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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

TUESDAY, 14 JULY 2015

(2nd day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

COMMISSIONER NEAVE: Good morning, everybody. Mr Moshinsky.

MR MOSHINSKY: Commissioners, the topics for both today and tomorrow relate to children. The topic for today is family violence and children, intervention and response. The topic for tomorrow is children, intervention and response. There is some overlap between the two topics. As they both relate to children, we will open those topics this morning for both days.

Starting with children has some importance because children suffer family violence both directly themselves, but also indirectly when there is family violence between one parent and the other. Children see or hear such violence and, as we will hear today, it can have very damaging impacts upon them.

We went through the statistics of the impact of family violence on children yesterday and we won't be repeating them now.

In recent years there has been an increase in the understanding of the damage caused to children by family violence. Whether the family violence is directed against the child or by one parent to the other, both can be damaging.

There's also an increased understanding of the long-term impacts of experiencing family violence as a child which can lead to intergenerational family violence. These facts demonstrate that stopping family violence is crucial, not only for the intimate partner themselves, but also for the children who may be affected. Further, intervening early to stop family violence affecting children holds the promise of stopping the cycle of family violence which may otherwise continue into the next

generation.

During the community consultations there were a number of themes that came through which relate to the impact of family violence on children, and I want to take a minute to outline some of the themes that came through on that topic. Some of the themes were that the impacts of family violence were raised by parents and workers. They raised concerns about the psychological impact, trauma and associated mental health issues such as post-traumatic stress disorder, depression and anxiety that children and young people exposed to family violence can experience.

References to intergenerational violence were made at many sessions. For example, "My kids have grown up thinking it's normal for their parents to hit each other." The Commission heard consistent messages that there aren't enough services for these children and young people and that the very limited services that are available have long waiting lists of three to six months or longer and don't offer different pathways for those who witness violence and those who use it.

Specific mention was made of the lack of child psychologists, limited access to therapeutic services for children and young people, the lack of alcohol and drug services and the lack of detox programs for children aged under 14. One quote was, "Specialist family violence services target women; child victims get lost in the noise."

Many of the sessions attended by women who had experienced violence referenced Child Protection and Department of Health and Human Services interventions,

both positively and negatively. Some women felt that they had been well supported by DHHS, while others had a different view. Some women, particularly those from Aboriginal and migrant communities, were fearful of reporting or disclosing family violence in case their children were taken from them.

Workers made reference to DHHS being overloaded as a result of mandated reporting. Concerns were raised about children being left in or returned to violent or unsafe homes if DHHS had deemed one of the parents to be protective despite exposure to violence from the other parent.

Against the backdrop of those consultations, what I will now do is outline rather briefly the different witnesses and the evidence that we will hear for the balance of today and tomorrow and explain how we will deal with the various issues that have been raised.

Firstly this morning we will hear concurrent evidence from Professor Louise Newman and Dr Robyn Miller. They will give evidence about the impact of family violence in all its forms on children. They will explain how violence, whether physical or psychological by one parent against the other, affects children's development. They will explain how critical both pregnancy and the early years are for development and how family violence can affect this.

They will also identify in broad terms some of the opportunities for prevention or early intervention. In particular, pregnancy and early childhood provides a window of opportunity to intervene with families. These are times when, as we have heard, there is an increased

risk of family violence. They are also times when the mother is already engaging with the health system.

After that session there will be a break, and then we will call Andrew Jackomos to give evidence. He is the Commissioner for Aboriginal Children and Young People. He will speak of the particular situation of Aboriginal children where there is, as his evidence indicates, a very high rate of out-of-home care. Mr Jackomos co-chairs the Taskforce 1000 Steering Committee, which has been set up in response to the number of Aboriginal children in out-of-home care. He will also speak more generally about the impact of family violence on Aboriginal children and some specific programs.

Then this afternoon we look more specifically at some of the opportunities there are for prevention and early intervention in the early years. We will call back Professor Newman to give evidence concurrently with Professor Stephanie Brown. They will address some specific initiatives for prevention and early intervention. Professor Brown will speak of some key findings of a research study on women and children exposed to family violence and will set out proposals for re-designing pregnancy care to combine high quality clinical care with a much stronger focus on addressing family violence and other social health issues. Professor Newman will speak about a model of pregnancy care being explored by Royal Women's Hospital.

Then we call Ailsa Carr. She is the Executive Director of Gippsland Lakes Community Health. She will briefly outline their integrated model for provision of health services and then will speak specifically about the

0-2 Program which forms part of the maternal and child health enhanced home visiting service. This is based within the universal maternal and child health program. It is an early intervention program that supports families with children between zero and 2.

Then we will call Anita Morris as the last witness for today. She is a social worker at Western Health and the theme of her evidence is that the views of children are rarely taken into account in the current system and we should give children more of a voice. We should be talking more to children about what is going on and potentially involving them in matters such as safety planning.

I will now outline the evidence for tomorrow. Many of the submissions have identified a perceived need to also work with men as fathers in the interests of their children. Despite this, there are currently relatively few programs specifically aimed at men as fathers. In the morning tomorrow we will look at a number of programs which involve working with the whole family and some programs about working with dads and some programs working with children and mothers.

First we call Mark Feinberg. He is a research professor at Pennsylvania State University who will give evidence by Skype. He advocates much wider prevention efforts, not just for so-called high risk families. He has set up a program called Family Foundations, which is a universal application program working with expecting and new parents. The key focus of this program is on co-parenting, how to create a positive team in the role as parents.

Now, this program was set up without having family violence in mind and without an objective directed at family violence. But an unintended side benefit of the program has been to materially reduce the incidence of family violence. Comparing those who had participated in the program with a control group, there were half as many incidents of family violence in those who had participated in the program compared with the control group.

We will then have concurrent evidence from three witnesses: Wendy Bunston, who is a senior social worker and family therapist; Dr Richard Fletcher, a senior lecturer from the University of Newcastle; and Julianne Brennan who is Director, Community Crime Prevention in the Department of Justice and Regulation. Each of them will speak about specific programs, some of which involve working with mothers and children, others involve working with dads and others with the whole family.

One of the themes that comes through is that there is little continuity. Many programs have been funded to be run for a period of time and then the funding stops. We will examine a number of these programs to see, to the extent one can say, what has worked and what hasn't worked.

Following that session we will then have a session of concurrent evidence involving Professor Cathy Humphreys, Professor of Social Work at the University of Melbourne; Dr Robyn Miller, who is giving evidence this morning and will return tomorrow for this session; and Beth Allen, Assistant Director, Child Protection Unit at DHHS.

In that joint session we will delve into a number

of difficult questions relating to how we currently protect children who are at risk, with a focus on the child protection system but also other related systems. Among other issues we will examine the concept of a differential pathway so that not all cases go to Child Protection.

Professor Humphreys advocates a differential pathway which routes many children or most children and their mothers to community based services. Another issue we will explore is how to address the risk of post-separation violence. Professor Humphreys will say that the child protection system is not designed to intervene effectively where there is a protective mother or father, but the child and often the mother are continuing to be subjected to post-separation violence and stalking.

Then finally tomorrow we will look at the treatment of children who have experienced family violence. We will have two witnesses: Emma Toone, a child psychotherapist, and Wendy Bunston who will return for this session, and we will address the question how do we best treat children who are exposed to family violence. How do we minimise the negative impacts on the child, particularly where parenting may be compromised because of family violence.

So, that is an outline of the evidence to be called and the issues to be explored today and tomorrow. Could we now turn to the evidence of Professor Louise Newman and Dr Robyn Miller, and I ask for them to be sworn in, please.

<ROBYN MAREE MILLER, sworn and examined:

<LOUISE CATHERINE NEWMAN, affirmed and examined:

MR MOSHINSKY: Thank you, Professor Newman and Dr Miller, for your time this morning. I will be asking questions to each of you, a sequence of questions in turn, but please feel free, if you wish to comment on an answer of the other witness, to do so. I will first be speaking with each of you about your background and experience briefly and then we have a two-hour slot for this session, so there is some time to develop the issues. There will be three sections to the material that I wish to cover with you during that two hours.

The first section will deal with the impact of family violence on children. The second section will deal with the long-term impacts of family violence on children. The third section will deal with the response of the health system, including opportunities for different responses to those we have currently.

Could I start with you, Professor Newman. Firstly, you have prepared and signed today a witness statement?

PROFESSOR NEWMAN: Yes, I have.

MR MOSHINSKY: And are the contents of that statement true and correct?

PROFESSOR NEWMAN: Yes, they are.

MR MOSHINSKY: Your speciality is in infant psychiatry?

PROFESSOR NEWMAN: That's right.

MR MOSHINSKY: And you are the director of the Centre For Women's Health at Royal Women's Hospital, a position you have held since 2014?

PROFESSOR NEWMAN: Yes.

COMMISSIONER NEAVE: Could you very briefly outline what the

centre does?

PROFESSOR NEWMAN: Yes. The Centre for Women's Mental Health is both a clinical centre and a research and teaching unit, so we provide mental health services to the range of women and families who attend at the Royal Women's Hospital and some services in the local community. We also undertake research in a wide area of different topics related to women's mental health. We are a research unit of the Melbourne University where I have a chair of psychiatry.

COMMISSIONER NEAVE: What does your role as director involve?

PROFESSOR NEWMAN: I do some direct clinical work. I work both with women during pregnancy and also with parents and infants. My work is mainly with so-called high risk situations where women might be experiencing stress, trauma, particularly with domestic violence and drug and alcohol issues. I also have a large research component to my position and I do research in infant-parent interventions and the prevention of child abuse.

MR MOSHINSKY: Thank you. Talking more generally over your career, what are the main areas of your clinical expertise?

PROFESSOR NEWMAN: I'm a psychologist as well as a psychiatrist. I qualified in adult psychiatry and then undertook training in child and adolescent psychiatry. Subsequent to that I have done work mainly on infancy and early childhood and developmental disability, developmental disorders. My main focus over the years has been in the area of child abuse, prevention of child abuse and maltreatment and parenting difficulties.

MR MOSHINSKY: Thank you. I note that your CV and your

publication record are attached to your witness statement.

PROFESSOR NEWMAN: Yes.

MR MOSHINSKY: Could I turn to you, Dr Miller. You have prepared a witness statement which you have signed today?

DR MILLER: Yes, I have.

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

DR MILLER: Yes.

MR MOSHINSKY: Dr Miller, you are a social worker and a family therapist?

DR MILLER: That's correct.

MR MOSHINSKY: And you have 30 years experience in the government and community sectors?

DR MILLER: Over 30 years.

MR MOSHINSKY: Can you briefly outline your roles with government between 2006 and 2012?

DR MILLER: Yes. In 2006 I began as the inaugural Principal Practitioner within the Children, Youth and Families Division of, as it was known then, the Department of Human Services. That role was primarily around practice leadership and promoting the training and also supporting the work with the most complex families, and also inputting the knowledge from practice directly into policy and service development. So it was a senior level but it retained a practice focus. That role also involved me then contributing and writing practice resources and a practice model that we used across family services and out-of-home care as well.

Then in 2011, I think it was, the role broadened to be Chief Practitioner across youth justice as well and then at the end of 2012 Chief Practitioner for the whole of the department, which was the department then of human

services.

MR MOSHINSKY: Thank you. Were you in your roles in that period involved with reviews of deaths of children?

DR MILLER: Yes, I was. I began as a member of the Victorian Child Death Review Committee in 2002 or 3, I believe, and so I was in that role being part of - it was a ministerial appointment and it was a role that was part of a committee that advised the - it was a report that was given to Parliament and to review the circumstances of children's deaths that were known to Child Protection. So I continued that role once I began in the Principal Practitioner role and so I was in that role for 10 years.

MR MOSHINSKY: Did you through your role - I think you have touched on this - but have a direct practice role with some children and families in the period 2005 to 2012?

DR MILLER: Yes, with many, many families.

MR MOSHINSKY: And prior to 2004, in the period 1992 to 2004, what was your role as a senior clinician? You worked as a senior clinician in that period?

DR MILLER: Yes. From 1992, so for approximately 12 years, I was employed at the Bouverie Family Therapy Centre as a family therapist and I had a teaching role there, but primarily a practice role and providing therapy to families who had endured trauma and I was part of a specialist team that became well known from Bouverie around sexual abuse work. So, we were dealing with cases where there was intrafamilial abuse, but also a strong theme was the presence of family violence, and in that role, as in my earlier work from 1980 onwards, I was also involved in working with perpetrators of violence and sexual abuse, as well as the victims, the children and

also the non-offending family members. So my experience has been across those different parts and working with the family as a whole, if you like, the relationships between children and their parents.

MR MOSHINSKY: Thank you. I note that your curriculum vitae is also attached to your witness statement. Can I now then turn to the first major theme of the impact of family violence on children, and can I start with you, Professor Newman. What is our state of knowledge on the impact of family violence on children?

PROFESSOR NEWMAN: We actually have quite an extensive body of both research and clinical experience about the impact of these sorts of very traumatic experiences on children. What we are now really I think understanding a lot better is the impact even on the very young, which maybe is an area that's more recent and maybe hasn't been focused on as clearly as we are now understanding it. So this is both research that looks at how traumatic exposure affects child development as well as research looking at how children respond to trauma, both in the immediate sense but also the potential long-term effects. So we are in a much better position now to help, I think, take that body of work and really look at the implications of that for how we better respond to children who have had that sort of experience.

What it essentially, I think, highlights for us is that children, even the very young, are directly affected by things that they might witness as well as things that they might directly experience and that they can be both short-term and immediate impacts on children, but also both biological and psychological effects in the

longer term.

MR MOSHINSKY: Okay. So just taking the stages of development bit by bit, if we start prior to birth, is it possible that family violence against the mother can have impacts even at that stage?

PROFESSOR NEWMAN: Yes, it is. The work that I'm referring to has looked at the impact of highly stressful situations on pregnant women, on the women themselves, but also on the developing foetus and the outcome for the baby when the baby is born. This is very important work that finds that when women, particularly in situations, as has been studied, of violence and severe trauma, are impacted in that way, they have a very strong stress response to that with the release of a lot of hormones that we understand are related to stress. Those hormones then can cross the placenta and impact on the baby's development in-utero.

There are possible very severe consequences of that sort of trauma on the pregnancy itself. Those women are more likely to have pre-term deliveries, so the baby is born early. They are also more likely to have problems in their physical health, obviously, as a result of stress and of violence itself.

The babies have been followed and those babies can have growth problems, both in their nervous system and brain, but also be small, small babies and so potentially very vulnerable in terms of their ongoing development. That means it's very important that we actually look at better identification of women who might be in those high risk situations during pregnancy.

MR MOSHINSKY: If I then ask you about the first few years of life, zero to three or four, before getting to the impact

of family violence, can you just explain for the lay person what is happening to the child's development, particularly the brain development, during that stage of their life?

PROFESSOR NEWMAN: Yes. Well, the nought to three or four year period is essentially the most significant period of development across our whole lifespan. That's when the brain and its functionings are literally being set up. Our brain grows at the most rapid rate in the first three years of life and then slows down. So, very important things are being laid down in the developing brain during that period, things such as our ability to learn, our memory systems, attention, so a whole range of psychological things that we need for healthy development and also, very importantly, our understanding of relationships and human interaction. So children during these critical early years are essentially learning about how to be with other people and how relationships and attachment operates.

Their brains are essentially very rapidly developing, so it's quite a vulnerable period of time and the evidence that we have suggests that traumatising children during these periods of rapid growth can impact and have an effect on the way that developing brain is put together. Those are the consequences that we are very concerned about if children are highly traumatised during that period.

MR MOSHINSKY: You referred to attachment. Can you just explain again for the lay person when you refer to attachment, what you are referring to?

PROFESSOR NEWMAN: Yes. Attachment essentially refers to our

human capacity to form relationships with others, and attachment relationships are those relationships that children need, all children, for feelings of safety and security. If children have what are called secure attachment relationships, which means having someone who is consistently available, at least one person, they can have several, but having that security of attachment is very important. It promotes better development overall, so those children are more likely to develop well emotionally, psychologically and in terms of their intellectual development or cognitive development.

Attachment relationships can also be what are described as insecure relationships where children might have some anxiety about who's available for them. But attachment theory is one of those very important theories in psychology that points out that all children need consistent and emotionally appropriate care to promote healthy development.

MR MOSHINSKY: Having outlined that stage of development and some of the issues, what is the potential impact on a child of witnessing physical attacks or threats to one of their parents, in particular the parent who is their primary caregiver?

PROFESSOR NEWMAN: Yes, the impacts of witnessing those sorts of threats or attacks on the person who might be the primary attachment figure or primary carer of that child are very significant, particularly for very young children. Young children are essentially dependent literally for survival and their feelings of security on the availability of their attachment figure or attachment figures. So, for the child to actually witness attacks or

potential loss of the attachment figure is a very terrifying experience. Those children, as we know from our clinical experience, are very much terrorised by that. It's a threat to the child's own existence as much as it is to the parent because of that dependency.

Young children, of course, are not in a position to emotionally be able to deal with that degree of anxiety and trauma. They are also not in a position to be able to understand in many ways what's actually happening and they are very likely to feel absolutely overwhelmed by the situation. Children will try in those circumstances to deal with that in any way that they can. So, some children might become very withdrawn and seemingly cut off from what's happening. That's a very normal, protective response in a situation of fear like that. Other children might even try and intervene in a situation like that. They might see their responsibility as being to try and protect the parent or carer who's directly under threat.

So we do see a variety of responses, but underlying the differences we see, we have a child who's literally terrified, worried about their own survival and fearing that they will literally be abandoned and will have no one left to care for them.

MR MOSHINSKY: Just going back to the development of the brain in this zero to three to four age bracket, if children witness physical attacks or threats, what impact can that have on the brain development and how would that impact occur?

PROFESSOR NEWMAN: Yes, I think the easiest way to explain that is to think about the impact of trauma and fear on brain development and essentially that's what's happening. We

do know that for children being in situations, particularly if they're prolonged and ongoing states of fear and terror, is associated with a very big physical stress response with a release of stress related hormones. So, hormones such as cortisol, adrenaline and noradrenaline, which are the main chemical responses, if you like, to fearful events. Those hormones can have a direct impact on the developing brain.

The brain, when it's developing so quickly during the early years, is very sensitive to the effects of those sorts of hormones and what we do know as a result of studies looking directly at brain development in these types of situations is that the brain can literally be changed by the impact of those stress related hormones. So some brains of children in these situations will show, if we look at them, problems in development of certain areas. They also show changes in their capacity to deal with stress in an ongoing way, so that children who have experienced these degrees of trauma can have a brain that remains very sensitive to the effects of any later trauma and less efficient at dealing with stress and trauma. So, it really sets up a vulnerable brain. So children who are impacted by severe trauma in these early years are likely to have ongoing vulnerability to the impacts of stress as they develop.

This is a very significant finding that we have known about in its broad sense since around the late 80s, 1990s, but I think the implications of these findings are very, very important and suggest clearly the need to protect children's development from this sort of trauma.

What I should say, though, is that we don't know

the threshold, if you like. The studies have looked at quite severe cases of trauma, so children who have either been indirectly exposed to high levels of ongoing threat or directly exposed to high levels of threat and violence. We don't know whether the brain effects are going to be seen in, let's say, less severe situations, but it is very significant that the changes in brain development have now been tracked from early childhood right through to young adulthood and are still able to be demonstrated in adulthood when we look at children who had early exposure to trauma. So, to all intents and purposes this is a very long-lasting impact that we see.

MR MOSHINSKY: So is a way of encapsulating some of the points you have made then by asking the question: is there a safe level of violence?

PROFESSOR NEWMAN: There is no known safe level of violence or traumatic exposure in children. What we should I think carry with us is that there are clear impacts of severe violence and trauma. There are likely to be maybe more subtle but certainly potentially very important impacts of lower level trauma exposure to children. We I think maybe have ignored and not studied enough some of the impacts of other forms of trauma on children, but particularly any child who's in a situation of ongoing traumatic exposure or exposure to familial violence is likely to show some physical and stress related effects which can potentially impact psychological and brain functioning.

MR MOSHINSKY: Thank you. If I could turn to you, Dr Miller. Do children have to see or hear violence to be harmed by it?

DR MILLER: No. One of the really important things to

understand is that children and very young babies can sense the fear in their parent and that has a profound impact. As Professor Newman just spoke about, the relationship between the baby and the primary carer, usually the mother, is critical to that child's development. So, if the mother is being hurt, the baby, even though may have been in a different room or not present in that direct sense, will be impacted by the experience of the mother, who is likely to be in shock, experiencing fear. If it is an ongoing state where the violence is embedded in the relationship in an ongoing way, that cannot but impact on the baby.

So children, they can smell fear. They sense it literally through the skin contact. As children grow older, toddlers, preschoolers, primary school age and adolescents are particularly wired to read the non-verbal cues of their parents and they will sense it. As children grow older, of course, they see the damage done without having to be told, even if they were at school when the violence occurred. They will notice things. They notice straight away the impact of the food that might be on the floor or the broken crockery. I have worked with many cases where the children straight away notice the bruise that might be trying to be hidden by the mother. Children are exquisitely sensitive to their parents. I think that's something that we need to put aside, that children are somehow passive witnesses or that they are not impacted if they are not directly exposed. They are.

MR MOSHINSKY: What impact does a child's environment have on them, on their development, both positively and negatively?

DR MILLER: It has a huge impact. Gone are the days where we thought it was all temperament or the genes we are given; it's that nature and nurture. Nurture has a profound impact to do harm and to do good and to heal and repair. So, the importance of actually addressing at the earliest point when there are indicators of violence, the impact of that on the children, I can't stress enough how important that is.

So our ability as a society, as services to engage with families who are vulnerable, where we suspect that there is violence, is very, very important and the earlier we can nip it in the bud, the more we can engage the offending parent to face up and take responsibility, the better. We need to get them out of the war zone, if you like. For children, that impact cascades on to their learning as well because they are often less able to concentrate at school. So that brain development, the impact on that child's brain, means that they are highly sensitised to stress and their energy, if you like, goes into surviving. So they are often acutely aware of relational issues and they struggle, if you like, with auditory processing sometimes at school. They will be more likely to be acting out.

Children we know through research, and I have seen this again and again and anybody working in women's refuges will see this again and again, day in and day out, that children are particularly vulnerable to having intrusive thoughts and memories of the violence at quiet times and at bedtimes. Adults can have flashbacks at any time of the day, but those times for children are particularly relevant.

So, for parents who are trying to parent children during those times, it's often when there's flash points because the children will want to avoid going to bed because that's often when they get these, what we call intrusive thoughts, or they get memories, they get feelings of not being safe. Sometimes they are direct memories and sometimes children just describe feeling yuk or scared or upset or they don't know what they feel. They just feel numb. So, quiet times.

Often at school these children are somehow misdiagnosed as having ADHD or frequently described as being feral or hyperactive and often teachers are despairing because children really struggle to settle down to their work and to concentrate. So they might well be able to concentrate when there is a direct one-to-one interaction or where there is a group process where the children are able to move around, but where they are told to put their heads down and work quietly at their maths, then they will become the class clown and act out. That's a pattern that we see. So, this impact from violence and the trauma that children experience can play out at different ages and stages in different ways.

MR MOSHINSKY: Can I ask you some questions about situations where children are affected by the aftermath of an incident of family violence. What are some examples where that may occur and what are the potential impacts?

DR MILLER: Children respond in different ways, and again I can't stress enough that it's variable and it really depends often on their relationship with both the offending parent and the non-offending parent. The victim of violence, usually the mother, is generally very

protective of the children and will go to enormous lengths to camouflage the violence, to compensate often. So I want to make that very clear, that the norm is that women act very protectively.

Sometimes, though, they are so overwhelmed and if it's a situation of sadistic and sometimes it's absolute torture that people are put through, that women are put through, they are victims of their own response in terms of a post-trauma response which means they are often shut down emotionally and hostage, if you like, to this torment from their partner. Therefore they are less able to respond to what the children need.

So we have a situation frequently that practitioners encounter where children who have been impacted by the violence are very needy for a loving, calm, nurturing, creative, spontaneous parent who can be the heroic parent, if you like, who can put up with the child's misbehaviour in avoiding bedtime and pulling clothes out of wardrobes or tantrums and all the stuff that happens when children are behaviourally disturbed, who can actually also attend to the quiet child who looks like they are daydreaming. Some children will act out, some will actually shut down, and some will do either of those at different times. It's variable.

But the children who are quieter and withdrawn, they often miss out. That's what the literature talks about, being a dissociative response. They are shut down. They are numb. So parents are often, at the very time the children need what we call heroic parenting, are often least able to provide it because the mother herself is just struggling to hang on and trying to read the

behaviours of the violent partner, trying to anticipate what will calm him down, what will prevent, trying to have that dinner on the table at 6 o'clock, trying to bite her tongue when he comes in drunk or trying to hide the money but then he demands it and working out much to give and how much you will need to pay the rent. This incredibly stressful situation that mothers are in cannot help but then impact on how the whole family dynamic plays out and how children are responded to.

So sometimes we see situations, and these are the more extreme cases. As I stressed before, most mothers will act very protectively, but sometimes their own depression, their own post-traumatic stress disorder, their own response then can mean they will seek out drugs or alcohol in order to numb or calm their own internal turmoil. Sometimes their own mental health issues get in the way then of them being the sort of parent they want to be.

All of this, of course, needs to be seen through the lens of the perpetrator's violence, who's organised this dynamic, if you like, in the family. Too often mothers have been blamed for not protecting the children, when in fact what we need to understand is that the violence is the dynamic that's driving all these other responses and you see it cascading.

Sometimes children will turn around and blame the mother for the violence because they become coached by the perpetrator. I have seen again and again fathers very skilfully, it's almost like a process of brainwashing where children will start to mouth the sort of language, the sort of disrespectful attitudes, the put downs, the

sarcastic comments about the mother, because if you are growing up in a family like that, you have to survive, and joining with the powerful one, the perpetrator, is often the best way to survive. So children will often become conscripted, if you like, into that dynamic that is very, very disrespectful and disempowering of women.

That can be played out and grow into - if you ask me about the later impacts, we see children who then become adolescents who are acting out and there's a strong correlation then with adolescents who use violence against parents and a history of earlier violence. I have seen adolescents - - -

MR MOSHINSKY: Perhaps we will come back to adolescents, if we may, a bit later.

DEPUTY COMMISSIONER FAULKNER: Can I just ask a clarifying question. Dr Miller, when you are describing the impact of violence, does it make any difference as to the nature of violence? So if it is emotional abuse or controlling behaviour, are you talking about those forms of violence or are you mainly talking about physical violence at this point in time?

DR MILLER: I'm talking about both, but where there's physical violence, the terror and the impact of seeing and feeling like somebody's life is at stake is more pronounced.

DEPUTY COMMISSIONER FAULKNER: Thank you.

DR MILLER: One thing I haven't explained, sorry, just to add, is the experience for the children is mediated by their attachment to their primary carer. So if the parent is somehow able to survive this and support and really nurture those children, sometimes we see that the children are doing well at school. So, whilst there's - and I have

listed this in my statement - the research that talks about the very harmful impact, and it's always harmful, but the level of that harm and the way that's played out then behaviourally for children is variable. A key ingredient in what creates that difference is how they are parented by the non-offending parent.

PROFESSOR NEWMAN: Could I just add a comment there?

MR MOSHINSKY: Yes, certainly.

PROFESSOR NEWMAN: Thank you. I think, just following on from those comments, one of the issues of course is the impact of the violence or the abuse on the woman, usually her mental health, and then the subsequent impact of those mental health problems on parenting and, as was pointed out, often that very negative impact on the mother's capacity to be protective in a way that she normally would want to, and sometimes it will impact her capacity to be aware of the impact on the children in the family. So she might literally find that a very painful thing to even consider and can be what superficially we might say is a bit neglecting or insensitive in terms of how she might be with the children in a variable way. So, sometimes being very protective, other times being overwhelmed.

In those situations we usually see women who are significantly depressed, who might also have traumatic features themselves, so what we think of as post-traumatic or ongoing stress related symptoms, but depression, drug and alcohol issues. So I think it's very important that we actually have that capacity to do proper mental health evaluations and assessments of women in those situations to be able to offer help for those problems if they have them.

The children then will have a variety of responses. If children are witnessing physical violence, if that's one of the major things that they are exposed to, then if we follow those children they are more likely to have taken that on board as the model they have been exposed to as to how relationships work. So relationships for those children operate around power, and violence is almost acceptable within these disturbed settings. Those children are more likely to show difficulties with their own behaviour, to have behavioural problems and sometimes to be violent and aggressive towards peers.

The emotional and psychological abuse that often goes on concurrently in those families affects also that child's understanding of relationships. So, if there's denigrating treatment, emotionally abusive treatment of one of the parents, the child is often a victim of that directly themselves and that will have the longer term impact on their psychological development.

MR MOSHINSKY: So just taking up that issue, if I may, Professor Newman, is it your opinion that both physical attacks by one parent on the other, as well as psychological abuse by one parent on the other, can be very damaging for children?

PROFESSOR NEWMAN: Yes, I think both can be extremely damaging and they are often happening simultaneously. But the psychological abuse, emotional abuse, is something that's really been probably somewhat ignored in terms of its impacts. But we do know that the impact of witnessing and experiencing things like seeing people belittled, denigrated, ridiculed, a whole range of behaviours and statements that are designed really to psychologically

invalidate someone or hurt them, often quite cruel and almost sadistic statements, that children find that extremely distressing and bewildering. They can't possibly understand that. As we heard, they will at times have to almost choose a side in these sort of very disturbed relationships. They might identify with the more powerful person if that's the situation, copy or take on board that that's again a model of relationships, that it's okay to be like that in relationships and to treat people in that way.

Other children are very overwhelmed with the fear and pain of that, might try and protect the parent who's the victim of those sorts of attacks. So we see different ways that a child might try and cope and adapt to a situation like that. The child has to survive. They are in a situation where they have no choice but to try and use whatever mechanisms they have to live in this quite distorted reality. For the child, that is their reality. They don't often have other - if they are fortunate they do - but it's not always the case that they have other models against which they can judge what their main experience is.

So, children are in this terrible psychological dilemma in these situations of being dependent and desperately wanting their carers or parents, no matter how damaging they are, to be there for them and to care and protect for them. But at the same time they are often very confused, distressed and terrified about what they are exposed to.

In terms of the damage that's done to children, that's really quite profound and that can have the very

long-term consequences on their actual understanding of relationships and how they work.

MR MOSHINSKY: Turning back to you, Dr Miller, we have touched on this in part already, but I just wanted to focus on the impact that family violence can have on the parent/child relationship between the non-violent parent and their child. You have touched on this already, but could you just encapsulate your views on how that can play out and how the parent/child relationship can be impacted?

DR MILLER: The relationship can be impacted in many ways. Children will feel responsible for their parent often. They will assume a sense of responsibility for the safety, usually of their mother, in many ways. They can then be compromised in terms of their ability to be a child and just have a childhood where they are free and able to go to school and learn like any other kid. They often feel ashamed. They will often feel embarrassed. They won't invite their friends home to play. They will have a sense that somehow they are different.

Children often internalise that as somehow meaning that they are not as good as other kids. They are often conscripted into the secrecy. We know that most situations where there's violence in families, there's not a report to police at the first occasion. It is usually way down the track, and this is in families where there's professional parents who don't have money problems, as well as parents who are struggling and unemployed and do have money problems. So I have seen this across the board.

The stigma attached to the family situation is something the child very quickly picks up. We know that

there's also a greater correlation between and likelihood of there being other forms of abuse, such as sexual abuse of children, in families where there's violence, and neglect, as we have stated earlier, is something that you see more often.

But that relationship with their parent is, as I said, critical and they are often part of the safety planning. So the family can often organise around the older siblings, you know, if dad comes in with that look on his face or smelling of alcohol, that they'll know to grab mum's phone so he can't get it or to go next door with the baby. Children are frequently very active agents in protecting their siblings and ringing the police for their mother, knowing where the documents are hidden. I have seen perpetrators who seem to delight in taking the maternal and child health books of the children. They will often smash things, destroy photos. I have seen children who very quickly know where those things are hidden and will take them in the heat of the moment.

So the impact of that, you can imagine then a child trying to go to school the next day and pretend nothing's happened. And this is what children adapt to. They frequently keep the secret. We expect children to be able to disclose about sexual assault and watching or being part of family situations. We forget too that children are often harmed directly. They will try to - I have worked with kids who have jumped on the back of their father as he has been stabbing their mother. I have seen children harmed. I have seen babies heading to lifelong consequences. We count child deaths, but what's often not recognised enough is the way that

children are harmed physically and often brain injured. That's a lifelong impairment.

I have seen children who have endured a range of different injuries and children have often said to me, "That was the easy bit, Robyn. That's the easy bit to get over. I just can't get it out of my head. That's the hard bit." Feeling that shame, feeling that they can't control, because we know part of the explosion in knowledge that Professor Newman has described in neuroscience, one of the ways we understand now is that the memories are laid down. The traumatic memories for children are stored differently, and for adults this is true as well, that they are stored differently. So they are not a nice sort of narrative language based memory like our normal memories, less stressful memories.

Traumatic memories are unprocessed. I often say in training they are like a dog's breakfast. They are not processed, they are not neat and they are not based in language. They are based in vivid images and sensations. So they can be triggered. A child can be triggered and reminded of things when they smell something, where they hear their dad's voice raised, where they see that look on their mum's face, when they suspect it's Thursday night and that's usually when the violence is going to happen. When somebody grabs them from behind at school in a game their body responds. We talk about body memory, and they turn around and king-hit the kid because that's what happened to them at home the night before.

So children will be triggered in various ways. It can mean they get into real trouble at school. They can often be seen to be bullies. They are more likely to

be bullied and to become bullies themselves. They are less likely to be able to reach their potential at school, and that's something that's often overlooked. There is some research that talks about reading scores being lower in children who have experienced violence.

So it's not like somebody hurts the hand and you can take them to the doctor and get the plaster on and it's fixed. The impact of violence and the way it impacts on family relationships, it's the whole of the child's experience. It's not just one bit of them.

Children develop their potential through healthy relationships. The research is in. The evidence is in in terms of what kids need in terms of healthy parenting. It is pretty simple. They need high warmth, low hostility and consistent boundaries.

Violence, where it is present, is the absolute opposite of that. So if you want to do harm to children you ignore the circumstances of their parents who are being violated. It is harmful. I have worked with many people later in life who have been parents, and at the point their child is born their own trauma from when they were little, where they have experienced violence, will come back. It can impact on their parenting, even though it's 20 years later. Men I have worked with too, "Will I be the sort of dad that my dad was?" They can become depressed. They can become highly anxious. So it can cascade in many ways across the lifespan.

MR MOSHINSKY: Professor Newman, can I turn to you and ask the question that there still seems to be in the wider community based on surveys a lack of understanding of why women in abusive relationships just don't leave.

I appreciate it's a very complex issue, but are you able to offer some comments to help to explain the complexity around that issue and the factors that may influence that sort of decision?

PROFESSOR NEWMAN: Yes, sadly it is still a statement that's sometimes made and people in the general community might puzzle about, literally asking, "Why don't people just leave these destructive, harmful relationships? Surely they recognise the impact it's having on themselves and their children," as if it's a fairly simple response that should be made.

I think what that fails to understand is a process sometimes we might think about as a form of entrapment, when people in these very harmful relationships can feel very disempowered in that context, be very unclear on a practical level about what they can actually do and limited options for actually getting meaningful support in a timely fashion. So there are some real practical impediments.

But what I would see, and in practice we see a lot of the time, usually women sadly for whom that it has become an acceptable reality. I have seen that even in adolescent young women, very young women who are in dangerous and exploitive and abusive relationships who feel they have little option but to stay there.

They are psychologically and emotionally dependent on that sort of treatment and have come, because of no other experience, to see that almost as what they deserve; so a terrible process of having very low self-esteem, sometimes feeling quite worthless, and of course that's often exacerbated and played upon in the

relationship that they are actually in.

When we talk to those women they often have their own histories of growing up themselves in families characterised by violence and psychological abuse. They might have directly experienced abuse and exploitation themselves. It is very much a pattern again of growing up with that sort of very deeply held lack of capacity to be self protective.

It is very important that we can actually - if we are going to help and support women in that situation - work psychologically with them to help them change, if you like, that way that they think about themselves and their situation to re-empower them, to allow them if at all possible to make choices which are choices for themselves but also choices for children, if they have children, because in those situations we frequently see the breakdown of parenting. So these women who feel very stuck and entrapped might also feel powerless in terms of child rearing, and children are exposed even more to a range of very difficult experiences.

MR MOSHINSKY: Dr Miller, would you like to comment on that question because it does seem to be a popular misconception? What observations would you make about that question, "Why doesn't she just leave?"

DR MILLER: It's so interesting because that's often the first question people ask when we really should be asking, "Why does he think he's got the right to treat people like that?" So again that societal, cultural sort of expectation of mothers and women is something we hear played out again and again.

One reason women frequently stay is because it is

too unsafe to leave, and that's something that's really important to recognise. A lot of violence actually happens post-separation. Homicides are actually more frequent post-separation. So we need to really understand that exiting a violent relationship has to be planned down to the nth degree. And it is a process of leaving.

We know that most women in fact do leave violent relationships. That's really important to put out there. We have research that talks about that. Most women do leave violent relationships. They leave in two sort of general pathways, and again this is - I'm speaking in general terms. So each person's experience is different.

But two general things we see in practice, and again the research has borne this out, one pathway is that "this time" - we call it the defining moment - "he's gone too far. This time he's hurt the baby. This time he rang my mother and threatened her. This time he's hidden the car keys." It's something. "This time Child Protection got involved. This time my neighbour was involved." The shame of it. "This time actually other people know." That defining moment can be very important. "This time I had a lovely police officer who cared for me, who came back, who really listened." So you hear different pathways that people will leave.

Again, we forget that these relationships begin as loving relationships. Most people don't intend to set out and hurt one another. There is actually a beginning point. We forget that this love for the partner is often a reason women stay. They want the violence to stop. They want to heal the relationship. So the other pathway to healing is often where they have exhausted all the

possibilities to have made it work.

Frequently where you have different cultural and religious expectations around, "You made your bed; you lie in it," the loyalty to, "Death do us part," a lot of that stuff that we all carry about wanting the happy ending and wanting the relationship to work, women who experience violence are no different to the rest of us. They held those same hopes and dreams we all have for the happy ever after. So they will try very, very hard to make the relationship work.

So one of the myths is that women don't leave. Yes, they do leave. We can intervene creatively at these different points in order to free up, if you like, or help women have the capacity to leave, psychologically but also practically. I have worked with many women who go back to the perpetrator because they just didn't have housing. They couldn't bear the children suffering because they didn't have the money anymore for the tennis lessons or the private school or they didn't have money for food, as basic as that. They are sleeping in their cars. The children get a flu. It's cold. It's winter. Sometimes it's absolute poverty of options that makes them go back.

Frequently the perpetrator will say, "I've changed. I want to change." Sometimes you see this - and it's not always a cynical, manipulative strategy. Some men who use violence will be genuinely remorseful. There's no one typical offender. We see a whole range of different patterns of violence. Some men can be engaged in behaviour change.

So in my statement I have talked about the different ways of - and we need to be very cautious about

that because couple counselling can actually do harm, family work at that point. So we need very careful assessments. But the reason women don't leave, we need to remain very curious about and not make simplistic judgments. More would leave if there was more support; I don't doubt that.

Frequently they have tried to leave and have been overwhelmed by the complexity of their experience with the different court processes. They sometimes think, "He's never going to leave me alone. I will never be free. I may as well manage it by staying." Some have tried and then become caught up in a whole - they have been shunned by extended family, by community. They have been blamed. They fear they will lose their kids. There have been threats to go to the Family Court. If she is anxious, if there has been some sort of problem in terms of mental health, that is often used against the mother by the partner, who can be incredibly manipulative. So I have seen a whole range of reasons that women stay.

MR MOSHINSKY: You referred in your answer to couple counselling. Are there observations you would make about some risks of couple counselling that should be borne in mind?

DR MILLER: Yes. I am a trained couple counsellor and family therapist. I have worked very successfully and seen many therapists work very, very well with situations where there's been violence. But we need to be very cautious that it's safe to do that. So it needs very careful assessment individually of the pattern of violence, and also a very careful assessment that the woman actually feels safe and that the violence has stopped.

It is contraindicated if there is an ongoing pattern of violence. You just shouldn't do it as a therapist because you may be unwittingly exposing the woman to further risk and harm because she may say something in a counselling session and then cop it at home.

Sometimes as a therapist you can't help that. I have worked in situations where the family come along for therapy because the child's refusing to go to school, and this is one of the impacts we see on children who experience violence. They often have a sense of wanting to stay at home because they can't trust things will be safe for their mum. As I said before, often this is secret.

So sometimes the family will take the child for therapy and as you start engaging with the child and getting them drawing and talking and helping them to feel safe out comes their worries, and their worry is about, mummy and mummy being hurt and not liking it when daddy hits mummy or daddy screams; "but I can't say anything because I will get into trouble."

That's a very tricky situation because sometimes the perpetrator is in the room; sometimes the mother is in the room looking at the child; sometimes you can feel this incredible terror. Anyone who has worked with families like this will know what I'm talking about. You actually sense it in your own gut. It requires very careful manoeuvring to make sure that this child and this mother - and, number one, you have to engage the father and you have to ensure safety immediately.

So sometimes it can't be helped. Sometimes the

violence will come out because of the family presenting because of other problems, if that makes sense. Sometimes, though, it can be helped and there is a knowledge of violence, but it hasn't been well understood. Some counsellors aren't trained to understand that this isn't a couple problem. The violence is the violence is the violence is the problem. Yes, there's a pattern around it, but at the end of the day the violence is the problem. "Who has thrown that punch?" The perpetrator of the violence needs to be held accountable.

So that I often talk about being the elephant in the room. Sometimes you will see couple counselling or family work that talks a lot about the childhood or the depression or this or that, but actually the risk that something that happened a month ago or even a year ago or even two years ago is not factored into the way the problems are understood here and now.

The mistake can be made, "He only hit her once." Actually it only needs to be once, because then the family organises around stopping that happening again. So the various ways that families organise around the violence is generally to pull in, to try to remain loyal and to stop the violence. That will be played out in many ways. So it is absolutely critical that couple and family therapists and individual therapists, I might add, are trained to understand the impact and the harm and what they can do to actually address the issue directly rather than skirt around it.

MR MOSHINSKY: Commissioners, I was going to move to the second topic, which will be briefer, about long-term impacts. Before I do are there questions about the impacts on

children that you wanted to raise?

DEPUTY COMMISSIONER NICHOLSON: Yes. Dr Miller, I was interested in your statement. You talk about or you refer to research that a significant proportion of children are actually quite resilient. I think you refer to research that indicates up to about half seem to adapt and recover. I'm interested what this means for practice and what does it mean for the type of interventions and the intensity of interventions for whom.

DR MILLER: The distance between the violence occurring and the quality of the safety and the relationships the child is exposed to once the violence ceases actually determines the resilience of the child. We know children have different temperaments, have different other protective factors such as extended family. So the quality of these other protective factors, if you like, or the strengths in the family dynamics in the extended family or they may be very bright kids and do well at school and the music teacher takes a particular interest in them, a child has just got that sort of happy temperament, they are kids who are naturally likeable so they will be invited more often to be friends with other families, so they will have more experiences of other families, they will have more positive social experiences.

Sometimes I have worked with some families and I remember saying to one young man, "What you have endured" - it was a particularly sadistic experience in his family that was ongoing of violence and sexual abuse. He was the most delightful young man. I said, "How have you survived this?" He told me about the bus driver. It was a country kid and this bus driver every day would have

this conversation and tell him what a good kid he was.

So sometimes it's the relationships with other people, and teachers are really important here. The experiences that children have can contribute to their resilience. But what we know from the resilience literature is it is the quality of the connection, and that's connection to the primary carer. That's the key.

DEPUTY COMMISSIONER NICHOLSON: I guess the question that I'm asking is are we at a stage where we can identify the characteristics of the children or their circumstances that would enable us to predict that this child is going to be resilient or a child is going to need some significant intervention?

DR MILLER: Again you look at the quality of the connections around the child. You also look at the child's behaviours and how are they being played out. So if they are already in trouble, if their language is delayed, if their behaviour has regressed, if they are socially ostracised because they are being bullied or a bully at school, for example, if they have speech problems, all of these things that can happen, and we will be hearing I think in the next few days about the impact on infants, and what we can call a disorganised attachment when the child doesn't know who to trust and sometimes can be frightened by the presence of the mother as well as the father because the child associates the mother with the horror and the terror.

So if there is a quality relationship with the mother, if the father or the perpetrator of the violence is distanced from the family or has faced up and engaged in change and things are calm and there's a whole sense of

reparation and healing that's happened for that family, all of these contribute to resilience for the child.

But the most resilient child will be overwhelmed if the violence and the other what we call cumulative harm is overwhelming for the child. So if you are talking Child Protection and Family Services it is rare to see family violence as the single presenting issue. It is generally a part of a complex set of problems that children are experiencing. That is exponential. That impacts on the child. It's not just the family violence. It's actually all the other things.

We mentioned before the increased rate of sexual abuse in families where there's violence. That matters enormously in terms of the resilience. So the most isolated families, those who are transient, those children are I believe most at risk because they are not being sighted by others, like maternal and child health nurses or kinders; they are often not attending school in any meaningful way. So people don't notice the changes in the child's behaviour. So you lose opportunities to pick up on the harm that the child is experiencing. So we know social isolation is a huge risk factor.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

COMMISSIONER NEAVE: Can I ask you both if we made recommendations relating to the provision of therapeutic support for children who have been affected by family violence would that be ongoing? Would it be something that would be provided sort of immediately after separation if separation occurred or would it be something that was needed later, say, in adolescence, or all of the above?

PROFESSOR NEWMAN: Potentially all of the above. I think the issues are that we might want to have a general approach, if you like, that says that all children who have been exposed to the range of these sorts of situations should be assessed for the immediate impact and a plan established about what sort of support and care they might need. Some of those children will already have significant psychological and emotional issues that need ongoing treatment. Others will not.

I think just as a comment on the resilience issue it's a very inexact science. We know a lot, as Robyn was saying, about the multitude of factors that can contribute to better or worse outcome. We are not very good at predicting on the basis of that. The science isn't really at that point, in my opinion. But we do know enough to know that some children will need ongoing services and supports.

The question really is about the quality of those services and supports, and can they be better based on the understanding of trauma and its impact. So in some ways it's probably not sufficient to say, "We will just refer these children who have had this traumatic exposure to a generalist service," whether it's a mental health service or a related service, unless that service understands about where that child is coming from and what problems they might have. I think it's important that we avoid misdiagnosing or using other labels for children who have experienced trauma of this magnitude, and actually talk about the trauma and its impact rather than say, "The child has a behaviour problem. They have Attention Deficient Hyperactivity Disorder" or whatever diagnosis is

popular at the time, because those things do change, and we can actually focus on that child's attachment relationships and the personal impact that this exposure has had on them.

So for some children the need for services might be into adolescence. It might be longer term. We then down the track might see people seeking help and support who have had these experiences early on in their lives who are young adults or thinking about becoming parents, again a crucial point that we might want to help people who are very clear that they don't want their children to experience or be exposed to what they experienced. So we need a system that's maybe more flexible and more responsive so that we can offer trauma informed care at various points when it's necessary.

DR MILLER: If I could add to that just one point. The whole notion of what we mean by trauma informed practice I think is probably worth reflecting on in terms of what's needed throughout the child's life. For some children it will be a very short burst. In fact once you can stabilise and support their mother and they are properly housed and there's a sense that they are safe now, the healing will happen.

For others, as Louise has said, there are profound disturbances. These children are frequently then, as I said, they are not doing well at school; they might be expelled; they then are transient. So they have this sort of cumulative impact that goes on, this ripple effect, and layer upon layer of trauma and loss.

So for some in adolescence you see the need to understand, even though the parent may have separated when

the child was - 10 years earlier, sometimes you see that trauma resurface in adolescence. We see this frequently where there has been sexual abuse as well. At particular developmental points a child who may have been doing well in primary school, for example, may start to act out, may start to not understand why they are feeling so angry, why they are not sleeping so well, why they want to take dope and drink and party all night because they are avoiding the nightmares of the night.

These children it's frequently not understood, as Louise said, they can get labelled with all sorts of conduct disorder et cetera without people really understanding what's happened to this child. I have worked with many, many adolescents and young adults who have a variety of different symptoms and behaviours. One young man, for example, had incredible depression, was suicidal. He had not quite a stutter but it was like that. He had social anxiety that was extreme. Gorgeous mother. His father had died earlier. REDACTED REDACTED His father, who was violent, an ex-war vet, had died when he was seven. So the belief in the family was that he had escaped the worst of it.

It wasn't until we started unpacking what he felt and how anxious he felt, and I started to ask what it was like as he was growing up, not expecting that there would be this presence of family violence. But then what came out was this horrific story of his life as a child and the sort of memories. He had never spoken about that.

What we were able to do was help him to connect and to speak out loud the unspeakable. In that family

those kids had all done very well as adults, but they had never spoken out loud about the violence. There was this loyalty to the dad. Their mother loved him. She was a fantastic mother. None of them had spoken out loud about it. What helped that young man to in fact recover was actually being able to support the family to talk about the elephant in the room. His symptoms subsided quite quickly.

But had I not dealt with what was his experience - so what we see with trauma, it can have a delayed impact. It can surface later. Vietnam War veterans talk about this. It's not uncommon in the trauma field. So your question about services, I would say all mental health services need to be informed about, number one, the prevalence and the impact and trained to understand that other presenting problems like depression, like anxiety can often have the underlying sort of issue earlier trauma, and particularly family violence trauma.

COMMISSIONER NEAVE: Do some of these issues arise when young people get into trouble because they have committed criminal offences? Do you see young people in that situation?

DR MILLER: Yes, often if there is violence in home, they are frustrated, they are powerless, mum hasn't been able to leave, they love their dad but they hate what he does, they are confused, so they will often be more likely to seek the peer support and be out there, and more likely to not respect boundaries because, "Why should I? I have had to survive." So there's a greater likelihood they will end up in trouble with the police. We see increased rates of children who have experienced family violence in youth

justice detention centres, for example.

DEPUTY COMMISSIONER FAULKNER: Again, Dr Miller or Professor Newman, either of you, what you are painting is a picture of extraordinarily skilled assessment, extraordinarily skilled treatment, a change in practice of psychiatry, psychology, child protection practice. Is it happening already? Are the bases there? Is it possible to build the sort of system that you are talking about?

DR MILLER: Yes, I believe it is possible. I'm very hopeful about that. I have seen enormous change in the Victorian child and family service system inclusive of Child Protection in the last decade, and the bridge building and the relationship building between women's services and the police reforms and men's behaviour change services are absolutely alive in Victoria. It needs more work, clearly. I think that in mental health some of our great champions in neuroscience have been psychiatrists. But in my view psychiatry generally at this point is not as across the trauma research as we would hope. But our leaders and researchers certainly are within psychiatry.

So the mental health field is certainly aware, and infant mental health particularly has been very well informed and we have very good research that talks about the importance of psychotherapy between the non-offending parent and the child. A lot of that research has come from within psychiatry. So we see I think a mixed picture.

DEPUTY COMMISSIONER FAULKNER: Before you answer, I'm also talking about the scale. I can understand that there may be pockets of good practice. I refer particularly, Professor Newman, to the hope that you expressed in your

witness statement about the women's offering this sort of service in antenatal services, and yet it's not there yet as far as I read your evidence. So I'm interested in the barriers; not just whether it is possible, but what needs to be overcome to get there.

PROFESSOR NEWMAN: Yes, I will comment on psychiatry, clinical psychology, sort of mental health disciplines. I think we are at a very important point at the moment where there is obviously a lot more understanding about the phenomenon and what we are dealing with. That is being put into training, and this is at junior training level. I think that's a very important step, that people training professionals actually have specific training about these issues and about trauma responses. That's certainly happening.

There's interest both obviously at a State level but also from the Commonwealth in terms of how better we can respond to abuse and trauma. There's quite a large group of psychiatrists and others involved in planning and advising at both levels around trauma informed services. So we are really at the beginning. I think there's a lot more work to be done in that area, but certainly we have a much clearer idea of what services could look like.

But it is a process of cultural change in many ways. There's not an easy solution to that. That's going to take some time. There are patches, as you say, of good models. What we do need, though, is to evaluate those properly, which is certainly what we are doing at the Women's Hospital and others are doing that. We need proper evaluation of the sorts of approaches we think might be helpful, and then we need to have that ongoing

support in terms of rolling them out.

I think it is actually possible, I'm also an optimist, because I think there are enough champions around the issues at the moment to push it. But we are, as we are all aware, in difficult times in terms of funding of some of these sorts of programs, particularly around early intervention, the sorts of services we would like. That's going to be an ongoing difficulty. Getting research dollars for these sorts of issues, and for domestic violence and sexual abuse related issues has always been hard. So we do need, I think, and what's very pleasing at the moment is to see community based interest in having the professions and the services actually respond better, and that's certainly shaping. So we are now in a much better position than we have been for some years, in my experience as an academic, to get some actual funding for these sorts of programs that we need to develop.

It certainly takes concerted effort at different levels, but the will is there. We have some preliminary ideas and which seem to work in practice. I think we need to research them better and actually be able to then roll that out in a more coherent sort of response rather than these little bits all over the system.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MR MOSHINSKY: I might come back to that topic in a few moments, but just before I do can I just ask you both some questions about the long-term impacts on children of having experienced family violence as a child. We have touched on this in part. But, Professor Newman, could you please explain what are some of the longer term

psychological and also more general health issues that can be caused by family violence as a child?

PROFESSOR NEWMAN: Yes, we have heard some of the potential long-term impacts on children's understanding of relationships, their capacities to enter into healthy relationships. Children who have been exposed to domestic violence and abuse are more likely to have difficulties in their own ideas about relationships. They are more likely to have problems with self-esteem, depression and a whole range of mental health issues, on the whole are more prevalent in those sorts of children who have had those experiences. Underlying that seems to be an effect on the child's attachment security. So these children are more likely to be puzzled and confused and anxious about relationships.

If we follow them longitudinally not all of those children by any means are going to enter into a mental health system, but they might well be children who grow up to be adults who are vulnerable. Some people are vulnerable in terms of entering into exploitive or dangerous relationships; others are vulnerable in the sense of being anxious about relationships and will it be safe for them and maybe being a bit avoidant. So there are different patterns there and the way it impacts relationships.

I think one of the major issues that we face is this notion of transgenerational effects of having grown up in these sort of situations, and the impact that that can have on children when they grow up and attempt to parent themselves. So it is quite clear that parents who themselves are more likely to have difficulties in either

protecting children or in having direct parenting problems are more likely to have had early exposure to risk and trauma themselves.

So what we see is the way in which that can affect the next generation. That's that vicious cycle of trauma and maltreatment. Particularly in child and adolescent mental health services we are often working directly with that next generation, so seeing that impact, also working with parents who themselves are struggling to make things better for their children who don't want their children to be exposed to the same issues that they have been exposed to but find that very hard in an emotional sense and hard in practice.

So there are the long-term impacts on mental health as one aspect, but particularly on attachment and quality of relating and anxiety about that. So we certainly see people with histories of coming from violent and abusive backgrounds who find it very hard, even though they might consciously be very clear that they want to have and enter into healthy relationships and not to repeat things with their own children, but are actually struggling with the reality of how hard it is to change those patterns when they are so deeply engrained. Those are the people who might sometimes need psychological therapies which sadly are of limited availability across our system, and they certainly need a psychological approach that understands the reality of trauma in their lives and the way it's affected them, and we don't have many in the way of dedicated services for those sorts of issues.

In the mental health system and in hospital type

settings we certainly see I guess - at one end of the spectrum we probably see people who have been very traumatised by childhood experience who can still be struggling with that and might have more complex mental health problems. But in general if we look at the population as a whole there are many people who don't come into contact with mental health services who might still benefit from counselling and other supports to help them deal with the reality of trauma in their lives and help them be, I guess, more positive and better able to engage in relationships of whatever sort.

At the severe end of the spectrum we do have evidence that those are the people who have had some of the biological impacts of trauma that I was describing earlier. We do understand a lot more about that. That's certainly not everyone. But that can be quite long-term difficulties. So we do need within a coordinated, comprehensive system some specific services for survivors of these sorts of experiences who have ongoing trauma and mental health problems, and that's sadly lacking within the mental health system at the moment. So I think what's important is that we have the spectrum of approaches that will be helpful.

MR MOSHINSKY: Dr Miller, I know you have touched on some of these matters already, but do you mind commenting on the long-term impacts that can occur?

DR MILLER: Yes. We see frequently, if I go back to adolescence, an increase in risk-taking behaviour. There is also the dynamic that I have seen quite a bit in practice where the adolescent starts to push the limits, like a normal adolescent, like any adolescent does, to

test where the boundaries are. Where there has been then a history of violence, particularly with boys who start to look like the father who the mother may have separated from years earlier because of the violence, he starts to get the look, the tone of voice, there can be this incredibly sort of triggering reaction where the mother can sometimes absolutely tense and there's a sense of this reactivity, this argumentative and very painfully conflicted relationship that emerges.

It's not uncommon when you go to the youth homelessness services to hear about this adolescent sort of family conflict that has precipitated the young person needing youth homelessness services. When you unpack that it's not always that the violence is recent or current, but sometimes it is and that's another cohort of young people who are literally running away to escape violence; but sometimes also there's this group of young people where it has been much earlier in their development but, as I said, at that developmental point the impact of it rears its ugly head, if you like. Again this dynamic and the way the parent reacts to the child and then the way the child then reacts to the parent and you get this escalation.

So that's something that's really important for any service that's offering help to adolescents to understand and to actually understand the frustration of the mother who - sometimes I have seen services become critical of the parent, when in fact she needs deep understanding and compassion and empathy for why she's reacting to that boy's behaviour or that girl's behaviour.

Sometimes the child is demonised. Sometimes the

lack of understanding means that the child is actually seen as the young criminal, rather than understanding the context and the background that that has contributed to that pattern developing.

I mentioned running away, and that's something that's really important. There is also a higher risk of young people ending up in sexually exploitative relationships. We have research now that's come in around - it's something we have seen in practice, but the evidence is starting to build around that. They are more vulnerable to being manipulated by offenders who sexually exploit kids. They will often be targeted and groomed because they are looking for love. They are looking for someone to tell them they are special. They are looking for a safe nest, if you like. So they are more vulnerable to that sort of grooming and manipulation.

As Louise has said, the behavioural disturbance can be more likely to be sort of triggered. They have a heightened startled reflex. They are also more likely to act out and find themselves in trouble on a whole range of things. They are not bad kids. They have done some bad things, but they are kids who actually are very, very able to be engaged and to work with them in a way that's healing and will help to settle those behaviours and help them to work through the trauma that's underneath it.

I have also seen, as I mentioned earlier, the anxiety at the point where they become parents themselves. Judith Herman in 1992, she talked in her book "Trauma and Recovery", she said victims of trauma are particularly vulnerable to harm, harm at their own hands and at the hands of others. I think that very neatly answers the

question, really. They are more likely to end up in relationships themselves where there's violence. I have worked with many practitioners who are perplexed about this. Sometimes the most sort of streetwise young woman who has often been involved with the police but can become, as Louise mentioned earlier, quickly sort of dominated in this sort of powerful - it's almost this unconscious sort of seeking out and replicating the trauma dynamics. Some people talk about this as trauma re-enactment.

They are more likely to be vulnerable then to soothing the stuff they can't get out of their heads. So often people will just say, "Put it behind you. That was years ago." If it was that easy of course they would. The difficulty with traumatic situations like this is, as I said, the memories are stored differently and it bypasses the thinking brain. So when they are triggered they are flooded. It's a physical reaction. So 20 years later you can be feeling something that you felt when you were four, and you are powerless, you are speechless and you are frightened and you don't know what to do. We call them flashbacks. We have all seen television shows that sort of portray this. But it's real and it happens.

I have seen babies two weeks old with what we call this frozen watchfulness, and they only have to hear the voice of the perpetrator and they are in this dissociative state. Then I have worked with their older siblings who are demonstrating other sorts of symptoms that are, as I said, playing out at school or they are more likely actually to develop problem sexual behaviours. There's a link, a correlation, the single greatest

correlate - I'm not saying it is a causal factor, but it is a correlate, part of the picture of children who develop problem sexual behaviours, and adolescents with sexually abusive behaviours, the presence of family violence is an issue. It is one of the strongest correlates that comes out in the research. So that's not well understood.

Therapy with these kids is very successful. They are not mini paedophiles. You know, children with these behaviours can be engaged and can very quickly settle if they are given the right conditions. But those therapeutic services have to be mindful of the family dynamics. If you are not dealing with the history of the war at home or the ongoing war zone they are still living in one hour a week therapy isn't going to do it. You have to actually be sensible and look at the whole picture. So we know children with these behaviours will require a longer service and probably one to two years therapeutic involvement; and not just with the child, with the whole family.

COMMISSIONER NEAVE: Is there any theory as to the link between problematic sexual behaviour among children and adolescents and family violence, why one may lead to the other? Is there any theory about why - - -

DR MILLER: We are gathering research as we go. But there are from practice, and I have worked in this area as a therapist, they are often children who have also been neglected. The rituals around the problem sexual behaviour are often part of them reducing anxiety and seeking out, if you like, some sort of comfort. That's one explanation.

The other is they have just been exposed to aggression and violence is instrumental, "This is how I get what I want." They hit a point where they are curious about sex, "And so I find out what I want to find out and I use sexual aggression." So there are different presentations that we see. Frequently these children have been sexually abused themselves.

DEPUTY COMMISSIONER NICHOLSON: Can I just ask while we are on long-term impacts, can either of the witnesses point to any evidence of the extent to which family violence may be causing young people to drop out of school, because we know in Victoria we have 10,000 young people of compulsory school age that don't attend school.

DR MILLER: I think it's a big issue.

PROFESSOR NEWMAN: Yes, I agree. As far as we know - we haven't sort of studied the entire population to actually quantify it exactly, but the links, the associations are quite clear. We can see that starting very early in these children in terms of difficulties in school attendance quite early, is often associated with family violence and trauma. There is the impact of that exposure on children's concentration, their ability to learn. They can be unsettled in a classroom. Sometimes they are just not able to concentrate.

They might be missed because they can be quiet children. They are not all overtly disturbed. But they can go under the radar. So they are more likely to fail at school. School failure compounds their feelings of being different, having low self-esteem and so on. They are more likely to leave. Then there are those who actually leave school themselves as part of leaving home

and who might be that group who end up homeless or on the streets. But those pathways I think are quite clear. So it is a significant factor in school failure and school dropout.

DR MILLER: We can forget the experience of the child who is embarrassed, and I remember one little boy very early in my career who taught me so much about his life and the impact of violence on children; he wouldn't ever take off on hot days his jumper because of two reasons: one, he was scared the bruises would be seen and he would get mum into trouble, because dad had done it, but mum would be blamed if he spoke out; and, two, he said to me, "I'll be killed if I lost my jumper." And the terror in that kid, I will never forget it.

So the children's experience at school is one, as I said earlier, of often not feeling as good as the other kids. If there are money problems associated with the violence and there's substance abuse and a whole range of other things and the money is going to gambling - as I said it's rare to get just family violence, you often have this coalescence of a whole range of problems. The child is often missing out on the excursions because there is not the money to send them on the school camp. They are often the children who need it most. So the education system is sensitive to this and there are wonderful principals around who make sure children don't miss out even though they don't have the money.

We know frequently that transition point from grade 6 to year 7 is where a lot of kids will drop out and they can be lost to the system. As I said earlier, the underlying issue of family violence is frequently there.

Where you get cases of so-called school refusal, it is often there. It's not always, but often. So it can manifest in various ways.

I have worked with a number of young people with eating disorders who drop out of school and can't cope et cetera, and sometimes what's underneath that is - there's a strong correlation actually with experiences of sexual abuse, family violence. So it can manifest in a range of ways. Where Margaret Cutajar's research 2010 published talked about an increased likelihood of psychosis where there have been victims of sexual abuse and also experiencing family violence, physical family violence. So the long-term impacts are many and varied.

MR MOSHINSKY: Can I turn now to the third heading, which is the role of the health system, and ask you each to comment on what should we be doing differently in your opinion. I perhaps ask you, Professor Newman, first.

PROFESSOR NEWMAN: Well, I think there's a lot we could and should be doing, but essentially to summarise it I would be very pleased if we could get better at early identification, meaning how we are going to better identify people who are in these situations, be it parents or be it children, so talking about both, and how we can better use the understanding that we do have about trauma to help us understand the way particularly in which children present, which can be quite variable. So we need to have a high index of suspicion.

This is a major public health problem, and yet it's one that we are not really focused on in a clear enough way. We have heard a lot this morning already about what we do understand about the association between

family violence, exposure to this sort of trauma and a whole range of different presentations with children both in the immediate sense and in the long-term sense. Yet our system doesn't really reflect that knowledge. So I think that's the challenge. How do we take this knowledge, translate it into approaches that can better identify risk, better understand children's presentations and provide early intervention?

A lot of the more serious difficulties we are seeing in adolescents, children and adolescents, where violence and traumatic exposure hasn't even been identified, yet they are presenting with a whole range of quite complex issues, if we had a more functional system that could identify early we should be able to put in place better - I mean, the obvious issues which Robyn has mentioned around protection and safety and re-establishing security which can do a lot for children, but for those who do need particularly in the mental health sense more mental health treatment, we should be able to have trauma informed treatments done early rather than try and treat people where there are established difficulties.

The other area of prevention I think is very important is that we look at the parenting issues where people may have risks of replicating or being uncertain or confused about how to safely parent their own children, and be able to have interventions that look at the needs of the very young, so infants and young children. Again, these are patchy across our system of care at the moment. There are some pockets in the State that are very good. Infant mental health programs which will provide services for high risk, some of those services currently are at

risk because of the withdrawal of Commonwealth funding which has been announced very recently, and we are awaiting further news about any ongoing funding. That's very concerning from my perspective because that would be a key area where we should be focusing more rather than facing, which we are at the moment, a constriction and withdrawal of services from some of our most vulnerable who are the very young.

So if we take it seriously, all this understanding we have about brain development and the need to protect young children from trauma, then it's an absolute travesty, in my opinion, that we are even in a situation where funding is being withdrawn from those services. That funding withdrawal also applies to training positions in this field and those positions, as I mentioned before, it is absolutely essential that we train professionals and clinicians of the future in how to better identify children at risk or children who have been impacted by trauma and treat them.

Risk identification is one issue, but we need to be able to offer actual treatment and intervention and support services across the system. So, we face some major challenges in doing that at the moment. It's a rather frustrating situation, obviously, because I think we have the building blocks. We have a lot more of the knowledge. We have a lot of interest in doing things better. We have a community that's calling on us, quite rightfully, to address this problem. We have interest at different levels of government. Yet how do we actually translate that into the services on the ground that we need remains our problem. But I think we have a vision of

how we would like to do it, we just need to have the actual support for that follow the rhetoric, in other words.

MR MOSHINSKY: Dr Miller?

DR MILLER: Just building on those comments, which I agree wholeheartedly with, the first respondents are often GPs. The first disclosures about family violence are often to the GP. So, confining my comments to the health system, that's your question, because I could go much broader, but confining it to the health system for now, training and equipping GPs with more resources is something that is very important.

The other key group in the health field, I think, are maternal and child health nurses who play an absolutely invaluable role in Victoria. They are key in terms of building trusting relationships with new parents and actually monitoring the baby's development. That's often where you will see the indicators of restlessness, et cetera.

If we could be more creative in the way we resource maternal and child health nurses and their specialist program, which is called enhanced maternal and child health nurses, because they are very skilled at being able to engage with very sort of complex and challenging families. Frequently at that point you have a window of opportunity, and I would go right back to the care during pregnancy, sometimes called antenatal care. If we could engage fathers at that point, there is a window of opportunity. Most men want to do the right thing by their children, and I think we would be able to intervene much more powerfully if we could train medical

practitioners to have the sort of conversations with women when they're pregnant that don't shame them and don't frighten them, but that actually open up a space for them to be able to talk about the difficulties in the relationship, without necessarily demonising the partner and expecting that they're going to separate, because women usually don't want to at that point, that's my experience, although some certainly need to and will want to. So, again it's variable.

But training health carers, health practitioners to be attuned to issues and indicators of violence and more than that, you know, you can have head knowledge, but how you speak about these things with families makes all the difference. So we need much more trained support in terms of role playing. How we train our practitioners is very important. They need experiential learning, not just being lectured at. They need to rehearse. Their tone of voice, the way they look, the way they sound, the way they treat the person will make all the difference as to whether the younger woman or the older woman is going to trust them to open up. Any woman going through a violent situation will be conscious of what the other person is going to think of them. They will be exquisitely tuned into blame or people looking down on them. So how we have respectful, compassionate, skilled professional engagement from our health professionals is critical.

Sometimes it's in the maternity ward that you get the indicator about the violence. Sometimes it's in the hospital. So again it's midwifery staff need to also be trained in this area. Again I stress - there's a range of ideas about how we could use the skilled way that maternal

and child health nurses run first parents' groups and they often run fathers' nights. If we had more joining up with men's services, with family services and more capacity, because that's the thing. As a nurse you can't do it all, you have to be able to refer, so we need more capacity within couples and men's behaviour change to actually outreach. But there's a very good platform, if you like, that we could be more thoughtful about reaching the most vulnerable.

My whole point here is the earlier the better. Frequently when parents become depressed after the birth, as I mentioned earlier, it's because it triggers their own experience and fear that they will be the sort of parent their own was, and they don't want to be. So having opportunities for that sort of counselling to be available is really important.

I don't want to miss out on adolescent health either, because whilst the early years and the prevention is where we need to really rejig the system, I'm very clear about that, it 's never too late, but we too often have the ambulance at the bottom of the cliff, yet we actually can generally know who are our most vulnerable families in the community. There are programs for family/nurse partnerships that have actually had terrific evaluation. They are evidence based, they are random control trials. The partnership model, David Oldsworth, is very clearly showing the reduction in violence and harm and so if we funded and used our health services and they target very high-risk young parents.

So there are ways to be more intelligent about where we place our resources and rather than getting into

a bun fight and competition around scarce resources, to intelligently look at where the funding dollar is going. I simply think we need more funding.

MR MOSHINSKY: Do the Commissioners have any questions?

DEPUTY COMMISSIONER NICHOLSON: Counsellor, just thinking about the lifetime impact of family violence on children, are you aware of any actuarial type analysis that might have been carried out to look at the lifetime cost to the public purse and to the returns on investment? Are you aware of any work done like that?

PROFESSOR NEWMAN: Yes, I'm sure we can both comment on that. There have been some attempts to do that, particularly models in Canada and the US, and they have taken the approach of trying to look at, firstly, the costs in terms of not doing anything, in terms of cost to the general health and welfare system with the range of negative outcomes that we know about that we have reviewed. So you can attempt to model the cost to a mental health system, the cost to an educational system when traumatised children are within that system, the costs in terms of juvenile justice and criminal offending, costs in terms of out-of-home care and so on. So there have been attempts to put that together. I can't quote the figures, Robyn might have them.

The other approach has been to look at the savings, potentially, to a system if we did early intervention, meaning intervention during early childhood with vulnerable families impacted by these sorts of issues. There have been a couple of very good studies that have looked at the savings per dollar investment in terms of these longer term outcomes and have estimated

that we are roughly saving 20-fold in terms of investing one dollar for every particular focused early intervention program for high-risk families.

In Australia we have some data that has been looked at in terms of the cost of child maltreatment including exposure as a global phenomenon, so not breaking it down but looking overall at the cost to the system in terms of again respite care, out-of-home care, child protection, all of those sort of interrelated issues, and these are hugely expensive systems to run and I think we need to be always looking at that. But the message seems to be, from my reading of it, that early intervention is cheaper than caring and providing systems dealing with the problems, significantly, and that we are spending billions, literally, on dealing with the aftermath of child abuse. But Robyn might want to add.

DR MILLER: I would agree. The studies I'm aware of show the savings to be somewhere between $17 for every one dollar you spend, $17 to $20 for every one dollar you spend in early intervention. I think there is some interesting work that the Cummins Inquiry did looking at the cost and they employed Deloitte, I think, to do some actuarial studies. I haven't got those figures in my head right now, but I'm happy to provide those figures.

DEPUTY COMMISSIONER NICHOLSON: The studies you are referring to, were they specifically dealing with the impact of family violence or were they more generally - - -

PROFESSOR NEWMAN: The ones I'm familiar with are general. I think that's probably more realistic in that the sort of violence we are talking about is associated with a whole range of other risk factors as well, so in terms of

modelling it probably is quite reasonable to do that. But that's been the approach, as far as I know.

DR MILLER: And that's my experience as well. It's generally looking at child maltreatment, broadly speaking. But, as I have spoken about in my witness statement, the whole notion of cumulative harm is the way this often presents in practice.

MR MOSHINSKY: Commissioners, that's all the questions that we have at this stage. I won't ask for the witnesses to be excused because each has been good enough to agree to come back for other sessions. Would it be convenient to have a 15-minute break now until 12 o'clock?

COMMISSIONER NEAVE: Thank you, Mr Moshinsky. Yes, we will rise for quarter of an hour.

<(THE WITNESS WITHDREW)

(Short adjournment.)

COMMISSIONER NEAVE: Yes, Ms Ellyard.

MS ELLYARD: Thank you, members of the Commission. The next witness is Mr Andrew Jackomos. He is in the witness box. I ask that he be sworn in.

<ANDREW MORGAN JACKOMOS, affirmed and examined:

MS ELLYARD: Mr Jackomos, what's your present position?

MR JACKOMOS: I'm the Commissioner for Aboriginal Children and Young People in Victoria.

MS ELLYARD: What does that position involve?

MR JACKOMOS: That position involves advocation for all Aboriginal and Torres Strait Islander children, particularly vulnerable Aboriginal and Islander children, also monitoring and evaluation programs, government programs that impact on those children.

MS ELLYARD: Is part of your work a focus on the involvement of

Aboriginal and Torres Strait Islander children in the child protection system?

MR JACKOMOS: That is primarily the centre of my work.

MS ELLYARD: Have you made a witness statement that you have signed dated 9 July setting out for the Commission some aspects of your knowledge and opinions in this area?

MR JACKOMOS: Yes, I have.

MS ELLYARD: Are the contents of that statement true and correct?

MR JACKOMOS: Yes, they are.

MS ELLYARD: I understand that in addition to that statement you have prepared some introductory remarks that you would like to read as supplementary to your statement; is that correct?

MR JACKOMOS: Yes, I do.

MS ELLYARD: I will invite you to do that now.

MR JACKOMOS: Thank you very much. I am a Yorta Yorta man of the lands that lie either side of the great Dunghala, otherwise known as the Murray River. The totem on my people is the long-neck turtle and these connection are through my maternal grandfather. I also have direct blood connections through my maternal grandmother to the Gunditjmara of south-west Victoria and to the Taunarung people of the lands over the Black Spur.

As is the tradition of my people, I would like to acknowledge the traditional owners of these lands, the Wurundjeri people and their good neighbours, the Boonarung. I acknowledge their elders both past and present and their continuing guardianship of these lands since time immemorial.

I also acknowledge that within close proximity to

us is Parliament Gardens in which stands the memorial to Pastor Sir Doug Nicholls and Lady Gladys Nicholls, two great Australians and two great ancestors of the Murray River people. Uncle Doug and Aunty Gladys Nicholls gave to our Koori community in Melbourne a solid foundation to build our community that comprised refugees escaping government repressive policies on stations throughout Victoria, policies that sought to break down our traditional structures, family networks and social mores and values.

In many, many cases the government was successful in achieving its goal and the dysfunction and disengagement of my community is the direct result of past government policies and practices that sadly continue today through poor child protection practices. I'm talking based on facts that I have seen over my life's journey, but have come together from over the past two years as the Commissioner.

Family violence may not have been part of our traditional culture, but it is certainly part of our current culture. A very negative part, but still part. I say this based on the currency, regularity and commonality of practices across the state and across communities. I know of a then government community where there was a shed by the fence line and when there was family violence, the station manager, the government station manager, would send off the couple to that shed until they sorted out their differences.

In that same community only a couple of years ago a government officer was reprimanded by a local elder responsible for health services in the community for

calling the police during a family violence incident. The elder commented that in their community they don't call the police, but take care of such matters in their own way.

Only recently I met with Koori women, both young and old, in a rural community who told me of the level of family violence and sexual abuse that was deeply entrenched in their communities, cultures and practices. In recent weeks I have had a first cousin's daughter tell me that the hardest part in dealing with family violence was the expectation that she would stay and make it work and that it only brought shame to her partner's family if she was to leave.

Where we have seen a 42 per cent increase in Koori kids in out-of-home care in 12 months in Victoria and the level of over representation is 63 out of 1,000 for Koori children compared to five out of 1,000 for all Victorian children, and in a key rural community hub we have close to 120 out of 1,000 Koori children in out-of-home care.

Nine out of 10 of these children have been removed because of family violence perpetrated against them and their mothers. The cause of family violence I believe is to do with the breakdown of our society's values and norms, traditions and culture that has increased over the past 30 or 40 years and its cumulative harm and dysfunction is happening for many families in generation to generation.

The impact of past government policies and programs have had a devastating effect on my community that continues to this day, but there is no, and will

never be, any justification for family violence, family violence that is ripping apart families and ripping apart children from their culture and heritage. From my perspective I'm looking at family violence from the perspective of Koori children in Victoria. In my families under threat from family violence, the offender is not always Koori and the victim is not always Koori, but the constant is that our children, our Koori kids, are always the victim.

For my work on Taskforce 1000 I have now had the opportunity to hear the stories over the past 12 months of over 550 Koori children in statutory out-of-home care in the care of the State. These children have come from dysfunctional families evenly spread across rural and regional Victoria and for nine out of 10 times the primary cause is family violence backed up by alcohol and drug and substance abuse where predominantly the perpetrator is male and more likely Koori male, but not exclusively, and where the mum is Koori, but not exclusively.

In our taskforce panel reviews we are presented with the genogram for each child, a family tree that for many of our children can go back three to four generations and more and more, and then for other children genograms that only take us back one or two genograms at best.

What is common for many of our children we see is the level of intergenerational trauma, dysfunction and disengagement from society that is associated with removal and child protection. We are seeing generation upon generation of contact with the criminal justice system, after graduating from the youth justice system and from out-of-home care.

My real concerns are that the current group of Koori children in the care of the State are potentially our next cohort of family offenders and victims, if we don't provide timely and appropriate counselling and support, if we don't provide them warm and loving homes in the interim whilst we work with their families for early reunification or, where that is not possible, to provide them with stability, preferably within the family network. We need to be working with our children so that they know what is a healthy, responsible and respected relationship. We need to be working with our young boys so that they are respective of women, their mothers, their sisters and their partners.

The greatest resilience we can provide our children is the power and knowledge of good culture, good community standards, positive role models and strong engagement in education. There is a falsehood in our culture that the black man has fallen from the top of the patriarchal tree and he needs to re-installed before we can find balance in our community. I'm not in favour of initiatives or programs that promote a renaissance of young warriors and male alteregos. However, I am in favour of growing young and respective men who are good boyfriends, good partners, good fathers and good grandfathers. And we have good men, a lot of good men in our society, and we desperately need more.

Sadly, the majority of Koori children in out-of-home care who have been victimised and traumatised from family violence are placed out of culture and out of community. Sadly, these children do not have exposure to positive Koori culture and positive role models for both

boys and girls and sadly the majority of them do not have the opportunity to develop positive relationships and friendships with other Koori children. But I will tell you that, without fail, the majority will come searching for their families and kin and blood once they are old enough to make the journey.

We need government and community to work together to ensure that today's young victims of family violence who are in out-of-home care have a real chance to develop their culture, know their heritage, grow their network of Koori friends, have a whole collection of successful Koori role models and gods and at this point in time I have not seen this and it is not happening, but there are positive signs that things can change.

The status quo can change. This Royal Commission can help provide direction to government, and government needs to act, but the real change has to come from within my community. Thank you.

COMMISSIONER NEAVE: Thank you, Mr Jackomos.

MS ELLYARD: Thank you, Mr Jackomos. Mr Jackomos, in your statement you make the point that within your community, Aboriginal community, there is a perhaps broader understanding of what family violence is than might be the understanding in the broader community. Can you explain a little what you mean by that?

MR JACKOMOS: The Koori community is like the broader community, it is a broad church. I believe that family violence is very much driven by male perpetrators. There are others in our community, many others in the community and probably the most influential in our community are also of the view that it is not a gendered approach, you

need to take a non-gendered approach to resolve family violence in our community.

MS ELLYARD: So just to unpack that a little, I take it that when you describe family violence as gendered in your view, you are talking about the disproportionate effect on one gender and the disproportionate percentage of perpetrators who are of one gender and victims who are of the other gender?

MR JACKOMOS: Yes. I know from the work that we are doing through Taskforce 1000, that I'm co-chair with the Secretary from DHHS, that we are seeing that predominantly 90 per cent of our children in out-of-home care have come from a result of family violence. In the great majority of those cases it is male offenders that are driving that family violence.

MS ELLYARD: One of the other points you make in your statement is that it is necessary for anyone seeking to work with Aboriginal families and the Aboriginal community on this issue to have an understanding of Aboriginal familial and kinship structures?

MR JACKOMOS: Yes.

MS ELLYARD: Can you explain to the Commission a little, please, what you mean by that family and kinship structure?

MR JACKOMOS: I mentioned in my opening statement about my first cousin's daughter who spoke to me about how she couldn't leave because there was shame, she would bring shame on her partner's family. You need to understand, you need to know networks, particularly in child protection. We see through Taskforce 1000 where Aboriginal children have been removed and not identified

as Aboriginal for two, three, four, five years, seven years after the removal, which misses the opportunities to build the children's culture up, reconnections with family, reunification. It's so important to understand the family and networks.

MS ELLYARD: You mention the fact that it might be the case that children who are Aboriginal children are not identified as such by the system - - -

MR JACKOMOS: Yes.

MS ELLYARD: For a long period of time. How does that come to be, that children who are removed from a Koori family are not identified by the system then as being Aboriginal children?

MR JACKOMOS: Either child protection workers may not ask the question because the woman doesn't look Aboriginal or the child protection worker will ask the question, but the manner in which the question is asked and without explanation as to why they are asking. Also, where we have a parent who's got prior experience with child protection, they might be less likely to answer the question.

MS ELLYARD: You said that one situation might be where people are asked the question but the reason for the question isn't explained?

MR JACKOMOS: Yes.

MS ELLYARD: Do I understand you to mean by that that people are asked the question in a way that makes them think that it's a negative thing if they answer "yes"?

MR JACKOMOS: Negative, but also people aren't sure why they are asking. As a general rule, child protection do not explain why they ask the question. In my period of time

prior to here, I worked in justice and we had the same issue with police asking the question and the same issue happened in hospitals when admissions are required to ask the question. People won't answer that they are Aboriginal if they don't know why the question has been asked.

MS ELLYARD: So in the context of asking that question of a mother or a parent of a child who is entering the child protection system, why is that question asked? Why is it an important question?

MR JACKOMOS: It's fundamental. Within the legislation, the Children's, Youth and Families Act, there is an Aboriginal Child Placement Principle in legislation. If the question is not asked, then straight away it undermines the application of the principle, the Aboriginal Child Placement Principle, of which it works through a tiered approach to ensuring that our children stay connected to community and family.

MS ELLYARD: So in the case of someone who is asked the question but isn't given that explanation, they are not told, "The reason I'm asking is because if your child is Aboriginal, then there's a structure that we are going to try to follow." If the question was explained in that way, do you think that people would be more likely to identify their children as Aboriginal?

MR JACKOMOS: Yes, and already there are areas within child protection that are developing brochures to help explain. Also, it's not just brochures, we actually need culturally friendly child protection workers to ask the question. I would also like to see more Koori workers. I would like to see the Department of Health and Human Services have a

Koori recruitment and Koori career development strategy where we don't just have Koori child protection workers, we actually have people in policy, we have people in central office as well as at the coalface.

MS ELLYARD: In your previous places of work, has that been the situation, that Aboriginal views and people are represented at multiple hierarchies within a system?

MR JACKOMOS: Prior to my appointment as Commissioner two years ago, I worked in the Department of Justice and we had a very effective Koori recruitment and career development strategy. I think we went up from two up to 160, where we have got now senior managers in the court system, in Corrections and throughout Justice involved in policy development. But also there is a venue called the Aboriginal Justice Forum in which we bring together community and justice, judicial officers to jointly develop programs and policies that are culturally attuned. I'm hopeful that that will come out of some work that's currently being done with the Victorian Government now.

MS ELLYARD: You have mentioned this need to understand culture and be culturally attuned. In your statement you go into some detail about the over-representation of Aboriginal children in out-of-home care and in child protection generally. Is it your view that that over-representation arises because those children are indeed at higher risk than non-Aboriginal children?

MR JACKOMOS: They are at higher risk.

MS ELLYARD: And why is that?

MR JACKOMOS: It's a whole - it goes back decades, it goes back to colonisation, it goes back to dispossession. We know that there are areas in Victoria where it is unsafer to be

a Koori baby than other areas. I mentioned we have an area in Victoria where roughly 120 out of 1,000 children will be in out-of-home care. We know the State average for Koori kids is 63, 63 out of 1,000, yet the average for non-Koori kids is five out of 1,000. This is just staggering.

MS ELLYARD: So when we start to unpack why that might be so, you have referred in your statement to poor practices of the past, government practices.

MR JACKOMOS: Yes.

MS ELLYARD: When we think about that vast over-representation now, are we talking about a situation where those children are now genuinely at risk and are being appropriately removed because of a whole lot of complex underlying factors, or is your concern that there is an inappropriate level of removal?

MR JACKOMOS: I think the government can do a lot more. Community can do a lot more to prevent removals. In my statement I spoke about an excellent program up at Mildura run by Mallee District Aboriginal Services called Bumps to Babes and Beyond which is in partnership with the Queen Elizabeth Centre, where the community works with young girls as soon as they are aware that they are pregnant. It provides one door where they walk in and where we ensure that they have good accommodation, they are safe from family violence, they have proper nutrition, dental health, all these things to protect them. I know in areas where we don't have such services, our young children and our young mums are more at risk.

MS ELLYARD: At paragraph 17 and onwards in your statement you speak a little about the particular history of Aboriginal

people that has contributed to the current plight of Aboriginal children. You talk, for example, about the past experiences of previous generations who have effectively been disenfranchised and unable to make decisions for themselves and in many cases cut off from the experience of their loving parents and a cultural environment. How does that in your experience play out in the generation of Aboriginal people who are having children now and their ability to offer their children the kind of loving support that children need?

MR JACKOMOS: If I can take you back to 1991 when the Royal Commission into Aboriginal Deaths in Custody handed down their report, they looked at 99 deaths of Aboriginal people nationally, including in Victoria. Sixty-six of those 99 were of Aboriginal children who had been removed from their parents and community.

Child protection is the front door to the youth justice system and the adult criminal system. If you go out to Dame Phyllis Frost, many, many of the women there have been through out-of-home care and through residential care. At the moment the Commission is doing a review into sexual exploitation of Aboriginal children in out-of-home care, which is still in draft. Ten of the 40 children that we are looking at are Koori kids. It's just over-representation.

The problem is we are having children at a much younger age, our young mums are having children at a much younger age. They are not being prepared. They are not being prepared for motherhood. Our young boys aren't being prepared. Things we have to be doing is working with our young children in out-of-home care now to prepare

them for when they leave care, and the majority of our children in out-of-home care don't have access to positive Koori role models, they don't have access to culture and community. Those are things that government and community must put in place now, not just to have Aboriginal cultural care plans, but to actually provide our children with positive experiences and relationships.

MS ELLYARD: I don't want to oversimplify what is obviously a very complicated problem, but if we were to try to state in very bald terms why there are 63 Aboriginal children out of 1,000 who are unsafe to be at home compared with five in the more general population, is that because those children are much more likely to have parents whose capacity to be good parents has been negatively affected by their own childhood background?

MR JACKOMOS: Yes.

MS ELLYARD: When we think about that own childhood background, are we likely to be talking about a history of involvement with child protection and perhaps removal themselves?

MR JACKOMOS: In our working taskforce, for each child we see the history, whether either parent has been in child protection, either parent has been incarcerated, and for virtually every child we see is one of the parents have been in child protection or one of the parents or more have been incarcerated or are still incarcerated.

We see the children, significant behavioural issues that come with that and then disengagement from school. We are seeing in child protection high numbers of Koori children who have poorer education outcomes and whether that's through suspension, whether it's through expulsion or whether it's through disengagement where the

child is pushed out rather than upsetting the numbers, these are all things that come to play.

MS ELLYARD: So were you present in the hearing room this morning when Professor Newman and Dr Miller were giving their evidence?

MR JACKOMOS: Some of the time, yes.

MS ELLYARD: Some of the evidence that they gave that the Commission heard was about the long-term impact on people, including on their own capacity to be a parent if they'd had a disruptive experience as a child and had been perhaps poorly parented or exposed to violence. Were you present when that evidence was being given?

MR JACKOMOS: Yes, I was.

MS ELLYARD: Did that evidence resonate for you with the observations you are making through the Taskforce 1000 project?

MR JACKOMOS: Yes, every day we are seeing kids who present with behavioural issues and you can see how it's impacted on health and education and leaving care and relationships with other people.

MS ELLYARD: You mentioned in the additional opening statement that you made that family violence, whilst definitely not a part of traditional Aboriginal culture, is unfortunately part of the present culture. Again, a very complicated question, but how has that come to be the case that there's been this toxic import, as it were, into Aboriginal culture?

MR JACKOMOS: I think it's been a breakdown, a breakdown of family values, a breakdown of standards, and you can see it in different places. We have taken the Taskforce across all of the 17 departments' areas and each area is

different, and the makeup. You can see the levels of family violence. You can see the levels of alcohol and substance abuse, different in each areas. You can see how they have come to play.

You can have a look at government policies. Some of our families and where we have got the highest levels of representation in out-of-home care are people from communities that only got out of government control in the last 40 years. You can see communities where they had the opportunity to get off the mission and access education and employment have much lower levels than those communities that were only able to rid themselves of government control in the last 40 years.

MS ELLYARD: So the extent to which there has been autonomy and capacity for self-independence in the community has a direct bearing on the level of family violence in that community?

MR JACKOMOS: Oh, absolutely. It's not family, it's the whole family's engagement. When I spoke earlier in my opening statement about I met with Koori women, both young and old, in a certain community and they told me about the level of sexual abuse and family violence in the area. That was from an area that was still under government control to 40 years ago. So there's a direct connection between past government policies and church policies and where people are today.

MS ELLYARD: Thinking about the past experiences of Aboriginal people and the role played by government in controlling their lives, how does that play out now in what it feels like to be involved with child protection or the extent to which families might avoid seeking assistance where they

need it from government services?

MR JACKOMOS: I think government - we need to ensure that government isn't intimidated by community influences, and I spoke earlier about a gendered approach. There is an organisation called the Aboriginal Family Violence Prevention Legal Service. They were excluded from a Police Commissioner's family violence forum held last year because there are certain influences in government that says that a gendered approach isn't the way to go, so the Aboriginal Family Violence Prevention Legal Service was excluded from sitting at the table. They eventually got there, but it was only after representations.

Up until the last election there was what was called the Aboriginal Services Round Table where the Aboriginal Family Violence Prevention Legal Service, which takes the gendered approach, was excluded from sitting at the table. So there's a 10-year indigenous family violence strategy that's currently being reviewed. Aboriginal women and children weren't mentioned until well into the document as being primary victims. So there's an attitude in government that needs to be more reflective of the broad church of views in the Koori community than one-sided.

MS ELLYARD: What about thinking down to the individual level and the individual experiences of a woman experiencing family violence needing help? Does that background of the way in which the government used to treat Aboriginal women and men and children affect the way in which the Aboriginal community views child protection and police and services of that kind?

MR JACKOMOS: Yes. There are services out there. For example,

the Aboriginal Family Violence Prevention Legal Service are not funded to deliver services, culturally appropriate services to Koori women, to Koori victims of family violence in metropolitan Melbourne. They are excluded. We have an excellent service called Bubup Wilam, which is a children's and family service, community run, which is based in the northern suburbs of Melbourne that works and the majority of their children in their care are kids from out-of-home care, parents on orders. They are aren't funded by government. They were funded by the Commonwealth. The Commonwealth pulled the funding and they are caught providing an excellent service but without funds. There is a whole range of programs that are missing out on being supported.

MS ELLYARD: And is there a willingness in the community to take those services up or is there any degree of reluctance associated with getting help from the government?

MR JACKOMOS: No, community organisations are banging on the door of government for support to run these excellent programs and what we need is government to respond.

MS ELLYARD: Can I ask you now about Taskforce 1000 which you talk about in your statement and which you have described as a project by which you are examining in detail the files, as it were, of at least 1,000 indigenous children who are presently in out-of-home care. You have prepared for the Commission and I think I have circulated or I can circulate now - in fact I might take my friend's one back. Do you have a copy in front of you?

MR JACKOMOS: No, I don't.

MS ELLYARD: We will give it to you. You have prepared, as

I understand it, some statistics. I will just check that there are enough copies for the members of the Commission to each have one.

COMMISSIONER NEAVE: Thank you.

MS ELLYARD: These are preliminary figures from some of the work that you have been doing. But before I take you to those statistics, can I ask you to summarise, please, in general terms what are you finding as you progress through these files about the common themes or experiences that have led Aboriginal children to be in out-of-home care?

MR JACKOMOS: The common themes are that family violence is the number one factor for children across the State being in out-of-home care. Very close to that is alcohol and substance abuse, followed by neglect. There is a sheet - - -

MS ELLYARD: Yes, so if we then go through the various tables that you have produced for us, and I understand that these are work in progress documents because you haven't completed the research yet, but on the first table which is headed "Parent Aboriginal", as I understand it you have identified by area the percentage of children identified as Aboriginal who have either an Aboriginal mother or an Aboriginal father or of course in many cases both.

MR JACKOMOS: Yes. So on the first sheet it notes under "mum" is whether the mum is Aboriginal or not.

MS ELLYARD: And these are in percentages?

MR JACKOMOS: Yes, in percentages, and for dad.

MS ELLYARD: Then if we turn to the next page which is headed "Parent Aboriginal", question 10, "Has the child experienced or had exposure to" a number of things, do we see here a table and we identify along the top you've

identified family violence, alcohol and drug abuse, mental illness and neglect?

MR JACKOMOS: Yes, correct.

MS ELLYARD: Being the factors you identified a moment ago. As I understand it, these are the percentage rates at which children of Aboriginal parents in out-of-home care have experienced one or more of these phenomena?

MR JACKOMOS: Children of one or more Aboriginal parents.

MS ELLYARD: Okay. Turning to the third page, this is also a case where one or other of the parents or perhaps both of them is Aboriginal. This is, as I understand it, a percentage table about children who can't go home because there's continuing family violence?

MR JACKOMOS: Correct.

MS ELLYARD: And identifying the number of cases where mum or dad is the offender.

MR JACKOMOS: Yes.

MS ELLYARD: Can you just explain in more detail, so on that first line, for example, we don't need to specify which area it is, but we see 19 under "mum" and 58 under "dad". What does that tell you?

MR JACKOMOS: That is where in 58 per cent of the cases there's still family violence that's being perpetrated by the father in that home.

MS ELLYARD: And 19 per cent in the case of the mother.

MR JACKOMOS: Yes.

MS ELLYARD: When we are talking about family violence, what definition of family violence are you using? Are you referring to family violence whether directed at the other parent or at the children, or are you confining your terms to family violence occurring between the parents and

experienced by the children?

MR JACKOMOS: These are in relation between parents.

MS ELLYARD: So it is in that sense a more narrow definition of family violence relating only to the relationship between the parents?

MR JACKOMOS: Yes, and these definitions are from the department.

MS ELLYARD: Those cases where children themselves are being directly impacted, would they be reported under another heading like "neglect" or something like that for the purposes of these figures?

MR JACKOMOS: Under emotional harm.

MS ELLYARD: If we turn then to the next page, this is looking at the other angle about the percentage of cases where mother or father is the victim of continuing family violence; is that correct?

MR JACKOMOS: Yes, correct.

MS ELLYARD: So again just to take the first line, in that particular area where continuing family violence is preventing a child from returning home, the mother is a victim - in 55 per cent of cases there was a mother who was still being victimised?

MR JACKOMOS: Yes.

MS ELLYARD: And in nine per cent of cases the father?

MR JACKOMOS: In many of these cases I have, I believe the figures are suspect.

MS ELLYARD: Why is that?

MR JACKOMOS: It is how the child protection workers decided to categorise the removal. We have gone through them and we have seen areas where figures are very low, but we know in reality it's much higher, but as a trend across the State

they give a good picture.

MS ELLYARD: So then can we look at the last table that you provided us which is headed "Parent Aboriginal family violence offender". What does this table show us?

MR JACKOMOS: This shows us that - and these figures are all from the Child Protection files - for dad, where dad was the offender, and that was under question 45 of our survey, or mum was the offender, under question 38.

MS ELLYARD: And so on a number of these tables that would indicate - depending on the area - a relatively high percentage of cases where both parents had been identified in child protection records as being a perpetrator and a victim effectively?

MR JACKOMOS: In some cases, yes.

MS ELLYARD: Leaving aside for the moment the question of Aboriginal children who are in out-of-home care, what's then the position of the next cohort down, if I can use that expression, of children who haven't been removed, but for the reasons we have been talking about are exposed to poor parenting because of their parents' past experiences? What's available at the moment to support children who haven't been removed, but who are at risk in their family of origin?

MR JACKOMOS: There are community programs, both Koori and non-Koori, that work with families to keep them together. I think one excellent example is Child FIRST, but there is a range of community and other programs to keep them together. My worry is for those children, vulnerable children who are outside of the service system, and I would say there's far more vulnerable kids that are outside the service system than inside.

MS ELLYARD: Why do you fear that and why would that be the case?

MR JACKOMOS: We would have children who are homeless, Aboriginal children, where they feel it's not safe to go home, who wander the streets at night because of the family violence at home. There's children outside the service system because I think workloads, pressures within the department, is one area. I think community protection where - I mentioned earlier about my cousin's daughter who said that her greatest barrier to escaping family violence was being told that it would bring shame on her family, on her partner's family. So there's community pressures, pressures from the system to respond. Then there's kids who have taken to the streets because of too dangerous being at home.

MS ELLYARD: When we talk about children who are in out-of-home care, what forms of out-of-home care does that include? Does it include, for example, children who have been placed in kinship care arrangements with family members?

MR JACKOMOS: It includes statutory care, so kids who have been placed with kinship care, kids who have been placed in foster care and kids who have been placed in residential care.

MS ELLYARD: And from your observation of the work you have done on Taskforce 1000 thus far, what can you say about the extent to which the particular policies that exist for the placement of Aboriginal children have been followed?

MR JACKOMOS: It differs in different areas. So, I mentioned earlier about the Aboriginal Child Placement Principle.

MS ELLYARD: Yes.

MR JACKOMOS: It's interesting. In the taskforce for each

child we see a genogram of the child and sometimes you will see all these Aboriginal people in the genogram and you might see one non-Aboriginal family member and odds-on you know where more likely that child will be placed with the non-Aboriginal than the Aboriginal. I think we need to do a lot more work about developing the child protection sector. I think there's an undervaluing - and I'm being polite - there's an undervaluing of potential Aboriginal carers.

MS ELLYARD: You have mentioned in your statement and you have identified in some notes that you have provided to the Commission that one of the solutions in your view is young people who have experienced family violence having a positive experience of their culture.

MR JACKOMOS: Yes.

MS ELLYARD: And positive Aboriginal role models. I wonder if you could expand a little on why you feel that's a potential suitable response to children who have experienced family violence. Why is it important that they have a strong experience of their Aboriginal culture?

MR JACKOMOS: I think it's one aspect of responding. We hear stories of where children deny their Aboriginality. In many cases our children are placed in kin outside of community and outside the culture, so it might be a non-Aboriginal kin placement. Sometimes it's safer for our children, culturally it's safer for our children to be in a foster care placement, sometimes, than in a non-Koori kin placement.

MS ELLYARD: When you say it would be safer for them to be in foster care than with family members who aren't Koori, what do you mean by that?

MR JACKOMOS: Not in all cases, but many cases we hear of where there's been acrimony between the parents, family violence, and the kids with the non-Koori grandmother who denies access to the Koori family, who tells the child that it's not a good side of their family, their Aboriginal side. These things we see every day.

MS ELLYARD: Where those views are taken, is it because of the presence of family violence or a perception that the family violence is the fault of one side of the family or the other?

MR JACKOMOS: Many times it's family violence. There are times ignorant people might consider that Aboriginal people aren't of the same value as non-Aboriginal people. But family violence is a significant factor.

MS ELLYARD: So then thinking - and I'm conscious that the Commission will be hearing from you again next week or a number of these issues will be unpacked in a lot more detail, but I wonder whether you could summarise for the Commission, other than that factor of strong cultural relationships which you have mentioned, what are the other potential solutions that you see to the problem of Aboriginal children being so much more likely to need statutory protection at present because of family violence?

MR JACKOMOS: I would love to see more Bubup Wilams across the State in communities. I would love to see government support for Bubup Wilams across the State. I would love to see support for programs that promote positive, healthy, respective relations to our young children so that they grow up and that they know that a relationship, a good relationship, isn't where dad bashes mum. I would

love to see where the department plays a lot more proactive role in providing cultural experiences to our children, and while there is work around ensuring that kids have good cultural care plans, that's different from actually having a cultural experience and developing positive relationships and having positive role models.

MS ELLYARD: Can I interrupt you there, Mr Jackomos. To be clear I understand you, I think you are saying there that if a child has had to be removed because of family violence and it's necessary for their safety that they need to be removed, that shouldn't be at the price of their connection with their Aboriginal culture.

MR JACKOMOS: That's right.

MS ELLYARD: So that some appropriate balance needs to be struck between protecting them from family violence, but keeping them in contact with the positive aspects of their heritage.

MR JACKOMOS: Yes, and to keep them out of statutory care we need to invest in places like Bumps to Babes and Beyond in our communities. We know where we have strong Aboriginal community-controlled organisations such as in Shepparton with Rumbalara or Gunditjmara down in Warrnambool or Mallee Districts up in Mildura, where there are one doors where young women can go in there and they can be provided family violence counselling, support, accommodation, dental, prenatal, all of those services. Where we see there's a lack of one door, strong Aboriginal community-controlled organisations such as in the Latrobe Valley is where we see high numbers of Aboriginal children entering out-of-home care and family violence.

MS ELLYARD: So what I think the Commission has heard described

in other contexts as a multi-disciplinary approach where you walk through one door and a range of services are made available for you in a culturally appropriate way, that's associated in your experience with lower levels of children entering statutory care?

MR JACKOMOS: Yes. Where we have strong community organisations that have strong family violence programs and housing is where we see lower numbers of family violence.

MS ELLYARD: Thank you, Mr Jackomos. As I said, members of the Commission, Mr Jackomos is coming back next week, but I have concluded my questioning. I wonder whether any of the Commissioners have questions for him at this stage.

DEPUTY COMMISSIONER FAULKNER: Commissioner Jackomos, I wanted to ask the question about the last point you have made, which is about the importance of Aboriginal community-controlled organisations, and in your evidence you said where they existed and were strong, that we saw benefits throughout the community.

MR JACKOMOS: Yes.

DEPUTY COMMISSIONER FAULKNER: Can you tell me what the constraint is in relation to more of these? Is it budgetary or is it competency?

MR JACKOMOS: I would say it is more about community dynamics and competency. I will use Latrobe Valley. We don't have a one door strong advocacy in the Latrobe Valley. There's a whole range of different services, good services across town, but people have to go across town to make services. Where we have a one door, strong community organisations that deliver a range of services, everywhere from child-care to health to advocacy, is where we are seeing

good responses. A lot of this is due to community dynamics, and I know in the Latrobe Valley there are some parts of the community that want to have it, have a strong community organisation; other community members say, "We don't want to go back there because it only brings disharmony in our community," and some people think is it better to be serviced by non-Koori organisations.

DEPUTY COMMISSIONER FAULKNER: Thank you.

DEPUTY COMMISSIONER NICHOLSON: Mr Jackomos, I refer to paragraph 12 of your statement, where I think what you are saying there is that many in the Aboriginal service provision don't accept that family violence is a gender phenomenon.

MR JACKOMOS: Yes.

DEPUTY COMMISSIONER NICHOLSON: I'm wondering what alternative explanation do they offer and, secondly, how does that shape the design of the services offered and what in fact does that mean for the effectiveness of the services they offer?

MR JACKOMOS: I think a lot of the approach about a non-gendered approach is people's fear of increased contact with the criminal justice system . I think many people will say that if you push the gendered approach, if you promote that men are the primary offenders, then that will only increase the level of contact and then overrepresentation of Koori men in prison. That is probably the most common response.

How it's played out in government programs, an example is that the government has a community - I can't think - there's a program that provides community groups with $600,000 for community initiatives. Those funds are

decided upon by, I think it's 11 IFVRAG Groups, Indigenous Family Violence Reference Action Groups, and they decide where those moneys go to. If you take the gendered approach, you are more likely not to get funded, so these groups, they recommend to the Minister and odds-on I would say that in the past Ministers have taken the recommendation of the community groups and unfortunately a lot of those community groups take the non-gendered approach.

DEPUTY COMMISSIONER NICHOLSON: So what sort of services get funded under a non-gendered approach?

MR JACKOMOS: A lot of worthy services. There could be young boys' programs. There could be football clubs. There could be other sporting activities. What we don't see is a lot of programs that support the rights of Koori women as victims.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

COMMISSIONER NEAVE: Could I just follow up on that. So the decision as to how the money is spent is determined by the individual IFVRAG Group. Have I understood you correctly? It is made by the Minister, but it is recommended by - - -

MR JACKOMOS: It is recommended by the group of representatives from the IFVRAGs.

COMMISSIONER NEAVE: From the particular area.

MR JACKOMOS: Yes.

COMMISSIONER NEAVE: I see. Thank you.

MS ELLYARD: Mr Jackomos is coming back, so I won't ask that he be excused, but that's the end of his evidence today.

COMMISSIONER NEAVE: Thank you, Ms Ellyard.

MS ELLYARD: I wonder if that is a convenient time.

COMMISSIONER NEAVE: Yes, it is a convenient time. We will break for lunch now and come back at 2 o'clock.

<(THE WITNESS WITHDREW)

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

COMMISSIONER NEAVE: Ms Davidson.

MS DAVIDSON: Thank you. As foreshadowed by Mr Moshinsky this morning, we are intending to have a number of witnesses this afternoon. The first witnesses are Associate Professor Stephanie Brown and we have brought back Professor Louise Newman. They will be really focusing on the issue of what might be able to be done in the area of antenatal and pregnancy care. It has already been foreshadowed in the original opening that the time of pregnancy and a new birth is a time of increased risk for family violence.

I will first perhaps remind Professor Newman that she's already been sworn and under oath, but I will ask that Associate Professor Stephanie Brown is sworn.

<STEPHANIE JANNE BROWN, affirmed and examined:

<LOUISE CATHERINE NEWMAN, recalled:

MS DAVIDSON: Associate Professor, you have previously made a statement in this matter?

ASSOCIATE PROFESSOR BROWN: Yes, that's correct.

MS DAVIDSON: Are you able to confirm that that statement is true and correct to the best of your knowledge and belief?

ASSOCIATE PROFESSOR BROWN: Yes, I can.

MS DAVIDSON: Your current role is with the Murdoch Children's Research Institute. Can you just outline what the Murdoch Children's Research Institute does and what your role is?

ASSOCIATE PROFESSOR BROWN: We are a research institute, as the name suggests. I lead one of the research groups at the institute. There are 20-odd staff in my research group. We undertake a range of projects that are focusing broadly on maternal health and the continuum of health between

maternal health and child health, and within that frame we are increasingly working with vulnerable populations and also taking an interest in how fathers' health intersects with maternal and child health as well.

MS DAVIDSON: If I can just take you through some of the matters that you have identified in your witness statement as being some of the principal areas of research that are relevant to the work of the Commission. You have undertaken some research in relation to first time mothers. Perhaps if I take you in particular to paragraph 7 of your witness statement, can you perhaps just outline some of the findings in relation to that research?

ASSOCIATE PROFESSOR BROWN: I think the first thing to say is that we used a very reliable validated measure of family violence to investigate the prevalence, just how common family violence is in the first year after having a baby, and based on using that measure we could see that there were about one in five of the families that were in the cohort that were being affected by family violence in the first year after the child was born . That was a mixture of a spectrum from the physical violence that we are seeing a lot about in the media, but also women who were experiencing a mixture of emotional and physical abuse, and some women who were experiencing emotional abuse without physical abuse.

What's striking from the findings is that the impact of being in a violent relationship is very similar, in terms of the impact on women's mental and physical health, if the abuse is emotional and emotional alone as the impact if there is emotional and physical violence. Similarly, when we looked at the outcome for children in

the cohort around the time they entered primary school or just before, the impacts for children were very similar, whether it was emotional or physical abuse that their mother had been experiencing.

MS DAVIDSON: In relation to those impacts, if we say in relation to women, what are the adverse impacts that you have been seeing through the study?

ASSOCIATE PROFESSOR BROWN: You can see very clearly the adverse impact on women's mental health. So, women who have been in an abusive relationship are four times more likely to be experiencing depression and about ten times more likely to be experiencing extreme anxiety. They are also more likely to experience a range of physical health problems such as incontinence, both urinary incontinence and fecal incontinence after childbirth, and things like back pain, headaches, a range of other physical symptoms.

MS DAVIDSON: In relation to children, what were your findings in relation to the ongoing impacts for children?

ASSOCIATE PROFESSOR BROWN: So far we have been able to look at the emotional and behavioural impacts, and children whose mothers are in abusive relationships are about twice as likely to be experiencing emotional and behavioural difficulties just as they are entering primary school. That said, I think it's important also to note that some children are actually quite resilient, so not all children that are in families where family violence is present are not doing well. Some children are doing quite well and that's an important thing for us to look at in terms of what actually enables those children to be resilient.

MS DAVIDSON: And I think you have identified that that area is one that needs some additional research.

ASSOCIATE PROFESSOR BROWN: Yes, I think that would be a very fruitful line of enquiry.

MS DAVIDSON: In terms of that general study, what do you see as being the implications, just generally, for antenatal and pregnancy care?

ASSOCIATE PROFESSOR BROWN: If we think about one in five families being affected by family violence in the first year after having a child, there are 70,000 births a year in Victoria, so that translates into 14,000 families affected every year in Victoria. If we take the picture out to when those children are turning four or five, it's actually more like one in three or just under one in three families that have been affected by family violence, so we are talking about many, many more families by that time. So this is a very significant, prevalent situation in our community and we at the moment really don't have the symptoms in place to address it in a systematic way.

Maternity services I think are struggling. Our public health maternity system is focused very much on providing high quality clinical care, principally focusing on identifying what are generally fairly rare pregnancy complications and medical conditions that have implications for maternal and child health. There's not an equivalent focus on social factors that influence maternal and child health, of which family violence is one that can have very grave consequences. So, I would think that we need to actually match the system of provision of clinical care around medical conditions and pregnancy complications with an equivalent effort to attend to family violence as one of the major social influences that's having a very detrimental effect on women and

particularly children as well.

MS DAVIDSON: I will come back to both yourself and Professor Newman about exploring those issues about what we can do in those systems further. But I might first take you to some of the other work that you have been doing and the research that you have been doing in relation to, firstly, Aboriginal families and then I will also take you to the work in relation to refugee families.

In relation to Aboriginal families, a lot of your experience you have identified in your witness statement involves experience in the Aboriginal health area in South Australia. Can you tell the Commission about the study that you were involved in with respect to Aboriginal families in South Australia?

ASSOCIATE PROFESSOR BROWN: Yes. I might tell a little bit of background because I think it's very important. The work we have been doing in South Australia has involved an eight year partnership with the Aboriginal Health Council of South Australia, who are the peak body for Aboriginal community controlled health organisations in South Australia. We went to the council some eight years ago to talk about the sort of work that our research group does in relation to pregnancy care and the absence of work really engaging with Aboriginal communities and families about their experiences of pregnancy care and the sorts of issues that families face.

The advice we got at that time was if we wanted to actually do some work in that area we needed to actually go and talk to communities about what they saw as the issues and engage with communities in how we designed our research. So, we have taken a very long time, but

it's been very important, I think, to engage in that kind of way to develop this program of research and it's been very much developed in collaboration with both the Aboriginal Health Council but also with a range of other organisations right across South Australia.

We very deliberately decided that the work had to be statewide in the urban, regional and remote communities in South Australia, and the reason for that was that so many programs, good programs, have been developed in local regions and local evaluations have been done and I think the same thing occurs here in Victoria and then, when the funding ceases, we don't have the evidence about the impact of those programs at a systems level.

So, in South Australia we have been really trying to look at the way in which the health system is actually working to try and support Aboriginal families through pregnancy and some innovations that have been made by the South Australian government to expand the range of what are called Aboriginal Family Birthing Program services in South Australia, which involve a different kind of multi-disciplinary team which includes an Aboriginal maternal infant care worker who is in a leadership role in each of those services and working in partnership with midwives and doctors in local regions to engage with Aboriginal families and support them to access maternity care, but also to address the range of social issues that are impacting on their health. In a way, going back to the issue I was raising previously about needing to actually balance the focus on clinical care with an equivalent focus on social health issues, the programs that have been developed in South Australia are an effort

at trying to do that in a partnership model.

So what we have done now, eight years down the track, we have completed interviews with 344 Aboriginal women who live and gave birth in urban, regional and remote areas of South Australia, and been able to compare the experiences of women who were able to access those services through the Aboriginal Family Birthing Program in urban areas and regional areas with the experiences of women who were accessing care through the standard universal systems.

MS DAVIDSON: I think at paragraph 11 of your witness statement you have got some particular figures in relation to women's reporting of family violence issues. Can you go through those figures with the Commission?

ASSOCIATE PROFESSOR BROWN: Sure. Again I would just like to give a little bit of background to the Commission about those figures. When we started this work, as I said, we were encouraged to go out and talk to different communities and to listen, and we engaged some Aboriginal researchers to help us do that. What we heard again and again was that if we were interested in pregnancy care we really needed to take an interest in what was happening in the lives of women and families during the period of pregnancy and specifically encouraged to enquire about family violence, drug and alcohol problems, housing problems, going to court. Family members passing away was another important issue we were encouraged to ask about.

So, having been given that advice, we were also given the advice that the standardised measures that researchers often use to enquire about these sorts of issues were not acceptable. So, we had to work with our

Aboriginal advisory group and pilot test some methods to be able to enquire about these issues. So we very much tried to word our enquiry in the ways that Aboriginal community women would talk about these issues to each other and we trained our research interviewers to adapt the way they talked in community to the context they were in.

So, what we have is some evidence about the extent of stressful events such as losing a family member while you are pregnant and what I would call social health issues like housing problems, and various ways of talking about family violence such as being upset by family arguments, being scared by other people's behaviour, leaving home because of a family argument were the ways we were encouraged to ask about this issue.

I will just go through those if you want me to. So over half of the women we talked to, 55 per cent, were upset by family arguments during the period of their pregnancy. Forty-three per cent had housing problems and they were quite significant housing problems. Often people were in quite transient living circumstances while pregnant and it's a major barrier to accessing antenatal care if you are moving around from one family member's house to another.

Forty-one per cent had a family member or friend pass away while they were pregnant. Thirty-one per cent were pestered for money, which is a common issue when money is scarce. Thirty-one per cent were scared by other people's behaviour and 27 per cent left home because of family arguments. There were also 22 per cent of women whose partner had drug and alcohol problems. This is the

women telling us about that. There were about nine per cent of women who disclosed drug and alcohol problems that they had themselves, thirteen per cent of women with problems with police or going to court, 16 per cent of women who were shoved, pushed or assaulted while they were pregnant.

The other thing I would say, and it is really important, is it's not just individual issues that families are experiencing. We could actually look at how commonly women were experiencing more than one of these problems, and over half were experiencing three or more of the issues I have just been talking about, and one in five were experiencing between five and 12 of those issues.

So, when you think about that, it really changes what the nature of the work is for antenatal care services, if that's the sort of picture that is the context for women when they come into pregnancy care services or early childhood services. We need a very different systems response to be able to address those kinds of issues and support families in that context.

MS DAVIDSON: Can I just perhaps turn to Professor Newman, because we have heard from you this morning about the impact of trauma for a woman while she's pregnant. The sort of figures that Associate Professor Brown has identified, are you concerned about those sorts of figures?

PROFESSOR NEWMAN: Absolutely. I think it's very, very important that we actually have a sense of just the magnitude of this problem and also, as we have just heard, it's the multiple risk factors that co-exist that's going to presumably impact on multiple levels. So these are

very concerning figures.

Putting that in the context of what we do know about the impact of stress on pregnancy in terms of the foetal development and the complications that I mentioned earlier, but particularly things like pre-term delivery, babies with growth problems, smaller head circumference, these are all indicators of a baby who's going to be vulnerable. Then we have obviously, in some of our communities that we are discussing, ongoing vulnerability and ongoing stress, adding to that stress burden for the baby.

The other I think really significant figure there is the extremely high rates of assault occurring during pregnancy, direct assaults on the pregnant woman occurring during pregnancy. We do know that attacks on women increase during pregnancy. That's probably a result of some of the psychological issues that go on for very vulnerable partners who in some ways find the woman's preoccupation with pregnancy - which is a very appropriate and normative response - difficult. They can feel excluded by that. They also in some cases recognise vulnerability in the pregnant woman. So, all those factors can contribute to this spike that we see in terms of rates of assaults on women.

So it's significant - hugely significant - in terms of both the short-term, but also the longer term impacts, particularly on the infant.

MS DAVIDSON: Associate Professor Brown, we have heard some mention this morning of a program in Mildura in the Aboriginal community called Bumps to Babes and Beyond. It was raised by Commissioner Jackomos in the context of

identifying that as a promising and good program. You have had some experience in relation to that program in its early days. Can you tell the Commission your experience and what your role was in relation to that program?

ASSOCIATE PROFESSOR BROWN: I worked with an Aboriginal researcher, Dr Sandy Campbell. This was actually an evaluation she did of the Mildura program as a part of her masters degree. She was invited by the Mildura Aboriginal Corporation to undertake an evaluation of the program in the very early days after it was established as part of the Koori Maternity Services Program. So it's really the precursor to the Bumps to Babes program.

The focus of the program at that time was on the partnership between a midwife and an Aboriginal health worker providing continuity of care to Aboriginal women in the Mildura community. They provided an outreach service, so they went out to families' homes to provide pregnancy care and certainly I was conscious that family violence was very much a context in that community at the time that those workers were needing to engage with.

The nature of the evaluation that was undertaken at that time was really to look at what women's experiences of that program were in comparison to the experiences of women, non-Aboriginal women and Aboriginal women, attending public hospitals in rural communities within Victoria at that time. What that evaluation very clearly showed was that Aboriginal women were much more positive about their care through the Koori Maternity Service Program at the Mildura Aboriginal Health Corporation, which was called the Women's Business

Service, than women in a statewide survey of Victorian women where we just looked at the experiences of women in regional and rural hospitals. So there was clear evidence right from the beginning that this was very positive from the perspective of Aboriginal women.

MS DAVIDSON: Can I perhaps move now to refugee families and the work that you have been doing in that area. You identify at paragraph 20 of your statement that a data gap effectively was identified in relation to refugee women and their experience of maternal health services. You went on to develop a research program that specifically looked at one particular group, which is Afghan communities. What did you learn from that program?

ASSOCIATE PROFESSOR BROWN: Again we designed that program to work in a very consultative way with the Afghan community and we partnered with an organisation called the Victorian Foundation for Survivors of Torture to be able to do that work. We saw that project really as a proof of concept project because we hadn't worked in this field before and we learnt a lot of things.

In relation to this issue, it's very striking the number of challenges that refugee families are experiencing in the Victorian community at the moment and the impact of past and present trauma for families is very, very apparent. Services that families were coming into contact with did not commonly enquire about the stresses on families or look at ways that they could facilitate supports for families, so the gaps in terms of the service system were very apparent in that work.

We also identified some very significant issues, bearing in mind this was the Afghan community, and it's

probably relevant in some other communities as well, about the gender of care providers. This came up in relation to the gender of medical practitioners, but also the gender of interpreters. So, for families with financial pressures the priority is often given to learning English language for the man in a couple and that then meant that men were feeling under pressure to accompany their wives to antenatal services because they felt the need to act as interpreter for their wife, but also because of concern that their wife may not be able to see a female practitioner, there were also issues for the woman and the man about the importance of her partner being present during antenatal care.

That of course means that it's very challenging for services to be able to enquire about issues such as family violence if the husband is both present and acting as an interpreter.

MS DAVIDSON: You have identified, as a consequence of that research and that experience, some things that you consider would be particularly helpful if we were to expect maternity services to also deal with the social issues of family violence. Can you explain what you think would be most helpful in that particular refugee context?

ASSOCIATE PROFESSOR BROWN: That's a very complex question. I think, just to talk to the issues about language services, it's clearly very important that we provide professional interpreting support in antenatal services and indeed when women come into hospital in labour as well, and there are a range of ways that that can occur to facilitate a female interpreter, including the use of telephone interpreting services. I think there's a lot

more that we could be doing to be doing that systematically within maternity services.

Broader than that, I think this goes back to the issue of how we see the focus of antenatal care and needing to combine the clinical care with an approach that addresses the social context of women's lives and enables services to have the systems in place and the sort of integrated service systems to support health professionals to actually enquire about family violence, and then know what they are going to do if family violence is uncovered in the course of that consultation.

MS DAVIDSON: You have identified in your witness statement a need to look at re-designing antenatal or maternity care. Perhaps can I turn to Professor Newman. You are now director of mental health services at the Royal Women's Hospital. Can you perhaps tell the Commission what your views are about this issue of the extent to which our current antenatal maternity care services are meeting the social issues for women?

PROFESSOR NEWMAN: The short answer is probably not well enough. There's variation across the State in terms of how much of that questioning is done and how it's done. It's very important, if we are going to go down the pathway which I would actually support of better identifying these sorts of issues in the antenatal setting, that we know how to ask that appropriately and that we know how better to respond.

But the current situation is that some services will have some psychosocial screening type of questions. We have also tried in various ways to have better screening across the system for things such as depression,

which often begins in the antenatal period, and there are some barriers to that in terms of how services are organised and I think it's reasonable to say a bit of resistance to actually improving that because of concerns that we don't have the appropriate referral pathways and responses mapped out.

So there are some complex issues here, but I certainly absolutely agree that orienting antenatal care and early postnatal care, and I wouldn't see them as separate in terms of this discussion, but reorienting them in terms of addressing psychosocial issues as well as we do general health care within our major hospitals is absolutely essential if we are going to be able to do proper early identification and, more importantly, that we can actually do early intervention and try and reduce risk.

We know, as we have heard, quite a lot about the pathways to poor outcomes for mothers, but also for children. We need to have a much better response system. So, in a simple way there's very little point in screening and identifying risk unless we actually do something about it. In fact, that would be absolutely - probably an unethical thing to do and there are lots of discussions about this.

There are some parts of the system that are probably in a better position to respond than others, and at one level the mental health services and women's mental health services are not adequately resourced at the current time really to respond to the numbers of high risk situations that we might uncover. That really needs to be dealt with.

But the other issue is about the quality of response and what sorts of programs should we have in place if we are going to go down this pathway of identification and screening. I would very clearly support that we do go down that pathway, but at the same time as we look at screening and better ways to do that, we need to look at response and what sorts of intervention programs we actually want.

In previous roles I have worked with New South Wales government in terms of attempting to bring in very broad psychosocial screening across New South Wales. We I think did some very important work in terms of screening which did include some questioning about current relationships and whether a woman felt safe in relationships. But the problems that we came up against in that context, maybe very similarly, were about lack of response capacity and I think if we are going to do that we need to work on those two things simultaneously. But I would be very supportive of that sort of approach. I think that would give us a very clear foundation for actually having an impact on these sorts of difficulties.

MS DAVIDSON: So you have identified that there needs to be some referral pathways, a response. Is it a matter of the maternity services asking and then we build the family violence sector some specialised response or is there also a role, in your view, for the maternity services, the health service as a whole, to be part of that response and to provide part of that response?

PROFESSOR NEWMAN: I feel very strongly that it is part of the overall health system responsibility to deal with this issue of response and these issues, as opposed to a

reaction which would be to refer people elsewhere. There are risks in doing that. One of the risks is of course not all services are going to be oriented around the needs of women and families during pregnancy or around infants and infant development and infant mental health. We can't make those assumptions.

The other risk, of course, is that people fall through the cracks if we don't have an integrated service response. So, if we tend to refer elsewhere, some people will not take up that offer or won't find themselves feeling that that's a smooth pathway. It disrupts continuity of care. We know that people, particularly vulnerable people, respond much better if we allow them to form relationships with people who can look in a holistic way at the sort of service response that they need.

So, my clear preference would be that we actually help our hospitals and clinics and community based services for pregnancy care and the early perinatal period or dealing with mothers and babies reorient around these issues and actually provide, if we can, a much more comprehensive and almost a seamless approach, if we can do it. That takes a certain amount again of cultural change, if you like. We need to have, as we have heard, and I absolutely support the point that the psychosocial care and psychological and emotional care of women needs to be as important as the physical care that goes on during pregnancy. We actually have an ideal time for early intervention and better engagement with women. They will obviously be coming into a system of care in a way that maybe they wouldn't do in other times of their life, and we know it's a high risk period.

So, for those obvious reasons it is the time, I think, to actually make sure that we can do that, but we don't then send people away, we don't want to fragment systems of care. Exactly the opposite we should be trying to do. That means we have a coordinated response, so it is not just the medical care or the nursing care, but that we can link to those other services and supports as needed in sometimes really complex family situations.

What we do need to address in the system is how we are going to involve some more I think focus particularly on partners, fathers in that situation and how we deal with sometimes quite high risk situations and work out better ways of trying to do that engagement and a focus obviously on safety as a priority when we first identify families where there really is quite high risk.

MS DAVIDSON: Associate Professor Brown, is there anything you would like to add to that, and actually particularly Professor Newman has identified the issue of fathers and this might be an opportune moment to identify some of the work that your group has been doing in relation to the mental health of fathers in the postnatal period.

ASSOCIATE PROFESSOR BROWN: Again that's a complex question, but I think it's part of what we need to do in terms of thinking about prevention of family violence alongside reducing the impact of family violence when it occurs. So I think the thing I would add really most of all would be to be thinking about the context for particularly vulnerable populations within our community and the sorts of different kinds of approaches we might need to take in that context, the need to think more broadly about workforce, multi-disciplinary teams and the involvement of

bicultural workers and Aboriginal health workers within teams.

I think to think about the way we support fathers we have to think about the fact that our health workforce in pregnancy care is predominantly female and that may not be the best way to engage fathers during pregnancy, and if we want to - or if services - how can I say this? It's complex to hold all of this, so I'm very conscious this is a very big ask of maternity services and early childhood services. So, it is about systems change and it might be about trying things out.

Part of that will be about workforce, and I was just really going towards the issue of needing to involve male health workers to be able to engage with fathers during this period and that needs to be both about supporting fathers under stress, and they are undoubtedly under stress as women can be under stress in this period, and ideally we would be taking the opportunity of the eight to 10 contacts that families have with antenatal care services and the many more contacts that families have with early childhood services as an opportunity to think about how we support families before those stresses actually escalate into family violence, as well as thinking about how we reduce the impact of family violence if it is occurring.

Just sort of to add to what you were saying, I think we need to think about training in a very thoughtful way so that it's training at all levels within organisations. Maternity service is very complex. Training needs to occur at the front of house level as well as with midwives and doctors and other professionals

within maternity services, and we need to think about that training in a way that engages with the pathway of women and families through services as well.

Often when we think about training, we drop programs in and at best it raises awareness. Actually, we need to use training as an opportunity to work on systems and engage with health professionals about how we can actually embed enquiry about family violence into routine practice and work on the systems that will need to be in place to support them to be able to be confident that, when they do that, they know what they are going to do next and the system will support them.

MS DAVIDSON: I think you have also identified in your statement the fact that maternity care doesn't just occur in public hospitals. Can you explain perhaps what the model of maternity care is and that additional layer of complexity that it adds?

ASSOCIATE PROFESSOR BROWN: Maternity care - there are many, many different models of maternity care in Victoria at the moment. Twenty years ago the majority of women in the public sector might have been receiving their care in a public hospital. Now the majority of women in the public sector are actually receiving a large proportion of their care from general practitioners and community based services, often working in combination with public hospitals. So, part of those seamless pathways and systems is actually to join up the dots between maternity hospitals and community based practitioners, so that will include general practitioners and midwives working in community based settings as well.

There are also models of maternity care now that

are trying to provide greater continuity of care. So within our public hospitals and sometimes outside of them as well there are midwifery group practice models of care where women are seeing the same midwife or group of midwives for care during pregnancy and also during labour and that kind of approach obviously generates more opportunities for relationships to be built between women and their caregivers which would likely be conducive to families feeling confident enough to bring up the sorts of stresses that they are under. I'm thinking there both of women and men in that context.

MS DAVIDSON: This is sounding like a very big task and I'm sure the Commissioners are wondering about the enormity of that task. Do either of you see anywhere a natural starting point for that task?

PROFESSOR NEWMAN: Some of it is needing really to have, if we are talking about big systemic reform and structural reform, is to actually have a planning process around that, which we don't even have at the moment. So that in a simple way I think means having at a Department of Health level an actual process for calling experts together to have a bit of a discussion around some of these issues and how we might actually develop a strategy to actually look at the reform process. That's been the sort of processes I have been involved in in the past.

But I think the planning is essential. The thing not to do, in my view, would be to have a bit of an ad hoc, "Well, let's do a bit of screening identification" and not know what to do with that. We need an actual process for thinking about what do we want to identify, how do we want to do things better, who needs to be

involved, and look very broadly at some of the issues around training, around how we actually engender that sort of change within systems which, as we all know, can sometimes get rather stuck in a traditional way of doing things.

The benefit at the moment is that we do have goodwill and I think raising awareness of these sorts of issues has been very important, but we would like to take it, I think, the next step forward. I think the key early steps might be to actually look at what sort of outcomes we want in the short-term, how we are going to evaluate those and looking at this issue of identification and planning and mapping of referral pathways. That needs to happen obviously at a senior level within the department, but also within hospital structures. That I would see as the first step.

Concurrently with that, though, my personal feeling is that we need to look at supports and interventions and what that actually means in terms of what sort of staff do we need, what skills do we need, but also what sorts of models of programs do we want for some of these very vulnerable families that we identify. But we should be actually reviewing what is the best practice and what's the evidence base around these sorts of interventions. There certainly are some of these interventions going on at the moment in my setting and also others that I'm aware of. Really, the time has come to look very critically at what we do know about interventions for vulnerable families and to look in a much clearer way at what benefits we actually get.

MS DAVIDSON: Is there anything that you wish to add to that,

Associate Professor Brown?

ASSOCIATE PROFESSOR BROWN: I think I agree with all of those comments wholeheartedly. I would add to that that there is wisdom in health services and our early childhood services around this issue, and I think working to engage the services in how to actually approach tackling this issue from a systems perspective is very important, and involving communities and diverse communities in Victoria in that discussion and really pooling our wisdom about how we go forward is also important.

So, it will need to happen at a meta level, at a health department, statewide kind of level, but it will also need to happen at a regional and service level and in the context of particular communities that are accessing those services.

PROFESSOR NEWMAN: Could I just briefly add to that.

I absolutely agree, and I think at the hospital and health service level we need to have - and the Women's Hospital has actually done this - a priority given to family violence and to prevention. So the Women's Hospital as an example has a strategic policy around identification and prevention as a beginning, and we are obviously engaging in those processes of better identification. We have been running out staff across the organisation, training, awareness raising type of training and about family violence and its impacts, and for clinicians there's more focused training on actually recognising vulnerable women in particular who may have been experiencing violence and how to approach that.

For an organisational response, I think that's something that could be a model that we could look at in a

broader sense across the system, but it does need to happen at both those levels, at a government level but also at an organisational level.

MS DAVIDSON: I'm just going to touch on one more topic and that is the question of the handover and the relationship between the maternity kind of care services and the maternal and child health system. Associate Professor Brown, you had some comments in your statement about that process and the way that things could potentially be improved. Can you comment on that for the Commission?

ASSOCIATE PROFESSOR BROWN: This would be anecdotal and I would be interested in your comments on this too. We know from our research that it is very challenging for maternity services to know actually how to hand over information to early childhood services because there really aren't the systems in place to facilitate that kind of communication. So it's not the sort of issue that you can actually simply put on a discharge summary, which is actually how information is transferred at the moment.

So that's a very good example of something that needs a systems approach that would facilitate transfer of that information, probably by a phone conversation or direct handover involving the maternity service actually having a meeting with the maternal and child health nurse with the family.

MS DAVIDSON: Professor Newman, do you have any comments in relation to that issue?

PROFESSOR NEWMAN: Yes, I agree it's a broad systems problem. In my setting we have been trying as much as possible, where there are these sort of complex issues, calling people together, having actual verbal discussions around

care planning where there are these risk factors and that might involve - social work department are often involved, child protection, a general practitioner who we are handing over information to, maternal child health nurse, mental health service as, well as whoever else has been involved within the hospital. So it's quite a complex system.

The risk is of course it gets very fragmented. But I think that handover - and it is obviously sensitive information and as much as possible we will obviously involve family members in those discussions as well. There are other community based supports and services that do need appropriate handover as well, such as family support services and so on. So, it is very, very complex.

MS DAVIDSON: I will perhaps give the Commissioners an opportunity to ask any questions that they have of you.

DEPUTY COMMISSIONER NICHOLSON: Perhaps to both witnesses. You pointed to the importance of trying to engage fathers during the pregnancy. Can you point to any programs that are successfully doing this?

ASSOCIATE PROFESSOR BROWN: I can. They are not in Victoria. So in Queensland there's a program run by the Apunipima Health Service for Aboriginal communities where they have been using a vehicle for engaging women and men in pregnancy and the postnatal period, which is the giving of a gift. So they give a mother and baby bundle to the family at eight different points, three in pregnancy and five of them after the baby is born. The giving of a gift is culturally very appropriate in those communities and it has been engaging the dads in coming in during the pregnancy visits and it has been being used as a vehicle

for improving health literacy and just engaging the families in what is happening as they are travelling through pregnancy and the postnatal period. It has increased immunisation rates, for example, and definitely increased the awareness of the dads about what's going on in the course of pregnancy. It hasn't yet tackled those broader issues about the sort of social circumstances of families in a broader kind of way that might support men's health and wellbeing during pregnancy.

The only other programs that I'm aware of are programs that have recently lost their funding from the Federal Government which were the Strong Fathers initiatives that were funded about three years ago. But they predominantly operated in the period after the child was born and were very much targeting places where men go to do things together and taking a strengths based approach to what it is to be a father and supporting men to share with each other what that experience is like and providing men with strong male role models for being a good father.

PROFESSOR NEWMAN: Just to add, at the Royal Women's Hospital there are a couple of programs running for fathers of new babies in high stress situations where a baby might have a health problem or have been in the nursery or there are other physical difficulties. That's been a group program that's been running through the Centre for Women's Mental Health.

The other programs that I'm aware of are being researched at the moment. There's a project that I'm involved in that I believe Dr Richard Fletcher who will be here tomorrow will be able to discuss that, but we are

undertaking research looking at helping fathers access information and support if they are feeling stressed or are having mental health difficulties using a smart phone app. The technology is beyond me, but apparently it is popular and accessible and we are developing that at the moment. I think that potentially improves access for some men in a way that might be more acceptable and easier for them.

DEPUTY COMMISSIONER FAULKNER: I would like to ask either witness to comment on I think the suggestion that was made about needing a statewide service plan for maternity services involving people experiencing domestic or family violence. It seems like an enormous thing to do, to do that statewide plan, and I understand the reasons why you have suggested it. Can I also understand the extent to which there may be smaller steps that can be taken.

For example, is there a standard at the moment about the maternity services that exist in hospitals about a person who may be homeless experiencing family violence and whether they may be discharged? I have heard of a concept of keeping someone in for a social admission. Are there policies that actually could be set in place by hospitals themselves at the moment to deal with this without statewide planning? Could it go to the location of antenatal services? Should they be in hospitals or should they be run by child and maternity health services?

I just wonder are there some smaller steps. I understand the need for the big step and I don't believe that we can do just small steps, as you have suggested. But is there some practical short-term sort of things that could be done immediately?

PROFESSOR NEWMAN: My response to that would be that it's clearly such a complex issue and probably both things need to happen simultaneously. My view is that there's clearly a need for overall strategic planning if we are going to have systemic reform in the way that we have been talking about.

However, I think it is very important that we look at some of the immediate needs and what can be brought in within the existing system, such as they are. Pregnancy care occurs in a variety of settings. There are some things that obviously we can help with in terms of, let's say, general practitioners and some of the share care arrangements that go on between a hospital and a GP in terms of helping them be better informed and respond to some of these risk factors. My unit does some training around those issues for general practitioners at the moment. I think those sorts of things are very important.

The hospitals already have so-called extended stay, so the vast majority of women that I see and treat are offered that extended stay for various risk factors or mental health issues. That is a helpful thing to do. I think at a hospital level it would be good to actually better articulate the indications for that, and if we made it clearer to all staff at all levels that these sorts of risk factors, particularly if we have concerns about the safety of the environment that a woman is going back to, are very clear indicators for offering other supports, including extended stay. So that's existing, but maybe could be clearer.

The issue of whether, as you raise, antenatal pregnancy care should be in hospitals or the community, it

is fairly varied anyway, but a lot of women, particularly those who might have other health factors or risk factors, will be referred into the major teaching hospitals, the larger hospitals by definition, because it's felt that the range of services there might be better for them.

The point I would make is that we could actually within that system do better in-service internal education and awareness raising about the issues, so rolling out some of the training for staff and awareness raising for staff might be very helpful. But as much as possible it is about integration, I think, between the hospital system with community services and all the other service components and at that level that's where I think a statewide planning process comes in.

There have been some very good initiatives that have happened in Victoria around these sorts of issues with some of the funding that we've previously had from the Commonwealth around perinatal, pregnancy and infant mental health care. We have had regional workers in some of the rural and regional areas with training in these sorts of issues. That was a system that was beginning, I believe, to have some impact and could potentially have had a major role. That funding is no longer available.

But there are some issues that need to be tackled I think at an overall State level. What we do need, though, is also simultaneously a buy-in from the hospitals and the services on the ground about how they will respond to these issues. So there might be variation, it might be that different areas will have different approaches or different capacities, but still important for them internally, I think, to have a planning process around

recognising the importance of these issues and how does their system feel that they can better respond to it.

DEPUTY COMMISSIONER FAULKNER: So the dominant reason for having antenatal care in the health service itself, in the hospital more specifically, is really around biomedical care as opposed to psychosocial care.

PROFESSOR NEWMAN: It should be doing both. It should be doing both. I think in the current health system as we have organised at the moment people do have some flexibility. If they have a general practitioner who does work in pregnancy care, then they are able to do that. But we have, I guess, people with more complex medical needs or other risk factors who would be advised to come to some of the more specialist clinics in the hospital, but we also have, and we need, programs and clinics which are for well women which should be - the issues are more about making sure we have continuity of care, midwife-led care systems, so that people can actually come to the clinic, be seen by people who will follow them through their pregnancy, form a better relationship with them, so those sorts of primary care midwifery programs which exist in some hospitals, but not all, I think would go a long way in better engagement with women and families and better identification of risk. So that's about continuity of care.

DEPUTY COMMISSIONER FAULKNER: I think what I'm hearing, and this is what I need clarification on, is that there are very, very serious implications for children's and mothers' health by not getting correct psychosocial care, yet the hospitals are not oriented to giving that sort of care at the moment and sort of the ethical dilemma of that is quite complex, I think. It could be that some of those

psychosocial conditions are creating more harm than some of the biomedical ones are. Do you want to comment on that?

PROFESSOR NEWMAN: Yes. I would essentially agree, but some hospitals are doing that much better than others. There is variation across the system which is a problem. Sometimes it's luck, geography as to which hospital or health service you might attend. Some hospitals are much better oriented around the psychosocial issues than others. I think what we need across the system is a consistent model.

DEPUTY COMMISSIONER FAULKNER: Thank you.

ASSOCIATE PROFESSOR BROWN: If I could just add to that. I think there is variation across hospitals and different models of care, but our research - and some of this is a little bit out of date. So a study we did in 2008 in Victoria, which was a statewide population based sample of women that were sent a postal questionnaire when their babies were about five to six months old and filled in questions about their care, that did indicate to us that at that time there was more enquiry about family violence in some models of care than in others. But the general level of enquiry was very low and the differences between the different models of care were actually very small.

I think it will be very apparent, I suspect, to the Commission that there is lots of effort going into supporting families when problems are identified and some of those families might be at the very extreme end. From our research I suspect that there are many more families that are slipping through the gaps and there may be different sorts of reasons for that. Some women may be

seeking not to disclose what's happening to them for different sorts of reasons.

If we are going to get better at this, then I would wholeheartedly agree we need a much stronger systems approach. I think it is about recognising that the risk to mothers and children is grave and it's at least as significant as the risk from rare medical complications in pregnancy that we are actually very good at identifying and treating. Our standards are excellent. I think we need to get to the point where our standards are excellent for the grave risk to mothers and children posed by family violence.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: Thank you. That would complete the evidence of both Professor Newman and Associate Professor Brown. May they be excused?

COMMISSIONER NEAVE: Thank you very much.

<(THE WITNESS WITHDREW)

MS DAVIDSON: The next witness for the Commission is Ailsa Carr.

<VICTORIA AILSA CARR, affirmed and examined:

MS DAVIDSON: Ms Carr, you have previously made a statement in this Commission?

MS CARR: Yes.

MS DAVIDSON: Have you had an opportunity to read your statement recently?

MS CARR: I have.

MS DAVIDSON: Are you able to confirm that it's true and correct to the best of your knowledge and belief?

MS CARR: It is.

MS DAVIDSON: You are going to be coming back before the

Commission on another day. Your witness statement broadly covers two issues. One is the challenges that are faced in rural and regional areas and how you have managed to develop an integrated services model in your area. The second issue that your statement deals with is a program that you have developed called the 0-2 Program. Can I first get you to tell the Commission what your position is and a little bit about your organisation.

MS CARR: I'm executive manager of Family, Youth and Children's Services unit at Gippsland Lakes Community Health. Gippsland Lakes Community Health is a regional community health service that covers a large area. We predominantly provide our services to the East Gippsland community, which is 21,000 square kilometres and has some larger centres, but also a large number of very small rural, isolated and remote communities.

The unit I particularly manage is one that provides a range of services for clients covering things such as integrated family services, Child FIRST, alcohol and drug counselling, homelessness programs, youth programs. We have the Maternal and Child Health Nursing Program in that unit and also our family violence services, including outreach counselling and our men's behaviour change program.

I guess over a number of years we have worked to create an integrated model across those services that helps provide a better experience for the client with a more streamlined entry process, a comprehensive assessment and then a case management approach, particularly for those clients who are accessing multiple services.

MS DAVIDSON: When you are talking about multiple services, you

are talking about not just family violence services but a range of health services generally?

MS CARR: Yes. So, it could be family violence. For a large number of the clients we would say it would be a combination of family violence counselling, drug and alcohol issues or involvement with the child protection system and Child FIRST. We also try and utilise the same approach in working with external agencies and use a case management type approach so that we can provide a coordinated multi-disciplinary response. So that would be with our partners such as our local Aboriginal controlled organisation and with the hospital and other key services in the area.

MS DAVIDSON: You have also worked as a maternal and child health nurse. How many years have you done that for?

MS CARR: I originally trained as a maternal and child health nurse in the mid-80s, so I spent a number of years working in Melbourne and then I guess I have had a number of positions that have been focused on working in the community, and then I returned to maternal and child health nursing in the late 90s and originally in our current organisation worked as a maternal and child health nurse before I moved up to the position I now have.

MS DAVIDSON: The Maternal and Child Health Nurse Program has broadly speaking two aspects to it. One is the universal program and the other is the Enhanced Home Visiting Program. Can you perhaps just describe to the Commission that model and what each of those programs actually provides or can provide?

MS CARR: The universal program is as I guess it is defined; it is a universal program. It is offered to everybody, to

nurses, solicitors, doctors. Anyone who has a birth in Victoria, the universal maternal and child health nursing service receives a birth notification and through that program there are 10 key ages and stage assessments that are conducted throughout the early years of that child's life, from when they are first returned home through until the child has its three and a half year old check in preparation for kindergarten and then moving on to school. The universal program usually operates through a clinic based system in that clients will predominantly usually come in to see the maternal and child health nurse, particularly after the first home visit.

The Enhanced Home Visiting Program was developed I guess to provide an early intervention approach to those families that were having more difficulties and were struggling with being new parents or second time parents and requiring some additional support, and the idea was to provide that support as an in-home service. So the Maternal and Child Health Nursing Program is provided with funding to provide both of those programs.

MS DAVIDSON: Does the Enhanced Home Visiting Program also seek to provide a service to families who might find the universal program a bit more difficult to engage with or have particular barriers in terms of accessing that service or are particularly difficult to engage from the service's perspective?

MS CARR: For families where they might be struggling to come into a clinic or if there is a range of other issues, if there are health problems for the mum, yes, the idea of the enhanced home visiting service was to provide a more flexible response than the traditional standard universal

service, but to be able to provide that in a way that would better meet the family's needs but also to be able to conduct the key ages and stages that are traditionally done in the universal service, but in a more flexible environment. Some enhanced home visiting services, ours included, will operate from kindergartens as well as doing home visits and we operate from our Aboriginal controlled health organisation and one of the Aboriginal controlled child-care centres.

MS DAVIDSON: Your statement deals with what you call the 0-2 Program that you have established in your area. Can you identify why you established that program?

MS CARR: Back in the early 2000s, as a group of staff and as a unit we were being exposed to a lot of the evidence that's been talked about here around the impact of stressors on the early years and the impact of that and the long-term consequences of that for both the mother and the child in respects of their development. So we attended a number of conferences and workshops, international speakers had been brought out, and I guess there was a feeling that it was an area that we really wanted to look at, could we do something a little bit differently from what we had currently been offering, given what the evidence was saying.

On top of that, one of our programs, our integrated family services program, was indicating that in the East Gippsland area we had significant numbers of children under the age of three who were being reported to child protection and clearly reports to child protection were suggesting that those families were not having the types of experiences that the evidence was suggesting that

the children should have to have a better trajectory.

So what we did was we pulled together a group of key stakeholders, which included our local GP who does most of our deliveries in the area. We had the hospital represented. We had Child Protection, our local Aboriginal controlled organisation, ourselves, and we spent six months, I guess, researching the evidence around the early years, around the importance of the first three years of life.

We had a look at a range of programs and a range of models and ways that are proposed as evidence based ways in working with clients who are experiencing stressors such as those as the nurse partnership model in America, but also Professor Hilton Davis's family partnership model. We looked at all of that evidence, but most importantly we actually looked at the context of where we were in Bairnsdale and in East Gippsland and we looked at the service system that we had there, because I think what was very important for us was we didn't have additional funding. So it wasn't that we'd suddenly received money to do anything; it was just that we felt as a service that this was an area we needed to look at.

So it was about whatever we developed needed to be able to fit within the context of the area that we were operating in. Out of that, after six months of us working together as a working group, we came up with what we have called the 0-2 Program.

MS DAVIDSON: Who does that program target or who are you trying to aim that program at?

MS CARR: It is targeting an early intervention approach, so it's really targeting those families, women in families

antenatally during their pregnancy who are identified as having broad stressors that might potentially be impacting on themselves, their pregnancy or be suggesting that they are at an increased risk of having Child Protection involvement post delivery.

The idea about making - I suppose we wanted - what am I trying to say? We wanted to make it so that it wasn't too specific in that we didn't want to be screening people out. We actually were suggesting that we would rather screen people in initially, and then undertake working with that family to see what level of support they actually needed.

MS DAVIDSON: Your statement identifies that the first component in the program is the use of a screening tool. Before we get on to the screening tool that you have used for the 0-2 Program, can you perhaps explain generally the approaches between the hospital or the antenatal service provider and maternal and child health and how ordinarily would those two systems connect?

MS CARR: Because we are in a rural area and we only have one hospital, the Maternal and Child Health Nursing Program would normally visit the hospital twice a week. They would normally actually pick up the birth notifications from the hospital rather than having them sent to them. They would have a handover from the midwives at the hospital around any of the cases, particularly if there were any they were particularly worried about, not even necessarily about psychosocial issues, but if there had been problems with breastfeeding or any problems around the health of the mother or during delivery. If the mother was still in the hospital, then the maternal and

child health nurse would make first contact with the mother while they were in hospital and book the first home visit.

MS DAVIDSON: How does that compare to what you would have done when you practised in this area in Melbourne?

MS CARR: Very differently. I guess in Melbourne, when I practised in Melbourne, I practised in outer-east. I had a number of hospitals that I would have received birth notifications from. So really - and we are going back to the 80s - I would have worked fairly much in isolation, and I know that's not always the practice now in Melbourne in maternal and child health nursing. But I would have worked fairly much as a sole practitioner in a building that wasn't necessarily attached to anything else and I would have received birth notifications from the hospital and my first contact with the mother would be to have given her a call and introduced myself as her maternal and child health nurse and asked if I could come and visit, with very little information.

I mean, back in the mid-80s we didn't even get much in the way of discharge summaries or there wasn't even much in respect of any information around the birth or breastfeeding or any of those sorts of things. I would have had no information about the mother's home situation or anything like that.

MS DAVIDSON: In relation to the 0-2 Program, you have developed a screening tool for the use by the antenatal service provider. Can you describe how you developed that screening tool and how it works?

MS CARR: So, as part of the initial six months we looked at were there indicators antenatally that we could use to

help us identify - to screen in, I guess as I said before, and there are large numbers of tools. I think the key thing that came out of our work in the antenatal period was we did want it to screen in. We wanted it to be really simple and easy to use, so it is a single page, it has half a dozen elements, and it needed to be done within a couple of minutes, because the idea was that that wasn't the primary area where we were looking to identify the needs of the client. It was really about purely looking to screen in those clients that might need any sort of additional support.

Because we were asking GPs to use it and we were wanting the hospital to use it at their book-in visit, preferably, as early as possible in the antenatal period before they might have even developed or engaged any sort of relationship with the mother, we needed to keep it really simple and straightforward.

We also wanted it to be simple and straightforward so that the mums who were being asked these questions, it wasn't too onerous and that it was relatively simple for them to understand, and then understand that they were actually being referred to a universal program that a large number of people receive and that this was really just about giving them an opportunity to explore any of the difficulties they had and see if there were any additional supports they needed.

So the key was to keep it simple and to make certain that we were clear about the referral process and then what would happen once that referral came through to us.

MS DAVIDSON: So what does happen once that referral comes

through to you?

MS CARR: The 0-2 Program I guess I should state is located within our Maternal and Child Health Nursing Program. Obviously we have been talking about that. It's predominantly, I guess, been a refocusing and redirecting of what was our Enhanced Home Visiting Program to work in this particular way. So the referrals come through to the maternal and child health nurse. The maternal and child health nurse will often make contact with the nurse who's made the referral and have a conversation about what's contained in the referral. They will then make contact with the family and organise to do a home visit.

I guess from there it's really about, as I said, we work on a partnership model, so it's about developing a relationship with that woman and her partner. It's about establishing a rapport with her, developing a trustful relationship and then through that process conducting a more comprehensive assessment around what the client's needs are, and then based on that assessment either linking them into other programs or, if it's things that the maternal and child health nurse can address, then the maternal and child health nurse would look at working with that woman to address the issues that are being raised.

MS DAVIDSON: Your statement identifies the second component of the program being a Young Pregnant and Parenting Group. Can you describe that part of the program?

MS CARR: The Young Pregnant and Parenting Group was developed as an adjunct to the program because in our area we also identified that 10 per cent of our births were to mothers under the age of 21 and that they have additional specific needs around their support. So they receive the intensive

home visiting, if they require that, but they are also linked into I guess what is really a supported play group type of approach that's facilitated by two facilitators who, as well as supporting the development of that group and the group relationships, also work with each of the mums, particularly to look at what are their goals, where they would like to see themselves and it has been particularly around developing plans to help them gain or go back to education, training, look at how they might want to move on.

We have had women - well, very young women in that group of 15 and 16 where their high school education has been interrupted, so it was felt it was really important to try and support those young women to have aspirations about where they might want to see themselves and part of that group is around supporting them to do that.

MS DAVIDSON: So does that mean linking them into services beyond those within your community health centre?

MS CARR: Certainly. We have developed really strong partnerships with our local TAFE. We have developed strong partnerships with the schools. We have supported some young women to access child-care and go back and complete year 12. We have supported them to go and do Certificates III and IV in TAFE. We have also developed strong relationships with other agencies that provide support around entry into employment and those sorts of things.

MS DAVIDSON: The third component is the intensive home visiting. Can you describe that program?

MS CARR: That's conducted by maternal and child health nurses.

They are a particular type of maternal and child health nurse. I shouldn't say "a particular type". That's not right. I guess what I'm saying is it wouldn't be every maternal and child health nurse's cup of tea, if I can put it that way, to work in this sort of approach. So it does require a certain set of - I would actually say qualities and skills in the professionals that we have in this program and they are particularly professionals that are really interested in working from their maternal and child health nursing framework, but also adding to that a strong interest in the psychosocial components, the impacts of stressors on families.

So, the nurses I have working in that program have done large amounts of professional development and further education, not just around things like Professor Hilton Davis's family partnership model around how we work with people, but also around understanding family violence, the gendered nature of family violence, about understanding drug and alcohol, the frameworks used in drug and alcohol. So they have also spent a considerable amount of time developing their skills, particularly in the area of perinatal mental health and the impact of that on the newborn.

So they are a highly skilled group of staff that use a framework that is about understanding mothers and babies, but that has had a range of skills added to that that then allows them to go in and develop strong relationships and trusting relationships with the clients that they are working with. That assists them to be able to support those families to access the supports that they need. Sometimes the families that we get referred might

only need a short amount of support; some families have needed quite extensive support.

MS DAVIDSON: Has there been any ability to conduct a formal evaluation of the program?

MS CARR: We did conduct our own evaluation - I wouldn't call it - I'm reluctant to say "formal", because my view of a formal evaluation would have been to have had an independent body do that. Because we basically developed this program out of what was already on the ground and because we have limited resources, it's really difficult to actually formally, how I would define formally, evaluate something like this.

We did conduct an evaluation after the program had been running for 18 months and we felt that there were some really strong indicators of the program achieving some significant outcomes. But I have to say since the program was established in 2004 we have also seen the program grow and develop in a range of ways, particularly around the level of complexity that we are seeing being referred to it and attempts at early intervention and that, but also around the impact on mothers in the early stages around depression and anxiety and the incidence we are seeing of that.

MS DAVIDSON: So in terms of your more informal evaluation, how do you see the program working in terms of its outcomes?

MS CARR: We've had positive client feedback in respect of the approach taken. The feedback from clients has been that they have felt that it being located within a universal service has meant there was no stigma attached to being actually referred to that program. We have also had examples where cases have initially been referred with not

appearing to have very complex issues occurring, but once the nurse has developed that trust and that relationship other things have come to light that have then been able to be supported.

I don't know whether it would be useful, but I have a recent example that might be an example of I guess how I have seen this program work for a range of clients. We had a young professional woman who was referred to the program antenatally. It was her first pregnancy. She was in a de facto relationship.

MS DAVIDSON: I will just stop you there, just to make sure that you are not giving away any sort of identifying details.

MS CARR: No, I certainly will make every effort. She was referred because basically what she had identified on the screening tool was that she felt socially isolated. Over the period of the first few months that the nurse was engaged, she was able to develop a really strong relationship with that young woman and what came out of that was that she was living in an abusive relationship. She was utilising ice and marijuana on a quite regular basis. She had great aspirations for wanting to be a really good mother to her child. She wanted to breastfeed. She didn't want to be using substances and she didn't want to be in the relationship that she was in.

The nurse was able to work with that mum to develop further trust and as part of that we were able to get her to accept a referral to drug and alcohol counselling. She initially didn't want to do that because that was provided through our agency and she was known to our agency in her professional capacity. So through the

Maternal and Child Health Nursing Program we were able to have her seen at a separate site where she was less known. We had the drug and alcohol appointments not made as drug and alcohol appointments, they were made as maternal and child health nursing appointments, and so she came in in effect to see the maternal and child health nurse, but while she was in, the drug and alcohol counsellor also worked with her.

We are some 12, 18 months down the track now. That mother was able to breastfeed. She was able to, with the support of the drug and alcohol program, stop using her ice. She has continued to use some cannabis, but that's reduced and as part of working with the drug and alcohol team and with the maternal and child health nurse that's being done in a way to minimise as much as possible the impact on her young child. She was able to be linked into our family violence outreach program and receive support when she felt ready to move out of her relationship and into a new home. I guess that epitomises what I would say is an example of some of the work that the 0-2 Program has done.

MS DAVIDSON: It stops at two. What happens beyond two?

MS CARR: Because we are using it within current resources and because we screen in, as I keep saying, we have seen the demand for the program increase. When we first started we had re-aligned 0.6 of an EFT of our Enhanced Home Visiting Program. We now have about two full-time EFT staff working on this program because of the number of referrals that we receive. It's just not within our capacity to be able to continue the program longer than two.

We also work from a strength based approach, so

it's about for those families, wherever possible, what we are wanting to do is get them to a place where they don't need the program, obviously. So for significant numbers of the families this works, but obviously there are some families that would benefit from a more extended support.

MS DAVIDSON: Is that support available elsewhere?

MS CARR: We have our Integrated Family Services Program, but I guess that program is really, because of the nature of the demand on that program too, is really very much targeted to high-risk families where we have predominantly significant risk of Child Protection or Child Protection involvement. So I guess there really isn't scope, certainly where we are, for longer term support for those families that don't reach that level of threshold of risk.

MS DAVIDSON: Just finally, in relation to the program, to what extent does it involve fathers?

MS CARR: Mixed. Where the fathers are at home, and a reasonable number of the families that we see the fathers aren't working, they will be at home, the nurse will work to engage with the fathers and to have them as part of the assessment and the planning and working around their issues. Certainly we will work with the mother independently, the father independently, them together where we need to to support them to address what's happening for them, keeping in mind a number of the things that have been raised particularly around family violence and risk.

But obviously for a proportion of the families we have limited contact with the fathers, and all of our nurses are female. So there are challenges around engaging fathers in the program. We are currently looking

at how we might do that differently, and we are looking this year to trial a program that will be run after hours and it will be run and facilitated by some of our male workers in the organisation. So we have male workers in our Integrated Family Services Program and in our drug and alcohol program and our family violence program. We have a really highly experienced and someone who's very supportive of our program, a male child psychologist, in the town. We are very fortunate in that regard. They have agreed to be part of trying to bring together men in a group forum to have discussions around what might be issues for men as being new parents in this. We are going to trial that over the next 12 months and see whether that helps us engage the fathers in our work better.

MS DAVIDSON: That completes my questioning. Commissioners, have you got any questions for Ms Carr?

DEPUTY COMMISSIONER NICHOLSON: Yes, Ms Carr. These initiatives undertaken without additional funding, did you have to stop doing something to undertake these?

MS CARR: No, I just worked longer hours.

DEPUTY COMMISSIONER NICHOLSON: Limited funds are - - -

MS CARR: There are. No, we have basically completely redirected our Enhanced Home Visiting Program to operate predominantly under the 0-2 Program. I guess - I'm trying to think.

DEPUTY COMMISSIONER NICHOLSON: And there is nothing within the funding guidelines from government to prevent you doing that?

MS CARR: No. My sense would be - my experience of previously having worked in maternal and child health nursing would have been that the Enhanced Home Visiting Programs

probably wouldn't have been working with the level of complexity and risk that we are currently working with in the 0-2 Program. It would have been more around supporting women with breastfeeding issues. But I wouldn't like to think that those women are now missing out because I would still see us as supporting that.

So we have really, I guess, tried to be creative in looking at what were the aims of the program and how could we better respond to what the needs were in our area using those programs, would be what I would say.

COMMISSIONER NEAVE: I would like to probe that a little more. It's sometimes said that the program specifications prevent that because the programs require - and I'm not going to get the terminology right - very specific inputs or outputs. You haven't found that in the case of the Enhanced Home Visiting Program?

MS CARR: No, not in the case of that program. I would totally agree with you. In a number of the other things that we have done in respect of integration it is actually very complicated because you have buckets of money that you have very defined reporting guidelines around. I guess, the Maternal and Child Health Nursing Enhanced Home Visiting Program is about early intervention and a home visiting program for families that are struggling. I suppose what we have done is we have added the antenatal component which is allowed in that program, but I would suggest probably isn't used very often. That would be my experience certainly.

I guess because of the nature of the screening and because of the skill level that we have developed in the nurses and I would also say their exposure to a range

of other programs what we are finding is they are working with larger numbers of probably more complex families than what would normally be seen in that program. So they do see significant levels of families where there are family violence and where there is drug and alcohol issues, mental health issues and I think that's because of the range of programs that we have.

But because it's a fairly broad program it's allowed us to do that. We report everything we do in the 0-2 Program up through our current reporting for enhanced home visiting. So that's been fortunate in that way.

DEPUTY COMMISSIONER NICHOLSON: Just one other thing. I took particular note of what you said about your Young Pregnant and Parenting Group, and the emphasis on engaging these young mums in education and training. That doesn't always happen and often it's hard to get practitioners to think more broadly about the wellbeing and prospects of their clients. Did you encounter any particular challenges in getting that particular orientation to your young parenting group?

MS CARR: I think because across both the Enhanced Home Visiting and the Young Pregnant we have worked from a premise of really trying to work in partnership with the clients. Really it's been about where is the client at, what is the client seeing as their issues. So the move to a stronger focus on education and workforce participation actually came from the participants themselves. It came from our evaluations that we did that the young women were saying that they had aspirations. When we talked to them about where they saw themselves in five years times they had aspirations of where they wanted to be that was, yes,

being a really good parent but also having other things in their life.

So because the focus has been very much client centred it was therefore quite easy to get the facilitators to then see that as a really important focus for the program. Because the facilitators aren't maternal and child health nurses, so they don't do the maternal and child health nursing, the maternal and child health nursing, the ages and stages, that support is still provided through the Maternal and Child Health Nursing Program, that's allowed them to be more flexible in what they can support the young mums to do.

I have to say that program continues to be a challenge to keep running, mainly because we don't have funding for it. It is a program that we established with a bit of pilot funding to begin with, and for the last 12 years we have cobbled money together every year to keep it going because we have seen it as really valuable. So we have had submissions that have gone into the Communities for Children. We have had funding from Healthy Mothers, Healthy Babes. So every year we go through this process or every couple of years of trying to identify money to keep that program going because the feedback from the participants and also the outcomes we have seen for some of the young women in achieving their year 12 and in getting part-time work and in achieving their goals has been so significant.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

COMMISSIONER NEAVE: No further questions.

MS DAVIDSON: Thank you. May Ms Carr be excused?

COMMISSIONER NEAVE: Yes, thank you very much, Ms Carr.

<(THE WITNESS WITHDREW)
MS DAVIDSON: The final witness this afternoon is Anita Morris.
<ANITA MORRIS, affirmed and examined:
MS DAVIDSON: Ms Morris, you have made a statement for the Commission. Have you had an opportunity to read that again recently?
MS MORRIS: Yes.
MS DAVIDSON: Are you able to confirm that that's true and correct to the best of your knowledge and belief?
MS MORRIS: Yes, it is.
MS DAVIDSON: I understand you have been able to be here for most of the day, and you have heard the evidence of Robyn Miller and Professor Newman. I understand that you would like to add something to the issue of the impact of family violence on children's development.
MS MORRIS: I was interested, and thank you for the opportunity to do that, in I suppose expanding the understanding of long-term effects on health outcomes, and that relates to my work in health settings where there's been back in the mid-90s a large American study that looked at adverse childhood experiences, sampled over 17,000 adults and looked at their long-term health outcomes in relation to the number of adverse childhood experiences they had had. So in fact they were able to look at if you had, for example, four adverse childhood experiences that was increasing your risk of longer term health outcomes and decreased mortality as a result of these experiences. So, for example, a person with four adverse childhood experiences versus one would have 12 times greater likelihood of suicide in their lifetime. They would have much more risk of things like lung cancer and autoimmune

diseases, and chronic pulmonary airways disease and a range of health issues that I suppose previously we hadn't been able to make those links. So I guess I just wanted to contribute to that health conversation.

MS DAVIDSON: Thank you. Your statement in particular deals with a study that you have undertaken where you have actually spoken with children to understand what their experiences are. You have described that in your witness statement. Can you perhaps just identify what you consider to be the key finding or the general sort of key finding from that study that you have undertaken?

MS MORRIS: Just a little bit of background. I was looking at children's safety and resilience in the context of family violence. The findings were that children end up having to negotiate their safety in these relationships both in the relationships with the violent parent but also in other relationships that they have as children and as young adults. To do that they actually require a voice and they require that their needs be heard. So as adults we need to give them opportunities to do that and to help them negotiate their safety when they are not able to for themselves.

MS DAVIDSON: In relation to the children that you spoke with had they been given that voice?

MS MORRIS: Not necessarily. I interviewed their mothers as well, and over half the mothers reported that there had been some involvement with police along the way in relation to violent incidents. So, as a result of that, children perhaps had involvement with emergency services, with the Family Court processes, with Child Protection services. But in those settings I would have to say that

it wasn't necessarily the case that children's needs had been understood and that their voices had been heard, even though they may - they may not have had any involvement in those processes, but they may have had some. But I don't believe at the time that they were given opportunities to really have a say.

MS DAVIDSON: Your witness statement deals with the implications for practice that need to ensure that children have a voice. Can I take you first to the question of early identification and intervention. In your research to what extent did children reveal their knowledge of what was happening in the relationship?

MS MORRIS: Of 23 children, nine spoke quite openly about the family violence. I have to say that I wasn't asking them directly about family violence; I was asking them about safety in terms of interpersonal safety in both their family and other social circumstances. Some children spoke of something being just not quite right within the home, within the parental relationship. Some children didn't talk about the violence at all, however their older siblings did when they spoke with me.

I also have to point out that mothers spoke of very young children's awareness of the violence just in relation to some of the things that mothers noticed in the way their children were behaving; so either in regression after violent incidents, so that might be bedwetting or stuttering, or often needing to co-sleep with the mothers for a period of time, and it may be just that they were particularly unsettled babies or one mother described her child, a very, very young child, under one year of age, cowering in relation to the violent father.

MS DAVIDSON: You have identified in your witness statement that the system relies primarily on disclosure of family violence by the mother. To what extent do you think there are opportunities to listen more to children and to provide opportunities for children to disclose that violence rather than just relying upon the mother?

MS MORRIS: I think it's about thinking where children are, and children are found in many universal services. If I think about health care, children and their mothers when they are experiences family violence have a much higher uptake of health services. So we are seeing those children, say, for example, in primary health care settings. We are seeing them in schools. We are seeing them in child-care centres. There's lots of opportunity to be able to ask children about their safety and to monitor children as well, just in terms of how they are doing in the world. It may not be just family violence. It might be other vulnerabilities that we become aware of because we are familiar with these children and seeing them on a regular basis.

MS DAVIDSON: You have also talked about safety planning and the opportunities to engage children in safety planning. How young is too young to engage children in that process?

MS MORRIS: I think it comes back to understanding that children are aware of danger and that they are reacting to it in some way. So I think there is certainly an ability, perhaps, to use a phone. But if you think about how little they are these days and being able to use a mobile phone that their parent hands them to keep them entertained, look, it may be just children from, say, as young as four and five understanding that if they don't

feel safe they can dial 000.

For older children, that developing awareness not just of their own safety but of siblings and of their mother, then they can be engaged in a broader form of safety planning. It was spoken about earlier just older children, often the eldest child often having some insight into what to do when they are feeling unsafe or mum's letting them know that things aren't safe. So then it can broaden out to discussions within the family, but I guess the reality is that can be very difficult. So families do need support to have those conversations. But certainly children under the age of 10 can be engaged in safety planning, rather than it just being reliant on the mother to do all of the safety planning for her and the children.

MS DAVIDSON: You describe in your statement the use of therapeutic tools such as a safety hand or a safety flower. Can you perhaps expand on that and describe that in a bit more detail?

MS MORRIS: Sure. It's a very simple system. Imagining, for example, that each of your fingers give you an opportunity to think about who the child - for the child to think about who they trust, who they might turn to if they are feeling unsafe or uncomfortable. Sometimes we might have 000 in the palm, and then coming out of that we might have some other emergency or formal services that children may be able to contact. But it's important to recognise the informal supports as well. So it might be a grandparent, a neighbour, a family friend, someone that that child knows that they can go to. The hand and the flower are exactly the same concept. So you have the middle of the flower and then you will have some petals around the edge,

and children can pick which one they feel most comfortable to complete.

I should add it can actually be unsafe to even have a physical safety plan; so even just helping children work through on their fingers and being able to bear that in mind without actually having to record it somewhere.

MS DAVIDSON: So they can look at their hand and it becomes a reminder; is that how it works?

MS MORRIS: Yes.

MS DAVIDSON: And they would think about who was on that little finger?

MS MORRIS: It's just another way of doing safety planning that can make it safe for children to have an idea of what to do in the moment if they are feeling unsafe.

MS DAVIDSON: What are the implications for the crisis response?

MS MORRIS: I think the crisis responses have often been centred around the mother and planning for her needs in a crisis. It's not to say that children aren't considered, but they are not considered as victims in their own right; nor are they necessarily considered individually. So children are often seen as this homogenous group, and it's really about getting them looked after or distracted or attended to whilst emergency services interact with the mother.

But I think we have to bear in mind that each of those children is having their own trauma reaction at the time. They may not actually even be present. So in terms of thinking about a crisis response it's important to think about how we might follow up those children who weren't even there at the time of the violence, but they

are aware that it's occurring. And they are living with it daily. So children in my study talked about being away at a friend's house for the night. Part of that was possibly a safety plan that mum had enacted by knowing things were going to fire up and sending the children away. Sometimes the children went away because they didn't want to be around the violence. But they would be returning home. If they returned home, for example, on a Sunday afternoon they may not actually want to go to school on a Monday knowing that mum had been injured or that there had been a violent incident.

MS DAVIDSON: So how do you see services as improving in that context in terms of the crisis response?

MS MORRIS: Certainly a need to consider children as a victim in the moment and ensuring that there's some continuity of care for those children. So at the moment if I think about the system where police go out to a violent episode they make a referral through to the local family violence service and the woman receives follow-up and an offer of support.

The children are certainly asked about and the women are able to give some indication of how the children are coping in that environment. But the service system that sits behind it perhaps will then - if the child is likely to be referred on for some support or some counselling, going to mean that the child will have to be on a waiting list to access those services. So there's not an immediate response to the child in the same way that there is for women.

MS DAVIDSON: You have also talked in your statement about engaging children more and hearing their voice in the

post-separation period. Can you expand on that for the Commission?

MS MORRIS: Just bearing in mind that it was a primary care sample, thinking about the fact that the families were all post-separation and yet the violence continued or its effects continued post-separation. So responses need to consider what life's like for children particularly where there might be ongoing perpetrator intrusion into children's lives. Can you just, sorry, repeat the question?

MS DAVIDSON: I just wanted you to talk about the implications of this idea of listening to the children's voice more in that post-separation context.

MS MORRIS: So I think when we understand more about the long-term effects of living in a violent home - children can't actually leave the violent relationship. So we talked earlier about the conundrum of women leaving or not leaving and whether they are safe to do so. A child is likely, at least until they are into adolescence and start to have more independence, they are probably going to continue to have an ongoing relationship with the perpetrator in some form, which means we have that responsibility to think about whether it's safe for them to do so and, if it is not safe, to put some things in place to ensure that the child isn't continually being exposed to the violence.

So the implications really are that if we have systems that don't understand the complexities of family violence and the complexities of post-separation dangers, then we may continue to put children at risk.

MS DAVIDSON: Do the Commissioners have any questions for

Ms Morris?

COMMISSIONER NEAVE: I had one question. I don't know whether any of the children in your study had been involved in Family Court proceedings. If they had, I wondered whether they had any comments to make about how they felt about the process.

MS MORRIS: I didn't specifically ask them about the process. I certainly was aware of the way they spoke about parenting arrangements that were in place post-separation. For young people it was interesting that often in their younger years they had quite regular court ordered contact. Now those court orders were still in place as the children got older. But, interestingly, the contact seemed to wane, and it seemed to be fairly mutual or even in that fathers would begin to have less contact. So even though they wanted very regular contact initially they would start to not make regular phone contact, start to not be as available to have the children.

Children I suppose started to appraise the relationship that they had with their father or how they understood that person in their lives and started to perhaps visit less often; so limiting it to school holidays and then perhaps dropping off to only every second school holidays.

For the children who were having regular contact, some of them were struggling with it and their mothers were reporting some of those symptoms, I suppose, that I talked about earlier in terms of when they would return home that they would be quite clingy or co-sleep or regress in some way. It was interesting the types of danger, I suppose, that children reported in the

post-separation context where it wasn't even necessarily a sense that their father was unsafe but perhaps the environment that he was living in felt unsafe. That may have been that they were fearful of their father's partner. They may have even been fearful of other children living in the house with their father.

One example which I spoke about in my statement was children going to a home where the father's partner's children would enact violence towards the children, and it had parallels with what the mother had told me had happened to her. So I certainly got the impression that these young children were modelling violent behaviour that they had seen perpetrated by the father.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: I just wanted to pick up on that. You talk about in paragraph 29 of your statement the idea of the quality of the child's relationship potentially being more important than the time spent. Can you expand on that point?

MS MORRIS: It's about someone who perpetrates violence being able to understand the impact of feeling unsafe and feeling like you don't have an easy relationship with that person, you can't necessarily trust that person, or you love them but you don't necessarily want to be around them, or other adults being aware that at this point in time it's not a safe situation to have that contact.

If we think about impacts of violence on very young children and some of the research evidence around where the young children have overnight contact with parents after separation and divorce and just thinking about that primary attachment relationship that children

need, so I guess it's about a parent being able to understand that the timing may not be right to have that regular contact with their child and understanding that there are other ways of having a relationship with a child that don't necessarily make the child feel uncomfortable or unsafe.

So I guess thinking about someone who keeps that child in mind on a daily basis, perhaps thinks that writing a letter to that child just explaining every day or once a week the type of person that they have hopes for their child, what they would like them to be and do, what sort of father they want to be to that child if they could be, and you can do all of those things and express your love and express your desire to be a part of that child's life without necessarily needing to take them to McDonald's every second weekend. I think that we put a lot of emphasis on this face-to-face contact but for some children we are actually putting them in the face of danger and not appreciating that - we can have distant relatives that we love dearly, but it doesn't mean that we actually see them regularly.

MS DAVIDSON: Any more questions from the Commissioners?

COMMISSIONER NEAVE: No.

MS DAVIDSON: That completes the evidence for today, including that of Ms Morris. Can I just ask that Ms Morris be excused.

COMMISSIONER NEAVE: Thank you very much, Ms Morris.

<(THE WITNESS WITHDREW)

MS DAVIDSON: I suggest that we adjourn until tomorrow morning.

COMMISSIONER NEAVE: 9.30 tomorrow morning. Thank you.

ADJOURNED UNTIL WEDNESDAY, 15 JULY 2015 AT 9.30 AM