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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

FRIDAY, 17 JULY 2015

(5th day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

COMMISSIONER NEAVE: Before we commence, just one brief statement that I want to make, and Deputy Commissioner Faulkner has a statement that she also wants to read. As I said in my statement when the Commission was opened, the Inquiries Act permits the powers of the Royal Commission to be exercised by one or more Commissioners separately. Today two Commissioners are present at this hearing as Deputy Commissioner Nicholson cannot be present. I now ask Deputy Commissioner Faulkner to make a brief statement.

DEPUTY COMMISSIONER FAULKNER: I wanted to make a statement that I am the Chairman of the Board of Jesuit Social Services, which holds shares of a nominal value in the youth substance abuse service, who will be presenting evidence today. I'm also a committee member of the Melbourne Racing Club, which operates a number of licensed premises. I do not believe that these roles are in conflict with my role as Commissioner. Thank you.

COMMISSIONER NEAVE: Thank you, Ms Davidson.

MS DAVIDSON: The issue of alcohol and drugs arose throughout the community consultations as being a complex issue, both for the perpetration of violence and for victims of violence. For many women their experience of family violence was inseparable from alcohol or drugs. They spoke of their increasing dread as they watched their partner getting increasingly drunk, knowing how bad it was going to be.

Sometimes they were able to protect themselves in advance by getting their children to friends or family, but at other times they had no warning. Their partner arrived home with a tankful, having been out drinking with

friends, with sporting mates or work colleagues.

The Commission also heard from victims whose partners or children, including adult children, had developed a drug habit that resulted in them being violent. Of particular concern was the increasing number of parents and grandparents being abused by their ice-affected children.

The Commission has received many submissions calling for action to be taken to reduce alcohol related harm as part of the response to family violence. The Commission is also reviewing the extensive literature that explores the role of alcohol and drugs and other factors in the perpetration of family violence. We will hear today from a number of experts in this area about the statistics of alcohol and drug related family violence. Those figures really are quite overwhelming.

But alcohol and drug use or abuse was also an issue for many victims of family violence. Women spoke of turning to alcohol or drugs as a consequence of their abuse. Others spoke of the addiction often being a barrier to escaping family violence. When children are involved there are significant barriers for women accessing services. They can't leave their children with their violent father and while they go into a rehab facility, nor can they really seek the help of child protection authorities.

The Commission heard from many women who were first introduced to drugs by their partner, who effectively became their dealer. For these women they became reliant upon their partner for their drugs. Participants in the community consultations and the

written submissions have commented on gaps in the provision of alcohol and drug services and access to limited, short-term crisis services that don't offer the necessary follow-up supports.

We intend to call evidence and examine these issues today and potentially also later through the hearings. We will seek to identify the opportunities to reduce alcohol and drug related family violence, and to support victims of family violence.

The first witnesses we are going to be hearing from today are four experts in the area of alcohol and drugs and/or family violence. They are Professor Cathy Humphreys, Ingrid Wilson, Associate Professor Peter Miller and Michael Thorn. I would ask that they be sworn, and then we will have some questions.

COMMISSIONER NEAVE: Ms Humphreys has already been sworn.

MS DAVIDSON: She has.

<MICHAEL THOMAS THORN, affirmed and examined:

<CATHERINE HUMPHREYS, recalled:

<PETER GRAEME MILLER, affirmed and examined:

<INGRID MARY WILSON, affirmed and examined:

MS DAVIDSON: Perhaps I can start with you, Mr Thorn. You have previously made a statement in this matter?

MR THORN: Yes.

MS DAVIDSON: That statement attaches the submission that your organisation has made to the Commission?

MR THORN: Indeed it has.

MS DAVIDSON: Can you confirm that that statement is true and correct?

MR THORN: I can confirm that.

MS DAVIDSON: You are the Chief Executive of the Foundation for

Alcohol Research and Education?

MR THORN: I am.

MS DAVIDSON: Also known as FARE, more commonly known as FARE. You have been the Chief Executive since January 2011; is that right?

MR THORN: I have.

MS DAVIDSON: And FARE has recently compiled a large body of research and material in relation specifically to the issue of family violence and alcohol and drugs?

MR THORN: Alcohol's contribution to family violence, yes.

MS DAVIDSON: That's dealt with in your submission?

MR THORN: Yes, it is.

MS DAVIDSON: Can I turn to you, Associate Professor Miller. You are a Principal Research Fellow at Deakin University's School of Psychology?

ASSOCIATE PROFESSOR MILLER: I am.

MS DAVIDSON: In terms of your current research you are the lead investigator on a number of large projects examining alcohol related violence in the night-time economy?

ASSOCIATE PROFESSOR MILLER: Yes.

MS DAVIDSON: But you are also involved in a research project entitled "Alcohol/Drug-Involved Family Violence in Australia"?

ASSOCIATE PROFESSOR MILLER: Yes.

MS DAVIDSON: That study commenced in early 2014 and runs until the end of 2015?

ASSOCIATE PROFESSOR MILLER: Yes, it does.

MS DAVIDSON: You have previously made a statement in this proceeding?

ASSOCIATE PROFESSOR MILLER: I have.

MS DAVIDSON: Are you able to confirm that it's true and

correct to the best of your knowledge and belief?
ASSOCIATE PROFESSOR MILLER: Yes.
MS DAVIDSON: Turning to you, Ms Wilson, you are a PhD candidate at the Judith Lumley Centre, La Trobe University?
MS WILSON: Yes, I am.
MS DAVIDSON: Your research explores opportunities to reduce alcohol related intimate partner violence, drawing in particular on the experience of women survivors?
MS WILSON: That's correct.
MS DAVIDSON: You have previously made a statement for the Commission?
MS WILSON: Yes, I have.
MS DAVIDSON: Are you able to confirm that that's true and correct to the best of your knowledge and belief?
MS WILSON: Yes, it is.
MS DAVIDSON: Professor Humphreys, you have previously given evidence to this Commission, so I won't traverse your experience and qualifications again, but have you previously made a statement to the Commission?
PROFESSOR HUMPHREYS: I have.
MS DAVIDSON: It's a supplementary witness statement addressing specifically the issue of alcohol and drugs in relation to family violence?
PROFESSOR HUMPHREYS: That's correct.
MS DAVIDSON: Are you able to confirm that that's true and correct to the best of your knowledge and belief?
PROFESSOR HUMPHREYS: Yes, it is.
MS DAVIDSON: The first question I would like to put to the panel is an issue that I think particularly Associate Professor Miller has identified in his witness statement

about the interrelationship between family violence and/or all violence and the interrelationships generally between different types of violence. Could you, starting with you, Associate Professor, expand on that and explain to the Commission what you are concerned about?

ASSOCIATE PROFESSOR MILLER: Certainly. In the course of our research we have conducted a number of systematic reviews and pieces of research, and what we have found is that people who grow up in households that have violence, whether that be child abuse or domestic violence, engage in or experience more - are more likely to experience violence in their adulthood. Really this comes back to the idea of risk and protective factors.

The formula goes along the lines that, the more you experience adverse life events that you experience as you are growing up, the more likely you are to experience harm. Sometimes you can find other protective factors which may alleviate that harm, and particularly this applies in relation to perpetration and victimisation of violence, both on the streets and in the house.

For example, one of our studies looking at the perpetrators of violence in nightclubs found that if your father hit you as a young boy you were up to 1.8 times more likely to be a perpetrator of that act. So that notion that the violence in the home predicts violence not just in terms of domestic and family violence into the future but also right across the gamut. That has implications for right across society.

MS DAVIDSON: Would anyone else like to comment on that issue?

PROFESSOR HUMPHREYS: I guess I would just like to add a caveat to it, that it's very easy for issues like this to be read

that because you grow up in a family where there's violence you will become violent, and it is commonly known as the cycle of abuse; whereas in fact we also know that there is a very large group of young people who grow up in households where there is violence who don't go on to perpetrate violence or to become victims of violence. I guess environment isn't destiny in that sense.

I know that Associate Professor Miller is not saying that, but I just sort of think that needs to be on the record really clearly because when people - children who have been victimised or are being victimised hear these issues, then there's a great deal of fear that "I'll grow up to be like dad". We know that that isn't necessarily the case. There are vulnerabilities, but it is not predictive.

ASSOCIATE PROFESSOR MILLER: Sorry, can I just pick up because I think that is an incredibly important point when we think about interventions going forward because, as I mentioned, protective factors can be such a vital preventative element. So identifying things earlier, finding role models, finding different ways in which we can intervene and intervening in that space will lead to better outcomes for young people going forward.

MS WILSON: Just a comment to add to that. I suppose within the research field we do tend to focus on the kind of negative behaviours and how to address them. We also need to kind of learn from those who have actually kind of moved on from these adverse conditions in their early environments, to actually study them to see what actually made those people not go on to either perpetrate or become victims. So I think from a research perspective that's a

really - some opportunities that perhaps we could look to in the future.

MS DAVIDSON: I think that we heard earlier on in the hearings from some other experts identifying that there was a need potentially to do more research in understanding the factors that give rise to resilience. Is that a view that you also hold?

MS WILSON: Absolutely. I just would add, my research has been involved in interviewing women who have experienced alcohol related intimate partner violence, and those women, they have all left the relationships but going on to their new relationships a couple of the women have actually been able to negotiate with new partners around their partner's drinking and actually be in a different position so that, where potentially their new partner's behaviour could have gone down the same path as the previous partner, they have been able to negotiate that. So that's something I suppose I'm interested in for future research, to be able to learn about what made that a different situation for that woman.

MS DAVIDSON: Moving on, then, to the relationship between alcohol and drugs and family violence, my reading of your witness statements is that you are all in agreement that the research is clear about alcohol and drugs increasing both the frequency and severity of harm. Can I get each of you to comment on that research and what it really is telling us, addressing both the issue of physical harm and also psychological harm. Perhaps start with you, Associate Professor Miller.

ASSOCIATE PROFESSOR MILLER: We have found in our research, which is still - the results are still coming out, we are

still very much in the analysis phase, but we have good evidence to show that alcohol and other drugs increase the likelihood of experiencing violence.

One of the key findings we also had was that it matters on whether you are a perpetrator or a victim. So alcohol has a greater impact on whether somebody is likely to be a perpetrator in the domestic sense, but in other violence sense it actually impacts more on their likelihood to be a victim.

One of the key issues is around the difference between psychological and physical violence as well. So what we found was that in fact these impacts are equal in both, so that alcohol plays a role in both physical and psychological violence, and that they are equally important when you look at the harms later in life to people. The differentiation between physical and psychological violence are not terribly great. There's no significant difference in terms of the harm that people are experiencing later in life from those types of violence. So it's very important that we don't neglect psychological violence for just physical violence.

MS DAVIDSON: Ms Wilson, do you have any additional comments to make to that? I think that you identified a particular risk on men's drinking days in your witness statement and also the impact on dating violence.

MS WILSON: Just in relation to that research, there has been research showing in terms of looking at the timing of drinking, so - sorry, the name has escaped me. But that research, they did this diary method where they got men to record their actual drinking, and they correlated that with levels of violence and found that the increased risk

of perpetration of violence increased when men had been drinking on the day of - in terms of closer to the time of perpetration. The odds increased significantly. Sorry, it was Murphy. Certainly that's very much showing in terms of the connection to high levels of intoxication and risk of perpetration.

MS DAVIDSON: You also identified the issue of alcohol and drugs in relation to dating violence?

MS WILSON: Yes. I suppose my predominant focus has been on adult relationships. But when you start to look at the literature alcohol is very - it's a consistent risk factor in youth and adolescent dating relationships, as well as particularly in kind of college populations, young adults. So certainly it is a common risk factor when it comes to any type of intimate relationship, whether it happens to be a kind of co-habiting one or a dating relationship.

ASSOCIATE PROFESSOR MILLER: Can I add to that to say we have research currently underway which demonstrates things like five per cent of women report being raped after being in a bar, three per cent report having experienced - engaged in a sexual act under physical coercion inside a bar. So these numbers are really high when we think about the numbers of young women, and the average age was 23. So these are young women who still have the rest of their life in front of them, and we are seeing numbers that high. So it is deeply worrying.

PROFESSOR HUMPHREYS: I guess just commenting on the issues around the relationship between drug and alcohol and family violence, it is very clear that there's a significant group of women where the drug and alcohol issues are not an issue, that they are being - they are

experiencing family violence where there is no drug and alcohol, or when you interview women a lot of women say, "Look, I have been experiencing domestic violence when he's drunk and when he's not drunk."

I guess when you look at the gamut of behaviours too, there's a lot that's very calculated. Yesterday you heard about financial abuse. That doesn't happen under immediate issues around drug and alcohol use. Clearly that's a calculation that happens over a period of time and is part of family or domestic violence.

But on the other hand what we do know is that where you do have drug and alcohol issues and violence supportive attitudes, then you do get an increase in severity and in the amount of physical violence that's occurring and the psychological harm that occurs. So I think it's a really - it's a complex issue but it's one where I don't know that we have necessarily addressed the complexities of that issue well within the family violence field.

MS WILSON: If I could just add to that with the things that women I have interviewed have told me, and certainly I explore with them about behaviours, "Does he do the same behaviours when he is not drunk versus when he is?" Some women will say, "He does, but it's not as severe. I don't feel as afraid. When we are having arguments, if he is drunk I have to shut down." You can't engage with someone who has been drinking, whereas when they are having conflict when he's not drinking at least the woman has a voice and is able to at least have some kind of negotiation capacity there. So it just seems to me that from my understanding that alcohol certainly - it makes

things worse and women certainly feel more unsafe.

Just on another point, the things also women tell me where their partners are quite alcohol dependent, there are some other aspects of disempowerment, coercion, either coercion to "you have to go and get me alcohol", and if he has lost his licence she is the one who has to drive him to do that.

There is also this notion of where he is spending their household expenditure on prioritising his alcohol needs, so then women are having to manage somehow, and particularly also if he can't work they are having to take on that additional burden. So there are some other aspects where for serious alcohol problems women are actually carrying a lot of burden that would be classed as family violence within the whole spectrum. So it's just something that is worth thinking about beyond the actual kind of alcohol and violence connection.

ASSOCIATE PROFESSOR MILLER: I think here it's really important to start to introduce the data that we talked about in my submission where when we are talking about the relationship between alcohol and violence we are talking about many different types of violence and many different types of relationships, and I think our data really clearly shows that there is a range of different relationships sitting behind a violent act. Things like mutual control and mutual violence represented about 10 per cent of the sample of people we had who were experiencing violence, and we would expect strongly that alcohol and drugs play different roles in different types of these violence.

So we are not just talking about intimate partner

terrorism here, but also when we talk about family violence, violence against men, violence against children, we expect and we see the data that alcohol plays a different role, as do drugs, in different types of violence.

MS DAVIDSON: Mr Thorn, have you got anything to add to that?

MR THORN: As the non-researcher on the panel today, but I think perhaps my job has been to translate this excellent work of the researchers and many others in Australia, the perspective that I come at this problem is really from a population wide perspective and looking at it through the lens of prevention.

It is plain to see from the research evidence that alcohol contributes significantly to the violence, depending on which set of numbers you are looking at, whether you are looking at - sorry, I look at family violence as both child maltreatment, physical violence, psychological violence to women - it's the whole kind of gamut, just so that we know what the terms are.

The issue from what I see is that for a proportion of the overall problem that we are dealing with alcohol is a significant contributor. It's not going to solve all the problems if you do what my foundation suggests we do, but it will make a very big difference and in my view can have an almost immediate impact on the behaviours of people.

The alcohol issue or alcohol and drugs contribution to this is not just about the perpetrators of violence. It's alcohol per se. It's both the victim's and the perpetrator's use of alcohol that can contribute to the outcomes that we have, leading to violent

incidents, to the police being called, kids winding up in the welfare system and those sorts of things.

I think it's important that we do sort of step back from the very specific. If we accept the sorts of arguments that Professor Miller has documented in his witness statement that there is clear evidence of alcohol's contribution, then it's a matter I think of then trying to work out what can we read from that from a population wide perspective, because I think we run the risk otherwise of going straight to a kind of individualised response, and I don't think that actually allows us to look at the kind of alcogenic environment in which our society operates today.

I think it's the important point about what the foundation has been trying to say in its submissions here and elsewhere, and it dates really from the work that the research centre, the Centre for Alcohol Policy Research, initiated in 2006 when they commenced a world-first study looking at alcohol's harms to others, not just in the family violence space but the impact on industry, the impact on a whole raft of different aspects in our community.

That's I think a very important contextual point in terms of what this Commission is trying to do and where it might find solutions to the prevalence and the severity of family violence, and in particular alcohol related family violence.

MS DAVIDSON: Just picking up on that, though, the research identifies that alcohol and drugs aren't going to be involved in all cases of family violence. This probably leads me to another question about do each of you accept

that there are a whole range of risk factors that contribute to family violence, alcohol and drugs being one of them, and alcohol and drugs won't necessarily play a part in all cases, and what is the need, just generally speaking, if you look at that range of risk factors to address all of those risk factors?

MR THORN: I think from our perspective and from the foundation's perspective - and this has been an exercise in careful diplomacy from my perspective because the characterisation of family violence through the lens of gender equity is very sensitive, and FARE has tried to I think come at the issue by just looking at what the data says and what the research is showing. It is plain that alcohol contributes to part of the problem.

We have been quick to say, I think, and write in all our submissions that the issue of the gender imbalance is something that is first and foremost I think in everyone's considerations about how to respond to the problem. But to ignore what the evidence says about one of the contributing factors for political reasons or whatever reason I think means that some of the low-hanging fruit around responding to the issue will be not taken into account and there will be no response. So that's my kind of take on the debate around this particular issue.

That said, I think that circumstances have changed dramatically over the last decade that we can actually have this conversation today about the nature of the problem and where we can intervene in the system to actually do something about reducing the rates of family violence in our community.

MS WILSON: Could I just add to that. What we are dealing with

here is - and it sounds like I'm stating the obvious - we are talking about really complex behaviour as to why are people violent and why are they violent to the people that they love. If we take the ecological model of violence, which looks at individual community - individual relationship community and more macro-societal factors, all of them having a role to play in why this happens, I think we should take the same view around problematic alcohol use because there's so many reasons why somebody drinks problematically and you can't just isolate that to individual characteristics.

Likewise, you can't just isolate things to individual characteristics as to why someone isn't violent. That's where the whole macro issues around gender equity are really important. The same goes for problematic alcohol use too.

So I think when you put the two - you overlay the two complex behaviours together, I think we just need to be really open about tackling all the risk factors, all the things that contribute at different levels. So it's not an either/or in terms of we can only deal with this from a gender inequity lens, we can only deal with this problem from an alcohol lens. So I think just being really open about here's some different ways of approaching a very, very complex issue is probably the best way forward.

ASSOCIATE PROFESSOR MILLER: I would like to agree furiously. I would like to add in the word "drugs", alcohol and drugs, and I think in terms of we need to be thinking about how we can respond across these different ranges. We need to think about the way in which alcohol influences

child abuse, which again creates these cycles of violence.

But on the whole we are very much in agreement around the importance of addressing gender inequity at the same time, but, as Michael says, these low-hanging fruits and the changes we can make in the next year or two are not unfortunately going to be around gender inequity, but we can address things like alcohol consumption and drug consumption in identified offenders now and we can act on it now.

PROFESSOR HUMPHREYS: I would just add that I think the Our Watch analysis, which has had a national consultation about a model for understanding violence and abuse, particularly in intimate partner relationships but not only, does look at two causal factors being gender inequity and violence supportive attitudes. So they have got that very clearly, and then they have a range of contributing factors as well, and alcohol and drugs being one of the contributing factors.

So I think that there's potential in what Michael refers to as a very sort of political area and a sensitive area that we can be on the same page and that there is a common language and some common understandings there that we can sign up to or that we could champion.

ASSOCIATE PROFESSOR MILLER: I think there's some differences too. I think supporting attitudes is not the only thing there. I think we have really strong evidence from a big body of longitudinal evidence to show that child abuse, experience of child abuse, growing up in adverse surroundings, in bad family settings, having peers - these are major predictors that go beyond just attitudes. We also have to talk about genetics. Genetics actually plays

a role and predicts a small proportion of violence.

So it is more than just attitudes and gender inequity. There are genuine physiological and psychological harms, and the biggest predictor again remains the experience of child abuse. So it is very much a different psychological trait and experience that people can't - you can change an attitude in theory. You can't change a lot of these things without a whole lot of other interventions.

MR THORN: Can I just conclude by saying where that takes me then is what are the lessons from public health about responding to these kinds of issues. FARE very much takes a public health approach to this. Australia has a terrific reputation, a wonderful record of success by using a public health model to deal with issues such as drink driving and the consumption of tobacco. It's a pretty simple recipe in the end. It's about the price of these products in the case of tobacco, its availability and the way it's promoted.

There's nearly 100 years of research that applies that same thinking to reducing alcohol related harms. That's kind of what we are saying. There's some ways to reduce part of the problem, and if you look at it through that kind of public health framing you will be able to make fairly dramatic impacts.

My argument here or the evidence I think is what happened in Sydney at the beginning of 2014. We are not talking about family violence here but we are talking about street violence. Following the massive public outcry about street violence in Kings Cross and Sydney's CBD which resulted in two one-punch killings to young men,

plus enumerable severe assaults, we saw the New South Wales government introduce what I have described as very modest availability restrictions. So cessation of the sale of alcohol at 3 am in the evening and what we would describe as 1.30 lockouts - in other words, people once they leave a licensed premises they can't go back in.

In six months in Sydney's CBD there was a 26 per cent reduction in non-domestic assaults and a 32 per cent reduction in non-domestic assaults in Kings Cross. That was just kind of one simple really intervention by the government.

COMMISSIONER NEAVE: Sorry, did you say a 32 per cent reduction in domestic?

MR THORN: Non-domestic.

COMMISSIONER NEAVE: Or non-domestic?

MR THORN: Non-domestic.

COMMISSIONER NEAVE: So there's no statistics relating to the difference - - -

MR THORN: Yet.

COMMISSIONER NEAVE: That it made in terms of domestic assaults?

MR THORN: Yes.

ASSOCIATE PROFESSOR MILLER: There was a 20 per cent reduction in sexual assaults.

MR THORN: This is research carried out by Don Weatherburn, Bureau of Crime Statistics in New South Wales. He's looking at the domestic violence numbers, because in addition the government introduced 10 pm closing times for all bottle shops. So we will be interested to see what impact that has on domestic violence because, really, if we are talking about homes we are talking about packaged

liquor to a large extent, not necessarily alcohol purchased on premises - consumed on premises.

MS DAVIDSON: I will pick up the issue of packaged liquor shortly, but before I do that another issue that seems to be an underlying concern in relation to talking about alcohol and drugs in the context of family violence is the risk of alcohol and drugs being used as an excuse for family violence. I would like you each to perhaps address your views on that issue. Can alcohol and drugs be regarded as an excuse? Perhaps Associate Professor Miller.

ASSOCIATE PROFESSOR MILLER: My statement is reasonably simple on this. We don't let people who are drunk off for drunk driving, and I don't think we can accept that it's an excuse in any format in any way. In the end, we need to be responsible for aggressive behaviour. We need to be responsible for our behaviour in this society, and alcohol and drugs are not an excuse.

PROFESSOR HUMPHREYS: I think the problem is that the community attitudes survey suggested that in fact for a lot of Australians it is an excuse, and I think that therein lies one of the problems and one of the messaging issues in relation to any public campaign would be in relation to how you shift that attitude to having time out from accountability and responsibility when you are drinking, because I think that that is a big contributing factor within the Australian culture about the ways in which we perceive when you are drinking to be an accountability free zone, and I think that that's a problem.

MS WILSON: I asked the women that question that I interviewed, and they basically said, "No, he doesn't blame his

behaviour on being drunk. He blames me." So they are the ones who caused him to behave in certain ways, which speaks to obviously the underlying attitudes towards women there. But certainly the women themselves - and I use this "blame the alcohol" more in terms of the fact that they feel more fearful and more under threat when he's been drinking. So from the women I spoke to the men didn't necessarily blame their behaviour on alcohol, but certainly it should be challenged in any case.

PROFESSOR HUMPHREYS: I do think too in terms of taking responsibility when you interview men on men's behaviour change programs or you interview women in the partner programs, when you have very serious incidents that involved a lot of alcohol - so one woman had a terrifying incident where her children were about to be drowned and he was sort of - in the backyard swimming pool and he was extremely drunk, and the thing is that the next day he couldn't remember any of it. She'd called the police. So it was a major incident.

Because he couldn't remember it, for him it hadn't happened or he pretends it hasn't happened. He can't understand the level of protection the systems are bringing in on him as well as his partner. So it's a great kind of excuse for a lack of accountability in this space, and it's a difficult space then for the responding agencies.

MS WILSON: That's where looking at also cultural attitudes around drinking, and certainly something that does kind of come up around this men's entitlement to drink, this sense that even where they are - their partners are saying to them, "You are behaving aggressively when you drink," and

for the men it's like, "But I'm entitled to drink. I work really hard. I can come home and have a relaxing beer," but obviously lack insight into then their behaviour when they get drunk. So that's something we also need to challenge more broadly around this entitlement to drink and to drink to get drunk.

ASSOCIATE PROFESSOR MILLER: I think that's core. I think I have to add in remember we also need to talk about women as well because it affects women in the same sort of way when they are perpetrators. Of the 13 to 20 per cent where police attend, the women are the identified offender as well. So I think that's a core part, that we see that.

But, again, it is addressing that issue of accountability for behaviour. We know that alcohol and the way it affects our brains does tend to block out first our cognitive functioning, then our memory functioning, and we are very much back to the brain stem in terms of the way in which we react. But in the end we can't have a system that says it's an excuse. Even though it's a causal factor on one level, it remains a behaviour that person has engaged in, and they can change their drinking behaviour to a degree.

MR THORN: Alcohol should never be an excuse from FARE's perspective, no question. It may well be a slightly different view I think in criminal cases in certain circumstances, but that's not what I think the street view around this issue is.

What I think we need to be wary of in terms of that excuse argument is people want to change behaviours and they think that they can achieve that then through a public education campaign, it's not going to happen, or

it's certainly not going to happen quickly, which is why I think then you need to as a recourse fall back on the sorts of things that we argue, and that is to address both the availability and the affordability of alcohol in the environment.

Another point I think that's important is a lot of this violence in the family is not just about a woman being controlled through to being seriously hurt. You have to remember the kids that are living in these households and the impact that heavy drinking can have on them, heavy drinking which may not lead to police being called or an ambulance being called. Those children, a million of whom there are in Australia according to the latest research from Dr Lasellet, are an enormous proportion of Australia's young people. That's the kind of magnitude of the issue we are trying to deal with and why, if you look at the policy responses, the sort of public health approach is both cost effective as well as effective in reducing the harms caused by alcohol.

PROFESSOR HUMPHREYS: There's very few people that support drunk driving in the community now. I think that that's been a major shift over a couple of decades, that actually people are very condemning of drink driving because of the level of damage and harm it can do. I think you could get similar messages across here too. We just have chosen not to do it.

ASSOCIATE PROFESSOR MILLER: And the lessons from drink driving from the policy and education stance are really important to take. So the government came out and made strong laws. That's the first thing. The government sends a clear message with strong laws, you back it up with public

education, not an occasional Saturday afternoon advertisement on telly but strong, strong advertising that shocks people, that makes them aware of what's happening and changes the message. We have really good evidence about what works, but it's first and foremost about the laws you put in place.

If you allow alcohol to be advertised by the companies to every kid who idolises a sportsperson, then you put on one single little advert that says, "Don't drink too much," it's a joke. It's a complete joke. So we need to be learning those lessons from drink driving very seriously. Legislation, serious messages from government and measures that people can see are actually serious about addressing the core of these problems rather than just advertising campaigns. That applies to drugs too. You have to fund services rather than put on TV ads.

MR THORN: I mentioned price, availability and promotion in terms of alcohol and tobacco, and the equivalent in the drink driving space, the price is the penalties, that if you drink and drive you will lose your licence. The availability is conspicuous policing, every police officer can be a kind of a random breath test; and the promotions side of things have been the strong messaging from government and the really kind of in-your-face advertising campaigns that we see. I think the same kind of prescription can be used in the area of family violence.

DEPUTY COMMISSIONER FAULKNER: Counsel, could I just ask any panel member if they are aware of any factors that suggest the same prescription won't work. For example, we have evidence that attitudes to family violence, people believe that sometimes family violence can be excused because he

was drunk. If you asked the same question about drink driving, you have already said that wouldn't occur. So is there something more fundamental that is going to stop that sort of campaign working? Have we any evidence of other areas of perpetration that may not be family violence where people excuse those sorts of events because people are drunk? Do we ask the question?

MR THORN: I'm not aware of any evidence, Commissioner Faulkner, but let's look at what happened when we got on the case around drink driving and smoking. The initial reaction from the community was very anti, "this is an imposition on my rights", there were - really, people were resistant to the idea. It took 20 years really to change the attitudes, to get the systems in place to where we now have a prevalent attitude in the community that you don't drink and drive, and really smoking has been so kind of demonised that by and large people don't smoke. I think the same kind of rule - the same pattern is likely to occur if you are dealing with family violence, if you adopt the sort of measures that we are suggesting.

DEPUTY COMMISSIONER FAULKNER: I'm trying to press a little, I think, to find out whether the nature of the offence is the same, that people are worried about having their right to smoke taken away or their right to drink. Isn't it slightly different to say, "Well, it's exactly the same, the right to hurt women is being taken away."

I'm just worried about the adoption of a campaign approach if there are other fundamental factors that might imply that the campaign approach won't work. I just see a difference between restricting your right to drink or smoke, different from your right to hurt women.

MR THORN: Obviously very different because you literally are impinging on someone else's rights if you are harming them in one way or another. But I think that what I would say is that this is around the kind of changing behaviours and attitudes, but you can't do that just by asking people to change their attitudes. You have to intervene across a number of different domains, and the price of the product and the availability of product are critical in that.

DEPUTY COMMISSIONER FAULKNER: Thank you.

PROFESSOR HUMPHREYS: I think it's an interesting question, and I think that you could be - it's a question of where you start, isn't it, and what sort of campaigns you run or whether it's actually done through the criminal justice system in the first instance, where someone has been drinking and violent that you actually have greater restrictions on their drinking or their use of drugs as part of an order or as part of their parole or bail.

I guess within Australia we have had I think probably one of the biggest developments in the world around the use of how we do the public health - how we do our public health. I think that it's a mixture of carrot and stick. If you think of the use of firearms, we have got gun control. We expect government to take a stand on some things, and we seem to have been relatively happy to do that - firearms, seatbelts, fireworks, cycle helmets, bicycle helmets, smoking.

Actually, particularly where there's health issues and harm to the public more generally, we have actually a very strong history in Australia in relation to having some restrictions that are put in by government to protect the public, and the public is in fact in this case

private but we can see the harm is fairly widespread.

So I think that we haven't done enough innovation in this area, and where you might start and how you might create that nexus I think has still got some way to go, and you wouldn't just sort of do something broadly without kind of looking at how it works in a small way or in demonstration models. But I think there is some potential there, particularly within the climate of - in relation to public health in Australia.

MS WILSON: We have seen it a little bit when it comes to public violence and as - the illustrations that Michael gave. But we haven't seen that - so that recognition that there's an issue with alcohol and violence in the public sphere, have people taking it to the streets and actually having some measures put into place. So we haven't actually seen that within the - where there's alcohol related domestic violence, except within remote communities where obviously for - huge problems going on there. But these issues aren't isolated to Indigenous communities. So having something that is more broadly based potentially could have some effect.

COMMISSIONER NEAVE: Could I ask what role vested interests might have in opposing such reform? I assume that the alcohol sellers didn't oppose the introduction of laws relating to drink driving.

ASSOCIATE PROFESSOR MILLER: They actually opposed them very strongly.

COMMISSIONER NEAVE: Did they?

ASSOCIATE PROFESSOR MILLER: Yes. They told us that in fact it would be the death of our hotel industry, statements along those lines. They said that about restrictions on trading

hours that have saved thousands of assaults and things like that. So they strongly opposed the introduction of drink driving measures back in the day.

PROFESSOR HUMPHREYS: It might be worth talking about how much a part of the different structures and committees they are in terms of the prevention agenda.

MS DAVIDSON: That was an issue I was going to take up. But before I do take that up perhaps we can explore the implications for policy in a bit more detail.

I particularly wanted to ask the panel members to talk about some of the programs where there have been alcohol reductions in other areas, such as the Fitzroy Valley and the like that have actually resulted in a reduction in family violence, just so that we can get an understanding of what the evidence is about putting in place those sorts of measures and how effective they might be.

ASSOCIATE PROFESSOR MILLER: Over the past three years we conducted a review for the National Drug Law Enforcement Research Fund, and we looked at effective interventions for the reduction of alcohol related supply, demand and harm. We came up with a range of - we came across a range of different solutions that indicated reducing alcohol consumption reduced alcohol related harm. That's both in Australia and outside Australia.

The key one that is the most promising was around mandatory sobriety that came from South Dakota and is now in place in 18 states. Do you want to discuss that later or?

MS DAVIDSON: No, I'm happy to proceed with that now.

ASSOCIATE PROFESSOR MILLER: Okay; and the other two key ones are the one in the Fitzroy Valley, where there is a

restriction on you can't sell packaged liquor over 3.5 per cent alcohol strength; and the other one is in Western Australia, Northern Territory and a number of other states where you are able to designate certain areas as dry zones, and in WA and the Northern Territory this doesn't apply just to entertainment districts. An individual can go to the Liquor Licensing Board and ask for their house to be designated a dry zone, so that alcohol is not allowed on that premises, you are not allowed to enter those premises if you are affected by alcohol.

This has been used widely in response to certain domestic violence cases. In fact, in the Northern Territory they almost treat it as a default mechanism when somebody is indicated as both family violence and alcohol - when alcohol is mentioned in those cases, that is almost their default. This is anecdote from the police responsible up there, but certainly that is a pretty standard response.

I will go back to the 24/7 sobriety model. In South Dakota they had a massive problem with drink driving deaths, and the Attorney-General of the day said, "We have in place a whole lot of the measures" - we have had in place in Victoria for a long time, like interlocks and things like that. They weren't addressing the issue. They still had lots of people being killed on the roads. They introduced a program whereby a recidivist drink driver, somebody who has already shown this pattern of behaviour, was breathalysed at 7 am and 7 pm every day, and if they didn't blow .00 they were then taken into the gaol cells for 24 hours and released.

The more general model - it's applied with drugs and has important lessons in drugs as well - is called "Swift, certain, fair". The idea is that you are guaranteed to be detected, you are punished immediately and the punishment is fair. When we think about raising children and doing things like that, that's actually the model we use in most of our life. But it is not the system that we have as our justice system, unfortunately. Our justice system is very much the opposite way around. I'm not critiquing any individual body here.

Most importantly, what they started to find was not only did they get a 12 per cent reduction in recidivist drink driving, which translated to huge changes in terms of road fatalities; at the same time the judges started to apply this for domestic violence cases as well and they found a nine per cent reduction in cases of domestic violence reported to the police in that state. The findings have been replicated to a different degree each time.

How much it applies in Victoria or in other states I don't think we can confidently say, but I think one of the key messages around this is, when you take alcohol out of the picture for a very, very small group of the population who are obviously indicated as problem people, you get this huge reduction in domestic violence. I think we are a bit crazy not to have tried it already in many ways, this idea that we can target individuals and do that.

But one of the key messages behind that was the systems were made to work together. An Attorney-General, a government took a stand and said, "You must work

together and you must respond in this way." It wasn't courts trying to do it and get everybody else on board, or police trying to do it and get everybody else on board. They had to have changes in the law and strong leadership to say, "This must happen in this way," so that you didn't get into a whole lot of resourcing arguments.

Some of the key numbers were that 66 per cent of the people, recidivist drink drivers, never failed a single test. Seventeen per cent only failed two tests. So this was already immensely successful in terms of getting people who have never been abstinent before in their life to become abstinent and change their behaviour, while not throwing them in gaol, while not costing the community a huge amount of money, and addressing the harms to their families and society more generally.

MS WILSON: Wasn't it the case that with the resourcing for that it was the actual - the offenders had to front up to the courts or the - - -

ASSOCIATE PROFESSOR MILLER: No, no, they showed up to the sheriffs and they paid for the honour of doing that. They actually paid to be able to not go to gaol. These are some of the key things. We hear discussions of resources. But then you think about where do we want to expend resources in our society. Do we want to expend it at a policeman having to breathalyse an individual at the police station, or do we want to expend it for the same policeman to be mopping up cases of domestic violence or people killed in car accidents.

I think these are key questions. But it goes back to that broader lesson of what happens when you remove alcohol from specific targeted offenders, and

I think that's the key message, is why we are so confident when we remove it from that setting that we will get a reduction in the domestic violence cases in Victoria, and I think that is worth a trial, not necessarily trying to change a whole system. I think that's the wrong approach. I think we need to trial these things and then go ahead and say, "It works in this way. We need to adapt these systems."

The other key intervention was around changing the restrictions in northern WA, and what they found there was substantial reductions in terms of levels of street violence and family violence. There was one interesting blip in that we know that people - victims who are intoxicated are less likely to report cases to the police. So there was actually an increase in reporting to police, which is a positive thing. However, what we saw also was a 23 per cent reduction in the number of women turning up to emergency shelters. That's only acting on the packaged liquor. So people could still go into the pubs and drink full-strength liquor, but just packaged liquor of 3.5 per cent. This has been running for 10 years now, and it is an intervention that has shown in those communities where it's impacted strongly quite positive effects.

MS DAVIDSON: In relation to the South Dakota project, that was for alcohol. There was also the Hawaii HOPE project?

ASSOCIATE PROFESSOR MILLER: Yes.

MS DAVIDSON: Was that in relation to drugs?

ASSOCIATE PROFESSOR MILLER: That was specifically in - Hawaii had one of the highest rates - still does have one of the highest rates - of methamphetamine or ice use in the world, and this program was specifically introduced there

by a judge called Judge Alm, same sort of issue, same sort of response mechanism, to try to deal with methamphetamine related harm in the society and these recidivist offenders that were constantly showing up on his door.

He now has something like 2,000 people on his list, and I think there's 8,000 offenders in the whole of Hawaii, so he has a very large list that he's dealing with, and the model is very similar. So there they get drug tested every two to three days because it is not as necessary and it is more expensive. It is a random system, and the alcohol one can be a random system too. So you don't actually need to expend all those resources. They have to ring up every day and they get code red and code blue, and code red is you have to come in. So you can actually halve or quarter or third the resources, but you don't know when you are going to get tested.

They go in, and he has used a graduated system whereby the first time you breach you get in gaol for a couple of days. The next time it's a week. The next time it's a bit more. But the key thing is in that model the system doesn't give up on you. It doesn't say, "Okay, we are now throwing away the key, and you are going to go to gaol for a year." They keep saying, "Come back. We will try to engage you with more support and do other things."

One of the key things is treatment is not involved here. These models have been running primarily, particularly the alcohol one, without treatment. So there's no expense related to treatment. Do I think that it will work better with treatment? I can't imagine why it wouldn't. But the evidence is so strong without the treatment that we should be at least going down that angle

as well to begin with. But the drug one does have treatment associated with it later if you indicate that you are not succeeding.

Unfortunately, we don't have domestic violence figures on this, but what we do have is figures like recidivism. There was over a 50 per cent reduction in repeat offences in this group. There was 70 per cent abstinence. Seventy per cent did not fail a drug test while they were under this program. So, again, most people when they are being tested regularly, when they know they are going to get caught and they know they are going to get punished immediately, do not break the law. That's the key lesson behind all of this.

MS DAVIDSON: Moving on perhaps to the issue of controlling the price of liquor and packaged liquor, can you outline the work of Michael Livingston and the area of packaged liquor and the density of outlets?

ASSOCIATE PROFESSOR MILLER: Certainly. We have price and outlet density. In Victoria Michael Livingston, as you mentioned, from the Centre for Alcohol Policy Research has demonstrated a strong relationship to the increased number of outlets in Victoria and the increases in domestic violence and other forms of violence. He's also demonstrated that relationship is stronger around places where density is higher. So the more outlets you get in a specific area the more harm you have, and particularly related to domestic violence; then on top of his work the work by Tanya Chikritzhs in Western Australia because they have better data, importantly. We have quite poor data in Victoria for a lot of this. It's getting better. I'm not lambasting anybody here. It is getting better. But they

have much better data, particularly around the consumption of alcohol and identifying that down to specific venues.

Unfortunately, the legislation just introduced in Victoria is so wishy-washy we can't even tell whether it's going to include purchase date let alone whether you bought alcohol from that supermarket on that corner or that pub over there. So unfortunately that change in collecting data is not going to be terribly helpful.

But Tanya Chikritzhs' research found that when you put in place new large bottle shops, not the smaller bottle shops but new large bottle shops, or supermarket outlets for selling alcohol into a socioeconomically deprived suburb you will get up to 23 per cent increase in domestic violence cases. That's related to how much alcohol they sell. Obviously it's not just putting it there; it's related more to an increase of 100,000 litres, I think it was.

MR THORN: I think just the supplementary research which has only been published in the last month or so is from Chris Morrison from Monash University who has gone one step further to show that the type of packaged liquor outlet, big box liquor outlets tend to increase the number of harms too. So the type of outlet is important in that consideration.

MS DAVIDSON: When you say "the number of harms", what do you mean?

MR THORN: His particular measure was ambulance call-outs. That's a better measure of the incidence than police reports because people can choose by and large whether to call the cops or not, whereas if someone has been severely injured to the extent that an ambulance has to be called

it's kind of a more reliable indicator of the prevalence in the community.

MS DAVIDSON: FARE is asking for particular recommendations in relation to those issues. Can you perhaps, Mr Thorn, outline what you see to be the key policy responses that the Commission could recommend in this area?

MR THORN: Sure. It might provide an opportunity to introduce into the evidence, if I may, the National Framework for Action to Prevent Alcohol Related Family Violence that FARE published in June 2015, just after the closing of submissions for this Royal Commission. The framework really is, unsurprisingly, very similar to what we recommended in our submissions. But, if I can introduce that, that would be appreciated because I don't think that's formally been done.

The way we look at this has been across really four domains. We haven't talked about the social determinants dimension to harms in our community, and we haven't spent a lot of time on it but I think it goes without saying, and I know, Commissioner Faulkner, in your previous role with the Commonwealth as Chair of the Social Justice - - -

DEPUTY COMMISSIONER FAULKNER: Social Inclusion Board.

MR THORN: You were well aware of that as a way of thinking. In terms of what we have done with our national framework we have looked at it in classic public health terms: the primary, secondary and tertiary dimensions of the harms. The primary side of things really goes to the heart of our public health thinking, and that is to look at the price, the availability and the promotion of alcohol in the community.

Bearing in mind that the regulation of alcohol in Australia is split across all tiers of government, if I can just sort of address my remarks to what the State of Victoria could do, we would be arguing that since most availability controls are down to the jurisdictions, to the states and territories, that that's where the best bang for buck is in policy terms. Looking to reduce the physical availability and where the State can look at the economic availability of alcohol I think would give us the best measures.

What's happened in Victoria of course has been the very significant increase in the number of liquor outlets over the last 20 years. Most of this has been driven by a national competition policy, but in Victoria it actually predated the adoption of that policy back in the mid-1990s. So I think that's the kind of principal area of focus.

We are in kind of a very curious situation where the total alcohol available for consumption in Australia has been declining at a moderate level in the last half a dozen years. But, looking back 25 years, Australians are consuming on average about 10 litres of pure alcohol per person per year. Only 80 per cent of us consume alcohol or at least report to consuming alcohol at any time during the year. We also know from drilling into that data that about 80 per cent of that alcohol is actually only consumed by 20 per cent of drinkers.

So we have on one hand this statistic about average per capita consumption and on the other hand a massive transformation in where liquor is available. So 50 years ago more than half of alcohol would have been

consumed in licensed - on premises; today, where nearly 80 per cent of alcohol is purchased from packaged liquor stores and mostly consumed off licensed premises. Some of it is consumed in restaurants, where bring-your-own rules apply.

Yet, the harms have continued to rise. One place that Victoria does an outstanding job is in fact on ambulance data, and that's shown these increasing not only rates but also the total numbers of alcohol related ambulance callouts. Very fortunately the data is coded in a way that we can see what proportion of those are family violence related to, and we have reported those in some of our evidence. So that goes to show I think why we need to be looking at alcohol's availability as one measure to tackle the problem of family violence.

We also think that there is work that needs to be done in what we call secondary prevention, and that's really to assist people who we think are at most risk of family violence. Again, the evidence is pretty clear that there are certain propositions within our community that should be prioritised for attention. I don't want to just dwell on Aboriginal and Torres Strait Islander peoples, but the rates of family violence are higher within that group, it's inarguable, and as a consequence I think there is a public responsibility to respond to that.

I think that what we know about certainly family violence - sorry, alcohol's contribution is that it's actually quite easy to identify - comparatively easy to identify who the people who consume alcohol where there might be problems, and certainly screening people would be a very positive way, I think, to make a difference. Those

screenings of people's use of alcohol can take place in many different settings - health and medical system, in our education system and certainly in our family violence systems, the welfare systems that respond to this. I think that's an obvious place to introduce screenings.

The evidence around that, while it's not overwhelmingly conclusive, but identifying people's problematic use of alcohol is the first step in achieving change. Certainly in the medical environment there's good, solid evidence that a doctor just talking to a person about their alcohol use can bring about change.

The other area, and I mentioned this earlier, we shouldn't forget the kids, and looking at providing sort of services and interventions that go to the welfare of children I think is another important point of intervention in the system.

From a tertiary prevention, obviously once you have identified people who are affected by family violence as a consequence of alcohol, I think there are a number of things that need to be done. Our analysis of the current problems in the system is really - what we believe is not happening is that the alcohol and drug system is not collaborating very well with the family violence system.

I think that in Victoria the work that government has done in the family violence area about identifying alcohol and drug problems is good, but it kind of just goes one way. What we need to be doing is to be looking at the alcohol and drug sector to see what family violence issues might be occurring that could be identified in that part of the sector, bearing in mind that people can come into the system through a whole range of different doors,

as it were. Our simple proposition is, if we adopt a kind of a "no wrong doors" approach, that we ask our services to be aware of the possibilities of family violence - if you are an AOD service or, equally, if you are a family violence service, that there is an alcohol or drug problem, that we can get better results.

So I think in short they are my main proposals, and not to forget that in all of this we need to be evaluating what we are doing, we need to be collecting the data, analysing it and reporting on what the impact of any of these interventions might be so that we can improve service delivery and improve the outcomes for women and children who live in violent circumstances.

ASSOCIATE PROFESSOR MILLER: I think probably the key one I would add is you have asked or mentioned price a couple of times, and we have compelling evidence from a number of countries both in terms of modelling but actual implementation around minimum price.

In British Columbia they implemented a 10 per cent increase in the minimum price of alcohol and they have seen a 10.4 per cent reduction in all violence, and it's equal proportions other violence and domestic violence. So we are talking about a 10 per cent reduction in domestic violence related to a 10 per cent increase in the minimum price.

What does that mean in terms of what people pay for alcohol? As Michael mentioned, 80 per cent of alcohol is consumed by 20 per cent of the population. These are the problem drinkers, and they are primarily younger drinkers and heavy drinkers, alcoholics, and they don't tend to drink what the rest of us drink. They tend to

drink for the most part much cheaper alcohol. Today, wine is one of the cheapest alcohols we have.

The modelling that's been done by Marsden & Associates identifies that the general cost - if you implement a minimum price on alcohol of, say, $1 a standard drink, you won't actually affect things like a can of VB or a can of Jim Beam or a glass of nicer wine. It's very much about the types of alcohol that are consumed - alcopops by very young people and the casks of wine consumed by alcoholics and young people again.

So we really need to have a serious look - when you are talking about being able to reduce domestic violence by 10 per cent in the State by introducing a minimum price on alcohol, it's an important element to throw into that policy mix on how we might prevent a whole lot of that.

MS DAVIDSON: Ms Wilson, do you have anything to add to those?

MS WILSON: I was just going to add something to what Michael was saying around getting better at identifying where people have alcohol problems, and certainly where it comes to the health system and focusing on those people who have the problems there's a lot that can be done.

But certainly I think if problem alcohol use was almost used as a bit of a red flag for what's kind of going on for the partners of those people. So the health systems, which - I know there's a lot of work being done around better identification of people experiencing partner violence just more generally, but specifically around alcohol use and what people might be experiencing there, there's some opportunities there.

One of the interesting things with my study, when

I was trying to recruit women to participate in the study, I didn't say, obviously, "Have you ever been a victim of domestic violence?" The question I used was, "Have you ever felt afraid when your partner has been drinking?" So it pulled the women out of the woodwork.

I didn't actually get women who are currently in the relationships. I had lots of people kind of clicking on the links to my Facebook posts and things. But it was the ones who came forward were those who had left the relationship, and even exploring with them they said, "I wouldn't have talked to you if I was still in the relationship." But certainly that was enough of a question for them to be able to identify with that they were experiencing fear and harm.

So I think there's some potential - and I'm talking specifically around alcohol related intimate partner violence - where the health systems can get better at perhaps asking the questions and also identifying what's kind of going on for the families in the background.

MS DAVIDSON: Professor Humphreys?

PROFESSOR HUMPHREYS: I probably am more experienced at the response level, so I'm just not sure - and we have spent a lot, quite appropriately, of the discussion on the primary prevention and secondary prevention. Do you want me to talk at this point about the - - -

MS DAVIDSON: Are you talking about treatment programs?

PROFESSOR HUMPHREYS: Yes.

MS DAVIDSON: Yes. You have some of that material in your statement, but it would be useful if you could expand on what you see as what is happening in the treatment space

here in Victoria and how that can potentially be improved.

PROFESSOR HUMPHREYS: It seems to me that if you look at the women's sector and if you look at women living with family violence, then they are significantly more likely than other women in the population to have drug and alcohol problems. A lot of that we do know comes from anaesthetising the effects of violence. There is quite a relationship between experiencing violence and then anaesthetising the effects, or abusers also dragging women into that area, as well as women also being vulnerable to actively being drinkers themselves.

So I think that there's a group of women who we are servicing very poorly because, for them, their drug and alcohol use is directly related to whether they can get out of a violent relationship. So I think that by not providing a service within the family violence area or the drug and alcohol area that looks across these issues, then we are doing that group of women a serious disservice.

I think the siloing in our sectors which hasn't allowed a kind of a "no wrong door" response for that group is really problematic. I think that they do it poorly in the drug and alcohol treatment area, and I think they do it poorly in the family violence area as well. I don't think we are responding well to that group of women, and I think we need joint training or secondary consultations or joint workers that can work across those issues.

I know in the UK by far the best workers in the area of cross-fertilisation of ideas or providing a holistic response were the women's drug and alcohol workers. They couldn't understand why there was a problem

in the siloing of the sectors because they provided both a drug and alcohol response as well as a family violence response. They knew about intervention orders, they knew about housing, they knew about how to respond and safety plan. They knew a whole lot of things, and they were very good at having a holistic response that responded to both drug and alcohol issues as well as understanding how you respond to women particularly in family violence crises situations. So I think it's not impossible to do that work at all, that in fact we should be doing more of it, but it does require cross-training and it requires champions on both sides.

So that's some of the issues for women as victims, but there's also some really major issues, I think, in terms of the perpetration of violence, that I think that again we just haven't had a cross-fertilisation of ideas in this area and of practice in this area.

In fact, when I was in England looking at some - gleaning where they were doing good assessment in relation to screening for drug and alcohol issues for men coming into men's behaviour change programs, you were looking at about 80 per cent who had some form of drug and alcohol problems. So there's a big group of men on men's behaviour change programs that have drug and alcohol problems, and yet we have done very little about addressing that as a joint issue.

Places like MonashLink have a drug and alcohol worker in the men's behaviour change area, and I think that's a promising model. Places like Ballarat, at CAFS, they have an agreement with the drug and alcohol agency

that men need to dry out, basically. If they have chaotic and out-of-control drug and alcohol use, then they have to deal with that before they come on the program. But in a way that's quite a limited response.

I really was interested in the community care model that ran for three years in Western Australia where they had a drug and alcohol worker working alongside men's behaviour change programs, and that men's behaviour change programs and drug and alcohol groups were running parallel to each other. So there was a sort of an addressing of both issues.

For many of these men it's a really important issue. When you interview women, they know that men are on the slide when their drug and alcohol issues start to - where there's a resurgence of their drug and alcohol issues. For them that's the first barometer - for many of these women - about when the man is starting to backslide.

So I just think it's an area where - in fact, there aren't very many models and there are no models so far as I know that have been strongly evaluated. There is a model in England as well with domestic violence - DVIP, where they are having men's behaviour change programs based within a drug and alcohol service. Again, I think that that's a good model and that's showed promising evaluation results on the initial evaluations. So there haven't been randomised controlled trials.

I think there is potential here, but I don't think - we haven't really - the Communicare model began because you had a drug and alcohol worker got trained in men's behaviour change who became a champion. You actually haven't got many champions and people that are

trained across both disciplines in terms of practice. So I do think you need champions that are well trained in both to be able to do like the joint training and to understand how you do the assessments, the risk assessment, and how you collect the data as well as men go through.

So I just think that it's an area where we really haven't tapped the potential. Our men's behaviour change programs are a terribly important part of the sector, but actually there's not a huge evidence base to suggest they are being particularly effective. I think there are probably things that could be done better in that space, and potentially dealing with drug and alcohol issues as part of that space could be something that could be looked at with an organisation that was prepared to champion it. You have to have champions. You have to have demonstration models that can provide the ripple effect in sectors where there hasn't been close collaboration.

I think if you think about the dual diagnosis stuff around mental health and drug and alcohol issues, that took ages to take off. Bringing those two systems together sounds a bit, I think, like these two systems at the moment as well.

MS DAVIDSON: Associate Professor Miller, you have also identified in your witness statement some programs that are specific to co-occurring alcohol or drug use and family violence. Can I just get you to briefly outline those programs?

ASSOCIATE PROFESSOR MILLER: I can. I will begin with a bit of a statement around - what you are talking about is primarily around men's behaviour change model, yet when we

talk about medicine or psychology, when somebody walks in the door we screen them for a range of behaviours. That's not really happening where - I think you are going to have more treatment people, forensic psychologists, talking to you next week. However, that's one of the key things, is that, again, these are not the only drivers of violence that are occurring in the home, and I think we need to be really clear that men's behaviour change models again don't actually have strong evidence, if evidence at all, around their effectiveness, particularly because they are not tailored to what's walking through the door. They are tailored to - they are imposing a model of treatment on people who walk through the door who it may not be appropriate for. So one of the reasons it may not be effective is it is not actually working on the key triggers. It may for one or two or some of those people.

There have been a number of responses developed in the USA around this. I am not a very strong expert in this but I can definitely say there are two, one developed by Professor Easton called the Substance Abuse-Domestic Violence Intervention, and they have a number of peer reviewed publications that show significant changes in terms of behaviour change and reductions in violence.

The other one is couples behavioural therapy. This is much more psychologically based. It screens people. It identifies problems in the relationship. It doesn't just presume that it's entirely a genderised event, and it looks at the relationship and it engages in couples therapy based on that, and it looks and includes substance use treatment. That's the work by Professor O'Farrell.

Both of these have found significant results, of the magnitude of before treatment seeing 68 per cent perpetration of violence; afterwards, 31 per cent one year later perpetrators of violence; so dealing with a perpetrator, identifying what the actual issue is, what their issues are, including substance use. But again we know aggression replacement therapy, treatments about dealing with people's aggression from a forensic psychology point of view are strongly evidenced based. They have good evidence. We should be identifying those aspects as well when we are talking about treatment, not just talking about accountability.

MS DAVIDSON: Commissioners, you will be aware that we will be coming back next Friday dealing with various interventions for perpetrators in a bit more detail and hope to pick up some of these issues then. One final question I might put to the panel is in terms of the population policies you are talking about, increases on price, restrictions on packaged liquor, those sorts of policies, you identified to the Commission before that the industry had pushed back on implementation of drink driving. Do you see there to be a likely backlash from the industry here and is that going to potentially impose impediments for the sorts of measures that you are advocating for?

ASSOCIATE PROFESSOR MILLER: Absolutely. We can expect strong pushback from the industry. They have entire departments that strategically engage with government. We have advisory committees in the Victorian Government and other governments where the industry is involved. The World Health Organization strongly states that industry is not appropriate in any form of health policy at the policy

development stage. You can talk to them about how you implement the policy, but their vested interest is so strong that they simply muddy the waters.

There is strong evidence from virtually every field where there is a vested interest industry involved. When you have those industries on committees, like we do in Victoria, you are very likely to get very watered-down recommendations and every point is challenged and it's usually challenged without evidence. So people will present evidence and then it's just said, "But we don't buy those figures. We don't agree those figures." It tends to water things down immensely. The industry is very effective at doing this. The AHA I think was the biggest contributor to - - -

MS DAVIDSON: This is the?

ASSOCIATE PROFESSOR MILLER: The Australian Hotels Association. They are major contributors to both Labor and Liberal at the political level. They have very strong ties to the government. We need to be thinking about how we break some of those ties at the policy development stage rather than at the consultation stage so that we start to get policies that are in the public interest that are evidence based rather than ones that suit the industry.

MS WILSON: I just think we need some leadership on this, and strong leadership, strong championship. Here we are talking about alcohol's contribution to family violence. We are talking about people's lives here, living day to day in fear when their partner starts drinking, for those particular women. We are seeing it in the community in terms of the coward punches, the violence going on in public places. So, okay, we have an industry that will

have vested interests and will oppose anything that will actually inhibit their bottom line. But that's what we have got governments for. Some leadership.

PROFESSOR HUMPHREYS: I just think it's really clear that it's absolutely wrong to have policy being developed - and we know that in a couple of our advisory committees in this area they are being chaired by industry representatives with a totally vested interest. So of course we are not going to get good policy in this area. I think it's a really appalling practice that we have here in Victoria around this area and it needs to be really seriously challenged.

COMMISSIONER NEAVE: Could I ask you the name of that advisory committee, or are there difficulties in naming it?

ASSOCIATE PROFESSOR MILLER: It's not exactly on the public record. There is the Liquor Control Advisory Committee. That's not chaired by industry, but working committees under that are, particularly looking at how to reduce harm of packaged liquor.

MS DAVIDSON: Mr Thorn, would you like to contribute?

MR THORN: In answer to the question about vested interests, where do you begin? It's a long story about vested interests. We shouldn't be surprised. But I think there is a very simple principle, and it goes to the points that have been made this morning.

The vested interests shouldn't be involved in the policy making, and that's a simple rule. In Australia they are too involved in the policy making. The reason that's important is because we know - we know from a long history - that those vested interests deny the evidence about the impact of their product. Of course the best

evidence of the behaviours of the corporations has been the tobacco industry. The release of all those documents in the US, 30 years or 40 years of documents about the behaviour of the tobacco industry I think kind of proves the point.

Let me tell you it is no different in the alcohol space. The industry is always doing its best to deny what we in public health say, and they put it through the lens of personal responsibility, "Isn't it the individual's responsibility to take responsibility for their behaviours?" Yes, that's true. But what we know from the evidence is that if you live in an environment where there is a lot of cheap booze available that is promoted in all sorts of ways through advertising on free media, increasing promotion and appropriation of social media, sponsorship of sport and appropriation of our kind of cultural identities, then it should not be a surprise that the use of alcohol is so normalised in our community. It is for these reasons that we need to be very wary of those vested interests.

I can go into more detail about how the alcohol industry seeks to undermine international agreements around what the evidence shows about responding to these harms. There's a plethora of documentation, research evidence. In fact my foundation is a part-funder of a big project that Peter is leading at the moment around the activity of the alcohol industry in trying to protect its interests.

My kind of simple message here is, yes, beware of vested interests when it comes to governments trying to respond to this. They will deny that there's a problem

and they will always say that the problem lies somewhere else, mainly with the individual.

MS DAVIDSON: Thank you. Do the Commissioners have any additional questions?

COMMISSIONER NEAVE: No. Is that a convenient moment for us to have a short break?

MS DAVIDSON: Yes.

COMMISSIONER NEAVE: 15 minutes.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

MR MOSHINSKY: We are now going to have a further session of concurrent evidence. We have with us both Superintendent Timothy Hansen from Victoria Police and also Associate Professor Peter Miller from the previous panel who has kindly agreed to join us also for this session. So first of all could I ask that Superintendent Hansen be sworn in, please.

<TIMOTHY JOHN HANSEN, sworn and examined:

<PETER GRAEME MILLER, recalled:

MR MOSHINSKY: Before I start questioning the witnesses, Commissioners, we will be on other days examining the role of Victoria Police in more detail and we will be hearing from several witnesses from Victoria Police, particularly week 3, on issues to do with police response and the criminal justice system. So my questions today for Superintendent Hansen are confined to the topic of today, which is the alcohol and drugs topic. I just want to indicate that.

Superintendent Hansen, you have prepared a witness statement for today's hearing. Do you have that witness statement with you?

SUPERINTENDENT HANSEN: I do.

MR MOSHINSKY: Are the contents of that witness statement true and correct?

SUPERINTENDENT HANSEN: They are.

MR MOSHINSKY: Could you please indicate what your current position is with Victoria Police?

SUPERINTENDENT HANSEN: I'm the superintendent in charge of the Community Safety Division, and the Community Safety Division is placed within our Corporate Strategy and Operational Improvement Department. The areas of portfolio focus of which I'm responsible are victim support, drug and alcohol strategy, crime prevention and a newly created unit called the Policing Innovation and Research Unit.

MR MOSHINSKY: Could you please just briefly outline your professional history with Victoria Police?

SUPERINTENDENT HANSEN: I joined Victoria Police in 1989, and primarily most of my policing experience is limited to metropolitan Melbourne and inner-city metropolitan Melbourne. I have performed a variety of policing functions from road policing through to plainclothes investigations. But I guess primarily my focus has been on front-line general duties policing.

More broadly than that, I was promoted to the rank of superintendent, I guess, about 18 months ago and this is my first posting at that rank.

MR MOSHINSKY: Superintendent, you also in terms of your qualifications, as indicated in your statement, hold a Bachelor of Policing Arts, a Diploma of Business Manager, a Diploma in Police Supervision, an Advanced Diploma in Policing Management and a Graduate Certificate in Applied

Management Policing.

SUPERINTENDENT HANSEN: That's correct.

MR MOSHINSKY: Could you briefly explain the structure within Victoria Police that looks at alcohol and drug policy issues?

SUPERINTENDENT HANSEN: Yes, okay. So when I commenced in this role about 18 months ago and took over the drugs and alcohol strategy unit it was clear to me the organisation didn't have a single policy position on alcohol and drugs. So one of the first things we set about doing - it had subset strategies, I guess is probably the best way to describe it. So the first thing we set about doing was developing an overarching strategy specifically in relation to alcohol.

So the policing alcohol strategy includes a 10-year policy position statement. It includes a three-year strategic framework and then is underpinned by an annual work plan of commitments the organisation makes around a whole range of things, from enhancing our own data collection sets through to developing, I guess, field based research projects to understand innovative solutions to alcohol related harm. Some of these include aspects of family violence, obviously.

The governance that sits around that strategic framework, we have a high level governance group called the Victoria Police Alcohol Advisory Group. That is chaired by the Director of the Corporate Strategy and Operational Improvement Department, and includes representation of a variety of Assistant Commissioners from the front-line policing commands and also our intelligence areas.

Underpinning that, just recently developed was a Liquor Licence Working Group. At the end of year 1 of the action plan it became clear that there were some issues for Victoria Police specifically around liquor licensing. So we decided to develop a subcommittee, which is the Liquor Licensing Working Group. That is primarily made up of front-line practitioners.

MR MOSHINSKY: Just to also pick up the drugs area, at paragraph 21 of your statement you refer to the Illicit Drug Advisory Group. That's a counterpart advisory group dealing with drugs?

SUPERINTENDENT HANSEN: Yes, it is, in the same framework. It commenced operation behind the alcohol piece. We saw at the time the alcohol piece probably being more important for it because of the level of harm we were experiencing throughout the community. So we really wanted to focus on alcohol. Having said that, we did have in place some specific drug type strategies. Methamphetamine, for example, was one that we had covered off by way of a strategy document. So we have since that time commenced developing again an overarching illicit drug strategy or strategic framework.

MR MOSHINSKY: Can I take you then to paragraph 27 of your statement where you start dealing with the statistics available on family violence and alcohol or drug presence in family violence incidents. Could you explain what the process is when police are called out to a family incident or a family incident is otherwise brought to the police? What's the reporting process involved there?

SUPERINTENDENT HANSEN: A member will submit a series of reports. Primarily the main one is what we call the L17,

which is the family violence incident report. Included in that is a risk assessment around some factors that might be prevalent. They include alcohol or drugs either being definite or probable.

MR MOSHINSKY: I think you have as one of the annexures to your statement - TH-5 is an example of a blank L17 report. That form includes on it both for the person identified as perpetrator and the person identified as victim a box to be checked for either definite presence of alcohol, possible presence of alcohol, definite presence of drug, possible presence of drugs; is that right?

SUPERINTENDENT HANSEN: That's correct.

MR MOSHINSKY: When does the police officer complete that form? Is that when going out to the house or at some other point in time?

SUPERINTENDENT HANSEN: It's general practice that is done there and then, manual copy. We also have an electronic IT platform. The member would then go back to the police station and download that information on what we call LEADR Mark II, which is the IT framework.

MR MOSHINSKY: So when the police officer fills in the form, let's say it's at the house, for those parts of the form is that based on their observation or is there any testing involved?

SUPERINTENDENT HANSEN: In relation to alcohol and drugs these are subjective tests that the member carry out either by way of questioning or their own observations.

MR MOSHINSKY: Are all L17s filled out at someone's house or are there other times when this police incident report for a family incident might be completed?

SUPERINTENDENT HANSEN: No, there will be other times. For

example, some incidents aren't reported to us for a whole range of issues until some time down the track. Often that will mean the victim will come to a police station by way of example, and that might be a week or two after the incident. So, therefore, when we look at that through the lens of the alcohol and drug collation of data, again not only is the victim providing the advice but I guess to an extent the victim is thinking back to the incident as well and trying to identify whether drugs and alcohol were present.

MR MOSHINSKY: So there's some occasions when an L17 form would be completed by police where they would not have visibility of the perpetrator when they are filling out the form?

SUPERINTENDENT HANSEN: That's correct. There would be times as well when police arrive where the perpetrator had left the scene, for want of a better term. So again you are reliant as the reporting member, I guess, on evidence provided to you through a third party.

MR MOSHINSKY: Could I take you then to paragraph 31 of your statement where you have set out some statistics. Before getting into the detail of the figures, could you just explain where these figures come from?

SUPERINTENDENT HANSEN: These figures have been provided to us by the Crimes Statistics Agency, who are the oversight body now for reporting on Victoria Police data.

MR MOSHINSKY: Can you then take us through these figures and explain what the figures are, perhaps starting with the year ending 30 June 2014?

SUPERINTENDENT HANSEN: Yes. So at 31.1, 12,686 perpetrators as at 30 June 2014 were identified by attending police

officers as definitely being affected by alcohol, and 10,558 perpetrators were identified by attending police officers as possibly being affected by alcohol.

MR MOSHINSKY: Just stopping there, does that indicate that the Crimes Statistics Agency has indicated - these figures are taken from the L17 police incident reports that we were referring to.

SUPERINTENDENT HANSEN: That's correct.

MR MOSHINSKY: That for the year ended 30 June 2014 there were 12,686 perpetrators identified in the reports as definitely being affected by alcohol, and 10,558 identified in the police reports as being possibly affected by alcohol?

SUPERINTENDENT HANSEN: That's correct.

COMMISSIONER NEAVE: Can I just clarify what's the total number of perpetrators identified in the L17s for that year, roughly? You don't have to have the precise figure, but I'm trying to get a feeling for the proportion of total incidents, total perpetrators.

SUPERINTENDENT HANSEN: I will have to refer to the annexure.

MR MOSHINSKY: Yes. If I could ask the Commissioners and the witness to look at exhibit TH-6 to Superintendent Hansen's witness statement.

COMMISSIONER NEAVE: Yes.

MR MOSHINSKY: Then in that document which has the Crimes Statistics Agency figures going over several pages there is a page which has the long number that ends .0101.

COMMISSIONER NEAVE: I'm not sure that I have that, but perhaps you could just tell me roughly what's in it.

MR MOSHINSKY: The number starts WIT. Do you have that at the top of the page, Commissioner?

COMMISSIONER NEAVE: Yes, I have. I have the exhibit.
MR MOSHINSKY: It's about four pages in, I think.
COMMISSIONER NEAVE: Thank you.
MR MOSHINSKY: Superintendent Hansen, do you have that page with you? You may not have the same numbering.
SUPERINTENDENT HANSEN: I'm not sure I do.
MR MOSHINSKY: Do you have the page for the year with the June dates?
SUPERINTENDENT HANSEN: Yes, I do now.
MR MOSHINSKY: That table there, at the far right of that table has 2013 to 2014 figures.
SUPERINTENDENT HANSEN: Yes.
MR MOSHINSKY: And the second last column has the figures which match up with paragraph 31 of your affidavit.
SUPERINTENDENT HANSEN: Yes. The figure is 12,686, 10,558 for a total of 23,244.
MR MOSHINSKY: Does that page help you answer the Commissioner's question as to what proportion of the total do the figures represent?
SUPERINTENDENT HANSEN: The page indicates here 35.7 per cent.
COMMISSIONER NEAVE: Thank you.
DEPUTY COMMISSIONER FAULKNER: Just before you proceed, counsel, I'll just ask a matter of clarification.
I understand that you have said that it's subjective testing. I want to know is there any reason it's subjective. Is there a legal requirement that you can't breath test somebody unless they are in charge of a car or is there an operational reason? I understand that drug testing is more complicated, but why is it subjective?
SUPERINTENDENT HANSEN: Exactly as you outlined, Commissioner. Either drug or alcohol testing in those circumstances

would have to be undertaken voluntarily. There is no legislative requirement.

MR MOSHINSKY: If I then ask you to go to the figures for the year ended 30 June 2014 for drugs that you have set out. Could you please read out those figures.

SUPERINTENDENT HANSEN: 5,764 perpetrators were identified by attending police officers as definitely being affected by drugs, and 13,474 perpetrators were identified by attending police officers as possibly being affected by drugs.

MR MOSHINSKY: By reference to the annexure are you able to say what proportion that represents of the whole?

SUPERINTENDENT HANSEN: Yes, just let me catch up.

29.5 per cent.

MR MOSHINSKY: Are the two categories there, the alcohol figures that you referred to and the drug figures that you referred to, mutually exclusive?

SUPERINTENDENT HANSEN: No. So there's the issue of polydrug use that would come into place. So there might be overlapping there where a person is identified as both affected by drugs and alcohol, which is quite common in the AOD world.

MR MOSHINSKY: In the next subparagraph you have some information about how those figures compare with the figures for the year ended 30 June 2010. Could you please take the Commission through what you have set out there?

SUPERINTENDENT HANSEN: The number of perpetrators identified as definitely affected by alcohol as of 30 June 2010 was 9,206 of those identified as possibly affected by alcohol, which had more than doubled over the five-year period.

MR MOSHINSKY: So I think in paragraph 31.2, paragraph (a), you

indicate a 37.8 per cent increase in the numbers for those definitely affected, and more than doubled in the numbers for those possibly affected.

SUPERINTENDENT HANSEN: That's correct, yes.

MR MOSHINSKY: Then in paragraph (b) what is the comparator for drugs between 2010 and 2014?

SUPERINTENDENT HANSEN: The number of perpetrators identified as definitely affected by drugs increased more than threefold from 1,667, and those identified as possibly affected by drugs more than doubled from 5,741.

MR MOSHINSKY: Thank you. You referred earlier to the process by which the information on the L17s is completed in answer to some of my questions. Based on those processes do the figures that we have just been through, in your opinion, possibly underreport the presence of alcohol or drugs?

SUPERINTENDENT HANSEN: That's a definite possibility. These are subjective testing, and especially I guess with drugs it's quite easy to mask the consumption of drugs from another person unless you are specifically trained in that.

MR MOSHINSKY: I want to then ask you some questions about liquor licensing over the years which you also refer to in your statement. The actual process of licensing outlets to be able to sell liquor, who handles that?

SUPERINTENDENT HANSEN: The agency that sits across it I guess is the Commission, but Victoria Police is a key party in that process as far as objecting or otherwise to a new application, seeking a variation to a pre-existing application or requesting an inquiry into a premise or a person that may not be deemed to be a fit or proper holder

of a licence.

MR MOSHINSKY: The Commission, is that the Victorian Commission for Gambling and Liquor Regulation?

SUPERINTENDENT HANSEN: That's correct.

MR MOSHINSKY: Does Victoria Police have some input into the process of whether new licences are issued by the Commission?

SUPERINTENDENT HANSEN: Upon a new licence being applied for, that application is referred to the local area commander of where the licence is relevant to. That local area commander will make enquiries in relation to the impact on the amenity of the area and the suitability or otherwise of the person to hold a licence and will then either object or not object on behalf of the Chief Commissioner.

MR MOSHINSKY: You indicate in paragraph 46 of your statement that in the case of packaged liquor outlets they have increased by more than 80 per cent between 1993 and 2008.

SUPERINTENDENT HANSEN: That's the data that we have available to us, yes.

MR MOSHINSKY: And packaged liquor outlets, what sort of places are you referring to?

SUPERINTENDENT HANSEN: They are your retail liquor outlets, your Dan Murphy's, where packaged liquor is sold through a retail environment and generally taken home or to another place to consume.

COMMISSIONER NEAVE: And the big retailers, presumably, Woolworths, Coles, all of those bodies?

SUPERINTENDENT HANSEN: Absolutely.

MR MOSHINSKY: Ms Carr, Catherine Carr, is going to be giving evidence later today also on behalf of the State of Victoria. She's the Executive Director, Office of Liquor,

Gaming and Racing. I might just pass forward, if that's okay, a copy of her statement. Superintendent Hansen, I just wanted to take you to a couple of figures that Ms Carr sets out. If you could turn to paragraph 33 of her statement. She indicates that between 30 June 2004 and 30 June 2015 the total number of packaged liquor licences in existence increased by approximately 26 per cent, and then sets out the figures; and then further on says, "This increase in the number of packaged liquor licences includes the establishment of big box liquor outlets which are estimated to have grown from five in 1998 to over 70 in 2015." That accords with your observations about the growth in packaged liquor outlets?

SUPERINTENDENT HANSEN: That would accord with my experiences both in my current role and previously when I have been a local area commander in both southern and northern metropolitan Melbourne where I dealt with those applications; a significant growth.

MR MOSHINSKY: She also indicates at paragraph 44 that, "The packaged liquor market is the largest liquor industry sector, reportedly accounting for over three-quarters of all alcohol sold in Australia." Does that accord with your observation that packaged liquor represents the majority of the liquor that is sold?

SUPERINTENDENT HANSEN: That wouldn't surprise me. I don't have data to confirm that or otherwise, but intuitively that would not surprise me.

MR MOSHINSKY: Just going back then to your statement, at paragraph 46 you make some observations about the connection between availability and harm by way of violence, including family violence. Could you elaborate

for the Commission what observations you would make about the connection based on Victoria Police's own data and experience?

SUPERINTENDENT HANSEN: We maintain a separate database called ADRIFT, which ADRIFT is attendance data when someone comes into police custody to be processed. This includes incidents of family violence as well. The data that we have drawn from there shows that in relation to assaults where alcohol was prevalent 53 per cent of those assaults occurred off premise and 21 per cent occurred either on premise or near a premise. What that tells us, I guess, is that packaged alcohol is a significant driver to non-premise alcohol related assaults, is one observation I would make.

Likewise, we have read Michael Livingston's review and I cite that in my statement. The data out of there again correlates with Victoria Police data around the number of assaults that are occurring directly out of, I guess, alcohol related incidents, and also how packaged liquor equates for 10 per cent of the outlets but supplies 75 to 78 per cent of the alcohol that's consumed around Australia. So again our own data and research sort of corroborates that.

COMMISSIONER NEAVE: Can I just clarify something. In your paragraph 47 you refer to alcohol consumed in domestic dwellings and public places. I suppose some of these offences could be people who have consumed alcohol in licensed premises and then left the premises, and the assault occurs outside the premises. Am I reading that correctly?

SUPERINTENDENT HANSEN: Yes, that could be exactly the case.

COMMISSIONER NEAVE: So we can't be absolutely confident that all of this was alcohol consumed in a domestic dwelling?

SUPERINTENDENT HANSEN: That's correct.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: I want to move then to the section of your witness statement at paragraph 54 where you turn to potential measures such as bail conditions and other measures which could be explored and in some cases have been explored by Victoria Police picking up programs, some of which we heard about in the evidence this morning, such as the South Dakota program. So I was wondering if you could, Superintendent, please, tell the Commission about what steps were taken, for example, to look at the South Dakota program and see whether something like that could be trialled in Victoria.

SUPERINTENDENT HANSEN: The South Dakota program initially came to our attention in 2014 through some contacts we have with VicHealth. So we went away and explored that, how it could be incorporated within the Victorian jurisdiction, potentially just in the drink driving setting or more broadly than that.

We also reviewed, I guess, the South Dakota experiment alongside the Credit Bail Support Program, which is already in pre-existence in Victoria, and we identified a number of limitations which probably at this time don't make it a sort of viable proposition for us to explore further and trial. They were mainly around the cost of alcohol and drug treatment services and our availability to get easy and readily access into alcohol treatment services; the commitment of police resources to monitor drug and/or alcohol bracelets or anklets; and then

also, as was highlighted through the panel discussion, the need for swift action when a breach is detected, the ability for police quickly in the current sort of environment where we have a whole lot of priorities and competing demands for us to quickly and efficiently and effectively bring someone in to the attention of the courts once a detection had been identified.

There were also some limitations with the current Bail Act that we identified, and that is primarily the Bail Act in Victoria is set up, I guess, to limit the opportunity of absconding or further offending. Generally the Bail Act considers serious levels of offending. So for the volume amount of crime that we may have been looking for or certainly through a road safety lens there would probably be a reluctance by the courts, was our advice, to enact provisions of the Bail Act in those circumstances. So it was a combination for us of the need for legislative reform, the availability of drug treatment services and the cost, who was going to bear that, and also the impact potentially of police resources.

MR MOSHINSKY: Just on the practical technical sides of it you mentioned the ankle bracelets. Did you investigate breathalyser tests such as referred to this morning as a possible way of testing?

SUPERINTENDENT HANSEN: Where someone comes to the police station are breath tested?

MR MOSHINSKY: Yes.

SUPERINTENDENT HANSEN: We did. Again the impact on the police service to do that - I don't know whether you have been in a police watch house recently, but they are very busy environments. Again, the impact that that would have had

on a whole range of functions that we deliver through a police watch house was considered quite, I guess, imposing on what we would be able to deliver and what we would be able to achieve.

COMMISSIONER NEAVE: I just wonder whether there had been any investigation of the possibility of outsourcing the actual testing, and I can imagine some problems with that. But was there any investigation on having a body which the person went to be tested regularly every day or something?

SUPERINTENDENT HANSEN: Yes, there were discussions around that and again cost came back, in a period of austere measures, I guess. Whether that's right or wrong, that was certainly a consideration of ours.

MR MOSHINSKY: I will come back to other projects in a moment, but could I invite Associate Professor Miller - if you have any observations about the project in Victoria to look at the South Dakota system.

ASSOCIATE PROFESSOR MILLER: A slight correction. When Assistant Commissioner Lay was in charge of traffic he was made aware of this in 2010. So I brought it to the attention of Victoria Police quite a few times.

I think the key thing here is that the model - and I applaud Victoria Police and have discussed it with them initially about trying to get something going, and I really applaud that effort. The key issue really came down to trying to fit it into the bail model, which is not appropriate for this model. This model is not a bail intervention because, first of all, the person hasn't even actually been demonstrated to be guilty of the offence, necessarily.

The model that's implemented in South Dakota is

one of where somebody has been convicted of the offence and it's an alternative to gaol. So I think that's a key issue that we need to address in terms of that. Also the Bail Act requires treatment whereas, as we discussed before, in fact the 24/7 model doesn't involve treatment at all, and that was one of the major costs and impediments that Victoria Police found.

Another key issue is around the use of those bracelets rather than breathalysers. When someone has to wear a bracelet it's quite stigmatising. Everybody knows that you are wearing it. The only other group in our society that wear bracelets on a regular basis are sex offenders. So there are issues around using that technology. It is also expensive.

So the consideration we need to be thinking about is what resources we can use within the Victorian justice system as a whole to try to implement this rather than - again, Victoria Police tried to do it under their remit, but we need Corrections on board to be able to do this properly, and we need the courts on board and we need legislation that allows that to happen and in fact encourages it to happen strongly.

MR MOSHINSKY: So you are referring to quite a few components of the overall system that need to be on board: legislative change, the police, the courts and Corrections.

ASSOCIATE PROFESSOR MILLER: And certainly the courts and police are very aware and very supportive of this model. We have worked closely with courts, with the deputy magistrates and the Chief Magistrate is very supportive, and Victoria Police have been supportive in trying to get

a model up. We can all see the benefits of it. The key thing is it actually needs to be driven from a higher level and we need to see some legislative change to enable that to happen.

MR MOSHINSKY: Superintendent Hansen, have there been other pilots or have there been other opportunities to look at overseas programs and whether something similar or an adjusted form of it could be used by Victoria Police?

SUPERINTENDENT HANSEN: In the panel discussion this morning there was talk about the Hawaiian HOPE Project and, likewise, we have reviewed elements of that and its suitability to be incorporated, I guess, from a Victoria Police point of view.

Again, as Peter rightly points out, we look at these projects through a specific lens and our part of the justice portfolio. So we are reliant on a whole of government approach to get any of these trials up. We are supportive of the concepts behind the South Dakota project and we are supportive of the concept behind Project HOPE in principle. But we make that observation dependent on the support of a whole range of agencies which also need to come to the party. First and foremost is access to funding and budget support as well.

MR MOSHINSKY: You refer also in your statement at paragraph 62 to intervention orders and the potential for intervention orders to be used more. Could you explain for the Commission what sort of ways intervention orders could be used more in this way?

SUPERINTENDENT HANSEN: I will keep it again through the lens, I guess, of the alcohol and drug aspect of it and more broadly that might be something that's fleshed out later

through the inquiry, if that's all right with the Commissioners.

From a Victoria Police point of view we would be happy to see changes which heightened, I guess, breaches of intervention orders and especially when it comes to bail conditions so that the offenders or alleged offenders were put in a position where they had to show cause why they wouldn't be remanded or why they wouldn't be put in a position where they had severe conditions imposed on them by way of bail. Again, likewise, we would say that could be considered by way of alcohol or drug treatment or access to that treatment as well, and zero blood alcohol conditions and abstinence from drugs conditions as well.

But, again, I make the observation that the whole system would need to - it would have to be a joined up approach through the whole of the justice portfolio for that to work effectively. We are also mindful of the impacts that would have on rates of incarceration across Victoria, the ability of the gaol system to have the capacity to incarcerate further numbers of offenders, and also the ability of Victoria Police to swiftly react to orders that come from the courts and things like that by way of extra resourcing.

MR MOSHINSKY: I was just going to move on to the next section of your statement, but are there any other observations you would like to make, Superintendent Hansen, about things that could be done differently in relation to alcohol and drugs in terms of Victoria Police's response?

SUPERINTENDENT HANSEN: If it's all right with the Commission, I might just give an example of what we have trialled as far as an initiative goes. So after considering Project

HOPE and the South Dakota trial we actually out at Dandenong implemented a trial of our own which is called the Alcohol Diversion Program and it is based in our southern metro region.

We identified there was a cohort of 15 young males out in the Dandenong area that were committing a whole range of alcohol related offences, to the extent that one of the males actually worked up over $100,000 worth of fines. So for some public drunkenness type offences they can be expedited by way of a penalty notice rather than going to court. So we had one offender here who had incurred over $100,000 worth of fines, and then we had within that cohort a whole range of offending and outstanding sheriffs' warrants.

So we got this group together. We realised quite quickly we weren't changing the pattern or consumption of alcohol, and we realised we weren't breaking the cycle of offending either; so looking at it through that preventative lens where our members out there wondered, "What can we do?"

So they got representatives of that cohort's community group together, local police got together and basically they came up with a program where that cohort would voluntarily sign up to become part of a program which provided a therapeutic justice based approach. So it offered them or it covered off on issues or underpinning issues such as transitional housing, counselling, mentoring, alcohol and drug recovery, peer support, a real holistic approach to, I guess, the drivers of their drinking and therefore the drivers of their offending.

We currently have 12 people going through that program at the moment. The first person is due to graduate in the coming weeks. He's remained sober during the period. So there is also screening for alcohol and drugs that goes hand in hand with this. He's remained sober and abstinent over that period of time. He's undertaken a range of programs, including education and retraining to enter the workforce. He will graduate in the next couple of weeks. At that point in time Victoria Police will go back before the courts and make applications for those sheriffs' warrants to be wiped; so the total amount of $100,000.

So we are seeing some real value. It's based loosely, I guess, on the concepts of Dakota and of Project HOPE. It was our way of navigating through some of the difficulties and limitations that we had identified.

MR MOSHINSKY: In the next part of your witness statement, at paragraphs 65 and 66, you deal with limiting alcohol advertising, and in the last part of paragraph 66 you indicate Victoria Police's position. Could you just explain that to the Commission, what is Victoria Police's position on this issue?

SUPERINTENDENT HANSEN: In relation to alcohol advertising. We are supportive of any legislative reform that seeks to limit the harms associated with alcohol. So, whether that be through reduction in alcohol or whether it be through other avenues or tools within legislative reform, we certainly understand there's value to consider those.

What we do ask, and I guess it was a theme that came up in this morning's panel, is that these matters are always evaluated. So, by way of example - and I will just

divert a little bit and then get back to your point - I'm involved with Peter in the Freeze Extension Working Committee and also looking at some harm reduction reforms to be trialled across Victoria. We find ourselves in this position currently because the initial freeze was never properly evaluated. We never really understood what was working and what wasn't working.

MR MOSHINSKY: Could you just explain what you are referring to about the freeze extension?

SUPERINTENDENT HANSEN: So the freeze was an initiative of the State Government across four LGAs to limit the number or the future increase in late-night licences across those four LGAs. It came to a conclusion, I think 30 June it was, and there was a decision by the State Government to extend that primarily because again a lack of evaluation around the success of the original freeze. So Peter and I both were involved in a subcommittee of the Liquor Control Advisory Committee that looks at harm reduction strategies that may be able to be implemented statewide at different trial sites and are properly evaluated so we can report back to the Liquor Control Advisory Committee on a way forward post the freeze or whether the freeze should remain in place or whether the freeze should be extended across the State of Victoria.

MR MOSHINSKY: LGA, you are referring to local government authorities?

SUPERINTENDENT HANSEN: Areas, yes, that's correct.

MR MOSHINSKY: Commissioners, those are the questions I had for the witnesses. Did the Commissioners have any questions they wished to ask?

DEPUTY COMMISSIONER FAULKNER: Superintendent, I'm interested

in this pilot that you have conducted, a therapeutic diversion program at southern, and you talked about being able to offer a range of supports to this group of people. How much of this is abnormal in terms of - I think you mentioned housing services, alcohol and drug services. Have you had to jump queues or has there been some special arrangement made to enable this group of people to get any form of assistance that's usually difficult to get?

SUPERINTENDENT HANSEN: Probably to give some context there, in southern metro region another concept, I guess, that we are trialling is we have an internal process called our tasking and coordination process and that very much looks at emerging crime trends and issues that we need to deploy resources to both in a responsive fashion but also in a preventative fashion.

What southern metro are trialling is bringing other government agencies to the table to have that discussion. So it's breaking down a lot of the barriers and the silos that are prevalent not only across the justice portfolio but across the whole of government. Straightaway we have influential decision makers at the table to have discussions around these type of issues.

So my take on that is was that format was very successful in getting agreement and buy-in from other government agencies to actually come to the party once they understood what the demand was and the harm that was being caused across their local area.

DEPUTY COMMISSIONER FAULKNER: But did it involve, for example, DHHS facilitating access to housing or the queues for alcohol and drug treatments? That's very specifically what I'm asking.

SUPERINTENDENT HANSEN: I don't know specifically whether we were able to fast track access to, but what I do know is it was looked at in a very sort of specific light and as much assistance that could be given to the program was provided. Whether that fast tracked access to housing or to alcohol and drug services, in relation to alcohol and drug services I suspect so because I know there is a limitation about how quickly we can get people into alcohol and especially drug treatment services.

COMMISSIONER NEAVE: I had one further question. I wonder whether any consideration has been given to the use of something like the South Dakota model in relation to community corrections orders. In the drugs court, as I understand it, people are required to undergo regular testing. Again, that's a model which might have some potential for dealing with some of these issues, although the drugs court is only available to people in particular areas, as I understand it.

SUPERINTENDENT HANSEN: Yes, and generally not mandated as well. So that would be another thing we would have to look at. But, absolutely, Peter and I have had this discussion that through those court orders, the community corrections court orders, that would be the appropriate solution in these circumstances. We looked at it purely through the lens of bail because that was our piece of the pie, I guess, at the time.

COMMISSIONER NEAVE: Yes, I understand that.

ASSOCIATE PROFESSOR MILLER: We discussed it with the deputy chief magistrates limb as well, and there's a drink driving list which is proposed along those sort of models and also the new family drug court model. I don't know

whether you are engaging with them at all, but they are also looking at trying to implement these sort of measures within the limitations of the law as it currently stands. So there has been a lot of that discussion.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Commissioners, those are all the questions for these witnesses. If they could please be excused.

COMMISSIONER NEAVE: Thank you very much indeed.

<(THE WITNESSES WITHDREW)

MR MOSHINSKY: We are a bit ahead of schedule. The next witness isn't available until 2 o'clock. So if we perhaps could have a slightly longer adjournment from now until 2 o'clock.

COMMISSIONER NEAVE: Until 2 o'clock then.

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

COMMISSIONER NEAVE: Mr Moshinsky.

MR MOSHINSKY: Thank you, Commissioner. The next witness is Dr Stefan Gruenert. If he could be sworn, please.

<STEFAN MARTIN GRUENERT, affirmed and examined:

MR MOSHINSKY: Dr Gruenert, could you please outline what your current position is at Odyssey House and give us an overview of your professional background?

DR GRUENERT: I'm currently the Chief Executive Officer of Odyssey House Victoria. I have been in that role for eight years. I have worked in the drug treatment sector for around 15 years as a counsellor, as a manager clinician, and I'm a psychologist by profession.

MR MOSHINSKY: In your statement you indicate that you have conducted research on alcohol use, treatment effectiveness, intimacy, family work and fathers, and the focus of your doctorate was on men and intimacy; is that right?

DR GRUENERT: Yes.

MR MOSHINSKY: You have prepared a statement for the Royal Commission?

DR GRUENERT: Yes.

MR MOSHINSKY: Are the contents of your statement true and correct?

DR GRUENERT: Yes.

MR MOSHINSKY: Could you outline for us briefly the types of services that Odyssey House provides, both residential and outside of the residential sphere?

DR GRUENERT: Odyssey House is a statewide drug and alcohol treatment service. We provide a range of services. We are probably most well known for our residential

rehabilitation programs, which are live-in programs and which we have two of those. One is in Lower Plenty in Melbourne, a 97-bed facility, and another one up in Benalla, a 15-bed facility, which is a shorter term program.

We have a range of counselling, assessment, home/family visiting programs, some prevention programs, we work in community schools, and we are also a registered training organisation that delivers training to both professionals and some of our clients.

MR MOSHINSKY: Approximately how many clients do you have in the community each year?

DR GRUENERT: We probably work with over 5,000 community service clients each year and around about 500 in residential programs.

MR MOSHINSKY: Recently, as in over the last couple of years, you have been involved in preparing two key resources, two documents, for use in the alcohol and drug sector. You have attached them to your statement as SG-1 and SG-2, so those documents are available to the Commission. One of them is called, "Can I ask: an alcohol and other drug clinician's guide to addressing family and domestic violence" and the other is called "Breaking the silence: addressing family and domestic violence problems and alcohol and other drug treatment practice in Australia." Could you tell us a bit of the genesis of those two documents, how did they come to be brought into existence?

DR GRUENERT: Sure. For a number of years I became more and more aware that family violence was an issue that the drug treatment sector hadn't really dealt with appropriately.

It was a can of worms, I guess, that we hadn't opened or uncovered. While we had been working hard to build the capacity of our sector to work with people with mental health issues and to work better with families and with children, family violence had been one issue that hadn't been addressed.

I kept my eye out for some funding opportunities to do some more work in this area, and we came across a Commonwealth grant, which we applied for. We did that in partnership with NCETA, the National Centre for Education and Training on Addiction. We were successful in that grant. Originally we were going to do just a small literature review to inform a resource for the sector, and NCETA decided to put some of their own resources into that to expand that literature review.

Following that literature review we ran a number of focus groups with the clients of Odyssey services and with a number of staff and a peak body in the drug treatment sector, and we worked with a steering group of people from the family violence sector, some academics to put together this resource, which I guess was the first step in a journey of raising awareness in the drug treatment sector that family violence was something that was certainly occurring within our clients and that should be something that we need to get better at addressing and form better links with the family violence sector.

MR MOSHINSKY: Is one of the two documents the literature review part, and the other document - what's the purpose of the document?

DR GRUENERT: So the purpose of the document was to be a resource for drug and alcohol workers and managers,

organisations working in drug treatment, and it was to help those workers, from the front-line workers to the managers, to understand a bit more about what family violence is, the associations with drug and alcohol, and to give some practical tips and ways in which drug treatment organisations could better screen and assess their clients for both the use of family violence among their clients and the experience of family violence amongst clients, and provide some interventions and also some referrals to some specialist services.

MR MOSHINSKY: You referred to the advisory group that came together as part of the project, and it involved people from the family violence sector as well as the alcohol and drug sector, if I can use those labels. Do you have any observations about what happened when the two sectors came together to work on this project?

DR GRUENERT: Sure. One of the things that we discovered quite early on, which we have also discovered when we have tried to create better links with other sectors, is there is often a difference in language and how we use words and what we mean by them. I think the most interesting observation or distinction that came up was around the use of words such as "perpetrator" and "victim". It has been common practice in drug and alcohol and mental health services, many of the helping professions, to label someone's behaviours rather than to label them as a person.

The reason for this is that labels to people, such as if you called someone a schizophrenic or an addict, can be very stigmatising, and by labelling behaviour it also suggests that that behaviour can be

modified and changed. So it is very important in our sector we label behaviours rather than labelling people. So those working in our sector were much more comfortable talking about people who use violence in their relationship than "perpetrators", and people who experienced violence in their relationship rather than "victims" or even "survivors" of violence.

Another reason that's particularly important in the drug treatment sector is because many of our clients have both experienced violence in their relationship, sometimes it's children, and then gone on to use violence in their relationship. So to some extent they have been both a perpetrator and victim, and it's much better to talk about their experience of violence and their use of violence in relationships than those words.

I think the other thing that came out of the experience of working with the family violence sector was the degree to which each sector assumed that the work could only be done by specialists and the level of training that was required. We know in our sector that many clients don't take up referrals to other sectors, and we have worked hard to try and skill our practitioners, our clinicians up to do the best they can in some brief interventions in case those clients don't make it into other sectors.

So I think what we found is that there was a greater level of expertise in pockets to address family violence in our sector than perhaps was understood or expected, and that our view was that our clinicians certainly would be able to assess for someone's experience of violence, put in safety plans, make appropriate

referrals across the board. But not only that. I think we saw that our sector, because two-thirds of those who access drug treatment services are men, we have a very privileged and unique opportunity to be able to intervene early with men and in their relationships to prevent family violence occurring. If we simply only made referrals our concern was that those wouldn't be picked up. So we had to I guess negotiate about the way we framed that in our resource.

MR MOSHINSKY: You referred earlier to the mental health sector and the alcohol and drug sector. Are there any observations about how those two sectors have interrelated that might be relevant here?

DR GRUENERT: Yes, absolutely. I think the work over a number of years to build capacity within the drug treatment sector to better identify and work with clients who also have a co-occurring mental health issue has been a very significant journey and I think an effective one, and vice versa, that mental health services have also built their capacity to better respond to their clients' co-occurring drug and alcohol issues.

I think what that relationship over a number of years has shown is that it takes a bit of work, it takes professional development at the front-line worker level, and that that needs to be ongoing because there is staff turnover in the sector. But we also need engagement and training and support for managers, and organisational change around policies and procedures for the practice to actually be embedded. While there was a lot of good intention for many years to improve the links between those sectors to ensure that clients weren't bounced back

from one sector to the other but had a holistic assessment and had all of their needs in those two areas responded to, it did take time and it did take some resources to really bed that down. Without some ongoing level of maintenance in that area, I think that practices could easily go back to areas of speciality.

I think that has also occurred to some extent in the intersection between child and family services and the drug treatment sector. I think that journey is a bit newer and there's some great pockets of practice there, but it's certainly not consistent and it hasn't had a sustained investment to make sure that those links are really strong.

MR MOSHINSKY: I will come back shortly to the alcohol and drug sector and family violence sector relationship. But, before I do that, in terms of those resources, the two documents that we have referred to, have they been implemented yet?

DR GRUENERT: No. So these resources are really a first step in trying to raise awareness and get engagement amongst the drug treatment sector, and on their own, sitting on the shelf, they are not going to have much impact. So certainly we see the next step as being a greater implementation of these and a range of other initiatives to I guess raise the level of practice in the drug treatment sector and improve the links between sectors. So, no, they haven't been implemented.

Again, there are some pockets of practice where aspects of this resource are being done. Whether they have seen it or not, that's certainly occurring. But they are fairly limited.

MR MOSHINSKY: Can I ask you about the extent to which, in people who either your organisation sees or the alcohol and drug sector more generally sees, you see people who have experienced family violence or used family violence?

DR GRUENERT: I think we rely on some of the studies, including international findings, around the proportion. Our understanding is it depends whether it is asked and who you ask. So most people in the sector would recall a lot of anecdotes if you asked them but would struggle to put a figure on it. I imagine that it's somewhere between 50 and 80 per cent of the clients accessing our services have experienced or used violence in their relationships. But again I think if you don't ask or perhaps if you only ask once at a very initial point in your engagement with someone you are not likely to fully uncover the extent of that.

I think it's fair to say that many of the clients that we have had discussions with actually don't appreciate what family and domestic violence is or the extent of it . They see violence as physical violence, sometimes sexual violence. They don't appreciate until you have the conversation. Controlling behaviours, stalking, linking phones to find someone's whereabouts, controlling finances or who someone has access to in their social relationship circles - they don't see that as violence. Many have grown up in households where violent behaviours are just commonplace and they have become certainly normalised in their life.

So part of the conversation is actually an education of helping clients to appreciate the full extent of controlling behaviours and what constitutes family

violence. I think if you have those conversations you would get a fairly different response around the degree to which people say, "Oh, yeah, that occurs in my family," or, "Yeah, they are things that have been done to me" or "that I have done with others".

MR MOSHINSKY: You indicated that it might be something in the order of 50 to 80 per cent of clients in the alcohol and drug sector who have either used or experienced family violence. Can you comment on the relationship between family violence and alcohol and drug - drugs in the sense of is there a bidirectional relationship as you see it?

DR GRUENERT: Yes, so I guess our view, and I think this is also shown in the literature, is that alcohol and drugs don't cause violence. We know that because there's a number of people who use drugs and alcohol who aren't violent in their relationships and many people who use violence or experience violence in relationships where there is no drug and alcohol.

I guess we see the association and the strong association as a bidirectional one in that where violence is present if there's also drug and alcohol it typically increases or contributes to the increased frequency of violence, so it's occurring more often, and the severity of violence in that the injuries are often more severe and intimidation and the fear that goes along with it is more severe.

But the reverse is true as well. So in relationships where drug and alcohol use is present, if you add family violence and violence into the mix, what we see is an increase in the frequency of drug and alcohol use and the severity and intensity of drug and alcohol

use. So together the presence of both of those seem to exacerbate each other and I guess create a spiralling pattern within that relationship, a negative spiral.

MR MOSHINSKY: We have talked about those resources, and you have said there are some pockets, I think, where in the alcohol and drug sector there is some awareness of family violence issues. To what extent are there programs in Australia which bring together alcohol and drug treatment together with the types of services that would be available from the family violence sector, bringing the two together? Do they exist in Australia at the moment, and what opportunity is there, in your opinion, to provide programs that integrate the two?

DR GRUENERT: So I think my knowledge is that the number of programs that formally do that is fairly limited. I think it's fair to say that staff in the community service sector often move between one type of service provision and another. So there is certainly people within the drug treatment sector that have worked in family violence or men's behaviour change programs in the past, including within our own agency. So they bring with them some knowledge and understanding and some details around interventions.

I think some programs by default end up working in this area in a less formal way. One of the fundamental things that we do in drug treatment in terms of helping people change their behaviours and bring about sort of sustainable change and recovery is working with people and their relationships. That's often seen as the No. 1 thing that we need to address: helping them to develop and maintain positive relationships. That's really important

for maintaining and achieving recovery around addiction issues.

So in addressing people's relationships you are always looking at what models that they have drawn on, what experiences they have had in their past, how they relate in their current relationships. In that sense many counsellors and many people are addressing some of those as part of the work they do in drug treatment.

I think what's often lacking is any framework or structure around that and consistency in that practice. I think that's where the enormous potential is in our sector. Particularly in residential programs I think the way people relate comes to the surface much more quickly, so there's a much greater level of practice in addressing violence in people's relationships in those services than in many community services.

But I think there's a huge opportunity right across the sector for all clinicians to be screening for, assessing for family violence, and that not to just be something you do once at the start of treatment but that you continue to do that as you develop a relationship and ask and invite different conversations amongst your clients as you build the trust.

MR MOSHINSKY: In the session this morning there was some evidence from Professor Humphreys, who made some observations to say that she - and I'm just paraphrasing - felt that, taking, for example, women who have experienced family violence, family violence aspect is done poorly in the alcohol and drug sector, and alcohol and drugs is done poorly in the family violence sector, and she I think was favouring a holistic response to both

and said that there was tremendous opportunity. Do you have any observations about those comments?

DR GRUENERT: I certainly would agree with her comment, notwithstanding that there is some examples of good practice. In a number of the programs that Odyssey runs, and I think this is true for some organisations, where you have had a specific family focus - for example, we have a Commonwealth funded program called Kids in Focus. We work with parents with addictions where typically they also have mental health and family violence in their relationships, and we are working with them holistically. Child Protection is typically involved.

The same can be said in family programs, residential family drug treatment programs. It's usually fairly clear and it's stated often on orders and things that come around child protection that there's family violence been involved.

So in many of those programs in fairly formal ways we have been and we continue to work with family violence as one of a number of things to address with those families. But it definitely is fair to say that that practice is not consistent across the youth or adult sector, where often you are working with one person. That may be a woman who has experienced violence in a relationship as a child, in current relationships or in past relationships, and the focus has just been on their drug treatment, maybe on their mental health, and the question may never have been asked whether they feel safe in their relationships, whether there's been any of the controlling behaviours and safety plans put in place, any specialist referrals made or some brief interventions

around that. So I think there's great opportunity to improve that practice.

MR MOSHINSKY: She also referred, in terms of people who have used violence, to the men's behavioural change programs, they are not being - an incorporation of alcohol and drug treatment together and was suggesting that there was potential - it was an area that we haven't tapped the potential, and referred to the need to have people with training in both who champion it and the need for champions. Do you have any observations about that?

DR GRUENERT: Yes. I'm a strong believer of quite a generalist front-line workforce across community services that can assess for and work with people holistically, and I think there's equally an opportunity in the family violence sector for the staff, the workers there, to have better understanding and knowledge of drug and alcohol issues, to be able to do some brief interventions when they are working with the clients, accessing their services and to have stronger links and referrals.

We have certainly experienced a number of women who have tried to seek support or help at times from family violence services and been knocked back or felt ashamed and stigmatised because of their issues of addiction or because of their intoxication. That's certainly understandable. But I think what's that done is create barriers for them to seek help from those services and to think very carefully about whether they disclose either their drug and alcohol issue when seeking help from family violence services and, likewise, to talk about their violence when they are seeking help from drug treatment sectors, often because of issues around child

protection and sometimes for fear around this is going to have implications in their relationship and what that might mean. So I think there's opportunities on both sectors to improve practice.

MR MOSHINSKY: In terms of the programs that exist at the moment I think you have indicated that these types of integrated holistic programs either don't exist or there's very limited examples where they happen. So it's probably not possible to talk about evaluation of those programs. If we talk about alcohol and drug programs, to what extent has there been evaluations of the success or otherwise of those treatment programs?

DR GRUENERT: There's a good body of international and some local evidence around drug treatment programs, and I guess that body of research suggests that treatment works for some people some of the time. So there's no one treatment that works for everyone all the time, and consequently we have a smorgasbord or a whole suite of treatment that works with different people at different levels of severity and also depending on what sort of goals they have around reducing the harm from their drug use all the way through to wanting to make big changes in their lives. Some of those come from medical models, some are psychosocial. So we have a good body of evidence there.

We have quite good understanding of what some of the critical ingredients in those treatment approaches are. I think the ones that focus very much on people's relationships and on their ability to regulate their emotions certainly have been effective alongside pharmacotherapies.

In the family drug treatment space, the programs

that focus on parent-child relationships seem to be the ones that are most effective. So we have a good understanding that working with people around their relationships is critical, and I think that would inform a much better response to what our sector is doing around family violence.

Having said all of that, while there's been a number of evaluations and reviews at the Victorian State level around drug treatment programs and various components of them, we have undergone a recent reform to our service to try and address some of those issues. But many of them haven't followed up long-term outcomes for clients. So I think it's very early in the new reform services to see whether those changes are actually benefitting clients long term, and the research is fairly limited in long-term evaluation of drug treatment programs in Victoria.

MR MOSHINSKY: What sort of waiting lists are there? If someone wants to get into or a court wants to send someone to an alcohol or drug program, in practice in Victoria these days what sort of waiting lists are there?

DR GRUENERT: That's complicated - to give a complicated answer to that question, it depends really what type of treatment you are seeking and where you are seeking it. In some parts of Victoria you would be able to get a response immediately, and that might be some telephone support, that might be a screener to identify what sort of issues you have over the phone, or even if you walk up you may be able to get a very brief - some information and a brief sort of assessment.

To then follow that up with a more comprehensive

assessment might take between one day and six weeks, again depending on which area of Victoria you are in. Then referral to counselling, withdrawal or detox may be from a number of days to a number of weeks. If you are then thinking about residential treatment, which is for those people in the system who have typically tried a whole range of other types of treatment, that can be anything up to three, four, five, six months.

There is some priority given to certain client groups. So your ability to get into any part of the system will depend on a number of issues - one, the severity of your drug use, obviously, but also whether you have co-occurring legal issues, whether there's safety and family issues that go along with that, whether there's co-occurring mental health issues, whether there's homelessness. So all these things are weighed up and some prioritisation is given.

So certainly clients with legal issues on orders - other things are often prioritised to get more immediate access. But the waiting lists for some parts of the system are still too long, in my opinion.

MR MOSHINSKY: Is there currently any prioritisation available if you are a person either using family violence or experiencing family violence?

DR GRUENERT: That wouldn't be specifically named as a condition. But in the sense that if you are experiencing violence and it's been identified that your current situation is unsafe or you might not be living at home or the protection of children is paramount, that that should elevate you in the prioritisation and you should get a more immediate response. For those using violence, again,

if there's a current legal issue that coincides with that, again you would probably be prioritised in the system to receive more immediate response.

MR MOSHINSKY: Thank you. I wonder if the Commissioners have any questions?

DEPUTY COMMISSIONER FAULKNER: Dr Gruenert, I'm interested just in that last point. I would interpret your answer as saying that you might have to wait for a very specialised service for up to six months?

DR GRUENERT: Yes.

DEPUTY COMMISSIONER FAULKNER: Is it ever longer than that or is that the worst it gets?

DR GRUENERT: In my experience that's about the worst it ever gets. Typically, even in residential treatment at the moment, it would probably be around three to four months and that would be the longest wait of any part of the system.

DEPUTY COMMISSIONER FAULKNER: Is the service long enough? So when you actually get the dose, is it the right dose of treatment that is available?

DR GRUENERT: The system is designed fairly flexibly so that that can change depending on what a person comes with. In residential treatment an effective dose is considered about 90 days, so three months. On average, people accessing residential treatment would get around four months. So the argument internationally would be, yes. There are some shorter term residential programs, and they have also been shown to be successful and sufficient for those who have a good level of community and family support around them. So many of the private providers have a shorter program that then continue the work that

was done in residential treatment back in the community.

If you are looking at counselling and other programs, again there's a lot of flexibility for a standard episode of care, which might be a briefer package. That can be extended for those more complex cases where there's other associated issues. There's also some workers in our system who can help case manage other support provided by a range of other sectors to complement the work that you might get in counselling.

So in theory the answer to that should be yes. People should get a sufficient dose to match the level of complexity, co-occurring issues and the severity of their drug use. I go back, though, to say that often the more intensive services have a longer waiting time than the ones that can provide a simpler lighter touch.

DEPUTY COMMISSIONER FAULKNER: The very last point was you mentioned that you may be assisting women who have care and protection issues for their children. Do you take children into the service?

DR GRUENERT: Yes. So there's a number of treatment programs around the country that do inter-residential treatment. So we do take children to accompany both fathers, their mothers and occasionally couples as families, up to the age of 12. Currently in Australia what's really limited is children being able to access withdrawal services, which may only be a week to 10 days with their parents. So that's been one barrier.

There is a planned service for Victoria for four beds that will allow women to be able to bring their children into detox prior to going into residential treatment. But, yes, we take children in up to the age of

12 with their parents into treatment. So that shouldn't be a barrier.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: What about the availability of detox facilities? What are the sorts of waiting times for those?

DR GRUENERT: Comparatively, Victoria has a higher number of detox beds or a sufficient number when you compare it to other states and territories compared to residential treatment. So residential treatment we have around about a quarter of the beds that New South Wales has, but we are similar on our sort of detox beds. So, again, it's a bit different depending on what area you go to. But the waitlists can be anything from a few days up to typically two to three weeks is the average time for withdrawal or detox beds.

MR MOSHINSKY: I have no further questions for the witness. May the witness please be excused?

COMMISSIONER NEAVE: Thank you. Thank you very much, Dr Gruenert.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: The next witness is going to appear by videoconference. Hello, Ms Hanna. Can you see and hear me?

MS HANNA: Yes, I can.

MR MOSHINSKY: Thank you for your time this afternoon. I will ask for the witness to please be sworn.

COMMISSIONER NEAVE: Yes.

<ALICE HANNA, (via videolink) affirmed and examined:

MR MOSHINSKY: Ms Hanna, you are the Clinical Manager of Jarrah House?

MS HANNA: That's correct.

MR MOSHINSKY: Jarrah House is a residential drug and alcohol treatment facility for women based in Sydney?

MS HANNA: That's correct.

MR MOSHINSKY: Have you prepared a witness statement for the Royal Commission?

MS HANNA: Yes, I have.

MR MOSHINSKY: Are the contents of your statement true and correct?

MS HANNA: Yes.

MR MOSHINSKY: I was wondering if you could briefly tell the Commissioners about the Jarrah House facility, what type of services do you provide there, how does it differ perhaps from some other facilities that are available?

MS HANNA: We are a 24 residential service, 24-bed residential service. We are open 24 hours a day, seven days a week. We offer medicated detox for women from substances like opiates, benzodiazepines, alcohol. Some of our clients also come off drugs such as amphetamine, marijuana and some (indistinct) drugs as well. We offer a 10-week program, four weeks of cognitive behavioural therapy and six weeks of dialectical behavioural therapy, and embedded in a program we also provide yoga, relaxation, meditation, and art therapy.

MR MOSHINSKY: Are you aware of whether there are any other or many other facilities that offer a detox facility for women with children?

MS HANNA: I think currently the only service in Australia that offers a medicated detox to women who can bring their children with them from the day of admission, and we also have women in residential treatment on what we call

selective detox, on methadone or suboxone (indistinct) programs. So they can stay on those programs, selectively detox of other drugs.

MR MOSHINSKY: Based on your work with your clients are you able to comment on what proportion approximately of the women who come have been affected by family violence?

MS HANNA: I would say anecdotally at least 80 per cent. We do a screening process during the admission process, and we ask specific questions about current violence. But what is clear throughout the stay is that a lot of women - around 80 per cent as I have said - have experienced violence in childhood and also in adult relationships.

MR MOSHINSKY: In terms of the programs that you run there for the women, is there a family violence component in the programs?

MS HANNA: It is embedded into our program in terms of looking at self-esteem, communication skills and safety. So throughout the four-week CBT and the six weeks of dialectical behavioural therapy we are looking at interpersonal relationships and communication and all those sort of issues. So, while we don't at the moment directly deal with domestic violence, it is certainly something in our minds and it is certainly actively processed during individual work with clients.

MR MOSHINSKY: Have you looked at whether there's scope to increase the family violence aspects of your programs?

MS HANNA: Yes. We have two things happening at the moment. We have an expression of interest from ACAP, which is the Australian College of Applied Psychology, looking at providing a program here initiated by psychology students running a domestic violence type of program at Jarrah

House which we are thinking about. But just as of recently we have had a partnership with our local domestic violence service and from mid-August our clients will be attending (indistinct) six weeks of actual domestic violence training sessions as well (indistinct) with our service.

MR MOSHINSKY: I was wondering if you could talk briefly about Indigenous clients. Have there been any trends or changes in the way that you have approached Indigenous clients over the last few years?

MS HANNA: Twelve months ago we were successful in obtaining a grant to employ a full-time Aboriginal drug and alcohol worker. Ever since Paula has been a part of our team we have actually almost doubled our Aboriginal women in treatment. Even more significantly, we have had Aboriginal women actually complete the whole 10 weeks and had some remarkable results in terms of their individual cases for Aboriginal women which has been really, really encouraging.

Paula, our Aboriginal worker, goes down to our local La Perouse community and is networking with clients down there and also statewide. There's a lot of referrals from outside of our metropolitan area. Those referrals are coming thick and fast, which is really good. We are really pleased with that.

MR MOSHINSKY: Apart from the number of Aboriginal women coming to use the service, has there been a change in how long they stay in the service?

MS HANNA: Yes. Prior to Paula working with us approximately 12 months ago I think the majority of women would probably stay sometimes 24 hours, possibly two to three days. We

have had women who have completed the 10 weeks and some even stay a bit longer so we can actually make sure that the transition back into the community or to longer term treatment is actually viable. So it's been a huge shift.

MR MOSHINSKY: Commissioners, those are the questions I was wanting to ask. Do the Commissioners have any questions?

COMMISSIONER NEAVE: No, I don't have any further questions, nor does Deputy Commissioner Faulkner.

MR MOSHINSKY: May the witness please be excused?

COMMISSIONER NEAVE: Thank you very much, Ms Hanna.

MS HANNA: Thank you.

<(THE WITNESS WITHDREW)

MS DAVIDSON: The next witness, Commissioners, is Horace Wansbrough. I ask that he be sworn or affirmed.

<HORACE AMBROSE WANSBROUGH, affirmed and examined:

MS DAVIDSON: Thank you, Mr Wansbrough. You have made a statement previously for the Royal Commission?

MR WANSBROUGH: Yes.

MS DAVIDSON: Can you confirm that that statement is true and correct?

MR WANSBROUGH: Yes.

MS DAVIDSON: Can you just outline your role with the Youth Support and Advocacy Service and what that service does?

MR WANSBROUGH: Certainly. So my role within the Youth Support and Advocacy Service, which I will call YSAS from now, is as a manager. But I'm also a practitioner. I have a small case load within that team, and I'm basically here as a youth worker. I look after a team that works within an early intervention program within YSAS, and uniquely for many youth services that is a much younger age range than you might typically see. So we work with people as

young as 10. It's a police diversion program. So it's working with young people who have had early contact with police.

More broadly, YSAS is known for its drug and alcohol treatment. We provide a very comprehensive range of drug treatment types, really a suite of services that might suit young people at any end of the drug treatment spectrum. So, for example, we have drop-in centres, recovery spaces. We have home-based withdrawal for young people who wish to withdraw within their own home setting, and everything from there all the way through to residential withdrawal services, which might be short-term detox, up to 14 days. We have 17 beds, mostly located within the metro, one in Geelong, but they have a statewide catchment. We have longer term residential withdrawal programs as well.

MS DAVIDSON: Thank you. You have outlined some rough statistics in your statement. Can you identify for the Commission what rate of family violence are you seeing in the young people that you work with?

MR WANSBROUGH: I think I would echo some earlier comments that were made about it depends - it depends on how far into the system you are, how complex the presentation is. So I need to also say that that question is quite difficult because, I will come clean, like in the youth sector generally and many other sectors, we don't assess for it very well. So we don't have screening tools within our common youth assessment tool that assess for family violence. What we do have is more global descriptions of "what's happening in your family."

We are certainly not assessing very clearly

whether there's intimate relationship violence happening. It just happens in our model that we are able to discover these sort of things because we have expertise in engaging young people and we do ongoing assessment.

So with those kind of caveats I can sort of say that within the early intervention streams of, say, the youth support service, where I manage a team in the north-west catchment, we can sort of speculate that young people who are saying that they are coming from family conflict situations that it's over half. So it's around 55 per cent.

When you look at I guess further downstream into the drug and alcohol programs, then you are looking at higher figures, over 60 per cent. If you combine I guess the scope of that question to encompass early childhood experiences of abuse, neglect, maltreatment and so forth, and contact with the child protection system, you are looking at in excess of 80 or 90 per cent of those clients.

MS DAVIDSON: You have also I think identified in your witness statement the rates of alcohol and drug use in the young people that your service sees, I think at paragraph 29. You have identified the picture of the drug or alcohol use and the changing nature of that. Can you just expand or explain to the Commission what sort of drugs or alcohol you are seeing in young people?

MR WANSBROUGH: Fundamentally the two drugs that young people - the drugs of choice that we see year after year after year are cannabis and alcohol. So that is just fundamentally the thing that comes through as the primary drug of choice, alcohol and cannabis.

But, that said, young people are generally polysubstance users. So within that alcohol and cannabis mix there will be any number of other substances. Certainly when I first started with YSAS that would have been opiates, back in the early 2000s, and that's shifted to methamphetamines, would be that third level of drug of choice.

MS DAVIDSON: You have also made some observations in relation to the rate of violence that you are observing in the dating relationships of the vulnerable young people that you are seeing?

MR WANSBROUGH: Yes, I was very keen to include that because I'm concerned that's something that's sometimes missed. We have had a lot of focus, quite appropriately, on established families and also the impact on younger children. But as a youth worker I'm very concerned about young people at that time when they are forming relationships. So what we are seeing increasingly in our case mix, our current case mix, that's live now, is that we are seeing a lot more - I guess some of the practices that we have heard about earlier in adult populations are happening at a very young age. So people in relationships who are 15 and 16 years old are being controlled through social media use, through physical violence, through sexual coercion and so forth.

MS DAVIDSON: You have also identified a particular issue for girls and young women in relation to adult male drug dealers. Can you expand on that for the Commission?

MR WANSBROUGH: Again, I have to sort of give that caveat that we just don't - we don't have really substantive data for this stuff. It's not very rigorous. I'm talking as a

practitioner in front of you today, as an individual youth worker making observations on just what I'm seeing day to day. So sometimes that information I think is valuable to have even in a setting like this because it is showing sentinel groups that are coming through that give us a picture of what is happening in the community before we get the research. So that may be the case.

I guess it's not a new phenomenon that young women are vulnerable and easily manipulated into relationships where there's a transaction around sex and drugs. That's not a new phenomenon. That's been part of my experience as a youth worker for the last 15 years.

What I guess is newer for us that we are trying to catch up with is that this is happening in a much more hidden way. So we don't see as much of the young people that we work with going down to Grey Street in St Kilda and doing street based sex work in the same way that we might see a changed pattern where young people particularly in the outer suburbs and regional areas are using online dating apps to arrange these sort of transactions.

What might happen and is certainly happening with our current case mix is that these young women will form enduring relationships with these older young adults where we see those troubling sort of intimate partner violence dynamics playing out over a period of time.

MS DAVIDSON: In terms of strategies to address these issues for young people, how would you describe the current state of play?

MR WANSBROUGH: It's very limited. I guess what I would like to emphasise here is that I think there is something that

youth workers have to offer in this space. Almost universally the young people that we engage in the modalities that we use, which is usually an outreach setting, so we are doing home visits and school visits and meeting at the local cafe, that's the kind of modality that young people respond to. Many of the young people that we work with do not respond very well to appointment based counselling clinical settings. In fact, they may even be hostile to those sort of settings.

So basically we would like to emphasise that outreach holistic engagement that youth workers offer is a modality where we can do this work around forming healthy relationships, which is really the bread and butter of our work, is modelling a safe relationship with that young person and then talking through their family and intimate relationships as part of their treatment plan.

MS DAVIDSON: You have identified that the youth assessment tools are not specifically identifying and asking questions about family violence. What about the training of youth workers more generally? Do you see that there is a need for better training for youth workers in relation to addressing family violence?

MR WANSBROUGH: Again, in my personal opinion I do think there is a need. I can talk from the experience within my program area, and that is that all our staff have done training in adolescent violence in the home and we have the capacity to do that sort of work.

Where there is history of trauma around family violence or current experiences of family violence, that is less clear that our staff have that capacity and expertise because individuals may choose to source that

kind of training, and some do, however it is not a universal thing in the youth work sector, and it would need the kind of resourcing and commitment from - a much wider commitment I guess than what we currently have to roll that out across the youth work sector, in a similar way to what we have done to become dual diagnosis capable with our mental health capacity.

MS DAVIDSON: Did you hear the evidence of Dr Gruenert?

MR WANSBROUGH: Yes, I did.

MS DAVIDSON: The concerns that he has raised there about the alcohol and drug sector not necessarily having the expertise and training to deal with the domestic violence or family violence issues, would you accept that that's a similar issue for youth workers?

MR WANSBROUGH: Broadly I would, yes. Again, I agree with the observations that there's pockets of very good practice where there are very good relationships with family services and the family violence sector. But it is not something that is universal across the youth sector.

MS DAVIDSON: You identified an issue in your statement at paragraph 25. You said that you had noticed a recent drop-off in referrals from Victoria Police. Can you just explain what that referral process was or is and what YSAS's role is in relation to receiving those referrals?

MR WANSBROUGH: Sure. Within our youth support service, that is that police referral program that I earlier mentioned, we are in close partnership with Victoria Police. They are our primary referral source. We have had certainly over 3,500 referrals from them since our program started in 2011, and mostly those referrals have come through an online secure platform called SupportLink. In October

last year, in 2014, that changed to an internal referral process within Vic Pol. My understanding is that it triages young people who have been violent in the home in a slightly different way. So my understanding is - and this is something we are working through with Victoria Police and we believe there will be a better outcome shortly, but what is happening currently is that a police callout to a home where there is a young person using these aggressive behaviours will generate a referral to a family service or the family violence sector, whereas in the past it may have been seen as a youth issue within that young person, which we would be able to work with that young person and do a bit of one-on-one work, within a family context as well. So I guess my observation is we just simply haven't had those kind of referrals since that platform changed.

COMMISSIONER NEAVE: Could I ask you about that. You have said you attribute that to the fact that the police now have a different triage system. So they are going to more specialist family - where are they going? They are going to family violence services, do you think?

MR WANSBROUGH: We believe so. So the front-line police that I talk to say that when they bring up the referral it will give an option, "Is this a family issue or a youth specific issue?" My understanding is that they will often view violence within the home as a family issue, and then it gets siphoned off into that L17 referral process. So there's no longer - less capacity for a referring police officer to sort of just pick that up as a youth issue and put it through to the youth support service.

COMMISSIONER NEAVE: This may be a question you haven't had a

need to consider, but would you think it appropriate that referrals relating to young people should go to a service such as yours rather than to the other services to which it now goes?

MR WANSBROUGH: I guess it would depend, and because we don't have a great deal of knowledge about where that might go - it might be a different destination in a different region because there may be a different service spectrum that's available in those different regions. So I imagine and I know that very, very many family services do work very well with adolescents. But many of the adolescents that we work with much prefer to have a youth worker intervention and have that one on one.

COMMISSIONER NEAVE: Thank you.

DEPUTY COMMISSIONER FAULKNER: I will just take the opportunity to follow that as well. When you were working previously with these referrals from police, where you ever in the process helping with the process of either helping to get an intervention order or defend an intervention order?

MR WANSBROUGH: Yes, that does very much come up within the scope of our work, yes.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: Just in relation to those referrals, do you have any idea of the numbers that you had previously and are now receiving?

MR WANSBROUGH: I'm afraid I don't for the reason I outlined before is that we simply don't capture specific data on family violence. It's a global family conflict type of - - -

MS DAVIDSON: Sorry, I was referring to the actual referrals that you were getting from police and the drop-off you had

identified. Are you able to identify the number you were getting before October and what you are seeing at the moment?

MR WANSBROUGH: Specifically to do with overall referrals or referrals where family violence or adolescent violence was a feature?

MS DAVIDSON: You mentioned the SupportLink referral system.

MR WANSBROUGH: Okay. Thank you. Yes, there has been a drop. I don't have the latest figures. Our year to date figures are being analysed at the moment. But I would say it is around half the referrals are coming through.

MS DAVIDSON: You have also identified just a general issue in relation to the availability of appropriate services for youth and adolescents and the particular gap in relation to services that are available the older the child gets. Can you explain what you are referring to there?

MR WANSBROUGH: Yes, I should clarify that a little bit more. What I'm referring to there is really the activation, I guess, of protective systems. If we were to sort of work with a referral from Victoria Police where we were concerned about violence within a home and that was uncovered through our home visits and outreach services, we find that it's much easier to get that activated within, say, a child protection intervention where young children are in the home. And that's appropriate. They are very vulnerable.

But it gets very difficult when that young person is 15, 16 and 17 for that same response to happen. Just with the volume of reports and notifications that come in to the child protection system, they have to make a decision somewhere. We find that we don't get that same

response for young people as they get to that age range.

MS DAVIDSON: Thank you. That completes my questions. Do the Commissioners have any additional questions?

COMMISSIONER NEAVE: I just wanted to follow up one point, and this is only a speculation, really. Why do you think that the level of dating violence has risen or become more visible? It might be either, I suppose.

MR WANSBROUGH: I'm not sure that it's risen. I just know that within the vulnerable populations that we work with that the way it's behaviourally sort of demonstrated to us has changed. That's all I can say.

COMMISSIONER NEAVE: A number of submissions have suggested that the availability of pornography has changed young men's expectations about what is appropriate sexual behaviour.

MR WANSBROUGH: Yes.

COMMISSIONER NEAVE: And that this has led to more violence in the sexual context. It's very hard to establish. It may be that it's always been there but we haven't known about it. I just wondered whether you have had any impressions about those questions.

MR WANSBROUGH: They are just impressions. Within my own case work at YSAS I have worked with a number of young - I'm going to say young men and children, because it is a young age range, and certainly that's something they are going to to learn about relationships. It's readily available to them to do that. Quite clearly that's a very skewed way to see a relationship and is very damaging to young people, without - - -

COMMISSIONER NEAVE: Has YSAS thought about doing anything to counter that, if it is a trend? Is there any educational

work that you've thought about doing to deal with sexual expectations of probably mainly young men?

MR WANSBROUGH: It would be very much part of our day-to-day work, so that individual one-on-one work. But we are currently not doing a great deal around, say, things like safe relationships within, say, a school setting. Our headspace programs would be doing that sort of stuff. We have a headspace at Collingwood and Frankston and they do work within the community to work on healthy relationships.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: May this witness be excused?

COMMISSIONER NEAVE: Thank you very much, Mr Wansbrough.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: By arrangement with the State we may, if this is acceptable to the Commissioners, recall Superintendent Hansen just to give evidence briefly in response to the point that was just dealt with in the last 10 minutes or so about the referrals from Victoria Police. If I could ask Superintendent Hansen to come to the witness box.

COMMISSIONER NEAVE: Thank you.

<TIMOTHY JOHN HANSEN, recalled:

MR MOSHINSKY: Superintendent Hansen, have you been in the hearing room when Mr Wansbrough gave evidence in the last 10 minutes?

SUPERINTENDANT HANSEN: Yes, I have.

MR MOSHINSKY: You will recall that he observed that from YSAS's perspective there has been a dropping off of about half of the referrals from Victoria Police. He also deals with this in paragraphs 24 and 25 of his witness statement, which I believe you have had an opportunity to

see. Are you able to comment on whether there has been a change of referral protocols or do you have any other observations about what Mr Wansbrough has observed?

SUPERINTENDANT HANSEN: To put some clarification around it, as well as my role with drugs and alcohol I mentioned in my evidence I'm also the business owner for victim support across Victoria Police. So one of the projects I oversaw over the last 12 months was the transition from SupportLink to what we now refer to as the Victoria Police e-referral process. Correctly alluded to, we transitioned from an e-referral process that leveraged off a third party or a private contractor to triage those referrals for us, and they had sole responsibility for nominating the referral agencies, identifying them and then also working with the referral agencies. That came at extensive cost to Victoria Police, and also we were getting some feedback from stakeholders that the relationship between the private contractor and some of the NGOs were strained, is probably the best way to put it.

COMMISSIONER NEAVE: Can I just clarify this. So in what area was this being done? This isn't the normal L17 process. This is something different. Could you perhaps elaborate on that?

SUPERINTENDANT HANSEN: Absolutely. What we are talking about here is referrals in circumstances of non-crisis, non-family violence. That is the same for SupportLink as it is for VPeR. Whilst there may have been circumstances whilst YSAS were dealing with a young person and it became evident they were also involved in a family environment that was exposing them to violence, the initial referral

would not have been for family violence because that is a separate business process within Victoria Police. It's operated, I have mentioned before, within LEADR Mark II. So that is that referral process for young people, for women and for men in incidences of family violence.

Notwithstanding, I would agree there would be an initial referral in a non-family violence incident that once a community organisation or a service provider was working with that young person they may uncover aspects of family violence and no doubt would work with that young person, I would suspect. But the original trigger would have been for a non-family violence incident, from our perspective.

So we moved to VPeR, or the Victoria Police e-referral process, in November last year. Through that process, can I say, we have now engaged 176 service providers across the State of Victoria to deliver a range of services. So what we have done is diversified our base of people or agencies we refer people to. Why we have done that is try to really drill down to the specifics of what is the causation of the person who is in need of assistance from Victoria Police and get the right appropriate level of treatment or advice or assistance for that person. We now manage that ourselves. That is also housed in LEADR Mark II, our IT program. There was reference before to our own self-supporting IT platform; that's correct.

I have never had any conversations with YSAS. I have heard anecdotally that they are concerned about the rate of referral, and I have charged some of my staff to reach out and make contact with YSAS where we have

explained what the new process is. Our referral rates did dip at a statewide level when we first rolled out with VPeR. As with any change management process, you can understand that there is a period where the workforce needs to acclimatise to the new process. What we did see was a dip. But we anticipated that in our transition programs.

We are now seeing pretty much parity. If I look at where we are at this time this year and where we were this time last year we have pretty much got parity with our referral rates for non-crisis, non-family violence referrals.

COMMISSIONER NEAVE: Just to make sure I have understood this, I'm going to feed back what I think you have said to the Commission. A person presents in some way or the police become aware of a person who needs help. It may presumably be because they are an offender or because they are in some other sort of difficulty, a young offender potentially. In those circumstances you may now refer that person out to a service through your own processes and there is now a wider range of services engaged than was previously the case; have I got that right?

SUPERINTENDANT HANSEN: That's a very good synopsis. So, just a clarification, we have YSAS, we have Child FIRST and we have child protection.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Unless there are any further questions for Superintendent Hansen, I will ask for him to be excused and call the next witness.

COMMISSIONER NEAVE: Thank you.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: The next witness is Catherine Carr. If she could please come to the witness box.

<CATHERINE MARY CARR, affirmed and examined:

MR MOSHINSKY: Ms Carr, you hold the position of Executive Director of the Office of Liquor, Gaming and Racing in the Department of Justice and Regulation.

MS CARR: I do.

MR MOSHINSKY: Have you prepared a witness statement for the Royal Commission?

MS CARR: I have.

MR MOSHINSKY: Are the contents of your statement true and correct?

MS CARR: They are.

MR MOSHINSKY: Could you explain briefly for the Commission what the role of the Office of Liquor, Gaming and Racing is?

MS CARR: Yes. The Office provides advice and support to the Minister who has responsibility for the Liquor Control Reform Act and the various pieces of gambling legislation. We also provide policy advice and support to the Minister for Racing. So, in relation to alcohol, we manage the Minister's legislative agenda, so prepare legislative amendments to the Act, provide general policy advice and support.

MR MOSHINSKY: There is a Victorian Commission for Gambling and Liquor Regulation. Can you explain what the Commission does, what its role is, just briefly?

MS CARR: The Commission is the regulator. So it is primarily responsible for the consideration and granting of licences to applicants for liquor licences under the Act. It also has an education and compliance function. So it

investigates and prosecutes offences under the Act and takes disciplinary action against the licensees.

MR MOSHINSKY: In terms of issuing new licences for liquor, that's something that was done by the Commission?

MS CARR: That's the Commission's responsibility, yes.

MR MOSHINSKY: In paragraph 9 of your statement you give a list of the different types of liquor licences that there are. They include a general licence. Another one that's been referred to today is the packaged liquor licence. Then there are various other licences listed. Can you just explain what's the difference between a general licence and a packaged liquor licence?

MS CARR: A packaged liquor licence is available to a business that wishes to sell sealed alcohol for consumption off premises; so typically your bottle shops, examples being the Dan Murphy's, Liquorland. So they don't have on premises consumption. A general licence - and I'm speaking generally here - is available to somebody who has both on premises consumption and sells packaged liquor for takeaway. So an example of that is a hotel with a bottle shop would generally have a general licence. So it authorises both on premises consumption and takeaway liquor.

MR MOSHINSKY: Are these licences for a finite period of time or do they automatically renew? What's the system in terms of timing?

MS CARR: There is an annual fee that is payable for the licence, but so long as the licensee pays the fee then the licence continues to roll over. There is no capacity for someone to have to re-apply for a licence.

MR MOSHINSKY: Who decides how many licences there are? Is

that something that the Commission decides?

MS CARR: There is no cap on the licence. With the exception of the freeze that was referred to in evidence this morning, there is no number of licences. The Commission has a statutory test that it applies. So when somebody applies for a licence there are a range of matters that they consider within the context of the objects of the Act which are about harm minimisation, diversity of liquor licence premises, fostering responsible industry; but things like whether the applicant is a fit and proper person to hold a licence, whether the granting of the licence will detract from the amenity of the area in which the premises is to be located and in the case of packaged liquor whether or not it's likely to contribute to the misuse and abuse of alcohol. So the Commission applies those tests to each licence application it receives and makes a determination according to the evidence that's before it.

MR MOSHINSKY: In your statement you set out some figures about the number of licences. At paragraph 19 you indicate that as at 30 June 2015 there were 2,007 active packaged liquor licences. Then going down to paragraph 21 you indicate that there are currently 1,991 active general licences. So, roughly speaking, about 4,000 packaged liquor licences and general licences; is that right?

MS CARR: That's right.

MR MOSHINSKY: After that in your statement from paragraph 25 onwards you outline some of the history. Can you just briefly tell the Commission about the history of general and packaged licences in Victoria and some of the major shifts that have occurred?

MS CARR: I guess at a very high level everybody will be aware of the 6 o'clock swill when the trading hours were very constrained. We then had the inquiry which freed that up. I think most significantly when you are looking at packaged liquor we had the National Competition Policy review. Prior to that review there was a cap on the number of packaged liquor licences that could be owned by an individual at 8 per cent. The National Competition Policy review essentially said that was anti-competitive. That was eventually lifted in 2002.

MR MOSHINSKY: If I could just interrupt you, sorry, at that point just to clarify prior to that National Competition Council policy that you just referred to, the 8 per cent was a limit on the number of licences that any one entity could hold?

MS CARR: That's right.

MR MOSHINSKY: And the competition review said that should be done away with?

MS CARR: That's right, on the basis that it was in breach of National Competition Policy.

MR MOSHINSKY: And then what happened next?

MS CARR: It took some time for that to be lifted, but it was eventually lifted through legislative amendment in 2002 and phased out between 2002 and 2006. The phasing out of the cap essentially meant that some of the big players in the industry could hold more licences. So that's when we started to see the growth of the big corporates into the market.

MR MOSHINSKY: In paragraph 33 you indicate the growth that has taken place. Between 30 June 2004 and 30 June 2015 you indicate that the number of packaged liquor licences in

Victoria has increased by 26 per cent.

MS CARR: That's right.

MR MOSHINSKY: And also in that paragraph you indicate that the number of so-called big box liquor outlets is estimated to have grown from five in 1998 to over 70 in 2015.

MS CARR: That's right. That's one of the significant changes in the market, is the advent of the huge outlets run by Coles and Woolworths predominantly. Those have grown - I think that's slowed a little bit now, but certainly grown from a very small number to quite a significant market share.

MR MOSHINSKY: What was the policy that led to this growth in number of licences and number of big box liquor outlets?

MS CARR: I think it's fair to say that no government had a policy that the number of packaged liquor outlets should grow or indeed that the size of the outlets should grow. I think it was a combination of removing the cap and allowing the big corporates to take a greater market share, and the effect of the statutory test. So it's difficult for an application for a new outlet to be shown to have a significant impact on alcohol related harm. The combination of those two things I think is what's led to the increased availability of packaged alcohol.

COMMISSIONER NEAVE: Can I just ask is there a definition of a big box liquor outlet?

MS CARR: No, not specifically. But I guess it's a bit of a shorthand description of describing the big outlets run by the chains that sell a large volume of alcohol. The criticism of the big box outlets is that they often heavily advertise and heavily price discount to the point that some retailers in fact purchase from the likes of Dan

Murphy's because it's cheaper. They can buy it cheaper at Dan Murphy's than they can through their wholesale arrangements. There is no definition as such, but it's that kind of stuff that we are talking about.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: If I could take you to paragraph 44 of your statement, you indicate that the packaged liquor market is the largest liquor industry sector and reportedly accounting for over three-quarters of all alcohol sold in Australia.

MS CARR: That's right.

MR MOSHINSKY: And then later in that paragraph you indicate that in 2000 it was reported that Victoria had more liquor stores per capita than New South Wales, South Australia or Western Australia. Do you have any more up to date information about how many liquor licences there are in Victoria compared to other states on a per capita basis?

MS CARR: I have some information from 2010 which is the most recent that we have access to. Essentially what that tells us is that on a per capita basis the most licences per capita is in South Australia; however Victoria ranks second, not that far behind South Australia. So per capita there are a large number of licences in Victoria. In terms of total number of licences, Victoria has the most licences of any Australian state or territory.

MR MOSHINSKY: Is there available data, either nationally or on a state basis, on total sales of alcohol and trends?

MS CARR: There is ABS data on consumption. There's some survey data at a state level, and this data is based on asking people how much they consume. As you might

suspect, it is accepted as being highly unreliable because the natural tendency is for people to underestimate or underreport the amount that they drink. We don't rely on it. There are various sources of this data, but it is I think pretty widely accepted that it is not reliable.

In the evidence this morning there was a reference to Victoria starting to collect wholesale sales data. That came about through a recommendation made by the Victorian Auditor-General. We did a fairly extensive piece of policy work in our office around how best to collect sales data to inform policy development, and we looked at collecting either on a retail basis or a wholesale basis and having industry report their sales to government because of the poor data that we have. The difference between the two is - - -

MR MOSHINSKY: Just to clarify, the difference between wholesale and retail data?

MS CARR: Between requiring the wholesalers to report as opposed to requiring the retailers to report, if we were to require the retailers to report their sales data we would require every cafe, every restaurant, every bottle shop, every club, every hotel. We did some kind of calculations on the cost of that to industry and looked at the alternative, which was wholesale reporting.

There are obviously much fewer wholesalers than there are retailers. The dataset that we will get from the wholesalers is almost as good as we would get from the retailers. Furthermore, it's consistent with the data that's collected in other Australian jurisdictions. They collect wholesale data, not retail data.

So the idea is that that would give us a proxy

for consumption, and we will be releasing that information in the public domain down to LGA level. But we will actually have quite granular data. I think there was something that was said this morning about the utility of the data that we are going to receive. I think it's important to point out that we will have quite specific data that says the types of alcohol that are being sold - so whether it's beer, light beer, wine, spirits, ready to drink - and the actual licensed premises that they are being sold into.

We will collate that into LGA data because there are confidentiality issues about publicly releasing the sales data into particular licensed premises. But it may be that that data can be released for research purposes on a basis that there are some caveats around that. But we will have much better data than we have now.

MR MOSHINSKY: Can I turn to the part of your statement at paragraph 45 and following where you deal with evidence and the growing body of research about the relationship between alcohol related harms, including violence, in particular geographical areas and the density of licensed premises in those areas. Are you able to expand for the Commission on or make any observations about that state of evidence?

MS CARR: Yes. I preface my remarks by saying I'm not a researcher, but my understanding of the research - and I think - there might be some disagreements about the significance and the kind of - the importance of some of the research. But I think generally everybody is agreed that there's clearly an association or there's an influence on the availability of alcohol and family

violence and violence more generally. I think we are all agreed that there is something specific - some specific association around packaged liquor and family violence.

The extent of that and the policy response to that is where we might differ. But I think it's fairly clear that the emerging evidence is that there is an association, particularly with the density and availability of packaged liquor.

MR MOSHINSKY: Can I ask you some questions about the Liquor Control Advisory Council. At the top of page 8 of your statement you list the current members of the Liquor Control Advisory Council. On the previous page you indicate in paragraph 34 the Liquor Control Advisory Council is established by section 5 of the Liquor Act to advise the relevant Minister on problems of alcohol abuse and any other matters referred to it by the Minister.

There was some evidence that you will have heard this morning about the appropriateness or otherwise of having industry representatives such as retailers or alcohol manufacturer representatives on these such bodies. Do you have any observations or response you wish to make to that?

MS CARR: Yes. I guess the first thing I would say is that the appointments of members to the council is at the discretion of the Minister. But, having said that, I have worked very closely with the council, and I have also worked very closely with the kind of gambling counterpart, which is the Responsible Gambling Ministerial Advisory Council, which is structured in a very similar way and also has industry representation. Whilst I understand the point that was being made about the power and influence of

industry, as a policy maker and adviser to government I think it's very difficult for government to assess and develop policy without understanding the industry's perspective, and in this area particularly having regard to the objects of the Act, which talk about encouraging a responsible industry and a diverse industry.

The other thing I think is worth noting is that the way in which the council provides its advice to government is not on the basis of majority or who has the loudest and the most powerful voice. What the council and its working groups attempt to do is to distil what the issues are, to distil where the various perspectives around the table might be, to understand what the research is telling us, to understand where the differences lie and see whether there is a sensible way through those differences.

It's really important to understand that people around the table often don't agree and I think - talk about vested interests this morning. Those vested interests are very obvious to everybody, and government makes its assessment of the positions that come out of those meetings, understanding what those vested interests are.

So an example where there was a really widespread agreement was around the extension of the freeze on the issue of new late licences in the four inner Melbourne municipalities. That working group had representatives of industry on it. The advice that was provided to the council and then subsequently to the Minister was that that freeze should be extended. That's despite there being some considerable criticism around the impact of a

freeze and its kind of anti-competitive nature.

There are other instances where the various participants have quite divergent views, and the way that's dealt with is that those views are reflected back in the advice to the Minister.

The other thing I would say about that is that the council is only one source of advice to government. Clearly the department has a role in providing advice to the Minister, and certainly we express a view about the advice that comes out of the council. The Minister obviously meets with a whole range of stakeholders as well who express their views to government. So it's important to understand the context in which the council operates.

MR MOSHINSKY: There are also four working groups under the Liquor Control Advisory Council; is that right?

MS CARR: That's right.

MR MOSHINSKY: You have provided a list of the people who are on those four working groups, and that's been provided to the Commissioners. I don't know if you have one in front of you at the moment?

MS CARR: I have, yes.

MR MOSHINSKY: You do. I won't read out the names, but it appears from that list that each of the four working groups - that's the Targeted Harm Reduction Strategies Working Group, the Alcohol Advertising Working Group, the Freeze on Late-Night Licences Working Group and the Packaged Liquor Code of Conduct Working Group - includes industry representatives?

MS CARR: That is right.

MR MOSHINSKY: You would make the same comments about their participation in those working groups; is that right?

MS CARR: That's right. My experience as a kind of policy person is you actually give better policy advice to government when you take into account a range of perspectives. Government, when making decisions around these kind of really complex areas - and you have an industry that is legal, you have objects in the Act that talk about encouraging a diversity of licensed premises and fostering live music and the licensed hospitality industry, and understanding that that industry also creates harm, they are very difficult policy issues to deal with, and in making decisions government has to understand the implications of making its decisions and the impact that that might have on things like investment, employment, tourism, a whole range of issues, including harm reduction.

MR MOSHINSKY: Is it correct that the Chair of the Targeted Harm Reduction Strategies Working Group is an industry representative?

MS CARR: That's right.

COMMISSIONER NEAVE: I just have a follow-up question. I don't know what bodies exist in relation to the sale of tobacco or have existed in the past . Has a similar approach been taken in that area in the past? Do you happen to know?

MS CARR: I can't answer that question, Commissioner.

MR MOSHINSKY: In your statement at paragraph 46 you indicate that there's to be a review of the Act. Could you please outline the general nature of that review?

MS CARR: Yes. The current Act, the Liquor Control Reform Act, has been around for some considerable time now, and I think it is true to say that the environment in which it operates has changed considerably, and some of those

issues have been kind of canvassed today. The government's decided that it's timely to conduct a review, and that review will look at a range of things, including whether the objects of the Act and in particular its harm minimisation focus remain appropriate, having regard to the changed environment. They include issues around alcohol related street violence and alcohol related family violence.

We will be looking at things like the licence categories. As you can see from my statement, there are a large number of licences that are available. It's complex. They overlap. It's very difficult to actually determine who should have what kind of licence.

We will also be looking at the kinds of things prescribed in the Act, like trading hours, conditions that be can placed on licence, the test that the Commission applies when considering an application and whether that is appropriate given the harm minimisation objectives of the Act. It is a very broad ranging review of the Act.

MR MOSHINSKY: Commissioners, those are the questions I had. I don't know if the Commissioners have any questions?

DEPUTY COMMISSIONER FAULKNER: I will just follow directly. When was the review established?

MS CARR: It was a decision of this government. So at the moment we are currently scoping it and developing its terms of reference and working out its timelines. We have started some preliminary work, but it's in its very early stages.

DEPUTY COMMISSIONER FAULKNER: And it is to report by the end of the year, however, according to your statement?

MS CARR: Not that review. The working groups from the council

are aiming to report their work by the end of the year. The review of the Act, because it is such a substantial piece of work and we think that it will result in a whole new piece of legislation, so that is much more a longer term project. The Minister hasn't determined yet how long those timelines will be.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: No further questions.

MR MOSHINSKY: Thank you, Commissioners. Would the witness please be excused?

COMMISSIONER NEAVE: Certainly. Thank you very much, Ms Carr.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: The next and last witness is Judith Abbott. If she could please come to the witness stand.

<JUDITH DOREEN ABBOTT, sworn and examined:

MR MOSHINSKY: Ms Abbott, you are the Director of the Drugs, Primary Care and Community Programs Branch in the Department of Health and Human Services?

MS ABBOTT: That's correct.

MR MOSHINSKY: Have you prepared a witness statement for the Royal Commission?

MS ABBOTT: I have.

MR MOSHINSKY: Are the contents of your statement true and correct?

MS ABBOTT: Yes, they are.

MR MOSHINSKY: I want to ask you some questions as you deal in your statement with mainly the alcohol and drug treatment programs and services that are currently available in Victoria. You outline in detail, and there isn't really time to go through them in detail, some of the State-funded alcohol and drug treatment services. What

I wanted to ask you about is the extent to which there are essentially combined services that bring together the types of treatments and approaches that are in the family violence sector together with the types of treatments and approaches in the alcohol and drug sector. We have had evidence today that there is very little available at the moment. Are you able to comment on that?

MS ABBOTT: I'm not a clinician but I can make some broad observations. So at the moment there aren't currently in the Victorian system integrated programs that bring together both behaviour change, family violence supports and drug treatment services in a single program. But we do see quite a lot of close local working relationships. There's something like 26 of our funded agencies that are funded for both drug treatment and family violence support. So we see in those instances those services working quite closely together to wrap around individual clients and what they might need.

MR MOSHINSKY: Are you there referring to people who have experienced family violence or people who are using family violence?

MS ABBOTT: It could capture both.

MR MOSHINSKY: Sorry, I interrupted you. Please continue.

MS ABBOTT: That's fine. The other thing is that my understanding - once again, whilst I'm not a clinician, my understanding is that some of the approaches to engaging with people who, for example, are managing alcohol and drug issues and some of the behavioural therapies may have similarities to some of those used by family violence practitioners as well.

MR MOSHINSKY: While the evidence is that there's some limited

pockets where in practice there is some overlap, it appears that - and correct me if I'm wrong - there aren't dedicated programs set up which bring together the two spheres; is that the position?

MS ABBOTT: That's correct.

MR MOSHINSKY: Is that something that DHHS has looked at, whether there is a need for such programs and whether DHHS should be funding such programs?

MS ABBOTT: It's something we are interested in exploring, and there are a range of things that could be explored, from things that are about how we bring together those two sectors and people working in the two sectors to have a better understanding and common language, through to ideas about how could we embed parts of content into different programs so they are mutually reinforcing, or even the idea of integrated programs like the kinds of things that are, for example, used by Communicare in Western Australia.

MR MOSHINSKY: Have concrete steps been taken to advance that process?

MS ABBOTT: Not at this stage, no.

MR MOSHINSKY: We have had some evidence this afternoon - were you in court when Alice Hanna from Jarrah House gave evidence?

MS ABBOTT: I heard her evidence.

MR MOSHINSKY: That Jarrah House offers a residential detox facility for women where they are able to bring children, and they have many clients who have experienced family violence. Is there any comparable facility available in Victoria?

MS ABBOTT: There is currently a mother/baby withdrawal unit

being developed in Victoria which will be a unit that allows mothers who are wishing to go through withdrawal to take their children with them. There are also a range of other services available that allow women who are going through drug treatment to have their children with them.

Examples include the Odyssey House community out in Lower Plenty, also a service run by Western Health that provides a rehabilitation service, an accommodation service, for mothers where they can take their preschool children with them. There are a range of other services that will make local child-care arrangements and other arrangements so that women seeking to go through drug treatment can do so without having to be separated from their children.

MR MOSHINSKY: I think the last couple of services such as Odyssey House that you referred to are drug treatment but not detox; is that right?

MS ABBOTT: Correct. So the service that's being built at the moment that will be out in Heidelberg is a detox service.

COMMISSIONER NEAVE: Can I just ask how many beds will that have?

MS ABBOTT: It will have four beds .

MR MOSHINSKY: In terms of the alcohol and drug services that currently exist in Victoria, are these funded through DHHS?

MS ABBOTT: Yes, they are.

MR MOSHINSKY: What sort of evaluation does DHHS carry out as to the efficacy of those programs?

MS ABBOTT: There's a couple of answers to that question. The first thing I would say is that when we fund agencies we don't specify particular types of modalities the

clinicians have to use. We leave it to them to judge what kinds of treatments are going to be most effective for the clients they are working with.

We know, however, having gone through a reform process and looked at evidence and information about the kinds of treatment approaches that are being used by our service providers, that they are using strong evidence based approaches such as cognitive behaviour therapy and the like. We are in the process of rolling out some non-residential rehabilitation approaches. We have a strong evidence base for that.

One of the things we have been trying to do - and I have to say that the State-funded drug treatment service system is going through a very large process of change at the moment. We have been doing some work around demand modelling and trying to better understand who is seeking treatment, what their needs are and what the impacts of treatment might be.

One of the tools that's helped us with that is implementing a standardised screening and assessment tool, which when used in effect provides a baseline measure. We then have a review tool that allows clinicians, if they choose, to administer a period after people have received treatment.

We have had our first very early data on this, which is a sample of about 700 people three months after they had entered treatment, which is really about understanding what have been the impacts of that drug treatment. What we have found is reductions in the use of substances but also reductions in things like the use of violence and the prevalence of being a victim of violence.

So over time we will be able to build up that kind of approach to really understand how the kinds of interventions that our treatment services are delivering are impacting on the people in those treatment services.

MR MOSHINSKY: Does the new screening tool include family violence questions?

MS ABBOTT: Yes, it does. There is part of that tool where clinicians who are administering the tool identify potential concerns about safety or risk or they have concerns. There's a module that's actually based on the CRAF, so it's first part of the CRAF, imbedded into that tool as part of a strategy to try to embed into practice consideration of family violence issues.

MR MOSHINSKY: When you refer to CRAF, that's the Common Risk Assessment Framework that is used in the family violence sector and by the police in effect through their - - -

MS ABBOTT: Correct.

MR MOSHINSKY: What sort of waiting lists are there to access alcohol and drug treatment services in Victoria nowadays?

MS ABBOTT: Individual agencies keep lists of people who are waiting for treatment, but those actually will change from day to day as people are admitted to treatment, as people join the list and as agencies are re-prioritising who gets in; that all influences wait times and length of lists.

The department doesn't keep a centralised real-time waiting list across the state, and it would be quite difficult to do so. However, in talking to agencies our understanding is that there are wait lists for most services. The duration of that wait list depends and can vary from day to day. How long people wait and how many people wait will vary between geographic locations and

will also vary between the kinds of treatment that they are waiting to receive.

We understand that the longest waiting lists at the moment are for residential rehabilitation programs. So a focus of our current efforts is on rolling out quite a large increase in structured rehabilitation programs to start to try and deal with that concern.

COMMISSIONER NEAVE: Without trying to pin you down on this because it's not possible, you said that the longest lists are for residential programs. Do you have any sort of a feeling about roughly how long people might have to wait to get into a residential program?

MS ABBOTT: I understand it varies a lot but can be at the extreme up to six months. I also understand that one of the factors that influences that is in some instances people want to wait to go to a particular facility. So, even if there might be one available a bit earlier, they want to go to the one that they have heard about or they know or they have had previous experience with.

COMMISSIONER NEAVE: Thank you.

DEPUTY COMMISSIONER FAULKNER: Can I follow too, Ms Abbott, in relation to the plan for purchasing, which DHHS is responsible for, when you are purchasing services are you looking for specific things in purchasing? Is it just geographic coverage or are you - we had evidence from Mr Wansbrough earlier that suggested that young people are more comfortable with non-clinical episodic care in relation to their addictions or their treatment. Is there an attitude to buy differential services, or are you really just trying to get a bit of counselling, a bit of this, a bit of that at every point?

MS ABBOTT: We do try and focus where we are growing our treatment system to where we know there are pressure points or need. So, for example, we are actually in the process of, 2015/16, putting some extra investment into youth treatment services and particularly focusing it at at-risk youth.

We are putting some extra money into residential rehabilitation programs, particularly because those are programs that can respond to the need of people who need a structured program of rehabilitation but may not be able to go into a residential program.

So we, in different parts of our purchasing, try to purchase things that respond to specific needs. At the same time we are also doing some expansion of our adult community services, which involves, as you say, some counselling, some care and recovery coordination and some of those other - there are a whole range of community based supports for adults.

DEPUTY COMMISSIONER FAULKNER: So you do have a fair idea of where the pressure points for drug treatment services are?

MS ABBOTT: We believe so. That is currently largely informed by what we hear from sector, from the agencies, from support services and from others in the system.

DEPUTY COMMISSIONER FAULKNER: And from waiting lists, presumably? A couple of people have mentioned it depends a bit where you live in Victoria whether you wait a long time.

MS ABBOTT: That's right.

DEPUTY COMMISSIONER FAULKNER: So where are the pressure points?

MS ABBOTT: What we have been trying to do is - for example,

one of the historic pressure points has been in rural and regional Victoria, where, for example, there haven't historically been residential withdrawal beds, so we are in the process of actually establishing some new rural withdrawal beds.

We also know historically when you look at weighted per capita investment by areas we know that there have been some locations that have had less investment in the past. So as we do expand our treatment system we are trying to address some of those inequities at the moment. So, if I give a very concrete example, Gippsland historically has had a relatively high per capita level of non-residential services but hasn't historically had any residential withdrawal or rehab services. So we are looking at putting four withdrawal beds into the Gippsland region to address that.

DEPUTY COMMISSIONER FAULKNER: Thanks, Ms Abbott.

MR MOSHINSKY: Next I want to ask you about the prioritisation. Is there in the current system an ability to prioritise some people who need access to alcohol and drug services? Is there within the current system the potential to take into account family violence, either as a person experiencing family violence or has experienced it or who has used family violence?

MS ABBOTT: In the new screening and assessment tool that allows people using it not just to look at the clinical presentation, so the level of dependance, but also to look at things like risk and safety and other life complexities to make a judgment about what's the relative priority of their need.

If the clinician is then in the circumstance

where they have two people who have the same assessed level of need - sorry, if I step back for a moment to answer that question. So that may take into account factors such as the perceived risk to the person that the assessment is being done on.

Then if there are two people within the system with the same level of assessed need there is a system in which some groups are prioritised. That includes people with dependent children for which they are responsible, Aboriginal people and forensic clients. So, if there is someone who has been charged with a family violence related offence and is in the forensic system, they would get some priority through that mechanism.

COMMISSIONER NEAVE: So does that mean they would get priority over the woman who has the children and also has a drug and alcohol problem?

MS ABBOTT: The first point is the question about - is the level of assessed need. But then you have two priority groups, and the clinician or the service is going to make individual judgments on a case-by-case basis. I can't speak to what an individual service would do in that circumstance.

COMMISSIONER NEAVE: Thank you.

DEPUTY COMMISSIONER FAULKNER: Can I just clarify. This is because a clinician has really the duty and the responsibility to make triage decisions rather than the State; is that what you are saying?

MS ABBOTT: Correct.

MR MOSHINSKY: Commissioners, those are the questions I was wanting to ask Ms Abbott. I don't know if the Commissioners have any further questions?

COMMISSIONER NEAVE: No, we don't.

MR MOSHINSKY: May the witness please be excused?

COMMISSIONER NEAVE: Thank you, Ms Abbott.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: Commissioners, that concludes the evidence for today.

COMMISSIONER NEAVE: Thank you very much, Mr Moshinsky. We will adjourn until Monday.

ADJOURNED UNTIL MONDAY, 20 JULY 2015 AT 9.30 AM