THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON VIOLENCE IN THE COMMUNITY MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON THURSDAY 3 NOVEMBER 2011.

Ms ROS GORRIE, AUSTRALIAN NURSING FEDERATION WORKPLACE REPRESENTATIVE, MENTAL HEALTH SERVICES, GAVITT HOUSE, **Mr IAN NETHERY,** AUSTRALIAN NURSING FEDERATION WORKPLACE REPRESENTATIVE, NURSE UNIT MANAGER, ASSESSMENT PLANNING UNIT, ROYAL HOBART HOSPITAL AND **Ms SUE DARCEY**, AUSTRALIAN NURSING FEDERATION SENIOR ORGANISER, WERE CALLED MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Wilkinson) - Thank you everyone for coming along. Comments that are made in this room they are privileged so anything you say cannot be used against you outside, by way of defamation or anything like that, but if you then move from this room outside and say things which may well be defamatory outside you do not have that protection.

Ms DARCEY - I would like to thank you all for the opportunity to be here and to present our information; it is something that is quite dear to the heart of all nurses, I believe. First of all I have a few documents that I would like to table. The first document there is unfortunately eight years old, it is the SWAN Report that was undertaken by Professor Gerry Farrell. He was at UTas Head of Nursing and it is Scoping Workplace Aggression in Nursing. This identified quite a lot of things about aggression in the workplace. There were surveys done and they looked at an actual four-week snapshot in time. The people who were surveyed advised that 64 per cent had experienced either aggression, verbal or violent, from the workplace.

CHAIR - From patients or from -

Ms DARCEY - It does break that down in the survey, but it is from patients, from visitors and also from other colleagues, but to a much lesser degree.

CHAIR - And violence being what?

Ms DARCEY - Physical violence, attacking in any form. It could be a hit. It could be a punch.

CHAIR - It did not include threats of violence or did it?

Ms DARCEY - The verbal abuse would be viewed as threats, yes. ANF did apply for funding to do repeat research following the SWAN Report because anecdotally it was reported to us that violence was increasing and that was perceived to be due to stress, use of alcohol and drug use and just society in general. That application went through Workplace Standards but unfortunately was unsuccessful. So there have been no further studies that we are aware of in Tasmania.

CHAIR - Since 2003.

Ms DARCEY - To my knowledge?

Ms GORRIE - And not to my knowledge, except for the snapshot study, which was just nurses applying on-line in mental health. For nurses in mental health, a questionnaire was sent out by the ANF.

Ms DARCEY - We can table the survey.

Ms GORRIE - That showed the level of violence experienced in mental health, that all nurses had experienced at some stage verbal or physical abuse within the work situation.

Mr HALL - Anecdotally?

Ms GORRIE - That was ANF members filling out different questions on a survey.

Mr HALL - Since this report was done in 2003 there has been an escalation of violence right across the board?

Mr NETHERY - There is a formal process by which you can report that type of incident?

Mr HALL - Yes.

Mr NETHERY - It is all reported through AIMS. Threats of violence are hardly worthwhile reporting because they are just so commonplace. When someone actually gets physically injured then that is more likely to be reported than someone who has had just verbal abuse.

Mr HALL - Where does most of that occur?

Mr NETHERY - Emergency would probably be the majority, but it is not isolated to just emergency. It is across the whole service really.

Ms DARCEY - Paediatrics and neonatal intensive care have high incidences of violence and aggression.

Dr GOODWIN - That is kind of surprising. Can you tease that out a little more?

Ms DARCEY - It would be - trying to think of a nice way to put it - the nature of the clients, the nature of the extended families. You could appreciate that in the neonatal intensive care unit there are a lot of babies born to people in society who have substance abuse issues. The baby is born with their own problems of withdrawal but the parents and the extended families, which can be quite extensive, have their own issues which are not always managed very well in any environment. They do not have respect for the environment of the hospital either. The hospital does have precautions in place for security. That is among things that have progressed since the department set up a committee to look at prevention and management of workplace aggression and violence but certainly there has been nothing concrete done since the SWAN Report.

Dr GOODWIN - When they are being aggressive like that in that environment, why are they doing that? Is that just because that is the way they are behaving normally for them, that

they are perhaps aggressive normally to each other, or they do not like being told that something has to happen?

Ms DARCEY - It may well be the nature of the individual and the way they would normally express themselves. Also hospitals are quite tense environments, and if you have a child or a relative in the neonatal intensive care unit the anxiety levels are high, the not knowing, the not understanding. People do endeavour to communicate information to families as carers as best they can. It is not always comprehended appropriately because of that level of anxiety. There are lots of triggers for it and I think in nursing and in health across the board people are very aware of that and alerted to it and watch for it so that ideally potential situations can be minimised. There are lots of things in place there for people to work with.

Dr GOODWIN - Are you seeing more babies born with drug and alcohol issues?

Ms DARCEY - I could not at the moment provide you with the statistics but anecdotally I would be comfortable to say yes. That is information that we can access and make available.

Mr HALL - Our second term of reference talks about demographic evidence of different sorts of behaviour. In Tasmania are there any particular areas which are worse than others? Obviously we have the three major hospitals - LGH, RHH and the Mersey. Are there any particular areas which are worse than others or do you see a common trend theme across the whole lot?

Ms GORRIE - The main areas for me would be in mental health. You see a lot higher incidence of potential aggression within the intensive care unit for mental health - PICU - and also in DOP, the Department of Psychiatry. I also work in the community and when clients are escalating there is a potential risk there. That is why we work closely with the police sometimes when we have to put people on initial orders or go into situations where people are really unwell.

Mr NETHERY - I keep in contact with my colleagues around the State who work in emergency departments and their stories are very similar. It seems to be across the board. I think also people's expectations of emergency departments have changed since I started nursing because there is like a one-stop shop for everything, from a workers compensation claim to a major illness. Despite what you see on the television you are treated in order of your priority. If you have a serious illness, that is cared for right away. If you have something that would be medically fairly minor you may have to wait quite some time but the community expectation is that it is an emergency for them, so it must be an emergency to everybody else.

Mr HALL - Do you see a relationship between to culmination of drug and alcohol use causing more issues? If we go back a couple or three decades, obviously drugs were not as -

Mr NETHERY - Friday night and Saturday night were the big nights. Even in those days we had police presence in the ED. But it is seven days a week now and it is any time of the day. Starting from now we might have people who might be under the influence of some sort of substance and will present either by police or by ambulance. So it is across

the board. We still get those peak times at weekends and late at night but it is across the day now.

CHAIR - Are you taking statistics at all in relation to people who present and who are aggressive as to whether it is as a result of the drugs, alcohol or both?

Mr NETHERY - We can provide statistics for you. Their final diagnosis might well be intoxication or ingestion of unknown substance, that type of thing. We can narrow it down to particular substances, which is a little more difficult.

CHAIR - So you can focus it down to the particular substance and that relates to the violence as well, does it? That is all we would be looking for: those who are violent and who present and whether it is intoxication, drugs or both.

Mr NETHERY - We have also seen an increase in police bringing people in for blood testing. I would say at least 50 per cent of those people are usually aggressive when they are brought in by police for blood-alcohol testing. I am not criticising the police at all; I know that is what they have to do because that is what their resources are. I certainly know from interstate colleagues that police usually employ their own nurse to do that type of testing within the station itself, so it avoids the ED altogether. That has a flow-on effect for the police officers as well because you are tying them up in an emergency department and they may have to wait some time to have that testing done. So it keeps them off the streets.

CHAIR - The police have to by law, as you know, with a person who undergoes the breathalyser, give them the option of a blood test if they blow in excess of 0.05. Are you saying that all those then go to the Royal Hobart Hospital and various hospitals around the State and that causes a problem, whereas in Victoria they have a nurse at the police station?

Mr NETHERY - That is right. That system is much better for police because they have those bloods done in a timely fashion, whereas here it could be quite some time before that is done and that affects the results of the testing as well.

CHAIR - I know money is a problem around Tasmania and in other States at the moment and one of the issues is going to be, who pays for that? Is it the police who employ a nurse to be at the police station at all times? Alternatively, in Hobart it would be quite easy because it is just across the road, do they give the Department of Emergency Medicine a ring and ask for a nurse to come across, but that still could cause a delay, couldn't it?

Ms GORRIE - But it you have the delay, which we find all the time, of being stuck in DEM then that has such a flow-on effect for the police and for community nurses because you are stuck in DEM and you cannot finish what you need to do in community, and hat has a flow-on effect as well. So I think it would be cost-effective to look at that measure.

Mr NETHERY - To have a nurse in the police station at peak times.

CHAIR - Employed by whom?

Mr NETHERY - Employed by the police, of course.

Laughter.

CHAIR - But is it more prevalent on Friday and Saturday nights?

Mr NETHERY - There are peak hours, usually after 6 p.m. to 2 a.m., seven days a week.

CHAIR - What about the weekends themselves? Normally it is younger people who have too much and get into trouble as a result of getting a bit of Dutch courage.

Mr NETHERY - Decades ago it was the weekends when that happened but it is not the weekends anymore; it is seven days a week.

CHAIR - Talking about the ages of those people, I said 'normally' it is younger people but am I right?

Mr NETHERY - You are right and you are wrong. Even quite recently we had a seven-year-old boy who was quite severely injured on his school bus on the way home. He was injured by a compass that one of his peers had in the bus. We would never have seen that 20 years ago. That is someone who is seven years old and you will get it up to 60 or 65 and you might get an older person with an aggressive-type dementia who may well inflict an injury on somebody else or be the subject of an injury.

CHAIR - That would have always been the case, though, wouldn't it, with people with dementia or has the violence increased in those people in recent times and, if so, why?

Mr NETHERY - There are lots of causes of dementia and one of them might well be substance abuse in your early ages or your life experiences and we know there is a group of people who are coming into that age group now who have had quite some traumatic times in their life and have been familiar with violence in their early years and they can react in that manner now when they are in a confused state or an environment which is not familiar to them. We get quite a lot of older people who can be quite physically violent and just because they are old it does not mean they are not capable of inflicting injuries on people. We have done a lot of work around that, particularly in our ED, in trying to manage those people a lot better and creating an environment that is more conducive to their care, and that is in that age group.

We have also done a lot of other initiatives in ED to try to better manage people with aggression. We have a psychiatric nurse when we can. We have them rostered on 24/7, not the one person but a number of people, and that has really helped the department in better managing people with some mental health issues. We have a clinical initiative nurse now who works the waiting rooms and looks after the patients out there and that helps to de-escalate any issues with the behaviour out there. We never want to work in a society where we have metal detectors at the front door of a public hospital, but we have structured the ED, and particularly the triage area, so that it is safer to work in with things like shatter-proof screens between staff and patients and having better security there and having it better surveyed.

We recognise that society is changing, it is becoming more violent and to try to respond to that and still provide care for people we serve, we have implemented some changes which have had a positive effect.

Mr HALL - With regard to security which is provided in the larger hospitals, has there been an increase in funding through DHHS for additional security or has the level of security been about the same as what it has been in the last few years? What happens there? I am talking about contracted security in there, too.

Mr NETHERY - It has been about the same as it has been for the past few years.

Mr HALL - Do you see a need then to increase that level of security within the hospitals?

Ms DARCEY - It is easy to say yes to everything but I would think the security that is there at the moment which provides 24 hours a day, seven days a week, in the Emergency department is adequate. There is a security person there all the time just based in the Emergency department and they do not need -

Mr HALL - Sorry, they are there all the time?

Ms DARCEY - All the time.

Mr NETHERY - There is one security officer -

Mr HALL - At each Emergency departments?

Mr NETHERY - I believe so. There are only two in the hospital now so one patrols the hospital and responds to issues throughout the hospital and then has to respond and assist in ED if there is an incident in ED which leaves the rest of the hospital quite exposed. We have Code Black teams in the hospital now and they are quite a professional group of people who have been well trained over the years - although I notice that probably training has dropped off a little bit recently - who respond very quickly to an incident.

Mr HALL - An alarm is pressed or a buzzer pressed and that team goes into action and can respond straightaway to a violent incident.

Mr NETHERY - Yes, that team responds.

Mr HALL - That seems to work okay?

Mr NETHERY - That seems to work okay. We used to have what worked even better, we had a clinical nurse on that team so we had a clinical nurse that responded with a Code Black team but now that nurse is not available so it is just working with whatever nurse happens to be working on the ward who coordinates that response for the team when they arrive. It has been disappointing that it has not been maintained.

CHAIR - Why is that?

Ms GORRIE - Budget cutbacks, and that is a really important thing, as a community mental health nurse and working in the different areas, I can say that has made a marked

difference for our consumers. When they go now to DEM and have an EPN nurse, specifically a mental health nurse, you get to know the consumers and families quite well. That has really decreased the stress for clients and families, so I strongly support our mental health. We would like that to be a priority. They are not replaced; if someone's off sick they don't replace them and that has a real effect. With the Code Black team, on the wards they say the continued training of those people is very important. With budget cutbacks some education is being let slip, but those men and women in that team are vital in keeping the hospital safe.

CHAIR - Which people are they?

Ms GORRIE - You can't just have a security guard doing it, the orderlies and certain other members of the staff - you have a code team for arrest and one for code blacks. Those people are trained and as soon as the Code Black is announced they come together to that area.

CHAIR - Your code team for arrest, you mean cardiac arrest?

Ms GORRIE - Yes.

CHAIR - And your Code Blacks are for the violent episodes?

Ms GORRIE - Yes. If you have a client in PICU or the Department of Psychiatry who is elevating and you want them to be encouraged to have some medication or take them to a safer environment, you will call a Code Black to pre-empt a situation.

CHAIR - Is there any communication between the police and the hospitals in relation to trying to get down to the reasons why, if it's the case, there is an increase in violence or otherwise within the community? In other words, the police get Jim Wilkinson who is making a nuisance of himself in the street and has become violent, they take him to the hospital and he needs a blood test - let's say I've been breathalysed and I want a blood test but I am making a nuisance of myself and become aggressive - as I understand it, the statistic is done that that person is aggressive and acting in a violent manner and they say what that manner is - in other words, he tried to assault the nurse or the doctor who was taking his blood - do they then say, 'That's as a result of alcohol or drugs' and that's a statistic that's kept within the hospital and shared with the police? Is there any of that going on?

Mr NETHERY - Not to my knowledge, no.

CHAIR - Do you believe something like that should be going on and do you think it would be help or not?

Mr NETHERY - I think it would help us identify the causes of the aggression. Perhaps if there were some strategies around addressing that, I think that would be useful.

CHAIR - Would it help then that if he came into the hospital again you could quickly look it up and see that on the last occasion he was aggressive because of such and such?

Ms GORRIE - That already happens.

Mr NETHERY - Yes, we have the alert on there for ever.

Ms GORRIE - You can have a client who was aggressive 20 years ago and that alert will still come up. The alerts for incidents after they happen are already there. It is a good system. As soon as someone presents their name comes up and the alerts will come up. That happens in in-patient and in community, as soon as that's noted.

CHAIR - If you know that that person is agitated because of ADHD, say, and can't bear to sit down and wait for one-and-a-half hours before he or she is treated, do they get any preferential treatment?

Mr NETHERY - No. Your presenting symptoms are what get you preferential treatment. The staff will be informed and be aware that you have an alert on you and there is the possibility that your behaviour might escalate. Security would be informed of that, so they would know of your presence. They would be aware and if there was an escalation in your behaviour within the department that would be dealt with, by security usually and also the triage nurses.

Mr HALL - It has been put to me - and you might like to comment on this - in years past, and decades past, it was much easier to get into a GP. That seems to have changed and therefore many people don't elect to go to a GP; they present themselves to the Emergency department of a hospital, which tends to then clog up the system. I have seen that happen and seen the people queuing up, then a fever pitch seems to build up with intolerance and everything else. Is that what you have seen?

Mr NETHERY - That is what it expands to. It is community's expectation that they present -

Mr HALL - It is a one-stop shop and I will be fixed pretty quickly.

Mr NETHERY - It is a one-stop shop.

Mr HALL - I am on the Public Works Committee, and whether we are doing some more with the Emergency department at the Royal, certainly at the LGH, increased capacity there may alleviate the situation, despite the budget cuts which are on the way. Would more streamlining in those departments help with the frustration levels?

Mr NETHERY - Certainly. There are new processes being put in place now which will be streamlining people into either an admissions stream or a discharge stream, so these are your 35 per cent - 40 per cent people every day who needed to be admitted to the hospital and that other group of people are your discharge stream. ED do not have a control over in-patient beds, the hospital itself has that control over in-patient beds, so that has been alleviated somewhat recently. That discharge stream are directed to a particular part of the hospital where there will be a concentration of particular people there with particular skills in order to try to get them out within that four-hour rule which is coming in January.

Mr HALL - That has proved its worth in other jurisdictions. Other places are doing that and getting that streaming right and everything else to assist.

Mr NETHERY - I suppose it is frustrating for ED-trained nursing and medical staff when someone comes up to the counter and the reason they are there is that they need a bus ticket home. That person might well be told, 'Actually we can get you a bus ticket, but the social worker who can do that is quite busy at the moment with a grieving family and you may have to wait some time while we can organise that for you.' Is that person a priority? It might be a priority for them, but is it a priority for that institution that he expects that ticket from? Probably not.

CHAIR - Susan, I know we stopped you very quickly into your presentation.

Ms DARCEY - No, that is fine. Actually the next document that is there is a summary of the advisory committee on preventive medicine and workplace aggression in nursing. That committee started in 2003 and was wound up in 2006, just at the point where they had developed and were about to implement the education and training package around the works that had been done, and due to budget restraints that did not occur, but a lot of good things did proceed from it, such as the things Ian is talking about. There is the prominent signage in departments - No Excuse for Abuse, with the police banner around it - and security in the Psychiatric Nursing Emergency Department and many other good things have flowed from it. But it was not to the degree that would be required and hence one of the things that Ian referred to - the training for the Code Black team has slipped somewhat and now there are people who are involved in the Code Black team who have not actually had the training. The nurse, the clinician, is always in charge of that team because they look after the patient's head, their airway, and instruct the team on what they can and cannot do. The training isn't being rolled out to that level any more, so there are flaws in that which need to be addressed. But I just wanted to table that because it implies that a level of work had been done but unfortunately went nowhere. The Alzheimer's Society actually bought the education package and have rolled it out privately through other organisations.

Another thing that was identified last year, the Nurses and Midwife's Heads of Agreement, which was signed off in 2010 after several months of negotiation and interest-based bargaining process and it was highlighted through that process that there was an increase in violence and incidents. In clause 7 it says that there is to be a joint oversight committee set up to look at all things about workplace violence, safety, health and wellbeing, and that was meant to be completed in 12 months and there has been no work done there. Where there is a verbal commitment from the department to deal with all of these things, nothing really has eventuated. As part of that document, the department have provided us with their data which is from the incident reports, the electronic incident management system - EIMS. So it is an electronic incident report system which a lot of staff, not just our members, will tell us that they do not use it. It is difficult to access the computer, it is cumbersome and after an incident all they want to do is just go home, they do not want spend another 20 minutes filling in a form.

So although the stats here are the department's figures on the incidents of violence between November 2010 and October 2011, we would seriously question them. That is really understating the issues but it is the information that is available as collected data but we would confident that it could be double that.

Dr GOODWIN - I am wondering if there is any way of addressing that problem. I think you mentioned that it is difficult to use and cumbersome and takes 20 minutes and I can quite understand that people would be disinclined to go down that path, but it is an important source of data and they help inform everyone of the extent of violence. Is it fixable? Is there something that could be done?

Mr NETHERY - Verbal aggression it is just so commonplace, I could be spending most of my day filling in EIMS for staff members or myself who have been confronted with that issue. When it is more serious - and I suppose all types of aggression are serious but if it physical and somebody gets injured or someone gets hair pulled or spat at - then that would be something that we would certainly record but the verbal aggression is just so commonplace. Honestly, there are not enough hours in the day for it.

Dr GOODWIN - In terms of the flag that you have for people who have been aggressive in the past, what level aggression would they need to have been at to get a flag the next time. I am thinking of people who come in and might start out being verbally aggressive but then it escalates the more they keep coming in.

Mr NETHERY - Lots of patients have alerts on them. It might even be a drug alert. They might be allergic to penicillin or they might have some forensic history that needs to be recorded on their patient record, but certainly violence alerts are recorded as a violence alert. Potential to escalate to violence is recorded as an alert. Verbally aggressive to nursing staff or medical staff would be recorded as verbally aggressive to members of staff. We would always record that. It might just be someone who is really upset and might be a bit abusive when they first come in. They worry about their mum or their partner or a child - whatever it might be. You would not record that because that is a fairly natural reaction for someone, but an alert states what the alert is, so if there is a potential to be physically violent or verbally aggressive that will be recorded as such.

Ms GORRIE - Protocols around dealing with that might also be put there.

Dr GOODWIN - I am wondering whether even if something did not make it onto the incident reporting system it might end up as an alert.

Mr NETHERY - It might.

Ms DARCEY - An no doubt it may well be recorded in the patient's history as well.

Mr NETHERY - And that is more difficult to do now because nursing staff do not do that - we have to go through a manager to do that and that could take a couple of days.

Dr GOODWIN - Sorry, can you explain that.

Mr NETHERY - To put an alert on someone's history or their digital medical records as they are called now, not everybody can do that. It has to be done probably through patient information management system manager, he would put that alert on for us. There is a form to write out to get that to them too.

Dr GOODWIN - Sounds awfully bureaucratic.

Mr NETHERY - Yes, there is a delay on them.

Ms GORRIE - It is really frustrating.

Mr NETHERY - And that has only changed recently.

Mr HALL - From my recall you have signs up saying verbal abuse will not be tolerated et cetera, et cetera, but it makes no difference at all. Is that what you are saying. Do you think it has any impact.

Mr NETHERY - It does make a difference. I think it is a constant reminder.

Mr HALL - Okay. Has that been a fairly recent innovation or not? I am trying to think where I saw it last. I have not been admitted but I have been in a couple of times.

Ms GORRIE - It is now up in all buildings across DHHS and it is useful thing. When we talked about what we were going to say today, first you had to have a reactive component to what is happening around you. When people present to DEM, things that are useful - and this is from clients as well - having the EPN nurse was great, having the clinical initiative nurse who wanders around the DEM waiting area, so you don't feel that sense of isolation - 'No-one cares, I've just been triaged and now I'm here for six hours'. For a lot of mental health clients, clients with headaches or a mother with a baby, having a well-lit DEM area and a quieter spot for some people is useful. The security guard, the well-trained orderlies and the signage, stuff ongoing, making sure your OH&S environment remains safe. The media campaigns around intolerance of abuse amongst partners was really useful and to continue with that sort of campaign would be very useful across Australia. That works and people talk about it. Schools often pick up on those campaigns and incorporate them into their education packages.

I wanted to talk about early interventions. All the statistics and information you need is already out there. Some 80 per cent of mental health clients have had some sort of issue with abuse, either sexual or physical. What really gives you good outcomes is, say, when a woman becomes pregnant she then accesses services at a time when a lot of people don't really access services. What is proven to be beneficial from a mental health perspective - and I've seen it work within my own work - are early intervention programs. For example, you have a woman who comes in when she is pregnant and you can see who is at risk. It quickly comes out if they have a drug and alcohol history, a mental health history, whether there is a history of abuse. You can look at their past history and their risks. You put in packages for that area for families. Midwives in the Royal Hobart Hospital often say that if they had a perinatal nurse with mental health experience it would be very useful because you need someone to coordinate the packages, that are probably already in existence, to support that woman in her pregnancy and in the early years of that baby's life. That is where you have the good outcomes because that stops a lot of situations developing further along the track.

I am here today to ask that that be taken on board. You need someone to coordinate and work with that family when a woman or a family is identified at risk. A lot of the follow-up is not mandatory. You may take your child to a child health nurse, you may have this stuff, but a lot of women become trapped in an environment where they don't do that and they are the women that you want to access. If you have someone who is

working in community, who goes into those homes and builds that relationship when the woman is pregnant, then that is so useful. I have seen that personally with some of my clients and those children who could have been at risk are now doing really well.

CHAIR - You said you had some documentation on that.

Ms GORRIE - I can cite my own personal experiences with my clients, but research shows - and I can get it for you - that if you put money into early intervention and childhood you have much better outcomes. I'm saying to you as a worker who has been doing this for 20-30 years that I have seen that work for those children, the mothers and those families. I don't only work with the mother; I inadvertently work with the children and the family because I have all the knowledge. You need someone to coordinate and say, 'Yes, that's out there. Here's the address. I'll help you get there.'

Mr HALL - Have you pushed that case with the department? Have you been proactive in trying to get something?

Ms GORRIE - Yes, I've been pushing this for years and encouraging other nurses to do the perinatal training. I think it is very useful.

Mr HALL - But you haven't got as far as you would like?

Ms GORRIE - There is a perinatal nurse project officer employed with DHHS, and I and other nurses have done perinatal training and we work within ourselves, but there is no actual pilot or acknowledgement that we can go into work with the midwives and develop a program with them. I would really like to see that. I think that would be so useful.

Dr GOODWIN - What is the mechanism for you to find out about the pregnant women who are at risk? How do you find out about them and how do you establish that relationship because some of them would be difficult to engage? What is the process?

Ms GORRIE - There is none; that is what I am saying to you. These women are already within the mental health community. I am part of the mental health community and work with clients, consumers and families. Within the mental health community if you have woman who is already in there who becomes pregnant, we go all out to put a whole lot of stuff in place to support her and her children and the whole family. We already do that. But for women who are highlighted as at risk there is no specific program. You could see an outpatient midwife and that midwife can highlight someone as at risk and offer something but you need someone to then go in and work with that family or that woman. There is no specific project around that as yet, to my knowledge.

Dr GOODWIN - Or no mechanism. Initially they might make contact with their GP when they become pregnant or what would be the procedure?

Ms GORRIE - If a GP sees a woman as at risk, they can contact the mental health triage line and get that woman triaged to have follow-up. But that is at the end where you really have a bad situation. I am talking about a young girl who is 16 to 21, around Glenorchy, who goes to the Royal Hobart Hospital and who, from the interview with the midwife we know this girl has issues and potential risks. That is the level where it would be really

useful to do the early intervention. When they are in the system with me, yes, I do it all, but why does it have to get to that stage?

Dr GOODWIN - So it has to be hospital-based for non-mental health patients or clients?

Ms GORRIE - Yes, because you have to have quite a severe mental illness before someone like me can come in and do all that stuff. If you think about it logically, I service the 5 per cent of the seriously mentally ill. Early intervention at the Royal Hobart Hospital through the midwives, having that family approach and early-intervention approach, would be very useful. I think it would give you really good outcomes and then they would work very closely with the child health nurses as well.

Ms DARCEY - The only other documents I had were three letters all related to the same issue - a violent incident at Spencer Clinic on the north-west coast. It highlights the unfortunate circumstances where the police, for whatever reason, in this State cannot always be that supportive and they are particularly unhelpful when it come to a nurse wanting the lay charges. This correspondence between John Crawshaw, who was the CEO, and the ANF in regard to the member who was assaulted, just highlights some the difficulties for nurses to do something about being assaulted.

The other concern, of course, is with budget cuts. That is not going to assist at all.

CHAIR - There is bureaucracy involved and a lot of form filling prior to anything happening. It is good for statistics. Has it been good for outcomes at all in relation to assisting with violence in the community? A lot of bureaucratic needs have to occur. So this person has been violent and it comes up on the screen that this person has been violent in a number of different ways. All those things take time to do on a busy night when nurses and doctors have plenty on their plate. Has it helped or is it just form filling without it being any real help?

Mr NETHERY - There are some statistics we could not get without form filling - and if you would not mind I would like to give you a copy of this one that I did yesterday. I am sorry, it is my way of presenting stuff and it is not very accurate - this is for mental health people having access to an in-patient bed at the Royal Hobart Hospital - the average waiting time for September last year was 10.3 hours and for the same period this year, it was 12.7 hours. For October 2010, the average waiting period to access an in-patient mental health bed was 11 hours and for the same period this year it was 15.7 hours. I am not saying that all mental health people are violent people, a lot of them are but a lot of them certainly are not and not all violent people have mental health issues but it is one of those things that contribute to an environment which can be quite unpleasant for an extended wait for getting them to in-patient beds. In the Emergency department it is not a ward situation, people are restrained, usually particularly if they are under an order. They might well be a smoker and you certainly can't smoke in the Emergency department and we don't have the resources to take people outside to smoke and you would have to take them off-campus anyway to somewhere else. I suppose, from my point of view, that is the type of statistic I can pull off quite easily.

Reporting back on the other instances, someone with better skills than I have could probably do that, but I certainly can't.

CHAIR - Do you believe there must be a way of changing people's culture? It has with smoking and it is a long-term process but certainly the culture has changed in relation to acceptance or otherwise of smoking. That being the case you would think with a prolonged project in place you could change people's attitude towards violence. Firstly, do you agree with that and, if so, how would you do that?

Ms GORRIE - I totally agree. We talked about this before and we thought that the use of media and the ads around the anti-smoking campaign have been very effective. I am the mother of three boys and that campaign around what is acceptable in relationships, like, if you push that is actually abuse that really highlighted for a lot men in society that it is not acceptable and I think the running of campaigns like that and putting energy into that and raising awareness - because schools then run with it - is very useful.

CHAIR - Are there any things you should do in the interim because that is going to take time to persist with what seems to be violence within the community?

Ms DARCEY - I think we certainly need to look at more funding for pilot projects such as the one Ros spoke about with early intervention whether it be for the young pregnant mother or whatever but I think looking at some pilot programs to identify what works, how it works and capturing the strong points of those types of things and looking at rolling them out and identifying some good work in doing that pilot project type work.

Dr GOODWIN - On that point about the young mums intervention, someone mentioned and I think it is the See You At Home or Are You At Home, it might be an education project that taps into young mums?

Ms GORRIE - There is stuff out there but again with a lot of these girls it is to do with confidence, it is to do with attitudes and what works the best is that you have all this available but you actually need one person to work with that person and that family to coordinate and support that care. It has to be a person who is mobile who goes to those young people and then works collaboratively and then that brings in other people. The trouble at the moment is that there is this emphasis that you travel to everything -

Dr GOODWIN - Meaning the client has to travel?

Ms GORRIE - Yes, they travel and a lot of these guys because of anxiety or lack of money or for a whole lot of reasons they just don't do it and I have a whole lot of clients who are sitting in all their little boxes and the issue is that I could do so much with them if I had a bus. I could take them to all the things. Transport and having people who go out is so much more useful.

Dr GOODWIN - Can I go back to this document you have just given us, just in terms of the average waiting times, can you just take me through the process there? Is there a way of addressing this problem in terms of waiting?

Mr NETHERY - This is waiting for in-patient beds and these are people who have been admitted by the mental health team and are waiting for a bed within in the hospital to be moved. That is the average for that month. It is not unusual to have someone for three days. Last weekend, last Monday morning two people had been there, one had been there for two-and-a-half days and there was a person who had been there for two days in

a cubicle in the Emergency department. They have been fed, they have been watered and they have been cared for, but they are basically contained within a very small space.

Dr GOODWIN - When you say contained, are they -

Mr NETHERY - They are under Mental Health admission orders.

Dr GOODWIN - So they are just there on a bed in a cubicle?

Mr NETHERY - On a trolley.

Dr GOODWIN - How do you actually physically keep them there if they want to leave, do you have to restrain them?

Mr NETHERY - Most people understand the system really well. It is explained to them that they are under admission order and you give them a pamphlet that explains it to them if they not familiar with that. We have a psychiatric nurse within the Emergency department who cares for them while they are there, assuming of course that that person is there at that time. They are also told that they are given as much liberty as they possibly can within that area, but if they attempt to leave or start to show signs of aggression then a security guard may well be assigned to them, to make sure that they do not abscond and they do not display aggressive behaviours.

Dr GOODWIN - You mentioned the issue of smoking, so if they want a cigarette?

Mr NETHERY - We can provide them with nicotine replacement therapy, but that does not satisfy everyone, I can assure you. You can only stick so many pieces of gum in your mouth, really, can't you?

Ms GORRIE - That is going to get worse to because with the State Government's with the beget cuts, PICU - the Intensive Care Unit for mental health clients - is being closed; it is being moved upstairs to the Department of Psychiatry and in the process of that we are going to lose three beds. We already have bed block. Everything affects everything and that is why early intervention is so good. So with the community cutbacks, we are going to have more people at risk to have to go to DEM and with the closure of the three beds, that will really impact on DEM. It is a great concern amongst workers.

Dr GOODWIN - So people could be spending longer in DEM waiting for beds?

Mr NETHERY - They will be.

Dr GOODWIN - So more than two days?

Mr NETHERY - I am not blaming anybody in particular, it is a lack of beds, it is not an individual's problems and there are people on DPM, who might well be there for a month on an acute bed, because there is nowhere else to put them.

Ms DARCEY - That is going to escalate as well because Mental Health Services across the State there are budget cuts as well removing some of those type of accommodation areas that Ian is referring to.

CHAIR - Time is starting to get away from us. Can I just ask one question, please, that I have been reminded of by Tom and it is in relation to consumption of alcohol. Has the number of people presenting at the Royal in the Emergency Department with injuries resulting from the consumption of alcohol, increased at all?

Mr NETHERY - Yes, it has increased. In the old days it was called PFO, but we do not do that anymore.

CHAIR - Yes, 'probably fell over.'!

Laughter.

Mr NETHERY - It might be a head injury or an injury of some sort that has caused them to present, and they may be intoxicated as well. It is rare that someone has just presented because they are intoxicated, but that is not unusual, they might be brought in by friends who might be concerned about them, but we are not a place of safety, we are a place of assessment.

CHAIR - So there has been an increase of people with injuries that are drunk or have taken drugs.

Mr NETHERY - Yes, most definitely.

Mr HALL - To clarify, Dr Goodwin asked a question about the issues with ICU, the levels of violence there, they were mainly to do with mental health patients or ICU across the board?

Ms DARCEY - You were talking about psychiatric intensive care.

Ms GORRIE - PICU is the Psychiatric Intensive Care Unit, which is for mental health clients which is just if you are completely out of touch with reality or at risk of hurting yourself or others, that is where we put you as a place for safety asylum and as soon as you settle then you go upstairs to the Department of Psychiatry, which is much more open and you can wander around and things like that. Then there are the physical intensive care units as well.

Mr NETHERY - Which are more medically based rather than mental health.

Mr HALL - Yes, I can relate to that. I have a daughter who is a nurse unit manager in the ICU at the Royal Melbourne. It is not the patients but associates of the patients that cause them. It is not unusual.

Mr NETHERY - That is not unusual because it is a place of high anxiety for everybody.

CHAIR - Thank you Ros, Sue and Ian for coming along and giving us your presentation.

THE WITNESSES WITHDREW.

DEPUTY COMMISSIONER SCOTT TILYARD, **INSPECTOR STUART SCOTT**, **DETECTIVE INSPECTOR FRANCIS (PETER) POWELL**, **Mrs SANDRA LOVELL**, TASMANIA POLICE, WERE CALLED AND WERE EXAMINED.

CHAIR - Thank you very much for coming along. We thought we would bring you in again and ask whether there has been an increase in violence over the last 12 months or otherwise.

Mr TILYARD - Stuart is the inspector in charge of the district support division in Southern District based here in Hobart. Sandra is the manager of our policy services area. Peter is in charge of the Hobart CIB.

Thank you for the opportunity to come before the committee again. We have provided some additional statistical information that the committee requested. On the issue of community violence, total offences, including violence-related offences, over the last five years have reduced by 24 per cent in Tasmania. In fact assaults have reduced by 12 per cent from last year, which is a positive. In addition to that, public-place assaults have reduced by 20 per cent in Tasmania over the last five years, with just over 200 fewer public-place assaults compared to last year. They are the up-to-date figures. Essentially, assaults and public-place assaults have been trending down now for some time, which is a positive. A lot of hard work has gone into achieving those results, from our perspective. Obviously what we do is important but there are other factors as well that do impact on these things, but the role that the police play, particularly in relation to public-place assaults, is significant.

The committee was particularly interested in the issue of assaults involving knives. In terms of total assaults - assaults in public places and assaults that occur elsewhere - knives featured in about 4 per cent of total assaults and they featured over the last five years in approximately 3 per cent of public-place assaults. So the involvement of knives is quite low in terms of overall percentage of public-place assaults and assaults overall.

We do have some additional information that we can make available about the sorts of weapons and dangerous instruments that people use. Knives are the most prominent, but after knives are scissors and then it goes into all different sorts of things, from baseball bats to -

CHAIR - The information I am getting from the southern jurisdiction is that youths are carrying knives more than they use to - 'shivs' as some of the youths call them. A lot of youths are carrying them now, as opposed to years ago when they did not carry them. Is that right?

Mr TILYARD - We certainly take possession of quite a number of knives off people. There is legislation that allows us to search people if we have reasonable grounds to believe that they might be in possession of a dangerous article. We also take a substantial number of knives and other dangerous implements off people who are arrested for other offences and they will be searched as a result of that. So there is a combination of the two. Our view, and we have discussed this quite recently, is that, yes, more young people seem to be carrying knives these days than, say, 10 or certainly 20 years ago. It is hard to know why because a lot of the young people we ask say they are carrying them to

protect themselves, presumably from other people with knives or similar types of weapon. Most of them are not saying they have an intention to actually use the knife, but of course in a self-defence situation they feel they could be justified in doing so.

After knives, scissors are the most common instrument we take possession of. They are not always carrying the scissors to use as a weapon. They are often the means to break into and steal cars, for example. Scissors are the preferred instrument. Whilst we are taking possession of those instruments and they fall within the category of dangerous instruments under the Police Offences Act, it is not as if people are carrying them for any other reason than to maybe steal a car or break into somewhere.

Mr SCOTT - That is entirely correct. There are a few more knives out there, but to keep it in balance I don't see there is an epidemic of knives or that knives are entering into the culture of young people. I don't think that is the case. We routinely search people for weapons when we arrest them and we are not getting an increase in the types of knives that would cause us concern. Scissors are there and they can be used as a weapon, but I think we need to keep it very much in perspective. I believe with section 15C we have the adequate mechanism to deal with that, so it's not causing me a great deal of alarm but it is something we need to monitor all the time. We are much more careful than we used to be when we arrest somebody now because we are routinely finding scissors and those sorts of items.

Mr HALL - I saw your statistics on the decrease in the level of public assaults. Do you think there is any lesser level of reporting by the general public, which may distort that figure, or do you think that the level of reporting is consistent with what it has been in the past?

Mr TILYARD - There is certainly no evidence to indicate there is any change in the level of reporting. If anything maybe people are more prepared to report these sorts of things because of the amount of publicity, for example, about public order issues and public-place assaults. In terms of assaults overall and public-place assaults, most of the time we only know what is reported to us. The figures you have are reported assaults that we have reported within our system. There are obviously other assaults and assaults in public places that aren't reported. Being realistic about it, there always have been and always will be. I am not aware of any suggestion that the actual rate of reporting might have varied significantly.

Mr SCOTT - On the street, we are aware that sometimes assaults aren't reported. Say two blokes have a punch-up over a dispute in the pub, that has traditionally not been reported. But over a period of time that has been statistically consistent, so I would say that some of the types of assault being reported now are very minor and they wouldn't have been reported in the past. I think it has balanced itself out and I would suggest that our statistics would be valid and reliable in the long term.

Mr POWELL - I think those comments are valid. One of the issues for a lot of people who do want to report assaults, even minor ones, is criminal injuries compensation and compensation if they've been assaulted in the workplace. There has probably been more emphasis on people reporting assaults than maybe 20 years ago. As has been said, there's no doubt that some assaults do not get reported but I wouldn't have thought it is a big number.

Mr HALL - So from a public safety point of view it's a very pleasing scenario that you have presented to us. The perception out there, whether that is sometimes media-driven or not, is that we are living in a more dangerous society.

Mr SCOTT - It's about perceptions. Certain times and certain places are very different to other ones. There are still 400 public-place assaults in the Southern District. It is reducing, and that's very positive and I believe we can continue to reduce it, but there are still 400 so there's quite a bit of work to be done yet.

Mr POWELL - I think we gave some evidence at the previous hearing that maybe the level of violence in some of the more serious assaults has increased - the types of things that people are prepared to do to each other and the injuries they inflict. That becomes a public perception. The media play a role. A headline like that creates a lot of public perception about the sorts of things that happen.

Mr SCOTT - If we examine when and where they occur, they are very concentrated and that adds to that perception.

CHAIR - I can see some documents in front of you relating to where they occur and when.

Mr SCOTT - To inform our strategy we have to know when assaults are occurring, where they are occurring and why they are occurring, so we map them. It is very revealing, when you map them, as to where that concentration is, which is where that perception can be built up. When the concentration is in your primary tourist area, that is a concern and the tension that we have.

Mr TILYARD - The fundamental question is whether society or public places are less safe than they were in the past? I would have to say no. Assuming, as we believe, that the rate of reporting on these things is generally the same or maybe even greater, then the reported offences are coming down. There are some instances, as Peter said, in your extremely violent cases where levels of violence in those cases might be more extreme, but there have been nasty assaults in the past as well. People's perceptions are driven by a whole range of reasons and one is the media. We all rely on the media for our perception of what is going on in the world, whether it is in Tasmania or elsewhere, and social media these days is a whole new dimension. Even going back 10 years, it just was not about, so a lot of people will be talking about things on their Facebook pages, for example, or Twittering things that the police will never find out about, but a lot more people can hear about them just through those processes.

Dr GOODWIN - You would be on Twitter and Facebook now, wouldn't you?

Mr TILYARD - Well, we have not Twittered but are certainly on Facebook. The department has done some work so we do have a capability with Facebook now and we will be using it more in the future for various things. One of the issues with public order-type violence, in particular, is that we don't just hear about what happens in Tasmania; we also read about the nasty assault that happened in Melbourne or Sydney. A lot of reporting is about things that happen in Victoria and you actually have to start reading the article to realise that this did not happen in Hobart. This is something that happened in Melbourne. In Tasmania, if there is an assault, particularly a relatively nasty assault in a public place, then it is newsworthy and you read about it, so you tend to hear about

almost every one that happens. In bigger jurisdictions obviously they just cannot do that sort of thing. It is a little bit like the dog bite scenario. A dog bites someone and then for the next three weeks you are reading about a dog biting someone, until we move onto different things for a while.

Mr HALL - It is called the tedium of Tasmania.

Mr TILYARD - That is the nature of it, so people's perceptions are a big factor in this. It is not just public places. Obviously there are other crime types as well that people form perceptions on and there are a lot more sources of information these days. We are all better informed than we used to be in the past.

Mr SCOTT - With customer perceptions of violence in Tasmania, we are way ahead of everybody else in terms of perceptions of safety. If you look at the map, if you are around during the day you will realise that it is an incredibly safe place to be.

CHAIR - What about phones? How is that going because you would think people are able to report assaults or violence pretty well straightaway because nine out of 10 have mobile phones. Reporting is much easier and quicker than it was previously. Has that played an effect? If there is an incident often what people used to is say, 'So and so is having an altercation with so and so at such a such a place,' and therefore other people were coming down and exacerbating the incident.

Mr SCOTT - I can give you a couple of examples. We have had some assaults on tourists and they were picked up by mobile phone call and we were able to apprehend the offenders very, very quickly. So it is double-edged; we might get more reports because of mobile phones but we also get more detections and apprehensions as a consequence of it. So there are two parts to that. Our clear operate-and-arrest rate for assaults is extremely high - I think it is in the 90 per cent area.

Mr TILYARD - It is extremely high, yes. Mobile phones are great in public-place assaults; people will ring when something is happening because most people have a phone in their pocket. They also have video and cameras on their phones and sometimes they utilise those to assist us. It has changed to some extent the way we even do some of our policing. We get a lot of calls now from people who are following a car and it looks like the driver is drunk. People have ready access to this communication so they call the police straightaway.

CHAIR - Can I focus on where and when is it happening.

Mr SCOTT - I can provide you with what is happening in the Southern District. It is different to the last time we gave you a map. This time we have divided assaults into three, eight-hour periods: daytime; afternoon, which is 4 p.m. to midnight; and the after-hours permit period, which is after midnight. You will see that there is a concentration. The red dots represent the after-hours permit period, which is after midnight. You will see that the nature of the assaults and the location shift. So you will have daytime issues in, for example, the transport hubs and then it moves into the licensed premises area after midnight. Those are the salient points that clearly we have to deal with in terms of developing our patrol strategies, where we put our high visibility patrols and how we roster people. That is concentrated on to Wednesday, Friday and Saturday nights.

If we were to take a global picture of public-place assaults, it is focused on that time period in very, very specific locations. I am sure that you would be able to pick out very specific locations where those concentrations of afternoon shift and night shift dots are. This about intoxication.

CHAIR - That is the 'why'?

Mr SCOTT - That is the why. That is the location, that is the time and that map tells you a thousand stories.

Mr HALL - I think last time you mentioned alcohol as the main driver of violence and I think we did discuss closing times and the Newcastle model. Have you any further thoughts on earlier closing times and whether that would help with the problem?

Mr TILYARD - Statewide, we are reasonably satisfied with the closing times at the moment. We have some liquor accords in place where licensees are working together to try to address some of these issues. We, at this point in time, have not been pushing for earlier closing times. On a case-by-case basis we have certainly done that through the Liquor and Gaming Commission, but as a widespread issue we are not advocating that at the moment.

CHAIR - People obviously go to where it is happening at night, the younger people as well, especially Salamanca Place, round the wharf area. The hoteliers are doing what they can. Often they say people have their pre-drinks or -

Mr SCOTT - Pre-loading.

CHAIR - Pre-loading, yes, and then go to the hotels all loaded up. Hotels have then to the deal with them and say you are not allowed in, go outside. They put them outside, they become aggressive and things occur. Is it fair to say that?

Mr SCOTT - That is partially fair..

CHAIR - What is the other part?

Mr SCOTT - Some pre-loading does occur. However, there are issues in terms of intoxication and what the definition of intoxication is. It is an offence to serve a drunk but what is a drunk? So there is some ambiguity about that which then informs the practice of responsible serving of alcohol. Our experience is that people are coming out of clubs, in particular, intoxicated but our capacity to police intoxication and RSA in part depends on definitions around that issue of intoxication within licensed premises.

CHAIR - How can that be sorted out?

Mr SCOTT - By redefining what intoxication and drunkenness is. We have to be able to establish that the person who served felt that the person was drunk, and we can't do that.

Mr TILYARD - It is a difficult issue and it can be difficult for the staff in some of these venues because if you have a noisy, somewhat crowded, dark venue at 3 o'clock in the

morning, your only interaction might be when a person wanders up to the bar or trying to identify someone else who is buying drinks for them. It is challenging for some of the staff.

Mr SCOTT - Legislation in other States addresses this in other ways by making it an offence to have intoxicated persons on the premises in possession of alcohol, so there is a range of ways that other jurisdictions address that.

Mr TILYARD - That is not to say they don't have the same issues but the legislation does vary a little around the country. It is a very challenging situation.

Mr POWELL - It is a matter of societal issues as well. We don't ever want to be the fun police. People should be able to go and enjoy themselves and we don't want to impinge on people's commercial interests either. A lot of those assaults in public places happen because people are out so late and drinking to excess, but that is a societal issue, more than legislation sometimes, and I don't know what the answer to that is.

CHAIR - We have talked to a number of witnesses that cultures can be changed - like smoking and how the culture around smoking has changed. With proper media support there can be a culture change surrounding violence but things in the interim need to be put in place.

Mr SCOTT - I believe there is a cultural shift and it is now less acceptable to be highly intoxicated among certain social groups. I think that will gradually spread but there are still some issues.

CHAIR - If you had an open book what would you do?

Mr TILYARD - We were criticised during the week of trying to impose all these laws on a society that doesn't need them. To pick up on Peter's point, we are not the fun police and we have a job to do. A level of regulation needs to occur for everybody's safety and generally speaking we are comfortable with the legislation we have. There are some other things we can look at but we constantly monitor what is occurring in other jurisdictions. If there is something with an evidence base that demonstrates it is making a positive influence then we will come forward and ask for some legislative change.

CHAIR - You are happy with it at the moment?

Mr TILYARD - Generally speaking, yes.

Mr SCOTT - The out-of-hours permit period seems to be a problem. If the legislation was such that there was some contingency between behaviour and the levels of violence around that permit area then that would provide a controlling mechanism, because it is pretty clear from the evidence and the mapping and the times that it is the out-of-hours permit. The permit is not the same as a licence. Indeed, anybody could have a permit. You don't have to have the same criteria around a permit that a licensee is required to have.

Dr GOODWIN - So if there is a known hot spot in the after-hours space then perhaps those after hours permits should be restricted?

Mr SCOTT - It is a permit and permits can be contingent.

Mr TILYARD - There are conditions on permits and most of them that I am aware of at some of the more popular venues do have numerous conditions attached. They have required, for example, premises to invest in additional security and even CCTV arrangements. Breaches are looked at and the permits are reviewed, so there is a process.

CHAIR - And places have been closed down. A place in Liverpool Street was closed down as a result of acting outside of a permit.

Mr TILYARD - Yes, that is right.

Dr GOODWIN - There is some research evidence that the proliferation of outlets in a particular area can also be problematic.

Mr SCOTT - Density is an issue and clearly we have a density issue on the waterfront. I believe that now we have some very good rules in terms of controlling alcohol in the street, and there is a very competitive market in that particular area and in other parts of the State as well. We will start to see a shifting towards the northern suburbs again as the market starts to work. That may reduce some of the transient violence that we can plot on that map. Density is an issue, particularly where there are motels and residences very close to those venues, and we have to manage that very carefully. At the moment we're not doing too badly with those issues.

Mr TILYARD - One of the significant statistics in relation to public places is that almost half the offenders and victims know each other. These are often disputes that have carried over from wherever and sometimes it is just a chance meeting on the street or at a hotel. The chances of being assaulted for no reason, a purely random act, are very low, particularly up until certain times of night. The main public-place assaults are between midnight and 2 a.m. A lot of people aren't out between midnight and 2 a.m., but the ones who are are the ones who are regularly out between those hours. A lot of them are young people and if you look at the age spread it is evident that most of the assaults are occurring amongst young people. If look at the day of the week and time of the day in the statistics we have given you, on virtually every week day there is this little surge after school, between about 3 p.m. and 6 p.m.

CHAIR - Where's that occurring?

Mr SCOTT - It's basically in those public transport areas. There is that specific shift in demographic.

Mr TILYARD - School is out and the kids start wandering around and there is a bit of public-place assault happening. A lot of them are not serious in terms of injuries, bearing in mind that under the legislation a push can be a public-place assault. Some of them are on the more minor end of the scale but others are more serious. It is interesting to look at those graphs. The trend has been happening virtually every year. There are two noticeable peaks: after school gets out each day during the week, up until about tea time; and Thursday, Friday and Saturday nights, which you would expect.

Mr SCOTT - I have a more recent one of Hobart and that daytime one has shifted a bit. That is a consequence of changes that have occurred in the malls.

CHAIR - Which is the no-smoking issue.

Mr HALL - Just getting away from the licensed premises for a moment, there have been some very widely publicised cases, particularly on the mainland, where private parties have been held and there have been riots and affray when several hundred people turn up because it has been put out on Facebook. Have we had any of those issues in Tasmania?

Mr TILYARD - We occasionally have some parties that get out of control. I know up on the north coast they've had a few issues in recent times, but it does happen in the south as well. We have the Party Safe program which allows people to register with us the fact that they are having a party and provide us with some details and a contact person. If we get a call, for example, from a neighbour that there is too much noise, we have the details recorded. Sometimes the first response is to ring the residence and say we've had a complaint, so turn the stereo down, and we might not even need to attend. On other occasions we have had to attend and shut some down because it has got out of control with young people. Social media have played a part in that, where someone gets on Facebook or Twitter and says, 'There's a party at such-and-such address' and a hundred kids turn up who weren't invited.

Mr SCOTT - We have some good powers under the Environment Protection Act to deal with that. We do have problems but we try not to let them get out of hand to that extent.

CHAIR - In relation to the interim measures you can put in place, you have your CCTVs and extra powers that police have in relation to -

Mr SCOTT - Move-on orders.

CHAIR - Yes, and alcohol in public places et cetera. Are there any others that you think you need because it is obviously going to be the case that where there are a number of people there is more likely to be an assault. You could say that because you have them all down in a certain area it is probably a good thing because you can police those areas better than you can if you have to spread your butter a bit thinly over a number of different areas, and you have to balance it with Tasmania being a tourist place. People want to enjoy themselves when they go out but without the fear of being donged over the head in the early hours of the morning. Are there any other things that you believe should be in place that would assist?

Mr TILYARD - Not any significant new legislative measures. We have some proposed amendments to the Police Offences Act that are out for public consultation at the moment. Certainly I have not been approached to see if we can ask for some specific legislation. We have a pretty good suite of legislative measures to back us up. One of the keys to public policing in particular is a highly visible police presence and we have put a lot into that over the years. We have established the public order response teams and we certainly do identify where our hot spots are and the key times and we make sure we have visible resources available to respond.

It is no secret that we are subject to budget cuts, like all the government agencies, and that will have an impact over the next few years on our visibility. We have to reduce by about 100 police statewide, so there is 100 police that are not going to be seen about the place, and there are other savings we need to make as well. Unfortunately that is the reality and we have to operate within our budget, so that will have a bit of an impact on some of our public order policing as well. As much as we are going try to minimise the impact on frontline service delivery, as indeed this is, we cannot say that there will not be some impact.

Mr HALL - There has been a program on TV about being safe with a friend.

Mr TILYARD - A good mates guide; in other words, look after your mates.

Mr HALL - Yes, that is the one.

Mr TILYARD - That is a program that ran until, I think, 30 September. So it went for a few months and there was advertising in relation to it. As opposed to some of our approaches in the past which were all about reducing your risk of being a victim if you do this and that, this was about looking after your mates when you go out there because a lot of us have friends who sometimes have a few too many and they behave unreasonably.

Dr GOODWIN - It is always the friend.

Mr TILYARD - And we always say that if you do not have one of those then you might be that person, so be careful. Later in the evening you try to discreetly separate from them, but what about looking after those people and making sure that they do not get into trouble. One of the features that did get a fair bit of publicity with this campaign was the iPhone application. Again, this is looking at social media and new technology opportunities. You can basically download this thing for free if you have an iPhone and you can keep track of each other. You can see on your iPhone where they are, where you are and you can call them to contact you and keep a bit of an eye on people in that way. It has been very well received, and that was only part of the campaign. Whilst our department basically implemented that in conjunction with some others, you will not see it badged up in a big way as police having anything to do with it because we are trying to influence a particular audience with this and a lot of that audience is young people. They do not like being dictated to by police or any other adults, for that matter, but they are interested in looking after their friends and making sure their friends are safe, so it is really trying to tap into that and change their attitudes around that.

CHAIR - I was at a graduation a couple of nights ago and one person said school is a good place, what other place forces you to see your mates every day, and it is pretty right, isn't it, it is that mateship?

Mr TILYARD - It means a lot too. It is often said that sometimes for these young people their peer group is more influential than their parents and I think we have probably all experienced that, those of us who have kids at that age. They are certainly very influential and they are genuinely concerned, most of them, about looking after their friends. Kids can see each other all day during school, but they are on the phone or on the computer to each other all the rest of the night as well, so they cannot get enough of each other.

CHAIR - Again, it probably sounds a bit old to say it, but I have noticed that schools now have not got the ability to discipline students like they used to, students know their rights more than they used to, students now virtually are confrontational - not all, but some - to teachers, teachers find it difficult to deal with that because they are in their face telling them where to go in no uncertain terms and then they walk away. Years ago that could not happen, often the teacher would be saying, 'No, you're staying here,' and plonk that person back down in the chair. He can't do that now. Have you noticed anything at all, and what I am looking at whether it causes a trend, with the lack of being able to discipline - and I know you can go over the top and people have gone over the top in the past - but there is now a lack of being able to discipline which seems to have caused some people in society to use that and therefore certainly not respect the people who are in the end trying to help them?

Mr TILYARD - I think the key word that you just said was 'respect' - that is what has changed. That is what underpins a lot of this, the lack of respect, whether it is for not only parents, but also teachers, police and other people in authority. I think that has been the fundamental societal change on this issue. It is extremely difficult. You say that we are unable to discipline them but a lot of people say, 'You can still discipline them, you just can't use physical discipline, there are other ways to discipline a child.' It is a difficult issue, but there has certainly been in my experience over policing and Stuart and Peter have been in policing as long as I have, if not longer, and we have noticed that there was a time when most people would not backchat a police officer, for example; now you have 12-year-olds telling the police where to go and making threats against their families as well. Yes, that is very frustrating and difficult for our people and a lot of other people who provide services to the community to put up with and it comes down to in a lot of cases family values, the upbringing a lot of these kids have had, a whole range of people and the fact that they just do not tend to have that respect for others.

CHAIR - Years ago - and you hear the anecdotal comments to this effect - the police officer would give that person a kick in the backside and say, 'Off you go, go home,' and that to me was more of a circuit-breaker than saying, 'Look, you are going to be charged with threatening a police officer,' a month later they might receive a summons and they come before the Youth Justice Court.

Mr SCOTT - If I can just put my early intervention hat on here, you are talking about a sociological phenomenon.

CHAIR - I know that.

Mr SCOTT - And we have moved to a restorative approach with young people and we have certainly changed the way that we do policing, and if we used that technique now it would actually cause more problems than necessary. But there has been response too in terms of allowing us to have other powers in terms of the move on, and it took people a considerable period of time to get used to the idea that if we told them to 'move on' they actually did have to move on. Whilst there has been a sociological shift, there has been a change in the way that we police and the way that we deal with young people through the courts, and also the powers that we have to deal with those issues. It sort of balances itself out and the end product is we do have a reduction in crime and in violence through the State. It is incumbent on us all to keep pace with that sociological change and it is

going to become more and more challenging as families break down, and that is what this committee is about.

Mr POWELL - I think we all acknowledge it is probably lack of respect and that comes back to discipline and that comes back to lack of self discipline as well. What you were saying before about the whole school situation is probably where a lot of it starts because if you are not getting discipline from home, you used to get it from school, and whether you then had self-discipline and respect with fear or whatever motivation, it was good in the majority of cases for society. So it is a lack of respect.

Mr SCOTT - The evidence is that if we can keep the kids at school that is the one normalising factor, so above all we must try to keep the kids at school.

Mr HALL - You mentioned it last time.

Mr TILYARD - That is certainly important. I know a lot of the people who are teachers and, whilst I do not like to generalise, it can be very difficult for them when they try to instil some discipline in some of these young people only to have the parents banging on the door of the principal and abusing them for daring to discipline their child. That is the reality, that is what is happening. Not in every case let me say. A lot of parents are very supportive of the discipline whether it be by teachers, by the police or whatever. But there are a lot of people out there too who want to have a go at the teacher or the police officer for daring to discipline their child. So there is not a lot of support amongst all the elements of society or all the elements in a young person's life. There are still people who say to us, 'Why you don't just give the young people a boot up the backside?' so those people are still out there. As someone who once had a boot up the backside from a police officer and then got another one from dad when I got home for getting into trouble with the police, I know that a lot of older people could share similar stories. That is what probably the thinking was back in those days - to sort it out very quickly. What happened when you got into trouble with the police or the teacher was reinforced and supported by the parents.

Dr GOODWIN - Look how well it worked for the police!

Laughter.

Mr TILYARD - It worked perfectly. I guess it is having that consistency in the things like discipline in the lives of young people. It is when it is entirely inconsistent that they get confused and you cannot blame them for that.

Dr GOODWIN - This is a general question I suppose. In acknowledgement that there is a limit to what the police can do to address the issues around violence and the causes, are there any programs, initiatives, interventions, things that are happening at the moment that you think are working well in this space?

Mr SCOTT - I could name dozens of them.

Dr GOODWIN - Okay, so are there any gaps? I think I have asked this before but just to keep it current.

Mr TILYARD - Stuart will want to talk to this I am sure, but I would like to mention the interagency support teams. I know you are familiar with them and in fact they just picked up an award yesterday as part of the community safety awards.

They are a great opportunity for agencies and local government at least to be working more collaboratively in addressing issues such as early intervention with some of these high-risk youth and they can do a lot more work in that space. My experience with programs that have occurred over the years, be they localised things or intrastate-wide programs for young people, particularly in the high-risk-type young people, is the programs themselves are very good but often suddenly the program ends and that is it. There is not a lot in terms of ongoing support for some of these kids. There are in some cases through various mechanisms but for some of them there is not.

We have run some programs ourselves as a department in the past where we will take some young people for a few days out into the bush, do some stuff with them. Most of the time it has been really good but then of course it comes to an end and that is it. See you later, it has been nice meeting you and away you go.

As a general comment, in terms of a lot of things that happen with young people, a lot of ways that they are engaged in various sorts of programs, I think that probably one of the biggest issues is actually the ongoing support, sustained stuff, rather than a short, sharp thing that was probably a great thing while it happened and it probably has a good effect on a lot of the kids involved but it is not sustained.

Mr SCOTT - I can name examples of good work going on out there. There are some strategic partnerships that are working really well in terms of dealing with infrastructure issues such as taxis, lighting, cameras, developing programs, but there are a few gaps. If we talk about young people who become violent and develop issues with alcohol and drugs, anger management is a big gap. Drug rehabilitation is a big gap for young people, particularly the type of drug rehabilitation where they can go and get away from their peers because it is the contact with their peers that turns it to pieces again. There are lots of programs on the mainland where they are able to go to other locations and they are basically in isolation and these are endorsed by the courts as well, so they have a choice of a custodial sentence or they can go get that. Those are the sorts of programs which can make a big difference to an individual who would otherwise become a repeat violent offender, which is what this is all about.

The other issue is that if we analyse young people who have long histories of violence, it is about child protection and support in the child protection system so that we can stop the cycles of violence and neglect which then lead them to go onto the streets and to the drugs and the abuse of alcohol. That is the cycle we need to invest in to prevent that from happening but it can't be just a passive thing, it needs engage with those young people as well.

Mr HALL - The only other thing I would like to say is how much we appreciated being taken out on the beat a few months ago. I think it was Inspector Hopkins who took Dr Goodwin, Mr Dean and myself, and it was a very cold night in Launceston so it was fairly quiet and certainly, as far as the members were concerned, there was nobody full of grog and bad manners, particularly Mr Dean and myself.

Dr GOODWIN - I don't know, you'd had a few before you came out.

Laughter.

Mr HALL - It was interesting and well worth it, so thank you.

Mr TILYARD - We extend that sort of opportunity to a lot of prominent people to experience it for themselves, I guess. You hear a lot of things about it, you read stuff in the newspapers, you see some snippets on television news or whatever, but sometimes to get a real appreciation you need to actually go out and experience it yourself, and sometimes you do get a quiet night like that and other times you get a night that our people say has 'gone off' and things are happening everywhere. That is just the way it goes, but there is nothing like that first-hand experience.

Dr GOODWIN - It was a really good opportunity because we got to talk to some of the hoteliers and they showed us what they were doing in terms of the CCTV -

Mr HALL - Yes, and the security - the whole lot.

Dr GOODWIN - We did see one fight.

Mr TILYARD - Launceston is quite a good example because, as Mr Dean knows only too well from his time up there as the former commander, it had quite a reputation for being unsafe at one point, and I am going back a number of years ago now but there has been a lot of work done by the key stakeholders and there is certainly not that perception these days. That is not to say there isn't a problem from time to time because, unfortunately, that happens everywhere, but it certainly has changed from the days when Mr Powell and I used to be up there.

CHAIR - It is an interesting debate really because it traverses a number of different issues but it seems to me that to some degree the legislation and the police now are just about where it should be, and I say 'just about' because the family violence matters, I think, have been good. They can be misused at times and from time to time they are being misused, there is no question about that, but in relation to endeavouring to show that there can't be violence within the household, the children aren't brought up in that violent household because if they are they normally revert to violence as a way of solving issues at some later stage, there still needs to be something and I don't know what it is. Perhaps what I am looking for is to be able to intervene during pregnancy and to assist these people who are going to have children, because by putting a lot of investment into the early years it is going to save a huge amount of money in the later years.

Mr TILYARD - Health and Human Services in particular are essential because they are doing a lot of work in that space with the child and family centres, and the concept there is to engage these young pregnant women and future fathers in their area. There is quite a lot of work being done in that space and we are involved in some of that work as well. You are right, you do need to get in early and provide a lot of support and assistance to these people. You don't need a licence to have a child and a lot of support needs to be provided to some of these young people.

CHAIR - It then comes down to money, doesn't it?

Mr TILYARD - Everything comes down to money at the end of the day, unfortunately. It is challenging, particularly in a challenging budget climate, to do these things, but that's not to say that these things aren't happening, because they are. One thing that has occurred within government in particular, especially over the last 10 years, is that there is a lot more collaboration between agencies. The old silos have been largely broken down in the key areas in particular, and that is something we need to do more of into the future because you get that synergy from working together. The interagency support teams are a classic example of that. Stuart was involved in the very first one down at Huonville, and they have grown from there. It is about bringing people together around the table. Some of this stuff doesn't require extra funding because these people work for the agencies anyway; they are all engaged in their own way in addressing the same sort of issues, often with the same kids. The concept is to come together and talk about how you can do it more collaboratively and therefore better. Whilst some initiatives do require funding, there are some very important things we are doing now and can be done that don't necessarily require any additional funding, or at least not significant amounts of it. But of course, we're all under pressure to deliver our day-to-day services as well so it can be more challenging to do some of that work in a tight budget situation.

Mr SCOTT - If you wanted to examine how we intervene with young people, I would invite you to come to our Early Intervention Unit and we can show you exactly how collaboratively with other agencies we identify risk factors. We prioritise them and try to address all of those risk factors with the family and other agencies. What the Deputy Commissioner is talking about is having a coordinated response from all government agencies to do that kind of work. That's the future - that's the way we have to go.

CHAIR - Are there any agencies that need a bit of a push?

Mr TILYARD - No. There are always different pressures on different agencies at a certain time and I don't want to sit here and be critical of particular agencies. There are some very good people working in them and there are some opportunities for us to work more collaboratively. I think one of the key issues with this is that the agencies have to see this sort of thing as core service delivery - 'This is how you do this'. It's not just an extra add-on, this is the way we work together to address these issues and make these kids safer. It has to be seen as core business and core function and everyone has to agree on that, otherwise it is at risk of dropping away and you will have people not turning up for meetings and that sort of thing.

Mr SCOTT - Those are the best words spoken today: it has to be core business.

Ms LOVELL - Can I draw your attention to this report that we haven't spoken about yet? It is titled 'Crimes Against International Students in Australia', an Australian Institute of Criminology report, 2005-09, and there is a section on Tasmania. If there has been an assault, there has been more publicity about international students. This report tried to provide information about whether crime against international students was of a higher rate than the general population.

CHAIR - And what did the report conclude?

Ms LOVELL - That it's not. For Tasmania for our five main groups, it is not as great as it is for that same age group.

Mr TILYARD - This goes back to what we were saying about the dog-bite issue. You do get an assault like that, particularly with what was happening in Victoria with the Indian students in particular. I say Victoria, but that became a huge national issue. The media is very sensitive to that and very alive to it and will report any incidents, so there can be a perception that this is happening all the time and it is not necessarily such an issue that it is made out to be.

CHAIR - Can we get a copy of that?

Mr TILYARD - I have a one-page summary. We can send down this additional information, if you would like, which includes a summary of that and some other things that Sandra put together.

Mr HALL - We had evidence some time ago where we talked about intervention measures - and I do not know whether it came from yourselves or somebody else - but we talked about teaching parenting skills in schools as an early intervention measure. Have you any comment on that at all?

Mr TILYARD - I think the point was well made by you, Mr Chair, that schools are somewhere where you actually get all these kids together and that might be the only opportunity you will have in somebody's whole life to get the vast majority of young people together in the one place at the one time. I think there is certainly scope. I know there is more of an emphasis now on home economics, for example, which was relatively big back in my day; the girls went off to home economics and the boys went to woodwork and metalwork. I think the gender lines have probably crossed a bit now because of *Masterchef* and the like and you will probably have more blokes wanting to do the home economics, I do not know.

We have made a similar point around issues such as road safety. If you are actually going to capture these young people and try to change attitudes you only get one crack at it and that is when they are at school. Having said that, I know quite a number of teachers and they will say, 'Well, the curriculum is very, very full,' and it is, so it is difficult sometimes to try to incorporate these things; something is probably going to have to drop off and some tough decisions need to be made around what is in and what is out, and I fully appreciate that. But when it comes to the important issue of driving, which costs a lot of young people their lives or serious injuries, then you only actually get one crack to get them all together and sit them down to do that sort of thing and that is generally while they are at school, so let's maximise that opportunity as best we can, being mindful of the fact that they have a full curriculum as well.

CHAIR - Thanks very much for coming and giving up your time.

THE WITNESSES WITHDREW.

Dr ROSCOE TAYLOR, DIRECTOR OF PUBLIC HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Roscoe, thank you very much for coming. As you know, everything that is said in here is under privilege, so there can be no defamation or any action taken against you as a result of your evidence today. If you go outside this room, though, of course it is not privileged and if anybody wants to take any action against you, you are not covered with the same cover that is the case now. If there is any evidence as well during the briefing that you want to give us that you believe should be in private, please let us know and we can sort that out as well. I hand over to you.

Dr TAYLOR - I thank the select committee for this opportunity to come and talk about this matter. Based on the information provided, I am focusing strongly on alcohol and the connection with violence, and from a public health perspective how in the future there may be options for improved harm reduction from better public health approaches to alcohol. In preparing this I have provided a handout because there are graphs and data. Because of the time constraints some of those we may go through quickly, and I would encourage you to pause and ask me anything you wish on the way through.

The overview of my presentation to you today is really to give information about alcohol consumption. There is some data for Tasmania and I am not quite clear whether this is new information or has previously been provided and if so I can rapidly accelerate through that section, so please tell me. Further on there are some of the public health impacts and information regarding associations with violence and some data for Tasmania, the causes that we see leading to potential harms from alcohol, some of the underlying factors and then potentially some of the solutions that may be available as approaches into the future for reducing those.

I am assuming that you are not really looking for a medical perspective on the harms to individuals from alcohol, but we can discuss that if you see fit. I have left it out -

CHAIR - Thank you. We are looking at violence in the community, as you know. We have had evidence from the police in relation to statistics as to whether it has increased, decreased or stayed the same. We have had evidence of the severity of the violence as well and some of the evidence is that it has increased when it does occur. What we are looking for is some ways to stop it occurring and some recommendations, and what you have just described could well be helpful to us.

Dr TAYLOR - If we firstly look at the alcohol consumption data for Tasmania there are some survey data from 2007, which is a national series, the Australian Health Survey, and more recently from 2010. The National Health and Medical Research Council defines risky and high-risk alcohol consumption as more than four drinks on any single occasion. It appears that in 2007 in Tasmania, of persons who were 14 years of age who took part in the survey, about 39.6 per cent reported that they had consumed that amount of alcohol on some occasion or another in the past 12 months. Then if you look at the people beneath that who did that on a monthly basis, the figure drops down to 13.3 per cent of Tasmanians. If you look then at the people who drink daily, not necessarily at more than four drinks a day level but who just report drinking daily in Tasmania in

2010 - it is shown on this side in the footnote - it was 6.4 per cent compared with the Australian average in that survey last year of 7.2 per cent.

CHAIR - That is at 2010.

Dr TAYLOR - Yes, last year. We tend to see a socioeconomic gradient with alcohol that does not follow the pattern it does for a lot of other health risk factors. For example, with tobacco we see a distinct gradient in that lower socioeconomic groups smoke more often than higher income brackets or socioeconomic groups, whereas with alcohol the gradient is a lot flatter and tends to go in the opposite direction, so that people who can afford it tend to drink more often than people in the poorer groups. Long-term drinking daily at excessive levels does have the potential for public health harms, but that isn't the focus of your select committee, so I think it is best if we focus on the short-term binge types of drinking patterns and move from there.

When we look at risky alcohol consumption by gender we see that in a survey from last year 52.2 per cent of males 14 and over and 29.2 per cent of females were drinking more than four standard drinks at least once a month. We know from the evidence that drinking four or more standard drinks on any occasion increases the risk of short-term harm such as accidents, falls - injury to self, that is - assaults and other violent acts. There is a correlation that has been demonstrated in some of the literature.

In a study that was carried out about the social and economic harm from alcohol consumption in Australia you can see the spectrum of harms there with pain and suffering being a direct impact: road accidents, crime, as well as the costs of loss of life, the resources expended in dealing with abusive alcohol consumption and the total health care costs. A number of the segments in that pie chart would have a component of cost associated with violence that is in turn connected with alcohol consumption.

You may have received information already from the police about surveys in relation to community attitudes to alcohol and the most frequently perceived problems in neighbourhoods and in Tasmania this survey published by the ABS just last year showed that 17.5 per cent of people felt that drunkenness in their neighbourhood was a problem for them. Later on I will come to community attitudes to control measures for alcohol-related harms which may be helpful for you.

If we think about alcohol-related violence falling into two main categories, there are the public violence offences which are the ones people think about in their neighbourhood most often, and then there is the more hidden factor of domestic violence and intimate partner violence aggravated through the consumption of alcohol, and that can be for both the victim and the perpetrator. In general we are talking about incidents occurring in private dwellings and we must not forget that children are also the victims of that violence either directly or indirectly, both inside and outside the home.

If we look at mortality rates - and again this may have been presented to you previously - the number of deaths from assault by jurisdiction shows Tasmania a little above the Australian average. I cannot tell you if it is statistically significant in that particular year but it is slightly above. Of course the Northern Territory has a much higher rate again than anywhere else in Australia.

Mr HALL - It is interesting, Roscoe, that we are probably 50 per cent above Victoria in that respect.

Dr TAYLOR - It is 1.1 versus 0.7, so significantly higher there, I would say. That is aggregated over the period 2003 to 2007, so it is reasonably reliable and robust data.

If we look at our emergency department presentations to the health-care system in Tasmania over the 2005-06 to the 2009-10 years, you can see a trend to increase over each of those years and the percentage of those admissions of categories related to either mental health problems or alcohol- or drug-related presentations. Alcohol-related admissions to the EDs were a very significant contributor, with the last years listed there, 2009-10, 38.9 per cent of admissions from the category were attributable in some way to alcohol.

CHAIR - Did they say what caused it?

Dr TAYLOR - It would have been a whole spectrum of matters, but coming in with lacerations from an assault or abrasions, contusions from fighting and violence would definitely be one of the more common forms of presentation to emergency departments.

CHAIR - What about presentation with breathalysers where people want blood tests?

Dr TAYLOR - That would be a much smaller percentage. In addition, you have the odd acute presentation of someone with a medical complication from alcohol, for example, they have developed cirrhosis of the liver and have a severe illness at the moment or they are vomiting blood from ruptured veins in their oesophagus. Those are the other factors that could be on that list.

CHAIR - Are we able to say within that statistic what percentage involved violence, and how many were perpetrators or recipients?

Dr TAYLOR - I think it would take a specific-purpose study to do that because the data the emergency departments collect may not help us determine whether it was a fall or perpetrated violence, for example. The injury side of our surveillance systems in the emergency departments isn't the best for collecting that extra bit of information. It is something that I could take away and clarify.

CHAIR - No, that is fine, thank you.

Dr TAYLOR - If we look at general hospitalisations, these are admissions in Tasmania for people aged 15 and over and you can see that there is a trend over the decade from 1995-96 through to 2004-05 for an increasing rate of admissions over time, although it bumps up and down a bit and the rates for females and males both dropped very slightly at different times. To generate that kind of graph you have to make some assumptions about the role that alcohol played and to do that we use a national algorithm to look at the codes for each admission and make some attribution, so it is not an easy thing to measure but there is some theoretical basis to it.

Perhaps this slide and the information here is not new to you again because the police may have advised you that from a drug use monitoring in Australia report recently

released this year, those who have been charged with an assault on a Friday or Saturday night were more likely than those charged at any other times to have consumed alcohol in the past 48 hours and attributed alcohol as a factor in their offending. The median number of standard drinks reported by those offenders was quite high at 14 standard drinks and there is also information regarding where they reported drinking their last drink, either in residential premises or at a licensed premises, and quite a percentage of people - 50 per cent or so - had consumed inside their residential premises and 30 per cent in licensed premises.

There has been a publication called 'Exploring the Harms to Others' published by the Alcohol Education Research Foundation, or AERF. At the Australia-wide level almost 70 000 Australians are reported as victims of alcohol-related assaults every year, including 24 000 victims in domestic violence, and approximately 20 000 children across Australia are victims of substantiated alcohol-related child abuse, so presumably that would be an underestimate of the actual figure.

We obtained information from the police in 2008-09 regarding the Tasmanian statistics about family violence offences and victims being impacted upon by alcohol and public place assaults. The noteworthy figure there I think is that around 40 per cent of the public place assaults occurred on a Friday or Saturday evening in or near a licensed premises and there is a trend for females to be increasingly represented in some of those figures. There were 2 607 liquor infringement notices issued in 2008-09 and there were 1 232 instances of liquor confiscations, with 1 230 people being detained in custody for drunkenness and 270 detained due to their level of intoxication. I am not quite clear on the distinction between the two.

As I mentioned previously, there are confirmed links in the research between alcohol consumption and domestic and family violence and underlying that there are existing issues about gender-power imbalances that also can contribute, with men having in addition to that significantly higher rates of community-based violence than women at the present. It is worth mentioning, too, the coexisting factors that can really increase the risk of causing harm to others in a domestic setting. There are other types of substance abuse apart from alcohol, use of multiple drugs or illegal substances - for example, amphetamines are recognised to be a factor - and also the presence of mental illness can destabilise people and be a factor in whether or not domestic violence ensues.

CHAIR - Do you know offhand the percentage of people in prison at the moment with some form of mental illness? I have heard it is as high as 80 per cent.

Dr TAYLOR - I don't know the percentage offhand, but 80 per cent would not surprise me in the prison context. There are some very high levels of morbidity in the prison population. They are one of the most disadvantaged groups in terms of health issues.

A quick skim through the information I have provided here today and the rest of the information underpinning that has certainly persuaded me that we do have a problem with alcohol and harms in the community. It is a more and more pressing public health problem, I believe, especially for the more vulnerable sub-populations in the community.

If we look at violence in particular, I will cover some of those aspects from our Population Health perspective. Some of the factors that we believe are related here - and

there are many - are the ease with which alcohol can be obtained physically and afforded, because access and affordability influence availability and that's a definite contributor to the level of consumption of alcohol.

Mr HALL - I presume many of those are discount liquor outlets that tend to proliferate around the place. There has been quite a bit of community opposition to some of those, as you probably would have been aware. The Licensing Board has jurisdiction over those. I worked it out to be one licence for every 348 people, so that is quite significant, isn't it? I don't know how that compares with other places.

Dr TAYLOR - The evidence I have looked at suggests that the rise in liquor licence numbers in Victoria and other States is equally steep, if not more so. I think many of the increases have been in off-licence permits for cafes and restaurants, so as to how many of them are discount liquor places, I think we would need to ask the Liquor Licensing Board. The overall impact of either group is to increase the availability and accessibility, without a doubt.

On the plus side, Tasmania's Liquor Licensing Board, to date hasn't seen fit to allow the sale of alcohol in supermarkets. I think we are one step ahead of the other States in that because some of them have gone down that path and there's no doubt that it normalises alcohol consumption culturally and makes it very available and accessible as part of the weekly routine for shopping.

Dr GOODWIN - There are some alcohol outlets here that are awfully close to supermarkets.

Dr TAYLOR - That is very true; there is a lot of co-ownership.

CHAIR - In relation to the affordability of alcohol, I have had some anecdotal evidence that people are now saying that having shots of Red Bull with vodka is far cheaper than a drinking beer and other alcoholic beverages. It would seem to me that what some outlets are doing is giving stronger alcohol to people who cannot afford other alcohol, so they are maybe preying on the vulnerable.

Dr TAYLOR - That strategy might work to loosen the pocket as well, after a couple of drinks, so the volume of alcohol sold could be higher from that. Happy hour, for example, is designed to do that so that you stay on and drink further. I think those strategies work commercially.

Perhaps we will come back to the issue of taxation of alcohol later but it is at the top of your list to raise in terms of affordability, and the other factors influencing availability and consumption are the quite persuasive marketing strategies and the advertising which is pervasive.

We have talked about the after-hours episodes of community violence on Friday and Saturday nights where they are commonly in proximity to an outlet of one type or another and the bunching of drinking outlets and clustering of nightclubs and so on are places that are more often associated with outbreaks of violence. That is no news to anybody.

CHAIR - But it is different, isn't it, say, to places in Singapore. Greg, you may be able to help in that area in Singapore where there are a lot of bars and eating places. Do you recall what it was called?

Mr HALL - Yes, Boat Quay or Clarke Quay.

CHAIR - Yes, both of them. In areas like Singapore, of course, where there is this bunching of outlets, there does not appear to be, on the face of it, the same type of violence taking place.

Dr TAYLOR - It is a different culture in Singapore; there is a zero-tolerance attitude there to many things. Another influence here of course is the extended trading hours and late-night, early-morning opening hours of some of the premises that can have an impact on the violence as well, with a lot of the violence occurring after these premises close. It has been shown that an increase of two hours in extending the trading time for an outlet can have an impact on violence, for instance.

Another factor has been the steady increase in the concentration of alcohol in wine over the last decade or two. The big red wines now carry quite a percentage of alcohol compared with previously and it has been a trend. I think that means the community's understanding of what a standard drink is has not kept up with what it means to drink three or four glasses of red wine.

Mr HALL - I didn't know that.

Dr TAYLOR - The 13.5 per cent strength in red wine is common now, whereas it used to be more like 11 per cent.

Mr HALL - Conversely, a lot of beers have come down. We have gone into the lights and mediums and most brewers do that now because of drink-driving rules and all those things, and they have become much more palatable, might I say, those lower-strength beers. Just an aside.

CHAIR - In relation to a standard glass, then, people used to say that a stubby of beer, as far as a breathalyser reading was concerned, would return a reading of 0.026. That has risen now with the highest being 0.03 for a stubby of beer. What would that be for a standard glass of wine?

Dr TAYLOR - A stubby contains two standard drinks?

CHAIR - There are 13 ounces in a stubby.

Dr TAYLOR - That is just under two standard drinks of beer. Your one glass of wine now is 100ml, I think, and sometimes you receive glasses of wine that are 150ml as a standard drink, which is a bit of trap.

CHAIR - Your whiskies and spirits?

Dr TAYLOR - I couldn't do the arithmetic for you, I'd need to go away and work it out.

CHAIR - It is just an easy figure sometimes for people to relate to.

Dr TAYLOR - I have some information I would be pleased to hand over which has the standard drinks. It is an illustration from the National Health and Medical Research Council in the back of a consumer pack about questions on alcohol. That publication came out at the same time as the 2009 National Health and Medical Research Council's alcohol guidelines. The other document is available on the web with that.

I will just in passing mention the alcopops' appeal to the younger drinkers which was quite marked and the most recent 2010 survey of alcohol consumption patterns still showed that there is a strong preference for that kind of premixed drink with the youngest drinkers, the young teens, but I believe that the tax measures put in place did reduce the overall numbers of alcopops consumed.

In our assessing of the public health side of this we have learnt that the industry is quite concerned about how their products are viewed and they are sensitive at the present especially to moves afoot that might threaten their business and profits through any attempt to reduce availability of alcohol in the community. There also have been concerns from the industry about the proposed labelling of alcohol with evidence-based health warnings, so I think we can expect a lot of tension and push-back as we move forward in the public health arena trying to inform the public better about alcohol.

Dr GOODWIN - Roscoe, that has started in some places, hasn't it? What is the situation there, is it some States only?

Dr TAYLOR - Some manufacturers of wine, for example, have elected voluntarily to put something on their labelling in anticipation of Federal regulation. The problem we are having with that is that although it is good and well-intended, sometimes, for example, the 'Don't drink in pregnancy' warning is very tiny in size on the label, so it may not have any impact. It is an issue that, in my view, probably should be picked up nationally and standardised in the same way we have with tobacco, with very visible health warnings and perhaps not covering the whole bottle, but something more evident would be a step forward for the nation.

We do see a bit of a push-back and a polarising of the debate in the media about whether attempts to curb public health harms from alcohol are part of a 'nanny State' environment. That is the debate we have to contend with in public health arena. I believe we have made tremendous progress in relation to tobacco for some decades, but I hazard a guess that to do the same with alcohol will be more challenging again. There is a more strongly entrenched culture and the harms are more difficult to demonstrate at times, but we certainly have some areas where the harms are unchallengeable, incontestable and inflicted on others, and the first starting point for that would be in relation to foetal alcohol syndrome and exposure of unborn children to the harms of alcohol.

When we try to create a population-wide shift in relation to any widely-spread population health-risk factor, we like to know first of all how the risk factor is distributed in the community and what it means for an individual's health and the community's health. Sometimes people place a lot of emphasis on trying to target, identify and find people who are at high risk, people who consume well over the recommended amounts every

day. Dealing with that is one way of addressing the problem, but our experience has been that you need to do much more than that because oftentimes the groups at that end of the spectrum are the tip of the iceberg and it is the whole cultural and social norms of the behaviour that push some people more in that direction than others, and we have to deal with the broader community as well. The idea is that a range of interventions, almost always it is more than one, is required to really push the whole community's consumption patterns back to the left a little and take some people out of that high-risk bracket.

A consequence of a lot of that type of logic is that I think we will be needing a combination of both population and targeted strategies to address alcohol harms and violence. Universal policy leaders target particular aspects. When we talk about universal policy leaders the sorts of things that we sometimes go to first are the legislation and regulation. That can really help start the trend but you then generally need other strategies such as social marketing and community awareness campaigns. Social marketing on its own, advising and educating people about alcohol harms, would never work on its own, I believe. It would be very costly as well.

Some of the main potential strategies available could include strengthening of legislation and changing the taxation approach in Australia, which is highly regarded as a potential strategy. This is what we call volumetric taxation and another report I referenced by the National Preventative Health Taskforce in 2009 made recommendations to the Australian Government about tobacco, alcohol and obesity. With relation to alcohol, one of their strong recommendations was that the Federal Government should address some unevenness that exists in the alcohol taxation system and the best way to do that would be to tax the drinks according to the amount of alcohol in the drink. Otherwise, we have the situation where wine casks are extraordinarily much cheaper per standard drink, down to about 40 cents a drink, compared with a beer at $1.79. There is a distinct discrepancy depending on what you buy and wine casks are recognised as a major problem because of the cheapness of the drink.

Increasing the floor price is another strategy so there is a minimum price for alcohol, although the Commonwealth Government to date has not expressed any enthusiasm for volumetric taxation, they have said this is not the time to introduce that measure with the wine glut at present. I am not sure what their concerns are for the impacts on the wine industry but they have asked the Australian National Preventative Health Agency to look at policy options and provide advice to the Federal Government on minimum floor prices, so that work is currently underway at national level. I happen to be party to that because I am member of ANPHA's advisory council and I hope we will see the results of that work in a few weeks.

Other options for reducing harms is to strengthen the liquor licensing requirements and perhaps be more strategic there. I think there is some work going on in Tasmania at present to consider that. If you have not been apprised of this already there is a Tasmanian Alcohol Action Framework document that was published by the Interagency Working Group on Drugs which is a multi-agency group. Until last week when John Crawshaw left the Department of Health he was chairing that group and it was actually Minister Giddings as Minister for Health at the time who wrote the foreword for that document and it is still extant and we have an implementation plan going on. One of the strategies in that is to look in Tasmania at the legislative options available and make

some opinion about whether there is anything that should be pursued. In amongst that there could be some work around liquor licensing, I hope.

Other strategies include making the product less available or less visible, which was a long journey we travelled with the tobacco legislation, but this would obviously need some thinking into how that would happen. I would recommend health warnings on labels at point of sale as a strategy, especially for drinking during pregnancy, as a starting point. In public health it is always wise to know what your target is and have a goal to try to achieve it and make the target something reasonable and based on evidence that you can keep monitoring over time.

For Tasmania, limiting or capping liquor licences is one option, as is reducing the hours and days of sale. I have heard mention of the idea that there should be a sliding scale for licence fees and the longer they are open after midnight the more fee is paid, which would mean that the user then would be paying, effectively. That seems inherently sensible to me, but that's my opinion. Addressing the density of outlets and being cautious about where those outlets are places is a good strategy in relation to proximity to schools. An issue that was raised is whether or not the legal age for purchase of alcohol should be varied. Internationally that is the case, and in America it is 21 for the purchase of alcohol.

Mr HALL - You'd have to do that nationally.

Dr TAYLOR - I think that's correct. For Tasmania to do this unilaterally would be rather difficult.

Mr HALL - I think you would have a lot of screams from the hospitality and tourism industries. In some other countries it is 21.

Dr TAYLOR - Tasmania's role there would be maybe more to advocate for a look at it the national arena. That's the way it would have to play, I imagine.

I have mentioned before about the strategy to find and manage the high-risk individuals. That is typically a very resource-intensive thing to do and the health care system struggles to do it completely in the first place. The tobacco brief intervention initiative is underway where health care workers are trained in brief interventions where they ask people if they smoke or would they like to quit, and just the act of doing that causes a percentage to quit. It's a water-on-stone effect sometimes. In relation to alcohol, we are working away at the briefest possible questions you could ask without impacting too much upon clinical time with the patient. That may become a plausible approach over time if we can get the research funded to do that.

I have mentioned previously that monitoring our progress is going to be essential to set targets and work towards them. In Tasmania we have lost the tool that we had previously where we could report on mature alcohol sales volumes; I think we lost that more than a decade ago. With the benefit of hindsight we can see that it would have been rather useful to have had because then we could actually set a population target to reduce alcohol consumption per capita.

In terms of the strategic approach already underway, I have mentioned the interagency working group on drugs. There is an annual implementation plan that followed on from that, which has been a useful forum for getting interagency agreement on priorities and ways forward for some of the work, but there is still a lot to be done obviously, and community engagement is going to be a long and ongoing task. I believe we need to increase our investment in social marketing and our legal policy resources to deal with anything we start to develop, because from our experience with tobacco it takes a lot of legal policy time to get something to Parliament to be debated and passed as law. Towards that end, the interagency working group has commenced a legislative scoping project which we hope will report back within about six months. A request for quotes has gone out for that bit of work and I understand the responses are being evaluated this week, so we are hopeful of being able to appoint someone to do that work.

At the national level, I have mentioned the National Preventive Health Agency which the Australian Government has asked to look at minimum floor price policy options, and I have also mentioned the issue of volumetric taxation which would be an effective policy tool but is being shied away from at the present time. In terms of community support for alcohol control measures there was a national drug household survey last year. I have just selected some of the questions that were asked of people as to whether they would or would not support moves in different directions, but in relation to tougher penalties or better enforcement there was strong support for that in relation to alcohol harm control.

There was an increase over a six-year period from 32 per cent to 48.2 per cent of interviewees who agreed with reducing the trading hours for pubs and clubs, so there has been a groundswell of people who say maybe the hours are too long. In terms of raising the legal drinking age there has been a slight increase over that same period of people who agree that maybe that should occur, from 41 per cent to 50 per cent.

If you have not had access to the rest of that survey I can provide the web link, and the national drug household survey has a chapter on community attitudes to control measures.

CHAIR - Thank you very much, Roscoe, for coming along, and if there are any other questions that we need to ask we may do so with information from documents that have already been written and we could get in touch with you hopefully in the near future.

Dr TAYLOR - I would be happy to do that.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.