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EXPLORING THE EXPERIENCES AND NEEDS OF PEOPLE AFFECTED BY VICTORIAN PUBLIC DRUNKENNESS LAWS

SUMMARY REPORT

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INTRODUCTION

Laws making public drunkenness an offence have been repealed in most English-speaking countries and most states of Australia, although not in Queensland and Victoria. The Premier of Victoria has committed to decriminalising public drunkenness and to developing and implementing a public health response. A public consultation process is underway to inform the development of this response. Understanding the experiences, needs and suggestions of the people that are likely to be directly affected by a public health response will be important in ensuring that the response is appropriate. This is particularly important as the relatively limited research on public health responses to public drunkenness does not provide strong guidance on the appropriateness of various models of service delivery. Recognising this, the Department of Health and Human Services commissioned Turning Point and Monash University to undertake a rapid research project with people affected by Victorian public drunkenness laws.

AIM

The aim of this project was to explore the experiences and needs of people affected by Victorian State public drunkenness laws in order to inform the development of a public health response to public drunkenness. In particular, this project addressed the following research questions:

1. What are peoples' experiences of being intoxicated in a public place?
2. How have people been impacted by public drunkenness laws?
3. What has helped people to be safe when intoxicated in a public place?
4. What ideas for the public health response do people have?

This summary report provides an overview of key findings and recommendations for consideration in developing a public health response to public drunkenness.

METHODS

This project was approved by the Monash University Human Research and Ethics Committee (Project ID: 22750) and used a qualitative approach to address the research questions and make recommendations for the public health response. This involved recruiting 11 people to participate in telephone interviews or a focus group in January 2020. To be eligible to participate in the study, participants needed to have at least one of the following experiences in their lifetime:

1. Affected by Victoria's public drunkenness laws (e.g., had contact with police and the justice system, placed in custody, fined) (n = 11, 100%)
2. Had contact with paramedics as a result of being drunk in a public place (n = 9, 82%)
3. Accessed an emergency department due to acute alcohol intoxication (n = 8, 73%)
4. Utilised a sobering up service, or rest and recovery area associated with a public event (n = 5, 45%)
5. Assisted/witnessed a family member or friend who was affected by public drinking laws (n = 7, 64%)

The sample included five women and six men, two people who identified as lesbian, gay, bisexual, transgender, gender diverse, intersex, queer and/or questioning (LGBTIQ), and one person who

identified as Aboriginal and Torres Strait Islander. The majority of the sample had not been to university and there were almost equal numbers of people who were employed (n=6) and unemployed (n=5). It should be noted that Aboriginal and Torres Strait Islander people were being engaged through a separate consultation mechanism outside the scope of the current project. Interview and focus group transcripts were analysed using thematic analysis, in which common themes as well as sub-themes were identified.

RESULTS

Four interconnected areas were explored: 1) Experiences of public drunkenness, 2) Experiences of responses to public drunkenness, 3) Health and safety needs of people who are drunk in public places, and 4) Suggestions for a public health response. Several sub-themes were identified in relation to each of these main areas (see Table 1).

Table 1: Overview of themes

1. Experiences of public drunkenness	**2. Experiences of responses to public drunkenness**	**3. Health and safety needs of people who are drunk in public places**	**4. Suggestions for a public health response**
1.1 Contexts of public drunkenness	2.1 Law enforcement	3.1 Immediate safety	4.1 Ideal immediate responders
1.2 Desirable aspects of being drunk in public	2.2 Health	3.2 Transport	4.2 Ideal immediate responses
1.3 Undesirable aspects of being drunk in public	2.3 Informal responses	3.3 Further support	4.3 Ideal longer-term responses
			4.4 Ideal community-wide responses

1. Experiences of public drunkenness

1.1 Contexts of public drunkenness

Participants discussed diverse experiences related to public drunkenness, which were shaped by the different contexts in which their experiences occurred. Most participants reported experiencing significant challenges in their lives, including poverty, homelessness, mental health issues, disabilities, violence, and trauma. For people who had experienced considerable adversity and marginalisation, public drinking and drunkenness occurred in places such as parks, train stations, gardens, around public housing, or on the street. Unable to afford going to a licensed venue and with little to do in the outer suburban areas in which they lived, many participants preferred to drink in more lively and atmospheric urban places, which they sometimes discussed in terms of escape from difficult life circumstances. Participants who were less marginalised tended to drink in private spaces, in licensed venues after work or on the weekend, or at sporting events, and their public drunkenness often materialised when they had left or been ejected from these places or events. Participants reported a wide range of activities undertaken immediately before or while they were drunk in public. These included socialising with others, working, watching sport, listening to a band, or dancing at a venue. Some were engaged in solitary activities, seemingly without harm to others or

themselves. These activities included drinking at a train station, resting in a park, or walking home from a venue.

1.2 Desirable aspects of being drunk in public

Although public drunkenness is typically framed as an inherently antisocial or risky activity, participants also reported desirable aspects of being drunk in public. Some participants, particularly those who were socially isolated or marginalised, described public drunkenness as facilitating social connection, and also as a tool to cope with, or obtain temporary reprieve from, challenging life circumstances. For others, drunkenness was viewed as a pleasurable and fun experience that tended to spill out into public places due to the location of the venues they drank at. Although safety while drunk in public was a concern for many participants, some participants described ways in which public drunkenness afforded greater safety than drunkenness in private spaces. These participants highlighted the value of formal and informal monitoring and care practices that occur in public places for safety and wellbeing.

1.3 Undesirable aspects of being drunk in public

Participants also described some of the undesirable aspects of being drunk in public. They recalled embarrassing experiences while drunk in public, such as members of the public seeing them vomiting. They also discussed the potential for these experiences of embarrassment to cause harm in future, due to the ubiquity of photo and video recordings on mobile phones. Participants also expressed concerns about accidental injuries, and being more vulnerable to verbal, sexual or physical violence while drunk in public. Many participants who had experienced law enforcement responses to public drunkenness described their encounters with police or security officers as an undesirable aspect of public drunkenness. Other participants viewed public drunkenness as being entangled with ongoing alcohol concerns and considered the potentially longer-term effects of drinking and public drunkenness as undesirable.

2. Experiences of responses to public drunkenness

2.1 Law enforcement

Participants reflected on the diverse responses to public drunkenness that they had experienced. Many participants had experienced law enforcement responses from police, such as being issued with a warning or fine, and/or being taken into custody. These responses were typically experienced as difficult, degrading, and giving rise to a number of harmful impacts. Participants sometimes reported law enforcement responses being applied in an aggressive or threatening manner with little or no communication about the response (such as how long people would remain in custody). Participants that were remanded in custody reported various negative experiences and impacts, such as feeling unsafe when locked in a cell, experiencing unwanted withdrawal symptoms, and feeling traumatised. Other participants who reported receiving fines for public drunkenness were unable or unwilling to pay these and suggested that fines did not necessarily deter them from continuing to engage in public drunkenness. One participant reported that his experience of a law enforcement approach deterred him from engaging in public drunkenness. However, as a result of not drinking with others in public, he also reported becoming increasingly confined to his home and socially isolated.

A small number of participants reported police as engaging with them in a way that participants felt was more empathetic. Examples of such responses included police transporting people home or allowing a participant who drank heavily every day to return home and drink an unopened bottle of alcohol to avoid feeling sick due to withdrawal.

2.2 Health

Some participants had experienced health responses when they were drunk in public, including being transported to hospital by an ambulance, and receiving subsequent care in the emergency department or from an alcohol and other drug service. Some participants described health responses as being positive. Positive experiences were characterised by health providers being non-judgemental or empathetic, communicating what was happening, and being technically skilled at identifying and addressing issues (relating to alcohol, mental health issues and/or other psychosocial concerns). However, some participants also recalled experiences of health responses that weren't so positive. These tended to involve health providers not communicating what was happening, people not being consulted adequately about the treatment provided, and health providers expressing judgemental attitudes about people who engage in public drunkenness, leaving people feeling humiliated and ashamed. In addition, two participants described situations where there was inadequate discharge care and consideration of transport home.

2.3 Informal responses

While members of the general public and other people they encountered sometimes expressed judgemental attitudes and remarks when participants were drunk in public, participants also drew attention to caring informal responses provided by the general public and others who do not professionally provide care. These included members of the public or venue staff checking in on participants when they were drunk in public to see how they were going and whether they needed any help. Rather than calling the police, such encounters often involved talking, directing people to transport home, or calling an ambulance.

3. Health and safety needs of people who are drunk in public places

3.1 Immediate safety

Participants identified several health and safety needs of people who are drunk in public and highlighted how these might differ by gender. Most participants thought ensuring the immediate safety of the person who is drunk in public was very important. Safety needs included protection from accidental injury (e.g., falling, walking into traffic), addressing potential physical health effects of acute intoxication (e.g., unconsciousness, seizures), and protection from verbal, physical and sexual violence. Women relayed safety concerns, including the possibility of encountering threatening men while drunk in public, and some recalled experiences of violence perpetrated by men while drunk in public. Similarly, men tended to discuss the threat of physical altercations with other men, with four of the six men reporting being involved in physical altercations, while none were reported by women.

3.2 Transport

Most participants identified transport and the ability to get home after engaging in public drunkenness or away from unsafe situations as important. However, several participants recalled challenges in accessing public or private transport late at night and/or when they were acutely intoxicated. As a result, participants described the often-difficult process of attempting to transport themselves home. This sometimes entailed falling asleep during a long wait for public transport home, or mistakenly hailing a police vehicle instead of a taxi (as one participant recalled). Another difficulty expressed by participants was a concern about the safety of current transport options for women in light of reports of women being assaulted in rideshare services and taxis.

3.3 Further support

As well as immediate health and safety needs related to public drunkenness situations, participants also mentioned longer term needs. Some participants viewed public drunkenness as an indication that a person might need further support for alcohol concerns, mental health issues and/or other psychosocial concerns. Given that some people who are drunk in public may be experiencing significant challenges in their life and may already be marginalised, compassion was also flagged as an important need and value to guide responses to public drunkenness.

4. Suggestions for a public health response

Participants discussed several suggestions for a public health response to public drunkenness. In many cases participants' suggestions about ideal responses contrasted with the responses they had experienced. Most participants also noted that an ideal response would depend on the situation, given the broad range of contexts and situations in which public drunkenness occurs.

4.1 Ideal immediate responders

Participants suggested that several types of people could be acceptable and appropriate first responders in cases of public drunkenness. While acknowledging the resource pressures faced by ambulance services generally, paramedics were suggested by many participants as one of the most appropriate first responders, especially in cases where there were potential health or injury concerns related to public drunkenness. Unlike police and security officers who some participants had experiences of being harmed by, participants viewed paramedics as trusted helpers. Participants also listed other reasons that police were not appropriate first responders, including that police may be confrontational, police were not equipped to deal with the complex needs that people who drink in public may have, and participants had a lack of trust in police. Some participants suggested that police could play a role in responding to public drunkenness when there was risk of violence from/toward a person who was drunk, although they felt the role of police should not be to fine or incarcerate people. In line with this, some participants thought police or security officers would be acceptable first responders if they provided a compassionate and caring response rather than a punitive one. Many participants suggested peer or lived experience workers as being highly appropriate first responders in certain situations and especially when no medical or violence issues were present. Lived experience workers were favoured for their experience and understanding of public drunkenness and the life circumstances of some people who are engaged in public drunkenness, and because they were less confronting than police.

As the diversity of views about who could be a first responder illustrates, participants felt that an ideal first responder is less about whom the responder is or what position they hold, and more about how they engage with people and respond. Almost all participants desired a caring, non-judgemental and calm approach in any response provided. Participants noted that empathy and compassion was often lacking in their experiences of public drunkenness (which often included punitive or aggressive responses), emphasising the importance of feeling valued, respected, and cared for at a time of vulnerability.

4.2 Ideal immediate responses

Participants described a variety of desirable immediate responses to an individual who was drunk in public, including transport, mobile outreach services, and safe places to rest and sober up. However, most participants were adamant that there is no 'one size fits all' approach to public drunkenness. Instead, participants felt that responses should be tailored based on the context, situation and needs of the person experiencing public drunkenness. Notably, no participants believed that criminal charges were an appropriate response to public drunkenness, and all endorsed the decriminalisation of public drunkenness. Having safe and available transport options was considered important, although participants suggested that any transport services offered as part of a public health response would need to ensure that people who may be marginalised or experiencing homelessness have a safe destination to be transported to.

Participants suggested that mobile outreach services could be used to ensure the safety of marginalised people in particular, such as people who are homeless or who have multiple psychosocial concerns, who are intoxicated in public. They thought that the role of mobile outreach services would ideally include identifying and responding to people who may be in need of assistance, as well as providing a presence on the streets to ensure safety. Participants expressed a desire for mobile outreach services to be staffed by people with expertise in providing outreach or other services to people with concerns about their alcohol use and/or by people with lived experience of alcohol concerns.

All participants agreed that establishing more safe places where people could rest and sober up would be valuable. These included rest zones or sobering up centres although for the most part these terms were discussed interchangeably. Participants thought rest zones or sobering up centres would fill a much-needed gap in current options for responding to public drunkenness, while reducing burdens on ambulance and hospital services (if they were not necessary). The main desirable function of safe places was to provide physical and emotional safety while people sobered up. However, participants also suggested that safe places could also offer further support or intervention to address any possible alcohol or other concerns that a person might have. Accordingly, participants thought safe places would need appropriate staffing to meet a range of needs. Required staff skills included being able to respond to aggression, respond to medical or health complications associated with acute intoxication or withdrawal, and provide support in addressing alcohol, mental health and/or other possible psychosocial concerns.

Many participants thought the design of rest zones and sobering up centres would be important to encourage access and ensure comfort and safety. In particular, participants identified a need for safe places to be comforting and calm spaces, in order to achieve the functions of feeling like a place of safety, preventing aggression, and being a place in which any alcohol or other concerns could be

identified and addressed. Participants also thought that provision would need to be made for separate spaces for men and women to ensure safety for women in particular, and also private spaces to allow partners to rest/sober-up together. One participant also mentioned the need to make provision for pets in rest areas and sobering up centres. Another participant also talked about the potential for rest zones inside licensed venues to allow people to take a break from drinking or party environments, without spilling out into public space, or being removed from friends.

4.3 Ideal longer-term responses

All participants agreed that there is a need for longer term responses to be available for people who are drunk in public. While participants acknowledged that not everyone would need or take up the offer of longer-term responses, participants felt that having longer-term responses available for people who drink in public and who have concerns about their own alcohol use and/or other psychosocial issues could be useful. While many participants focussed on longer term responses related to alcohol use, others also thought that these could and should focus on psychosocial and welfare concerns (e.g., related to housing for people who may be homeless) and broader health and wellbeing.

Some participants saw immediate responses, such as mobile outreach teams and safe places, as opportunities to initiate trajectories of change (in relation to alcohol or other psychosocial concerns) and/or help seeking. Once immediate health and safety needs were met, participants felt that if trained to do so, first responders could assess peoples' needs and provide information about services and perhaps even provide referrals. Some people thought that service provider first responders could provide a follow-up phone call after the immediate response to see check in and encourage people to access help/support if they wished to do so during (what some participants viewed as) a 'window of opportunity to change'.

4.4 Ideal community-wide responses

Participants also highlighted the need for community-wide responses to underpin, complement and enhance the individual responses they suggested. Such responses included education, stigma-reduction and responsible venue practices. Participants indicated that people who respond to public drunkenness (and alcohol concerns more broadly) need appropriate training and education, to ensure that they were able to adequately respond in the caring and empathetic way that participants desired. Suggestions included education related to developing knowledge about alcohol 'problems' and the life circumstances that people who are drunk in public may experience, skills to manage acute intoxication (e.g., through first aid), and skills to communicate with people in an empathetic and non-confrontational way.

Participants emphasised the importance of reducing stigma and changing attitudes about public drunkenness and people who are drunk in public. This was considered to be something that needs to occur across the community, as any member of the public could act as a first responder. Participants also thought stigma reduction activities would be important across professions, but due to their experiences with particular first responders, particularly singled out police, security officers, and hospital staff. Participants also thought that more needed to be done to promote responsible venue practices, such as ensuring that people who are highly intoxicated are provided with water, access to first-aid trained staff, an area to rest, and transport home.

CONCLUSION AND RECOMMENDATIONS

The findings of this project reiterate that people who engage in public drunkenness are supportive of decriminalising public drunkenness. In light of typically negative experiences of law enforcement responses in the past, participants thought public health responses, such as transport, mobile outreach services, safe spaces and further support would be valuable. Given the diversity of people who engage in public drunkenness, their diverse life circumstances, and different contexts in which public drunkenness occurs, offering a range of responses and tailoring responses to the needs of individuals' is likely to be important. Participants desired any and every response (irrespective of who provides it) to be applied in a caring and compassionate way. Particular effort and care needs to be taken to ensure that responses are gender-sensitive and appropriate to the needs of marginalised people. While developing immediate and further responses to individuals are needed, community-wide responses, such as education and stigma reduction activities, are also likely to be important as any member of the community could be a first responder.

Recommendations

Based on the findings of this project, further specific recommendations for consideration in developing the public health response include:

1. **Safe transport**
    a. Increase the availability of safe transport options.
    b. Create and implement plans for where to transport people who are homeless or don't have a safe place to be transported.
    c. Investigate methods to increase the safety of transport options for women.
    d. In cases where a patron is ejected from a venue, establish measures to ensure their safe passage home or to a safe place.
2. **Mobile outreach services**
    a. Develop mobile outreach services designed to proactively identify, respond and ensure the safety of people who are intoxicated in public, particularly marginalised people.
    b. Mobile outreach services require staff with alcohol and other drug outreach experience. Lived experience of public drunkenness or alcohol concerns could be valuable.
3. **Safe places**
    a. Establish safe places, such as rest zones and sobering up centres, where people could rest, sober up and be offered further support.
    b. Safe places require appropriate staffing to meet a range of needs. Staff skills required include being able to respond to aggression, respond to medical or health complications associated with acute intoxication or withdrawal, and provide support in addressing alcohol, mental health and/or other possible psychosocial concerns.
    c. Design safe places to afford possibilities for comfort and calm.
    d. Provide separate areas for men and women, and consider the needs of non-binary or transgender people, to ensure their safety and comfort.
    e. Provide private spaces to allow partners or friends to rest/sober-up together.
    f. Provide rest zones inside venues to allow people to take a break without spilling out into a public space, or being separated from friends.

4. **Longer-term responses**
    a. Offer people who have concerns about their alcohol use information about available services to facilitate longer-term support for those that desire it.
    b. Design resources to be distributed by police, paramedics and hospital staff, to people who may need or desire longer-term support (e.g., DirectLine number, information about seeking help).
    c. Offer people who have concerns about their alcohol use the opportunity for a follow-up phone call to check-in to see how they are going.
    d. Offer transfers directly from hospitals to detox services, in cases where individuals have presented for public drunkenness and are experiencing withdrawal symptoms.
    e. Promote or establish a dedicated telephone helpline (similar to the '1800 ICE ADVICE' helpline run by DirectLine) accessible to members of the public who desire support or advice about their own or someone else's public drunkenness.
5. **Community-wide responses**
    a. Implement targeted education and stigma reduction activities among professional and staff groups who are likely to be first responders (e.g., police, paramedics, hospital staff, security staff) to ensure responses are caring, compassionate and non-stigmatising. Ideally, this would include training to recognise and respond to people who may require longer-term support.
    b. Given that anyone could act as a first responder, broader community-wide education and stigma reduction activities should ideally be a part of the public health response.
    c. Address social determinants of health, which is likely to be important for marginalised people who engage in public drunkenness.

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