Royal Commission into Family Violence

WITNESS STATEMENT OF DR STEFAN GRUENERT

I, Stefan Gruenert, Odyssey House Victoria Chief Executive Officer, of 660 Bridge Road, Richmond in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

2. I am the Chief Executive Officer of Odyssey House, Victoria and I have been performing my current role for the past eight years.

3. I am a Board Director of the Victorian Alcohol and Drug Association, and of the Alcohol and other Drugs Council of Australia.

4. I am also a member of the Australian Psychological Society's Substance Use Interest Group and the Victorian Legal Aid Community Consultative Committee and I was a member of the previous Victorian Government's Sector Reform Council.

Background and qualifications

5. I am a registered psychologist with more than 13 years' experience in the drug and alcohol sector as a clinician, supervisor, researcher, and senior manager.

6. My entry into the sector occurred about 15 years ago when I undertook a student placement at Odyssey House. I had previously done some one-on-one student counselling placements and generic counselling, but I was interested in trying something quite different. Therapeutic Community work was recommended to me as an alternative specialty, which is how the placement at Odyssey came about. During my time on placement, I found that everything (from one-on-one interaction with clients, to group work, to recreational activities with those in its residential program) presented an opportunity to be therapeutic; behaviours that emerged at

any point could be discussed and explored immediately. I found that fascinating and highly appealing.

7. After my placement, I continued at Odyssey House working as a counsellor in its residential program before my focus moved towards working with parents with addictions and their children. The majority of my work with families was undertaken in the community (as opposed to a residential context).

8. I have conducted research on alcohol use, treatment effectiveness, intimacy, family work and fathers. The focus of my doctorate was on men and intimacy and there were a number of threads in there about men's relationships with their fathers and how they informed the ways in which men related in other intimate relationships.

9. I established a number of specific programs to support families, and also became particularly interested in how we could better support fathers. Odyssey House accommodates both men and women in our residential program, which is rare within the sector. We regularly see single men attending the program with their child(ren), either because the mother has died of an overdose or is in prison or has entered a new relationship, etc.

10. At the time we started to work more closely with families and fathers, we discovered that generalist family services providers were struggling to assist parents with addictions, and the associated mental health and family violence issues, and we developed significant expertise in this area.

11. For the past ten or so years Odyssey House has been providing in-home parenting support to communities, including working with children when their parents have addictions. We now work with approximately 5,000 clients in the community each year, including youth, adults and families, and we accommodate more than 500 annually in our residential treatment programs.

12. I was involved in one of the reviews into child deaths, working with some staff from Berry Street and representatives from La Trobe University, examining cases where a child had died in circumstances in which drug and alcohol, mental health and violence were all present factors. We found that an obvious lack of connection between the service providers in those respective sectors was an issue in many cases.

13. I have been actively involved in promoting change to better address the needs of children affected by problematic parental substance use, and to better support

parents, and I continue to be very passionate about this area. I raised this issue and had a motion unanimously adopted at a United Nations meeting in Vienna in 2008, in which NGO organisations from around the world developed drug policy positions. Prior to this, families had not been mentioned in these policy documents. I want to continue challenging the drug treatment sector to better address family needs and do more to link in with other sectors.

Development of two key resources

14. Approximately eight years ago, in partnership with the Parenting Research Centre, I developed a 'parent support toolkit' for drug and alcohol workers to assist them in working with families.

15. For some time, I have recognised the need for the drug treatment sector to connect with the family violence sector in order to better support clients who have co-occurring issues. As a result, I have recently been involved in the development of two critical resources, which are aimed at assisting alcohol and other drug clinicians to address family violence. Attached to this paper and marked "**SG 1**" and "**SG 2**" respectively, are copies of:

    (a) *Can I Ask…? An alcohol and other drug clinician's guide to addressing family and domestic violence*; and

    (b) *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia.*

    These resources were prepared in conjunction with the National Centre for Education and Training on Addiction and were supported by funding from the Commonwealth government.

16. We wanted to create a practical resource to assist those working in the drug treatment sector and, to achieve that, it was also essential to conduct a review of the current literature that provided the background to the strategies that we were proposing.

17. The literature review (SG 2) reaffirmed the association between alcohol and family violence. Namely, that when violence is occurring (generally on an ongoing basis), the violence is more likely to be more frequent (and be more severe and result in greater injuries) when alcohol is involved. This association is widely acknowledged now, but what remains challenging is that:

    (a) the literature is not entirely robust;

(b) the literature is limited in relation to other drugs; and

(c) the way in which the association plays out is complex and multifaceted.

18. I will expand on the bi-directional nature of the association later in this statement.

Advisory group

19. We established a project advisory group, members of which contributed to the creation of these resources.

20. Working with representatives from the family violence sector on this project brought about some interesting discussions in relation to various concerns, and the assumptions that each sector made about the other were extremely informative.

21. The conversations that we had regarding the terminology used by the respective sectors were fascinating and brought into focus the degree to which sectors had been taking divergent approaches. For example, in the drug and alcohol and mental health sectors it is important to label behaviour rather than people. We do not say “addicts” or “schizophrenics”, we talk about “people experiencing addiction” or “experiencing mental health issues”.

22. Accordingly, when we work in the family violence space, we prefer to not use labels like “victim” or “perpetrator”, instead we refer to behaviours. For example, someone has “experienced family violence” or someone who “uses violence” in their relationships. In the drug treatment sector, we work with people who experience and use violence regularly and in that sense they would often be both a victim and a perpetrator.

23. Another challenge we faced in working together with the family violence sector on this project was the reaction to our proposal to screen participants in the drug treatment sector about the ways in which they use violence in their relationships. I saw this as an opportunity to be proactive in addressing the use of violence, particularly when 65 per cent of clients in our sector are men.

24. However, the view of those working in men’s behavioural change programs was that this work should only be conducted by those with specialist skills and that otherwise there was a risk of collusion with men using violence.

25. We have a unique access to men that many sectors do not. Men do not typically go to child and family services; they do not voluntarily engage in family violence

sectors, and they will often not follow up on referrals, so we have been wanting to use our unique opportunity in many ways.

26. Odyssey House has always strived to work with men, not only in relation to their addictions, but also as partners and as fathers. Many of our clients have children and again there is a great opportunity to talk to them about their fathering role, because they typically do not access other sectors to do that.

27. If we are not able to challenge them about their relationships and related issues, I consider this to be a wasted opportunity.

Focus groups

28. In relation to the development of the resources at SG 1 and SG 2, Odyssey House ran a number of focus groups with staff and with people who had experienced family violence. We met with men and women separately and had some mixed sessions as well.

29. Through this process, we discovered that men were open to talking about violence and how they use it and have experienced it. These were men who were engaged in our treatment program, so to some extent they had already seen the value of being open to having their behaviours challenged.

30. We found that women were equally open to sharing their experiences. Some expressed that, during intake and preliminary assessment, they were cautious about what they shared around their experience of violence. We noticed, however, that if we asked regularly and throughout the treatment program once trust had been established, their responses were likely to change and they would become more open, especially in groups with women only.

31. One of the challenges we face in the drug treatment sector is that, as part of recent reforms, we now have a prescribed/standardised intake & assessment questionnaire. This has core modules and several optional components, one of which is about family violence (in a limited way), with a focus on physical violence. My sense is that the family violence section is not frequently used because staff are struggling to complete the basic section with their available resources.

32. In addition, many of these initial discussions are had over the phone and that is not a particularly engaging environment. People expect you to talk about their drug use because that is what they are seeking help about, but to move into a line of questioning about the person's children, or safety, or violence, can be difficult

when there has not been the opportunity to develop some sort of trusting relationship. Further, the person conducting this initial assessment often ceases involvement at that stage and the person is then referred to someone else for treatment. I would still encourage the question(s) to be asked at intake, but it should be the first of several efforts to have these conversations along someone's treatment journey.

33. The input gathered at the focus groups was extremely valuable and was ultimately incorporated into the resources.

Not yet implemented

34. Once these resources were published, unfortunately we did not have sufficient resources to implement them into organisations. We only launched the documents in many of the States and Territories across the country, with the help of alcohol and drug peak bodies, that invited their member organisations and other stakeholders.

35. We have subsequently presented at some conferences to raise awareness, but we have not yet attracted resources or found a way to actually implement them in terms of training drug and alcohol workers and engaging people to put them into practice. So the idea of assessing for, and then addressing family violence, is very much in its infancy in the drug treatment sector, especially outside of residential or family treatment settings.

Bi-directional nature of association with problematic substance use

36. The association between substance use and family violence can be bi-directional. For example, to some extent, drugs and alcohol may be causing greater frequency of violence and more severe violence in relationships, where violence is already occurring. We also see that people who experience violence in their relationships, then use drugs and alcohol more frequently and heavily because of the violence, that is, to cope with the effects of violence (e.g. anxiety, fear, trauma). In this way, the presence of either violence or alcohol and other drug use, increases the risk and severity of the other.

37. Subsequently, in terms of the support services that those who are experiencing violence might seek to access, we understand that they may be refused access if they themselves are using drugs or alcohol heavily. We see people in those situations experiencing shame and guilt because they are viewed as addicts or alcoholics, and then miss out on support.

38. I estimate that 80 per cent of the adults and families that Odyssey House is servicing are experiencing and using violence even though alcohol or drug use is presented as the prime issue for them. This is because other services have difficulty in assisting people when they are intoxicated or affected by substances and alcohol and other drug treatment services are considered specialists in that regard. In terms of what I mean by "violence", there is a spectrum on which I would include anything from verbal abuse, emotional abuse, control around finances, stalking, abuse of power, sexual coercion to rape, and other physical abuse. These behaviours are not always viewed by our clients as constituting violence. In the families we see, violence can occur between partners or ex-partners, be directed towards children from parents, or be directed towards parents by children. In some families the violence is pervasive and intergenerational.

39. The drug treatment sector has an opportunity with men, women and young people to talk about relationships and help them to understand what violence is. A lot of young people that we see in our sector seem to be learning about relationships and sex from pornography. When there is an absence of any guidance from parents or adults about relationships, young people turn to the internet for answers and this can give them all sorts of concerning expectations and misconstructions about relationships.

40. The number one thing that leads to sustainable change from addiction is positive social relationships, which is why our main focus is on helping people to develop and sustain positive relationships. Greater awareness about the breadth of violence and the issues that sit behind violent behaviour will drive change and assist in better outcomes for clients in the drug treatment sector. In my view, we should be having conversations with all our clients about their experiences and use of violence, because this will lead to better outcomes.

Incorporating family violence component into drug and alcohol programs

41. The key objective in the drug treatment sector is to reduce the harm created by drug use. In the first instance, that might be providing safe injecting equipment for people who are not ready to give up their use of drugs. In these cases, we seek to ensure the drug use is as safe as possible, in terms of not allowing for the transmission of blood-borne viruses and safe injecting practices. There is a natural extension around harm reduction, in terms of making someone's environment as safe as possible too, and therefore to look at issues regarding family violence.

42. When you move to people who want to reduce or stop their drug use, the ultimate goal is sustainable recovery, so we start breaking that down to evaluate how we will get there. This includes an examination of what is happening in their world that is currently preventing them from ceasing drug use. Usually the number one issue is their “people problems” or relationships, and this is usually tied to self-esteem issues, their inability to regulate their emotions, and trauma. Violence is almost always present in some form, if you ask about it. If you do not ask, people will often ignore that component, work on everything else and then continue finding themselves in dysfunctional relationships and falling back into drug use.

43. In our residential programs, family violence is relevant to the work that we do in groups, as well as individual work where specific instances of violence have been identified, whether it be sexual assault or other trauma. Individual counselling for this sometimes happens offsite. We are very proactive in identifying all aspects of control and violence in relationships in our residential programs, and have zero tolerance for it in all forms, although of course our responses could be further developed. Moreover, there is real scope for this work to be incorporated into our community programs, although we understand that not all programs will have the skills and resources to address the use of violence at the present.

44. As a minimum, drug and alcohol workers could be:

(a) screening for the experience of violence;

(b) doing safety planning for families and children, as required;

(c) providing advice about what support is available; and

(d) linking clients with other services by providing referral options.

45. Ideally, the next step is to have more holistic services where clients can be assessed, and the necessary skills and capacity can be applied to deal with family violence issues within an alcohol and drug program, such that only certain cases need be referred to specialist family violence services. Regardless of the operating model, the situation calls for greater professional development of staff and much tighter ties between the different sectors.

Alcohol and drugs use is not an excuse for violence

46. I acknowledge that there are some genetic predispositions and a whole range of life experiences that may limit the choices available to an individual person, and that may in turn influence a person’s choices. However, I believe that there is

always some choice. A choice to use drugs or not, a choice to engage in any other behaviours such as using violence, or not.

47. A person who uses violence should not be blamed for the traumatic experiences they may have had, nor for their genetics or other drivers that may have contributed to their drug use or impulsiveness, regardless of their gender, but they need to be responsible for their choices and responses to their experiences. Many men in our services have experienced sexual abuse in their childhood, violent fathering, and a whole range of other abuse, and they are as much "survivors of violence" in a sense, as they are people who have gone on to use violence.

48. Whilst we do not blame them for things that have happened in their past, their recovery is absolutely and always about them taking responsibility for their responses to these experiences. If they want to achieve the goals they set for their recovery, then they have to take responsibility for not continuing to use drugs or alcohol. The same applies if they use violence.

49. We can create the appropriate environments and facilitate recovery through challenging our clients in the provision of our services, but at the end of the day it remains our clients' responsibility.

Child protection services

50. In my experience, child protection services in the past would often not deal with fathers and would encourage women to cut all ties and have nothing to do with problematic partners. In fact, this was sometimes a prerequisite for providing help.

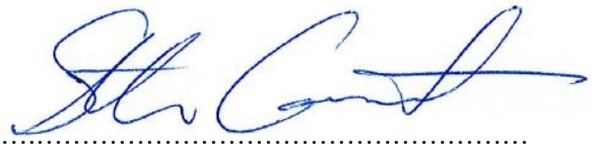
51. What I then observed is that some women excluded the father of their child(ren) to comply, and then found themselves lonely (not having the capacity or skills to form other positive relationships) and subsequently entered a new relationship that was as bad, if not worse, than the previous one, especially given the loss of the biological connection between the father and the child (and the associated protective factor). Essentially the situation was made worse because the system pushed the man out, rather than dealing with the dysfunction and working with both the woman and the man to create a safer environment. This seems to have improved more recently, but not consistently.

Reconciliation Action Plan

52. We have had a Reconciliation Action Plan in place for the last three years, which is essentially an organisational strategy to improve access to, and the relevance of, our services to the Aboriginal community.

53. We created the plan with Aboriginal community leaders and it addresses things from being proactive about recruitment, to providing physical spaces for cultural activities, and celebrating events. We have an Aboriginal advisory group, we have employed young Aboriginal people to 'skill up', and employed more experienced Aboriginal people to assist in the provision of our services.

54. We have seen very positive outcomes since implementing the Reconciliation Action Plan, with an increase of participation of Aboriginal people in our residential program in Lower Plenty from 2 per cent to 10 per cent, while in some other programs it is now around 20 per cent involvement.



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Stefan Gruenert

Dated: 8th July 2015