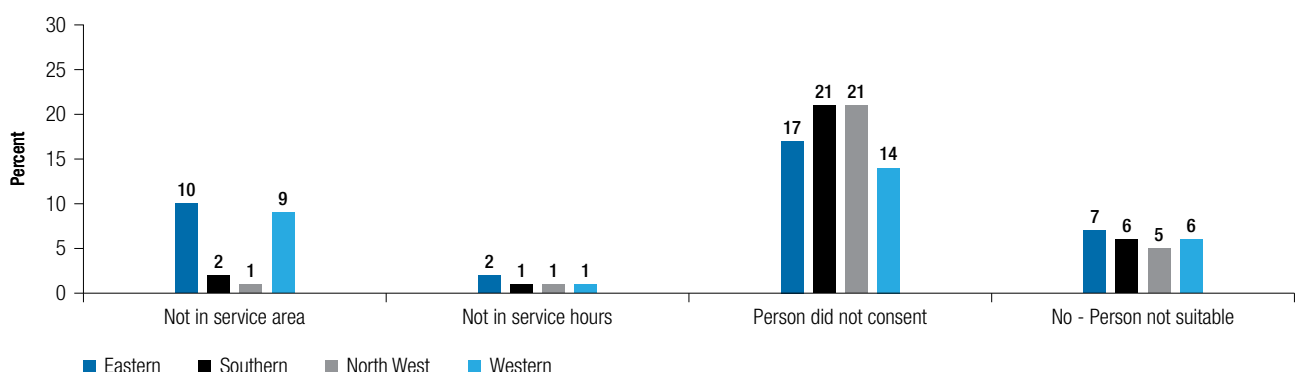


Table 9 shows that three out of four outreach service requests were attended. There were no significant differences based on ethnicity or homelessness status. Although only 16 requests were made for incidents involving people under 25, all of them were attended. Regional differences were more noticeable: the Southern region had nearly full attendance (97%; n=36), and the North West region was close to 90% (n=63). Attendance was lower in the Eastern (63%; n=19) and Western (53%; n=9) regions, although the Western region had very few requests overall (n=17).

TABLE 9:
Outreach requests that were attended

	%	NO. REQUESTED
Police Region		
> Eastern	63%	30
> Southern	97%	37
> Northwest	87%	70
> Western **	53%	17
> Victoria	72%	174
Ethnicity		
> Aboriginal	80%	30
> Non-Aboriginal	78%	90
> Caucasian	78%	88
> African **	100%	12
Age		
> Under 25 **	100%	16
> 25 and over	81%	116
Homelessness		
> Yes	77%	31
> No	80%	123

Note: ** indicates less than 20 requests

Ambulance requests and attendance

The evaluation also examines handovers of intoxicated people to Ambulance Victoria because of early concerns that gaps in PIR health services, especially in areas with limited or no outreach coverage, could lead to Ambulance Victoria becoming the default provider of health responses.

The data indicates that ambulance and hospital services were called more often than outreach services. Requests for ambulance or hospital involvement were made in 21% (n=327) of recorded incidents and comprised roughly double the incidence of outreach service requests (10%, n=154). Ambulances were already on site for around 11% (n=170) of incidents, meaning that in total, approximately one in three cases involved ambulance or hospital services either being requested or present.

As shown in Figures 16.1 to 16.4, there were no significant differences in ambulance requests based on ethnicity, age, or housing status. However, homeless people were slightly more likely to have ambulance services already present at the scene (16%, n=27) compared to others (10%, n=143). Regional variations were significant: the Western region recorded the highest rate of ambulance requests at 31% (n=110), while the Southern region had the lowest at 13% (n=60).

FIGURE 16.1:
Ambulance and hospital requests by ethnicity

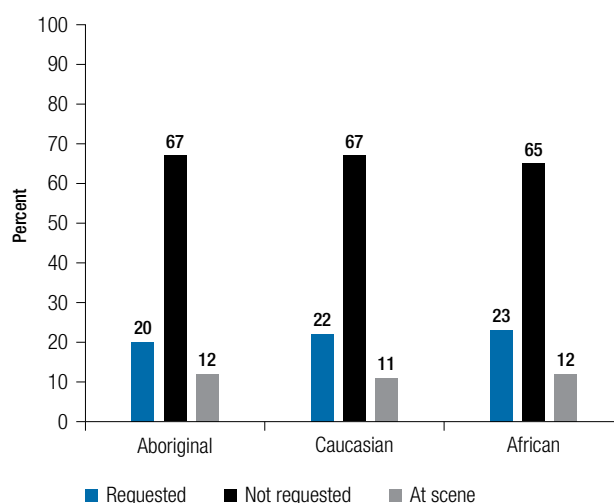


FIGURE 16.2:
Ambulance and hospital requests by age

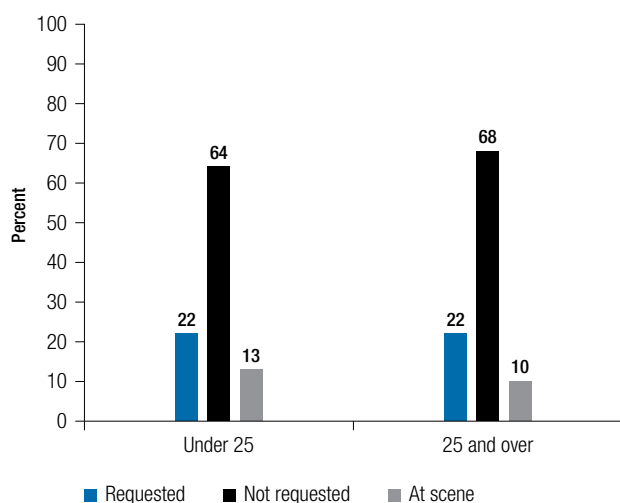


FIGURE 16.3:
Ambulance and hospital requests by homelessness status

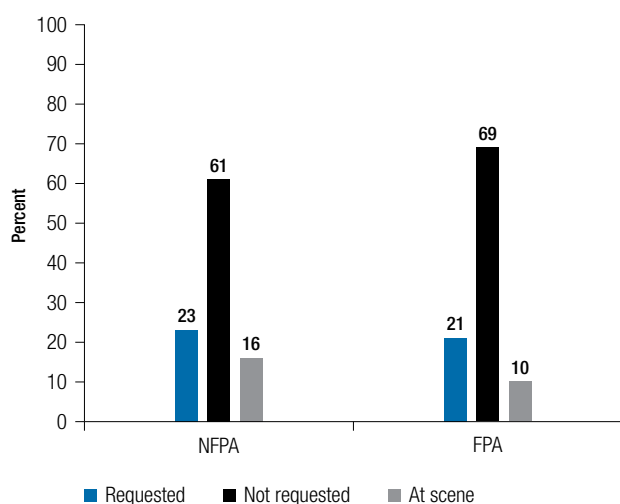


FIGURE 16.4:
Ambulance and hospital requests by police region

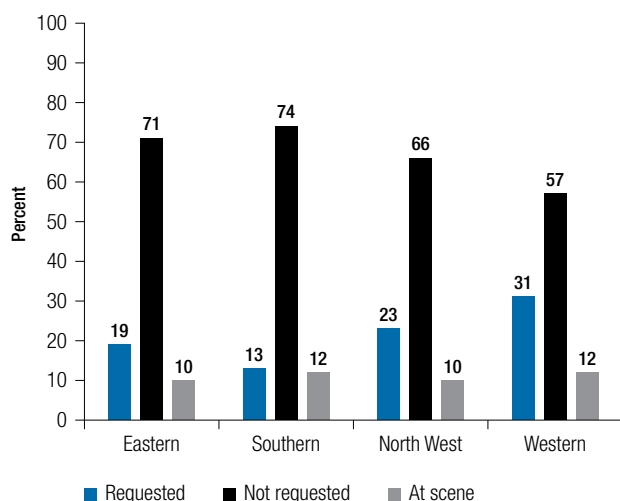


Table 10 shows that about three-quarters of ambulance and hospital service requests were attended, a rate similar to outreach services. Attendance rates were higher for Aboriginal people (83%; n=19) and homeless people (89%; n=34) compared to 74% (n=25) for people from African backgrounds. The number of requests for Aboriginal people was small (n=23), so these differences should be interpreted cautiously. There were no notable differences by age. Regional variations were more significant: the Western region, which had the highest rate of requests (31%, n=110), also had the highest attendance (82%; n=90). In contrast, the North West region had the lowest attendance rate, with about one in three requests (38%; n=32) going unattended.

TABLE 10:
Ambulance requests that were attended

	%	NO. REQUESTED
Police Region		
> Eastern	76%	70
> Southern	77%	60
> Northwest	62%	85
> Western	82%	110
> Victoria	75%	327
Ethnicity		
> Aboriginal **	83%	23
> Caucasian	78%	187
> African	74%	34
Age		
> Under 25	76%	46
> 25 and over	77%	218
Homelessness		
> Yes	89%	38
> No	73%	209

Note: ** indicates relatively small number of requests

Requests for outreach services were made in 10% (n=154) of incidents, a relatively low proportion. In 6% (n=96) of cases, services could not be requested because the incident took place outside service hours or areas. Another 19% (n=287) of cases involved refusal of service by the intoxicated individual. Aboriginal people were three times more likely to be offered services (27%, n=30) than others, while people from African backgrounds had the lowest rate (8%, n=12), which may relate to a higher rate of service refusal (25%, n=37). Aboriginal people were also more likely to need services outside available hours (4%, n=4 versus 1%, n=8). Homeless individuals were more likely to be provided outreach support. Despite similar numbers of overall incidents in the North West (24%, n=365) and Western (23%, n=355) regions, North West accounted for nearly four times as many requests (19%, n=70 compared with 5%, n=17), representing almost half of all statewide requests. Attendance rates for requests were about 75% (n=125), with lower rates observed in the Eastern (63%, n=19) and Western (53%, n=9) regions.

There were no major differences by ethnicity, age, or homelessness, although Western region recorded the highest ambulance request rate (31%, n=110) and Southern region the lowest (13%, n=60). Ambulance attendance rates were also around 75% (n=244) overall, with Aboriginal people seeing slightly higher attendance than African people. Western region had the highest attendance rates overall, while one in three requests in North West went unattended. Outreach request rates did not differ meaningfully by age, but all requests involving under-25s were attended (100%, 16/16). Ambulance requests showed no notable age differences, and attendance did not vary by age.

Follow-Up and Wraparound Services

Stakeholders consistently emphasised the critical role of wraparound services in ensuring that PIR achieves more than a short-term response. Similarly, Yoorrook, in Recommendation 70 of its Yoorrook for Transformation report,²⁵ urged the Victorian Government to increase funding to First Peoples'-led health services to ensure they are sufficiently resourced to deliver to First Peoples, regardless of where they live. This included alcohol and drug services.

Services such as mental health support, AOD treatment, homelessness services, and youth outreach are therefore seen as essential for addressing the underlying drivers of repeated intoxication in public. Without these broader supports, people who come into contact with PIR are likely to cycle back through sobering centres or police encounters, rather than moving towards stability and recovery.

In fact, the evaluation heard many examples of contact with PIR outreach services creating new opportunities to funnel people into wrap-around care, especially through ACCHOs and AOD services. Examples include a case in regional Victoria where police contacted VAHS for an intoxicated homeless person which led to VAHS coordinating follow-up through the local ACCHO. As a result, the person received food, short-term accommodation, AOD support, and reconnection with family. Other cases include AOD clinicians based in VAHS providing on the spot triage and guidance to intoxicated people when PIR health services were unavailable, and later linking them to ongoing AOD support services.

Sobering centres, in particular, were identified as a valuable point of intervention. They create an opportunity for 'warm referrals' —initiating the process of connecting a person with follow-up services at a time when they are safe, supported, and able to articulate their needs. Health providers explained that these moments of readiness are often fleeting; if not acted on quickly, the opportunity can be lost. As one stakeholder observed: *'Wouldn't it be great if we could line up detox or mental health without a 6 to 12 week wait?'*

These insights were echoed by non-health-based stakeholders who noted that when a person is receiving care at a PIR service, they may be more amenable to referrals to ongoing support, thus providing the perfect opportunity to organise wrap-around services for them:

"If people do end up going to the sobering centre and then decide during that time, maybe they want to go to detox, if there is a way to expedite that, because, you know, that is the key time that people might say 'Look, I've done this. Now I can do this'. But we know that there's a wait, so then it's like the person goes back into the system again, and it just felt like we're always waiting." (Stakeholder)

Several health services expressed a desire to become more than just a site for immediate care. They envisioned sobering centres evolving into service hubs, with representatives from mental health, AOD, housing, and youth services co-located or available on call, so that people could access the next stage of support then and there. This model, they argued, would ensure that the first step into the health system is not the last.

25. Yoorrook for Transformation Summary Report.

The urgency of this approach was underscored by widespread concern about long wait times for services. Current referral systems are complex and slow, often requiring people to wait weeks before accessing the support they need and these issues occur system-wide, regardless of how and by who the referral is made. One health organisation noted that Victoria Police has access to a community referral service that operates via e-referrals (Victoria Police e-Referrals or VPeR); however, they noted that this service is plagued by the same systemic issues including lag times between referral and response and chronic delays in services and support.

In discussing the system as a whole, one participant explained: *'It's a complicated referral system. The wait times is hard, and those wait times is the most perilous time for people. You know, people can really, really go downhill.'* In practice, delays can mean that people disengage before receiving help, increasing the likelihood of relapse and repeated contact with PIR services:

"Referring someone into something where they can't get into means they won't have a lot of confidence in that service system. They're going to give up trying, I suspect." (Stakeholder)

Overall, stakeholders viewed investment in wraparound services as both a pathway to reducing demand on PIR in the long-term and as a way of achieving better outcomes for individuals. By embedding warm referrals and resourcing sobering centres to act as hubs, the reform could move beyond managing intoxication on a single night to addressing the broader health and social factors that perpetuate it. Expanding the remit of services and engaging local partners—as shown in Recommendation 14—is a first step in addressing these concerns.

Recommendation 14

Where PIR services **have not** been established via Recommendation 11, **Department of Health** to:

- A.** Leverage infrastructure, linkages and expertise of existing Alcohol and Other Drug services, Aboriginal Community Health Organisations and position these as lead delivery partners in a scaled-up health response.
- B.** Secure long-term (multi-year and indexed) funding that enables Aboriginal Community Health Organisations to cover both core operations and growth, securing long-term provision of culturally safe services.

Refer to Recommendation 11

It should also be noted that while stakeholders strongly supported the inclusion of wraparound services in the evaluation, many emphasised that this must not obscure the central purpose of the reform. PIR was established to move away from a justice-led response and to reduce deaths in custody, and stakeholders were wary of setting up unrealistic expectations that its success should be judged by the strength of referral pathways or the adequacy of wider service systems. They cautioned that improving access to mental health, AOD, homelessness, and other supports should not be made the sole responsibility of PIR, as this places an unfair burden on the reform. Instead, they saw PIR as an opportunity to spark broader conversations about how society as a whole looks after intoxicated people beyond their immediate contact with PIR services:

"It's Public Intoxication Reform, and to me, that's really the gist of it at the moment. Sure, when we can expand later on, but let's get this right first before we go looking for, you know, making it bigger in the future... Our community always wants more, you know. They're always looking for more services and all of that, and that's fine, and that's what we need. But let's not put so much pressure just on this service at the moment, that's what I feel is happening." (Stakeholder)

Service usage

As part of the evaluation, CSA conducted linked data analysis using the Victorian Social Investment Integrated Data Resource (VSIIIDR) data to compare health service use in the pre-reform and post-reform periods. This analysis provides insight into what services intoxicated people accessed after their initial encounter with Victoria Police, including whether they presented at hospitals or engaged with other health supports. While the dataset does not capture the full breadth of referral pathways, it does offer an indication of the extent to which people are connecting with wraparound services (discussed on p.74)—as well as highlighting the ongoing reliance on emergency departments. This evidence helps to situate PIR within the wider health system, shedding light on both availability and access to follow-up care.

For this analysis, CSA compared the experiences of two groups—a pre-reform cohort and a post-reform cohort. The pre-reform cohort consisted of 4,049 individuals recorded for public intoxication-related offences between 1 October 2021 and 6 November 2023. These individuals were then tracked for the following 12 months after their first police contact to assess their use of health and social services.

The post-reform cohort comprised 491 individuals recorded in Victoria Police's PDR App for incidents of public intoxication between 7 November 2023 and 31 December 2023, who were similarly followed for a 12-month period. Indigenous people comprised 7% (n=295) of the pre-reform cohort and 6% (n=31) of the post-reform cohort, while Sudanese Australian and South Sudanese Australians comprised 5% of each cohort (n=208 pre-reform; n=26 post-reform).

CSA examined five of the six health and social services that could be accessed by these groups (see Table 10; Figures 17 and 18). Only 5% (n=47) of the pre-reform group and 6% (n=7) of the post-reform group had contact with non-admitted health services for alcohol and drug-related episodes. Given the small number of cases, these non-admitted service contacts are not discussed further.

FIGURE 17:

Contacts with health and social services

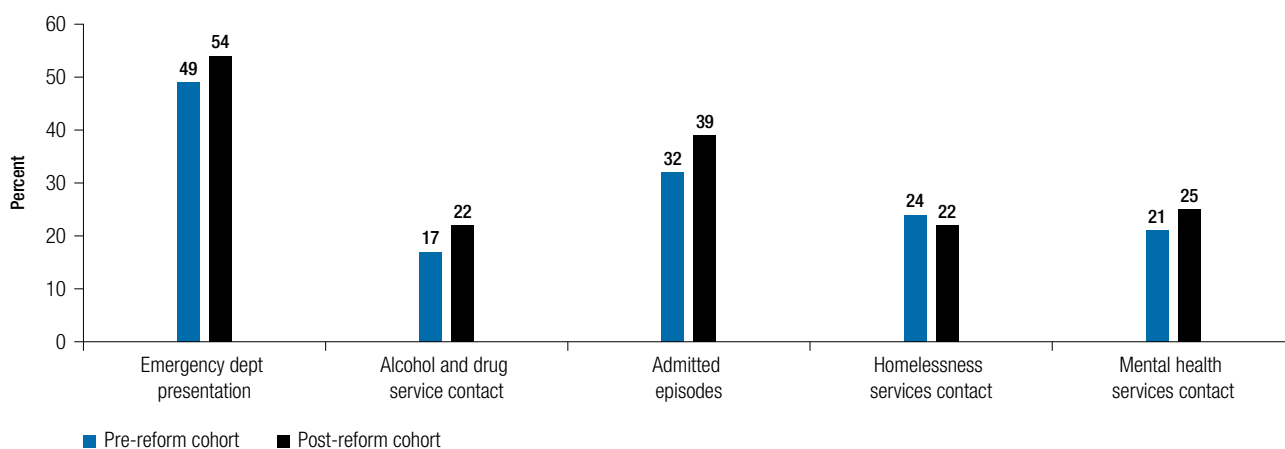


FIGURE 18:

Contact with health services for alcohol and drug related diagnosis

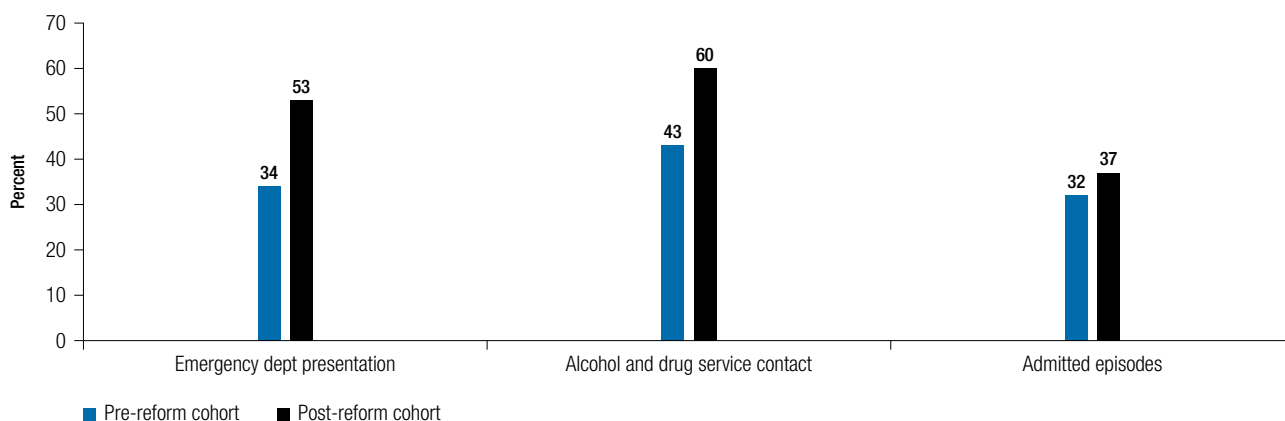


TABLE 11:
Use of health services*

HEALTH SERVICES	PRE-REFORM COHORT (N=4,049)	PRE-REFORM COHORT %	POST-REFORM COHORT (N=491)	POST-REFORM COHORT %
Emergency dept presentation	1995	49%	264	54%
For alcohol and drug related diagnosis	685	34%	139	53%
> Among under 25	110	16%	15	11%
> Indigenous people	60	9%	8	6%
> Sudanese/South Sudanese	59	9%	15	11%
> Avg time (days)	111		65	
> Avg presentations	3		4	
Alcohol and drug service contact	673	17%	109	22%
Among under 25	149	22%	9	8%
> Indigenous people	74	11%	14	13%
> Sudanese/South Sudanese	41	6%	7	6%
> Avg time (days)	142		122	
> Avg events	6		7	
Admitted episodes	1314	32%	190	39%
For alcohol and drug related diagnosis	567	43%	114	60%
> Among under 25	77	14%	5	4%
> Indigenous people	43	8%	<5	3%
> Sudanese/South Sudanese	50	9%	12	11%
> Avg time (days)	123		107	
> Avg episodes	2		2	
Homelessness services contact	961	24%	108	22%
For alcohol and drug related diagnosis	307	32%	40	37%
> Among under 25	50	16%	<5	7%
> Indigenous people	39	13%	<5	7%
> Sudanese/South Sudanese	20	7%	<5	7%
> Avg time (days)	137		114	
> Avg contacts	1		1	
Mental health services contact	833	21%	123	25%
For alcohol and drug related diagnosis	23	3%	<5	2%
> Among under 25	171	21%	16	13%
> Indigenous people	73	9%	8	7%
> Sudanese/South Sudanese	31	4%	8	7%
> Avg time (days)	95		96	
> Avg contacts	19		12	
> Had mental health episode	494	59%	73	59%

Note: * Small counts (values between 1-4) are displayed as <5, with a value of 3 used for totals and percentage calculations.

Emergency department presentations

Roughly half of individuals in both cohorts presented at an emergency department: 49% (n=1,995) of the pre-reform cohort and 54% (n=264) of the post-reform cohort. However, there were notable differences in the proportion of those presentations that were related to alcohol and drug diagnoses. Among the pre-reform group, only 34% (n=685) presented for alcohol and drug-related reasons, compared with 53% (n=139) of the post-reform cohort.

Patterns also varied across specific groups. A smaller proportion of Indigenous people in the post-reform cohort presented for alcohol and drug-related reasons (6%; n=8), compared with 9% (n=60) in the pre-reform period. Among young people under 25, the post-reform figure was also lower (11%; n=15) than the pre-reform group (16%; n=110). By contrast, individuals of Sudanese/South Sudanese Australians in the post-reform cohort recorded a slightly higher rate (11%; n=15) than their pre-reform counterparts (9%; n=59).

Timing of presentations also differed. On average, those in the post-reform cohort who presented for alcohol and drug-related reasons did so more quickly, with an average of 65 days from their first police contact, compared with 111 days for the pre-reform group. Despite this difference in timing, there was little variation in the number of presentations: the pre-reform cohort averaged three presentations, compared with four for the post-reform cohort.

Alcohol and drug services

A greater proportion of the post-reform cohort (22%; n=109) engaged with alcohol and drug services compared to the pre-reform group (17%; n=673). There were no significant differences between Indigenous or Sudanese/South Sudanese Australian participants across the two cohorts. However, younger people showed a marked difference: only 8% (n=9) of those under 25 in the post-reform group contacted alcohol and drug services, compared with 22% (n=149) of the pre-reform youth cohort.

The timing of service engagement also shifted. On average, it took 142 days for the pre-reform cohort to access alcohol and drug services, compared with 122 days for the post-reform cohort, a reduction of around 20 days. The average number of contacts with services remained relatively consistent across both groups. Notably, however, treatment completion rates improved in the post-reform period: 37% of individuals completed treatment, compared with 32% in the pre-reform cohort.

Admitted episodes

Around one third of individuals in both cohorts had admitted episodes (32% or n=1314 of the pre-reform cohort and 39% or n=190 of the post-reform cohort). However, the proportion of admissions specifically for alcohol and drug related diagnoses was much higher in the post-reform period. Among those admitted, 60% (n=114) of the post-reform cohort were admitted for alcohol and drug related reasons compared with only 43% (n=567) of the pre-reform cohort.

Patterns across different groups were not uniform. For young people, admissions for alcohol and drug related diagnoses declined sharply, from 14% (n=77) in the pre-reform cohort to 4% (n=5) in the post-reform cohort. Indigenous people also recorded a decrease, from 8% (n=43) to 3% (n<5). By contrast, the Sudanese/South Sudanese Australians cohort experienced a slight increase, from 9% (n=50) to 11% (n=12).

The average time before an alcohol and drug related admission occurred decreased from 123 days in the pre-reform period to 107 days in the post-reform period. However, the frequency of admitted episodes did not change, with both cohorts averaging two episodes.

Homelessness services

Around one in four people in both cohorts made contact with homelessness services. Among these, 32% (n=307) of the pre-reform cohort and 37% (n=40) of the post-reform cohort did so for alcohol and drug related reasons. Accommodation was provided in roughly half of the individuals that had an alcohol and drug related contact (56% or n=172 of the pre-reform cohort and 53% or n=21 of the post-reform cohort).

Subgroup patterns varied. Indigenous people showed a significant decline in alcohol and drug related homelessness service contacts, dropping from 13% (n=39) in the pre-reform group to 7% (n<5) in the post-reform group. Young people experienced a similar decline, from 16% (n=50) to 7% (n<5). By contrast, there was no observable difference between the pre- and post-reform cohorts of Sudanese/South Sudanese Australians.

The average time taken to first access homelessness services decreased by more than 20 days, from 137 days for the pre-reform cohort to 114 days for the post-reform cohort. However, the frequency of contact did not change, with both cohorts averaging one contact.

Mental health services

A slightly greater proportion of the post-reform cohort (25%; n=123) accessed mental health services compared to the pre-reform cohort (21%; n=833). However, contact specifically for alcohol and drug related diagnoses remained minimal in both groups (3%; n=23 pre-reform and n<5 post-reform).

Patterns across subgroups reflected similar disparities to those seen in other services. Young people in the post-reform cohort had lower levels of engagement (13%; n=16) than those in the pre-reform group (21%; n=171). For Indigenous people, contact declined slightly from 9% (n=73) to 7% (n=8), while people of Sudanese/South Sudanese Australian background showed an increase from 4% (n=31) to 7% (n=8).

The timing of access did not vary, with both cohorts taking on average about three months (95 days for the pre-reform group and 96 days for the post-reform group) to make contact. However, the frequency of engagement did decline: those in the post-reform cohort averaged 12 contacts compared to 19 in the pre-reform group.

Overall trends in service use

The linked data analysis shows that post-reform cohorts were more likely to engage with several health and social services for alcohol and drug related reasons compared with the pre-reform group. Specifically, the post-reform cohort was more likely to present at an emergency department (by 53%), experience an admitted episode (by 39%), and contact homelessness services (by 16%). In each of these service areas, the average time to contact was shorter for the post-reform group, although the frequency of contacts did not differ between cohorts. Mental health services were the exception, where the number of contacts fell noticeably, from an average of 19 in the pre-reform cohort to 12 in the post-reform cohort.

The patterns were not consistent across all groups. Young people under 25 in the post-reform cohort were significantly less likely to engage with any of the five health and social services examined for alcohol and drug related reasons. Their likelihood of contact ranged from 68% lower for admitted episodes to 33% lower for emergency department presentations. Similarly, Indigenous people in the post-reform cohort were also less likely to access most services, with the decline ranging from 26% less likely for mental health services to 65% less likely for admitted episodes. The only exception for Indigenous people was alcohol and drug services, where the post-reform cohort was 17% more likely to make contact. By contrast, Sudanese/South Sudanese Australian community members in the post-reform cohort were more likely to access all five service types, particularly mental health services (75% more likely) and emergency department presentations (25% more likely).

Overall, the results suggest that while PIR may be prompting earlier connections to health and social services, access is uneven across cohorts. For young people and Indigenous communities, engagement has declined, highlighting a risk of exclusion from the intended benefits of a health-led model. Conversely, Sudanese/South Sudanese Australian community members appear to be engaging more with follow-up services post-reform, which may reflect both community trust in health pathways and the importance of culturally responsive support. As suggested in Recommendation 15, one way of addressing the barriers for some marginalised communities involves strengthening cultural safety within services, and embedding cultural safety as a core component of partnerships for Aboriginal and non-Aboriginal communities.

Recommendation 15

Where PIR services **are being** established (via Recommendation 11) or a community service **is being** leveraged (via Recommendation 13), **Department of Health** to:

- A.** Build funded pathways for Aboriginal controlled health organisations, Alcohol and Other Drugs workers and community responders to lead responses across triage, outreach, transport, and aftercare, making Aboriginal Community Controlled Organisations the preferred providers where feasible.
- B.** *Fund ongoing training, reflective practice, and partnership mechanisms with culturally and linguistically diverse (CALD) organisations to embed cultural safety as a core rather than additional function of PIR and include consideration of Aboriginal-led cultural safety frameworks as a mode to be adapted in consultation with specific communities.
- C.** Where culturally appropriate and feasible, make Aboriginal Community Health Organisations the preferred providers.
- D.** Fund and co-design youth-focused strategies that are:
 - 1.** Targeted towards young people and include cultural support via peer workers.
 - 2.** Targeted at the broader family group, using young people as the conduit to build trust in police and repair family separation.

Refer to Recommendations 11, 13

*** Refer to** Recommendation 17 (training)

The analysis also reflects what community members and stakeholders consistently told the evaluation: while wait times for accessing follow-up services may be declining, they remain very long. These delays can discourage people from pursuing support even after initial contact, particularly when the urgency of their need cannot be matched with timely care.

Support and trust in health-based responses: Insights from the South Sudanese Australian community

Community members overwhelmingly support the shift to a health-based response to public intoxication, viewing it as a move away from harmful police contact and toward culturally-safe care. As one South Sudanese Australian community Elder stated: *'The reform is giving room for humanity to be supported.'*

Participants across all locations expressed greater satisfaction with health services compared to police. Health services were consistently described as respectful and proactive, particularly in their use of interpreters to bridge language barriers. In contrast, participants described police use of interpreters as 'rare'. One stakeholder explained:

"If you don't understand English, we [health services] can get an interpreter for you so that you express yourself so that we understand what you're going through." (Stakeholder)

Despite community support for a health-based response, concerns remain regarding the availability and responsiveness of health services, particularly in Werribee, where long wait times and missed call-outs were reported. In one instance in Sunshine, police allegedly told a caller that it was *'not their job,'* leaving a community representative to facilitate contact with the sobering-up service through Victoria Police. This raised concerns about inconsistent awareness or implementation of the reform across both police and health services.

Many community members expressed a preference for referring intoxicated individuals directly to health services rather than police, whom they associate with punishment or shame. There is a strong desire for referrals to services that provide long-term, culturally sensitive support for alcohol use, rather than one-night sobering-up centres. At the same time, community members highlighted the need for greater clarity regarding the identity of health providers, the locations where people are taken, and whether these centres are considered safe—particularly for young people.

Concerns about service accessibility

Focus groups in Werribee raised significant concerns regarding the limitations of the 45-minute service window for responding to public intoxication. Participants expressed fear that people in need might be overlooked due to geographic location, long wait times, and the limited capacity of health services to cover large catchment areas. One participant highlighted this concern:

"What has been put there if we have one Centre only? And it's all the way in Collingwood. While Wyndham has this big number, or the Western suburb has big numbers like that." (Participant)

For participants living on the outskirts of the 45-minute service window, there was considerable uncertainty about who is responsible for providing support to intoxicated individuals. As one participant explained:

"If we see somebody who is in trouble in the street... we know that police are not gonna be responding as soon as possible... I think that's a real gap actually. It happened to us a couple of days. We had a meeting at five o'clock, after five o'clock, on a Friday night and two people were sitting there. What do we do? Do we call the police? And then, and, and we didn't know what to do and I said, I told the guys, yeah. Go to the police and we're going to have our own meeting. So, we didn't have time to spend there waiting online until somebody actually picked up, you know, so yeah, we left them. We didn't do anything about it." (Participant)

These accounts indicate that gaps in service coverage and delays in response can leave community members feeling uncertain and unsupported in urgent situations. Participants emphasised the need for clearer guidance on responsibilities, as well as potential strategies to extend service reach and responsiveness in outer suburban areas, to ensure vulnerable individuals do not fall through the cracks (as outlined in Recommendation 8, p.47).

POLICING AND MARGINALISED COMMUNITIES

Marginalised communities have historically experienced, and continue to experience, discriminatory policing practices that cause profound harm, often amplified by several intersecting factors. This section presents quantitative data to represent how different marginalised communities have encountered the reform. Throughout the report, we supplement these data with insights from community dialogues and stakeholder discussions to contextualise patterns and illuminate lived experience.

CSA data insights

The PIR incident data showed that Aboriginal people experienced both higher justice-based outcomes and markedly higher referrals to PIR services. Arrests occurred in 9% of incidents (around double the overall rate of ~5%), while referrals to PIR services was 20%, over three times the rate for African or Caucasian groups (6%). In the first post-reform period (Nov 2023-Mar 2024), outreach was requested in 27% of incidents involving Aboriginal people, compared with 10% for Caucasian and 8% for African-background cohorts. Ambulance and hospital attendance, when requested, was relatively high at 83% for Aboriginal people.

From a PDR incident data perspective, people of African background showed distinct patterns across several outcomes. Arrests occurred in roughly one in twenty incidents (~5%), and referrals to PIR services were 6%. Alternative transport (public transport, rideshare, or taxis) was used comparatively often (21%), while handovers to family, friends or carers were less frequent (9%). While outreach was requested in 8% of incidents involving African-background people, this group had the highest rate of 'no consent' recorded as the reason for not requesting outreach (25%). South Sudanese Australian community representatives and stakeholders described a mixed history of relationships and trust in police and health providers, especially among young people, who face increased criminalisation (as outlined earlier in this report).

Young people accounted for a smaller proportion (5–10%) of incidents in the PDR App narratives reviewed, but their interactions with Public Intoxication Reform (PIR) reveal complex vulnerabilities and strong justification for moving away from punitive models toward protective and intersectional responses. Police and PSO often acted with care—arranging safe transport, contacting family, or staying with young people until support arrived—reflecting PIR's emerging principle that safety, not penalty, must guide youth interactions.

Reflective Engagement and Fragile Relationships

The PIR evaluation recognises that culturally safe engagement strategies are still underdeveloped for these communities. However, examples such as ACCHOs and relationship-based outreach by Cohealth demonstrate what is possible: trust grows when services are consistent, respectful, and visible in community spaces. Government and police can learn from these efforts, resourcing tailored engagement approaches that acknowledge stigma, peer dynamics, and cultural values, while ensuring that discretion is exercised with sensitivity rather than suspicion. Recommendations 10 and 11 speak to the importance of culturally safe engagement via the centring of ACCHOs and other community workers that hold expertise in the spaces defined above and situating ACCHOs (and community health providers) as the leverage point for any expanded PIR health services or scaled-up health support.

Across both Aboriginal and Torres Strait Islander and South Sudanese Australian community experiences, trust-building is not a one-off exercise but an ongoing process and commitment. As the evaluation highlights, consent is shaped by trust, cultural norms, and the perceived legitimacy of services being able to be responsive to community member needs. Governments and police must recognise that community members declining assistance is not always refusal—it may reflect fear, shame, or a lack of viable alternatives. Addressing these dynamics requires transparent communication, good community relationships with leaders and representatives from the communities, and a willingness to hear and to act on difficult truths.

LIVED EXPERIENCE AND DIFFICULT TRUTHS

Case studies, community voices, and direct testimony have not been supplementary to this evaluation—they are its foundation. They provide government and police with an essential lens into the lived realities of those most affected, and they expose the ways reforms succeed or fall short in practice. Listening to these stories is more than an ethical obligation: it is a methodological necessity for reform that aspires to integrity, equity, and cultural safety.

In the following section, we discuss the complicated notion of consent as it plays out in policy but more importantly, in implementation of the PIR.

Consent

The PIR's shift to a health-led approach operates on a clear principle: assistance is only provided with a person's ongoing and voluntary agreement. This means that, at every stage, whether the contact is with Victoria Police, outreach teams, or emergency responders such as Ambulance Victoria, securing and maintaining consent is fundamental. The model is intended to protect the dignity, autonomy, and legal rights of people who are intoxicated, while minimising the likelihood of complaints about coercion.

For Victoria Police, the CCI states that *'the health-based model requires a person's voluntary participation in order to receive assistance.'* This means that a person must give informed consent for members to:

- > Make enquiries, such as to contacting the person's family or friends; and
- > Refer the person to receive support, such as from a sobering or outreach service' (section 19, page 5).

Crucially, the policy places these duties within the broader obligations set out in the Charter of Human Rights and Responsibilities 2006, which states that limitations on a person's rights must be reasonable and demonstrably justified.

Evaluation findings show that while the principle is clear, putting it into practice can be challenging. Consent is shaped by multiple, interlinked factors including a person's cognitive capacity at the time, their level of trust in services, their awareness of available services, and the history of their community's relationship with health and justice systems. These dynamics make consent a nuanced and often contested space within the reform's implementation.

Consent is influenced by multiple factors. **Capacity to consent** is a key influence. Determining whether an intoxicated person has the cognitive capacity to provide informed consent is a critical step at every stage of engagement: before a referral to health services is made, during transport by outreach teams, and while receiving care in a sobering centre. All organisations participating in the PIR have developed policies and procedures to guide this process.

The CCI provides police and PSO with guidance on how to evaluate a person's capacity to consent as follows:

"Informed consent can only be obtained from an adult or young person with decision-making capacity. The fact that a person is drunk does not necessarily mean they are incapable of providing informed consent, or that they do not have decision-making capacity.

A person's decision-making capacity must be assessed on an individual basis, and in the context of the seriousness of the decision which they are being asked to make.

In order to give informed consent, a person must be able to demonstrate that they:

- Understand the information relevant to the decision they are being asked to make. For example, understand that they are being asked to voluntarily nominate a family member or friend, and that if they do members will attempt to contact the nominated person on their behalf.
- Are able to retain relevant information, including using or weighing that information, to the extent necessary to make that decision. For example, be able to retain the information being explained to them, about what steps police will take if they consent to a nominated person being contacted and potential outcomes.
- Communicate their decision in some way."

(Victoria Police 2023a, Sections 23–25, page 7).

It further advises that *'members must not proceed with considering response options where the person refuses consent or is incapable of giving informed consent for those options. If in doubt, members must apply the presumption that informed consent has not been given'* (sections 26–27, page 7).

For health services, confirming capacity is not a one-off exercise but an ongoing responsibility. Staff conduct multiple checks during transport and again upon arrival to ensure the person continues to agree to receive assistance.

The ability to consent, however, can fluctuate—alcohol and drug use may impair judgment, reduce comprehension, and hinder decision-making, particularly when combined with other health conditions or heightened stress. A licensee participating in the evaluation described instances where intoxicated patrons were unable to recall even basic personal information, such as a phone number. This raised concerns about the person's ability to fully comprehend what a referral to a PIR service would involve, including the nature of the service, who would attend, the destination, and the potential outcomes. Given these doubts about

capacity, the licensee reported that they would more often choose to contact the person's family or friends rather than initiate a referral to a PIR service. While handing over an intoxicated person to family and friends is a safe and appropriate option for some people, it is not the case for all. Risks to be considered include family violence, cultural shame related to drinking, and other intersectional issues discussed in this report.

Capacity can also decline over time. Someone who initially agrees to transport may become more intoxicated en route, potentially losing the ability to provide ongoing consent. Service providers address this by conducting repeated, case-by-case assessments.

Finally, the process of ascertaining consent can be complicated by the need to determine whether impaired decision-making stems from intoxication, an underlying cognitive or health condition, or both. This distinction requires skill and training that is not available to all stakeholders and community members.

Overall, stakeholders recognise the delicate balance between respecting a person's autonomy and ensuring their safety. They agreed that while it is vital that the model remains consent-based, systems must be equipped to respond to varying levels of impairment, using tailored communication strategies and additional support at the point of contact to safeguard both rights and wellbeing. Consideration of consent also relies on strong partnerships with community organisations, including an openness to alternative justice models (such as community policing). This is reflected in Recommendation 16.

Recommendation 16

Victoria Police to identify models of community policing that are working well (including cultural liaison roles for marginalised groups, Aboriginal Community Justice Panels and night patrols) to:

- A.** Assess where these models could be expanded or replicated to further enhance trust and partnerships between police and community, giving consideration to:
 - 1.** Areas/communities where a large number of public intoxication incidents take place;
 - 2.** Areas/communities with a significant representation of marginalised or underrepresented group; and
 - 3.** Areas/communities where a large amount of public order offending linked to public intoxication is occurring.
- B.** Develop an implementation plan that identifies resourcing required to expand/replicate successful models into other areas/communities.

Community trust

The evaluation found that while PIR is designed to be a shift away from a justice response, longstanding perceptions of police as an enforcement agency continue to influence community responses. These perceptions, shaped by both historical injustices and ongoing experiences, can make people reluctant to engage with support when it is offered through police contact.

Workers in the homelessness sector described a deeply embedded distrust of police amongst homeless people. One frontline worker explained that even without any wrongdoing, some people feel anxious or targeted when officers approach. Aboriginal-led focus groups voiced similar concerns, emphasising that racial profiling and racism continue to affect interactions with police.

"How do you consent to something that you don't really know what it's going to be? And anytime police are involved with our community we'll say that there's just no trust." (Stakeholder)

Notably, there were clear regional variations in how communities viewed and trusted Victoria Police. In some areas, relationships were described as cooperative and respectful, contributing to greater acceptance of police involvement. In others, trust remained fragile or absent. For many in the South Sudanese Australian community, for example, the difference in trust between health services and police was stark. Participants consistently described health workers as more respectful, proactive, and willing to accommodate needs such as interpreter access, something they had not experienced from police. Across age groups and locations, health professionals were viewed positively, and alcohol dependence was framed as a health issue best addressed through supportive care rather than punitive measures. Consent was reported as being more readily given when support was offered by health services rather than police. However, participants called for more transparency about who the service providers are, what the process involves, and where people are taken. While hospitals were viewed as safe spaces, sobering centres were less familiar, leading to uncertainty about whether they were part of the health system or linked to policing. As one interviewee explained, *'I don't know — the idea of just being where I am, and then someone taking me away is like, 'why am I being taken away?' It feels very similar to what the police do to you.'*

For other cohorts, the perceived independence of health providers from the justice response strongly shaped willingness to consent. Early in the reform, some health providers experienced lower consent rates until they redesigned their vehicles to emphasise a health identity rather than a justice connection. Aboriginal-led services reported higher success rates, with their clear cultural identity and community-controlled governance providing visible assurance of safety and cultural appropriateness.

Social and cultural factors impacting consent

The circumstances surrounding a person's intoxication can strongly influence whether they agree to accept help. Stakeholders noted that those in group settings often decline assistance due to embarrassment, peer influence, or a desire to maintain social standing. Some are reluctant to appear vulnerable in front of friends, while others resist separating from their group. One licensee pointed out that referring someone to a sobering centre located 45 minutes away also means their companions cannot easily collect them later—making refusal more likely. In such cases, people tend to opt for leaving with friends or family, which stakeholders agreed can be an acceptable outcome if there is confidence they will be safely cared for.

Stakeholders explained that some Aboriginal and Torres Strait Islander people may decline consent to transport to PIR health services because they do not trust police-made referrals, worry about having to identify as Aboriginal, fear that they would be placed in the back of a police van (which can be experienced as being taken into custody), or simply lack clear information about what PIR services involve. Alcohol use is also associated with stigma in many Aboriginal communities, and laws governing public drunkenness have historically been weaponised against them, further increasing hesitancy to accept referrals in alcohol-related contexts. Aboriginal health services report, however, that community members place strong trust in ACCHOs and are more likely to consent to an Aboriginal-dedicated health service or sobering centre. They noted that it is therefore vital to explain to the intoxicated person that outreach workers, not police, will provide transport, and that the destination is a culturally safe service with Aboriginal staff present.

Cultural expectations and community norms in other communities also affect willingness to engage with police and other services. Shame or stigma associated with alcohol and drug use may deter people from accepting assistance, particularly in close-knit communities where reputational harm carries weight. This is especially relevant for young people from South Sudanese backgrounds, where alcohol consumption is widely viewed as culturally inappropriate and strongly stigmatised (see Appendix 4 for detailed insights from the South Sudanese Australian case study).

For individuals experiencing homelessness or family violence, the concept of 'refusing' help becomes more complex. The absence of a safe place to return to can limit genuine choice, meaning that even voluntary consent may be shaped more by necessity than preference. Health services noted the importance of stabilising the consent model with trauma-informed practice, for example, through the use of wellbeing checks so that help can still be available if full consent has not been given.

Overall, stakeholders emphasised the need to strike a careful balance between upholding a person's right to make their own decisions and protecting their safety in situations of intoxication. They were clear that the PIR should continue to operate on a consent-based model, seeing it as fundamental to preserving dignity and human rights. At the same time, they stressed that the system must be capable of responding to the varying levels of impairment that can affect decision-making capacity.

They noted that this requires more than simply asking for consent; it involves adapting communication to meet the needs of the person at that moment, providing clear, accessible explanations, and ensuring that any offer of assistance is genuinely understood. They also highlighted the importance of additional supports at the point of contact, such as culturally competent staff, interpreters, or trusted community intermediaries, to help safeguard both the rights and the wellbeing of the person involved. In their view, a truly consent-based approach is one that is meaningfully informed, compassionate, and responsive to individual circumstances.

Overreliance on Victoria Police

Police have been positioned as a major source of referrals and—in lieu of widespread community awareness of services—this critical dependence remains. Further, this lack of public awareness of services (see the next section) also results in police frequently working from a 'zero understanding' basis when responding to someone who is intoxicated in public. Understanding of the service by the individual is therefore frequently wholly dependent on how the police officer explains and frames the services to the person. However, it has been made clear in other sections of this Report that police understanding of the services is mixed. The depth and accuracy of explanation that an individual may receive can therefore be inconsistent. This is compounded by the inherent disinclination of marginalised community groups to engage with or be responsive to police, as well as by issues in obtaining consent, meaning that police face multiple barriers in getting to a referral point.

Despite this reliance on Victoria Police, CAD data indicates that the majority of calls that are transferred to police for action come from members of the public. Notwithstanding the limitations of the general public's ability to accurately recognise signs of intoxication, there remains an opportunity for more referrals to be generated from the public rather than perpetuating a continued over-reliance on police. Again, this speaks to questions of awareness and public education of the reform and of referral pathways that now exist, as we discuss in the following section.

AWARENESS OF PIR

A consistent finding of the evaluation has been the low level of community awareness of PIR. Members of the public, especially marginalised cohorts, reported little to no knowledge of the reform or of the new health-led services, especially in areas with no PIR service coverage:

“[There’s] not a lot of awareness in community around people’s rights, around public intoxication. In some sites where there’s no services, nothing’s changed.”

(Stakeholder)

Awareness has largely been shaped by traditional and social media coverage, which has been limited and predominantly negative. Most reporting has focused narrowly on the financial cost of establishing sobering services and on how often they are being used, rather than on the broader health and human rights aims of the reform.

Low awareness has direct justice implications for how PIR functions in practice. It impacts consent, as people are less likely to agree to being transported to a service they know little about. Without clear understanding of where they are being taken or what support they will receive, many people default to refusing assistance. It also affects referral pathways. For example, one licensee told the evaluation that many others in the hospitality industry had little knowledge of PIR services and were therefore reluctant to use them for intoxicated patrons. This lack of knowledge risks re-entrenching the very criminal justice responses PIR was designed to move away from.

Stakeholders emphasised that any successful awareness strategy must combine cohesive, consistent messaging with tailored approaches for specific cohorts and local contexts. CALD communities, for instance, require linguistically and culturally appropriate resources, while Aboriginal and Torres Strait Islander communities expect information to be community-controlled and culturally safe.

Limited public knowledge of PIR

A consistent theme raised by stakeholders was the limited level of public understanding about the PIR, stemming from minimal communication and promotion. They noted that awareness tends to be confined primarily to people already connected with relevant services or staff. Knowledge of the previous offence of public drunkenness in Victoria was already low, and awareness of the new health-led outreach and sobering services appears similarly limited. According to stakeholders, most people who have heard about the reform or the PIR services learned of them through media coverage, both mainstream and social, which has largely focused on negative angles, such as high-profile critical incidents or the perceived expense of operating sobering centres in relation to their usage rates.

The lack of awareness is particularly acute in regional communities. One legal professional reflected, *‘the wider community would have very little knowledge, because there’s certainly nothing, been very little in our local media.’* Among South Sudanese Australian participants, most had no knowledge of the reform and believed public intoxication remained illegal in Victoria. Many joined the focus groups, some travelling great distances, precisely to learn more about the changes, as they had received no prior information. Indeed, of the South Sudanese Australian community members consulted as part of this evaluation, only a handful were aware of the reform, and no participants reported having been consulted about it. This highlights a significant gap in communication and engagement between government authorities, service providers and community members. As one participant explained:

“A lot of people are not aware, even the young people. They don’t know the changes... Because in September last year there was a young person who was intoxicated around 1am.... And a family member called me at 1am because they called the police. And the police said, ‘that’s not our job. We can’t do anything about it’ and he was scared to leave that person there. So, he called me at 1am and said, ‘do you know this person, how can I reach their family?’ because they don’t want to leave them on the road. And he asked ‘why are the police saying that this is not their job? If something happened to that person, what will happen?’ There’s no awareness in the community even like the services that could help people. So they don’t know what to do about those cases. Either you take that person to your house and then something bad happens to them. You get held accountable for it or you try to help as much as you can as a community member, but information is not out there for the community.” (Participant)

This example illustrates the practical consequences of limited community awareness of legislative changes and available support services. Community members reported confusion about police responsibilities and the role of other services, creating uncertainty about how to respond in urgent situations. It also highlights the critical need for proactive communication and engagement strategies, ensuring that reforms are clearly explained, widely understood, and accessible to the communities they are designed to support.

The above quote also illustrates how a lack of familiarity with the reform poses a barrier to informed consent. Stakeholders stressed that people need to know not only that public drunkenness is no longer a criminal offence, but also what assistance is available, what accepting support entails, and what happens if they refuse. This includes clarity about transport to sobering-up centres, the roles of different health services, and what declining support means in practice. As several participants observed, it is unrealistic to expect an intoxicated person to fully absorb these details in the moment unless they already have a baseline understanding. Without such knowledge, the default response for many may be to refuse assistance, fearing that transport to a health service could resemble being taken into custody.

Efforts to raise community awareness have been fragmented and limited by a lack of appropriate funding. Many organisations focus on targeted outreach to specific client groups, which ensures relevance and cultural appropriateness but leaves significant sections of the population uninformed. Aboriginal-led organisations have taken proactive steps to address this gap. VALS, for example, produced an accessible fact sheet on Victoria's Public Intoxication Reform, using a Q&A format to explain rights and processes, particularly for Aboriginal and Torres Strait Islander communities disproportionately impacted by past laws. The fact sheet emphasises the consent-based model, including the right to decline or change decisions, outlines limits on police powers, and lists culturally safe support services.

However, as health services have highlighted, these efforts cannot reach all Victorians: *'We're concerned that, you know it seems to have fallen on us to create awareness for this program and understanding and do all the communications. And there's 6 million people in Victoria, and it's literally just our team in conjunction with the outreach teams.'*

Across the board, stakeholders expressed a strong preference for a centralised, coordinated public awareness campaign, complemented by continued funding for grassroots organisations to deliver targeted, community-specific messaging. Most expressed that such a campaign should be led and resourced by the Department of Health, aligning with the reform's shift toward a health-led response.

Police Awareness and Training

Victoria Police's primary policy document, *Chief Commissioner's Instruction: Persons drunk in public*, is intended to be the instructional cornerstone for police and PSO. This evaluation has not directly reviewed Victoria Police training materials, so is not able to comment in detail on the content, scope or duration of training delivered. However, it is clear that Victoria Police invested considerable effort into developing comprehensive training for public intoxication. The training comprised multiple learning formats (e-learning and scenario training) and was designed to be a 'tiered' suite of training packages, enabling higher level information in the e-learning training to be supplemented and built upon by more detailed scenario training.

Police and PSO expressed generally positive views about training, but some concerns were raised. The scenario training was praised for enabling police and PSO to ask questions and voice concerns, as well as workshop scenarios from a range of angles. However, feedback indicated that the e-learning was high level in nature and (as discussed previously) one of its key training scenarios raised concerns, situating a young woman left alone in a park at night:

"The e-learning was a bit, I don't know, probably wasn't great... I think the example that they gave was... a drunk girl at a park who was able to say she didn't want help from police, and so they said, just leave her there... She was... alone in the park... [So] we just leave this girl in a park drunk because she's physically able to say she doesn't want our help?... I think that's stuck with a lot of members." (Victoria Police member)

It is important to note that the concerns with this scenario (which was raised multiple times by police and PSO and is thus highlighted in a number of sections within this report) do not necessarily reflect the quality of the e-learning training, but speak to a broader issue around ethical duty of care and a genuine concern for the welfare of individuals.

The intent of this section therefore is to identify key gaps in training methodology, design and content that have been highlighted during consultation, and not to suggest that comprehensive PIR training does not exist. Stakeholders have been clear that there are a number of factors of key importance:

1. To make training on areas that impact particular groups **explicitly visible** to those groups.

This evaluation makes it clear that public intoxication impacts a number of marginalised groups, including but not limited to the Aboriginal community, Sudanese and South Sudanese Australians. Stakeholders have reported uncertainty and, in some cases, anxiety, about what training police received and whether it equips members to implement PIR, with several recounting interactions where police appeared unfamiliar with key PIR processes. They have requested greater transparency from Victoria Police in articulating what training has been delivered, to whom, and how its effectiveness is monitored over time.

2. Embedding a detailed understanding of **racial bias, cultural safety and trauma informed practice** into training, in a way that is sensitive to the distinct requirements of different groups and directly relevant to PIR.

Police have highlighted the role of PIR in exemplifying the gradual evolution of operational responsibilities, via the bridging of 'traditional' law enforcement and a more 'contemporary' community-focused approach centred around communication and persuasion:

"[We are] having to get a bit more persuasive to try and convince... people to kind of do what you want, to avoid something happening in the future with them, whether it be they commit an offence or get harmed, or something like that." (Victoria Police member)

This shift lays the groundwork for further training to address racial bias, improve cultural safety and enhance trauma-informed practice that community and legal stakeholders, in particular the Aboriginal community and South Sudanese Australian communities, have stressed as essential. They have been clear that police and PSO need to be trained in and supported to implement identification and mitigation strategies that are both specific to the PIR policing response framework and tailored to reflect the unique needs, values, and lived experiences of local cultural communities.

A one-size-fits-all approach to training in this context risks minimising social and historical contexts inherent in different cultural communities, including and in particular the way past experiences with policing may shape current encounters. Ideally, this training would be developed via a **co-design process** with community members and local service providers and would incorporate practical, scenario-based models and refresh training.

Integrating **intersectional needs** into training is also essential. The recognition that people who are intoxicated in public have unique needs and that their experiences are shaped by a range of factors enables both more compassionate and equitable interactions and better outcomes. An example of this can be seen when considering young people, who have been identified as being particularly vulnerable in circumstances involving public intoxication. The unique risks they face, including a lack of safe housing (or homelessness), family violence, mental health concerns and even general unfamiliarity with their surroundings are all reasons as to why they might be intoxicated in a public space. Enhanced training for police to recognise *why* young people are publicly intoxicated and to enable them to respond with appropriate protective rather than punitive measures is imperative.

It is also valuable at this juncture to consider how police are currently trained in the foundational skills of communication, influencing and—importantly—de-escalating of events (which has also been identified by stakeholders) and consider how these could be further developed and adapted within the context of public intoxication.

Engaging with empathy, respect and cultural confidence, and with a view towards the nuanced experiences of community members is a building block for enhanced safety outcomes. Police engaged in this evaluation have been clear that the will to support people who are intoxicated in public is genuine. It is important then that this intention is facilitated by Victoria Police via those training mechanisms called for by community stakeholders.

Recommendation 17

Victoria Police to lead the co-design of a bespoke, public intoxication education program with the South Sudanese Australian community and the Aboriginal community that builds on existing recruit and probationary constable training and Aboriginal Community Awareness Training and is supported by real-life case studies to:

- A.** Educate police and PSO on the unique experiences of both communities with public intoxication, including the reasons why public intoxication can occur and the cultural, historical and social contexts that lead to public intoxication.
- B.** Empower police and PSO to understand how systemic racism, racial profiling, unconscious bias can contribute to the perception of police/ Protective Services Officers in responding to public intoxication, including how these issues can be overcome during interactions.
- C.** Empower police and PSO to understand how intersectional issues (for example, homelessness and mental health) manifest alongside public intoxication enable responses that consider the whole person.
- D.** Provide police and PSO with a review of Aboriginal cultural safety training, adapted to be specific to public intoxication.
- E.** Provide police and PSO with a nuanced understanding of what cultural safety looks like for the South Sudanese Australian community, including consideration of religious and familial dynamics.

Community and organisational education and awareness

Organisational awareness is also uneven and stakeholders consistently reported frustration at the lack of direct communication from DH to some organisations on the ground affected by PIR. They recalled receiving some early information well before implementation, followed by a long gap, and then a brief flurry of communication just as the reform commenced. Some stakeholders were not aware of why the reform came into place:

“When it first came about, I think everyone was a bit sort of perplexed as to why it was happening, and what was the issues, and what was the catalyst... It wasn’t really that transparent at the start.” (Licensee)

This pattern left many uncertain about how the reform would operate in practice—what services were available, where they were located, who could be referred, the parameters for referral, and the end-to-end pathways. Consequently, some services have not fully briefed staff on the reform, its processes, or its implications for daily operations, meaning key personnel remain uninformed. In the absence of clear guidance, organisations frequently contacted one another to clarify details and learn from each other’s experience. The absence of consistent and coherent messaging from DH was a frequently raised issue.

“There’s no cohesive message that’s coming from one source. Everyone’s educating people that are related to the organization separately.” (Stakeholder)

Several stakeholders also noted the importance of more DH engagement at the local level to improve bi-directional communication and increase awareness.

Aboriginal organisations leading awareness campaigns

As part of the reform’s rollout, several organisations including VALS and VLA were provided with funding to deliver community awareness services, though many have stressed that the funding did not always meet the scale of work needed to increase awareness in the community. Stakeholders noted that, Aboriginal organisations have been carrying much of the responsibility for informing communities about PIR. For example, VALS has delivered over 15 in-person community legal education (CLE) sessions across the state with more than 150 attendees, alongside additional sessions for organisational staff (including BADAC, Djirra and a CLC working group). Sessions have often been co-delivered with VAHS and local ACCHOs (Figure 19), ensuring participants receive information on both legal rights and available health support. VALS has also produced flyers and posters (tailored to regions with or without health responses),

maintained a webpage with PIR information, conducted a four-week street poster campaign (Figure 20), and hosted a webinar featuring representatives from VAHS and Ngwala.

Similarly, VAHS has been sharing information about PIR through community events, health networks and outreach, explaining the role of sobering centres and outreach teams within the new health response. Both organisations stressed that their efforts, while valuable, cannot replace the need for a properly funded statewide campaign. They raised concerns that the responsibility for educating the Victorian public about PIR has largely defaulted to Aboriginal organisations already stretched with service delivery demands.

Overall, stakeholders made two clear requests regarding community education:

1. A centralised, cohesive campaign using mainstream and social media to reach the broader community. This campaign should focus on the positive role of health services and counterbalance the negative media coverage to date. Stakeholders suggested that such a campaign should be both funded and delivered by the Department of Health.
2. Dedicated funding for community organisations (such as legal services, ACCHOs, and other community-based services) to deliver tailored education for their own cohorts. These campaigns could be adapted to the specific cultural, linguistic, and social needs of each community, ensuring the messages are trusted and relevant.

Through its analysis of CAD data (outlined earlier in this report), the evaluation has also identified an impetus for a significant campaign to increase public awareness of the VAHS Centralised Service phone line.

These requests are reflected in Recommendations 18 and 19.

FIGURE 19:
VALS CLE workshop Ballarat



Image courtesy of VALS

Recommendation 18

Department of Health, in partnership with the **Department of Justice and Community Safety** (see 'Recommendation 19') to:

- A.** Fund a public education campaign co-led by Aboriginal and South Sudanese Australian community groups, peer workers and other groups as indicated by public intoxication community stakeholders that:
1. Significantly increases public awareness of the Victorian Aboriginal Health Service Centralised Service phone line.
 2. Designs, develops and widely distributes the following categories of plain-language guidance about Public Intoxication Reform:
 - > General (Victorian community)
 - > Community-specific (including the Aboriginal and Torres Strait Islander Community and South Sudanese Australian communities)
 3. Identifies, via consultation with co-leadership groups, those cohorts that require additional multilingual support and design, develop and distribute culturally relevant and safe information to these cohorts.
 4. Designs, develops and distributes age-appropriate education for young people on alcohol related risks, the Public Intoxication Reform and pathways for support, ensuring cultural relevance and safety is taken into consideration.

Reference – Recommendation 19

Recommendation 19

Department of Justice and Community Safety, in partnership with **Department of Health** (see 'Recommendation 18') to:

- A.** Fund a rights-focused public-education campaign co-led by community legal organisations, Aboriginal and South Sudanese Australian community groups, other multicultural groups, peer workers and other groups as identified by public intoxication community stakeholders that:
1. Designs and develops legal information specific to community rights in relation to the Public Intoxication Reform.
 2. Uses localised methods of dissemination including councils, libraries, sporting clubs and community centres, Aboriginal Controlled Community Organisations, licensee forums and auspicing bodies such as Liquor Control Victoria and the Municipal Association of Victoria.
 3. Is oversighted and validity tested by the Victorian Aboriginal Legal Service and Victorian Legal Aid.

Reference – Recommendation 18

FIGURE 20:
Street posters



Images courtesy of VALS

REFLEXIVE PRACTICE AND REFORM MONITORING

Robust data collection, monitoring, and analysis are essential for ensuring that Public Intoxication Reform continue to achieve their intended outcomes and remain responsive to the communities most affected now and for the future. A consistent theme throughout this evaluation has been the limitations arising from the paucity of available data. Without the ability to track how community members move through health, policing, justice, and support services as a consequence of these reforms, it is difficult to tell the full story of reform's impact.

Disaggregated and Localised Data

Community organisations consistently communicated their need for access to a range of data to assist them in making local place-based decisions. Data must be disaggregated by demographics—including age, gender, Indigeneity, place of birth, disability, and other factors. This allows tailored responses to be co-designed with specific cohorts and communities, ensuring that services are culturally responsive and trauma-informed. Monitoring at the local level is particularly important for identifying shifts in patterns of intoxication, for example if presentations shift over time from alcohol-related to drug-related, or remain mixed. Such monitoring will allow for timely adaptations in service design. Establishment of a PIR Statewide Monitoring and Reporting Framework (SMART-Frame) is essential to this commitment to continual improvement (Recommendation 20).

Recommendation 20

Department of Health and Department of Justice and Community Safety together, to:

- A.** Implement a Statewide PIR Monitoring and Reporting Framework by:
 1. Working with health and community service providers and Victoria Police to identify the key health and justice data, held by different agencies, relating to an individual's 'journey' through a public intoxication event.
 2. Enlisting the support of CSA to validate design tools and data to ensure completeness, accuracy and overall robustness.
 3. Producing regular (6-monthly) reports and submitting these to key Government and public intoxication response agencies (to be determined in partnership with health and community service providers and key Aboriginal community groups) and publishing to the general public.

Pathways for Data Sharing

Stakeholders have emphasised that access to timely and transparent data is vital for them to undertake their own monitoring, advocacy, and practice improvements. Clear pathways to shared data with Aboriginal Community Controlled Organisations, health providers, community legal services, and local government partners will strengthen trust and accountability. This aligns with Yoorrook's findings that systemic failures in justice and policing are perpetuated when Aboriginal communities are excluded from decision-making and denied access to data. Moving forward, data sovereignty must be a core principle, ensuring Aboriginal peoples have both access to and authority over the data that concerns them. A potential pathway to this is to apply the Maïam Nanyri Wingara Collective²⁶ principles of data sovereignty, which means Aboriginal-led governance over what data is collected, how it is linked, who can access it, and how it is reported—so that the data centres on community-defined indicators rather than de-contextualised performance metrics.

Commitment to educating communities

An important part of reflexive practice includes the commitment to address the concerns raised in any evaluation. Given the strong themes around lack of awareness and education across all jurisdictions, Recommendation 21 calls for the establishment of a cross-agency training partnership.

Recommendation 21

Department of Health, supported by **Department of Justice and Community Safety** to develop, implement and oversight a training partnership framework that:

- A.** Positions Regional Aboriginal Justice Advisory Committees (RAJACs), Local Aboriginal Justice Advisory Committees (LAJACs), Local Site Executive Committees (LSECs) and other relevant bodies (as identified by the Department) as advisory partners providing expert local and cultural guidance, facilitating stakeholder engagement and collaborating on design, development, monitoring and evaluation of training products.
- B.** Reviews and audits all current education and training for public intoxication (public drunkenness) across the health and justice sectors.
- C.** Identifies training gaps and inconsistencies as well as opportunities for enhancement in all current education and training for public intoxication (public drunkenness) across the health and justice sectors.
- D.** Designs, develops and implements a co-designed* training package that delivers enhanced, integrated training for all health and justice agencies that provide a response to public intoxication (public drunkenness).
- E.** Evaluates co-designed training at regular intervals to assess currency, monitor completion rates and issue continuous improvement directions.

Reference – Recommendation 17 (training)

***Note** – In line with the intent of the reform, co-design activities should limit Victoria Police input to only those areas where operational policing activities cross over with the health response

Youth-Focused Monitoring

For those who are most vulnerable in our communities—particularly young people and those who have already encountered punitive systems—monitoring must specifically examine whether practices are youth-specific, peer-led, culturally responsive, and trauma-informed. Evaluations must adopt an intersectional lens that recognises young people as whole persons with complex needs and strengths. Ongoing reflection on these practices will help prevent the re-embedding of punitive approaches within what is intended to be a health-based model.

Future Evaluations

This evaluation should be repeated in several years to assess whether reforms are delivering on their long-term goals (Recommendation 22). Importantly, a future evaluation should be conducted alongside a health impact evaluation to understand the broader public health implications of the reform, beyond system-level outcomes. This dual lens will help to capture both the justice and health dimensions of the reform, ensuring that it remains genuinely health-led.

Recommendation 22

Department of Justice and Community Safety to:

- A.** Commission a Government-funded independent justice evaluation in four years that:
 - 1.** Uses this Report as a baseline and replicates its independent status.
 - 2.** Centralises the Aboriginal community and enables meaningful input by the South Sudanese Australian community.
 - 3.** Assesses whether Victoria Police's role has meaningfully reduced (including whether a scaled back primary response role for police and Protective Services Officers).
 - 4.** Assesses what the contemporary status around ongoing criminalisation is (in particular the offences linked to public intoxication in this Report) and whether there has been tangible improvement.
 - 5.** Assesses how valuable the PIR Statewide Monitoring and Reporting Framework is as a tracking tool and whether enhancements or amendments need to be made.
 - 6.** Measures the status of the recommendations articulated in this Report and accepted by responsible departments and agencies.

Reference – Recommendation 23

Recommendation 23

Department of Health to:

- A.** Commission a health evaluation in four years that runs parallel with the Department of Justice and Community Safety evaluation in order to support alignment of findings and recommendations across agencies/sectors.

Reference – Recommendation 22

Body-Worn Cameras and the role of accountability

The use of body-worn cameras (BWCs) is a significant aspect of transparency, accountability and evidence collection and Victoria Police has a robust governance framework in place that is explicit about the circumstances under which BWCs are to be activated. The Victoria Police Manual (VPM) contains a section concerned with Body Worn Cameras, this sets a clear expectation that BWCs will be recording the majority of operational incidents in a given shift. Members are directed to start a BWC recording when exercising legislated or common law powers as well as when capturing a range of incidents that are occurring, have occurred or are likely to occur. These incidents include being approached by a member of the public in need of assistance, and/or where police or PSO observe and attend to a member of the public in need of assistance.

Timing of BWC recording commencement is explicit with members required to start recording at the point that a decision is made that circumstances meet a specified range of criteria (incorporating the exercising of powers and incidents as outlined above) and, ideally, prior to attending an incident, while response planning and developing operational tactics. Where a recording is not able to be made, police and PSO are required to use the clearly listed alternative recording options.

Victoria Police Manual *Persons drunk in public* also sets a clear expectation that police and PSO should activate BWCs in accordance with primary policy, including but not limited to when a member of the public is in need of assistance.

While Victoria Police's overarching BWC governance appears sound, it has been made clear during the course of this evaluation that there is inconsistency in police and PSO application of BWC policy. This inconsistency does not appear to be across the board, but limited to discrete areas, particularly in regional Victoria where there can arise a more 'informal' relationship between police and the local community. This can be seen in the case study submitted by IBAC.

IBAC Case Study 11

IBAC received a notification from Victoria Police of a complaint relating to an alleged duty failure. It is alleged that a Victoria Police member failed to activate their body-worn camera (BWC) while interacting with an intoxicated male, while the other Victoria Police member turned off their BWC during the interaction. It is also alleged that the male was transported home by police, in breach of the CCIs.

This case illustrates the importance of compliance with BWC policy and the subsequent issues that can arise when police and PSO operate outside of organisational policy frameworks. The case also speaks to the broader interplay between police decision making and public behaviour, and the accountability and transparency gaps that arise when evidentiary data systems fail in their fundamental role of presenting unbiased information. This issue was underscored in the Yoorrook for Justice Report, which identified police accountability and lack of decision-making transparency as a central and critical issue, citing evidence of over-policing and police brutality. This evaluation explores these issues in depth in the Ongoing Criminalisation section.

It is critical at this juncture then to underscore that BWCs are not monitoring or reporting mechanisms, but neither are they simply operational tools of compliance. Rather, they are an essential piece of equipment that police and PSO have on their person and that are required to be utilised in a specific set of circumstances defined clearly in Victoria Police policy. The power of BWC footage is that it has the ability to provide an objective point of reference for public behaviour and police decision making during an incident. Footage arising from BWC captures are a rich source of critical police/public interaction data enabling independent oversight, building public trust and providing compelling information to continue driving the reform's health and human rights intent. They are a necessary part of the dataset in any public intoxication monitoring and reporting process. Recommendations 24 and 25 speak to the need for a formal reporting process.

Recommendation 24

In line with CCI persons drunk in public and VPM BWC, **Victoria Police** to:

- A.** Roll out once-off organisation-wide communications to reinforce *CCI Persons drunk in public* and *VPM BWC* policy positions as they relate to public intoxication.

Recommendation 25

Victoria Police, Department of Justice and Community Safety and **Department of Health** to:

- A.** Develop a process for integrating body-worn camera data for public intoxication/drunkenness into the PIR Statewide Monitoring and Reporting Framework to ensure compliance with obligations to use BWC.

26. [Maiam Nayri Wingara](#).

PARTNERSHIPS

Partnerships between government agencies, between government and community organisations, between criminal justice and health systems, and between grass-roots organisations lie at the heart of this reform. It is only through prolonged efforts at the community and policy level that this reform has been implemented, and embedded throughout this report are detailed commentaries on the partnerships required to ensure PIR is implemented to date and into the future.

Partnerships are also key to the next steps of PIR implementation. Community members viewed PIR as a starting point rather than a complete solution, emphasising the need for services that extend beyond immediate intoxication support to address underlying alcohol dependency and facilitate long-term recovery. Throughout consultations, participants consistently highlighted the importance of culturally informed, community-led responses to the intergenerational trauma, mental health and/or substance use challenges affecting their community. For Aboriginal peoples, participants stressed that reform efforts must be grounded in genuine partnerships with Aboriginal Community Controlled Organisations and guided by self-determination, consistent with Yoorrook recommendations calling for Aboriginal authority over justice and health responses that affect their communities. This need was particularly pronounced among young South Sudanese Australian men, from late adolescence to their mid-30s.

Yet it is dangerous to see partnerships as uniform across marginalised groups. A central theme for the Aboriginal and South Sudanese Australian community focus groups was the community's active role in supporting young people and people who are intoxicated. Many participants described efforts by leaders and volunteers in their community to conduct informal night patrols, engage directly with intoxicated people, and escort them home. This model is widely regarded as highly effective and culturally safe.

Generational differences persisted, with community leaders expressing a strong desire to be notified and involved when young people are affected. Organisations such as VALS, VAHS, RAJACs and LAJACs are involved across the state, providing effective responses and advocating for Aboriginal people's needs. However, participants from other at-risk cohorts—particularly South Sudanese Australian youth—were more cautious, citing concerns about shame, confidentiality, and gossip.

This may have been particular to the South Sudanese Australian youth, who indicated they would only support community intermediaries if those individuals were properly trained and strictly adhered to confidentiality protocols. A youth leader suggested that church leaders could play a role, as they are trusted within the community and can provide discreet support. While community-centred approaches were broadly favoured, young people emphasised the importance of determining the extent of elder involvement and defining the capacity in which Elders participate.

Across all participants was the widely-supported notion of community-led, community-controlled, government-funded local holistic health and support centre, which could partner with existing health service providers to deliver alcohol and drug services, as well as culturally and racially sensitive mental health support tailored to the community's needs. Across all suggestions and efforts was a desire and commitment for the communities to be actively involved in the leadership and delivery of any interventions.

Importance of Peer and Culturally Safe Approaches

Multiple contributors to the evaluation highlighted the value of peer-led and culturally responsive models. For Aboriginal and Torres Strait Islander communities, these models—delivered through ACCHOs, Elders, and peers—are central to making the reform meaningful in practice. They can build trust, support informed consent, and reduce re-traumatisation by grounding care in cultural safety, kinship, and local knowledges. When Aboriginal communities lead the design and delivery of services, consent improves and connections to AOD, Social and Emotional Wellbeing, housing, and family supports are strengthened. These models also honour principles of self-determination by embedding Aboriginal governance and accountability to community, as the following stakeholder quote suggests:

“[In our sessions], participants emphasised that young people are far more likely to respond positively to peer support than to authority figures... the credibility of peers in navigating sensitive situations often outweighs formal interventions.” (Stakeholder)

Peer-led outreach and ‘grassroots’ initiatives—like community night patrols—were repeatedly cited as approaches young people trust more than authority-driven interventions. PDR App narratives also illustrate how young people often find safety in groups, with friends providing support that reduced the need for formal intervention as the Case Study below demonstrates.

PDR App Case Study 3

While on patrol, PSOs observed a group of youths congregating at the Railway station shortly after exiting a train. Among the group was an individual who appeared to be intoxicated. A welfare check was conducted with the individual to assess their condition. During the interaction, the individual disclosed that they had been consuming alcohol throughout the day and were travelling with their friends to another location. The PSOs offered assistance, including the option of additional support services, but the individual politely declined, expressing gratitude for the concern and help offered. The youth was ultimately deemed safe to remain with their group of friends, who appeared supportive and attentive. The matter was concluded with no further intervention required.

Embedding peer and culturally safe models within PIR is therefore not an optional add-on but a necessary reform if engagement is to be authentic and effective. Stakeholders suggested embedding peer support programs within PIR services, such as youth outreach models with follow-up from trained peers—approaches echoed in the call for *‘grassroots stuff that would work, like night patrols picking up whoever and be like, ‘Come on, we’ll take you home’...’* This was also recognised in the context of the potential safety risks for young people being taken to PIR services that are primarily targeting adults.

DISCUSSION

This evaluation report seeks to assess the justice impacts of the first 22 months of Public Intoxication Reform (PIR) following the decriminalisation of public intoxication in Victoria on 7 November 2023. This not only marked a landmark shift away from punitive justice responses towards a health-based, culturally grounded model of care, but established Victoria as a national leader in recognising and working towards addressing the historical harms caused by criminalisation. The PIR embeds a recognition that the disproportionate impacts of criminalisation are borne by Victoria's most marginalised communities, and responds to decades of advocacy—particularly by Aboriginal leaders, families and organisations—that called for a fundamentally different approach.

In this report, led by Monash University scholars, we have examined changes to policing practice, legal outcomes, community experience and system behaviour, with a focus on Aboriginal and Torres Strait Islander communities and other groups who have long faced disproportionate police attention. Guided by the Reform Theory of Change and supported by the RE-AIM framework, the evaluation tests fidelity, outcomes, adaptations and sustainability across the reform landscape.

Critically, the evaluation is grounded in a robust Indigenous research methodology, supported by governance structures essential to achieve credibility and trustworthiness. The CLAS Advisory Committee and the involvement of Aboriginal and Torres Strait Islander researchers provided the authority, accountability and cultural integrity required to undertake work of this sensitivity. Drawing on four interconnected pillars of Indigenous research methodologies, the evaluation was designed and overseen through community-led decision-making about priorities, tools, language and interpretation. This governance was not symbolic; it enabled an evaluation process that was collaborative and adaptive, capable of surfacing real-time challenges while strengthening trust among the communities most affected. In doing so, the governance model safeguarded rigour and integrity, while also actively supporting reform delivery—modelling the culturally grounded, community-led systems of accountability and care that the reform itself aims to achieve.

As detailed in this report, a number of improvements have been made in the way in which intoxicated persons are dealt with by public authorities in Victoria since the enactment of the *Summary Offences Amendment (Decriminalisation of Public Drunkenness) Act 2021*. The reform has enhanced aspects of the health and safety of intoxicated persons in Victoria. This has implications for a number of rights in the Victorian Charter, including the right to life (section 9), protection from torture and cruel, inhuman or degrading treatment or punishment (section 10) and the right to liberty and security of person (section 21).

AN ONGOING RESPONSE

This justice-focused report illustrates that Victoria Police has not abrogated its responsibilities to the community in responding to intoxicated persons. At the same time, community members and organisations have highlighted there are embedded cultural and operational beliefs, norms and rules that have negatively shaped the response to public intoxication. However, the organisations'—Victoria Police and the Department of Justice and Community Safety—implementation of the reform appears broadly positive. At each level of policy, training and operations, data indicates that police and protective services officers have been equipped to provide a competent response to a frequently marginalised cohort of people. Evidence provided directly by Victoria Police officers indicates that—for the most part—police and protective services officers are genuine and intentional in their desire to provide the best outcome for the intoxicated individual and the broader community.

Data also indicates initial success in aligning the intent of the reform with tangible outcomes. Most importantly PDR App data from the point of decriminalisation for the first five months post-implementation clearly shows that no arrests for public intoxication alone have occurred. Further, PDR App data from the same period indicated a steady reduction in arrests for an offence where the person was also intoxicated. Concurrently, and also for this period, PDR App data indicates that referrals to health-related services have steadily increased. Broadly, this suggests that the reduction of the criminal justice response and the corresponding shift towards a health-based response for public intoxication is being realised.

However, while the overarching message is positive and a holistic shift away from police and the criminal justice system can be seen, there remain discrepancies in treatment between the general population and particular groups. Critically, the Aboriginal community remains over-represented in criminal justice outcomes, with data indicating that an Aboriginal person was nearly twice as likely to be arrested than a member of the general population.

The criminal justice-based disparity for other marginalised groups, including homeless people, those with mental illness and the Sudanese and South Sudanese Australians is—from a data perspective at least—slightly less stark. However, it remains clear that the unique characteristics of and factors affecting these groups can leave them exposed to uneven patterns of intervention and missed opportunities for support.

VICTORIA POLICE PERSPECTIVES

Victoria Police members have noted that decriminalisation is the culmination of a gradual cultural shift towards a non-judicial public intoxication response by police and that the reforms have been successful in formalising that shift. There is a feeling of relief around the reduced role of police in providing intensive caretaking to intoxicated people in custody, and acknowledgement of a reduced risk of aggressive behaviour towards police in a custodial environment:

“[There are] so many positives... we are no longer babysitting intoxicated people... the stress that has been taken away from custody, sergeants... I can't even explain to you, because [they] are constantly looking at [the intoxicated person], checking them... you know, [worrying about] the repercussions if they get injured.”
(Victoria Police member)

Nonetheless, police members emphasised the fundamental organisational and cultural change that has been necessitated by the reforms. Some concern was expressed around ensuring police members were not contravening training and policy parameters while also providing an appropriate solution for people who are marginalised. Concerns were raised about the perceived need to remove personal empathy and bias when providing a response. Indeed, some police members perceived the reform as the removal of previous clear operational boundaries, instead being replaced by a broad and inconsistently applied health response.

In summary, outcomes have generally been favourable with police and protective services officers commonly expressing positivity towards the reform. However, they continue to navigate through a complex and uncertain period triggered by major operational and cultural shifts. This uncertainty is compounded by police and protective services officers being compelled to bridge the substantial gap between the anticipated health response and the actual services in place. Victoria Police is an organisation that is legislated to provide a community safety response, but has become a default provider of a health response. This is a fundamental tension that needs to be recognised to improve upon the strong foundations of the reform.

HUMAN RIGHTS FACTORS

In terms of human rights, the evaluation data demonstrates that there remain a number of concerns with the way in which the PIR has been implemented. Police use of discretionary powers (such as move-on powers) and alternative charges (such as public order and hindering emergency worker offences) means that the ‘quasi-criminalisation’ of intoxication remains an element of the response to intoxicated persons in practice. This response may limit human rights including the right to recognition and equality before the law (section 8 of the *Charter of Human Rights and Responsibilities*),²⁷ protection from torture and cruel, inhuman or degrading treatment or punishment (section 10), freedom of movement (section 12) and the right to liberty and security of person (section 21).

Human rights issues also arise relating to stigmatising of intoxicated persons, and to the proper consideration of cultural rights relating to section 19 of the Charter. In addition, the practice of charging a person and then later dropping the charges raises human rights concerns because charging decisions made by police should be based on whether evidence obtained during an investigation has a reasonable prospect of sustaining a conviction.²⁸ They should not be based on the desire to ‘hold a person’, or take them ‘out of circulation.’²⁹ While it is acknowledged that a decision to charge may be made in ‘fluid circumstances’, charging practices can impact on the likelihood of an inappropriate guilty plea, or refusal of bail, or even ultimately the likelihood of an individual receiving a term of imprisonment. The Australian Law Reform Commission has identified the fact that police charging practices can result in an Aboriginal person being charged ‘too high for an offence’ (at p. 457). Similarly, the NT Royal Commission into youth justice identified charging practices as contributing to youth incarceration.³⁰ The human rights issues are discussed in greater detail in Appendix 2.

27. *Charter of Human Rights and Responsibilities Act 2006* | legislation.vic.gov.au.

28. Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report, ALRC Report 133, December 2017) at 456.

29. Jonathan Hunyor, ‘Imprison me NT: Paperless Arrests and the Rise of Executive Power in the Northern Territory’ (2015) 8(2) *Indigenous Law Bulletin* 1.

30. Commonwealth, Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory, *Findings and Recommendations* (2017) 249.

APPLYING THE RE-AIM FRAMEWORK

This evaluation was guided by the RE-AIM framework (Glasgow et al., 1999), and considers the **Reach**, **Efficacy**, **Adoption**, **Implementation** and **Maintenance** of the PIR. Our report highlights the following insights in relation to each of the RE-AIM dimensions:

- > **Reach:** Through the multiagency and cross-sector collaboration, a comprehensive model to ensure a health-based response has been developed. In particular, services have been designed to support the cultural, spiritual and wellbeing needs of Aboriginal and Torres Strait Islander Victorians, although service provision outside of metropolitan Melbourne is uneven. The evaluation identified the importance of the PIR for other at-risk cohorts, although the extent to which it has been accessed by these groups is limited due to the nature of service provision (as outlined in Table 5 of this report). Participants all emphasised that they want the reform to work and are committed to its success, but also recognise that this is the start of the reform process, with much still to be done. Due to the structures and relationships in place, it is reasonable to anticipate that the PIR will continue to expand its reach. Recommendations 11 through to 17 provide strategies to enhance this dimension.
- > **Efficacy:** Analysis of data provided by the CSA (Table 4) and the PDR App data highlights that arrests due to public intoxication have decreased following decriminalisation, however issues of ongoing criminalisation remain. These insights are supported by qualitative data. The capacity to assess efficacy of the reform implementation is limited by data provision, and Recommendations 4 through to 7 highlight the need to ensure documentation is maintained and that reporting is as fulsome as possible.
- > **Adoption:** The detailed information on the models of care developed by VAHS and Ngwala, alongside the publicly available data and observational data from Cohealth, highlight the incorporation of the PIR goals into health service provision. This is supported by changes in policing policy and practice outlined in this report. Recommendations 7, 11 and 14 highlight opportunities to enhance adoption into the future.

- > **Implementation:** Processes of implementation and the associated challenges have been the focus of this report, ranging from terminology (Recommendations 1 to 3) to leveraging community-led initiatives (Recommendations 13 to 16) and enhancing the education, awareness and training interventions (Recommendations 18 through to 22) to policing practices (Recommendations 24 and 25). Referral pathways offer the clearest insights into the process of implementation and reinforce that the early stages of the PIR rollout are already delivering some benefits, with the potential for this to increase as the reform matures and the implementation process advances.
- > **Maintenance:** The commitment of the three main Victorian government agencies involved in the PIR—DJCS, DH and Victoria Police—will ensure the continuation of the PIR rollout into the future. However, this report recommends the need for ongoing evaluations as part of a process of continual refinement and improvement (Recommendation 22), as well as to ensure accountability and that the needs of at-risk communities are met into the future.

SUMMARY

The justice evaluation of PIR is more than an accountability mechanism. It is a living process, carefully designed to handle a contentious issue with integrity, respect, and cultural safety. By reducing criminalisation, preventing Aboriginal deaths in custody, and embedding health-led, community-driven responses, PIR represents a fundamental shift in approach.

The evaluation mirrors this shift, showing that how we measure change must be as just, trustworthy, and respectful as the change we seek to deliver.

RECOMMENDATIONS

TABLE

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
1 Victorian Government, supported by the Department of Justice and Community Safety to: A. Review all alcohol-related legislation with a view to standardising the definition of 'intoxication' for the purposes of consistency and clarity under Public Intoxication Reform. Note – this recommendation refers to standardising language only; it is not recommending an adjustment to reform scope or intent.	> Department of Justice and Community Safety	> RQ1: Implementation Fidelity > RQ10: Partnerships	Terminology Clarify and standardize the terminology used to describe the Public Intoxication Reform
2 Department of Health to: A. Update all public-facing material to incorporate standardised legislative terminology.	> Department of Health	> RQ1: Implementation Fidelity > RQ10: Partnerships	Terminology Clarify and standardize the terminology used to describe the Public Intoxication Reform
3 Victoria Police to: A. Align all policy, training, IT and communications material with standardised legislative terminology, and B. Design, develop and implement training for Police and Protective Services Officers that explains standardised legislative terminology and acknowledges the historical harm and stigma of the term 'drunkenness.'	> Victoria Police	> RQ1: Implementation Fidelity > RQ10: Partnerships	Terminology Clarify and standardize the terminology used to describe the Public Intoxication Reform
4 Victoria Police to: A. Make publicly available (via CSA) the use of the following offences under the Summary Offences Act 1966 (SOA) where they are used in conjunction with incidents of public drunkenness as legally defined: i. Direction to move on (s 6 SOA) ii. Assaulting, resisting or obstructing an emergency worker (s 51 SOA). iii. Assault police iv. Common assault v. Criminal damage vi. Offensive conduct vii. Resist or hinder officer B. Make publicly available (via CSA) the use of local laws prohibiting the possession or consumption of liquor in a public place, where they are used in conjunction with incidents of public drunkenness as legally defined. C. Make publicly available (via CSA) rates of individuals who are arrested for an offence and placed in custody in a Victoria Police-owned and operated premise and who are also drunk as legally defined. D. Make publicly available (via CSA) all incidents where a person who is legally defined as drunk in public is charged with an offence, and where the charge is subsequently dropped.	> Victoria Police	> RQ5: Police contact > RQ6: Use of power > RQ7: Human rights alignment	Ongoing Criminalisation Monitor and publicly report on police powers explicitly linked to public intoxication in <i>Chief Commissioner's Instruction: Persons drunk in public</i> or as identified by this evaluation

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
5 Victorian Government to: A. Make an explicit public commitment that there will be no re-expansion of police powers under Public Intoxication Reform, including an explicit commitment to prohibiting new or alternative police powers.	> Victorian Government	> RQ5: Police contact > RQ6: Use of power > RQ7: Human rights alignment	Ongoing Criminalisation Monitor and publicly report on police powers explicitly linked to public intoxication in <i>Chief Commissioner's Instruction: Persons drunk in public</i> or as identified by this evaluation
6 Department of Justice and Community Safety to establish an independent oversight process/body separate to IBAC that: A. Provides continuous monitoring and oversight of police use of the following powers where they occur in conjunction with incidents of public intoxication. B. Provides an independent complaints pathway for members of the public to use in order to report issues arising from police contact as a result of being intoxicated in public. C. Requires Victoria Police to report all instances of duty failure, death, injury or other adverse outcomes that are usually investigated internally and/or via the Independent Broad Based Anti-Corruption Commission that are related to public intoxication.	> Department of Justice and Community Safety	> RQ5: Police contact > RQ6: Use of power > RQ7: Human rights alignment	Ongoing Criminalisation Monitor and publicly report on police powers explicitly linked to public intoxication in <i>Chief Commissioner's Instruction: Persons drunk in public</i> or as identified by this evaluation
7 Victoria Police, in line with <i>Chief Commissioner's Instruction: Persons drunk in public</i>, to: A. Initiate an organisation-wide process that explicitly monitors police and Protective Services Officer consistency in completing the PDR App (enterprise solution) for every instance of public drunkenness at a station, police service area and regional level. B. Working with the Department of Justice and Community Safety, develop a report that is submitted internally to the Chief Commissioner and is part of the PIR Statewide Public Intoxication Monitoring and Reporting Framework that enables identification of areas in the organisation that are consistently neglecting to use the PDR App (enterprise solution) to record public drunkenness incidents. C. Establish clear disciplinary process for police and PSO who consistently neglect to utilise PDR App (enterprise solution) to record public intoxication incidents. D. Initiate regular validity audits with CSA to test the completeness, accuracy and reliability of all data collected via the PDR App (enterprise solution). E. Ensure that all data currently collected via the PDR App continues to be collected via the enterprise solution and that data points are not otherwise reduced, constrained or removed when transition from the PDR App to the enterprise solution occurs. F. Make data collected via the PDR App (enterprise solution) available as part of the PIR State-wide Monitoring and Reporting Framework.	> Victoria Police	> RQ1: Implementation fidelity > RQ2: Police responses > RQ6: Use of power	Oversight and Accountability Uplift PDR App (enterprise solution) data recording via compliance

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
8 Department of Health to: A. Significantly enhance public visibility of the Victorian Aboriginal Health Service triage line to ensure widespread public and community service providers and partners' awareness and reduce reliance on Triple Zero Victoria and Victoria Police.	> Department of Health	> RQ1: Implementation fidelity > RQ4: Use of outreach	Health Services Expand referral pathways
9 Triple Zero Victoria, in consultation with Victoria Police, to review the call-taking pathway for events which may involve public intoxication to: A. Identify where these events can be diverted away from police towards a health response, and B. Identify if and how a direct referral function to the Victorian Aboriginal Health Service Centralised Service phone line can be integrated with the triple-zero call-taking and dispatch process.	> Triple Zero Victoria	> RQ1: Implementation fidelity > RQ4: Use of outreach	Health Services Expand referral pathways
10 Department of Health to: A. Establish a referral feedback loop that enables the Department to track the outcome of all public intoxication referrals (including via the Victorian Aboriginal Health Service triage line and Victoria Police referrals), and that is fed into the PIR Statewide Monitoring Framework.	> Department of Health	> RQ1: Implementation fidelity > RQ4: Use of outreach	Health Services Expand referral pathways

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
11 The Victorian Government, supported by the Department of Health to: Forward agenda A. Identify and clearly define the forward agenda of Public Intoxication Reform, with an emphasis on future expansion – including adequate resourcing—to support sustainability. Funding and resourcing B. Ensure that existing funding and resourcing for current PIR services is maintained. Service expansion - metropolitan C. Expand service coverage across Metropolitan Melbourne that: - Prioritises coverage in the South-East metropolitan area. - Establishes more services for the Aboriginal community and general public in those metropolitan areas that are beyond the 45-minute radius of existing services (Co-health and Ngwala). Service expansion – regional D. Use available data (including Victorian Aboriginal Health Service, Victoria Police and the Victorian Social Investment Integrated Data Resource) and community consultation to identify areas of unmet demand and establish more services in regional Victoria. E. Use available data (including Victorian Aboriginal Health Service, Victoria Police data and the Victorian Social Investment Integrated Data Resource) to align PIR service hours to demand in both regional and metropolitan areas (including extending 24/7 coverage in large regional hubs and extending metropolitan and regional hours to include peak demand periods). Service expansion - major events F. Build in capacity for surge in demand during major events (including consideration of casual staffing pools, on-call capacity and flexible operating arrangements) and ensure responsiveness to diverse stakeholder groups (including the Aboriginal community).	> Victorian Government > Department of Health	> RQ1: Implementation fidelity > RQ3: Custody reduction > RQ4: Use of outreach	Health Services Expand Public Intoxication Reform Health service coverage
12 Department of Health to: A. Establish a centrally integrated statewide Public Intoxication Reform Hub that: - Enables real time assessment of individuals and provides seamless, warm referrals to existing health and social services, via expedited pathways. - Includes integrated 'nodes of expertise' (including homelessness, mental health, LGBTQIA+, drugs, children and young people and multicultural services) and embeds culturally safe and trauma-informed expertise. - Includes a bespoke 'node of expertise' staffed by Aboriginal community members. B. Establish a community-governed and culturally safe service for South Sudanese Australian young people, co-designed with community leaders and integrating alcohol and other drugs, mental health, family support, education and employment pathways and case navigation.	> Department of Health	> RQ1: Implementation fidelity > RQ4: Use of outreach > RQ10: Partnerships	Wraparound Services Close the gap between the public intoxication response and the broader health and social service support system.

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
13 Department of Health, supported by the Department of Justice and Community Safety and in consultation with local communities (focusing on regional Victoria, Aboriginal community and South Sudanese Australian communities) to: A. Identify current transport service gaps across the State. B. Identify previously successful community-based transport solutions (for example night buses and community designated drivers). C. Fund and implement local transport solutions in service gap areas. D. Fund peer-led community education and communication to facilitate understanding of local transport options, including why these are preferable to police transport.	> Department of Health > Department of Justice and Community Safety	> RQ4: Use of outreach > RQ5: Police contact > RQ10: Partnerships	Transport Establish multiple transport solutions/options to eliminate police transport issue.
14 Where PIR services are not being established via Recommendation 11, Department of Health to: A. Leverage infrastructure, linkages and expertise of existing Alcohol and Other Drug services, Aboriginal Community Health Organisations and position these as lead delivery partners in a scaled-up health response. B. Secure long-term (multi-year and indexed) funding that enables Aboriginal Community Health Organisations to cover both core operations and growth, securing long-term provision of culturally safe services. Reference – Recommendation 11	> Department of Health	> RQ1: Implementation fidelity > RQ4: Use of outreach > RQ5: Police contact > RQ10: Partnerships	Health Services Expand community-based services
15 Where PIR services are being established (via Recommendation 11) or a community service is being leveraged (via Recommendation 13), Department of Health to: A. Build funded pathways for Aboriginal controlled health organisations, alcohol and other drugs workers and community responders to lead responses across triage, outreach, transport, and aftercare, making Aboriginal Community Controlled Organisations the preferred providers where feasible. B. *Fund ongoing training, reflective practice, and partnership mechanisms with CALD organisations to embed cultural safety as a core rather than additional function of PIR and include consideration of Aboriginal-led cultural safety frameworks as a mode to be adapted in consultation with specific communities. C. Where culturally appropriate and feasible, make Aboriginal Community Health Organisations the preferred providers. D. Fund and co-design youth-focused strategies that are: i. Targeted towards young people and include cultural support via peer workers. ii. Targeted at the broader family group, using young people as the conduit to build trust in police and repair family separation. Reference – Recommendation 11, Recommendation 13 *Reference – Recommendation 17 (training)	> Department of Health	> RQ7: Human rights alignment > RQ10: Partnerships	Health Services Guarantee cultural safety

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
16 Victoria Police to identify models of community policing that are working well (including cultural liaison roles for marginalised groups, Aboriginal Community Justice Panels and night patrols) to: A. Assess where these models could be expanded or replicated to further enhance trust and partnerships between police and community, giving consideration to: i. Areas/communities where a large number of public intoxication incidents take place. ii. Areas/communities with a significant representation of marginalised or underrepresented groups. iii. Areas/communities where a large amount of public order offending linked to public intoxication is occurring. B. Develop an implementation plan that identifies resourcing required to expand/replicate successful models into other areas/communities.	> Victoria Police	> RQ4: Use of outreach > RQ5: Police contact > RQ10: Partnerships	Consent Strengthen police and community relationships
17 Victoria Police to lead the co-design of a bespoke, public intoxication education program with the South Sudanese Australian community, the Aboriginal community and PIR service providers that builds on existing recruit and probationary constable training and Aboriginal community awareness training and is supported by real-life case studies to: A. Educate police and PSO on the unique experiences of both communities with public intoxication, including the reasons why public intoxication can occur and the cultural, historical and social contexts that lead to public intoxication. B. Empower police and PSO to understand how systemic racism, racial profiling, unconscious bias can contribute to the perception of police/Protective Services Officers in responding to public intoxication, including how these issues can be overcome during interactions. C. Empower police and PSO to understand how intersectional issues (for example homelessness and mental health) manifest alongside public intoxication enable responses that consider the whole person. D. Provide police and PSO with a review of Aboriginal cultural safety training, adapted to be specific to public intoxication. E. Provide police and PSO with a nuanced understanding of what cultural safety looks like for the South Sudanese Australian community, including consideration of religious and familial dynamics.	> Victoria Police	> RQ2: Police responses > RQ3: Custody reduction > RQ5: Police contact > RQ6: Use of power > RQ7: Human rights alignment	Training Establish bespoke public intoxication (drunkenness) training that builds on existing training, is contextualising and addresses cultural safety, racial profiling, trauma and unconscious bias

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
18 Department of Health, in partnership with the Department of Justice and Community Safety (see Recommendation 19 below) to fund a public education campaign co-led by Aboriginal and South Sudanese Australian community groups, peer workers and other groups as indicated by public intoxication community stakeholders that: A. Significantly increases public awareness of the Victorian Aboriginal Health Service Centralised Service phone line. B. Designs, develops and widely distributes the following categories of plain-language guidance about Public Intoxication Reform: - General (Victorian community). - Community specific (including the Aboriginal and Torres Strait Islander community and South Sudanese Australian communities). C. Identifies, via consultation with co-leadership groups, those cohorts that require additional multilingual support and design, develop and distribute culturally relevant and safe information to these cohorts. D. Designs, develops and distributes age-appropriate education for young people on alcohol related risks, the public intoxication reform and pathways for support, ensuring cultural relevance and safety is taken into consideration. Reference – Recommendation 19	> Department of Health > Department of Justice and Community Safety	> RQ1: Implementation fidelity > RQ5: Police contact > RQ7: Human rights alignment	Community Awareness Fund a multi-pronged statewide campaign to promote community awareness about Public Intoxication Reform
19 Department of Justice and Community Safety, in partnership with Department of Health (see Recommendation 18 above) to: A. Fund a rights-focused public-education campaign co-led by community legal organisations, Aboriginal and South Sudanese Australian community groups, other multicultural groups, peer workers and other groups as identified by public intoxication community stakeholders that: - Designs and develops legal information specific to community rights in relation to the Public Intoxication Reform. - Uses localised methods of dissemination including councils, libraries, sporting clubs and community centres, Aboriginal Controlled Community Organisations, licensee forums and auspicing bodies such as Liquor Control Victoria and the Municipal Association of Victoria. - Is oversighted and validity tested by the Victorian Aboriginal Legal Service and Victorian Legal Aid. Reference – Recommendation 18	> Department of Justice and Community Safety > Department of Health	> RQ1: Implementation fidelity > RQ5: Police contact > RQ7: Human rights alignment	Community Awareness Fund a multi-pronged statewide campaign to promote community awareness about Public Intoxication Reform

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
20 Department of Health and Department of Justice and Community Safety together, to: A. Implement a Statewide PIR Monitoring and Reporting Framework by: i. Working with health and community service providers and Victoria Police to identify the key health and justice data, held by different agencies, relating to an individual's 'journey' through a public intoxication event. ii. Enlisting the support of CSA to validate design tools and data to ensure completeness, accuracy and overall robustness. iii. Producing regular (6 monthly) reports and submitting these to key Government and public intoxication response agencies (to be determined in partnership with health and community service providers and key Aboriginal community groups) and publishing to the general public.	> Department of Health > Department of Justice and Community Safety	> RQ7: Human rights alignment > RQ9: Reflexivity > RQ10: Partnerships	Oversight and Accountability Establish a Public Intoxication Reform State-wide Monitoring and Reporting Framework
21 Department of Health, supported by Department of Justice and Community Safety, to develop, implement and oversight a training partnership framework that: A. Positions Regional Aboriginal Justice Advisory Committees (RAJACs), Local Aboriginal Justice Advisory Committees (LAJACs), Local Site Executive Committees (LSECs) and other relevant bodies (as identified by the Department) as advisory partners providing expert local and cultural guidance, facilitating stakeholder engagement and collaborating on design, development, monitoring and evaluation of training products. B. Reviews and audit all current education and training for public intoxication (public drunkenness) across the health and justice sectors. C. Identifies training gaps and inconsistencies as well as opportunities for enhancement in all current education and training for public intoxication (public drunkenness) across the health and justice sectors. D. Designs, develops and implements a co-designed* training package that delivers enhanced, integrated training for all health and justice agencies that provide a response to public intoxication (public drunkenness). E. Evaluates co-designed training at regular intervals to assess currency, monitor completion rates and issue continuous improvement directions. Reference – Recommendation 18 (training) *Note – In line with the intent of the reform, co-design activities should limit Victoria Police input to only those areas where operational policing activities cross over with the health response.	> Department of Health > Department of Justice and Community Safety	> RQ1: Implementation fidelity > RQ2: Police responses > RQ3: Custody reduction > RQ7: Human rights alignment > RQ10: Partnerships	Oversight and Accountability Establish cross-agency training partnership

RECOMMENDATION	RESPONSIBLE AGENCY	RESEARCH QUESTION	THEME
22 Department of Justice and Community Safety to: A. Commission a Government-funded independent justice evaluation in four years that: i. Uses this Report as a baseline and replicates its independent status. ii. Centralises the Aboriginal community and enables meaningful input by the South Sudanese Australian community. iii. Assesses whether Victoria Police's role has meaningfully reduced (including whether a scaled back primary response role for police and PSO). iv. Assesses what the contemporary status around ongoing criminalisation is (in particular the offences linked to public intoxication in this Report) and whether there has been tangible improvement. v. Assesses how valuable the PIR Statewide Monitoring and Reporting Framework is as a tracking tool and whether enhancements or amendments need to be made. vi. Measures the status of the recommendations articulated in this Report and accepted by responsible departments and agencies. Reference – Recommendation 23	> Department of Justice and Community Safety	> RQ1: Implementation fidelity > RQ7: Human rights alignment > RQ10: Partnerships	Oversight and Accountability Commission an independent follow-up evaluation of Public Intoxication Reform
23 Department of Health to: A. Commission a health evaluation in four years that runs parallel with the Department of Justice and Community Safety evaluation in order to support alignment of findings and recommendations across agencies/sectors. Reference – Recommendation 22	> Department of Health	> RQ1: Implementation fidelity > RQ7: Human rights alignment > RQ10: Partnerships	Oversight and Accountability Commission an independent follow-up evaluation of Public Intoxication Reform
24 In line with <i>Chief Commissioner's Instruction: Persons drunk in public</i> and <i>Victoria Police Manual Body worn cameras</i>, Victoria Police to: A. Roll out once-off organisation-wide communications to reinforce <i>Chief Commissioner's Instruction Persons drunk in public</i> and <i>VPM Body worn cameras</i> policy positions as they relate to public intoxication.	> Victoria Police	> RQ3: Custody reduction > RQ5: Police contact > RQ6: Use of power > RQ7: Human rights alignment	Ongoing Criminalisation Ensure body worn cameras are used in line with <i>Victoria Police Manual Body worn cameras</i> and <i>Chief Commissioner's Instruction: Persons drunk in public</i>
25 Victoria Police, Department of Justice and Community Safety and Department of Health to: A. Develop a process for integrating body-worn camera data for public intoxication/drunkenness into the PIR Statewide Monitoring and Reporting Framework.	> Victoria Police > Department of Justice and Community Safety > Department of Health	> RQ3: Custody reduction > RQ5: Police contact > RQ6: Use of power > RQ7: Human rights alignment	Ongoing Criminalisation Ensure body worn cameras are used in line with <i>Victoria Police Manual Body worn cameras</i> and <i>Chief Commissioner's Instruction: Persons drunk in public</i>

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APPENDICES

APPENDIX 1: CHIEF COMMISSIONER'S INSTRUCTION: PERSONS DRUNK IN PUBLIC

Please note this CCI has expired and has been incorporated into policy via Victoria Police Manual – Persons drunk in public (effective from 2 April 2026).

Chief Commissioner's Instruction

The following instruction is issued pursuant to the powers of the Chief Commissioner of Police under section 60, Victoria Police Act 2013. This Chief Commissioner's Instruction was originally published on the Victoria Police intranet on 13 October 2023 and is effective from 7 November 2023. This instruction expires 18 months from publication or until earlier cancelled or reissued.

CCI 09/23 Persons drunk in public

Context

Public drunkenness has been decriminalised in Victoria, effective from 7 November 2023.

The offences of drunk (s 13), drunk and disorderly (s 14), and drunkards behaving in a riotous and disorderly manner (s 16) have been repealed from the *Summary Offences Act 1966* and corresponding arrest powers (s 15) are no longer available to be used to manage or transport a person who is drunk in public. No new powers or additional duties (including no additional duties of care specific to persons drunk in public) were provided to police or Protective Services Officers (PSOs) (members) as part of this reform.

Victoria has transitioned to a new health-based model for responding to public drunkenness. The health-based model:

- prioritises the use of non-criminal justice response options (consent-based options) such as the use of local health-based, outreach and alternative support services, to respond to people who are drunk in public, who require non-emergency forms of support and assistance
- seeks to reduce unnecessary contact with the criminal justice system, by minimising the role of Victoria Police in responding to public drunkenness incidents.

Under the health-based model, members will:

- only attend public drunkenness incidents involving risks to community safety
- continue to provide general support and assistance, in a community policing capacity, to members of the public that are drunk in public and in need of assistance when members are on patrol or alerted to a person in need of assistance while on duty.

The successful operation of the health-based model requires members to exercise discretion in determining whether to take enforcement action against persons who are drunk in public. It is important that members note that it is not the intent of decriminalisation for members to rely on alternative low-level offences as a substitute for the repealed public drunkenness offences.

The decriminalisation of public drunkenness does not affect:

- the use of other existing police powers
- liquor licensees' obligations, and Victoria Police's enforcement of breaches under the *Liquor Control Reform Act 1998*
- event organisers' obligations with respect to the safe planning and management of private, community, sporting, and major planned events.

The decriminalisation of public drunkenness does not alter members' existing duties or functions. Members must act in accordance with legislation and Victoria Police policy in the performance of their duties and functions, and the exercise of their powers. This includes acting in compliance with existing obligations under the *Charter of Human Rights and Responsibilities Act 2006* (the Charter) and the *Occupational Health and Safety Act 2004*.

Contents

Context	1
Contents	2
Scope and application.....	2
References	2
Definitions.....	3
Responsibilities and procedures	4
Human rights.....	4
Body worn camera activation.....	4
Risk assessment.....	5
Persons requiring emergency medical attention	5
Response and referral options.....	6
Placing a person into the care of family or friends.....	7
Leaving a person in situ	9
Transporting a person to the nearest place of safety.....	10
Children and young people	10
Use of police powers.....	11
Information sharing.....	12
Further advice and information.....	14
Appendix A.....	15

Scope and application

This CCI applies to members and their interactions with people who are drunk in public but does not extend to interactions with people who only are affected by other drugs or substances. Nothing in this CCI limits the use of existing police powers.

References

This CCI is supported by and should be read in conjunction with the following:

- VPM Arrests and warrants to arrest
- VPM Body worn cameras
- VPM Breach of the peace and move on powers
- VPM Care and control under the Mental Health and Wellbeing Act 2022
- VPM Family violence and child information sharing
- VPMP Information sharing
- VPM Infringement notices and official warnings
- VPM Operational duties and responsibilities
- VPMP Police attendance at incidents and events
- VPMG Safe management of persons in police care or custody

Except as outlined above, where there is conflict between the Victoria Police Manual and this CCI, the CCI takes precedence.

Definitions

The following definitions apply to this CCI:

Drunk and drunkenness refers to the state of a person whose mental or physical faculties (such as speech, balance, co-ordination, comprehension, or judgment) are materially impaired by the consumption of alcohol, or alcohol and other drugs, in the conduct of their ordinary affairs.

Imminent risk of harm refers to when an individuals' actions or behaviour would be likely to result in one or more of the following, if protective action was not taken immediately:

- endanger life,
- place themselves or others at a serious risk of harm (including serious physical or mental harm),
- result in serious property damage, or
- result in a serious risk to community safety.

Imminent risk to health refers to when, in combination, the following factors would be likely to result in serious injury, serious illness or death, if protective action was not taken immediately:

- current state of health, having regard to factors including a person's age, disability, injury, or impairment,
- level of drunkenness, and
- physical environment, having regard to factors such as likely exposure to extreme weather.

In situ means to leave a person at the location where they currently are.

Health information, as defined by the *Health Records Act 2001* (HRA), includes any information or opinion, that is also personal information, about:

- the physical, mental, or psychological health of a person
- a person's disability
- a health service to be provided to a person
- other personal information obtained for the purposes of providing it to a health service provider.

Health risk refers to a risk to physical or mental health, including from alcohol consumption, but extending to other risks, such as the risk of suffering hypothermia on a very cold night. It does not extend to safety risks, such as a person walking onto a roadway or being a victim of a crime.

Family violence, as defined by the *Family Violence Protection Act 2008*, is behaviour by a person towards a family member if that behaviour is:

- physically or sexually abusive
- emotionally or psychologically abusive
- economically abusive
- threatening or coercive
- in any other way controls or dominates the family member, causing them to fear for their safety or wellbeing, or that of another person, or

- behaviour that causes a child to hear or witness, or otherwise be exposed, to the above.

Local outreach or sobering services refer to local support services operating as part of the Victorian Government's health-based response to public drunkenness. These are clinical services that are intended to support people who are drunk in public that need immediate assistance (but who do not require urgent or emergency medical treatment). While the local outreach and sobering services may also provide support to those who are only affected by other drugs this is not the role or focus for Victoria Police in the decriminalisation of public drunkenness.

PDRApp refers to the Public Drunkenness Reform application on mobile devices. The PDRApp is used to capture members' interactions with people who are drunk in public, regardless of whether the drunk person was the subject of enforcement action. The PDRApp collects demographic information, response locations, details regarding a drunk person's demeanour during interactions, and the time spent attending public drunkenness incidents.

Also refer to the general **VPM Dictionary** for definitions and acronyms.

Responsibilities and procedures

Human rights

Charter of Human Rights and Responsibilities 2006

1. Members have extensive powers to protect the community and uphold the law. Consideration must be given to the human rights of all people that members interact with, including acting in a way that is compatible with the Charter.
2. A person's human rights can only be limited to the extent that it is reasonable and justified. Prior to limiting a person's human rights, members must consider the least restrictive means available to address the behaviour.
3. The PLAN principles (proportionate, lawful, accountable, and necessary) are designed to assist members to act in a way which is compatible with their human rights obligations.
4. See **VPM Human rights standards** for further guidance.

Human rights engaged in responding to persons who are drunk in public

5. The protected human rights most likely to be engaged when responding to people who are drunk in public include, but are not limited to:
 - freedom of movement (s.12)
 - culture (including Aboriginal culture) (s.19)
 - protection from torture and cruel, inhuman, or degrading treatment (s.10)
 - peaceful assembly and freedom of association (s.16)
 - humane treatment when deprived of liberty (s.22).

Body worn camera activation

Requirement to record

6. When engaging with a person who may be drunk in public (including persons in need of

assistance), members must commence body worn camera (BWC) recording in accordance with the Activation Framework. This includes:

- when exercising legislated or common law powers
- to capture an incident which is occurring, is likely to occur, or which has occurred, such as:
 - when attending an ESTA task
 - being approached/hailed by a member of the public in need of assistance
 - in observing and attending to a member of the public in need of assistance.

Refer to **VPM Body worn cameras** for further guidance.

Recommended use of preamble

7. If time and circumstance permit, members should record a verbal preamble providing a brief summary of the incident and other relevant details known at the time, including the initial response strategy or plan for contact and risk assessment. Refer to the **Body Worn Camera Practice Guide** for further guidance.

Risk assessment

8. Calls for Victoria Police attendance at public drunkenness incidents should be assessed and managed in accordance with **VPMG Resource management and patrol supervision**.
9. Where calls for attendance at public drunkenness incidents are received via ESTA, patrol supervisors should consider whether a community safety risk is present, when making decisions regarding the prioritisation and allocation of police resources in accordance with that policy. Where no community safety risk exists, patrol supervisors should inform ESTA that police will not attend.
10. Members should have regard to the operational safety tool SAFE TACTICS and safety-first principles when determining how best to approach a drunk person, or a person who appears to be drunk.
11. In assessing risk, members must consider whether the person's actions or behaviour present a foreseeable risk to:
 - themselves
 - the health or safety of another person(s)
 - community safety
 - property.
12. Members should prioritise de-escalation strategies to engage the drunk person, avoiding the need for enforcement action where possible.
13. Refer to the flow chart at Appendix A guidance regarding member interactions with people drunk in public.

Persons requiring emergency medical attention

14. Where a drunk person requires emergency medical attention, members must:
 - request Ambulance Victoria attendance

- remain with the person until Ambulance Victoria arrives.
15. A drunk person's informed consent is not required to request Ambulance Victoria attendance for medical emergencies. Members are not required to consider other response options in these circumstances.

Response and referral options

16. Where a drunk person does not require emergency medical attention, members may consider providing a drunk person with support and assistance in a community policing capacity. There are a range of options which members can consider including:
- placing the person into the care of family or friends (refer to sections 28-33 of this policy)
 - referring the person to a local outreach or sobering service (refer to sections 34-42 of this policy)
 - leaving the person in-situ (refer to sections 43-45 of this policy)
 - transporting the person to reach the nearest place of safety (refer to sections 46-50 of this policy).
17. The form(s) of assistance a drunk person may require from members will vary, based on the person's:
- individual circumstances
 - preferences, including cultural preferences
 - ability and willingness to provide informed consent to receive that assistance (refer to sections 21-27 of this policy).
18. In identifying what form(s) of assistance may be suitable to offer a drunk person, members should have regard to:
- whether the person self-identifies as being Aboriginal and/or Torres Strait Islander
 - the person's cultural and linguistic needs, and preferences
 - whether the person has any additional support or mobility needs, such as those associated with age, disability, injury, or impairment
 - the person's gender
 - the person's current means and ability to safely and independently:
 - reach a place of safety
 - access safe transport options (if required)
19. To determine whether a drunk person consents to the assistance being offered, members must ensure that the person is able to:
- comprehend and retain the information that is material to the decision about which their informed consent is being sought
 - use the information and weigh it in the balance as part of arriving at a decision.
20. A person may have capacity to make some decisions and not others. To determine whether a person has capacity to make a decision, consider the seriousness of the decision they are being asked to make.

Voluntary participation and requirement for informed consent

21. The health-based model requires a person's voluntary participation in order to receive assistance. This means that a person must give informed consent for members to:
 - make enquiries, such as to contacting the person's family or friends
 - refer the person to receive support, such as from a sobering or outreach service.
22. A person who gives informed consent retains the right to withdraw that consent at any time. Members must comply with the person's decision to withdraw consent as soon as practicable and safe to do so.

Assessing a person's decision-making capacity and ability to provide informed consent

23. Informed consent can only be obtained from an adult or young person with decision-making capacity. The fact that a person is drunk does not necessarily mean they are incapable of providing informed consent, or that they do not have decision-making capacity.
24. A person's decision-making capacity must be assessed on an individual basis, and in the context of the seriousness of the decision which they are being asked to make.
25. In order to give informed consent, a person must be able to demonstrate that they:
 - understand the information relevant to the decision they are being asked to make. For example, understand that they are being asked to voluntarily nominate a family member or friend, and that if they do members will attempt to contact the nominated person on their behalf
 - are able to retain relevant information, including using or weighing that information, to the extent necessary to make that decision. For example, be able to retain the information being explained to them, about what steps police will take if they consent to a nominated person being contacted and potential outcomes
 - communicate their decision in some way.
26. Members must not proceed with considering response options where the person refuses consent or is incapable of giving informed consent for those options.
27. If in doubt, members must apply the presumption that informed consent has not been given.

Placing a person into the care of family or friends

28. A person who is drunk in public should be placed into the care of family or friends in instances where it is safe and practical to do so. This option should be prioritised for both adults and young people, provided the person provides informed consent.
29. Members must request that the drunk person nominate a person(s) that they consent to being contacted. Members must not contact or share personal information about the drunk person with someone other than a nominated person.
30. Prior to contacting a nominated person, members must attempt to obtain from the person voluntarily information to:
 - verify their identity
 - verify the identities of any nominated family member/s or friend/s

- satisfy themselves that, based on available information, there are no family violence, personal safety or other relevant risks. For example, the presence of any intervention orders, relevant bail conditions or control orders.

Information sharing with nominated persons

31. Subject to sections 21-27 of this policy, where a nominated person has been contacted and is able to take the person into their care, members are permitted to share relevant information with that person enabling them to:
 - attend to provide further support the drunk person
 - arrange private transport, such as a taxi or rideshare service, to collect the drunk person and take them to a place of safety
 - provide the drunk person with support and care.
32. Where a nominated person is uncontactable, unsuitable or unwilling to take the drunk person into their care, members must consider the options outlined at sections 34-42 (referring a person to a local outreach or sobering service) and sections 43-45 (leaving a person in situ) of this policy.
33. Following an attempt to place a drunk person into the care of family or friends, regardless of whether this was successful, members must record:
 - all decisions, reasons for decisions and actions and refer to their obligations under **VPM Operational duties and responsibilities**, and
 - details of their interaction with the drunk person in the PDRAApp.

Referring a person to a local outreach or sobering service

34. When a person cannot be placed into the care of family or friends, members are encouraged to consider referring the drunk person to an appropriate local support service that is able to provide them with immediate assistance.
35. Based on the person's immediate needs, members should consider referring the person to:
 - a local outreach or sobering service or
 - an alternative local support service that is best placed to respond to the person's immediate needs (e.g., a crisis accommodation service).
36. Where a person consents to the referral, the Standard Indigenous Question (SIQ) must be asked for each interaction to determine if they self-identify as being of Aboriginal and/or Torres Strait Islander descent.
37. If a person communicates a positive response to the SIQ, members should give the person the option to be referred to a culturally appropriate local outreach or sobering service, where available.
38. A drunk person may also be referred to a support service with their informed consent using the Victoria Police eReferral (VPeR) system. Referrals via VPeR must not be made for crisis, family violence, sexual offence or child abuse support.

Refer to section 3 of **VPM Victim support** for further information.

Requesting the attendance of local outreach or sobering services

39. Members may refer a drunk person to local outreach or sobering services either:
 - directly, via relevant contact details on the Public Drunkenness intranet page, or
 - by requesting assistance via Police Communications.
40. Refer to the Public Drunkenness Reform intranet page for available mainstream and Aboriginal services, and service eligibility.
41. The relevant local outreach or sobering service that attends is responsible for:
 - obtaining the person's informed consent to receive any health services offered
 - determining whether to offer health services to the person
 - placing a drunk person into the care of family or friends.
42. When an attempt has been made to refer a person to a local outreach or sobering service or alternative support service, regardless of whether the attempt was successful, must record:
 - all decisions, reasons for decisions and actions and refer to their obligations under **VPM Operational duties and responsibilities**, and
 - details of their interaction with the drunk person in the PDRApp.

Leaving a person in situ

43. A person must not be left in situ if they require emergency medical attention. In accordance with sections 14-15 of this policy, where a person requires emergency medical attention members must request Ambulance Victoria attendance and remain with the person until Ambulance Victoria arrives.
44. Where the person is not causing an imminent risk of harm, a person may be left in situ where one of the following applies:
 - the person does not or cannot consent to receiving assistance
 - the person does not require, or no longer requires assistance
 - assistance has been provided and the person is awaiting the arrival of:
 - a nominated person
 - private transportation (such as taxi or rideshare)
 - a local outreach or sobering service
 - an alternative local support service
 - assistance has been provided and no nominated person and/or relevant local support service is willing or available to attend.
45. When leaving a person in situ, members must:
 - take reasonable steps to communicate their decision and reason for doing so with the person, and any nominated person(s) and/or service attending
 - record all decisions, reasons for decisions and actions and refer to their obligations under **VPM Operational duties and responsibilities**
 - record details of their interaction with the drunk person in the PDRApp.

Transporting a person to the nearest place of safety

46. Police must only transport a person who is drunk and not under arrest to the closest place of safety if all of the following apply:
- the person is capable of providing informed consent (refer to sections 21-27 of this policy), and agrees to being transported
 - a local outreach or sobering service is not available to attend within a reasonable time
 - transport is necessary to mitigate and/or eliminate an immediate or imminent serious risk to the person's health
 - the patrol supervisor has approved this action.
- To determine whether a drunk person consents to being transported members should refer to sections 21-27 of this policy.
47. If a PSO considers that a person meets the circumstances at section 46 of this policy and should be transported, they must contact their police sergeant supervisor to discuss this action. If their police sergeant supervisor considers that the person should be transported, the police sergeant supervisor must contact their patrol supervisor for approval for this action. If the patrol supervisor approves transportation, the police sergeant supervisor must arrange for police to attend for this purpose.
48. Members must not offer or agree to requests by local outreach or sobering services to transport a person to the service's location, or to any other location, on the service's behalf.
49. A person who has been sedated or has serious medical issues must not be transported in a police vehicle. Refer to section 3 of **VPMG Safe management of persons in police care or custody** for further guidance.
50. When transporting a person to the nearest place of safety, police must:
- ensure the person understands that they are not under arrest
 - record all decisions, reasons for decisions and actions and refer to their obligations under **VPM Operational duties and responsibilities** and
 - record details of their interaction with the drunk person in the PDRApp.

Children and young people

General

51. Children and young people are subject to all of the response options outlined in this policy. However, members must consider that the inherent vulnerability of children is embedded in a range of legislation which is covered by various other Victoria Police policies.

Children in need of protection

52. Police are mandatory reporters. This creates obligations when a member forms a belief on reasonable grounds that a child has suffered or is likely to suffer significant harm as a result of physical injury and/or sexual abuse. See **VPMP Protecting children** and **VPMG Protecting children** for more information.
53. Police should consider exercising their role as a Protective Intervener under the *Children,*

Youth and Families Act 2005 (CYFA) where a child is:

- drunk or is under the care of a drunk person, and
- in need of protection.

54. The CYFA defines the circumstances when a child is in need of protection. This includes, among other things, where a child has:

- been abandoned by their parents, and after reasonable enquiries:
 - the parents cannot be found and
 - no other suitable person can be found, who is willing and able to take care of the child or
- suffered or is likely to suffer significant harm as a result of:
 - physical injury
 - sexual abuse
 - emotional/ psychological harm that has or is likely to significantly damage their emotional or intellectual development, and

the parents have not protected or are unlikely to protect them from harm of that type.

55. When encountering young people, members should be aware, public spaces may be the only (or preferred) place for young people to socialise and may be a safer space than home.

56. Members can share information with other prescribed entities under the Family Violence Information Sharing and Child Information Sharing schemes, for the purposes of identifying, assessing and managing a range of wellbeing and safety needs and risks for children, families and individuals. See **VPM Family violence and child sharing information sharing** and the Family Violence, and Child Information sharing schemes for more information.

Use of police powers

Use of discretion

57. Discretion is the choice made by a member on whether the law, having regard to all the circumstances, should be enforced.

58. In deciding what enforcement action is to be taken against a person who has broken the law, members must:

- balance the need to:
 - enforce the law to its full extent and
 - take appropriate action (or no action) in relation to the person that recognises their individual circumstances and the circumstances of the offence.
- choose the least severe action that achieves the purposes of taking that action against the person.

Refer to section 2 of **VPM Disposition** for further guidance.

59. Members have discretion as to whether enforcement action is taken against a person found drunk who is also committing an offence. However, it is not the intent of decriminalisation for members to rely on alternative low-level offences as a substitute for the repealed public drunkenness offences. This includes in circumstances where other low-level offences may

have been detected, but prior to decriminalisation public drunkenness offences might typically have been relied upon as the primary or only charge.

60. Many alcohol-related policing functions continue to be subject to specific legislation and policy, outside the scope of this policy. This includes enforcement of offences where being drunk forms part of the offence (e.g., breach of a condition of bail or a court order).

Use of breach of the peace and move on powers

61. Members should consider exercising their:

- breach of the peace powers
- move-on powers under section 6 of the Summary Offences Act, to issue a direction to move on from a public place, or part of a public place, if they suspect on reasonable grounds that the person(s) is/are:
 - breaching the peace or likely to breach the peace
 - endangering or likely to endanger the safety of any other person
 - behaving in a manner likely to cause injury to a person or damage property or is otherwise a risk to public safety.

Refer to **VPM Breach of the peace and move on powers** for further information.

Use of arrest powers

62. The offences of drunk (s 13), drunk and disorderly (s 14), and drunkards behaving in a riotous and disorderly manner (s 16) have been repealed from the Summary Offences Act, and corresponding arrest powers (s 15) are no longer available to be used to manage or transport a person who is drunk in public.

63. Powers of arrest must only be used to support the purpose for which the arrest power has been conferred, considering the need to:

- investigate offences and enforce appropriate legislation
- ensure a person's appearance before a court
- preserve public order
- prevent the continuation or repetition of the offence or the commission of a further offence
- ensure the safety or welfare of members of the public or offender
- apprehend a person who has escaped from legal custody.

Refer to **VPM Arrests and warrants to arrest** for further information.

64. For further guidance, see:

- **VPM Cautions**
- **VPM Infringement notices and official warnings**
- **VPM Disposition.**

Information sharing

65. Members are permitted to share personal and health information with relevant third parties

(such as Ambulance Victoria or local outreach or sobering services) if they have a reasonable belief that sharing the information is necessary, in order to discharge their duties appropriately for that particular incident. For example, to ensure the safety of the person being referred to a local outreach or sobering service, and/or the safety of the staff at that service).

66. Any release of personal or health information could impact on a person's human rights, including a person's right to privacy and reputation. Members must ensure that release of this information is both necessary and proportionate, having regard to any relevant human rights impacts.

Information which can be disclosed

67. The following personal and health information may be shared with relevant third parties, where they have met the requirements at sections 65 and 66 of this policy:
- the person's name, age, gender, address or other relevant personal information
 - general information about members' interaction with the person
 - relevant information, including health information, from the following LEAP warning flags:
 - carries firearms
 - carries weapons
 - drugs association
 - suicide/self-injury
 - use of force warning
 - violent
 - custody risk
 - medical condition
 - mental disorder.

Disclosure of family violence-related information

68. The *Family Violence Protection Act 2008* allows for the disclosure of relevant confidential information regarding a victim of family violence, if doing so is necessary to lessen or prevent a serious threat to an individual's life, health, safety, or welfare.
69. Seriousness could relate to the nature, timing, or severity of the threat and is informed by any known past conduct of the person. There must be a link between the serious threat and the relevant confidential information being disclosed.
70. If the criteria for seriousness is not met, then members must obtain informed consent from the victim to share their information.
71. Disclosure of relevant confidential information regarding a perpetrator of family violence can be made to assess and/or manage the risk of future family violence. Consent is not required.
72. If utilising these powers, members must comply with **VPM Family violence and child information sharing**, including all recordkeeping obligations.

Information that cannot be disclosed

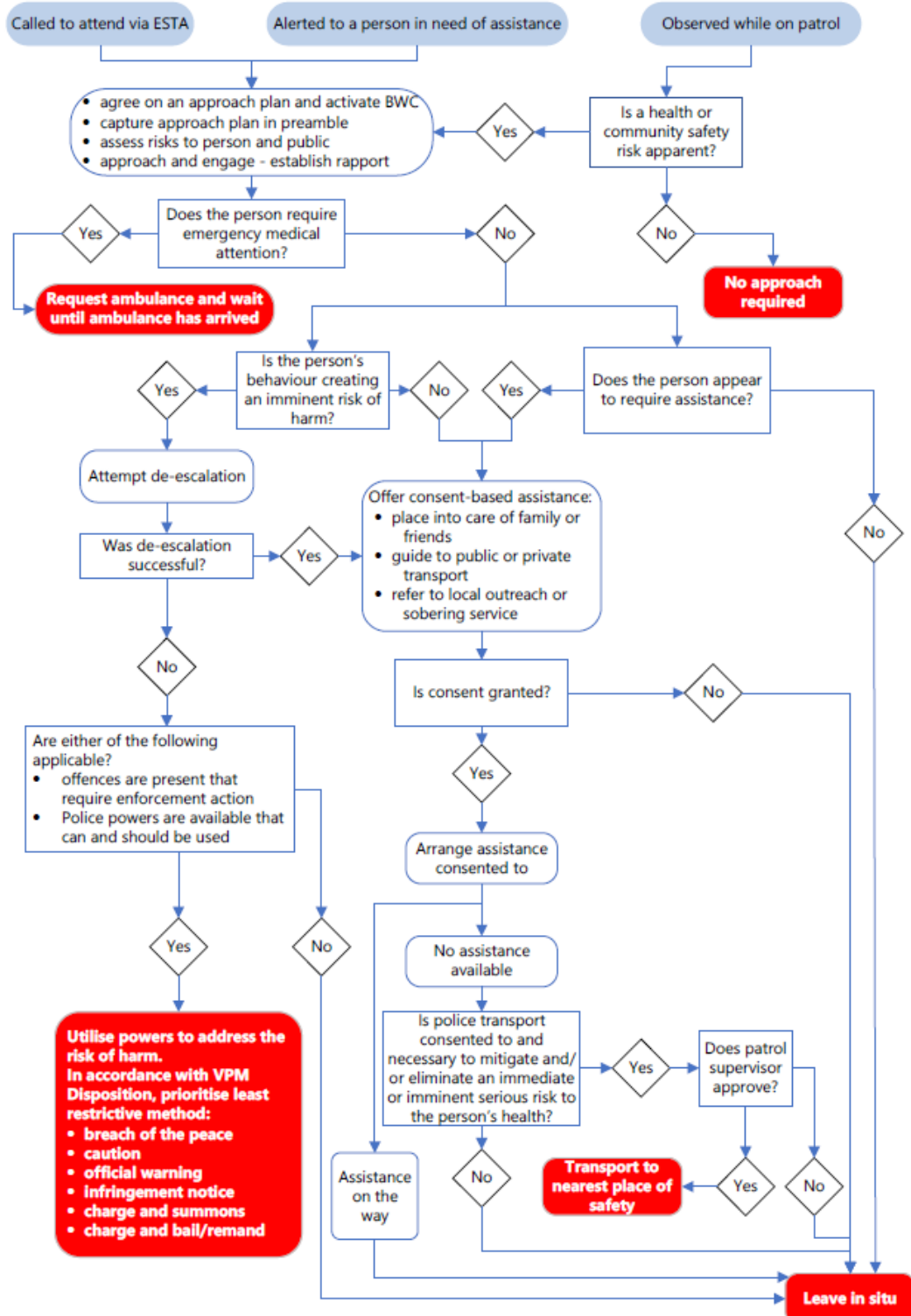
73. Members must not disclose information:
- if they have a legal obligation not to do so, for example, if the person is:

- a registered sex offender under the *Sex Offenders Registration Act 2004*
- subject to a supervision order under the *Serious Offenders Act 2018*.
- from Person of Interest flags (for example POI-OMCG or POI National Security)
- that might disclose sensitive police methodology or prejudice an investigation.

Further advice and information

For further advice and assistance with this instruction, contact the Superintendent, Coordination Division, Capability Department via PUBLIC-DRUNKENNESS-REFORM-MGR@police.vic.gov.au

Appendix A



APPENDIX 2A: HUMAN RIGHTS ANALYSIS

By Stephen Gray, Maria O'Sullivan and Tania Penovic

Executive Summary of Human Rights Analysis

The material collected as part of this Evaluation indicates that a number of improvements have been made in the way in which intoxicated persons are dealt with by public authorities in Victoria since the enactment of the Summary Offences Amendment (Decriminalisation of Public Drunkenness) Act 2021, and the institution of policies to support this change in law (referred to in this analysis as the Public Intoxication Reform – PIR). Those improvements are detailed in this report.

In that respect, the reform has enhanced aspects of the health and safety of intoxicated persons in Victoria, with implications for a number of rights in the Victorian Charter, including the right to life (section 9), protection from torture and cruel, inhuman or degrading treatment or punishment (section 10) and the right to liberty and security of person (section 21).

However, the Evaluation data demonstrates that there remains a number of concerns with the way in which the PIR is being implemented. In this analysis, we focus on three issues:

1. The use by police of discretionary powers (such as move-on powers) and alternative charges (such as public order and hindering emergency worker offences), which means that the criminalisation of intoxication remains an element of the response to intoxicated persons in practice. This means that a number of human rights are engaged by the present system. These include the right to recognition and equality before the law (section 8), protection from torture and cruel, inhuman or degrading treatment or punishment (section 10), freedom of movement (section 12) and the right to liberty and security of person (section 21).
2. The Evaluation data showed that there remains significant stigma attached to intoxicated persons despite the PIR. This is relevant to our human rights analysis as there is increasing recognition by key international and domestic human rights and other legal bodies that stigma can result in human rights violations.
3. The Evaluation raises issues relating to the proper consideration of cultural rights under section 19 of the Charter. We note here that culture is interrelated to and interdependent with other human rights, such as the right to protection from cruel, inhuman and degrading treatment and the right to life. The issue of public intoxication also engages a range of intersectional markers of identity, e.g. people from groups that experience discrimination on the basis of race as well as other characteristics such as disability, gender and age.

These issues are addressed in detail in the pages that follow.

Part 1: Introduction and Background to the Human Rights Analysis

Section 38(1) of the Charter provides that *'it is unlawful for a public authority to act in a way that is incompatible with a human right.'* We note that both Victoria Police and Ambulance Victoria meet the definition of a 'public authority' under the Charter, and therefore both police and first responders are required to act compatibly with, and give proper consideration to, relevant human rights in the course of their duties.³¹

We also note that rights in the Charter can be subject to reasonable limitation under section 7(2) of the Charter which provides:

(2) A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including:

- A. The nature of the right;
- B. The importance of the purpose of the limitation;
- C. The nature and extent of the limitation;
- D. The relationship between the limitation and its purpose; and
- E. Any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

In applying this to the PIR, one important question will be whether responders have employed the least restrictive options possible to align with the Charter.

31. This is recognised in a number of Victorian Charter cases, including *Finding into Death with Inquest of Veronica Nelson* (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), at [274].

Part 2: Human Rights Analysis

Human Rights Issue 1: The use of discretionary powers, move on powers and emergency worker charges; the practice of charging and then dropping charges

The decriminalisation of the offence of 'intoxication' in Victoria has been beneficial to the rights of Victorians in a number of respects.

However, it is important to note that Victoria Police retain a number of other powers and offences that may be utilised against intoxicated persons under the Summary Offences Act (Vic).

For instance, police retain a wide discretion to use 'move on' powers against intoxicated persons under section 6 of the Summary Offences Act (Vic). These powers can be used where the police officer 'suspects on reasonable grounds' that the person/s 'are breaching, or likely to breach, the peace' or 'the person is or persons are endangering, or likely to endanger, the safety of any other person' or 'the behaviour of the person or persons is likely to cause injury to a person or damage to property or is otherwise a risk to public safety'.³²

These are relevant to a human rights analysis as case studies collected as part of this Evaluation indicate that, in some instances, intoxicated persons have been subject to move-on orders.

In other cases, other charges have been employed. These include charges of resisting arrest, or of hindering or assaulting an emergency/ambulance worker. It appears that on occasions these charges have been used largely in order to hold the person, with the charge later being dropped. The Evaluation has also collected information which suggests that intoxication has been used as a trigger for the execution of warrants against individuals.

We note that the Chief Commissioner's Direction provides guidance on the use of move-on powers and alternative offences in relation to intoxication persons.

In relation to move-on powers, the Chief Commissioner's Direction provides that:

'Members should consider exercising their:

- > *Breach of the peace powers; and*
- > *Move-on powers under section 6 of the Summary Offences Act, to issue a direction to move on from a public place, or part of a public place, if they suspect on reasonable grounds that the person(s) is/are:*
 - *Breaching the peace or likely to breach the peace*
 - *Endangering or likely to endanger the safety of any other person*
 - *Behaving in a manner likely to cause injury to a person or damage property or is otherwise a risk to public safety.*³³

In relation to the use of other offences, the Chief Commissioner's Direction provides:

*'The successful operation of the health-based model requires members to exercise discretion in determining whether to take enforcement action against persons who are drunk in public. It is important that members note that it is not the intent of decriminalisation for members to rely on alternative low-level offences as a substitute for the repealed public drunkenness offences.'*³⁴

Powers of arrest must only be used to support the purpose for which the arrest power has been conferred, considering the need to:

- > Investigate offences and enforce appropriate legislation;
- > Ensure a person's appearance before a court
- > Preserve public order;
- > Prevent the continuation or repetition of the offence or the commission of a further offence;
- > Ensure the safety or welfare of members of the public or offender; and
- > Apprehend a person who has escaped from legal custody.³⁵

We acknowledge that the PIR did not amend existing public order provisions in the Summary Offences Act and that, as a result, move-on powers can be utilised by police where there are grounds to do so under section 6 of the Summary Offences Act. However, we emphasise that care must be taken to ensure that these offences are not utilised against intoxicated persons in a way which serves to frustrate the objectives of the PIR.

32. Summary Offences Act (Vic) section 6: 'A police officer, or a protective services officer on duty at a designated place, may give a direction to a person or persons in a public place to leave the public place, or part of the public place, if the police officer or protective services officer suspects on reasonable grounds that— (a) the person is or persons are breaching, or likely to breach, the peace; or (b) the person is or persons are endangering, or likely to endanger, the safety of any other person; or (c) the behaviour of the person or persons is likely to cause injury to a person or damage to property or is otherwise a risk to public safety.'

33. Chief Commissioner's Instruction CCI 09/23: Persons drunk in public, para 61.

34. Chief Commissioner's Instruction CCI 09/23 Persons drunk in public, p 1 (Context).

35. Chief Commissioner's Instruction CCI 09/23 Persons drunk in public, para 63.

In addition, it has been recognised in a number of key government reports that police move-on powers grant a broad discretion to police which can create disproportionate outcomes if exercised in an inconsistent and unequal way.³⁶

In the context of public intoxication, this was noted in a submission by the Queensland Law Society to the Queensland Parliamentary Inquiry into the Decriminalisation of Certain Public Offences, and Health and Welfare Responses:

*'Both public nuisance offences and police move-on powers grant police wide discretionary powers in deciding who and when to prosecute, and this has the capacity to result in the selective enforcement of these laws, and particularly unjust outcomes for marginalised groups. The nature of public order offences and police move-on powers is that they are 'police offences'; that is, they are largely police-generated by police on patrol, and thus have a far greater impact on those groups who exist more prominently in public spaces.'*³⁷

It should be noted in addition that the practice of charging a person and then later dropping charges may raise human rights concerns. Charging decisions made by police should be based on whether evidence obtained during an investigation has a reasonable prospect of sustaining a conviction.³⁸ They should not be based on the desire to 'hold a person', or take them 'out of circulation'.³⁹ While it is acknowledged that a decision to charge may be made in 'fluid circumstances', charging practices can impact on the likelihood of an inappropriate guilty plea, or refusal of bail, or even ultimately the likelihood of an individual receiving a term of imprisonment. The Australian Law Reform Commission has identified the fact that police charging practices can result in an Aboriginal person being charged 'too high for an offence' (at p. 457). Similarly, the NT Royal Commission into youth justice identified charging practices as contributing to youth incarceration.⁴⁰

The evidence from the PIRE is that move-on powers and alternative offences have been utilised against intoxicated persons that engage the following human rights:

Right to equality and enjoyment of rights without discrimination (section 8)

Section 8(3) of the Charter establishes the right to equality, stating that every person is equal before the law and is entitled to the equal and effective protection of the law without discrimination.⁴¹ This right ensures that all laws and policies are applied equally, and do not have a discriminatory effect. Discrimination in this context means discrimination within the meaning of the Equal Opportunity Act 2010 (Equal Opportunity Act)⁴² such as age, disability, employment activity, gender identity, personal association, political belief or activity, pregnancy, race, religious belief or activity, sex or sexual orientation, or status as a carer. Measures that assist or advance persons or groups of persons disadvantaged because of discrimination do not constitute discrimination.

Discrimination against a person can be direct or indirect, and consists of impermissible differential treatment that is less favourable based on one or more of the attributes listed in section 6 of the Equal Opportunity Act. Under that Act, indirect discrimination occurs where there is a requirement, condition or practice that has, or is likely to have, the effect of disadvantaging a person with a protected attribute, and the requirement, condition or practice is not reasonable. Discrimination may be justified if the criterion for differentiation is reasonable and objective, and has the aim of achieving a legitimate purpose.⁴³

The third limb of section 8(3) provides a right to equal and effective protection against discrimination. This right extends beyond merely requiring that the law protects people equally and without discrimination. That is, it also gives every person a separate and positive right to be effectively protected against discrimination.⁴⁴

36. See e.g. Crime and Misconduct Commission, *Police move-on powers: A CMG review of their use* (Report, December 2010); Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report, ALRC Report 133, December 2017) at 363.

37. Submission 28, Queensland Law Society, Queensland Parliament Inquiry into the Decriminalisation of Certain Public Offences, and Health and Welfare Responses, at p 9 [citations omitted].

38. Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report, ALRC Report 133, December 2017) at 456.

39. Jonathan Hunyor, 'Imprison me NT: Paperless Arrests and the Rise of Executive Power in the Northern Territory' (2015) 8(2) *Indigenous Law Bulletin* 1.

40. Commonwealth, Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory, *Findings and Recommendations* (2017) 249.

41. Recognition and equality before the law

(1) Every person has the right to recognition as a person before the law.

(2) Every person has the right to enjoy their human rights without discrimination.

(3) Every person is equal before the law and is entitled to the equal protection of the law without discrimination and has the right to equal and effective protection against discrimination.

42. On the basis of one of an attribute set out in section 6 of that Act.

43. Section 3 of the *Victorian Charter of Human Rights and Responsibilities Act 2006*, provides that: 'discrimination, in relation to a person, means discrimination (within the meaning of the *Equal Opportunity Act 2010*) on the basis of an attribute set out in section 6 of that Act;', noting that 'Section 6 of the *Equal Opportunity Act 2010* lists a number of attributes in respect of which discrimination is prohibited, including age; disability; political belief or activity; race; religious belief or activity; sex; and sexual orientation'.

44. *Lifestyle Communities Ltd (No 3) (Anti-Discrimination)* [2009] VCAT 1869 at [141]; *Matsoukatidou v Yarra Ranges Council* [2017] VSC 61 at [50], [61], [106].

In light of available evidence, it appears that the application of move-on and alternative offences limits the right to equality under the Charter due to the disproportionate impact they are having on certain groups in the Victorian community, namely Aboriginal and Torres Strait Islander Peoples and migrant and refugee groups. If such powers are being used to protect public safety, then consideration should be given as to whether the use of these mechanisms are reasonable and demonstrably justified, and whether there are less restrictive and reasonably available ways to achieve the protection of public safety. This will require greater resourcing of the health response component of the PIR so that police are more readily able to utilise the health response in situations of public safety concerns.

Right to freedom of movement (section 12) and Right to liberty and security of person (section 21)

Evidence about the use of move-on powers and alternative offences by police also may engage the right to freedom of movement (section 12) and the right to liberty and security of person (section 21).

Section 12 of the Charter provides that '*[e]very person lawfully within Victoria has the right to move freely within Victoria and to enter and leave it and has the freedom to choose where to live*'.

Section 21(1) of the Charter provides that '*[e]very person has the right to liberty and security*' and section 21(2) provides that '*[a] person must not be subjected to arbitrary arrest or detention*'. Sections 21(3) to (8) provide further detail about the content of this right.

In terms of case law, the Victorian Supreme Court has considered the scope of section 12, particularly the relationship between section 12 and section 21 of the Charter in the case of *Kaba*, the Court stated that section 12 '*is directed to restrictions on movement which fall short of physical detention coming within the right to liberty in section 21*'.⁴⁵

In light of available evidence, it appears that the application of move-on and alternative offences against intoxicated persons may be being used in a way to limit the right to freedom of movement and right to liberty under the Charter. Further work (including training) should be carried out to ensure that move-on powers and alternative offences are not being used to temporarily hold intoxicated persons in the absence of an intoxication offence.

In other jurisdictions, courts have considered the compatibility of move-on powers with the human right to freedom of movement. The effect of the law is that merely directing a person away from a particular vicinity in general terms does not give sufficient respect to the right to freedom of movement. For example, in *Temoannui v Ford* [2009] ACSC 69, the ACT Supreme Court examined the compatibility of a move-on direction given under the *Crime Prevention Powers Act 1998* (ACT) with the rights to freedom of movement protected under the *Human Rights Act 2004* (ACT). Higgins CJ held that although the move-on provision interfered with the freedom of movement, it could be justified if the measures were necessary and reasonable to prevent disorder. In the circumstances of the case, however, the move on direction was found to be incompatible.

Human Rights Issue 2: Stigmatisation of publicly intoxicated persons which may lead to inhuman treatment.

The second human rights issue which is central to the PIRE is the continuing influence of stigmatising narratives and views of intoxication which is impacting the ways the laws are being operationalised.

As a starting point, we highlight that submissions made to the Coroner's Inquest into the death of Aunty Tanya Day indicate that racially-discriminatory policing and views about intoxication were important elements in her treatment. As the Submission of VHEROC to the Coronial Inquest noted:

Associate Professor Anthony identifies in her report several indicia of systemic racism (that is, discrimination on the basis of race) in the treatment of Tanya, including allegations of:

- 16.1** Racially discriminatory treatment of Tanya in the police call-out and the response to the call out;
- 16.3** Racially discriminatory policing, including racial profiling, in the course of the arrest;
- 16.4** Racially discriminatory treatment of Tanya in the police cells and by paramedics,⁴⁶ including the failure to check and attend to welfare and health needs,⁴⁷ rough handling of Tanya and the **pervasive view of intoxication between police and paramedics leading to delayed medical assistance and Tanya's transfer to hospital;**
- 16.4** Other types of discrimination in the treatment of Tanya, including on the basis of her gender; and
- 16.5** Systemic racism in the flaws in the investigation into the death of Tanya.⁴⁸

We wish to emphasise here that the influence of stigmatising narratives on human rights violations is increasingly being discussed at both an international and domestic level.

45. *DPP v Kaba* (2014) 44 VR 526 at [79]-[82].

46. *Ibid* [69] – [72].

47. *Ibid* [73] – [79].

48. *Report on systemic racism in relation to the death of Tanya Louise Day for the Coronial Court of Victoria, Dr Thalia Anthony, 26 March 2019 at [59] – [89]* (emphasis added).

At an international level, the UN Special Rapporteur on the rights to freedom of assembly and of association has observed that:

*'Stigmatization, whether intentional or not, especially when propagated by authorities, effectively denies these fundamental rights [of peaceful assembly and association]. It misrepresents legitimate exercises of freedom as illegal and those involved as criminals or threats to national security, public order or morals. This fuels harmful stereotypes, fosters hostility, justifies punitive measures and triggers undue restrictions on these rights.'*⁴⁹

Whilst this report relates to the right to assemble and associate and is not directly about public intoxication, it does indicate a greater awareness at the UN level of the impact which stigmatisation has on the enjoyment by individuals of fundamental human rights.

At domestic level, the comments of Coroner McGregor in the Coronial Inquest into the death of Veronica Nelson are important to highlight:

*'examination of the circumstances proximate to Veronica's passing includes consideration of whether decisions made about her, her care and treatment might have been affected by discrimination or stigma based on protected attributes, including any compounding forms of discrimination due to the intersection of these attributes...'*⁵⁰ *I find that Veronica's care and treatment by CV and CCA staff while at DPFC was influenced by drug-use stigma, and that this causally contributed to Veronica's passing.*⁵¹

This is important because Coroner McGregor found that the treatment Veronica received in custody was contrary to section 10 of the Charter:

*'I am not satisfied that the treatment available to Veronica for her opioid dependence... was adequate to treat her withdrawal and so I find that the treatment she received constituted cruel and inhumane treatment contrary to section 10 of the Charter.'*⁵²

This raises an issue as to whether greater work must be done in the context of PIRE, to ensure that police and other responders act in a non-stigmatising way towards intoxicated persons.

It is helpful in this regard to examine legal developments in related areas, such as drug reform. Here, leading academics on drug reform have noted that 'international drug policy increasingly recognises the need to address drug-use stigma.'⁵³

In particular, there is a body of academic work carried out by academics in Australia in relation to drug reform and stigmatisation which considers the relationship between cruel, inhuman or degrading treatment and stigma. This work is very relevant to the PIRE as there is evidence that stigmatisation of intoxication remains an impediment to the full realisation of the objectives of the PIR.

We highlight here the important points from the academic work on stigmatisation and inhuman treatment.

First, the academics have focused on the findings in the Coronial Inquest into the death of Veronica Nelson, finding that '[t]his case has potentially significant implications for how drug-use stigma is understood, and for the obligations of a wide range of public authorities and officials to **act in a non-stigmatising way**'.⁵⁴ Similarly, we would submit that the findings in the *Nelson* case also have implications for the way in which 'alcohol intoxication' is understood and for the obligations of public authorities to act in a non-stigmatising way in relation to PIR.

49. UN Special Rapporteur on the rights to freedom of assembly and of association, Gina Romero, *Protecting the rights to freedom of peaceful assembly and of association from stigmatization*, UN Doc A/79/263 31 July 2024, para 11, <<https://documents.un.org/doc/undoc/gen/n24/226/62/pdf/n2422662.pdf>>.

50. Finding into Death with Inquest of Veronica Nelson (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), 29 [90].

51. Finding into Death with Inquest of Veronica Nelson (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), 5 [33].

52. Finding into Death with Inquest of Veronica Nelson (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), 149 [417].

53. Sean Mulcahy, Kate Seear, Carla Treloar, 'Is drug-use stigma a breach of human rights law?: Insights from Australia' (2025) 143 *International Journal of Drug Policy*, article 104902, citing Kate Seear, 'Addressing alcohol and other drug stigma: Where to next?' (2020) 39(2) *Drug and Alcohol Review*, 109–11; and A Tsai, M Kiang, M Barnett, L Beletsky, K Keyes, E McGinty, L Smith, S Strathdee, S Wakeman, & A Venkataramani, 'Stigma as a fundamental hindrance to the United States opioid overdose crisis response' (2019) 16(11) *PLoS Medicine*, Article e1002969.

54. Sean Mulcahy, Kate Seear, Carla Treloar, 'Is drug-use stigma a breach of human rights law?: Insights from Australia' (2025) 143 *International Journal of Drug Policy*, article 104902, at p 2 (emphasis added).

More specifically, the authors discuss two key implications for human rights law arising from the Coronial findings in the *Nelson* case:

'First, the definition of stigma that the Court adopts explicitly connects stigma to discrimination, concluding that drug-use stigma culminates in discrimination, which is a breach of the right to equality under section 8 of the Charter and Australian anti-discrimination law, though Australian human rights and anti-discrimination law only prohibits discrimination based on protected attributes such as disability, which includes drug dependency but not drug use more broadly (Mulcahy & Seear, 2024).

*Second, the Court raises the possibility that stigma may constitute cruel, inhuman, and degrading treatment under section 10 of the Charter. We say this because, in its finding that stigma influenced or was inherent in Veronica's treatment and that her treatment was cruel, inhuman, and degrading, the Court appears to suggest that stigma—or, perhaps more precisely, stigmatisation as an act—constitutes treatment as cruel, inhuman, or degrading. This has clear implications for public authorities and officials because section 38(1) of the Charter provides that 'it is unlawful for a public authority to act in a way that is incompatible with a human right', including the human right to protection from torture and cruel, inhuman, or degrading treatment.'*⁵⁵

The authors therefore conclude by suggesting that 'based on *Nelson*, stigma could constitute cruel, inhuman, and degrading treatment that is a breach of both domestic and international human rights law.'⁵⁶

Against this context, we find that the continuing stigmatisation of intoxication demonstrated by the available evidence collected during the PIRE raises the following rights:

Freedom from torture and cruel, inhuman or degrading treatment or punishment (section 10)

The interviews carried out as part of our Evaluation indicate that there remains concerns about the treatment of Indigenous people who are subject to arrest and are physically hurt during the arrest process.

Section 10 of the Charter provides that a person must not be:

- A.** Subjected to torture; or
- B.** Treated or punished in a cruel, inhuman or degrading way; or
- C.** Subjected to medical or scientific experimentation or treatment without that person's full, free and informed consent.

Victorian case law has established that treatment may be cruel, inhuman or degrading whether it is inflicted intentionally or negligently (including by an 'accumulation of errors').⁵⁷

To engage the right to protection from cruel, inhuman or degrading treatment, there is a minimum threshold that applies to the standard of treatment, that is, it '*must reach a minimum level of severity or intensity before it can amount to cruel, inhuman or degrading treatment.*'⁵⁸

As Coroner McGregor noted in his decision in the *Veronica Nelson* decision:

*'To fall within s10(b), the treatment must reach a minimum level of severity, which will depend on all the circumstances of the case; factors like a person's poor health, substance use disorder and Aboriginality may aggravate the effect of treatment to render it cruel, inhuman or degrading.'*⁵⁹

These rights will be limited by any involuntary action taken against the person engaging in this behaviour, particularly a criminal justice response such as requiring the person to move on or be detained. The history of the treatment of Aboriginal and Torres Strait Islander peoples in custody (often after arrest for the offences under review) is particularly relevant to the potential limits on section 17.

55. Sean Mulcahy, Kate Seear, Carla Treloar, 'Is drug-use stigma a breach of human rights law?: Insights from Australia' (2025) 143 *International Journal of Drug Policy*, article 104902, page 4.

56. Sean Mulcahy, Kate Seear, Carla Treloar, 'Is drug-use stigma a breach of human rights law?: Insights from Australia' (2025) 143 *International Journal of Drug Policy*, article 104902, page 4.

57. *Certain Children v Minister for Families and Children* (No 2) (2017) 52 VR 441, 519 [250], cited in *Finding into Death with Inquest of Veronica Nelson* (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), 32 [97].

58. *Kracke v Mental Health Review Board* (2009) 29 VAR 1; [2009] VCAT 646 [559] – [560], [574]; *Certain Children* (No 2) [2017] VSC 251 [250].

59. *Finding into Death with Inquest of Veronica Nelson* (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), [97], citing *Certain Children v Minister for Families and Children* (No 2) (2017) 52 VR 441, 519 [250]; *McGlinchey and Others v United Kingdom*, Judge Costa, 22 [4]; *Vogel v New Zealand*, CAT, CAT/C/62/D/672/2015, [7.3]; *Brough v Australia*, HRC, CCPR/C/86/D/1184/2003, [9.4].

Rights raised by detention of intoxicated persons – Humane treatment in detention section 22

If intoxicated persons continue to be arrested and placed in detention when they should in fact receive a health-response, then section 22 of the Charter requiring humane treatment of those deprived of liberty will also be engaged (in addition to the prohibition of inhuman or degrading treatment under section 10 as discussed above). We note that Victorian Charter case law has established that public authorities are required to take positive measures to ensure that detained people are treated with dignity and humanity and that the protection of human dignity encompasses measures such as ensuring adequate conditions of accommodation, food and personal hygiene, clothing and bedding standards and access to medical services.⁶⁰

Human Rights Issue 3: Cultural rights including cultural rights of Aboriginal persons (section 19) and intersections with other rights

Victorian public authorities are obligated under the Charter to give proper consideration to cultural rights, including the cultural rights of Aboriginal people, when making decisions with respect to intoxicated persons and in the design and implementation of public health responses.

In this section of the human rights analysis, we examine the applicability of section 19 of the Victorian Charter to PIR and, importantly, discuss the way in which cultural rights may intersect with other human rights and vulnerabilities (intersectionality).

Section 19 Cultural Rights

The Charter provision and relevant case law section 19(1) of the Charter protects the right to enjoy and practice culture and section 19(2) protects the distinct cultural rights of Aboriginal people in Victoria.

Specifically, section 19 provides that:

(1) All persons with a particular cultural, religious, racial or linguistic background must not be denied the right, in community with other persons of that background, to enjoy their culture, to declare and practise their religion and to use their language.

(2) Aboriginal persons hold distinct cultural rights and must not be denied the right, with other members of their community:

- A.** To enjoy their identity and culture; and
- B.** To maintain and use their language; and
- C.** To maintain their kinship ties; and
- D.** To maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.

This right is largely derived from article 27 of the International Covenant on Civil and Political Rights (ICCPR) which provides that:

'In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practise their own religion, or to use their own language.'

60. *Castles* at [94], [100], [106]-[108], [113]; *Haigh v Ryan* [2018] VSC 474 at [85], cited in *Finding into Death with Inquest of Veronica Nelson* (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023) at [96].

Victorian case law on the right to culture under the Charter illuminates the following key aspects:

(i) The link between section 19 of the Charter and international human rights law treaties – A positive obligation on public authorities

Victorian Charter case law has noted that **international jurisprudence** suggests that public authorities may be under a **positive obligation** to protect against the denial or infringement of cultural rights. This is acknowledged in the findings of Coroner McGregor in the Coronial Inquest into the passing of 37-year-old proud Gunditjmarra, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman Veronica Nelson while remanded in custody at the Dame Phyllis Frost Centre. Coroner McGregor observed that:

*'In the absence of any detailed consideration of the scope of the cultural rights protected by s19 in Victorian law, international jurisprudence suggests that positive measures may be necessary to protect against the denial or infringement of the right to culture. Further, that while denial or violation of the right to culture must meet a threshold, when 'interference' becomes 'so substantial' that it amounts to a 'denial' of the right is a question of degree.'*⁶¹

*Care and treatment that is culturally safe for Aboriginal people and delivered by staff who are culturally competent is likely to promote the rights of Aboriginal people to enjoy their identity and culture by incorporating Aboriginal cultural practices and holistic understanding of health as well as social, emotional, spiritual and cultural wellbeing and allowing Aboriginal people to safely express their culture and identity when seeking and receiving care.'*⁶²

Coroner McGregor found that the police prosecutor, in their appearance before a Magistrate in which bail was denied, failed to properly disclose that Veronica Nelson was Aboriginal and thereby failed to properly consider Ms Nelson's rights to liberty, equality and cultural rights under sections 21, 8 and 19 respectively of the Charter,⁶³ and the right to a fair hearing in section 24.⁶⁴

(ii) Section 19 Charter and kinship ties, cultural connections to country and community and the need for cultural support for Aboriginal persons

Coroner McGregor furthermore found that the Magistrate who denied bail did not give appropriate weight to Veronica's kinship ties, the significance of her mother and brother's ill health, her cultural connection to Country and community, and the unique disadvantages she experienced as an Aboriginal woman in the criminal justice system.⁶⁵ There was thus a failure to properly consider Veronica's rights to liberty, equality and culture.⁶⁶ He further found that at the time of Veronica's appearance before the Melbourne Magistrates' Court on 30-31 December 2019:

*'culturally specific support for Aboriginal court users was under-resourced and designed to address the cultural needs of only some Aboriginal people – those attending Koori Court. The restrictions of the cultural support role as planned by the Magistrates' Court of Victoria, and the inadequate process for identifying people who might need it, failed to give proper consideration to Veronica's rights to equality and culture and those of other Aboriginal court users.'*⁶⁷

In another coronial inquest - the Coroners Court's Finding into the Passing of XY, a proud young Wemba Wemba woman aged 17 and under the care of the Victorian Department of Families, Fairness and Housing - Coroner McGregor observed that:

*'XY's Aboriginal identity raises for consideration the cultural competence of those who interacted with her proximate to her passing, especially whether the treatment and care she received was culturally safe. Care and treatment that is culturally safe for Aboriginal people and delivered by staff who are culturally competent is likely to promote the rights of Aboriginal people to enjoy their identity and culture by incorporating Aboriginal cultural practices and holistic understanding of health, as well as social, emotional, spiritual and cultural wellbeing, and allowing Aboriginal people to safely express their culture and identity when seeking and receiving care.'*⁶⁸

61. Finding into Death with Inquest of Veronica Nelson (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), [92] citing *Poma Poma v Peru*, United Nations Human Rights Committee, Views: Communication No 1457/2006, UN Doc.

62. Finding into Death with Inquest of Veronica Nelson (COR 2020 0021) [2023] VicCorC 28312 (30 January 2023), [93], citing Martin Laverty, Dennis McDermott and Tom Calma, 'Embedding Cultural Safety in Australia's Main Health Care Standards' (2017) 207(1) Medical Journal of Australia 15; Judy Atkinson, 'Trauma-informed services and trauma-specific care for Indigenous Australian children', Resource sheet no. 21, 23 July 2013, <http://earlytraumagrief.anu.edu.au/files/ctg-rs21.pdf>; Finding into Inquest into the Death of Harley Robert Larking (18 September 2020).

63. Finding into Death with Inquest, Inquest into the passing of Veronica Nelson COR 2020 0021, para 333 - 335; Appendix B para 11.

64. Finding into Death with Inquest, Inquest into the passing of Veronica Nelson COR 2020 0021, para 333, n 358.

65. Finding into Death with Inquest, Inquest into the passing of Veronica Nelson COR 2020 0021, para 332, Appendix B para 13.

66. Finding into Death with Inquest, Inquest into the passing of Veronica Nelson COR 2020 0021, paras 333-335.

67. Finding into Death with Inquest, Inquest into the passing of Veronica Nelson COR 2020 0021, Appendix B, para 13.

68. Finding into Death with Inquest, Inquest Into the Passing of XY, COR 2021 003810, 19 June 2024, [80].

Furthermore, in its submission to the 8 Year Review of the Victorian Charter, the Victorian Aboriginal Legal Service set out the case of an Aboriginal woman who was served by police with a possession order to evict her from her rental property, after returning from her country after the death of her nephew for 'sorry business.' She had failed to comply with the requirement in her rental agreement that she engage with community services due to her grief, responsibility for family members including a grandchild and trauma. Her non-Aboriginal housing provider withdrew its application for eviction after it was argued on her behalf that they had failed to give appropriate consideration to her cultural rights and the rights of her grandchild and other family members.⁶⁹

(iii) Cultural rights and self-determination

Cultural safety must also be interpreted in line with self-determination principles.

The UN Declaration on the Rights of Indigenous Peoples (UNDRIP), adopted by Australia in 2009, is relevant to a human rights analysis under the Victorian Charter.

This Declaration elaborates upon international norms with reference to Indigenous Peoples. It was adopted by Australia in 2009 and recognises the right of Indigenous peoples to maintain and strengthen their cultural institutions (art 5), to not be subjected to the destruction of their culture or denial of cultural values (art 8) and to practice their culture (arts 11, 31). Article 31 embodies the idea of 'nothing about us without us' which is also intrinsic to self-determination. Art 31(2) provides that in taking measures to protect cultural rights, states need to take measures 'in conjunction with Indigenous peoples.'

UNDRIP informs the interpretation of section 19 of the Charter for a number of reasons. Specifically, a report of the United Nations Expert Mechanism on the Rights of Indigenous Peoples⁷⁰ states that UNDRIP '*has contributed to the development of—and reflects—general principles of international law or customary international law*' and '*includes several key provisions that correspond to existing State obligations under customary international law*' and calls on states to implement the declaration into domestic law in cooperation and collaboration with Indigenous peoples.⁷¹

For Aboriginal people, the right to culture is intertwined with the right to self-determination, which lies at the heart of UNDRIP. Indeed, the process of self-determination has been described as a '*founding principle of cultural safety*' in a 2002 NSW government report.⁷² The key point is that the right to self-determination is a corollary of cultural safety and enjoyment of the right to culture.

In addition to this, General Comment 23 of the UN Human Rights Committee on the rights of minorities under Article 27 of the ICCPR, provides that the enjoyment of the rights in Article 27 '*may require positive legal measures of protection and measures to ensure the effective participation of members of minority communities in decisions which affect them.*'⁷³ This, again, supports the principle of consultation with minority groups in decisions which affect them. This is important, as part of an official visit to Australia, the UN Special Rapporteur on the Rights of Indigenous Peoples observed a lack of cultural awareness and sensitivity in policing, prisons, schools and healthcare services⁷⁴ and called for greater investment in Aboriginal health delivery and capacity-building.

69. Victorian Aboriginal Legal Service Submission to the 8 year review of the Charter, Submission 98 (Case Study 1).

70. Study by the Expert Mechanism on the Rights of Indigenous Peoples, Constitutions, laws, legislation, policies, judicial decisions and other mechanisms through which States have taken measures to achieve the ends of the United Nations Declaration on the Rights of Indigenous Peoples, in accordance with article 38 of the Declaration, UN Doc A/HRC/57/62, 2 August 2024, Annex para 2. <https://docs.un.org/en/A/HRC/57/62>.

This body was created in 2007 by resolution of the Human Rights Council to provide expertise and advice on the rights of Indigenous peoples Human Rights Council, Resolution 6/36 of 14 December 2007, https://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_6_36.pdf. Its mandate was updated in 2016 to provide the Human Rights Council with expertise and advice on the rights of Indigenous peoples as set out in UNDRIP and assist member states in achieving the ends of the Declaration through the promotion, protection and fulfilment of the rights of indigenous people: Human Rights Council, Resolution 33/25 of 30 September 2016, <https://docs.un.org/en/A/HRC/RES/33/25>.

71. Study by the Expert Mechanism on the Rights of Indigenous Peoples, Constitutions, laws, legislation, policies, judicial decisions and other mechanisms through which States have taken measures to achieve the ends of the United Nations Declaration on the Rights of Indigenous Peoples, in accordance with article 38 of the Declaration, UN Doc A/HRC/57/62, 2 August 2024, paras 3-4 <https://docs.un.org/en/A/HRC/57/62>.

72. NSW Government, Department of Communities and Justice (DCJ), 'Cultural Safety and Wellbeing: Evidence review: Self-determination: Critical Element', 2022, <https://evidenceportal.dcj.nsw.gov.au/our-evidence-reviews/cultural-safety-and-wellbeing/critical-elements/self-determination.html>.

73. UN Human Rights Committee (HRC), *CCPR General Comment No. 23: Article 27 (Rights of Minorities)*, CCPR/C/21/Rev.1/Add.5, 8 April 1994, <https://www.refworld.org/legal/general/hrc/1994/en/26900> [accessed 22 August 2025].

74. Report of the Special Rapporteur on the rights of indigenous peoples on her visit to Australia, UN Doc A/HRC/36/46/Add.2, 8 August 2017.

Application to public intoxication

While the above cases may be factually distinct from the context of Public Intoxication Reform, they illuminate the reality that the right to culture is interrelated to and interdependent with other human rights, such as the right to protection from cruel, inhuman and degrading treatment and the right to life. The failure to give appropriate consideration to culture, as seen in culturally unsafe practices and programs, is associated with a range of human rights violations, including breaches of the right to equality, protection from cruel, inhuman and degrading treatment and the right to life.

Accordingly, in responding to public intoxication, public authorities must give proper weight to cultural considerations in decision-making, including the significance of cultural identity and the need to provide culturally safe responses and support. To ensure that programs are culturally safe, members of affected communities should be involved in their design and implementation.⁷⁵ A lack of cultural safety in service delivery, including healthcare, is associated with preventable suffering and death and is inconsistent with other fundamental rights, including the right to life and the prohibition of torture, inhuman and degrading treatment.

Thus, in the context of individuals presenting as intoxicated in public, section 19 of the Charter requires public authorities to take proper consideration of cultural considerations (including sorry business and kinship) and must furthermore ensure that its decision-making and the design and implementation of support services and health responses is culturally safe.

Cultural Rights and Intersectionality – disability, gender and age

The issue of public intoxication engages a range of intersectional markers of identity, e.g. people from groups that experience discrimination on the basis of race as well as other characteristics such as disability, gender and age.

Culture is critically important to what is known as ‘intersectionality’⁷⁶, as it is a key marker of identity that intersects with others to compound discrimination and disadvantage. Intersectionality in essence seeks to recognise the way markers of identity intersect to compound discrimination and other violations of human rights. It has been defined by the UN as a ‘*concept and theoretical framework that facilitate recognition of the complex ways in which social identities overlap and, in negative scenarios, can create compounding experiences of discrimination and concurrent forms of oppression.*’⁷⁷

Intersectionality has been adopted as a tool in human rights analyses, including a report by the United Nations High Commissioner for Human Rights on the multiple and intersecting forms of discrimination faced by African people and people of African descent in confronting legacies of colonialism and systemic discrimination.⁷⁸ The High Commissioner observes that the markers of identity which interact ‘*to produce distinct, unique and compounding experiences of discrimination*’ include race, colour, descent, or national or ethnic origin; age; sex; gender; sexual orientation; gender identity; gender expression; sex characteristics; socioeconomic status; migration status; disability; minority status; Indigenous origin; health status; political or other opinion; religion or belief.⁷⁹ Cultural identity, such as Aboriginal culture or membership of a racial or ethnic minority must be considered in applying an the lens of intersectionality to a human rights analysis.

75. In this regard, Article 31 of UNDRIP, which asserts the right to maintain, control, protect and develop cultural heritage, expression, etc, para (2) states: In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights. This is consistent with the Human Rights Committee’s General Comment 23 and the recognition in para 7 of the need for positive measures.

76. The concept of intersectionality derives from the work of American legal theorist Kimberlé Crenshaw, who first used it to examine the law’s failure to comprehend the ways that the intersection of gender and race has shaped African-American women’s experiences of discrimination and exclusion: Kimberlé Crenshaw, ‘Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics’, (1989) *University of Chicago Legal Forum* 139.

77. See United Nations Network on Racial Discrimination and Protection of Minorities Guidance Note on Intersectionality, Racial Discrimination and Protection of Minorities, 22 September 2022, at <https://www.ohchr.org/sites/default/files/documents/issues/minorities/30th-anniversary/2022-09-22/GuidanceNoteonIntersectionality.pdf>, p 3.

78. Report of the UN High Commissioner for Human Rights, Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice and equality, UN General Assembly, UN Doc A/HRC/57/67, 25 July 2024, p 2.

79. Report of the UN High Commissioner for Human Rights, Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice and equality, UN General Assembly, UN Doc A/HRC/57/67, 25 July 2024, p 2.

Intersectional Rights - International Human Rights Law obligations

Because the issue of public intoxication engages a range of intersectional markers of identity, e.g. people from groups that experience discrimination on the basis of race as well as other characteristics such as disability, gender and age, rights in other human rights treaties beyond the ICCPR and ICESCR are also engaged. Insofar as the right to culture is concerned, these rights arise in other treaties that Australia has ratified, including:

- > Article 30 on the Convention on the Rights of Persons with Disabilities which recognises (1) the right of persons with disabilities to take part on an equal basis with others in cultural life, including (4) recognition and support of their specific cultural and linguistic identity. Note that persons with disabilities are broadly defined and would include many people covered by the reforms. Article 1 provides that... Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.
- > Article 30 of the Convention on the Rights of the Child which largely replicates art 27 ICCPR, providing: In those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.
- > Article 31(2) of the Convention on the Rights of the Child which recognises the right of the child to participate fully in cultural life.
- > Article 5 of the Convention on the Elimination of All Forms of Racial Discrimination. Article 5 provides that state parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: (a) The right to equal treatment before the tribunals and all other organs administering justice; (e)(iv) the right to public health, medical care, social security and social services; (e)(vi) the right to equal participation on cultural activities.
- > Article 13(c) of the Convention on the Elimination of All Forms of Discrimination Against Women which provides that state parties shall take all appropriate measures to eliminate discrimination against women in economic and social life in order to ensure... (c) the right to participate in recreational activities, sports and all aspects of cultural life.

A number of further mandates of the UN Human Rights Council have elaborated upon cultural rights. A consistent theme has been the reality that cultural rights are deeply enmeshed in other human rights. For instance, in 2009, the UN Human Rights Council created a mandate of the UN Special Rapporteur in the field of cultural rights in a resolution that '*[r]eaffirms that cultural rights are an integral part of human rights, which are universal, indivisible, interrelated and interdependent*'.⁸⁰ The Special Rapporteur has recognised that: 'Provided that cultural rights are fully understood as being part of the wider human rights system and therefore grounded in existing norms and principles of international human rights law, they allow for an enriched understanding of the principle of universality of human rights by taking into consideration cultural diversity.'⁸¹

Summary

Thus, in summary, our human rights analysis demonstrates the following:

1. The use by police of discretionary powers (such as move-on powers) and alternative charges (such as public order and hindering emergency worker offences) engage a number of human rights including the right to recognition and equality before the law (section 8), protection from torture and cruel, inhuman or degrading treatment or punishment (section 10), freedom of movement (section 12) and the right to liberty and security of person (section 21). Further work should be done to ensure that the aims of PIR are not frustrated via the use of other offences by police. This will require further training of police and also, importantly, increased resourcing of health response mechanisms.
2. The Evaluation data showed that there remains significant stigma attached to intoxicated persons despite the PIR. This should also be addressed via further training and education.
3. The Evaluation raises issues relating to the proper consideration of cultural rights under section 19 of the Charter which also need to be considered in relation to other human rights, such as the prohibition of inhuman treatment and freedom of movement. The issue of public intoxication also engages a range of intersectional markers of identity, e.g. people from groups that experience discrimination on the basis of race as well as other characteristics such as disability, gender and age. The complexity of the rights impacted by public intoxication mechanisms should be considered in implementing the PIR.

80. Human Rights Council, Tenth Session, Resolution 10/23. Independent expert in the field of cultural rights, at https://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_10_23.pdf.

81. Report of the independent expert in the field of cultural rights, Ms. Farida Shaheed, submitted pursuant to resolution 10/23 of the Human Rights Council, A/HRC/14/36, 22 March 2010, para 3. <https://docs.un.org/en/A/HRC/14/36>.

APPENDIX 2B: COMPREHENSIVE DUTY OF CARE ANALYSIS

In this part of the Evaluation, we analyse the question of the duty of care owed by police to intoxicated people in their custody.

In the period leading up to Victoria's Public Intoxication Reform, police expressed their concern about the health-based model recommended in the Expert Reference Group report (Seeing the Clear Light of Day: Expert Reference Group on Decriminalising Public Drunkenness, August 2020). The Police Association argued that it was important to recognise that *'not every intoxicated person that police come into contact with is consenting, nor is everybody necessarily a natural fit for services that already exist.'* It argued that the Public Intoxication Reform *'would leave police without any powers to manage those intoxicated people who fell through the cracks and with no viable alternative'*, stating that the *'ERG ignored... the extent to which police are forced to engage with people in a state of intoxication in the community.'* (see Brendan Roberts, 'Policy Hangover: The missing details in Victoria's public drunkenness plan' (2021) 94(2) Police Association (Victoria) Journal 22.) Underlying this expressed concern is another concern which remains largely unexpressed: that police may be civilly or perhaps criminally liable for failing to act, or perhaps for acting negligently, towards a person who is intoxicated in public and who subsequently suffers harm.

In considering this issue, a preliminary point to note is that the expression 'police liability' does not generally imply, in Victoria, that police will be individually or personally liable to pay damages. Rather, under section 74 Victoria Police Act, the State is generally liable for torts committed by police. Individual police officers will only be personally liable for torts they commit in the course of carrying out their duties if the State establishes that their conduct amounted to serious and wilful misconduct.

More generally there is considerable literature on police civil or criminal liability towards people in their custody or care. In general, courts in the UK and Australia have been reluctant to impose civil liability on police officers (Anthony Gray, 'Liability of police in negligence: A comparative analysis' (2016) 24(1) Tort Law Review 34). This is, in part, because of a traditional reluctance of the courts to find the Crown (of which the police form a part) liable in tort. It is also because 'courts have repeatedly affirmed the general principle that one person (or authority) is not generally liable to another for the consequences of actions or omissions of a third party' (Gray, p. 35). Thirdly, there is a traditional reluctance in the courts to impose liability for omissions as opposed to actions—a reluctance of clear relevance to the question of police liability for harm suffered by an intoxicated person where police chose not to act. There is also a reluctance to impose liability in tort 'in areas which could compromise the performance of important public functions or have implications for the greater good' (Gray, 35).

In the UK, the traditional reluctance to impose a duty of care on police was most forcefully stated in *Hill v Chief Constable of West Yorkshire* [1989] 1 AC 53, in which the mother of a victim of a mass murderer sued the police, alleging that defects in police investigation of the killings that occurred prior to her daughter's murder led to her daughter's killing. The English courts raised various public policy considerations which in their opinion negated the existence of a duty of care. Lord Keith denied that the public interest would be advanced by recognising that police generally owed families of victims of crime a duty of care. He said that though police made mistakes, they applied their best endeavours in the performance of their work, and he feared that imposition of a duty of care upon them would lead to them adopting a *'detrimentally defensive' approach to their policing. Policing involved decisions as to which line of inquiry to pursue, and how to deploy limited resources most efficiently, decisions which it was not appropriate for courts to second guess.*^[1] It should be noted that the imposition of an apparently blanket immunity for police in this case has been the subject of significant criticism.^[2]

In Australia, the courts have accepted the 'general principle that one individual is not usually liable for injury or loss caused to another by the acts or omissions of a third party' (Gray, p. 48). In *Stuart and Another v Kirkland-Veenstra* (2009) 237 CLR 215, police were alleged to be negligent in their actions towards a person who was apparently contemplating suicide. They had failed to apprehend the person under mental health legislation, and they committed suicide later that day. In denying that the police were liable, the Court noted the principle that one person was not usually liable to another for injury caused by a third party, noting that the police did not control the 'source of the risk of harm' to the deceased. They also considered it relevant that the claim concerned a failure to exercise a power, rather than the negligent exercise of a power, as well as the lack of a general duty to rescue in Australian law.

In a more recent Victorian case, *Smith v State of Victoria* [2018] VSC 475, the plaintiffs were a mother and three children who were victims of multiple acts of violence by the children's father. The plaintiffs alleged that, in failing to protect them from this violence, Victoria Police acted contrary to its obligations under the *Victorian Charter of Human Rights and Responsibilities Act 2006*, and breached the family's human rights (Yusur Al-Azzawi, 'Opening the door on police's duty of care,' 153 Precedent, July-August 2019, 22).^[3] In considering this case, the Victorian court noted that the restrictive approach to police liability taken in *Hill* should be distinguished, given the priorities contained in the applicable legislation governing family violence, in particular maximising the safety of those affected by violence.

In one case from the US, *Busby v Municipality of Anchorage* 731 P 2d 230 (Alaska Sup Ct, 1987), a municipal authority was found civilly liable for failing to take a citizen into protective custody when he was intoxicated. The Supreme Court, Burke, J., held that a statute requiring persons incapacitated by alcohol to be taken into protective custody was intended to benefit and protect the health of such persons and imposed a mandatory duty on law enforcement to place persons in protective custody.

However, this decision was dependent on the existence of a specific, mandatory duty. In several other US cases, liability was held not to exist against police or municipal authorities. In *Marshall v Ellison* 477 NE 2d 830 (Ill Ct Ap, 1985), the plaintiff brought an action against the city for injuries sustained by him when he was hit by a truck while walking in an intoxicated state on a city road. The Appellate Court, McCullough, J., held that the city owed him no special duty after a police officer stopped while on route to an emergency call and told him to get off the roadway; and secondly, that a statutory provision stating that a police officer shall take into protective custody a person who appears to be intoxicated while in a public place, did not create a cause of action for failure to take a person into protective custody.

In another case, *Morey v Palmer* 556 A 2d 811 (NJ Ct Ap, 1989), a police officer observed a pedestrian staggering in the middle of the road. Determining him to be intoxicated, the officer ordered the pedestrian to leave the roadway. Three hours and forty minutes later, the pedestrian was struck and killed by a truck. The court determined that the officer and the borough were not liable. The officer was immune from liability for an act done in good faith in execution or enforcement of any law, and in the exercise of a discretion. As the court commented:

'Inherent in that discretion is the realization that police officers are themselves a scarce resource and in a large measure their duties stretch them to the outer limits of human capabilities. While on patrol, officers must constantly balance the extent to which they pursue possible minor offenses and other routine daily problems or remain available for patrolling against more urgent offenses... We hold that on these facts, Vinci had no mandatory duty beyond that of physically getting decedent off the highway at 5:15 p.m. Absent special circumstances a general duty to render aid arises only in instances where the failure to render aid is palpably unreasonable.'

In another case with not dissimilar facts, *Rodriguez v City of Cape Coral* 451 So 2d 513 (D Fla, 1984), the police were also found not liable. This was a wrongful death action brought against the city and police officer for the death of the victim, who was struck by a car as he attempted to cross parkway after the officer decided not to take the victim, who was allegedly intoxicated, into protective custody. The District Court of Appeal, Hobson, J., held that the determination of whether the victim appeared to be incapacitated was the officer's judgmental decision that was limited by time, lighting conditions, communications, and other circumstances, so that neither city nor officer could be held liable for the exercise of officer's discretion in not taking victim into protective custody.[4]

Where police have taken positive action, on the other hand, it is clear that there are occasions on which they may be civilly liable for their actions. In *Kirby v British Columbia* (Attorney General), for example, the plaintiff, who had consumed a large amount of alcohol in his parked van, was removed by the police and left unattended, following which he fell and sustained severe head injuries. The police were held liable for their gross negligence in leaving him unattended. Similarly, in a South Australian case, *Akers v P* (1986) 42 SASR 30, police officers directed a man who was concerned in a domestic dispute, and who had ridden to the premises on a motorcycle, to get on his motorcycle and leave the premises. The man rode off on the motor cycle and shortly afterwards collided with a traffic light standard on the road and was seriously injured. The police were found liable for his injuries. On the other hand, in *Adams v New South Wales* [2002] NSWSC 530, police were found not liable after an intoxicated person climbed and fell from a tree, falling whilst climbing down on police instructions.[5]

Overall, it would seem that it is far more likely that police may be found liable in Victoria for their positive actions than for their omissions or failure to take actions.[6] Thus, police may be found liable for false imprisonment, or for wrongful deaths in custody. Survival of actions legislation in all Australian jurisdictions allows the estate of a person who has died in custody to sue on their behalf; and dependants may also bring an action for their own harm.[7] Where police intervention actively places an intoxicated person in danger—in other words, increases the level of danger to which the person was already exposed—it is possible police may be liable. It also seems that there is some authority from overseas that where police are under a mandatory (as opposed to discretionary) duty to place an intoxicated person into protective custody, they may be liable if they fail to do so.

It is worth noting that the Expert Reference Group report recommends that the 'Victorian Government undertakes further research and consultations to establish an offence in relation to negligent conduct when detaining an individual who is intoxicated' (para [33], p.12). An offence of negligent conduct would appear to cover conduct that creates a risk of danger, or increases an existing risk. It is also expressed to apply only to conduct while detaining an individual, not omitting to detain such a person. Thus, it appears to cover only positive conduct rather than omissions.

It is also worth noting that a plaintiff's illegal acts or their intoxication may limit or even occasionally completely exclude the liability of the police for harmful events. In New South Wales, section 54 *Civil Liability Act* 2002 (NSW) provides that no damages can be awarded if the death or injury was 'at the time of, or following', the plaintiff's own conduct which constituted a 'serious offence', where that conduct 'contributed materially' to the death/injury. In Victoria, section 28LAF of the Wrongs Act 1958 (Vic) provides that the court must make a reduction in damages (up to a potential 100% reduction) in light of the victim's criminal record, and their relationship to the defendant authority.[8]

References

[1] *Hill v Chief Constable of West Yorkshire* [1989] 1 AC 53, 63–64, with whom all other Lords agreed; McHugh J referred to these policy reasons in *Hill v West Yorkshire* with evident approval in *D’Orta-Ekenaike v Victoria Legal Aid* (2005) 223 CLR 1; [2005] HCA 12, 17 [101]–[102].

[2] See for example Mandy Shircore, *Police Liability for Negligent Investigations: When will a Duty of Care Arise?*, (2006) 11(1) Deakin Law Review 33.

[3] On the human rights of substance-affected people in detention, see Bernadette McSherry and Sarah Lenthall, ‘Legal issues: Laws to detain individuals with substance dependency: Breaching human rights or restoring health?’ (2011) 19(2) Journal of Law and Medicine 225.

[4] Again, in *Stout v City of Porterville* 148 Cal App 3d 937 (Ct App, 1983) the plaintiff was struck by an automobile after an officer refused to arrest him or take him to a facility for protective custody. The police were found not liable. Police had done nothing to change or increase the level of risk to which the plaintiff had exposed himself; and the kind of harm plaintiff incurred was not the kind of harm addressed by the statute.

[5] ‘It is more probable that the plaintiff was skylarking in the jaccaranda tree while intoxicated and when alerted to the approach of the police vehicle decided to leave the tree and because of her state of intoxication failed to do so safely...’ (53) By section 213 of the Police Service Act 1990 a member of the Police Service is not liable for injury caused by any act or omission in the exercise in good faith of a function conferred by law with respect to the protection of persons from injury or death. It was accepted by counsel for the plaintiff during the course of submissions that by reason of the provisions of section 213 of the Police Service Act the second and third defendants are immune from liability in this case.

[6] For a recent and well-known example of criminal liability for manslaughter being imposed, see *R v White* [2025] NSWCCA 111 (in which the defendant police officer used a taser against a 95 year old victim who was holding a knife in an aged care facility).

[7] Laura Griffin, *Sue the Police: the Role of Civil Liability in Addressing Indigenous Harms in Custody*, (2024) 47(2) University of New South Wales Law Journal 589 at 594.

[8] See discussion in Griffin, *Sue the Police*, above, at 611.

APPENDIX 3: ADDITIONAL NGWALA CASE STUDIES

Ngwala Case Study 5

Ngwala Willumbong's Public Intoxication Response Program received a referral via the centralised dispatch system from Victoria Police regarding a 17-year-old Aboriginal girl in Melbourne's CBD. Police reported that the young person had been arrested after allegedly matching the description of someone attempting to steal. She was believed to have been with a group of other youths who were not detained. Police also advised she had consumed a significant amount of alcohol, including a bottle of vodka.

Police stated the young person was too intoxicated to be interviewed and was '*not currently detained*,' despite being held in an interview room and asleep. When Ngwala staff asked whether the room was locked and whether she had been informed she was free to leave, police repeated that she was '*not detained*.'

Ngwala staff also queried whether Victoria Police had contacted the Victorian Aboriginal Legal Service (VALS), in line with protocol for any arrest or detainment of an Aboriginal child or young person. Police advised that because she was '*not under arrest*,' they felt there was no obligation to report it. However, they stated she required support due to her level of intoxication.

Police confirmed they knew her name and date of birth but had been unable to confirm her address, next of kin, or any emergency contacts.

When Ngwala's Assertive Outreach team arrived at the police station, the young person was in the reception area, waiting to be collected. She was visibly intoxicated but alert, able to communicate, and able to walk steadily with supervision. She consented to receiving support.

The team transported her safely to the Sobering Up Centre, where she was provided a culturally safe environment to rest and sober up.

After several hours of monitored rest, the young person was able to provide her home address and details of her family. Ngwala staff contacted her family, who expressed relief and confirmed they were unaware of the incident.

Once coordination was completed, the young person was transported home safely by Ngwala staff.

The following day, Ngwala conducted a welfare check via phone. The young person reported she was safe at home, feeling embarrassed but physically well, and stated that she would reach out should she need support in the future. Staff provided information about available youth, family, and alcohol-related supports.

Ngwala Case Study 6

Ngwala Willumbong's Public Intoxication Response Program received a call through central dispatch regarding a man in his mid-40s who was heavily intoxicated at a suburban train station. The man had no fixed address and was known to be rough sleeping in the surrounding area.

Ngwala's Assertive Outreach and clinical staff attended the call-out and conducted an assessment. He was deemed eligible for support, provided consent, and was transported to the Sobering Up Centre for further monitoring and a health assessment.

While at the Sobering Up Centre, the man disclosed a long-standing history of chronic alcohol dependence. After several hours of rest and support, he began experiencing early symptoms of withdrawal. He informed staff he suffered from both alcohol-induced seizures and severe withdrawal seizures.

The on-site nurse completed a comprehensive set of observations and strongly advised that he attend the Emergency Department or a medical centre where he could receive appropriate treatment and medication. Despite this advice, the man declined and chose to leave the centre, stating he did not want further support at that time.

Over the following weeks, the man became a near-daily contact for the Public Intoxication Response team. Police and ambulance were frequently called, and he experienced multiple hospital presentations. On one occasion, he collapsed in the middle of a road during a seizure, an incident that almost cost him his life.

Throughout this period, Ngwala's staff continued to engage him with compassion and persistence, offering transport, health monitoring, and repeated encouragement to access detox and treatment services.

Eventually, during one of the interactions, the man agreed to accept help. Ngwala's Public Intoxication Response team transported him to Ngwala's Homelessness Entry Point, where he was assessed for immediate needs. He was placed in crisis accommodation and given the severity of his alcohol dependence and mental health risk, the PIR team provided twice-daily welfare checks.

He was then connected with Ngwala's AOD team for assessment and intake into withdrawal management and treatment. When a detox bed became available, he attended and completed the program.

Following detox, the man was admitted to one of Ngwala's residential treatment programs for 16 weeks.

During this time, he:

- > Engaged in AOD counselling;
- > Participated in cultural healing activities;
- > Attended Ngwala's community engagement lunches;
- > Maintained consistent relationships with PIR and AOD staff; and
- > Worked with the housing team on longer-term goals

Upon completion of treatment, Ngwala's Housing Team supported him to secure his first ever long-term home.

While he maintained stability for a period, he eventually relapsed. Instead of withdrawing from support, he attended the Sobering Up Centre voluntarily and informed staff he needed help.

Ngwala immediately re-engaged him with the AOD team, coordinated another treatment admission, and worked with the housing team to ensure his home was held for him during his re-engagement with detox and rehabilitation.

The man continues to engage with Ngwala's wrap-around services, including:

- > Homelessness and housing support;
- > AOD case management and residential treatment;
- > Counselling; and
- > Social and Emotional Wellbeing support

Aside from detox (as Victoria currently does not have an Aboriginal-specific withdrawal service), every element of his support pathway was delivered by Ngwala. This has enabled cultural safety, continuity of care, and trust—critical components in supporting individuals experiencing severe alcohol dependence and homelessness.

APPENDIX 4: INSIGHTS FROM SOUTH SUDANESE AUSTRALIAN COMMUNITY MEMBERS - CASE STUDY

Relationships between Victoria Police and South Sudanese Australian community members vary significantly by location and age.

Location 1 (regional)

Focus groups in Location 1 (regional) reported consistently positive relationships with local police. Strong community engagement, including the presence of a dedicated Cultural Liaison Officer, has fostered trust and effective communication. Participants noted that the officer actively sought their input in addressing anti-social behaviour. Community leaders viewed the police as collaborators and had established a respectful partnership aimed at ensuring community safety and cohesion. This partnership has helped ensure minimal contact between the criminal justice system and community members in Shepparton.

However, concerns were raised regarding South Sudanese Australian young people who travel to the Melbourne metropolitan area for university:

'our young people get in trouble when they go to Melbourne... they become drunk, and then they can get arrested... the parents don't actually know what is going on, and later on, we will hear that they have been taken to the police.'

Location 2 (metropolitan)

Disrespectful or dismissive police conduct and racial profiling

Our engagement with young people during this consultation indicated that a negative relationship continues to exist between South Sudanese Australian youth and Victoria Police. A distinction emerged between generations: young people consistently described adverse relationships with police, while older community members expressed concern for their children's interactions but emphasised that they did not wish to have an adversarial relationship themselves, and instead wanted to work collaboratively with police.

This tension was particularly evident in this location, where participants provided numerous examples of racial profiling and disrespectful conduct by Victoria Police. A recurring concern was the ongoing use of the term 'gangs' to describe young people's behaviour:

'people in my community live in social groups... They work together, they congregate, but now unfortunately, it [has] become a problem. The police, when they look at these young people working together, they call them gangs... while they are working together, congregating together, they are given this name gangs.'

When asked if this still occurs:

'Yes, I can say this labelling is still there, but all these problems now they are more, they are more.'

In another example, police were described as deliberately antagonising and provoking young people. A mother recounted an incident she had personally witnessed between South Sudanese Australian young people and the police:

'When they use the language [gang] they mute their body camera's microphone and when the children respond they will unmute it, so they capture the response... and I said... 'oh okay that's why our kids become aggressive.''

Participants also described young people being told to 'move on' while simply congregating in public spaces. Such interactions reinforce perceptions of over-policing and unfair targeting. As one community elder explained:

'the police would typically say, 'you need to move on', 'you need to move away', even though they're [youth] not doing anything wrong.'

Community members also raised concerns that, in some cases, police used unnecessary force to ensure compliance with these orders. These experiences contribute to the ongoing sense of being unfairly targeted and continue to fuel negative sentiment towards Victoria Police.

These experiences were further compounded by reports of disrespectful and dismissive conduct. Several participants described negative experiences when seeking police assistance. For example, one participant, speaking through an interpreter, shared:

'She has a daughter, who is an adult who turned 30 years old. She was looking for her. She was away for nearly 4 weeks. Then she was wondering what happened. She went to the police station and told them, 'look, my daughter, I haven't seen her for 4 weeks now. I am concerned'. And they [the police] asked me, 'how old is your daughter?' I told them that 'she's 30 years old', and they all, all of them laughed. They told me, 'Why are you looking for such a person? This person is an adult'. I said she's an adult, but still she's my daughter.'

South Sudanese Australians, particularly older community members, also bring with them complex relationships with police shaped by experiences of political instability and conflict in their country of origin. This can lead to mistrust or caution, even in situations where police officers are acting to assist them. One older woman described her first encounter with police in Australia:

'The police was there. They were stopping the cars, and then from there I nearly collapsed because it was my first time to see police [in Australia]. They talked to me and I was shivering. I couldn't open the window. They helped me and then I was fainting. I couldn't speak. I was fearful, scared and then they tried to find out whether I was fine. Later on, one of the police, said 'OK, yeah, now we can see she hasn't done anything wrong, maybe she can go'. From that time, I made U-turn. I did not go further. I went back home on that day because I was fearful.'

Intoxicated youth can be 'triggered' by police and situations quickly escalate

Community members highlighted how young people who are intoxicated could be easily 'triggered' when approached by police, with these interactions likely to escalate quickly, particularly for young people who had previous history with the police and criminal justice system. A youth participant explained:

'The police will come and open up your file. And they'll find all last week you did this, the week before you did that, the week before you did this, it's not about your condition, they're not gonna treat you as someone that needs medical help. You're a criminal. The judgement is there from the police. Whereas if it's a health provider they don't care what history you have, they just care about the condition you're in now and want to provide help. So that's why, like, it's very easy to get triggered when seeing the police in a uniform.'

Escalation often leads to multiple charges and, at times, allegations of excessive force:

'People become very aggressive when drinking alcohol and fight and assault officers and you know when they throw them in the back of the divvy van? [They] (police) beat them up as well.'

Optimism about strengthening community-police relationships

Despite recounting numerous negative encounters with police, many community members—particularly older participants—believed police were 'doing their job' and expressed optimism that police could better support their community in the future. At the same time, they emphasised that police often failed to understand the unique challenges facing South Sudanese Australians. Interactions between police and young people were seen as contributing to high rates of incarceration, with devastating flow-on effects including persistent socioeconomic disadvantage, limited employment opportunities, and significant mental health challenges.

Community leaders in particular were hopeful about building stronger relationships with Victoria Police and highlighted ongoing efforts to improve trust. For example, in one focus group, participants described their approach:

'We are working on it. Yeah, because I think five years ago, it wasn't very good. Yes, but now I think we are doing things which are aimed at making sure our relationship is strengthened. We've got a group of women meeting here and every third week, the police come, we sit down with them for two hours. Having a conversation, asking questions, getting responses and stuff like that. So I think we are building the relationship now.'

Community Elders in another location suggested that cultural liaisons or South Sudanese officers could play a critical role in bridging the gap between Victoria Police and their community. Young people also highlighted the importance of African officers within Victoria Police, stating:

'With the white folks they discriminate... if I saw a black officer, I'd probably respect a black officer a bit more than a white one.'

Consistent with insights from South Sudanese Australian participants in a different location, participants emphasised that greater collaboration between police and the South Sudanese Australian community in Melbourne could help build stronger relationships. Given the city's larger and more dispersed suburbs, they noted that multiple outreach organisations and culturally appropriate liaison mechanisms may be necessary. At the same time, participants raised concerns around limited community capacity and the risk of inconsistency where different districts or facilities adopt varying approaches.

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