Royal Commission into Family Violence

WITNESS STATEMENT OF LORNA DOROTHY MCNAMARA

I, Lorna Dorothy McNamara, Director, New South Wales Health Education Centre Against Violence, 73 Miller Street North Sydney, in the State of New South Wales, say as follows:

1. I am authorised by the New South Wales Health Education Centre Against Violence (**ECAV**) to make this statement on its behalf.

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

Current role

3. I currently hold the position of Acting Director of the Child Protection Violence Prevention Team, NSW Kids and Families which is part of NSW Health. I commenced this role on 1 June 2015, as part of a six month secondment.

4. My substantive position is as Director of ECAV, a position that I was appointed to in 2002 and which I still hold.

5. In my current position, I am responsible for leading the work of NSW Kids and Families in relation to child protection and wellbeing. I also implement strategies to reduce the incidence and impact of violence and neglect on individuals, families and the communities in which they live.

6. I am also responsible for representing NSW Kids and Families at the state and national level and brokering agreements that result in the best health outcomes for NSW's mothers and their babies, children, young people and families.

7. I lead the Child Protection and Violence Response Teams, which sits within NSW Kids and Families.

8. In my role as Director NSW Health ECAV, I am responsible for managing a team of 24 staff and approximately 50 contractors in the development and delivery of programs and resources that address:

8.1. adult and child sexual assault;

8.2. adult survivors of child sexual assault;

8.3. child physical abuse and neglect;

8.4. domestic and family violence;

8.5. working with children under ten with sexually harmful behaviours; and

8.6. working in culturally safe ways.

9. Additionally, a current focus of mine is the development of qualification pathways to support an Aboriginal work force skilled in case management and counselling in the areas of sexual assault, family violence and child abuse. This pathway has recently been recognised by NSW Health Workforce Planning & Development.

Background and qualifications

10. I began working in the mental health and disability sector in the early 1970s.

11. Between 1978 and 1980 I worked as the Coordinator of the Community Emergency Support Centre in Townsville. It was here that I began focusing on sexual abuse and other forms of trauma, and the effects that this had on victims' mental and physical health.

12. In 1984, along with several others, I established a steering committee which eventually resulted in the establishment of Coffs Harbour's first sexual assault service.

13. In 1994, I commenced working at ECAV as the Senior Health Educator for the Mental Health and Sexual Assault Portfolio. During this time, I led the research project named 'Every Boundary Broken' (1997), which identified the risk of sexual assault for women using mental health services. This report went on to be instrumental to NSW Mental Health Services in the development of sexual safety policy, which addressed the sexual assault of women in NSW mental health services.

14. In 1999, I wrote a module for the NSW Institute of Psychiatry, for inclusion in the post graduate program, on responding to adult and child sexual assault. This module has been revised and continues to be delivered.

15. Next, in 2002, I was appointed as Acting Director of ECAV. In this capacity, in 2003 I worked to establish the Aboriginal Communities Matter Advisory Group (**ACMAG**) which aimed to tackle issues of racism, discrimination, white privilege, intergenerational trauma, cultural safety and workforce development.

16. I also supported the expansion of the program for Bilingual Community Educators (**BCEs**) to include two modules on domestic violence. The two modules, with handouts, are available in twelve languages to support BCEs to educate their communities, particularly women.

17. I am also an Honorary Associate of the Faculty of Education and Social Work at the University of Sydney.

18. I was appointed Director ECAV in 2004.

ECAV

19. The predecessor to ECAV was the Sexual Assault Education Centre, which was established in 1985. From there, the centre evolved to include a broader scope of educational areas, including family violence and mental health, and became known as ECAV. In effect then, the centre has been in existence for almost 30 years.

20. ECAV is located on the grounds of the public Cumberland Hospital in North Parramatta.

21. ECAV is a government funded organisation and is part of NSW Health (**NSW Health**). We use our funding to provide training, undertake research, run pilot programs, develop resources, provide clinical supervision and run training programs for both governmental agencies and non-governmental organisations (**NGOs**) with the aim to provide a whole of system response, not just a departmental or organisational response.

22. ECAV, being embedded in NSW Health, is uniquely positioned to achieve such a whole of system response. This position provides ECAV with the necessary influence, perspective and funding to identify and close capability gaps across the system.

23. Our vision at ECAV is of developing and supporting a highly effective multi-sectorial workforce, including NSW Health. One that is well equipped with the skills and knowledge to prevent interpersonal violence and to identify and respond to adults,

young people and children who have experienced sexual assault, domestic violence, Aboriginal family violence and childhood physical and emotional abuse and neglect. We are committed to developing a system that is coordinated and responsive and a workforce that has the capacity to improve the health and wellbeing of victim/survivors.

24. ECAV recognises that professional responses to interpersonal violence need to reflect the multi-dimensional nature of violence in any given context. This means that we require a workforce that is capable of both specialist responses and inter-agency collaboration. Consequently, we see that there is a need for both single agency/uni-professional training and for multi-agency/multi-professional training. We offer training programs that reflects these different needs.

25. ECAV provides training to around 2,500-3,000 people who are employed in the government and Non-Government Organisation (**NGO**) sector per year. Specifically, ECAV provides training for:

25.1. NSW Health senior health clinicians;

25.2. Aboriginal family health workers;

25.3. specialist child protection workers;

25.4. sexual assault workers;

25.5. medical and forensic examiners; and

25.6. mental health workers (only provided for a fee).

26. ECAV continues to offer training to mental health and drug and alcohol workers, but this is no longer provided free to the sector. We were unsuccessful in tendering for this work in 2014, after seventeen years of holding this contract. This training was, and is, provided to mental health workers on the Sexual Safety Policy, which addresses sexual assault and harassment within mental health services.

27. Further, the topics which these training courses cover include:

27.1. sexual abuse trauma;

27.2. children under ten with problematic sexualised or sexually harmful behaviours;

27.3. sibling sexual abuse;

27.4. same sex domestic violence;

27.5. elder abuse;

27.6. domestic violence routine screening;

27.7. the medical and forensic management of adult sexual assault;

27.8. Aboriginal cultural competency; and

27.9. Strong Aboriginal Men and Strong Aboriginal Women violence prevention community development programs.

28. These training programs are offered in metropolitan, rural and remote areas across NSW and interstate. Training courses also vary in length; from one, two, three, four and five day professional development courses, through to one year qualifications. Further, the methods of training include face to face and online training.

29. In addition, ECAV provides learning and resource development services, clinical and policy consultation, monitoring and supervision, and community development programs.

ECAV's training philosophy and general approach

30. The central focus of ECAV training is to improve the protection and safety of victims of interpersonal violence as well as their emotional, social and physical wellbeing. This is done through a holistic care approach that empowers victims to grow and heal, whilst reducing the shame and self-blame associated with their past and present traumas. That is, we provide a victim centric model and it is this model that is applied when we train those who interact with victims.

31. ECAV believes that as part of its training, a trauma informed approach is essential to assist workers to understand and respond effectively to the underlying trauma issues that surround the victim's experience.

32. In addition, ECAV seeks to help those who work with victims to recognise negative and dismissive attitudes about sexual and physical violence. This is an important part of moving towards a place of understanding and empathy, which is essential to

their work with abuse victims. Part of this involves working to break down and to understand the structural and policy issues that underpin current attitudes and beliefs around family violence, substance abuse and mental health. We combine this with an exploration of the therapeutic paradigms and clinical provisions relied upon by practitioners but which vary across practice groups. This process helps to build a greater richness of understanding of what are inevitably multifaceted trauma and illness experiences with the aim of enabling workers to deliver a more holistic therapeutic approach to victims.

33. Accordingly, our approach to training recognises that domestic violence, substance abuse and mental health illnesses are very complex, and often inextricably linked, matters. As a result, the training that ECAV offers is much more than simple one-dimensional training sessions. Rather, a combination of didactic, group and self-paced exercises are adopted, underpinned by adult learning principles, which ensures that participants have the opportunity to integrate their learning into their practice and that this fits within their role and agency context.

34. In support of these approaches, a co-facilitation model is commonly utilised within ECAV training programs, to maximise learning opportunities and to ensure the emotional safety and wellbeing of participants. Co-facilitators are selected who have different skill sets and backgrounds to one another to ensure that participants receive a truly multi-disciplinary learning experience. For example, a highly skilled and experienced domestic violence employee might co-facilitate with someone who is highly skilled and experienced in working with drug and alcohol issues.

35. Of course, participants are only able to get enduring value out of ECAV training, particularly training beyond the basic levels, where they have a foundational matrix of understanding upon which to tether the material being taught. This, together with an immediate way to put their new skills into practice, are required to solidify the learnt information into long-term memory, which can later be applied in new and varied clinical settings. Ideally, to embed what has been learnt, a worker who has completed the training will return to their place of work and implement change in their practices.

36. Front-line worker training needs to be complemented with management training, where managers are trained in how to support staff in delivery of trauma informed services. Management training can often be done in a shorter format or online and is really targeted at building an understanding that better allows managers to support

their staff. Managers need also to be aware of domestic family violence in the workforce, how this presents and the impact it might have on the worker and on client care.

37. The training for managers takes them through their responsibilities, within a policy context, to both their staff and to consumers using the service. Mental Health workers have continued to identify that without management support, implementing change is very difficult. It is therefore important for managers to be aware of the significant safety issues that may be impacting consumers using the service and the roles and responsibilities of workers and managers in identifying and responding to these concerns. Further, managers explore the implications of safety issues for mental health treatment delivery and patient discharge planning.

38. Accordingly, training for managers may include updated governance models, revised policies that acknowledge and recognise family violence, the mental health impacts of that violence and what appropriate responses by the workforce might be. There should also be an update in the standards to which the service has to be delivered, to bring it up to best practice as well as an update in the guidelines used to deliver that practice.

39. All training offered by ECAV provides opportunities for participants to consider and to develop a range of strategies to better identify and respond to domestic violence, sexual assault and child protection. In my current role with NSW Kids and Families, standards and guidelines are currently being developed for a range of trauma specific services such as Sexual Assault Services, Child Protection Counselling Services and New Street Services (working with children and young people with sexually harmful behaviours from ten years – 17 years).

40. Finally, there needs to be specialist training for "champions"; individuals within the organisation who will be able to provide more detail and guidance on particular matters. These people are seen as the experts in the workplace, the "go-to" person for more complex or obscure questions. They are often repositories of large amounts of historical information, which they combine with their training to provide high value outcomes to other staff, to clients and also to the organisation or agency in which they operate, through process change, leadership and innovation.

41. In terms of setting aside the time needed to provide this training, many workplaces are loath to release staff for long periods of time. This attitude creates difficulties

when trying to develop a good skill mix in the complex areas of domestic and sexual violence and workforces may not be trained to a sufficiently high level. One of the strategies that ECAV has employed to assist the sector to overcome this issue of time paucity, is to offer a range of training options. This allows most staff to undertake at least one full day of training on how to identify and respond to trauma with the clients they work with as well as providing them with instruction on how to implement policy and guidelines so as to embed the learned knowledge. Then, a smaller number of staff undertake longer programs that address more complex therapeutic skills that are required to work with people experiencing both current and historical abuse. This approach provides that workplace with the depth of knowledge required to deliver to patients, high level care.

42. In essence then, it is insufficient to simply train people. This alone would merely result in a peak of understanding of family law, mental health and related issues, but it would be unlikely to deliver long term, measurable improvements in the outcomes for victims. Any education program which seeks to improve industry wide, long-term change needs to be accompanied by embedded systems change, supported by policy and funding commitments. If there is real intention to change the culture and practice of a service sector, then a range of tools are required to ensure that this is delivered, and maintained, over time.

43. Looking at training specifically, two common failures are:

43.1. one-off training; and

43.2. train the trainer.

44. Dealing first with the issue of organisations providing only one-off training sessions to their staff, this approach is not effective as it has an insignificant influence on the overall knowledge and capabilities of a workplace, but for the lucky few that are able to participate in the training. Further, as staff leave their organisations through natural attrition, this one-off training approach can be seen to fail in the short, medium and long term.

45. Second, train the trainer is another very flawed model, particularly where the content of the training is so vastly different to what is being delivered within the service stream. Usually, a worker attends a two or three day training session, and is then expected to deliver and answer complex questions in an area where they have almost

no expertise. This too often results in incorrect ideas and beliefs being reinforced instead of challenged.

46. If these flaws are to be overcome, the next issue to be cognisant of is that the training model implemented needs to take account of a range of variables.

47. Importantly, trauma within the group must be recognised as one of these variables and the training structured to take account of this. All groups will have a number of participants that have or are currently experiencing their own history of abuse, or know someone close to them that is. Facilitators must have the skills to respond to and address this and create enough safety to enable good reflective practice throughout the training. The model must also address different levels of knowledge and skill, from first responders to those undertaking more detailed therapeutic responses. Additionally, different target groups require different content and processes, for example management needs compared to frontline workers, high dependency units compared with community based case management and so forth.

48. Additionally, training must also be provided in context. If training is delivered without a specific context, the knowledge and skills taught will prove to be of little value in the actual workplace.

49. To ensure consistency of message throughout the training and to ensure that everyone understands the various roles and responsibilities of the other people involved in the end-to-end delivery of patient care services, policy or service standards and clinical guidelines are also required to be delivered as part of the training. Training can then assist workers and managers to move policy into practice. The majority of workers and managers are unable to do this effectively without training support, so this is a very important factor.

50. Accountability for the delivery of training, to the agreed standards, should be structured through regular external evaluation and/or audits of the training.

51. The final element that holds this training approach together is funding. A funding stream should be made available to organisations like ECAV so that they can provide free or low cost training that enables managers from Government or NGO organisations to release workers for training as and when required, without concerns over cost implications. Accordingly, funding should be recurrent and reliable.

Specific family violence training

52. ECAV provides specialist family violence courses, namely:

52.1. DV-601: Practical skills in responding to people who experience domestic violence;

52.2. DV-602: Domestic violence routine screening facilitators training;

52.3. DV-603: Domestic violence routine screening implementation: Refresher course;

52.4. DV-605: Domestic violence for NSW Health workers;

52.5. DV-606: Domestic violence and child protection for maternity & child & family health nurses;

52.6. DV-607: Domestic violence and child protection: Developing good practice responses to a complex problem;

52.7. DV-608: Domestic violence for drug & alcohol & mental health workers;

52.8. DV-610: Knowing me, knowing you: Domestic violence group work with women & children; and

52.9. DV-611: Advanced workshop for domestic violence counselling.

53. In addition, ECAV has also developed and keeps up to date a comprehensive suite of materials that support the family violence training modules, which are produced using the latest research. It is vital that the training and the support materials reflect best practice thinking and that these are filtered out to the whole family violence system.

54. In terms of our own in-house structure, ECAV has a range of social workers, psychologists, Aboriginal family health workers and consultants who are involved in responding to domestic family violence more generally. Almost all ECAV staff have come from the clinical sector – either sexual assault services, Aboriginal family health, mental health or child protection services, and have current and high level clinical skills. We use consultant educators with our in-house staff to ensure currency, both in content and the context of service provision.

55. Because ECAV provides training to so many service providers, particularly in regards to family violence screening, we have observed an increase in the awareness of those who provide services, both directly and indirectly, to victims of family violence.

56. When domestic violence routine screening (**DVRS**) was first introduced, there was some criticism from parts of the health sector outside of NSW. This stemmed from concern regarding the adequacy of screening training for staff, and therefore the safety of women.

57. However, as I pointed out at the time, training workers is only one part of changing service provision. The NSW health sector has over 100,000 workers. To change such a large institution requires a systemic response delivered over time. To try and bring about this change, the DVRS training program targeted four streams within NSW Health; mental health services, drug and alcohol services, antenatal and early childhood services. Tools and training were developed to support the implementation of this program, and yearly snapshot data was taken from each of the streams to provide feedback and accountability. It has been a long and slow process to implement an effective and comprehensive DVRS program, but a very successful one. One that we need to continue to build upon.

58. Building this baseline understanding of family violence in the health worker population has been very important. Indeed, it is the first step towards developing capability in this area. If clinical staff do not realise that family violence exists, they will be unlikely to screen for it, report it, refer patients with indicators of abuse, or seek out further education to develop their capabilities in this area.

59. Additionally, as part of our family violence training we also include training on substance abuse and mental health issues, as often victims present with a range of these interrelated issues that cannot be dealt with in isolation.

The inter-relation between family violence, substance abuse and mental health

60. Much of the symptomatology that comes from trauma, such as domestic violence and recent or historical sexual assault, is interpreted as symptoms of mental illness, rather than being identified as a trauma symptom. As a result, the clinical response tends to be medication, supplied as part of a mental health framework of care. This is not the most appropriate response and does not deal with the client's underlying issues. A response like this results from a siloed understanding of mental health issues.

Indeed, historically there has been a siloing of the family violence and mental health sectors.

61. At ECAV, we believe that the better approach is to provide a multi-faceted training platform that draws from the knowledge and experience of other disciplines and delivers a clinical response that treats the person and not simply the symptom. Most clients that present within the family violence, mental health or sexual assault sectors have complex needs and a one-dimensional response is simply inadequate.

62. Substance abuse and mental health issues provide an example of why this is so. It is our experience that most people who access either drug and alcohol or mental health services, have both substance abuse and mental health issues. These issues are not experienced in insolation of one another and so it is not appropriate or effective to treat one or the other on their own. Both must be dealt with, each with a recognition of the other. The same can be said for family violence, where substance abuse and/or mental health issues are often also present.

The different paradigms that family violence and mental health workers operate within

63. One of the difficulties in trying to bring these different practice areas together is that the paradigms from which the family violence and mental health workers come from is so different.

64. For example, with family violence workers dealing with victims, the clear message is that it is not the victim's fault, rather it is the perpetrator who has chosen to use violence and so is responsible for the impact on the victim. In contrast, in the mental health sphere, clients are told that they have a responsibility for their own mental health. The issue being of course that often, the mental health issues that a victim of family violence is suffering has been directly caused by that abuse. How can a victim have responsibility over their mental health when the cause of their illness is not something that they had control over? There are these kinds of paradigm issues that must first be worked through and unpacked to get to a point where we have mutual understanding around trauma and the impacts of violence across the different disciplines. This is necessary so that different groups can work together to provide a cohesive, multi-faceted response to abuse. In NSW I think that we have come quite a long way in this regard.

65. When I first started training mental health and drug and alcohol workers for ECAV twenty years ago, most participants in workshops said that they had never worked

with anyone that had been sexually assaulted, and violence was viewed as being part of a mental illness. A domestic violence framework was unheard of. In contrast, this is the antithesis of groups today. Mental health workers come to the training as they are aware that the majority of their client group has experienced some form of interpersonal trauma, often historical as well as recent sexual assault, and that domestic violence is a current issue for a substantial proportion of clients.

The provision of drug and alcohol and mental health training together

66. Although participants are coming from different paradigms and different therapeutic models, ECAV's training approach enables them to deal with a client with complex needs as they are better equipped to make those cross-disciplinary linkages, supported by a trauma informed foundation, to provide a best practice therapeutic response.

67. It is for the reasons discussed above that ECAV provides training on domestic violence to drug and alcohol and mental health workers together. The participants in these training sessions simply get so much more out of it when it is run as a combined session.

68. ECAV was a partner agency with Sydney University on a project about enhancing collaboration between domestic violence and mental health services. Attached to this statement and marked "**LM 1**" is a copy of Towards Better Practice: Enhancing Collaboration between Domestic Violence and Mental Health Services. The overall aim of this research project was to enhance collaboration between domestic violence and mental health services with the anticipated outcome of improving service delivery for women who experienced both domestic violence and mental illness/health concerns, and their children. The three year study was funded by the Australian Research Council and was conducted by researchers in the Faculty of Education and Social Work at the University of Sydney, in partnership with Joan Harrison Support Services for Women, Fairfield and Liverpool Mental Health Services, the Education Centre Against Violence and the Transcultural Mental Health Centre. The results from the project were published. Attached to this statement and marked "**LM 2**" is a copy of the report "They Never Asked Me Anything About That" dated September 2010.

69. Two pilot projects were funded from the research, one in Liverpool and the other in Gosford. Both pilots worked at developing local responses to identifying and

responding to domestic violence and mental health for women victims and their children. The pilots resulted in highly successful outcomes, but were not recurrently funded.

Trauma informed responses

70. The critical elements for working with mental health workers and drug and alcohol workers are:

70.1. participants need to be able to understand the mental health or drug and alcohol issues and to be able to apply a trauma informed framework to those issues when they present in a patient; and

70.2. they need to be able to recognise the type of trauma they are dealing with, be it historical and/or recent trauma.

71. Admittedly, assessing trauma when working with clients that are very unwell, for example those that have serious psychotic episodes or extreme trauma symptomatology such as dissociative illnesses, is difficult. These more serious conditions are not being picked up easily within the system and highlight the need for specialist as well as cross-disciplinary learning. On the whole though, a trauma informed response, with access to trauma specific skills, is effective in the family violence, substance abuse and sexual abuse spheres.

72. However, trauma informed approaches are not without their limitations. A trauma informed approach is really premised on the basis that by providing a safe disclosure space, victims will volunteer information about their abuse. The approach does not promote the asking of questions by workers; it is a much more passive, rather than pro-active, approach. It also seems that the kind of trauma disclosure that is being sought is historical rather than current. Where abuse is ongoing, a passive approach may not be appropriate as we know that often, with this kind of abuse, women are unlikely to disclose unless they are directly asked. This includes both sexual assault and family violence. Accordingly, ECAV believes that the trauma informed response tool is effective and necessary in some contexts but for many of the types of abuse that our workers are dealing with, it has limitations that must be addressed.

73. An optimal approach would be one that applies a trauma informed approach where appropriate but also has the flexibility to incorporate more pro-active forms of clinical response.

74. As part of the training that ECAV offers, clinicians are shown how to take a more pro-active approach with domestic violence routine screening. We provide training on the use of a pre-amble with standard screening questions. The pre-amble informs the patient that the questions are asked of everyone and that they do not have to answer if they do not want to. This approach gives permission to the client to either disclose or not disclose, which is really important. We find that even if a client does not disclose on that first visit, disclosure may occur on subsequent visits.

75. There is also an issue around cultural safety with trauma informed responses. We work closely with people within Aboriginal and CALD communities who tend not to access a service unless they perceive that it is culturally safe for them to do so. If someone does not feel that their history and culture are being recognised and appreciated then they are much less likely to disclose abuse. It is essential therefore that any response is tailored to the client and that workers are trained in delivering culturally appropriate services.

76. In order to make a trauma informed response more effective, such an approach really needs to take account of and manage the limitations and risks outlined above.

Issues associated with adult or child specific approaches

77. In NSW we really have two systems: the child protection system that is child focused, and the domestic violence network that is adult focused. There needs to be a greater interrelationship between the two.

78. From my perspective, domestic violence is a central structure, within which other forms of abuse will be found. You may see quite a lot of adult physical abuse, and also child physical abuse, psychological abuse, financial abuse together with increased levels of child and adult sexual assault. It is important to remember that only one act of violence, or the belief that violence will occur, is enough to control and dominate a victim. Accordingly, under the banner of domestic violence there is actually an extraordinary range of abuses that occur, with linkages between all of these types of abuse. It is not uncommon to also find mental health and drug and alcohol issues as well, either for the victim as a result of the abuse, or on the part of the perpetrator.

79. However, our system tends to identify and manage only one part of this chain of abuse, rather than trying to grapple with the entirety of the problem. In recognition of these gaps, ECAV provides training for counsellors working with children under ten

who display problematic sexualised behaviours. We provide this training with the understanding that often these children are living in situations of family violence. It is not enough to look at the behaviours and try to deal with them. A therapeutic response needs to be family centred, and to recognise where there is a context of domestic violence. If we are going to intervene in these complex situations, we need to do so in a way that addresses the needs of the woman, her children while also addressing the violence of the perpetrator, in a holistic way.

80. In recognition of the need to provide a more holistic response, NSW Kids and Families is currently working with other agencies including NGOs to roll out the "It Stops Here" Domestic Violence response system, which is a reform framework aimed at reducing family violence. Attached to this statement and marked "**LM 3**" is a copy of It Stops Here: Standing Together to End Domestic and Family Violence in NSW. The "It Stops Here" approach is based on the Multi Agency Risk Assessment Conference (**MARAC**) Model from the United Kingdom. This program has the benefit of providing a multi-system informed and coordinated approach.

81. The "It Stops Here" approach is premised on the ability to share personal information about the victim between agencies. In NSW this is made possible under Chapter 13A of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) for adults and Chapter 16A of the *Child and Young Persons (Care and Protection) Act 1998* (NSW) for children. The details of the Information Sharing Protocol which supports this approach, is the subject of a publication by the NSW Department of Justice. Attached to this statement and marked "**LM 4**" is a copy of the Domestic Violence Information Sharing Protocol, dated September 2014.

82. This approach however does raise some issues, the main one being information sharing where the information collected relates to a victim of sexual assault or any condition arising from a sexual assault. Special protections exist for that kind of information. Sexual assault communications which occur in the course of a confidential relationship between a victim and a counsellor are privileged. This privilege belongs to the victim and so this information cannot be shared without their permission, as provided for in Part 5, Division 2, sections 295 to 306 of the *Criminal Procedure Act 1986* (NSW). Under s 296(5) a "counsellor" relationship might, for example, arise where a victim interacts with a women's domestic violence service or health service and a specialist listens to and gives verbal or other support or encouragement to the victim, or advises, gives therapy to, or treats the victim. This

then limits the completeness of the data and consequently the response that might be made in a particular case.

Changes to child protection legislation

83. One of the factors that has been quite complex in developing an appropriate statutory response to domestic violence has been that the statutory child protection system has historically not fully recognised the dynamics of family violence in a way that could support both the children and their non-offending parent in a family abuse scenario. That created tensions where women who were victims of violence were held accountable by the State for failing to protect their children from the offender. It was quite a punitive approach; one that punished the mother and coincidentally the child, even though the mother had no ability to control her violent partner's behaviour. This approach reflects a lack of understanding of the issue of family violence. The system must evolve to be able to support both the child and the non-offending parent in what are very complex situations.

84. The other issue that compromises progress in this space is the perception that if a women leaves the home then she and her children will be safe. However, we know that women are actually more at risk in the period when they attempt to leave. In some situations, the safest course is to remain in the home at that particular time. What we need then are structures that are in place to support a women and her children if she decides to stay and when she decides to leave, and to provide ongoing support to her afterwards to help her move forward with her life.

Child focused education and therapeutic approaches

85. With regard to the training that ECAV provides around dealing with children, we always ensure that the impact that family violence has upon children, including neurological and developmental damage, is explained and explored. The impact upon the mother of that abuse is also outlined and we teach participants how to work with women who have been victims of family abuse, including working with women on how to make reports about the abuse to child protection.

86. We provide introductory training that is child focused as well as more advanced forms of training that have a therapeutic aspect, specifically around children.

87. As well as providing child specific courses, we also provide for example a four day assessable course, "Practical Skills in Responding to People who have Experienced

Domestic Violence", which is frequently used by the NGO sector as core training for new workers. It is a comprehensive introduction to family violence. This course addresses the policy context, legal context, issues around what family violence is, what it looks like, different definitions, impacts upon women and children, as well as Aboriginal and CALD issues. We include in this introductory course training, specific training around the child, including neuro-biological impacts, the impacts on attachment and the impacts on mothers.

The benefits of ECAV being located within the NSW government

88. ECAV is funded by NSW Health and provides services at a subsidised cost, with prices varying based on whether the participants are from NSW Health, the NSW Health system more generally or whether they are private or interstate participants. Many courses are free to specific target groups. Cost for other groups range from $80 for a one to five day course for a NSW Health employee to $500 for a five day course for a private practitioner. This cost is very low compared to other commercially run training courses.

89. ECAV is charged with providing training that is very high quality and which continues to develop with the evidence. It is about educating people so that we can change and improve practice. In the end, we are seeking better outcomes for victims wherever they interact with the system.

90. The brief from NSW Health has been for ECAV to provide training both to government agencies and to NGOs. This has placed us in a unique position, where we work across government departments and agencies as well as with NGOs, giving us a broad perspective across these different organisations. It has allowed us to see where the gaps are across the whole system and where inter-agency processes do not function optimally. We are then able to advise on that and develop broad reaching training solutions to address the gaps. Without this line of sight, gaps in service provision would result in further isolation and silencing of victims.

91. This cross departmental, cross agency position has allowed ECAV to deliver a state wide response to many of the health issues that we provide training for, including family violence, which would not occur if we did not hold this position.

92. Because our mandate is so broad in terms of the various bodies that ECAV traverses, we have been able to develop a very unique range of training and other services.

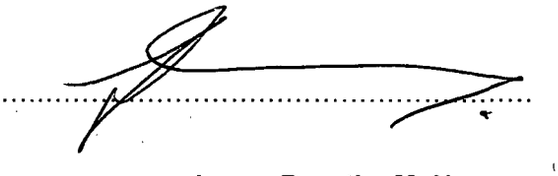
This position has also allowed ECAV to be very integrated with the workforce that we train and support.

93. In addition, we are able to use this interagency position combined with the knowledge and capabilities of our team to develop innovative and forward thinking approaches. The work of ECAV has been recognised by the NSW Ombudsman in recommendations responding to child sexual assault in Aboriginal communities. The Special Inquiry into child protection by Justice Wood recognised the role of ECAV in addressing domestic violence.

94. I absolutely think that this type of inter-government position, combined with the inclusion of the NGO sector in the training scope, is essential to developing and delivering best practice to those who deal with sexual assault, mental health problems and family violence, wherever they may work within the state.

95. However, the benefits that flow from having ECAV positioned within NSW Health are greater than just the training and educational value. Because ECAV is funded by and sits within the NSW government as part of NSW Health, ECAV has been able to participate in high level meetings and be involved in policy development including inter-agency policy development. Being inside government means that concerns regarding policy gaps or service provision problems, can be discussed and addressed. I think this would be less likely to occur if confidentiality were a consideration, for example, where there was an external training provider.

96. Family violence, child abuse and sexual assault require an inter-agency response and unless we are working as an inter-agency structure, there will be a disjointed response to these problems, with inevitable consequences for victims.



Lorna Dorothy McNamara

Dated: 12 August 2015