Royal Commission into Family Violence

WITNESS STATEMENT OF FRANK OBERKLAID

I, Frank Oberklaid, Foundation Director of the Royal Children's Hospital's Centre for Community Child Health, in the State of Victoria, say as follows:

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

Current role

2. I am currently:

3.1 Foundation Director of the Centre for Community Child Health at The Royal Children's Hospital. I have held this position since 1980. In this position I am responsible for directing an academic centre with clinical and research responsibilities, along with research translation.

3.2 Co-Research Group Leader (Policy, Equity and Translation) at the Murdoch Children's Research Institute. I have held this position since 2012. In this position I am responsible for undertaking and supervising research.

3.3 Chair of the Victorian Children's Council. I have held this position since 2011, and have been a member of the Council since its inception in 2005. The Council advises the Premier and Ministers on child health policy. I am especially interested in prevention and early intervention, and the use of research findings to inform public policy and service delivery.

3.4 I have chaired or been a member of a number of national and state policy committees relevant to children's health.

3.5 An Honorary Professor of Paediatrics at the University of Melbourne.

Background and qualifications

3. A copy of my curriculum vitae is attached to this statement and marked **'FO-1'**. A short biography is also attached to this statement and marked **'FO-2'**.

4. I am an internationally recognised researcher, author, lecturer and consultant with expertise in the following:

- Early childhood development and behaviour;
- Brain development and life-course;
- Prevention, early detection and intervention of problems affecting children (obesity, mental health, language, learning and literacy, hearing);
- Refocusing early childhood services for better outcomes;
- Early childhood and health policy; and
- School reform.

5. I have authored two books, numerous book chapters and over 200 scientific publications on various aspects of paediatrics.

6. I have received the following awards:

2014 Nils Rosen von Rosenstein Medal, Swedish Pediatric Association and Swedish Society of Medicine

2012 'Invited Member,' Reggio Emilia Australia

2012 Victorian Health Minister's Lifetime Achievement Award

2011 Tikkun Olam Award, Hadassah Australia

2009 Howard Williams Medal, Royal Australasian College of Physicians

2007 Medal of Distinction, Children's Hospitals of Australasia

2003 Chairman's Medal, Royal Children's Hospital

2003 Victorian Health Minister's Lifetime Achievement Award

2003 Centenary Medal, Commonwealth of Australia

1998 OAM (Medallion of the Order of Australia)

The impact of family violence on children

7. The social and psychological impacts on children of family violence can be as significant as the physical impacts. Exposure to maltreatment and family violence can have long term effects on a child. It is therefore important to work with children from a prevention and early intervention perspective so that they do not grow up to be perpetrators themselves.

8. The research is now uncontested in regard to the deleterious effects of persistent stress on a young child and the developing brain. When a child's brain is developing and maturing it is so exquisitely sensitive to the effects of stress due to family dysfunction, including exposure to violence. Toxic stress 'gets under the skin' and changes a child's physiology, and can have a long term impact on their life. Once we understand the effects of the stress response we can begin to understand the intergenerational nature of family violence and child abuse.

9. We obviously cannot completely remove stress from a child's life. However, stress is not harmful when it is transient – for example when a child experiences the pain of an immunisation injection or when a child falls over and hurts themselves. It is also made tempered by an adult who mediates the effect - for example, cuddling a child when they fall over. Toxic stress however, is persistent high levels of stress, and manifested in situations involving issues such as extreme poverty, family violence, mental health problems and sexual abuse, and where there is no adult to mediate its effect. Indeed, the adult may be the cause of that stress in the first place – for example in situations of abuse.

10. When stress hormones are high and persistent, they interfere very significantly with a child's optimal brain development. There is also increasingly robust evidence that what happens in the early years of a child's life can have life-long effects. Many adult conditions such as diabetes, poor literacy, mental health problems, criminality and family violence start in pathways that begin in the early years

The importance of early intervention

11. The attraction of early intervention, if approached correctly, is that risk is not destiny, and we can intervene to ameliorate the effects of toxic stress. Early childhood

(antenatal to eight years of age) is the elephant in the room in terms of policy reform in Australia. A focus on young children is the key to our future prosperity as children grow up to be healthy and well adjusted adults and make a contribution to society.

12. In addressing family violence it is important to recognise that family stress and dysfunction exists on a continuum, with abuse at the extreme end, like a bell curve. Traditional public policy is focused on trying to correct established and often entrenched problems, at the extreme end of the spectrum. This means that large amounts of money are directed to a small number of individuals, at a time when the evidence proving that at a population level established problems can be fixed is very slim. Rather than focusing only on the extreme end of the spectrum of abuse, we need also to be working to reduce the level of stress and family dysfunction for the whole population, and thus shift the whole bell curve to the left. These are often termed policies that 'shift the curve'.

13. It is also important to recognise that family violence issues exists alongside a number of other risk factors that also impact on children's health and development, and that they need to be addressed holistically. There will never be enough resources if the focus is only on intimate partner violence, or child abuse, or mental health, or alcohol/drug abuse, or homelessness, or any other single risk factor, and I am sceptical of any program that focuses on just addressing family violence while ignoring associated problems. Problems and risk factors tend to cluster together,

14. Early intervention is complex, expensive and long term. However, it is still infinitely cheaper than later in life that person ending up in prison because problems were not addressed early in the life cycle. Attachment **'FO-3'** shows the rates of return to human development investment across all ages. Attachment **'FO-4'** shows the relatively low cost of implementing prevention and early intervention programs in the early years, compared with the increasingly high costs of responses in later years.

15. If prevention and early intervention are approached correctly, they are able to achieve improvements in both the short and long term. This will have major implications for Australia as a whole because building social infrastructure is ultimately more important to this country than building physical infrastructure. It is the key to productivity, our productivity and ability to hold our own in an international economy, and maintaining social cohesion.

The role of the universal services in early intervention

16. Any intervention must be based on relationships; the best chance of sustained behaviour change occurs in the context of a trusting relationship – for example when someone the person trusts or has a relationship with tells them that they need to stop drinking or that family violence is not acceptable. These sorts of relationships could be built with nurses or general practitioners. That is one of the reasons why universal platforms – preschools, child care, schools, community nurses, GPs - are so important because they are used and accessed by everyone.

17. A big challenge is therefore how to reconfigure those universal platforms to be able to identify risk factors and emerging problems and intervene early before problems become entrenched and so much more complex and difficult (and expensive) to treat. This would involve an extensive re-training and professional development agenda so that every nurse and doctor is sensitive to the signs and know what to do once they have identified a problem.

18. These strategies should operate in the context of service mapping so that the universal providers know what and where relevant services are in the community. For example we would not expect an early years professional (child care or preschool) to have clinical expertise. However we can as an example articulate her central role in the case of a child with persistent sleep problems which is the cause of parental fatigue and family stress. The professional would:

    26.1 Recognise that a mother looks tired;

    26.2 Ask her if she is ok;

    26.3 Listen when she explains that her child has not been sleeping, has been coming into her bed and that her husband is cranky because he has had to sleep in the child's bed;

    26.4 Refer the mother to someone who can assist with the problem, ideally making that appointment there and then; and

    26.5 Follow up to make sure that the mother attends the appointment.

19. The above model is also applicable to family violence. The clues of family violence include things such as family stress, anxious mothers and physical injuries like bruises or cuts. If nurses and GPs really get to know families, they would be able to pick up on those clues.

20. The professional working in a universal setting knows there is an issue, cannot ascertain what it is, but refers to someone in the community who can sort things out and takes responsibility for ensuring compliance with the referral.

21. There are, of course, various factors mitigating against the use of the above model. Other than expertise and a knowledge of the various services available in the community, the fee for service scheme for GPs creates a financial disincentive for them to become involved in these activities – there is a cost for them to spend an extra half an hour teasing out a patient's problems. GPs simply do not currently have the time.

22. The poor state of children's mental health services is a further issue that needs to be resolved, with unclear referral pathways and long waiting lists which makes access often problematic. Paediatricians currently undertake the vast majority of children's mental health work in Victoria; they see many children with stress problems such as attention deficit and hyperactivity disorders (**ADHD**) and sleep issues however, and a good paediatric assessment also looks at family factors. All paediatricians would see identifying family violence issues as their responsibility and would get involved with varying degrees of confidence and interest.

Maternal and Child Health program

23. Victoria's maternal and child health program is unique in the world, and one of the jewels of our service system. The service is funded jointly by state and local governments. There have been ongoing reforms to that service and the Department of Education and Training has done an admirable job of continuously reviewing and updating the service.

24. MCHNs make contact with about 99% of young mothers and babies when they are born and undertake a home visit within two weeks of birth. MCHNs are located in the community, are free, accessible and non-labelling or stigmatising. The good nurses are wonderful and are skilled in exploring sensitive issues, and preparing the family for referral then referring appropriately.

25. The Centre for Community Child Health at the Royal Children's Hospital facilitates family partnerships training with maternal and child health nurses. This is an intensive program which helps equip professionals with the skills needed to work with families and address difficult family issues such as family violence. The training is very intense but effective. Successful interventions with families have to be relationship-based

because it is the quality of the professional's relationships with the family that really makes the difference.

26. The enhanced MCHN program is also helpful as it identifies risk factors and enables MCHNs to undertake more than one home visit. However, I would like to see the enhanced program better integrated and co-located with services such as allied health and GPs. Each individual service needs to be part of an integrated service system in order to achieve the desired outcomes.

The principles of a family violence service response and place based reform

27. There is no magic bullet in terms of designing an appropriate service response. Some of the risk factors for family violence (for example, alcohol and drug addiction, mental health issues and family stress) cluster together, and can have adverse outcomes for children even if they do not ultimately lead to family violence. This is why it is important to recognise that no single program is likely to be the sole solution. We need to consider stacked interventions or programs with five or six problems addressed by a range different programs simultaneously.

28. The response must be broad, long term, multi-faceted, whole of government and place based so that every community is recognised as different in terms of its service mix, demographics and requirements. What works in Footscray may not work in Camberwell because of community attitudes, access to services, public transport, employment levels, culture, language and other such factors. A top down, 'one-size-fits-all' approach is unlikely to work. Local communities are much better equipped to advise on how to solve local problems.

29. Governments fund a range of services. Common services for children funded by governments that have the potential to prevent, intervene in, or respond to family violence and other risk factors include:

    29.1. Child care

    29.2. Family day care

    29.3. General practitioners

    29.4. Maternal and Child Health nurses

    29.5. Preschool services

29.6. Schools

29.7. Specialist services

29.8. Parenting programs

29.9. Neighbourhood houses

29.10. Family support

29.11. Telephone counselling

29.12. Family violence services

29.13. Problem gambling services

29.14. Child protection services

29.15. Adoption/foster care

29.16. Mental health services

29.17. Alcohol and drug services

30. However, just because there is a service system in place does not mean that all families use it. The service system is fragmented and there are many barriers to using services.

30.1. Structural barriers include:

30.1.1. Not being aware a service exists;

30.1.2. Cost

30.1.3. Waiting lists

30.1.4. Transport

30.1.5. Hours of opening

30.1.6. Narrow eligibility requirements

30.1.7. Lack of affordable child care

30.1.8. Poor co-ordination between services

30.2. Family level barriers include:

30.2.1. Limited income

30.2.2. Lack of private transport

30.2.3. Unstable housing/homelessness

30.2.4. Large family size

30.2.5. Low literacy levels

30.2.6. Day to day stress

30.2.7. Disability or mental health problems

30.3. Relationship or interpersonal barriers include:

30.3.1. Professionals

30.3.1.1. Lack of awareness or cultural sensitivities

30.3.1.2. Poor listening and helping skills

30.3.1.3. Insensitive attitude or behaviours

30.3.1.4. Failure to engage families as partners

30.3.2. Parents:

30.3.2.1. Lack of trust in services

30.3.2.2. Fear of child protection

30.3.2.3. Easily intimidated by professionals or other parents

31. We need to focus on wrapping services around families in need. We have a strong universal system which is accessible and affordable – child care, preschools and schools, MCH nurses, general practitioners. Every child and family needs a basic suite of these universal services; well-functioning families who access services need additions such as immunisation and reassurance that they are doing a good job. Other families need more than a basic suite of services – they function at the

'intensive care' end of the spectrum of needed social support. Issues or problems could be identified by professionals in the universal system who are then able to refer families for additional support and intervention as appropriate. The current fragmented service system does not do this well. The slides attached to this statement and marked **'FO-5'** identify how a child is expected to navigate his or her way through this fragmented service system, and how that could look if we had good, integrated services.

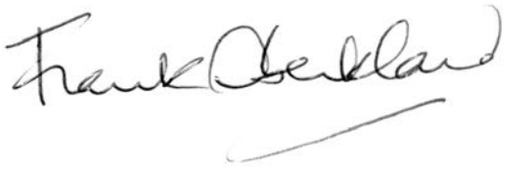
32. In terms of place based reform, the first step for each community would be to undertake detailed mapping of services. Currently, families and workers may not know who is providing family violence or other services, where they are located and the types of services offered, and the gaps in service provision. It is not until you actually immerse yourself in a community that you gain this knowledge.

33. I would like to see every community provided with some resources to undertake mapping. Some communities have already done it well, others have not. It would be the beginning of a move to place based reform.

34. The next step is to enable communities to be involved in the design of the way in which services are delivered, in order to meet the needs of that particular community. This requires that government adopts 'tight/loose controls', that is it is tight on the outcomes/outputs that are expected, but loose on the inputs, thus allowing the community to determine how best to achieve the government set outcomes.

35. I am aware of probably half a dozen local government areas in Victoria that would be ready to participate in some form of trial which could incorporate broadband funding – bundling up some of the many individual government-funded programs operating in the community and allowing the local community input into how the services are configured.

36. My vision is that Victoria becomes the best place in the world to raise children. We have a strong existing system, we just need to build on it. We need to encourage identification and referral and create physical and virtual one-stop shops so that if one worker cannot help, they take responsibility for referring to someone else who can.



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Professor Frank Oberklaid

Dated: 12 August 2015