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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

WEDNESDAY, 15 JULY 2015

(3rd day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

MS DAVIDSON: Thank you. Commissioners, the first witness for today is Professor Mark Feinberg, and he's joining us from a videolink in the United States. Professor Feinberg, can you hear me.

PROFESSOR FEINBERG: Yes, I can hear you. Can you hear me?

MS DAVIDSON: Yes, we can hear you; thank you. We will first ask that you be sworn in so we can tender your witness statement.

<MARK FEINBERG, affirmed and examined:

MS DAVIDSON: Professor Feinberg, you have previously made a written statement for the Commission?

PROFESSOR FEINBERG: Yes, I have.

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

PROFESSOR FEINBERG: Yes, I am.

MS DAVIDSON: Professor Feinberg, I just wanted to confirm you are a Research Professor of Health and Human Development in the Prevention Research Centre at the Pennsylvania State University?

PROFESSOR FEINBERG: Correct.

MS DAVIDSON: You have a PhD in Clinical Psychology?

PROFESSOR FEINBERG: Correct.

MS DAVIDSON: And you have also worked as a mental health counsellor and family therapist?

PROFESSOR FEINBERG: Correct.

MS DAVIDSON: You have developed a program called Family Foundations. Can you just explain what led you to develop that program?

PROFESSOR FEINBERG: A couple of strands, but before I launch into that are you looking for a two-minute answer, a five-minute answer?

MS DAVIDSON: Perhaps a two-minute answer would be great.

PROFESSOR FEINBERG: I noticed a significant lack of support for fathers in my work and personally as I became a father, and I wanted to increase supports for father engagement in families. I noted that in my clinical work and in the research literature there is a lot of evidence that fathers are only engaged to the point that they have a good relationship with the mother. So I began to look at the co-parenting relationship, and so that - the research indicated that the co-parenting relationship is quite important for both parents' adjustment, parenting quality and children's adjustment.

MS DAVIDSON: So this program you have identified in your statement wasn't ever really developed specifically to address family violence; is that correct?

PROFESSOR FEINBERG: Yes, that's actually correct. Violence was not on our radar back then.

MS DAVIDSON: But you have identified that more recently you have actually done some research and it shows that it's having a significant impact upon reducing family violence?

PROFESSOR FEINBERG: True. We found reductions in physical, intimate partner violence amongst couples, reductions in physical parent-to-child aggression and violence, and also psychological aggression, yelling, shouting, swearing, both for couples and parent-child relations.

MS DAVIDSON: And that has been done as a controlled randomised trial; is that right?

PROFESSOR FEINBERG: That's correct, and the reason, even though this was never on our radar, we were targeting what turned out to be the risk factors for family violence - parental stress, relationship conflict, depression - and

as we impacted those we naturally I think then had an impact on reducing family violence. In fact, it was a little bit surprising to me that we saw an impact on parent-child violence because we assessed that a child aged one year, and it was notable to me that there is enough parent-to-child violence at one year that we could measure a decrease in it.

MS DAVIDSON: So a decrease in parent-to-child violence even at one year?

PROFESSOR FEINBERG: Correct.

MS DAVIDSON: You have identified in your statement that the program has four to five sessions before the child is born?

PROFESSOR FEINBERG: Correct, four to five prenatal sessions and four postnatal sessions. That's the standard version for adult couples, although we have different versions for high-risk populations now.

MS DAVIDSON: In terms of the evaluation and the reduction in family violence, how confident are you that your program in terms of its uptake wasn't simply preaching to the converted?

PROFESSOR FEINBERG: The research design was a randomised controlled trial. So the two groups were randomly assigned and presumably equivalent, and then when we went and looked at their pretest data we did in fact find that they were equivalent to each other on a wide variety of variables, including pre-existing aggression and violence in the couple relationship.

Even though we did not measure violence as an outcome in our first randomised trial of the program, we also found consistent effects on parent depression and

anxiety, parenting quality, on child outcomes that we found in the second trial, where we did measure family violence. So we are clearly well convinced by the consistency of the results across the two trials of what we call replication of the results that we can trust these results.

MS DAVIDSON: So your witness statement talks about I think the family violence randomised trial identifying I think something like around a 50 per cent reduction in physical violence, including both intimate partner and parent-to-child violence; is that correct?

PROFESSOR FEINBERG: Correct, yes.

MS DAVIDSON: In terms of psychological aggression both between the parents and to the children, around a 75 per cent reduction; is that correct?

PROFESSOR FEINBERG: Correct.

MS DAVIDSON: And that's been done at age two; is that about 18 months after the completion?

PROFESSOR FEINBERG: It was about one year. It was about one year, I believe, after birth. So the child was one year old.

MS DAVIDSON: In relation to the original outcomes that you were seeking to look at, you have done randomised controlled trials and evaluated children as much as six years after the end of the program. What have been the broader outcomes for children and for families?

PROFESSOR FEINBERG: For children we found when we asked teachers to report on the children's adjustment, and this was about age six to seven, that the children whose parents had been involved in the program around birth, those children showed less we call internalising, which is

depression, anxiety, less externalising, which is less disruptive behaviour and acting out. For those parents who had moderate to higher levels of conflict, of arguing during pregnancy, their children showed better academic adjustment, better academic motivation by teacher report than in the control group.

MS DAVIDSON: Did you also assess the outcomes for parents?

PROFESSOR FEINBERG: Yes. So we did find reductions in parent depression and anxiety, reductions in parental stress. We found better parenting quality, as I said before, better father-child relations and better co-parenting relations.

MS DAVIDSON: Can I just move next to the issue of engagement with the program and the issue of attrition. I think in your statement you identified that up to 50 per cent of the eligible population took up the program.

PROFESSOR FEINBERG: Right.

MS DAVIDSON: And you have identified that combining it with antenatal childbirth education significantly improved that uptake?

PROFESSOR FEINBERG: Right. We found when we offered the antenatal education that parents were even more likely to sign up for the program than before.

MS DAVIDSON: Was attrition an issue?

PROFESSOR FEINBERG: Attrition was not an issue. We were actually a little disappointed by this because we tend to like to compare folks who attend more sessions to those who attend fewer sessions, and then if we can find that the folks who attend more sessions get more benefit then we can say that's another piece of evidence that it was due to the program attendance that folks were benefitting. But we had such high levels of attendance that we couldn't

do that kind of analysis.

MS DAVIDSON: Have you got any reflections on why you think there was a high level of attendance and a low rate of attrition?

PROFESSOR FEINBERG: Well, I think people - I think parents or expectant parents are very open and eager for education and support. It's a special time. It's a window I think that's brief; and then once people have children they get very busy and it's hard to recruit people for parenting programs. We are happy when we get 15 per cent of the parenting population into a program in large scale work. So I think this is a very special time, and I think they also enjoyed and found benefit in the program we were offering. I also just want to give a one- or two-sentence background, which several other programs have been developed for couples and tested around the transition to parenthood, and very few in rigorous research have been found to be beneficial. They're a very large US federal study with seven or eight sites that found no effects, and a few other programs that found no effects. So it's a rather hard task to find substantial positive impact in a few sessions, I believe.

MS DAVIDSON: Are you able to reflect on why you think the program that you have developed has had that benefit?

PROFESSOR FEINBERG: I think it has to do partly with some of the approach we take in terms of just the intervention content and the way we deliver it and the way we make it accessible and adaptable for people. But I also think the focus on the co-parenting relationship is quite key, again that in families, whether they are two-parent families or even one-parent families, that co-parenting relationship,

especially in the first couple of years after birth, is crucial for parent wellbeing and therefore parenting quality.

MS DAVIDSON: You have identified that yours has been done through a randomised controlled trial. Why do you regard it as crucial to have a randomised controlled trial to assess programs like this?

PROFESSOR FEINBERG: That's a good question. First of all, without a comparison or control condition there is no way to know if the program is having a negative impact, what we call iatrogenic effect. In the large federal US study I mentioned there was one site where there was increased levels of family violence as a result of the program. Nobody who develops a program would ever intend or expect that their program would have negative impact. But it's hard to know what kind of effects when you provide certain perspectives, education, exercises, expectations. Couples may go home and argue, and you may lead them to have more conflict rather than less. There is no way to know that unless you have a control group.

If you are only looking at change, so you look at their pretest measures and then you look at their post-test measures, you can see improvement over time, and you can say that's because of the program but you really don't know because in a controlled group of couples they may have improved even more or they may have not improved. There's no way to know unless you do a randomised trial. So I think because we are dealing with violence it's especially important not to do harm, and therefore to use our most powerful research tools.

MS DAVIDSON: You have identified some opportunities for

improvement in your witness statement, including the possibility of additional modules in the toddler period in particular, and you think that it would be interesting to look at an enhanced version for couples at a specific risk of family violence. Have you done any work in relation to specifically high-risk families that have been identified as high risk?

PROFESSOR FEINBERG: We do have a trial now in the States where we are assessing the efficacy of a version of the program that is delivered in the home for individual couples who are receiving more traditional home visiting services, usually for the mother. So we have a version of this Family Foundations co-parenting class theories that's delivered in the home alongside home visiting, and we also have a version that's designed for low-income high-risk teens who are expecting a baby. But we don't have any outcome results on those yet.

We have not tried the screen for risk of violence because that would cut across all socioeconomics data. We have not had an opportunity to be funded to do that kind of research.

MS DAVIDSON: You have identified that you have done a cost benefit analysis and - - -

PROFESSOR FEINBERG: Correct.

MS DAVIDSON: I think you have identified it as a conservative estimate. What is that estimate?

PROFESSOR FEINBERG: We are estimating now that the economic benefits that we can capture, because we can't capture all of them right now, that based on those benefits the benefits are three to five times the economic cost of delivering the classes.

MS DAVIDSON: I'm going to move on to the issue of sibling violence, but before I do so I will just ask if the Commissioners have any questions about the Family Foundations Program and your research there?

COMMISSIONER NEAVE: We know that family violence is often secret. It's often concealed by the victim of the violence, the direct victim of the violence, the woman. How could you be confident that you adequately measured the extent of that violence before and after? What was the technique that you used to do that, before and after participation in the program?

PROFESSOR FEINBERG: Sure. We had each parent fill out a series of questionnaires independently, on their own. There's no way to know if certain individuals were hiding the levels of violence, but because it's a randomised trial those who are hiding it in the intervention group should have had counterparts who were hiding violence in the control group as well.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Moving to the issue of sibling violence, the Commission has received some submissions that have identified the extent of sibling violence. But perhaps you could identify for the Commission why it is that you think that sibling violence requires more attention.

PROFESSOR FEINBERG: I think there's a norm in our societies, in Western societies, that brothers and sisters will argue, they will be in conflict and the conflicts will become physical at times, and that's just part of growing up. I think if we saw the kinds of aggression occurring between non-siblings that happens between siblings we wouldn't hesitate but to step in.

Siblings tend to spend more time with each other than anyone else. A lot of that time is unsupervised as they become older. There are opportunities for exploitation, ongoing humiliation and just the manifestation of simple power dynamics, and severe abuse does occur. It's less common. But the commonality of violence among siblings is not benign. We know that variation, that higher levels of aggression in sibling relationships is associated with problems with peers, with aggression with peers, with aggression in dating relationships, and as well with mental health problems, academic problems and so on. So I think there are a lot of reasons to be concerned with sibling violence.

MS DAVIDSON: You have identified that as a fairly underdeveloped area in terms of both research in relation to programs that address sibling violence and also just generally in relation to the impact - the potential outcomes of those sorts of programs. But you have talked about a program that you have trialled, the Siblings Are Special Program. Can I ask what was the uptake for that program?

PROFESSOR FEINBERG: I don't have the figures in front of me. I think we published them. But I think we had very good uptake, especially compared to other multi-session family programs of this nature. I think we had probably between 30 and 50 per cent of the population signing up for the program, which is very high.

MS DAVIDSON: What were the outcomes from that program and that trial?

PROFESSOR FEINBERG: We did not follow the kids as long as we did in the other research I talked about, but what we did

find were improvements in parenting and improvements in the sibling relationship. We did not find improvements in sibling violence. But I think two things. First, that was our first stab and one of the first ever to try to improve sibling relationships. Secondly, it may take more time, that we might make changes in terms of improving the relationship, helping the family have better conflict resolution skills, and then it may take time, months or even years, for those changes to snowball into impact on sibling violence.

But also I should say that we did not target sibling violence itself and we did not talk to parents about sibling violence.

MS DAVIDSON: In terms of for the Commission going forward do you have any views on what you think would be useful recommendations from the Commission in the area of sibling violence?

PROFESSOR FEINBERG: I think there's a real opportunity to take the leadership role in this in the world. Nobody else has recognised the problem of sibling violence, how general it is and how general the effects are. So I think a combination of promoting positive sibling programs; promoting expertise amongst clinicians in dealing with sibling conflicts in family situations; and also maybe some kind of public messaging campaign might be useful to just demarcate where the line is that families and communities should not tolerate violence in families at all, including sibling relationships.

MS DAVIDSON: I wonder if the Commission have any questions in relation to those matters?

COMMISSIONER NEAVE: I have one question. Thank you, Professor

Feinberg. Have you considered or been involved in discussions about the possibility of rolling out these programs to deal with people who are mandated to undergo some sort of behaviour change program because of criminal offending or because they have come to the attention of authorities in other ways?

PROFESSOR FEINBERG: These programs that I have been working on that I have been discussing, we have not had mandated participants. We are moving in that direction. I think when you get to that point, when you are getting to talk about people who are mandated, it's because of a past history, and then you are talking about I think a deeper intervention approach than these universal prevention approaches that I have been talking about.

COMMISSIONER NEAVE: In terms of prevention as opposed to dealing with the problem after it's occurred, do you have any views on the relative cost benefits of prevention?

PROFESSOR FEINBERG: Yes. I think we have to be careful because I don't want to say that all prevention is necessarily cost effective. It depends both obviously on the cost and the benefits. So both have to be measured. But in my view it's important to match the cost of the prevention program to the needs of the individuals and families, so that, for people we know or have identified as high risk, prevention should be more intensive and more costly and hopefully pay off bigger, but for people who are at lower risk, then our prevention strategies should be less costly because they are not going to pay off as much for each family because the opportunity for a low-risk family to benefit is smaller than for a high-risk family.

I'm not alone in this. I think having a range of universal selected and indicated programs is very helpful. From my perspective, 30 to 50 per cent of the families with young children have need of at least moderate level of prevention.

COMMISSIONER NEAVE: Thank you, Professor Feinberg.

MS DAVIDSON: Thank you, Professor Feinberg. That completes the Commission's questioning of you. We do thank you for your attendance, particularly given I think it might be quite late for you in the States. Thank you for your attendance. May the witness be excused?

COMMISSIONER NEAVE: Certainly, and thank you very much indeed, Professor Feinberg.

PROFESSOR FEINBERG: Thank you. I look forward to your recommendations.

<(THE WITNESS WITHDREW)

MS DAVIDSON: We are about to call three witnesses to give concurrent evidence, but at this point we wanted to play an advertisement. We are talking about working with dads, so we wanted to play an advertisement that the Mallee District Aboriginal Service has provided to us. It is one that has been developed locally within the Aboriginal community and actually stars a number of local Aboriginal people. It's just really an introduction to the issue of working with dads and how we might look at men with children who are using violence.

(Video played to the Commission.)

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Now I call - we have three witnesses together - Ms Wendy Bunston, Dr Richard Fletcher and Ms Julianne Brennan.

<RICHARD JOHN FLETCHER, affirmed and examined:

<WENDY BUNSTON, sworn and examined:

<JULIANNE HELEN BRENNAN, affirmed and examined:

MS DAVIDSON: Commissioners, before I proceed with the evidence of these three witnesses I would first seek to tender a statement that's been made by Dr Rebecca Giallo. We are not calling her to give oral evidence today, but it relates to some emerging research in the area of men's mental health, particularly in the postnatal period, and it identifies that this is, as it is for women, a time of increased stress and mental health concerns. So I just seek to tender that first. Then I'm proposing to introduce each of the witnesses and then explore some issues arising from their statements.

COMMISSIONER NEAVE: Thank you, Ms Davidson. The statement is accepted.

MS DAVIDSON: Ms Bunston, you have made a statement in this proceeding already?

MS BUNSTON: Yes, I have.

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

MS BUNSTON: Yes, it is.

MS DAVIDSON: You are a clinical mental health social worker?

MS BUNSTON: Yes.

MS DAVIDSON: You are a qualified family therapist?

MS BUNSTON: Yes.

MS DAVIDSON: You are an infant mental health specialist?

MS BUNSTON: Yes.

MS DAVIDSON: From 1996 to 2012 you worked at the Royal Children's Hospital in the Addressing Family Violence programs?

MS BUNSTON: Yes.
MS DAVIDSON: You have created a number of award-winning programs working with infants, children and their mothers and fathers?
MS BUNSTON: Yes.
MS DAVIDSON: The Royal Children's Hospital program is no longer operating; is that correct?
MS BUNSTON: That's correct.
MS DAVIDSON: You are currently, though, a senior consultant and trainer?
MS BUNSTON: Yes.
MS DAVIDSON: And you are supervising a number of programs in Children and Family Services?
MS BUNSTON: Yes.
MS DAVIDSON: Dr Fletcher, you have previously made a statement in this proceeding?
DR FLETCHER: Yes.
MS DAVIDSON: Are you able to confirm that that's true and correct to the best of your knowledge and belief?
DR FLETCHER: I am.
MS DAVIDSON: You lead the Fathers and Families Research Program at the University of Newcastle?
DR FLETCHER: I do.
MS DAVIDSON: You are currently the project leader on a number of projects that you have identified in paragraph 3 of your witness statement?
DR FLETCHER: Yes.
MS DAVIDSON: You have been involved in your work designing and delivering courses and seminars to teachers, nurses, occupational therapists and medical students?
DR FLETCHER: Yes.

MS DAVIDSON: And that work focuses on working with and engaging fathers in particular; is that correct?
DR FLETCHER: Yes.
MS DAVIDSON: And you are responsible for coordinating both undergraduate and postgraduate online and blended courses; is that correct?
DR FLETCHER: Yes.
MS DAVIDSON: Ms Brennan, have you made a statement in this proceeding?
MS BRENNAN: I have.
MS DAVIDSON: Sorry, in this Commission. Are you able to confirm that that statement is true and correct to the best of your knowledge and belief?
MS BRENNAN: I can.
MS DAVIDSON: You are the Director of the Community Crime Prevention Unit within the Department of Justice and Regulation?
MS BRENNAN: That's correct.
MS DAVIDSON: You have held a number of director positions within the department prior to that?
MS BRENNAN: That's correct.
MS DAVIDSON: And that includes working in the Working With Children Unit and Responsible Alcohol Victoria?
MS BRENNAN: That's correct.
MS DAVIDSON: And you have a Bachelor of Laws degree?
MS BRENNAN: That's correct.
MS DAVIDSON: Perhaps if I can turn to you first, Ms Bunston. We identified that you had a program at the Royal Children's for investigating sort of family violence programs. How was that program originally funded?
MS BUNSTON: Very poorly. The initial sort of work started not

long after I commenced working at the Children's Hospital, and it was at the request of the Djerriwarrh Health Services at the time. So I was situated there as part of my role, and they asked if I would be involved with their Family Violence Prevention Program in developing a children's program. So that's sort of where it all started in 1996. I think at that stage I just became very interested in the area of work, so probably was primarily the driver for how that work came about.

I was in a senior position, so I had the capacity to have a bit of leeway to do that. Then I took on the position of Manager of the Community Group Program, which was programs for children in schools with mental health issues. Under that umbrella I negotiated when I was offered that role that I would be able to continue doing the family violence work.

Then as a result of that work I was very successful at the time in getting some philanthropy funding through places like the Sydney Myer Fund, Victorian Women's Trust and RE Ross to actually fund the work that we were doing. It really was a natural progression of learning from the children themselves in doing the work clinically that led to the development of the program. So it really just - that took me on a trajectory as a clinician that I wouldn't have gone on if I'd sort of said, "How am I going to do this?" It was really just I learnt as I went along and that knowledge came from the children and then the infants themselves, I think.

MS DAVIDSON: So a large part of that funding was philanthropic?

MS BUNSTON: Yes, philanthropically, philanthropy, yes.
MS DAVIDSON: Was any funded by government?
MS BUNSTON: Through the hospital - I was employed as a hospital employee, obviously, through the Mental Health Service. So of course the infrastructure, all sorts of components of that came through the Children's Hospital. I suspect that the reason I was allowed to perhaps get away with as much as I did was because I did get external funding to assist with that, and the RCH Foundation I think was incredibly supportive of the work.
MS DAVIDSON: As a general rule, how have you found the funding for work and research with children?
MS BUNSTON: I haven't found it, really. I'm not sure where you find it. It must be out there somewhere. But, no, it's been very poor. So I guess if philanthropy hadn't come on board and said, "We want to do some seeding funding for those programs," particularly the infant based work, which was very, very new, it wouldn't have happened.
MS DAVIDSON: You have talked in your statement about originally developing - you started initially working with children and their mothers?
MS BUNSTON: Yes.
MS DAVIDSON: You moved then to working also with men?
MS BUNSTON: Yes.
MS DAVIDSON: Why did you work with men?
MS BUNSTON: Because it became apparent very quickly in the children's groups that the children wanted their dads involved in their lives. In the very first group we ran, myself and a colleague who developed PARKAS, which was the Parents Accepting Responsibility Kids Are Safe Program, we were talking I think in very generalised terms about men

and women. So we very much I think were talking in the language that most people talked around family violence, which was men were the perpetrators and that women were the victims, and we found that very quickly shut down the children.

So the experience of the children coming to those groups was much more complex than that. There were kids who were still having regular access to their fathers, and when we spoke in those terms, in the good and bad, we just shut down conversations. So we learnt very quickly that we needed to shift our framework in thinking about how kids see this situation, and we very much broadened our perspective in terms of the complexities and the attachment these kids have, because a lot of these children have very significant attachments to both parents and a lot of kids - whether or not we would see it in that way as adults, a lot of children would see both mum and dad as potentially violent at times, and certainly have experienced both mum and dad as being violent at times.

So we just had to move to a position of not knowing as opposed to assuming that as the adults we knew all about their lives. We had to come to a position of we didn't know these kids lives, we didn't know their stories, we had to find out.

MS DAVIDSON: As a general rule, is the family violence sector working with men?

MS BUNSTON: That's a broad question. You mean men as fathers or - - -

MS DAVIDSON: As fathers.

MS BUNSTON: I wouldn't say that I'm the best person to answer that because I don't think I have the knowledge base to.

My assumption is that the work that is done in men's behaviour change programs is very psycho-educational, which I guess as a clinician I don't think has long-term benefits for people who've themselves suffered intergenerational and early childhood trauma.

I think if I was to sort of say from the scientific evidence that that psycho-educational approach would be very much left brain, which is very much speaking to the semantic part of how people function, I believe that trauma work is very much right brain work, particularly if you have experienced that yourself as an infant, and you need to emotionally engage with men and in a way that enables them to tolerate their feelings of vulnerability, their feelings of being at a loss as being a parent, a father, all sorts of things, that they can tolerate being able to talk about, which then I think facilitates a shift in their ability to engage empathically with their child.

So as a clinician, and I'm very, very biased, I would say, no, I don't think it's being done well. But I'm open to be corrected on that.

MS DAVIDSON: Can you perhaps outline to the Commission how you have worked with men as dads and their children?

MS BUNSTON: Yes. Within the Parkas Program we ran a Parkas dads program a few years into running that program where the dads that came into that program had been through the men's behaviour change program, and that was based not on looking at the age group of the kids that came in with their mothers but actually was looking at the father-child dynamic. So we actually had in that group a three-year-old through to a 13-year-old child and then

their dads; and we did some really groovy stuff with their dads. We had a guy who is a music therapist who came in and brought in the electric guitars and drums and all that sort of stuff, which very much excited the fathers such that they pushed their way past their children to get to the equipment. We did artwork, and we did discussion work. So we actually had the children and dads together in the group. I think that was quite successful.

We wished that we had videotaped it because I think we would have been able to show the dads - we actually did take the opportunity after our first music session to talk to the dads individually about how they thought they interacted with their kids in that session, because what we saw was perhaps very different to what they thought they were doing. So I wished we had videotaped it because it would have been very telling for them to see how they just forgot their kids because they were so busy rushing to get the electric guitar or whatever else it is that they wanted.

But what we found in that group was that we had one dad where I think we made poor judgment about his inclusion because I don't think we made very much difference to his relationship with his daughter. But the rest of the dads, I think we made a significant shift in terms of how they saw their children, and it was a combination I think of role modelling, how we were in that space with their kids, because we had very significant feedback from the dads at one point where we were making some clay figurines with the kids and their dads. The kids got sick of it fairly quickly and went off and were mucking around and making lots of noise. It was in the

evening, so we weren't disturbing anybody. They were running up and down the corridors, and the dads were getting really tetchy. You could see that they were wanting to tell their kids off, and myself and the co-facilitator just - it didn't worry us because they weren't doing any - you know, it was all cool.

So one of the things that I think was important for us in the feedback from the dads after that group was taking cues from us because of the fact that we didn't get stressed, the fact that we were just letting these kids play together and not telling them off; and the feedback from them was, if that had just been us, say, at a barbecue or something we would have gone in hard on those kids and said that behaviour is not acceptable.

So I guess it's that stuff of - I can't quote what Professor Feinberg is quoting with all his outcome measures, which I think is pretty impressive, but I can say for the small amounts of that work I think we saw shifts in the way that the children were with their dads, and I think that advertisement was very telling because I think what we perhaps don't do well in this sector is actually use children as barometers to how safe a family is, because that little excerpt was a brilliant example of here's a dad who I'm assuming had been violent, here's a dad who is spending quality time with his child, but here's a dad who raises his hand to do something very benign and the son automatically, from the amygdala, has the response to that which is like, "You are going to hit me." I think that's the stuff that kids show us time and time again about how safe they do feel or don't feel with their parents that we don't sort of take on board what

kids' experiences are.

MS DAVIDSON: In your work with dads and children, I understand you use those sorts of interactions to enable the father to reflect. If that kind of - what we saw on that ad, if that had occurred in one of your sessions, how would you have used that to engage?

MS BUNSTON: I would have grabbed that in the here and now, and I would have talked to dad about, "Wow, what did that feel like when your son moved himself away from you," and if I felt that it was safe for the son I would have said, "Wow, what did that feel like for you when dad put his hand up?" I would have used that in the here and now, and I also perhaps would have used, "Have you ever had" - to dad - "someone raise their hand to you and you have been frightened that they were going to hit you?"

I guess - so I sort of didn't get past Parkas to say that we actually developed a father-baby group called Dads On Board and very much used what happened in the group as the material for unpacking what it was that was going on in that space. So an example that I gave in my session with you was around in the dad's group we had mums and dads come to the group as a result of going out and doing home based assessments for these men who have been through a men's behaviour change program and had then been referred by their workers in the men's behaviour change program to Dads On Board, that we had mums decide they wanted to come along, which they did, because we didn't know what we were going to do. We just went out and said, "We want to run a dads group with babies, and let's see how it all sort of comes about."

So, apart from one dad, all the partners of these

dads came along to the groups. In those sessions the mums took a bit of a backseat because it was the group for the dad. But we would sit on the floor, we would have us in a circle and we had a particular example of two little boys who were fighting to sit on mum's knee, literally, talking about sibling violence, they were wanting to sit on her knee, and I think it was a two-and-a-half, three-year-old and a four-year-old, and then dad was sitting in the circle with a big lap empty, and we used that straight away to reflect on, "I wonder what makes it difficult for these two little fellows who are trying to sit on your lap, mum, to take advantage of the fact that there's an empty lap over here with dad."

Immediately that takes you to a very different place emotionally than to what it would if you were talking at a psycho-educational level around what makes kids feel scared of their fathers, whatever. Yes, you can by rote probably talk about that, but at an emotional level when it is happening in the room it's very difficult to avoid the emotional impact that has and then to unpack what that might be about.

MS DAVIDSON: So how did you unpack it in that situation?

MS BUNSTON: In that situation we talked about what would happen for dad when he was little, like whose knee would he want to go and sit on, and it certainly wasn't his father and it certainly wasn't his grandfather. He was quite violently abused by his - I think it was his father or his grandfather. His prominent male figures. Then we were able to sort of talk about what that meant for him. So lots of linking between his past, his experience and what his experience was with his children.

I won't go into details because I don't think that's appropriate. But I think certainly this father and all the dads that were in the Dads On Board Program loved their children enormously. How they expressed it was very much at odds with how they felt about them. Lots of their children's behaviour triggered lots of unresolved issues for themselves. We had a little boy in the group who his father kept talking about him being a bit of a sook. So he would cry often and he would go to mum and different sorts of things that occurred. Essentially we were able to look at where did this idea of a sook come from, and he disclosed some stuff that happened between him and his father where he was given a very sound beating by his father when he had - an incident occurred for him that he became emotionally distressed about.

Once we were able to put those two things together for this dad, it made a significant shift in how he saw his son because he was able, I think, to go back to when he was a kid, and he would sook off to his mum because he was a kid and he needed an adult to come in and contain and protect him. So he did what a kid needs to do, but in his mind, because of the way his father spoke to him, that was seen as something very negative and something pathetic that he had to be afraid of. So he transferred that to his son.

MS DAVIDSON: What do you say to people who say that we shouldn't be allowing a man's own experience of abuse in their childhood as being effectively an excuse for how they are behaving today?

MS BUNSTON: I think - because I was thinking, "You are going to say the word 'excuse', aren't you," and I don't think I

see it in that way at all because I think it is absolutely unacceptable for an adult to ever place a child in any situation where they are at harm, and I think as a society we are crap at looking after kids, we really are very - we are not good at it. I don't know if you are allowed to say "crap" at the Commission, but we are very adultcentric in the way that we work and the way that we think, and we leave children in horrendous situations all the time.

So I guess as a practitioner working with dads there is no doubt in their minds, and mums', no doubt in their minds, that as a practitioner and as an intervention that to put their child in any situation that's creating harm for them is unacceptable and that we will make notifications, we will do whatever it takes, and we also very clearly say to parents, "Would you want to be in a group where we as the adults are not actively protecting the children," and I haven't had a parent yet say, "Yes, I would want to be a group where you are not going to do that."

So I think it's very clear in my mind that that stuff is unacceptable. But if you split off things like we tend to do in this sector where we have the women and the men and the children and whatever, when these are family units that live together when they are not busily coming to our offices or into the Commission, then I think that we are splitting off opportunities to use what's already there to create change.

So I don't think it's acceptable for anyone to use that as an excuse because there's lots of people out there that have had very horrendous traumatic childhoods that don't go on to hurt people and to abuse children. So

it's not acceptable. But if we don't have a more empathic response to some men and some women who have had horrific backgrounds, who have had - I was going to swear then - who have had really terrible things happen to them, then I think we are going to keep them alienated and we are going to keep them at a level where they will continue to repeat their traumatic and reactive responses to life, which often involves using violence.

I'm not saying there aren't some people out there that perhaps with all the work in the world will still be very difficult to reach, because I think as a society we will always have those people. But there's a lot we can be doing.

MS DAVIDSON: Can I move to you, perhaps, Dr Fletcher. You identify in your witness statement that approaches that have demonised men have ended up putting up a number of barriers for men to be able to be engaged and to be involved in services. Can you explain your concerns in that regard?

DR FLETCHER: I don't know if I could put it as eloquently as Wendy just did. I see the sector I work in, I have been working in this area of engaging fathers for some time, and I see that the idea of saying men are violent, men are wanting to dominate women, the power analysis that says that domestic violence is simply an issue of power and that men as a group seek to dominate women and have power over them, so every man you meet you can easily tell just by identifying whether he's male or not what he's trying to do, I think that simplistic model is really strong in the sector, and I think it infects people's thinking so that they don't notice the complexity that's in front of

them and it stymies approaches.

Recently I was in a meeting with New South Wales Health where there was a discussion about the way that the domestic violence questions are asked of the mothers and that hospitals were sending out letters saying to the mothers, "Don't bring your partner to the booking-in visit." So this is the first time that the couple are engaged at the hospital where they are going to have a baby, and the hospitals are asking fathers not to come.

They weren't talking to the fathers, of course. They were just addressing the mums, saying, "Don't bring him with you." I think some of them had an age range so that if he was older than four or eight or something you weren't supposed to bring a male. That was to ensure that they could ask the domestic violence questions without thinking that she might be intimidated and silenced.

So the motivation was understandable, but the simplistic model that "he's going to be bad and therefore the solution to that is to keep him away", that's what I'm thinking of as demonising. So maybe "demonising" is an emotive word. In an administrative way fathers are sort of pushed to the side and not engaged, and I think that's the point that I would make, the support - what Wendy was describing in particular cases.

MS DAVIDSON: From your perspective, why should we be engaging men?

DR FLETCHER: It is a funny question, isn't it? I was in a meeting yesterday. I was in a workshop with child protection workers in Townsville, and I told them that I was coming here today and I said, "You know, one of the questions they asked me" - so this is a room full of,

I don't know, 60 child protection workers and people like that. I said, "They asked me 'why should you work with fathers?'". Yes, they got the joke. They all laughed. It is such an obvious question but why aren't we working with fathers, not "why should we". But we should if we want to do anything about the problem. It seems an obvious thing to do.

MS DAVIDSON: And why aren't we?

DR FLETCHER: And why aren't we? I suppose my perspective goes back quite a way. I was around when the first women's refuges were established, and I saw how hard they had to work to get across this idea that domestic violence is something you should take seriously. So I don't begrudge I suppose the protectiveness of that view that we have to be sure that we don't go backwards and start minimising what happens and accept any statement by a man, for example, that he just gave her a push or something like that. So I understand that.

But I think that hasn't been productive in our thinking, certainly not now, with what we now understand about family violence. I think that that's one of the reasons that we are slow to even start thinking about fathers, and I think when I look - I'm not aware of all the programs that are running, but when I look around at what's happening around prevention the only program I'm aware of that's funded at a decent level, you might say, is the Movember funding for the father-son project out of the University of New South Wales. I'm not aware of any government program, really, working in prevention. Our own prevention work is funded by Beyondblue and by the Young and Well Research Cooperative.

MS DAVIDSON: Is this perhaps the work that Professor Newman mentioned yesterday in relation to the SMS messaging services that you have with men or developing for men?

DR FLETCHER: Yes, probably. Louise Newman is on the advisory committee.

MS DAVIDSON: Can you perhaps outline that program for the Commission?

DR FLETCHER: Having worked for a long time trying to get dads to come to programs, I have recently in the last few years thought really maybe we are bashing our heads against a brick wall. With the change in the way technology operates in our society now it seems like we have an opportunity to not try and get dads to come to everything. So if you think of the antenatal period, for example, dads are typically busy trying to get the place ready if it's their first child, their wife is usually cutting down her work at some point, and so they are feeling the pinch in terms of economics, and our miserly two weeks paid paternity leave doesn't really solve that. So those men are busy, have a lot happening. Then to try and get them to come to programs, even though Mark had a good take-up rate for his program, I'm not sure that would happen in Australia, you would get the same success.

I'm aware of attempts to get dads involved on a large scale, like John Condon's work that was well funded, where the take-up rate just to get dads to go into a research study was 10 per cent, and that's pretty average, that you won't get dads to come to things.

So our take on that was to reach dads where they are now using their mobile phones. So we have an SMS project, sms4dads.com, and that sends messages to fathers

on their mobile phones. That's funded by Beyondblue. So the focus there is on fathers' distress or depression. So as well as giving the messages about co-parenting, about father-infant attachment and about looking after themselves, we also have a mood tracker which asks them how they are going. So every week they get a question which says, "How are you doing?" There are five options, from terrific to terrible. If they click "terrible", then they get a phone call - well, another screen asks them, "Can we call you?" Then they get a call from PANDA, the postnatal/antenatal depression group here in Melbourne, and they ring them to check that they are doing all right.

So our take on this idea of recruiting fathers around this area is that fathers are not part of the system. They don't have to go to the booking-in visit, even outside of New South Wales, where they are discouraged. They mostly attend the birth. They often attend the ultrasound, and that's one of the places we are recruiting in the research we are doing now, at the ultrasound, where the dads often do come, recruiting them to this SMS4dads, and they don't often - after they appear at the first home visit, they are often absent after that.

So our idea would be to not simply use those models of programs which involve couples coming together to do things or with their baby coming to do things, although they might have good outcomes for those ones. Our idea would be to use those, and the parallel program for Aboriginal dads is using young Aboriginal dads to build a website for young Aboriginal dads.

MS DAVIDSON: You have also I think got a program with Aboriginal men in prison that you have talked about?

DR FLETCHER: Yes. I referred to that. Craig Hammond, "Bourkie", who I have worked with for many years, he is the lead on that program and has run that program in prisons around New South Wales.

MS DAVIDSON: How do those programs sort of seek to engage and I suppose change men's behaviour?

DR FLETCHER: They change their behaviour by yarning about what it's like when you are going to get out or what you are doing now with your kids, which is quite important because some of the dads are in there for 20 years. So he's talking to them about, "What are you doing now with your kids," and about the importance of fathers.

In that program, for example, one of the outcomes that I thought was important was a shift in the way that the men used their telephone time. So these Aboriginal dads in Brothers Inside, when they'd start they'd - you get three minutes on the phone and then you have to go to the back of the queue, line up and get another three minutes, and so you've only got a limited time to talk. What they would tend to do - Bourkie's description is what they would tend to ask about at the beginning of the program was, "Who's coming around? Who's seeing my missus? What she's doing," using conversations with the children to check up on how things were romantically, so to speak. That was the focus of the conversations.

Through the program they started to make those phone calls to the kids, to ask the kids, "What are you doing at school?" Some of the examples from those conversations were the dads who were in there for more than 10 years started to develop a relationship with their children where the children would ask them, you know, "I'm

thinking of going to this thing" - you know, teenagers - "What do you reckon, dad," and putting him back in a father role even though he was never going to see them, except at visits, for a long time.

So I think that sort of change was what - it's anecdotal change. It's documented in write-ups of the project rather than randomised trials. That's the sort of effect I thought was quite significant.

MS DAVIDSON: You have identified a number of programs in your statement but also identified that there's limited evidence about them.

DR FLETCHER: Yes.

MS DAVIDSON: Where are we at in terms of an evidence base for what works and what doesn't work with men?

DR FLETCHER: I thought Mark put it very eloquently when he said I haven't had the opportunity to do that research. Well, I don't think we have - I mean, the gold standard isn't actually a randomised trial. It's a meta-analysis of a series of randomised trials if you want to really establish something works. We don't have any, I don't think, that I'm aware of for any of the programs that we are talking about in this area. So that we have very little evidence, and I think that's partly because there's been no funding stream identified around fathers in this area - so I'm talking about fathers' programs - in general as well as in this area about family violence. So I think we are at a very low evidence base, which is a problem, of course, if you want to make recommendations based on evidence.

MS DAVIDSON: Bearing in mind the lack of evidence, have you got any suggestions for the Commission about where they

might start, where you might want to start developing programs?

DR FLETCHER: The evidence that we have now that says that fathers' positive involvement with children from birth has a separate effect to the influence of mothers' relationship with children - I think the evidence that we have now is very strong. So that if we - the old model was that mothers attached or infants attached to their mothers, basically, and that's what secured their future in a healthy way, and dad's job then was not to get in the way. So if he didn't abuse or drink or take all the money then he was basically doing okay, because the primary attachment was what we focused on.

I think the evidence now doesn't support that model and that the evidence now says that if you want the best for your baby then they will have a secure attachment with both the mother and the father. So I think that changes the framework that we should be working in. We also have of course now great evidence that there's a lot of bad things that can influence children's development, including the father's behaviour. So for those two reasons we should be looking at early intervention, and I would say the time that's already been nominated, antenatal, is an obvious one. That would be my recommendation, would be to start early and to identify programs like Mark's or like the others that I mentioned, like the Healthy Relationships: Healthy Baby Program in the UK that start antenatally to try and identify potential for violence and reduce it.

MS DAVIDSON: So we have heard from Professor Feinberg, but can you perhaps describe in a bit more detail the UK program?

DR FLETCHER: The UK program again is funded by an independent source, the Stefanou Foundation. That's a program which enrols couples who see that they have some problem in terms of violence. It's run by the people I'm aware of. I think it's important that the female lead there, the woman who's a co-leader, is somebody who's worked in the domestic violence field for decades and has a lot of credibility; and, similarly, the male is a man who has worked with men in violence programs for quite a while.

They have developed a program based on co-parenting models, if you like, not specifically Feinberg's but co-parenting ideas, to take families in an intensive program from when they identify as early as possible in the pregnancy, and they are doing it in two regions in the UK as a test of the model. The idea is to support them to figure out how to relate without violence.

MS DAVIDSON: Perhaps can I move to you, Ms Brennan . You have outlined in your statement the Baby Makes 3 Program that's being piloted in a number of places around Victoria.

MS BRENNAN: That's correct.

MS DAVIDSON: Your statement hasn't attached the actual evaluations, but there have been at least one or two evaluations of that program; is that right?

MS BRENNAN: There was an initial evaluation undertaken under the auspices of VicHealth when the program was first developed, and that evaluation identified it as a program, a very promising practice. The current funding of the pilot through my unit under the reducing violence against women and their children grants does include a mandatory element of an independent evaluation and grant funding is quarantined for that purpose, and those evaluations are

due at the conclusion of the funding period in December this year. So we have had interim evaluation reports through the progress of the grants, but the final evaluation of this component of the program is due in December 2015.

MS DAVIDSON: What outcomes are being evaluated in that evaluation?

MS BRENNAN: The evaluations at this stage are formative. We are very conscious that we have taken examples of programs that have been piloted previously in many cases and we are looking at building the evidence base. So the primary rationale for the funding was to respond to - particularly from the women's health sector but more broadly - a concern that there had been a development of a number of projects and initiatives focusing on primary prevention of violence against women, that there was a need to further develop that evidence base.

While Victoria is recognised as having done a lot of early work in that space, there is still a lot we don't know about what works. So it was about taking some of that early work and building on that foundation in a formative and developmental evaluation process.

So it is about taking programs that are aligned with the evidence about where we need to focus on primary prevention work, and seeing how we can look at opportunities to scale that up and embed that in broader systems across the government sector, local government sector and community.

So these particular programs, the Baby Makes 3 Programs, are delivered in a family setting. They are associated with the Maternal and Child Health New Parents

Program as an add-on. But the initial program was run in a single local government area, and it is important to look at how could you build on that initial success and work out what are the factors and supports that it would need in order to be able to embed that more generally across our different sectors and service systems.

So part of the model was funding one program, trialling that program in a regional and rural setting, and seeing what different challenges may emerge in delivering that in that setting, but also in the metropolitan area expanding it across a number of local government areas and what are some of the economies of scale, what are the challenges that may emerge in engaging facilitators to run the program and simple logistics about coordination, facilities and support.

That then helps examine a range of options for how this could be applied in different settings and a cost benefit analysis of investing in that program in that setting, and how that may interrelate with other programs focusing on primary prevention in other settings, such as workplaces, religious institutions, sporting clubs, for example.

MS DAVIDSON: Is my understanding correct that it's really based on the proposition that if you address gender inequity in the relationship that will lead to a reduction in family violence?

MS BRENNAN: That's correct.

MS DAVIDSON: In terms of assessing the outcomes, have you assessed the change in gender inequity?

MS BRENNAN: The outcomes of the program - it's an interesting question of how to measure, and with a lot of primary

prevention programs we have this challenge of what some proxy indicators could be. So it's really about attitudes and developing an awareness of the impact of societal expectations and attitudes and gender stereotypes on how families or couples coming together and becoming a family, how it influences how they relate to each other and the role of the family as a unit moving forward. So this is a critical point at which they are moving from being a couple into being a family and negotiating their respective roles and how they value their respective roles.

So underpinning that is really a focus on equipping them to recognise the influence of gender stereotypes, and to equip them with language and tools to enable them to discuss that and negotiate in an equal way and a respectful way how that is going to work for them in their family.

So the measures are about not necessarily are you expecting a gender equity to emerge, and particularly I think an expectation that suddenly as a result of attending three two-hour programs that an appropriate measure is whether men are somehow now undertaking 50 per cent of the housework. That's neither a realistic nor appropriate measure. It's about are we equipping them to recognise the expectations imbued by the rigid gender stereotypes and to understand that this is a negotiation between them, equipping them to do that, but also it's about valuing the different contributions that each partner is making.

So the assessment and the evaluation is about whether they are having healthy respectful discussions and

have the tools to be able to do that with an awareness and to do that in a healthy way, and looking at their attitudes to gender stereotypes and the role of them as male and female and as mum and dad. Those are the key areas that you would be looking at changing.

If you were expanding the program you would start looking at proxy indicators around attitudes and attitudes that are supportive of violence against women and rigid stereotypes. You wouldn't have as an immediate proxy indicator, for example, had you seen a reduction in incidence of family violence reports to police. So it's about coming up with the right proxy measures, and in this case it's about engagement of the couple and it is about their attitudes and their willingness to have that discussion in a healthy way as a new family.

MS DAVIDSON: So it still proceeds on the assumption that if that happens then there will be a reduction in family violence?

MS BRENNAN: Yes.

MS DAVIDSON: But there is not actually a measure of whether it is in fact having that result?

MS BRENNAN: I think that's the crux of the issue of assessing primary prevention programs. It's important to understand these programs are not focusing on identified at-risk cohorts. It's a universal program. There is no selection criteria about whether there are any indicators of potential violence in that relationship. It is a universal approach.

So to say, "But for this program would that family have gone on and experienced family violence" is a very difficult measure. It's working on the causal and

the theory of change model of if you accept the evidence that says gender inequity and rigid stereotypes about gender are a key driver of violence against women and family violence, then any program that is attempting to work with community attitudes in the different settings and in this case in the family setting at that point, the theory of change says if you are changing those community attitudes you will see a reduction in violence against women and family violence.

However, to say that one program in one setting could have a measurable impact community wide is also problematic. It's understanding that we need to work across the continuum of the community and provide programs that challenge these attitudes and behaviours and work to change those in all of our community settings. So this is one program in a particular setting.

MS DAVIDSON: Dr Miller yesterday identified an issue about working with couples where you may not necessarily know that there is violence and raised the issue about the potential for working with couples together actually increasing the risk of family violence because of whatever has come out of, say, a family therapy session or so on. Professor Feinberg also identified that some of the programs that have been assessed in the United States have actually had negative outcomes in terms of parenting programs. What consideration has been given to assessing, firstly, the risk of that and whether or not any risk is being mitigated?

MS BRENNAN: I think that's a good question. The first point to make is, unlike a number of the programs that the witnesses to which you refer were speaking about, they

were talking more often than not about programs dealing with identified risk couples or where there was some early intervention or response. Here we are talking about primary prevention, and the program is not about family violence in that sense. It is not marketed or portrayed as a family violence program. It's a program about healthy relationships.

In the program itself it largely does not mention family violence or interrelationship issues in that sense. It's talking about the tensions that arise as you negotiate a new family model. It encourages communication as couples work through that negotiation process and it's about drawing out and helping couples focus on how stereotypes may impact that. So it isn't a program that is talking specifically about violence. It doesn't ask about whether there's been an experience of violence. It is talking in general terms about healthy, equal relationships.

Having said that, the model is such that any new parent who attends the standard Maternal and Child Health New Parents Group the expectation is that that will filter into the following Baby Makes 3 Program. I think that one of the things I will be looking for in the evaluation is any indication of how that transition works and whether or not if the Maternal and Child Health nurse or any of the other health or other services that have been involved identify that there is in fact a risk of family violence, whether or not there is a mechanism for that to be identified and perhaps consideration of whether that couple should in fact participate in the Baby Makes 3 Program, because I do think that the dynamic of the

program and the way it is designed is certainly not intended to be dealing with couples that actually are experiencing family violence or are at significant risk.

MS DAVIDSON: Picking up from that point, one of the evaluations or the most recent evaluation referred to a number of people specifically commenting that the program was preaching to the converted. What sort of assessment has been done in relation to that? Are you potentially preaching - are the people who are taking up this program already the people that you don't need to be concerned about?

MS BRENNAN: I think that that is a valid question. It is a voluntary program. So all new parents are in theory invited to participate in a new parents program through their Maternal and Child Health Service, and in this model - in the original pilot program they were offered it as an optional extension program. So it was an opt-in model. They had to specifically elect to attend these additional three sessions. Through the formative evaluation the model has changed where it's an opt-out. So it's presented instead of as a six-week program, a nine-week program but the parents can elect not to attend.

In any program of that nature you will have some element of self-selection. You could reasonably theorise that new families that have healthy relationships where the man or the father is very well engaged in the new parenting role may be more likely to be interested in participating in a program about healthy relationships. To that sense there is an element of self-selection.

However, the program is premised on the fact that this is a critical time for a couple who is starting a new

family. The men are often actively engaged in reaching out for services at that point. Their entire life has just changed and the men are actually looking to connect to other new dads and for support on how to negotiate this brave new world. So to some extent it's an optimal point to engage dads as well as mums as a couple with that intent.

But, yes, there is an element of self-selection, and some couples who may be resistant and hold strong stereotypical views of the role of the mother, for example, the men may simply elect not to attend.

MS DAVIDSON: I think the evaluation identified quite a high rate of attrition. Can you explain what kind of rates of attrition were involved?

MS BRENNAN: I think that the evaluation data still hasn't been finalised. The evaluation material to which I think you are referring is the most recent update from the Baby Makes 3 Plus Program down in Warrnambool. I'm interested in the comments about the level of attrition in that program. One of the considerations I will be looking for in the evaluation is trying to understand whether that's a dynamic of the particular communities. Generally there's an assumption that regional and rural communities may be more conservative, may have a stronger emphasis on gender stereotypes. Some of the dads may find some of the material more confronting. It could be a factor of the manner in which the program is being developed in that area. Unlike the original Baby Makes 3 Program, which has now been running in different forms for many years in the eastern metropolitan area, this is the first program of its kind in a regional setting. It could be that there's

a lack of experience with the facilitators in how they are delivering the program. It could be that we need to look at some questions about their fidelity in delivering the program materials.

I think it's hard at this point on the evidence I have to make a conclusion either way, but it's certainly a question that we will work through in the evaluation, and we do expect the evaluation to clearly identify what steps each organisation has taken to address that and what has worked and not worked in that sense. But it does seem to have been more of an issue in the regional setting than the metropolitan setting.

MS DAVIDSON: In terms of that attrition, does the evaluation actually go out and follow up the families that have dropped out and find out - are they asking them why they have dropped out, or how is that being evaluated?

MS BRENNAN: The evaluators for, and particularly in the Barwon south-west region with the Baby Makes 3 Plus, do mention in the interim evaluation reports that they have followed up with some of the parents. In some cases it has been through parents who did participate in the program. They have then contacted the other parents who didn't attend and asked them why they didn't. In some cases it has been a direct follow-up with the family concerned.

The issues that have come out of that so far are varied. Some of it is simply about time, so there may be other commitments that have precluded either the mum, the dad or both from attending. In other cases - and there were some comments in the most recent evaluation of negative feedback from some of the fathers and indeed the mothers, that they felt the second component of the

program was negative in its portrayal of men or that the men felt uncomfortable or that it was about somehow attacking them. Again, we have to look at what might be the explanations for that.

But also accepting that it is a program that is intended to challenge people's attitudes and perceptions of stereotypes and their roles and to some extent it may be uncomfortable for some people.

MS DAVIDSON: Thank you. Do either Dr Fletcher or Ms Bunston have any comment to make in relation to the Baby Makes 3 Program? You don't have to.

DR FLETCHER: I suppose the first thing is to commend Victoria in trying to do something in this area. So there's very little that happens in this area. I suppose as an idea of addressing a particular factor leading to violence in the family, I suppose what occurs to me is that there are a number of factors that lead to violence in the family and gender stereotypes is one.

It is a pity that there isn't a parallel program addressing some of the other factors; for example, depression and mental health is one. So, I suppose rather than see this as a solution - which I'm sure you are not suggesting it is, but in terms of funding it seems to be it is - I would be interested to see what the accompanying programs were that were directed to fathers.

I think it's an interesting point about it's meant to be confronting so that fathers might drop out. That's a self-defeating approach, I think. If it is meant to be confronting, then it needs to be confronting in a way that engages the fathers rather than just confronts them and then they stop coming. So I think that's an

area, one of the areas that needs a lot of work which I think Cathy Humphreys is involved in at the moment.

MS DAVIDSON: Ms Bunston, did you have any comments to make about that?

MS BUNSTON: I don't know. I don't think I know the program well enough to make those comments. I guess I would see from my clinical experience of working with children and men and women where there has been quite extreme family violence, that I think something different needs to be created for that cohort, just because it really is about being able to engage really at-risk and highly difficult to engage families.

So, I guess it's that thing that there's not one size that fits all, but anything we are doing that is enhancing people's ability to feel more confident as parents is a good thing. That's probably it.

MS DAVIDSON: Thank you. That completes my questions for these witnesses, but does the Commission have any other questions?

DEPUTY COMMISSIONER FAULKNER: I have a couple, but I would like to start, as we were in this place, with a question to Ms Brennan. The program of funding the $7.2 million bucket of money that you have had to administer comes with a heading of "Crime prevention". I assume therefore that if Baby Makes 3 is successful, it is seen as partly successful in helping alleviate crimes related to family violence; is that correct?

MS BRENNAN: That's correct.

DEPUTY COMMISSIONER FAULKNER: So in the future, if this proves successful, the platform for delivering it isn't a normal Justice platform, is it true that you would expect then

Justice to fund this program into the future?

MS BRENNAN: I think it's about, Commissioner, the need as with so many primary prevention programs to work across government in a much more collaborative way. So in this program it's attached to a Maternal and Child Health Service, which of course is funded through my colleagues at the Department of Education and Training in conjunction with the Municipal Association of Victoria, and obviously we are engaging them in discussions with the sector about opportunities of how we would work at embedding it.

So it may be that we use this program and the evaluation to work across government and identify what is needed in which department to support a further roll-out of this program and direct the funding to the best equipped agency to make sure that that occurs. So in that example we may very well lead the development of a business case, but we do that in consultation and collaboration with our colleagues to make sure it had the best chance of success.

DEPUTY COMMISSIONER FAULKNER: Can I just push a little harder on that to say then theoretically, if it had benefits to different portfolios, and I appreciate the complexity of where benefits fall, but if there was a benefit in the justice system, you would expect an advocacy from the justice system and perhaps a redeployment of funds from another crime prevention area such as police to pay for this?

MS BRENNAN: I think it's very difficult to say you take funding from one area or re-prioritise funding from a response and enforcement agency to another part of Justice to fund this program. Those are options that we look at,

how do we best re-prioritise resources. But fundamentally it may be that the costs are in fact sitting in local government areas or the Department of Education and Training. It's about putting through a reasoned business case, looking at where we can re-prioritise funds and which is the appropriate department to expend those funds. That may sit in Justice under a community crime prevention banner, but equally, if the program would be better administered somewhere else, it's about identifying that early and agreeing across government of where that should be and how we should support it.

DEPUTY COMMISSIONER FAULKNER: Thank you.

DEPUTY COMMISSIONER NICHOLSON: I was particularly interested in Baby Makes 3. I guess what I'm puzzled about: why wouldn't you have established this with a randomised controlled group? It would be pretty easy to do that.

MS BRENNAN: I think the answer, Commissioner, is the nature of the grants program as it developed. It very much was a circumstance where we had an opportunity. We did re-prioritise funds that had been earmarked for other funding initiatives to create a grants program focusing on primary prevention and early intervention. We ran expressions of interest and we worked closely with key stakeholders, including Domestic Violence Victoria, VicHealth, the CASA Forum, No to Violence, in developing the grant framework.

We then went through a process of assessing the expressions of interest and there was a two-stage process. It wasn't directed funding of saying, "Here is a program that we would like to explore," in which case we may have taken the approach of doing a randomised trial. This was

an expression of interest, invited competitive grants program and so we worked with the applications that we had which was two discrete organisations looking to build on the early evidence base.

So I think there are always options of how you approach these. In this circumstance it was about a program that was developed in direct response to community concerns about the need to further develop the evidence base and it was a competitive grants process rather than a directed funding model, if that answers your question.

DEPUTY COMMISSIONER NICHOLSON: So would you agree that the problem that you identified in the self-selection is going to call into question the validity of any findings?

MS BRENNAN: I don't think so, because with elements of any program there are limitations on how it's developed. I think the clear intent here with this funding for these pilot programs is to build the evidence base and to identify some of those key questions and look at ways that we could address and ameliorate them. In doing that we will be very interested in what the organisations come back with in their final evaluations. But certainly the data I'm seeing thus far is a very healthy percentage of the parents who were attending the new parent program are transitioning through to this Baby Makes 3.

I think there's always an element of some parents and particularly those, frankly, who are at high risk are harder to engage in base maternal and child health programs and also may not engage in these programs. But I don't think that invalidates the work and the very good work that I think these programs have been doing at taking an opportunity, where the families are linked in with

existing services, to challenge some of those attitudes and behaviours that really impact on how that family relates to each other and the environment the children grow up in.

I don't think that just because it's not universal in terms of every single family in Victoria goes through it necessarily invalidates those achievements. But I think it is important to understand it isn't a silver bullet and we need to have a range of programs across different settings that are mutually reinforcing this work about tackling some of those attitudes and behaviours that lead to violence against women.

DEPUTY COMMISSIONER NICHOLSON: One of the very common complaints that the Commission has heard through our consultations has been particularly from community organisations that complain, "We get funding for pilots and then they cease," and that this causes great problems for those community organisations. I noted when you were talking about Baby Makes 3, I think you said the evaluation coincides with the cessation of funding. This is a complaint we have heard often, that we start something, it gets stopped, it's evaluated and nothing happens. Surely we have to get more sophisticated in the way we fund these pilots so that the program doesn't stop before we know whether it's working or not.

MS BRENNAN: I think that is certainly a common complaint and concern raised generally across all sectors and it certainly was a consideration in how we developed this program. I think it's important to be really clear that the primary objective of this funding that we developed in consultation with peak bodies was to address the

identified issue that while we had a clear focus and had done some good early work on primary prevention, we needed to build the evidence base.

I do understand that when you fund a pilot program and the funding ceases and the evidence says, "This program worked brilliantly, where does it go," we were very clear that we wanted to fund these programs over a long enough period, being three years, to give them an opportunity in a formative evaluation to really help inform what is working, what isn't, what blend of programs across different settings are working and to help inform a deliberate series of options that could be presented to government about where to develop further investment.

So, the programs were never intended to be ongoing. They were intended to deliver evaluations that could inform further direction on investment because it was about building the evidence base. We were very clear that that was what we were trying to do.

The important thing is to then say, once we do have that evidence about what works, it's not so much for me the focus on continuing a pilot in, for example, Barwon south-west, but how do we take the evidence from that pilot to look at opportunities to scale that up in other settings and broaden it across the state. So for me it's about utilising pilots to build an evidence base to see what you could embed statewide rather than continuing to fund programs that just operate in isolated areas across the state.

COMMISSIONER NEAVE: Can I ask what advice was given to the department about the best way of testing the success of these programs? That is, how is the evaluation process

developed? Because the randomised controlled trial does seem to me the best evidence base for saying, "We should go forward with this" or "This didn't really work" and yet that has not been built in.

MS BRENNAN: I think that's correct. The nature of the grants program at the time was that we would require an independent evaluation to be built in and we specifically quarantined funds for that. That's not a randomised controlled trial. We know that. But in the simple logistics and timeframes within which we were operating, that was important to include some element of independent evaluation. But, no, it's certainly not a randomised controlled level.

However, we did have discussions with, for example, VicHealth and others in coming up with that framework for the grants and felt that that was, within the other constraints we had, a very good place to start. But I do think that the importance of developing this emerging evidence base about primary prevention in particular, that is something that I certainly would be looking at providing options to government around how to do more rigorous longitudinal and randomised evaluation.

COMMISSIONER NEAVE: That might be difficult, might it not, given the relatively short term for which these pilots run, because if you really are wanting change on a population level, three years is a pretty short period.

MS BRENNAN: And I think that is the point. The original funding for these grants was for a finite three-year period. Being able to do longitudinal studies in that period is not really feasible. However, if we use that evidence from that three-year formative and developmental

evaluation to look at where options are for promising or evidence based practice into the future, it's at that point that you would be looking at longer term funding and more rigorous evaluation over the longer term.

COMMISSIONER NEAVE: Thank you. I think Ms Faulkner has a question.

DEPUTY COMMISSIONER FAULKNER: Yes, I wanted to ask Dr Fletcher a question. I think in your evidence you were spanning across a range of intervention points as people actually went deeper into the service system towards the tertiary end where you talked about evidence from prison studies as well, and I think you said your view was that the earlier the better, so things at antenatal or postnatal level are the best things for dads.

We have had a lot of evidence or a lot of submissions to us that talk about the place of, not just for dads but for men in general, education relating to respectful relationships and the value of that. I'm trying to test whether people believe, and particularly you, Dr Fletcher, that you need a burning platform or a life event to make people take notice of what they need to learn, compared with a more generic universal education that might be delivered through schools to boys about what respectful relations are and how one develops them.

If it is not within your expertise, please say so, but I would just be interested in your view.

DR FLETCHER: I have done quite a lot of work with boys and I think that area is something that should be happening. So I don't think - if I got your question right - I don't think it's an either/or. I think, yes, we should be having programs in schools and Rock and Water is one that

we supported in Australia which I thought was very effective. But that's a different question to when young men are ready - I wouldn't put it quite the way I thought you did. It's not that they are having a life experience which then says to them, "Oh, I need to know something." I think that's the issue. They don't know what they need to know.

When you have dads in antenatal classes and you say, "How long are you going to take off after the birth?" They say, "Two weeks," which is the average. You say, "Why two weeks?" They go, "What do you mean why two weeks? That's what you do." There's been little thought from them about what they might do. You say, "What are you going to do in your two weeks?" And the most common answer is, "Well, whatever she asks me to do," which indicates to me that they don't have a picture of their role after the birth. They don't know what they're going to do and so they don't know what they don't know.

So they'll think the answer is, "Yes, that's the time," because they are ready maybe to be engaged in something, but they don't have a whole series of burning questions they're trying to answer.

DEPUTY COMMISSIONER FAULKNER: I'm probably trying to press you into a priorities question, which is the one we are trying to have to answer, and getting a bit of help on that priorities question. So, if you had a finite bucket of resources to apply to preventing domestic violence or in fact lessening the impact of domestic violence on the community, would you invest in education of a generic sort with boys - I know you've said you'd like to do both - or would you take a life event like the first intervention

order, the first child? Where would you apply - if you had to say in the three-year horizon what would you do, or in the five year, I'm trying to push you on prioritisation to help us.

DR FLETCHER: I think the birth of your first child is the most significant event, with the potential to be the most powerful, particularly for the most disadvantaged groups in the community, the most disadvantaged males in the community. So I think that is the obvious place to start our interventions to support their development of their relationship. That is their first relationship as a family in that sense of they're going to have a baby.

The Aboriginal young men we have just been filming make remarkable statements about what a significant event that was, the fact that they are now going to be responsible for this person. So it isn't about their romantic relationship, it's about this baby and what a change it's made to who they think they are. So my money would be on that period, the antenatal, postnatal period.

MS BUNSTON: I guess coming from the perspective of having worked in my career predominantly with infants, children and young people, I guess I see there are some other opportunities apart from the birth of your child. I think at the crux of all of this is that violence is expressed as a relational response to things. So violence, generally when we talk about family violence, is expressed when there is some sort of trigger happening within the relationship itself where one person's feeling vulnerable and to counteract their feelings of vulnerable, if they don't have the equipment socially to sort of say, "I'm

feeling vulnerable" or "I'm worried about our relationship" or "I'm worried about what's happening in my family," and their repertoire of responses is fairly limited, then they can resort to using violence or other fairly destructive means to get their message across.

I get the money issue. I get that. I guess what I find very confounding and very frustrating as a practitioner working with people, not as an academic and not as a manager of a big system, but as someone that's spent most of her career working on the ground, is that there have been some brilliant opportunities to work with really high-risk young people to change that trajectory through really interesting and creative programs and if you were to take the ilk of talking about - I don't know if it is worth mentioning his name, but Adrian Bailey. I was really interested when the media reports suggested there was obvious evidence before he started to commit offences about having a father who was violent, coming from a broken home, all sorts of indicators that I think would have probably been fairly obvious to quite a few professionals that were in the life of this person, but obviously nothing was picked up or, if it was - I don't know the circumstances - but I assume if it was, it wasn't done very well.

I guess having worked with a lot of at-risk young people, I think generally speaking most of us in this room who have worked with kids would say you can see there's a bit of a lineage here, it doesn't just happen in isolation. Yes, I do know that there's some evidence that says that men who kill spouses might not have had a history of other violence and it's a one-off incident, but

I think there's also a lot of evidence to suggest there's a pattern that's there. It's about how do we support that really high-risk group. We are fairly certain that they are going to find it difficult to actually negotiate and manage some pretty big life events. They are the high-risk group that aren't going to come along to a program and it's how do we be creative about that client group.

One of the programs that I have been involved with is a program called Operation Newstart, which was for at-risk young people and it was an Education Department and Police Department initiative and it was at the Royal Children's Hospital, so it had a mental health component in that region. It didn't in other regions, but it did in that region. It was run by two blokes, a police officer and by a school teacher, and I think they did phenomenal work with a really high-risk group of young people, and not because those kids were brought in saying, "You're violent" or "You're this" or "You're that". These were kids at risk of expulsion from school, had horrific histories, on the whole. Their parents were involved in the program. Essentially they took them for a term out of school and they did adventure based programs and it was expensive, it cost a lot of money to do, but they also got in - CFA did stuff with them for free, apparently Grollo used to put money in; there were all sorts of people who used to put money in.

I think the success of that program was the hook was these kids came in because they thought, "Oh, this is cool, I'm getting out of school for a term and doing really cool stuff." But what made the difference for

those young men's and young women's lives were the relationships they formed with the two facilitators, the two blokes. These were kids that were desperate, they were starving for having a relationship with a good male role model.

In my work therapeutically, because I used to run the parent groups and I used to do the group work with the kids, when I worked with those kids I would work as a therapist with those two facilitators, saying to those facilitators, "If you could have something really amazing change in the life of this young person in this group by the time it's finished, what would it be?" And those young people would be rapt to just sit and hear an adult that they respected and wanted approval from to say what it is they wanted for their lives, because I bet you they didn't get that from their parents.

So I think sometimes we have to put our money where our mouth is and say there are pockets there that really need more than universal - a few hours of whatever - because there are families that will benefit very much from that and I really commend that it's with maternal and child health nurses, because I think they are a discipline that can do amazing work, often very anxious about talking about family violence, because I supervise a lot of maternal and child health nurses, but they are in an ideal position to really do early pickup work, not underfunded but overworked.

But I do think that there are niches of groups that really need more than what we are giving them and they are going to cost money. But I would have to suggest common sense would tell me that if we put the money in

when they're younger, if we do that work with the infants, with the children when we know we are already getting indications with the higher risk groups, I would suggest that it's going to surely cost us less money in the future, but I'm not an economist.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Perhaps we can have a 10-minute break and return at 10 to 12.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

COMMISSIONER NEAVE: Thanks, Mr Moshinsky.

MR MOSHINSKY: Thank you, Commissioners. As foreshadowed, we now move to a part of the children topic concerned with intervention and response in cases where there is child abuse or maltreatment or children are experiencing family violence in other ways. We look at the operation of the child protection system in Victoria and also the Child FIRST system which will shortly be explained through the witnesses. We look in particular at the interaction of these systems with family violence, both where this is directed against the child or young person and where there's other family violence including intimate partner violence.

We have three witnesses who are in the witness box: Professor Cathy Humphreys, Dr Robyn Miller and Beth Allen. If I could ask for them now to be sworn or affirmed.

COMMISSIONER NEAVE: Dr Miller was before us yesterday, so she's already I think affirmed or sworn.

<CATHERINE HUMPHREYS, affirmed and examined:

<ROBYN MILLER, recalled:

<BETH MAREE ALLEN, affirmed and examined:

MR MOSHINSKY: Could I start by asking Professor Humphreys some questions. Professor, you are a Professor of Social Work at the University of Melbourne?

PROFESSOR HUMPHREYS: I am.

MR MOSHINSKY: And you have been a Professor since 2006. You have been an academic for many years and previously you practised as a social worker for 14 years before becoming an academic?

PROFESSOR HUMPHREYS: Yes, that's right.

MR MOSHINSKY: And you have worked in the areas of child protection, mental health and community development and in your statement you say that you have been involved either in a voluntary or paid capacity in the area of violence against women and their children all of your working life.

PROFESSOR HUMPHREYS: That's right.

MR MOSHINSKY: You also have had experience with the systems in the United Kingdom as well as Australia?

PROFESSOR HUMPHREYS: I was 12 years in the UK.

MR MOSHINSKY: Thank you. Have you prepared a witness statement of your evidence before the Commission?

PROFESSOR HUMPHREYS: I have.

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

PROFESSOR HUMPHREYS: They are.

MR MOSHINSKY: Can I next turn to you, Ms Allen. You have prepared a witness statement in this Commission?

MS ALLEN: I have.

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

MS ALLEN: They are.

MR MOSHINSKY: Could you please just very briefly outline what your current position is with the Department of Health and Human Services and what the role involves?

MS ALLEN: So, my employment and role is as the Assistant Director of Child Protection with the Department of Health and Human Services, and essentially that role is responsible for the development of policies, legislation and practice advice to our Child Protection workforce within Victoria.

MR MOSHINSKY: Thank you. Could you just at a very high level just outline your professional background and experience?

MS ALLEN: So my background is as a welfare worker, having graduated probably around 30 or so years ago and I came into the department and have worked fairly solidly in relation to child protection practice over that time. So beginning in Child Protection operations as a base grade worker, working predominantly in the area of deinstitutionalisation, through to management roles and more recently an Assistant Director in what was then the North and West Metropolitan Region.

I then moved into the central policy position as Assistant Director approximately three years ago, moving out of operations, and assumed that role overseeing the development of quite a large legislative program, policy program, but also the development and review of a range of practice advice for our Child Protection workforce.

MR MOSHINSKY: Thank you. Dr Miller, you gave evidence yesterday and I asked you some questions yesterday about your background and experience. I won't go over them all again today. But can I just note for anyone who wasn't here for your evidence yesterday that from 2006 until 2012

you were Principal Practitioner in the Children, Youth and Families Division in the Department of Human Services, as it then was, and from 2010 to 2012 you were Chief Practitioner, Child Protection and Youth Justice, and from December 2012 until January 2015 you held the position of Chief Practitioner.

DR MILLER: Yes, that's correct.

MR MOSHINSKY: Thank you. Witnesses, what I propose to do, as indicated to you, is to follow a list of topics which hopefully you all have there and the Commissioners have as well. I want to first deal with some introductory matters about the system and introduce some basic concepts and ask you each to explain some aspects of the system that may not be widely known or understood.

I then want to move through eight separate topics and on each occasion I will be asking questions to each of you to give each of you an opportunity to comment on that topic. If at any time you wish to add a comment to something that another witness has said, you should feel free to do so.

To start this introductory section, what I think it would be useful to have explained is really what does the Child Protection system do, but also another part of the system which is known as Child FIRST, when was that introduced, why was that introduced and could I ask you, Dr Miller, to start with that topic. Could you please explain fairly briefly what was the genesis of the introduction of Child FIRST and how does that part of the system relate to the Child Protection part of the system?

DR MILLER: Child FIRST began in the mid-2000s, I think 2006, 2007 it was on foot. But the precursor to that was what

we called the innovations pilots and they were quite innovative because it was actually saying in local areas of the State, instead of having 10 different agencies working with families who were vulnerable, all with their own intake, all with their own training and all have individual relationships with the department and frequently not many relationships between each other, in Warrnambool, in Shepparton, all around the State, there were 24 catchments were developed.

What happened with Child FIRST was that those networks joined up and there were lead agencies established that had a joined-up intake process, so it was easier for families in trouble to make one phone call rather than have to ring around. It was also a way of actually co-locating a Child Protection worker in the community and we developed positions called Community Based Child Protection Practitioners. They have been gold. They have been a wonderful development because it meant that we broke down silos between what was traditionally a separate service system, which was the family support system and the child protection system. What we did was actually develop relationships much more closely and trying to outreach more intensively.

So, Child FIRST and the Family Services alliances, so there were all different agencies in different areas that became part of this alliance and they chose a lead agency and it was a pretty much - there was top down directions around targets and expectations, but there was a lot of capacity for people in local areas, bottom up, to join up and work out what's going to work best in Swan Hill versus Footscray, for example.

So, all over the State, people - it was a bit of a revolution, really, because it also coincided with the whole explosion of knowledge around neuroscience and the impact on brain development that we talked about yesterday particularly of the under-threes and the importance of having a family centred approach and early intervention.

There was an article that Professor Humphreys wrote with others talking about the planets aligning in Victoria and I think this time in history was very important because it meant that the system actually did join up and did make significant changes, which later evaluations by KPMG - and we have some serious evidence that talks about the success of those reforms.

MR MOSHINSKY: So what's the difference in simple terms between what Child FIRST does on the one hand and what Child Protection does on the other?

DR MILLER: Child FIRST, which is the intake - so it meant that we were able to get a principal of a school who was worried about a family, they could actually make a choice between Child Protection and Child FIRST knowing that there would be an outreach to that family. So Child Protection would still be dealing with the very serious at-risk cases. Child FIRST and the Family Services would be what we called wellbeing reports, where there were still serious family problems. However, what was different was that instead of it being dependent on the family to seek help or to make the contact, if another party referred and made a report to Child FIRST, they would actually get an outreach. The expectation was that the Family Services system and Child FIRST would target

and outreach the most vulnerable families and prioritise those children, actually.

MR MOSHINSKY: If we put Child Protection to one side for the more extreme cases. If one is looking at a family that is referred to Child FIRST or approaches Child FIRST, does Child FIRST itself provide services to that family or does someone else provide services?

DR MILLER: Child FIRST will do the initial intake and triaging and do some short-term holding sort of work. Then there are referrals made to the family support agencies in that area. The other significant difference is they shared training. We shared a practice model across Child Protection, Family Services and Out-of-Home Care, known as the Best Interests Case Practice Model. So that was a significant shift in terms of developing a shared language and an understanding of the risk framework and an understanding of how we wanted to practice in Victoria, so there was much more of a joined-up understanding and approach.

In answer to your question, there's the initial sort of intake and organisation, if you like, of the local area practice is with Child FIRST and then different agencies will still provide that ongoing support and outreach to families.

MR MOSHINSKY: What's the relationship between Child FIRST and Child Protection? If Child FIRST is referred a case and thinks that Child Protection needs to get involved, or Child Protection has a case and thinks that this is something that Child FIRST should be looking at, what's the relationship there?

DR MILLER: There's a relationship where there's a referral

pathway. That position that I described earlier, the community based Child Protection practitioner, plays a fantastic role there of really mediating and often helping the Family Services agency to work with the family, even though there are very significant issues in the family. The whole aim is to try to support families and reach families earlier without needing the stigma of being reported to Child Protection and having that sort of investigation.

So it's a challenging process at times because everybody is very - there are great demands on both systems. That point of referral in and out is sometimes a tense one, but we rely on the importance of those good relationships and I think again the development of those partnerships, and it's very much a partnership model, is critical to the success of that.

MR MOSHINSKY: Could I turn to you, Ms Allen. In terms of the overall structure of the system, before I ask you some more specific comments, is there anything that you want to add to the description that Dr Miller has given?

MS ALLEN: I think one of the important things to note is that Child FIRST and the Integrated Family Services systems and indeed Child Protection sit within a much broader system of Child Protection as well. So, if we think about the Child Protection system consisting of mainstream and universal services, those services that we have heard about over the last few days, maternal and child health, the role of schools and early childhood services, we then have secondary service systems that families can reach out to and they may include family services and what Robyn has just described, but also treatment services that might

involve mental health Services, drug and alcohol services, and then we go through to the statutory Child Protection system.

So in Victoria and in most of Australia we talk about that three-levelled system, but the focus of the Integrated Family Services and Child Protection system is what's under examination and what we generally refer to as a differentiated response. So generally it's about saying in very blunt terms we have children who are in need who are very vulnerable and require services, but their family may be willing and able to seek the supports they need and can do so independently of the State's intervention, as opposed to those families where their children are at most risk and they are assessed as being unable to seek the necessary supports and ultimately protect their child. So in those cases the State will intervene to do so.

So, it's important to differentiate vulnerability and families that can be worked with voluntarily without coercion and without State intervention as opposed to those families that actually require a service that is imposed and can be mandated by the Children's Court.

MR MOSHINSKY: I will come to a bit more detail around what Child FIRST does and what Child Protection does in a moment, but just an initial question. If there is a mandatory report that needs to be made because a professional, for example, is required by the law to report, where does that go? Does that go to Child Protection or to Child FIRST?

MS ALLEN: All mandatory reporters must report to the Child Protection program.

MR MOSHINSKY: If I can just take you to some parts of your

witness statement, Ms Allen. At paragraphs 16 and following you provide some detail about the Child FIRST system. You indicate that the Child FIRST system usually does an initial assessment to determine which services the family requires and then refers the family to a provider.

MS ALLEN: That's correct.

MR MOSHINSKY: Then you indicate in paragraphs - if I could ask you to turn to paragraphs 33 to 34 - the growth that has taken place in families accessing the Child FIRST part of the system, and you indicate that Child FIRST families grew by about 20 per cent in the last two years.

MS ALLEN: The families that are referred with complex issues, so generally that's defined as those issues that involve family violence, mental health, drug and alcohol, they grew by 20 per cent between 2011/12 to 13/14.

MR MOSHINSKY: You indicate that there was a presence of family violence in over a third of the cases that you are referring to.

MS ALLEN: That's right. In 2013/14, of the referrals made to Child FIRST there was approximately 37 per cent of families where family violence was identified as an issue.

MR MOSHINSKY: In paragraph 35 you indicate that the model works on the basis that Child FIRST has funding for about 10 hours per case; is that right?

MS ALLEN: That's right. It's important to note that Child FIRST is really the intake point. They receive reports concerning the wellbeing of children. They gather information, undertake a brief assessment of that. As was indicated, they can do holding work. But on average they are funded to provide 10 hours of service for that family until such time as they refer them and make links to the

appropriate services that the family require.

MR MOSHINSKY: You indicate that in the most recent year there were about 12,000 assessments made by Child FIRST.

MS ALLEN: That's right.

MR MOSHINSKY: So does that mean there were approximately 12,000 families who either were referred or sought the assistance of Child FIRST in that year?

MS ALLEN: In actual fact there were many more than that. So for some families they may not go through to Child FIRST undertaking an assessment. There might be simply advice provided to the person making the referral, for example a school teacher. They might be given direct advice about where to get assistance for the family. For a family who is making contact with Child FIRST directly, again advice and phone numbers provided as to how someone might be able to make their own referral.

So Child FIRST has many, many more contacts. But of those, the 12,000 are the ones that they undertake assessments for.

MR MOSHINSKY: You refer also to Integrated Family Services. Could you just explain what Integrated Family Services refers to?

MS ALLEN: So we need to think about Child FIRST as being the intake or the front door for all of our family service providers in Victoria. There's approximately 90 family service providers across the State that deliver services in either one or multiple areas across the State. So typically Integrated Family Services involves all of the family services that operate in one catchment with Child FIRST as their front door.

It's common that an integrated family service

catchment would have in the vicinity of perhaps, on average, five or six providers in that area.

MR MOSHINSKY: How is Integrated Family Services resourced? Through what funding stream are those services funded?

MS ALLEN: Primarily family services are State Government funded but they may also, as part of the services that are being delivered through that family service, also receive philanthropic trust money as we have heard today. They might also attract Commonwealth money for other funding activities, but the actual what we call Integrated Family Services is State funded.

MR MOSHINSKY: Is that through the Department of Health and Human Services?

MS ALLEN: That's correct.

MR MOSHINSKY: Has the increase in demand that we referred to earlier been met by an increase in funding?

MS ALLEN: Yes, obviously the increases in demand have attracted funding over time and certainly in the most recent budget received additional funding for future years.

MR MOSHINSKY: Could I then ask you some questions about the Child Protection part of the system. In paragraph 41 of your statement you explain that children and young people who are in need of protection and do not have a parent or other suitable adult who is able or willing to protect them are the group that the Child Protection system is looking at. Can you rather briefly explain what is the object of the Child Protection system and how does it operate?

MS ALLEN: In broad terms the Child Protection program is mandated through the Children, Youth and Families Act, so

a legislative program that really defines how the State or how - I should go back - how the State intends to protect children from both harm and risk. So that Act sets out how our community based and Integrated Family Services are to be delivered, but also the State run Child Protection program.

In relation to the Child Protection program, the legislation provides for the Child Protection program to receive reports about children who are yet to be born for whom there are risks and from birth to 17 years where there is concern about that child's wellbeing or where reporters believe there is a significant risk to their health and wellbeing.

COMMISSIONER NEAVE: Can I just have a follow-up question. I'm just trying to clarify this in my own mind. Take our hypothetical headmaster who may not know, or may know, whether it's Child FIRST or Child Protection. Let's assume that the headmaster thinks it's a Child Protection matter. Am I right in thinking that then Child Protection does its review, decides that those powers are not relevant and refers the matter to Child FIRST or, alternatively, it could go to Child FIRST, who might then refer it back to Child Protection? Have I got that right?

MS ALLEN: That's correct. So both Child FIRST and Child Protection, if a reporter to Child Protection or a referrer to Child FIRST doesn't make the correct assessment or they get to the wrong door, then both have the capacity to refer to the other.

COMMISSIONER NEAVE: I see.

MR MOSHINSKY: At a high level, what are the powers of the Child Protection system if there is a report made to Child

Protection?

MS ALLEN: So, upon report, Child Protection generally takes about three days to classify a report, may take up to three days, I should say, to consider, gather information from people who are working with the child, it might be their maternal and child health nurse, their kinder teacher, their school teacher, any other professionals involved in the family, to gather information that will inform them about the nature of the report that's been received and ultimately determine whether that report requires advice to the reporter, advice to the family about where to access services, a referral to community based Child FIRST and Integrated Family Services or to some other service.

But when the information at hand suggests that the child may be at significant risk and in need of protection, then Child Protection can commence a direct investigation with the child and family. Essentially that involves the direct contact with both the child and the family to assess the risks at hand. That's called a Child Protection Investigation. Those investigations are typically undertaken over a 28-day period, over the course of a month or so, sometimes longer depending on the complexity. The ultimate aim of that investigation is to consider whether the concerns are substantiated.

If the decision is that those concerns are substantiated, Child Protection has a number of options available. One is again that the family can be referred to another support service, an appropriate support service to meet the family's needs and reduce that risk. They can take no further action at all because the family may in

fact have taken appropriate action themselves, or in the extreme situation where they believe that the child is in need of protection and has either suffered significant risk of harm or is likely to suffer significant risk of harm, the matter may be taken to the Children's Court via a protection application.

It's noteworthy, though, that of the 82,000 reports received last year to Child Protection, only around 4,000 of those - so a very small percentage - end up being taken to court in order to gain a mandated court order to enforce involvement with the family. The vast majority of reports are concluded - are either managed at the point of intake. 25 per cent of those, of the reports that are received, proceed to investigation, so about a quarter, with only around 4,000 of those ending in a protection application.

So a vast amount of work is undertaken by Child Protection to assist families, get them to services that would support them, to work what we call voluntarily without the need for a court order, generally for a few months following the report and investigation.

MR MOSHINSKY: Thank you. If I can just go through some of the figures that you mentioned just then from your witness statement. At paragraph 59 you indicate that in 2013 to 2014, so a one year period, Child Protection received approximately 82,000 reports concerning child abuse and neglect of children in Victoria.

MS ALLEN: That's correct.

MR MOSHINSKY: And then the next stage is to determine whether that is a protective intervention report and then will be the subject of an investigation; is that right?

MS ALLEN: That's correct.

MR MOSHINSKY: So, of the 82,000, approximately 25 per cent were determined that they should be the subject of an investigation?

MS ALLEN: That's right.

MR MOSHINSKY: So that's approximately 21,000. Then, of those that were the subject of an investigation, about 60 per cent, in other words about 12,000, were substantiated?

MS ALLEN: That's right, 12,500 were substantiated.

MR MOSHINSKY: And then after substantiation does that necessarily mean that the matter is taken by Child Protection to the Children's Court?

MS ALLEN: No, it doesn't. So if we think about the fact that 12,500 reports were substantiated last financial year, only approximately a third will have been taken to the Children's Court. The others, as I indicated, would be subject to direct work, direct case management and case work with the family, referral activity, family conferencing to mobilise supports for the family and very frequently professional case conferencing where we are bringing professionals together to rally around families and bring whatever services they have to bear in that local area to the family's aid.

MR MOSHINSKY: Dr Miller, would you like to add any comments about those figures that we have talked about and the taking the matter to court, I think as you indicate in your statement, is a last resort?

DR MILLER: That's right, particularly the removal of children into out-of-home care in Victoria is absolutely seen as a last resort. There is a strong preference to do as much

as we can to support the children to stay with their biological parents wherever possible. But that's always balancing risk of harm. It is traumatic often to remove children from their families of origin, but if a situation is so dire and the children are in absolute danger, then it's absolutely traumatic to leave them there. But it is a very serious decision and there are enormous powers involved. The Children's Court always oversees those decisions, that they are never taken lightly.

I would add if you look comparatively around Australia, Victoria has the lowest rate per 1,000 children in the population. It's around six children in every 1,000 are living in out-of-home care. We are one of the lowest in the Western world and we are certainly the lowest in Australia. Some states are double that, more than double that. So that strong process around joining up to prevent harm, to try to get to the most vulnerable families earlier through the joining up the family services in local areas is a really important step in that early intervention work.

The other thing I would add is that there is an awful lot of good work done by Child Protection that goes unnoticed and that isn't well known in the public space where, as Beth said, there might be substantiated risk of harm, terrible things might have happened to children, and what Child Protection does is bring people together in a family conference or a family-led decision-making meeting at the front door, and that's been a very deliberate shift in practice to bring in both sides of the family, look for extended family, and families generally will come up with very strong solutions around how do we establish safety,

not just a flimsy sense of "We all love the kids," but who is actually going to be there on Saturday night? Who will help mum because of this problem that she has, this depression? Who will help dad because of his substance abuse? Who is going to really make sure that the children are actually going to school and, more than that, are actually learning and able to concentrate and play and be kids?

So, just because it's not taken to court doesn't mean that there's not a strong safety plan and that's the expectation before Child Protection closes. Frequently there is an intervention that's on foot that might run over a few months before Child Protection closes. So it's always trying to work out, "Okay, are we in a positive trajectory here? Are things getting better? What are things like for the children? What are the children saying? What are the people who know the children best saying? What are the teachers saying? What is the maternal and child health nurse saying, as well as the extended family?"

So the decision to close the case then generally is because there is a network of other services who are involved, and of course there's always the possibility that people can re-report if that's necessary.

MR MOSHINSKY: Thank you. Ms Allen, can I turn back to you and ask you a question about the concept of being a protective parent. The Act sets out in section 162 some principles about when a child is in need of protection. These include the child having suffered or likely to suffer significant harm as a result of physical injury and the child's parents have not protected or are unlikely to

protect the child. It also refers to sexual abuse, and it also refers to emotional or psychological harm. In each case it refers to the children's parents not having protected or being unlikely to protect the child from harm of that type. Could you please explain what does it mean to be a protective parent and how does that concept fit into the system?

MS ALLEN: So going back to the legislation, as you rightly say, in order to bring a matter before the court to seek an order for the protection of the child, very careful assessments need to be undertaken about not only whether a child has suffered harm, but whether or not the parents have the capacity to prevent that harm from happening in the future or in fact contributed to that harm either through omission or commission.

So, the role of Child Protection in considering whether they have grounds to bring that matter before the court really need to weigh and balance a range of factors. Some of the things that are weighed and balanced go to their acknowledgment of the concerns, their insight into those concerns, their willingness or ability to change, their willingness or ability to accept other services that might bring about change, so that we are only intervening in those situations again from the State's perspective where that's absolutely a position of last resort, noting that the legislation again talks about the State intervening only to the degree that's necessary to protect the child.

So we are very clear in making those assessments that we need to look at the parents' capacity to change and what services the State could bring to bear to bring

about that change before such intrusive action is taken. So, in doing so we engage with parents, we engage to talk about their views of the concerns, what they may be prepared and willing to do in relation to change. We always look back over time in terms of looking at their past behaviour, because that's always a very strong indicator of their capacity for change and their future behaviour. We take into account the views of all other professionals involved with the child and the family to consider what assessments they may have made that goes towards our assessment of whether the parent is able to afford the ultimate protection for the child.

MR MOSHINSKY: They are the questions I was going to ask by way of introduction in terms of the overarching structure of the system. Could I turn now to the first topic, unless there's a question the Commissioners wish to ask?

DEPUTY COMMISSIONER FAULKNER: There is just one. It follows on from what Ms Allen just said. You said that the Child Protection worker attempts to bring practical assistance to help the family keep out of the system, really, is the way I would see it. How far does that extend? Does Child Protection have the right to prioritise housing or mental health services or drug services, those sorts of things? So what is the limit of practical assistance? If you have a person who really just needs housing to stabilise, can you achieve it, and the same with drug services or mental health services.

MS ALLEN: The answer is a little complex in the sense that Child Protection undertakes, broadly speaking, case planning for families and can identify the services that are required. The degree to which they have the levers to

bring about those services in a timely way or to prioritise those services can vary. In some instances there are specific memorandums of understanding or protocols with particular services. So if I think about our mental health services, child and family mental health services as an example, we have a protocol and an understanding that requires that children in out-of-home care that require mental health services receive priority access.

So while we don't necessarily have the funding streams to be able to necessarily purchase precisely what might be required at any point in time, there are agreements about specific vulnerable groups and/or specific programs for Child Protection programs that either give them priority access and/or programs that are exclusive to Child Protection clients because of the risk that's been assessed for them.

COMMISSIONER NEAVE: Is accommodation an area where there is any capacity to ensure entry into suitable accommodation for, say, a mother and child?

MS ALLEN: There's no capacity necessarily to jump the wait lists that are obviously very, very pronounced in Victoria. However, having said that, I think it's fair to say that, as one department, Child Protection will be regularly having discussions with colleagues in housing to advocate strongly and to make known any situations where there are emergency situations.

For example, if Child Protection were needing to intervene primarily because of the lack of accommodation and housing, conversations would be had at that area level and it is likely that if it was to avert a child coming

into out-of-home care, that housing would be prioritised for that family.

DR MILLER: If I could add to that that the advocacy is important, and I think there's a strong expectation in a local area that, for example, if there's a family that's attracted a lot of complaints in a Ministry of Housing property and they are looking at eviction, there's a strong expectation that if there are children involved that Child Protection are advised immediately, that there's a sense of a joined-up approach to preventing harm to those children and also looking at what are the issues underlying the housing problem.

But there's a lot of phone calls made every single day by Child Protection practitioners looking for accommodation for vulnerable women and children and there's an awful lot of cots purchased to make sure there is safe sleeping adherence to the guidelines to prevent SIDS. So there are some brokerage dollars that Child Protection use very creatively to try to deal with some of the immediate sort of issues around utilities bills being paid, and there's a limited capacity to do that sort of practical assistance, buying nappies, getting the fridge fixed, those sorts of things. Child Protection are very focused on doing whatever it takes to try to maintain the children at home.

DEPUTY COMMISSIONER FAULKNER: Just following Commissioner Neave's question, we have had a lot of people who say that housing is their primary problem and that they might attend to get housing, and I know that this is not Ms Allen's specific responsibility, and they will be told that if they don't have an address they can't get housing

or if they are living with relatives who really don't want them there, they can't get housing. I suppose at some stage we would like to test, and I'm not sure that it's appropriate for Ms Allen to have to answer that, but do you see any experience of people being treated in that way?

MS ALLEN: There is undoubtedly demand for housing and I think obviously for our client group affordable housing that can be provided very quickly. I think what's been described to date suggests that there's a whole range of improvements that can be made, but particularly I think where women are escaping family violence and housing is required as a matter of urgency, I think they are probably the situations where the Child Protection program experience the most difficulties navigating emergency housing programs and supported housing programs to try and bring about the greatest degree of stability possible for children and families.

The lack of address, the fact that people might be living temporarily with someone else doesn't prevent people being able to make application for longer term housing. But what it means is that they would receive a lesser priority for emergency housing if they have somewhere - perhaps a relative to stay with.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MR MOSHINSKY: Could I turn now to the first topic that I want to ask a series of questions about which is how effective is the current system involving both Child Protection and Child FIRST. Can I start with this question, and I will start with Ms Allen, but I will invite each of you to respond.

We have now had described the basic architecture of the Child FIRST part of the system, providing a central entry point to a series of services for families, and also had explained the separate Child Protection part of the system with its role to protect children. Has the introduction of that system affected who decides which children are in need of protection and has it affected Child Protection's ability or practice in relation to protecting children who are most at risk?

MS ALLEN: I think it's probably enhanced. The Differentiated Response Model has probably brought about enhancements to those decisions because we have an alternate pathway. So the Differential Response Model means that we can try and engage families as early as we possibly can, bring the services to them where they are willing and able to accept and receive those services, and ultimately prevent protection applications being taken unless they are absolutely necessary. So I think in fact the system works well to identify those children most at need where that decision and action or intervention needs to be taken.

MR MOSHINSKY: Dr Miller, could I invite you to comment on that? The question essentially is: are the children who are in need of protection being looked at by the Child Protection part of the system?

DR MILLER: The answer is yes. The answer is also that the system is under incredible pressure and stress because of the volume of reports to Child Protection. We know that there have been improvements, though, and the differentiated system has meant that there's a stronger understanding across the board about what harm it does to children, the sort of impact of family violence that we

were talking about yesterday, the harm where a child is neglected, the whole notion of cumulative harm.

One of the changes was the introduction of those words "cumulative harm" into the Act, in the Children, Youth and Families Act in 2005, and the focus actually on the neglect of neglect; that in fact that's actually extremely harmful. Where children are neglected, that's extremely harmful to their development, just as serious as the physical abuse.

So the shared language and the shared understanding - and I did some PhD research on this area and looking at practitioners' views about the change and the differentiated system, and one of the key findings was that the change has been quite a cultural shift and a fundamental shift that there's a sense of being a joined-up system where previous to the reforms the Family Services were seen as parent focused and Child Protection was seen as child focused; whereas when you start to work with families and children at risk you need to be able to be child focused and family centred. It's not either/or. It has to be both/and.

That fundamental shift in understanding the importance of engaging with family but also remaining forensically astute to the harm to children and engaging with children and not just relying on parents' report or a phone call where they are saying, "No, she's right, she's right," actually remaining much more curious and at times sceptical about what's really going on.

So what I mean by "forensically astute" is saying that everybody, not just Child Protection, but Family Services and other services like mental health needing to

have that awareness about harm to children. So there was a lot of training done, a lot of joined-up training, and that's been ongoing since 2005 across the State. That's been very important also working in a much more partnership way with Aboriginal Controlled Organisations.

MR MOSHINSKY: Professor Humphreys, if I could ask you to comment.

PROFESSOR HUMPHREYS: I guess in terms of differential response I prefer to talk very specifically about the family violence route because actually Child FIRST is taking on mental health, a lot of drug and alcohol as well as some - about a third where there's family violence. But actually the route we are not talking about and haven't discussed yet is the specialist women's services because in fact an awful lot of the referral goes there, and I think that we have got an extraordinarily inefficient system here because one of the biggest referrers into the Child Protection area are family violence incidents from police, and what we are looking at is that if you have all these - different areas are doing different things in this space, but really what we have in a lot of areas is you have anything with children going both to the Women's Services as well as to the Child Protection service.

MR MOSHINSKY: So can I ask you just to explain that. In practical terms how does that happen?

PROFESSOR HUMPHREYS: What the police do is they do a fax back - they must be the only people in the world still using faxes.

MR MOSHINSKY: Is that the L17 Form?

PROFESSOR HUMPHREYS: Yes, the L17 Form. That goes to Women's Services, and an awful lot of those - for the most part

anything with children - any of those women with children, they are going there as well because they don't differentiate or separate - quite appropriately they don't separate the pathway for children and women. But where you have children, you also have the police referring anything with children to Child Protection. So in fact you are overwhelming both systems. You are overwhelming the Women's Services and you are overwhelming the Child Protection system.

As we know, up to really about 85 per cent of what comes into Child Protection goes straight out again. Only about 12 to 15 per cent goes forward for an investigation. So we have the system wrong in this space, I think, just to make it really clear.

MR MOSHINSKY: I would like to invite you to expand on these points. In your witness statement you set out some figures, and at paragraph 26 of your statement you indicate that in a one-year period, November 2012 to November 2013, showed the following data.

PROFESSOR HUMPHREYS: Just in one area.

MR MOSHINSKY: That's in one area, thank you. And in that area the rate of closure of police family violence incidence referrals of Child Protection intake requiring no further action was 79 per cent, and then of the 1,960 police referrers to Child Protection only 13.9 per cent resulted in a Child Protection investigation. So is that what you are indicating, that there was a large number of referrals by the police through the L17 Form fax to police, so in about almost 80 per cent of cases Child Protection determined that it did not warrant an investigation, and then of the total number there was only 1,960 of the

referrals - of those number of referrals only 13.9 per cent resulted in a Child Protection investigation. You said there's inefficiency in the system. What do you think needs to be changed?

PROFESSOR HUMPHREYS: It seems to me that we have done net widening into Child Protection services quite inappropriately. The children shouldn't be living with violence. I'm not saying that children don't have a right to live free from violence. But actually statutory child protection is the tertiary end of the system. It's way down the line. The threshold to get into the Child Protection system to get to an investigation, you have to have a lot of serious risks of harm to the children that are obvious.

Actually most of the family violence cases don't involve that. You might have actually some serious risks to children, but you also have a protective parent. So about a third of the intimate partner violence cases coming to the police are where there's separation . So it is post-separation violence. I don't have the figures about how many of the cases with children going through to Child Protection from police are post-separation. But I know that in the case-tracking study in the UK that was done across two major child protection areas of police referrals to Child Protection that in fact 50 per cent of the cases were post-separation violence. So you do have a protective parent and actually that will be usually a trigger for Child Protection not to be involved, because that doesn't meet the threshold.

We could argue about that and I think maybe later in the session we can discuss some of those issues,

because some of those children are still at serious risk of harm through post-separation violence. But we have a kind of a system that's not differentiating enough early enough. I think there should be an earlier triage to actually not have Child Protection overwhelmed with all these referrals that shouldn't be going there in the first place.

Women hate that route. When they ring in an emergency for help they are not making a referral to Child Protection. They are not going, "Help, and also could you refer my child to Child Protection." They are not doing that. They are horrified when they find that's the case, actually, because that's not their intention when they ring in an emergency for the police.

MR MOSHINSKY: How is it done in other States? Are there examples of how it could be done differently?

PROFESSOR HUMPHREYS: New South Wales does now have a differentiated response. So they have gone down one route. Western Australia has now also got several pilots of a differentiated response. We are doing an earlier triage either with - well, with New South Wales they have developed the Child Wellbeing Unit. So they have initially an electronic system, which is based on a structured decision making, so that the threshold of getting through - if you are a referrer you go through the structured decision making electronic system, and most of that won't go through direct to Child Protection. It will go through to the Child Wellbeing Unit, who then decide where the referral should be made.

In Western Australia, they have at the triage point police, Child Protection and Women's Services to

decide what's the most appropriate pathway for this referral. You see a lot of it is crisis. So we have been talking a lot about Child FIRST and Child Protection. But actually, say, Berry Street, in its family violence service, they have a database of 12,000 women. So they really need to be part of the triage point because of the level of information they have in relation to the history of women and children in that space.

MR MOSHINSKY: I will ask the others to comment in a moment, but, Professor Humphreys, what would your recommendation be about who would do that triage? How would you see it ideally operating?

PROFESSOR HUMPHREYS: The thing is it costs. So it does require some diversion of funding, and you also have to have it at a big enough scale. Say, in the northern metro region you have six police stations all with their specialist family violence. You can't get a triage in six of those stations with the Women's Services and Child Protection. So you have to have it at a scale that's big enough to divert within a region but not to take too many of the resources into your initial pathway assessment or triage.

So in some ways each area is a bit different. One of the problems is there's not on alignment between the police areas and the Child Protection areas and the Women's Services areas, the health areas. So we have a problem of boundaries. So where you would place that triage is kind of a bit problematic, and whether you are placing it with the police, whether you are placing it with Child Protection, whether you are placing it with Women's Services is an issue to be decided and which you

would need to pilot and try in different demonstration sites to see what is going to work best within our current system.

The other part of our current system that adds complexity is the fact that we do have Child FIRST, and in a way that's been a great blessing and in terms of family violence a bit of a problem because it's not clear what the pathway is where you have children who are clearly living in situations that are far from perfect, living with domestic violence, and what the role - and what goes to the Women's Services and whether they can be capacity built more around their response to children or whether you go into the Child FIRST services. You again have to build capacity there around their response because they are not specialised in family violence. So there's an issue there.

I guess for myself one of the things that I have been discussing with a range of different people would be - all these systems are overwhelmed; so we just have to work out what's the best pathways. I guess just for my two cents worth and part of discussions that we have been having recently the fact is that there is an awful lot of women who are not in a position to separate; that their resident status is dependent on their partners, their husbands; or there is no housing for them; that in fact separating children into homelessness is not a safety option. They are no safer if they are homeless than they are necessarily living with someone who is violent. So there's a lot of risks about being homeless. In our current family law system a lot of these men who are very limited in their capacity to father are getting very high

levels of unsupervised access.

So for a whole group of women there's another group of women who aren't at that point of being ready to leave. So there's a whole group of women who are not at the point of being able to separate for a whole range of different reasons. I do wonder whether we don't need to be doing some more development within our Family Services about what you do with and develop the practice, which is a very specialised practice, around how you work with family violence when the offender is still at home. I think that that's probably rightly the area of Family Services, because the women's sector is never going to develop an offender focus. That's not part of their business or their core business.

But Family Services are already dealing with intact families where they have got other issues as well. What happens is they tend not to deal with the family violence; they tend to deal with the drug and alcohol and the mental health issues because the family violence stuff is too delicate, too vulnerable, too risky. But there are ways and there are a range of different models that are being developed in that space, and maybe we should be looking in that space as the bit of the pathway that fits for Family Services where there are children and the development of children - - -

COMMISSIONER NEAVE: I have a question about that. I'm just trying to follow through on your point about the L17s. Is what you are envisaging that the police are called to an incident. The policeman doesn't simply just send off the fax. There is then a small group that is brought together to decide what is the appropriate response, "Is it a Child

Protection response? Is it some sort of family service response?" Is it all the other possibilities - - -

PROFESSOR HUMPHREYS: The Women's Services or the drug and alcohol.

COMMISSIONER NEAVE: And you do that in a way that is reactive to the particular region. So in a regional area you might have one group of people involved in that triage; in some parts of metropolitan Melbourne you might have a different sort of group. The body that does the triage would be adaptive to the particular circumstances. Have I understood what you are saying?

PROFESSOR HUMPHREYS: I'm saying that every area is doing it slightly differently at the moment and that there isn't a triage process but there is a very different way of doing pathways at the moment where there's family violence. With, say, Child FIRST and Family Services, they worked extremely hard over a number of years through the innovations projects to actually go, "All right, everyone's not going to look the same, but the basic high level model is the same." You have an entry point, which is Child FIRST, and you have a sifting out to Family Services. It looks a bit different in every region, but there's a regularity about it. You would want a similar regularity, I think, if you shift to a process of triage - - -

COMMISSIONER NEAVE: But this would involve the police as well, would it not?

PROFESSOR HUMPHREYS: Absolutely.

COMMISSIONER NEAVE: So you would have to have the police involved and plus whatever components of Child FIRST and Child Protection?

PROFESSOR HUMPHREYS: And Women's Services.

COMMISSIONER NEAVE: And Women's Services, and they would be sitting down together and saying, "The appropriate route for this family is this or this women and child is this." Can you do that quickly? Could it be done responsively and quickly enough?

PROFESSOR HUMPHREYS: It seems to me that it would be interesting, and they are very positive about what they are doing in Western Australia on that triage model.

COMMISSIONER NEAVE: Yes.

PROFESSOR HUMPHREYS: You wouldn't necessarily have Child FIRST involved there. You would I think be referring into Child FIRST rather than necessarily having them as the triage point because they are not quite the same crisis level. In the UK they have developed the MASH, which is the Multi-Agency Support Hub, where you actually have a whole group of - you have a larger group of services coming together. One of the issues that needs to be sorted out to be able to do it I think is to work out your privacy stuff. It may require legislation to - - -

COMMISSIONER NEAVE: To share the information.

PROFESSOR HUMPHREYS: To share the information.

MR MOSHINSKY: Commissioners, I do want to take up this issue of the potential triaging with the other two witnesses, but I see the time. Would it be convenient if we adjourned until 2 o'clock.

COMMISSIONER NEAVE: Yes, it would.

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

MR MOSHINSKY: Professor Humphreys, I might just ask you one or two more questions before I turn to the other witnesses on this topic of really your proposal of a more differentiated system for dealing with the referral reports from police. Can I just ask you this, in a sense to test some aspects of the proposal. It seems to be a part of the rationale is that only a small percentage of cases that the police report to Child Protection merit investigation. But I just wanted to ask you whether that is in fact the case or whether the low percentage of cases that are being investigated is something driven by resources and whether more cases should be being investigated. Are you able to comment on that?

PROFESSOR HUMPHREYS: I guess if you look at any sample, it doesn't matter where they are drawn from - whether they are drawn from refuges, whether they are drawn from primary care, whether they are drawn from drug and alcohol - there's usually about a third of children in any sample that are doing as well as any other children in the community. So you could say, "Look, every child's got a right to not live with violence and abuse, absolutely." But actually it's a very heterogeneous problem, and some children have many more protective factors in place than other children.

Also, family violence is one of the factors that makes you more vulnerable to other forms of abuse as well. So there's a group of children that really are at risk of significant harm, and clearly there's a group of children that are dying and being killed. So clearly Child Protection has a role, a big role, but there's also a

group of children that under normal circumstances wouldn't come anywhere near the thresholds for a Child Protection system. So I think that we do need a differential response because actually they are doing just as well as other kids in the community, for a range of reasons, maybe because the symptoms of abuse aren't showing yet or maybe they have enough protective factors in place to make them much less vulnerable.

So I do think that it isn't just about Child Protection not doing the investigations that they should be doing. I think it is that in fact you have a group of children that shouldn't be in there and that we should be getting them out of there because I don't think it works to just overwhelm the Child Protection system by bringing them in and then sending them straight out. I think that that is about not necessarily that Child Protection has it wrong about not investigating but, rather, they shouldn't be in there in the first place.

If they go down a different pathway with Child FIRST or Women's Services or drug and alcohol services or wherever, or Maternal and Child Health, they can be referred back in. It's not as though - in fact, just about every other area, they do have - you have to reach a certain threshold before you can get into Child Protection. It's just that the police referrals are going straight in.

MR MOSHINSKY: Okay. Thank you. Can I turn to you, Ms Allen. You have heard Professor Humphreys' suggestion and you have read in her witness statement this recommendation set out as well. Could I invite you to comment on this proposal?

MS ALLEN: Thank you. Essentially I think what needs to be pointed out is that in relation to the L17 Reports that are received from police Child Protection receives just over 14,000 of those or they receive just over 14,000 last year. Of those we investigated 16 per cent compared to almost 26 per cent of all other reports that receive investigation. So the conversion rate from report to investigation for those L17 Forms is substantially lower than for all other report types.

When we then look at how they move through the system, of those 14,000 reports, less than 0.5 per cent, in fact 0.45 per cent, of all L17 Reports result in a protection application. It is not uncommon that when we talk about L17s in the Child Protection space we talk about them creating a lot of unnecessary noise and the fact that they are diverting Child Protection from being able to identify and respond to children who are at greatest risk.

So in Victoria we have a Differential Response Model that allows for two doors - one for children where we have concerns for their wellbeing, another for children who are in need of protection - and yet all of these Victorian police L17 Forms are not being filtered to get them to the right door and, rather, they are going to the Child Protection door, who then need to sift and sort those reports against all of the other 65,000-odd reports that we receive.

So it does divert a substantial amount of the resource that we have in our intake system for very, very low yield or if I can say in terms of - it's a bit like trying to find the needle in the haystack or the one child

in the thousand that actually needs some form of greater protection that couldn't be served somewhere else.

So to that end I think a couple of things that we are really trying to invest in, one is that we are working very closely with police, one to encourage them to more appropriately move the L17 Forms to the best door, and we are doing a piece of work with them at the moment to redesign the L17 Form so that police in the field are better able to make the decision about which door to go to, because I think it's fair to say and I think it's true to say that Victoria Police would recognise that they prefer one door and if they can only have one door then they will go for the more risk averse approach, "We will get it to Child Protection, and if it is not right they can move it down the ladder rather than having us miss a child who might be at risk and therefore they don't get the approach they need."

So we want to work with them around the redesign and redevelopment of the L17 Form that helps them differentiate those children who are in need versus those who are in need of protection. I think that's going to be a really critical first step in managing all the noise that I spoke of.

MR MOSHINSKY: So the picture I think that's being painted is one of a system being a bit overwhelmed by the numbers, including cases that don't need to go to Child Protection. Is another issue the information that is being made available to Child Protection through the L17 process? Is that another issue that needs to be looked at?

MS ALLEN: So beyond the sheer volume that we are dealing with - I think Cathy said earlier that they are faxed. So

frequently - it's not uncommon that Child Protection will receive mounds of faxes in relation to these reports and very often they can be incomplete or that they can contain no information that supports the view that a child may be in need of protection. So it will have scant information. That then requires that Child Protection - because every L17 is in fact a report, it must be loaded into our client information system by typing it into a computer based system, opening a report on that particular child. It then requires that further - where information is needed, we have to go and chase that information, whether that's from the police officer who attended, other professionals involved. So there's a whole process of information gathering that then needs to occur, noting that in the vast majority of cases it is assessed that it doesn't meet a Child Protection threshold and no involvement is required.

MR MOSHINSKY: We have heard Professor Humphreys' recommendations regarding the triaging process before it goes in one direction or another. Do you support that approach, or do you have a different recommendation of how you would like to see things done?

MS ALLEN: I think we need to recognise that we have invested very heavily in Victoria in a Differentiated Response Model that for all intents and purposes works very, very well for the vast majority of reports and referrals. Most professional groups manage that process quite well. If I talk about teachers being a very predominant reporter group, they have worked very hard and they have invested in training of their workforce to support their teachers being able to distinguish between children in need versus

those in need of protection.

So over time what we have found particularly - one of the things that a recent study in relation to mandatory reporting has found is that the professional workforce has responded very, very well to that - to the Child FIRST and Integrated Family Services model in respect to neglect cases. So a lot of our neglect cases to - neglect reports to Child Protection have reduced in number and have been quite appropriately referred to Child FIRST and Integrated Family Services.

Again, that's not just about managing demand for Child Protection but it's getting people to the right door, to the right service in the least stigmatising way. We have seen it happen in the neglect space. We haven't yet seen it happen in the family violence space, and we believe that that's primarily due to the police reporting practice that we feel really needs to be addressed.

MR MOSHINSKY: Dr Miller, do you want to comment about the proposals we have been discussing?

DR MILLER: Yes. I have written about this in my statement and essentially concur with what Professor Humphreys and Ms Allen is saying, and that is that the current situation is wasteful in terms of the scarce resource that is within Child Protection. It is a finite resource. So each intake that comes in, I think it's estimated it takes about eight hours at least.

So for all of those L17s that come in as reports - and I think about 15, 16 per cent of them are translating into investigations; most of them aren't - you are tying up then valuable practitioner time, because they are all trained practitioners, usually social workers,

psychologists, welfare workers as child protection practitioners, in the intake room when in fact you are having to devote more of your workforce and practitioner expertise to intake when in fact you could redivert that to practice at the front line. So it just doesn't make sense to keep doing that.

I'm of the view that we need to - as Cathy was talking about before, we have got a much - the need around to shift the family violence reports into a more differentiated service is obvious. When I was speaking earlier about Child FIRST and Child Protection, that was the Family Services network and Child Protection. There's another network, for anyone listening that's not clear, that's what we call women's services or specialist family violence services. Then there's men's behaviour services over here.

What needs to happen is the expertise in the women's services, women's family violence services, I believe needs to be co-located - and I think there's been a recent announcement to co-locate family violence expertise within Child Protection, but I also think we need to do much more blending between family support services, the Child FIRST, and the Women's Services because, although I think the statistics were given a third of cases in Family Services involve family violence, we all concur actually it's much higher than that.

I have personally trained all around the State and had a lot to do with the Family Services. I wonder whether that's at the point of intake somebody ticks a box that says family violence is the presenting problem, because in practice in the field when you are talking to

family support services and Child FIRST it's more like 80 per cent. So it's not like Family Services aren't already working with family violence issues. They are. Sometimes they don't come out, though, until you are six months into working with the family. Then someone talks about what happened five years ago or what's been happening but no-one's told yet because of the secrecy and the fear.

So what is needed, though, is more support for those - a specialist triaging point, and, as Professor Humphreys' said, I wonder about piloting something or saying, look, we have Child FIRST, which has joined up 24 services in 24 catchments around the State. If we resourced and partnered Women's Services with family violence expertise, which are getting a lot of the L17s anyway, and the Child FIRST platform, which has a family focus, child focus, if you partnered up with police and the links are already established with Child Protection, that could be a very sensible triage point.

You also have multi-disciplinary centres, the MDCs as they are known, around the State. At the minute I think there's four. There's funding for six. Mildura, Geelong, Dandenong's just opened. Where's the other one? Seaford. Of course, that was the first. Frankston, Seaford.

So those multi-disciplinary centres co-locate police, Child Protection, counselling staff and health. So that's another already established network, if you like, of multi-disciplinary teams that are very effectively engaging with sexual abuse cases and sexual assault for children and for adults. So that's something

to keep in mind.

But I'm a pragmatist and I think we have such volume of demand in the family violence area that if we used the local expertise - and in family violence cases the local intelligence on the ground with your local police is so important. So the more we could link up the local police - and we have some nice models and pilots that have already happened. So in Preston, for example, in the north there's a terrific partnership between police, women services, Child Protection, Child FIRST, meet weekly for a whole day and they triage.

MR MOSHINSKY: Thank you. I think you have raised a broader aspect of the system issues than just the L17, and perhaps, Professor Humphreys, if I could ask you to comment on that broader issue because I understand you have some proposals which Dr Miller has referred to about referral pathways between - - -

PROFESSOR HUMPHREYS: I think that one of the things that I might not have been clear enough about is - I have done that family violence intervention pyramid, which is about the primary prevention, the secondary prevention, the crisis intervention and the post-crisis intervention. I think when we are talking the triage, we are talking about the crisis intervention.

So there's quite a well-developed service system in some ways around crisis that's been developed with family violence services and the police, but where we do need to work out is the pathway for children in that process and where we haven't yet got agreed risk assessment and where we haven't got agreed who else should be capacity building that triage point early on.

So I think that's the - then there's the service system and how you capacity build and where you capacity build the response to children within the service system, because if you take everything out of Child Protection, if you take most of it out of Child Protection, one of the things is that Child Protection's got a duty of care - a statutory duty of care to children. Actually, no-one else does in quite the same way. You could argue under the legislation that's child concerned that maybe in the differential response with family services there is attention to children in that process as well.

But, overall, you kind of have to be thoughtful about the fact that most of the response work in this area are short-term pilots that continue to struggle to retain funding over a period of time. So at the response level we do need to think about how and where you develop the response system for children and their mothers and their fathers.

MR MOSHINSKY: Can I just try to clarify it in this way. Is your proposal that there be a triaging for family violence cases?

PROFESSOR HUMPHREYS: I think so, because of the volume and the specialisation and the crisis. One of the things is - if you go to, say, Berry Street or Women's Health West and you watch the triage process at the point of - when all those fax backs are coming through, they are a streamlined machine and they are working extremely fast because many of these women are in crisis, they need an immediate response and an urgent response, and their lives are still under threat. So there's both the volume and the level of crisis and urgency in some of these cases which means that

you have to be able to have a responsiveness and a flexibility and a nimbleness that's actually life saving at points.

So we have to be careful in developing any system that you don't lose that sort of streamlined machine, really, which is about how you look at cases. I think that the redevelopment of the L17 so that the police are providing better data in relation to the risk will really be very helpful for information sharing as long as we have the ability for them to be able to information share.

MR MOSHINSKY: Is your triaging proposal broader than just the L17 Forms? Is it other family - - -

PROFESSOR HUMPHREYS: I think it would be a waste of a specialist response to only have it as the police L17, because there's a lot of other family violence that comes in which isn't via the police.

MR MOSHINSKY: Ms Allen, could I ask you to comment on this broader differentiated pathway proposal that we have just been discussing?

MS ALLEN: I agree that there's absolute merit in bringing together integrated family service and family violence providers, and I think that that's probably the next phase of our reform work that really needs to be undertaken. I believe that bringing those two parts of the partnership and system together, along with adult services, and I'm talking about - when I talk about adult services, those services that provide secondary services to parents, so mental health, alcohol and drug services really need to be brought into our Child FIRST alliances, an Integrated Family Services platform, so that we get a much better partnership approach there.

MR MOSHINSKY: Sorry, can I just interrupt you for a moment just to clarify. You have referred to Integrated Family Services, and we have talked about that earlier. You have also referred to some generalist services, such as alcohol and drug services or mental health services. Are they currently part of the Integrated Family Services?

MS ALLEN: They are not part of Integrated Family Services but they come together in some areas in some alliances. So those partnerships are - I think it's fair to say the partnerships are forming and they are variable across the State. So Integrated Family Services coming together to meet regularly to undertake prioritisation exercises, case allocation. Some of them may or may not have mental health and alcohol and drugs at the table, but we are of the view that we really need to be moving there fairly rapidly.

MR MOSHINSKY: So is the theme of what you are saying that you think the Integrated Family Services should come closer to the domestic violence services, alcohol and drug services, mental health services, et cetera?

MS ALLEN: That's correct. So I think they need to be brought into the tent, if I can put it that way, to bring about greater alignment and partnerships, and for all of those parts of the service system to be thinking about children who are impacted by family violence. One of the particular reasons I talk about mental health and alcohol and drugs is that we need to I guess be cautious and resist the temptation to talk about triaging family violence cases because, despite the fact that we have these things called L17s that give us a discrete clue about some cases that involve family violence, many other

cases of family violence, parental family violence, co-exist with alcohol and drugs and mental health. So they may hit the service system at different points and different parts of the service system.

So if I use for an example parents who hit the mental health system it may be some time into their treatment or intervention that family violence is uncovered. So simply having I guess a triage or a partnership approach that is only supported at the point of intake will not support service provision.

So, to go back to the question, I think if we can bring about greater alignment, greater partnership, one of the things I think we need to be very careful about with any proposal for triaging is that we are very mindful of the prevalence and the demand. So if I think about last year, 14,000 L17s. In addition it's estimated through various pieces of the Child Protection program database that about 60 per cent of the Child Protection reports that were substantiated involved family violence. They didn't necessarily hit the Child Protection system because of family violence, but family violence was discovered in the course of the investigation and confirmed at some point prior to or at the point of substantiation.

We are talking tens of thousands that would need triaging. Subject to how you triage, if you are going to bring multiple people to the table, for example the ideal and what's been talked about in some of the overseas models with MARACs and MASHs and so forth, and indeed our own RAMPs here, is that you would generally have at least four or five disciplines, often more - police, Child Protection, Family Services, family violence, mental

health, alcohol and drugs - at the table all sharing information which is very, very valid. But if you think about how many you can get through in a day, RAMPs get through four or five, some other more rapid responses can go through perhaps, I don't know, a case every half an hour by the time they join up a very streamlined process, we are really just getting to the tip of the iceberg.

So I think notwithstanding that we need to share information, we need to bring all of our knowledge to the table to make the most informed decision, I think we need to be cautious about multi-disciplinary triaging which is going to bring a lot of the available resource to the front end, perhaps divert it from the response where we have people, senior people, triaging every day of the week to determine the most appropriate response, and we are diverting that from the actual response. So I just think we need to hold that in mind and think very carefully about that as an approach.

Notwithstanding that, as I said before, good information sharing is really critical. But I wonder whether there's other avenues of getting to that where you might be able to access each other's information and data without necessarily having to have six people sit around the table and consult on every single case on every single occasion for days on end.

MR MOSHINSKY: Is the essence of your sort of preferred approach what you have in paragraphs 106 and 107 of your statement, which is - and please clarify this if this isn't putting it correctly - that you would prefer the police to be appropriately skilled to make the decision about which door to go to so that less would go to Child

Protection, rather than setting up a triage model?

MS ALLEN: No, I think that one of the critical first steps in managing the current demand in relation to family violence and getting families to the right door is having police use the Differentiated Response Model. So I think, given the data that we have, that the vast majority of the current reports coming to Child Protection should or could go to Family Services and that police be asked only to refer those cases where there is significant harm to the child. I think we can do that by helping them with the redesign of the L17 Form, and with additional training and supportive leadership within the police to do that more effectively.

The second thing is then having cleared some of the inappropriate reports to Child Protection, Child Protection can get on with the business of identifying the kids who are most at risk. Then I think we need to turn our attention to what does - if we were to take it to a Child FIRST door and were better able to integrate Child FIRST with Family Services and those adult services I talked about, what would a good risk assessment and triaging model be at the front end.

I don't necessarily support triaging for every case, though, because of the demand and because of the way cases enter into the system. Rather, I would probably rather see triaging for the more complex or cases where that service system is struggling to make the decision, so where things are borderline, where people are perhaps dealing with multiple reports or what we sometimes call recidivist families where it doesn't matter what we have done the violence continues.

So I think in broad terms if we were able to invest in that particular redevelopment of the service system to better align family services, family violence and adult services, really invested in their training around family violence so that all professionals can do the sort of risk assessment that's required of them in this space, but that we perhaps have some form of unique triaging for the more complex, tricky cases where people are really struggling or the highest risk cases as we are proposing for the RAMPs.

MR MOSHINSKY: Professor Humphreys, can I invite you to respond?

PROFESSOR HUMPHREYS: I think that maybe our language is getting in the way a bit, because in the northern region where we did some piloting work where we were observing the system there was a process which was called "triage" which brought different agencies together to look at the more complex cases. Actually, that's not really triage. That's information sharing and decision making, which is different from this crisis point triaging where you actually - it's a bit like going to hospital emergency where you have only limited information and you go boom, boom, boom, boom, "What are we doing?" So the notion of triage is a rapid triage.

My understanding, and when I have seen it done, is that - Berry Street at the moment isn't triaging, they are just getting it, but they go through an awful lot of - they go through 50 cases in a morning. They are not spending an hour on each case. But they would be better off if the police database and the Child Protection database was available to them at whatever point, you

know, maybe - at whatever point you have to do a rapid triage, and the upscaling effect that you get from doing it rapidly but with other people at the table, other agencies at the table, is you have more information. So you can know the history from the police being on the database at the same time as the Women's Services being on the database. But it's a rapid triage, you know, it's the hospital emergency triage, to set the initial pathway and to try and be as efficient as you can about that so we are not doing double referrals or triple referrals.

But that's different from the RAMPs process, which is bringing together the multi-agency for high-risk offenders to go actually, "What information have you got, you got, you got? How are we going to" - and making some decisions about case management. You are not making any decisions about case management at this point in the rapid crisis triage at the front end.

MR MOSHINSKY: I'm going to move to more general resourcing issues in a moment, but did the Commissioners want to ask any questions about this?

DEPUTY COMMISSIONER FAULKNER: I just want to clarify something with Ms Allen. As I have understood what you have said so far, there is an Integrated Family Services system and family violence services are not part of that at the moment?

MS ALLEN: They are not part of Integrated Family Services alliances, so the alliances being - an alliance is the Child FIRST provider, the intake provider, the main agency, and then all of the family service providers. So some of the family violence providers sit outside of that.

However, where it gets complicated is that some

family service providers are also family violence providers. So if I think about Berry Street as one example, they provide family violence and family services. So they may be as part of the - at the table and they may bring those resources to the table. But it's not - they are not routinely part of all of the alliances, and they are not part of the definition of Integrated Family Services.

DEPUTY COMMISSIONER FAULKNER: I will ask them when I get the opportunity will there be drawbacks for them or would they see limitations on their flexibility if they were drawn into that system?

MS ALLEN: It would probably be variable across different area partnerships. So in some areas where family violence services are reasonably well resourced - it's all comparative, but reasonably well resourced - that probably is something that they would see value in, albeit would say will take resources for them. But it's something that we might consider - we may be able to consider if there were additional resourcing and/or reconfiguration so that they were able to better participate in those alliances.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: Can I have a follow-up. Do I understand you to say that the Family Services don't include the alcohol and drug and mental health and the accommodation?

MS ALLEN: That's right.

COMMISSIONER NEAVE: So what is in?

MS ALLEN: Family Services. So family support services, which predominantly are practitioners who work with families in the home offering practical family support, guidance, mentoring, parenting skills, development group work. So

home visiting is a way that it was probably described historically. But they don't have - they are very generic rather than being highly specialised in the way that alcohol and drug, family violence, mental health providers are.

MR MOSHINSKY: Can I follow on from that then to a slightly different topic, which is - - -

DEPUTY COMMISSIONER NICHOLSON: Counsel, can I just ask Ms Allen just to clarify my understanding of what your reform proposal is. Are you suggesting that the police ought to be given discretion, firstly, in whether they make any referral at all about a child and, secondly, whether that referral goes to the integrated family service provider or Child Protection?

MS ALLEN: In terms of the first question, the police standing orders requires that they do one of two things in relation to - - -

DEPUTY COMMISSIONER NICHOLSON: I know what they are required to do. I'm asking what your proposal is.

MS ALLEN: My proposal. I don't believe that that should necessarily be changed in terms of needing to provide either a referral or a report in relation to family violence incidents involving children.

DEPUTY COMMISSIONER NICHOLSON: So that means you will still generate the same volume of reports but they will go to different places than they currently do?

MS ALLEN: Not quite. I think there will be a reduction if we actually redesign the form, because what they are being asked to do is that where there is either concern - they have to have a concern for children to do something in some cases they attend now, and they give an example about

attending family homes where two young women, teenagers, are fighting over the hairbrush. Are they really concerned about that? The answer is probably no. In those situations, if there's clearly no wellbeing concern or a child in need of protection, then no referral should have to be made to either - to anywhere.

What I'm recommending, though, which is currently at their discretion and their judgment, they can make - where they do believe there is a concern, they can make a report to either Child FIRST or Child Protection. No-one is telling them that they - the standing orders don't require them to report only to Child Protection. They have that discretion currently. However, they - - -

DEPUTY COMMISSIONER NICHOLSON: Aren't they mandated to report to Child Protection any concerns?

MS ALLEN: Mandatory reporting in Victoria only relates to cases where there's a concern in relation to physical or sexual abuse. So they are not mandated to report all matters of family violence to Child Protection unless they believe that the child is at risk of physical or sexual abuse . So in some cases where you may have exposure - for example, an adolescent who is exposed to high levels of arguing between parents and there's no suggestion that the child is at risk of physical or sexual abuse, that certainly wouldn't hit the threshold for mandatory reporting.

MR MOSHINSKY: Can I take up the answer you gave, Ms Allen, about Integrated Family Services and what's covered. There was quite a bit of evidence yesterday about the harm that children can suffer by being exposed to family violence, can be quite damaging in terms of their

development, longer term health effects. In terms of what's currently available in the Integrated Family Services, are there supports available, services available to help children or young people affected by family violence? What sort of programs are there at the moment?

MS ALLEN: Within Integrated Family Services where they identify that a child is impacted by family violence it would be most common that they would undertake a needs assessment for that child, consider how they have been impacted and make referrals to other services. So it's not to say that they wouldn't engage directly with the child. They would. They would talk about impacts and interview the child, have conversations with the child about how they have experienced and how they're - what their needs might - to assist in assessing their needs. But, broadly speaking, if a child was impacted by family violence and an intervention was required, then Family Services would usually refer them to another service.

MR MOSHINSKY: What sort of services and programs would that be, for example?

MS ALLEN: Again, it could be any - the services that respond to children affected by family violence can start with services that might go to their general practitioner because they might be bedwetting, as an example, and you are looking at a very low-level, perhaps a medical response. You might be looking at referrals to community health centres, right through to the extreme end, where children have come into contact with - involved with a Child Protection program and have been adversely impacted. There's a range of specialist services that are provided for the Child Protection client, such as Take Two, which

is an intensive mental health program.

Then, going back into the middle, we have child and family counselling services that are funded to provide services to children impacted by family violence. There's a suite of other programs. We have child and adolescent mental health programs through the mental health program. There's a range of services across a very wide continuum that are available depending on the child's needs and the intensiveness of the service that's required.

MR MOSHINSKY: What about the resourcing? Given the level of harm that we have heard can be experienced by children, are there sufficient resources currently to offer the range of supports that are needed and are they realistically available? What are the waiting lists like in practice to get help through these means?

MS ALLEN: Because we have such a myriad of services it's really hard to talk generically. I think there are some services where, certainly in the specialist family violence area, I think where we would all agree that we would benefit from additional services, and in some areas, particularly in some rural areas, wait lists are greater than what we would like. So needing to wait, for example, three to six months to access a service is not ideal.

In other areas access can be far faster because we have - if you are living in metro Melbourne, for example, the choice of services that you may have available is far greater. In addition, of course, there are the new Medicare rebates to access psychologists, gives children and families at least four therapeutic sessions if they are choosing to go down a private route, and we are finding increasingly that particularly the

families that come into contact with Child Protection if there is an immediate response required families will often access that as a starting point and to get a needs assessment when they will then be referred to other services along the way. So that's been quite helpful as a strategy.

DEPUTY COMMISSIONER FAULKNER: Mr Moshinsky, could I ask very specifically, something like Take Two or the Queen Elizabeth mother and baby program, what sort of waiting lists are we talking about to get someone into those? I can understand you don't have to wait long for the more universal service system GP things, but what about those very specialised things?

MS ALLEN: Take Two I think - I'm not absolutely sure what their wait list is right at the moment, but it is not unusual that they are constantly having to prioritise. So it could be three to six months, as an estimate. We could certainly get you data on that. But there's a constant prioritisation process.

Queen Elizabeth and Tweddle, which offer parenting assessment and skill development services particularly for infants, again they are in high demand and can take several months also to be able to access those, depending on where you are. You might be lucky enough that there is a vacancy and families can get straight in. But at other times there is a waiting period, and we are constantly prioritising who is on the wait list.

COMMISSIONER NEAVE: Did I understand you to say that these services were available for children who were Child Protection cases, not children who went off to Child FIRST

and then were able to access some of those other critical - - -

MS ALLEN: Yes. So Take Two is specifically for Child Protection clients. I should say I think they're - they provide - Take Two, to be clear, is funded to provide just under 300 - to service just under 300 clients on any given day. So it's quite a large, sizeable program.

The PASD, parenting assessment and skill development, services run through Queen Elizabeth and Tweddle Family Services are again specifically for Child Protection clients. They are residential programs and in-home programs that are aimed to assess risk to children and parenting competency for those children not yet three. That can happen in a residential setting and/or in the home environment.

MR MOSHINSKY: Dr Miller, can I ask you about this topic. In light of the evidence from yourself and Professor Newman yesterday about the damaging effects of family violence on children, are there sufficient accessible therapeutic programs available for children in that situation?

DR MILLER: I would have to say the short answer is no, there is not. Even within Child Protection the waiting list for Take Two resources is long. So there's a constant juggling of who is the most at risk. As we know, the earlier you can intervene, the better. So it's contradictory in that sense.

Before I go on any more about that, can I just make one thing clear about these L17s and the triage point. Perhaps what's not been well understood is that there's a double referral. Police are referring the same reports to the Child Protection and to Women's Services.

COMMISSIONER NEAVE: Yes.

DR MILLER: And that I think is not sensible. The triage that I was talking about was that initial triage where you wouldn't have a case conference. You would filter down. So your most complex cases where there was - someone was carrying weapons, where there was a criminal history that's significant, obviously they need more case conferencing and planning, but there needs to be a better system at that very initial triaging point.

MR MOSHINSKY: So it's similar to Professor Humphreys' proposal?

DR MILLER: Correct; and I'm wondering about whether we can be more creative in using the systems already in place and further resourcing those systems to be quite child focused as well as not losing what we have got, which is terrific expertise in women's services.

MR MOSHINSKY: Professor Humphreys, did you want to make a comment about the resourcing or programs available?

PROFESSOR HUMPHREYS: I think that there is just a huge problem about how we create a better resource to service children who are living with domestic violence, whether they are infants, whether it's prenatal or whether it's post, because even the Enhanced Maternal and Child Health Service is very specific to four targeted groups of very vulnerable women. So, if you are living with family violence and you are pregnant, it doesn't necessarily get you into the Enhanced Maternal and Child Health Service.

So that would be just a very basic part of opening up that system a little bit more to family violence clients so that - we know that one of the most vulnerable points for women is when they are pregnant, and

if the domestic violence continues or starts when they are pregnant, then that's a huge risk for both the infant and the child. It's a double-intentioned violence from the perpetrator of violence, and we do know that you have to bring in the service system around that woman immediately because she's highly vulnerable.

If she is being beaten up by a bloke who - most men, if you are pregnant, they respond with protection, actually, you know, it's often the nicest stage in your relationship is when you are pregnant and being looked after. If someone - if a man responds with violence rather than protection you know that you have problems ahead that are very serious for that child and for that woman.

So that's the point when we should be bringing the service system around the woman and the child very immediately. So not to be able to bring it in and not to have the Enhanced Maternal and Child Health response open to that group of women I think is very problematic. So it is just a very obvious place where you could expand the system, and you could say that across other points in the system as well. We have to develop some better pathways there.

MR MOSHINSKY: Did you want to add something, Dr Miller?

DR MILLER: Just to state the obvious, and that's in agreement with Professor Humphreys, that the whole systemic sort of - where things get truncated is that you have the antenatal, the pregnancy care, people, and then you have Maternal and Child Health when the baby is two or three days old, and too often we have missed the opportunity, which is during the pregnancy. So that continuity of

care.

I note in New South Wales there's greater capacity legislatively for information sharing. So where Child Protection receive unborn reports, they are called, that's where there is severe risk during pregnancy, there is that capacity to report, and frequently Child Protection will then as a response refer that to Family Services.

There's all sorts of creative work that happens on the ground. In Warrnambool we have terrific family support workers. You were asking what they did. With the unborn reports, they had these young pregnant women, and instead of calling it a social worky thing, they set up a TAFE course on parenting. So there's all sorts of creative ways people intervene.

The other critical point is around engagement of men, and Family Services obviously work with men, whereas Women Services are dedicated to working with women who are victims of violence. So you have a very narrow sort of remit here, and Family Services gives you a broader scope to look more.

This is the point back to referring around therapy. There is a lack of knowledge and skill in working with the family dynamics. So some programs will operate with, "Here's the child service, and here's an adult mental health service." In fact, the parents and the child are living together. The relationship between them is what needs to be the focus. So that is generally a family therapy sort of training that we need to actually expect more clinicians to have that sort of what we call relationship based practice, skills or systemic

therapeutic skills, to actually be able to know how to help the mother to help the child at two in the morning when they are having the nightmares, help the father to understand that the child's bedwetting is actually not him being naughty.

So the sort of work that Wendy Bunston was talking about earlier with the parents, including the father, is really, really important. But then there's another group. In practice we talk about the 80:20 rule. It is interesting some of the research from some of the men's behaviour change talks about this same group, that roughly 80 per cent of men who use violence are probably engagable in some sort of change. They are not a homogenous group. They are quite different.

But there's this group, the 20 - probably more under the banner of the 20 per cent - they are seriously disturbed people who are going to be criminal and some of them are sociopaths and downright dangerous. So to know the difference and to properly assess what you are working with - and in the Child Protection space the cases that come into Child Protection we are generally seeing more where there's very severe history of violence and recidivist offending.

So I just wanted to make those distinctions clear because when you talk about therapeutic services it's a very generic term, and I think what we do need to embed at every stage of the system - and I spoke yesterday about adult mental health being more child focused, that some of the most dangerous perpetrators of violence at times will be picked up by police and then taken for a psychiatric assessment, and that's a critical point, actually, for

picking up some of the more dangerous cases; and there is generally a lack of follow-up with those cases.

MR MOSHINSKY: I would like to just ask Ms Allen a couple of questions about the Auditor-General's Report which you have annexed to your witness statement as BA-6, and I think you have a copy there with you. There's a couple of recommendations. This report is relatively recent. It's from May 2015. It contains a number of recommendations and conclusions about Child FIRST. I want to ask you about a couple.

Firstly, at page 13, if you could go to that page, under the "Conclusion" heading it says, "The department's planning for Child FIRST and Integrated Family Services has been reactive and rudimentary. While the department has made significant effort to build the capacity of child and family services alliances to undertake catchment planning, it has not forecast overall demand for these services, assessed unmet or potential demand, or responded to emerging demand drivers in a timely manner." Then, "the Integrated Family Services are delivering beyond their funding capacity, casting doubt upon the sustainability of the current model."

I just wanted to ask you whether you had some comments you could make about what steps are being taken in light of those conclusions from the Auditor-General?

MS ALLEN: I think it's fair to say on receipt of the VAGO Report around a month ago the department accepted each of the recommendations made by VAGO and are now in the process of looking at how to best implement the overarching recommendation, which was one that an urgent review be undertaken, a comprehensive and urgent review of

its current approach to early intervention.

I think it's acknowledged that, like the Child Protection program, the Integrated Family Services program and Child FIRST have been experiencing unprecedented demand. We have ample evidence to suggest that we are not keeping pace with the level of demand and the level of reports, which means that Child FIRST and Integrated Family Services have been very much pushed close to the Child Protection door, if I can put it that way.

So VAGO were very concerned that opportunities for early intervention with the very vulnerable groups of children and families is being overtaken by those with more complex needs which I spoke of earlier. So they were very strong in recommending that further work needed to be undertaken around projecting demand and looking at how we are going to I guess future proof the system going forward, and the department is obviously accepting of that recommendation and we need to do some very serious work to look at how we are going to best manage that demand within potentially resource neutral or modest investment in increases in resources so that we can make best use of the available resource.

Everything that we have talked about this morning and this afternoon about managing demand and how we get cases to the right door to avoid duplication, replication and churn, cases going between the services, available services, and bringing about greater partnerships will all impact there. But probably most critically to say is that we are in the process of looking at how we contract that review so that we have a very close look at how we can better manage demand.

MR MOSHINSKY: Could I ask you to look also at page 27, where the conclusions are set out about governance. Under the "Conclusion" heading the report says, "Inadequate governance arrangements and significant variability in the quality of local Integrated Family Services partnerships have impeded the delivery of an integrated and well-coordinated Child FIRST and Integrated Family Services." I won't read out the rest, but it goes on to talk about the need for clarity around roles and responsibilities, and inadequate communication. Are there any comments that you are able to make about what steps are being taken in response to those conclusions?

MS ALLEN: I think that this is probably - well, while it will be part of the review that's undertaken, there's very comprehensive discussions happening between the department and each of the alliances to look at what governance arrangements exist and to address the variability. So, as I indicated before, we have some alliances that are operating with absolute strength and where we have all of the or most of the available partners that should be at the table actively involved in catchment planning and providing service responses.

In other areas that's very patchy where we have in some instances Child Protection not at the table or critical partners absent, and that obviously undermines the whole purpose of an integrated service system. So we are needing to work more closely, and I think from a central departmental perspective I think helping those alliances that are struggling or aren't performing as well as others get back onto their feet is going to be really important, but probably re-establishing the planning

that's required going back to what's referred to as the Shell Agreement and memorandums of understanding that exist, going back to - revisiting the intent to make sure that they are not drifting on in a fairly I guess aimless way without purpose and without a clear objective in mind is really important.

I should say that we probably in considering the VAGO Report go back to the KPMG report that was undertaken in 2011, and, albeit it was four or five years ago, that KPMG report talked about the integrated family services reforms as being incredibly positive for Victoria in the sense that it did bring about partnerships that we hadn't seen before. It talked about the fact that it was an effective platform to identify need and bring services to children and families. It talked about ACOs, Aboriginal Controlled Organisations, being involved for the first time, universal and secondary systems coming together. It talked also about the reforms, which is really important, moderating the growth that would otherwise have completely overwhelmed the Child Protection program in a way that it has in many other Australian jurisdictions as having been very much a success of the program.

So I think we probably need to temper the fact that we have got a system that is in many respects performing very, very well against the national stage in terms of assisting us to manage demand, providing different and variable responses to vulnerable children and families in a way that is consistent with our legislation and not overly intervening.

But, having said that, I think what the VAGO Report points out is that we really now have a second

stage of reform to undertake and we do need to be more outcomes focused, we need to go back and have a look at how we are performing and to do a bit of a service check, really, a bit of an engine check, and get it back on track where it's perhaps not performing all that well.

MR MOSHINSKY: Before I move on to the next topic, did the Commissioners want to ask any questions?

COMMISSIONER NEAVE: No, thank you.

MR MOSHINSKY: Witnesses, I would like to now move to the next topic, which is how the Child Protection system deals with cases where there's intimate partner violence, including the risk in the post-separation period. Professor Humphreys, can I ask you to start with your observations about how well does the Child Protection system deal with cases where there is intimate partner violence as a general proposition, and what are your particular observations about the risk in the post-separation period?

PROFESSOR HUMPHREYS: In a general sense, the Child Protection system has a number of challenges and problems to solve when there's domestic and family violence. Historically it's not been set up to deal with domestic and family violence, so that these then arise as challenges that need to be addressed.

What you would say is in Victoria, (a) you have some very good practitioners that do address those issues in a holistic way and are excellent practitioners, and women, children and men get a very good service. You also have seen some systemic developments that have really tried to address some of these systemic challenges.

But the challenges include (a) the differential response. They also include the fact that you have

in child - where you have domestic and family violence you have an adult and a child victim, except where you have adolescent violence in the home, which is a different kind of scenario. But you have an adult and child victim.

At the moment there's new funding being found to deploy 17 family violence workers into Child Protection. So you could say that there's really been a development around trying to address this issue of having a child and an adult victim, because historically the focus on the child and the woman only as mother rather than as a victim with her own needs has been a systemic problem within the Child Protection system which has led to a lot of criticism.

So how those practitioners develop and their role and how they support themselves and not just get sucked into the Child Protection system, that's all got to be developed. That will be a work in progress. But that is one of the issues to be addressed and we will need to keep an eye on. Seventeen across the State where you have 14,000 referrals in a year, it's not a lot. But it's a good start, and it recognises the issue.

There's the issue of risk assessment. There's not an actuarial risk assessment tool that says, "This child is more at risk than another child." It's a complex process. So agreements need to be further developed, really, to understand which are the children - if we are going to make a differential response, under what criteria are we using to get a group of children into Child Protection that should be there and the others that you are trying to sift out. So your risk assessment.

The perpetrator focus. Traditionally the Child

Protection system has been very focused on really the - have you got a protective mother. So they have been overly focused on the woman and is she protective versus the perpetrator and assessing for his violence and danger to the family and his potential to change and be referred. So Dr Miller has developed this - has written a very good guidance for Child Protection around shifting to a perpetrator focus, and some initial training occurred.

But that's a complex process, to shift a whole culture which has been focused in one direction to really having a different sort of focus, in an area where there's high levels of danger for Child Protection workers. So it's a skilled process. It requires a lot of professional development. You would say that the first steps are being taken, but there's a long way to go.

I think that they are looking at bringing David Mandel from the States, the Safe and Together Program, over. So there is developments that are happening in this area, but there's a long way to go there to shift the focus. That would be also - you would say the same thing in the family services area.

There's also a need to look at particularly the issues around separation, that really the notion that separation is a safety measure is - everywhere else separation is seen as a high risk, and it's often in an undeveloped Child Protection practice separation is seen as the step to safety. I think that we have been seeing a lot of shifts in that space with better development of practice, but it's very problematic, the notion that separation is - and particularly kind of statutory ultimatums to separate have a very poor prognosis, really.

So we have to recognise that separation requires an enormous amount of support. I guess it's why I sort of talked earlier in the day about potentially Family Services developing that practice a bit more, because there are many women where separation is not necessarily a very good process, and particularly given how unresponsive the family law system has been to recognising domestic violence as a risk factor in the post-separation period.

So I think that there's a whole kind of range of issues. I could go on, but those are some of the key ones that make it very kind of complex territory for Child Protection, and where actually moving a lot of these cases out of Child Protection is probably why you would want to be trying to develop the practice in other parts of the system and just leaving Child Protection where they belong with the tertiary response.

MR MOSHINSKY: Dr Miller, would you like to comment on that topic? How well does the Child Protection part of the system deal with cases where there is intimate partner violence, and are there things that could be done better?

DR MILLER: It's variable. Yes, of course there are things that could be done better. But we have put out a whole range of resources that address the issue of family violence since 2006 and trained to those across the State continuously, and not just for Child Protection but all these resources are for Family Services and for the out-of-home care. So they are for the Child FIRST networks as well.

Both are true. As Cathy said earlier, most women who are separating from a violent partner don't want Child Protection in their lives, yet there's this small group

who are at extreme danger and sometimes are ringing Child Protection, saying, "Can't you stop him having access to the kids?", "He's made a threat to kill," or whatever. So this is very sensitive and it does require very skilled assessment at the front door.

I have written in my statement that the simplistic response of putting everything into Child Protection is not sensible. But equally we need to have a more sophisticated knowledge base and practice skill base - it's not just knowledge; it's how you work with people - to differentiate those cases where in fact Child Protection has got a role and at times can appear in the Family Court jurisdiction as a friend of the Family Court to advocate for why in fact there should be no contact or why those orders shouldn't be given to allow the child to live with the perpetrator.

So there's a small group of cases where Child Protection post-separation even where you do have a protective mother, there is a role. Because of that we needed to improve information sharing and joined-up practice with the Family Court jurisdiction. So the co-location of Senior Child Protection Practitioners inside the Family Courts has occurred in Victoria in the last two or three years. That's currently being evaluated, both in the Melbourne Family Court and also Dandenong.

If you look at the filicide issue and child deaths, often there's not been a Child Protection history. Sometimes there has been, but often there's not. It's rare. I want to stress that. But the same factors that are there for risk of post-separation violence, there's no

actuarial risk assessment for filicide. Some experts have said it's less common than being struck by lightning. So it's a fair phenomenon. It's a tragedy when it happens, though.

So how do we in Child Protection actually differentiate those cases that are the most extreme? It does require often very good police work and information sharing in rapid time between those key services, usually police, Child Protection and - all of this discussion, none of it will be any good unless the partnership with police is front and centre. Those 30-odd teams now that the police have in place around family violence teams that actually have a more case management response to your more serious offenders, your recidivist offenders, they are critical I think to any planning of any systemic change because at the end of the day often what's needed is not a social worker or a service response, it's a police criminal response to those more extreme cases.

MR MOSHINSKY: Ms Allen, can I ask you about the particular difficulties around the post-separation period because some of the submissions or community consultations have suggested that once there's separation if Child Protection takes the view that the mother is being a protective mother they close their file, but it is in fact a very dangerous period. I know these are very complex issues, but are you able to comment on that?

MS ALLEN: Sure. I think it's very, very difficult to generalise in this space, but a few things I would comment on. One is that Child Protection - where we identify there is a protective parent and are unable to identify grounds for a protection application, it's correct that

Child Protection will ultimately close. That's because the State can't stay involved indefinitely in a family's life.

Where we are involved, though, and family violence is identified, practice should and generally does involve safety planning for women and children to a point where Child Protection are saying, "We are not going to be able to stay involved, we are not going to issue a protection application, therefore have a Children's Court order." There's planning and protective planning that goes on in order to link women and children to the services they require; so typically making sure that if we have a protective parent who is able to care for the child but there's a risk of generally the father recontacting and perpetrating violence, things like making sure that Family Law Court orders are on foot, using the co-located worker as Robyn talked about, making sure that there are referrals to family violence services and so forth. So, while Child Protection close the case, that should only be done once adequate protective planning and safety planning has been put in place and activated. That's often what we refer to as that protective intervention phase.

Having said that, I think the other thing - one of the other criticisms of Child Protection and questions that have been asked recently is whether or not we should be involved; so if in fact you have a protective parent, the mother caring for the child but the father basically persists in the risks that he presents with, whether or not there should be some other means by which we stay involved. I guess part of the challenge there is and the question has to be asked is to what end.

So if we were to accept that the child lives with mum we could do one of two things with our current legislation. One is we could get a supervision order, and Child Protection would maintain some form of supervision over the family. The question then is how does and is Child Protection best placed to supervise the offending father and what does that look like. So if you have a father who continues to pose a risk, does it mean that Child Protection somehow monitors his behaviour, surveils his behaviour and can ultimately control that behaviour in the middle of the night if he comes knocking on the door, but does that really increase risk.

The other option that we have currently in the legislation is that if we were to stay involved through some form of application is that you can remove the child. Obviously where we have a protective parent we wouldn't want to be intervening and removing children from generally their mother's care because the mother has done everything she can to separate and to protect the child and for all intents and purposes doing her best to do that, but the father continues to present a risk. It would not be in the child's best interests to damage that relationship and to remove the child, nor would it be in the mother's interest.

So I think we just need to bear in mind and question if Child Protection were to continue a role what would that look like and should it be child protection vis-à-vis some other law enforcement agency. I think generally speaking most of the sector talk about the police having a very active role here and the justice system needing to really step in in terms of perpetrator

accountability.

Having said that, though, I think there are other strategies that we could probably consider around holding perpetrators to account beyond intervention orders which seem to be one of the main strategies we use. So particularly with Child Protection parents that have separated we go to the Family Court, we make sure there are orders and generally speaking you look for an intervention order to be made.

Where you do have those fathers who are unwilling to comply - and you look at the police data that suggests they had 15,000 intervention order charges brought for breaches of compliance, that's an awful lot and many would involve children - the degree to which we might be able to look at different strategies around reporting for these men, like our bail parole conditions, whether or not they need to come to the table and report regularly and be more visible, when they are actually taken to mental health facilities what our health system needs to do in terms of monitoring perpetrators who are persistent breaches of intervention orders and are visibly violent towards their children and partners on a regular basis, whether or not we need to up the ante in terms of those groups of men so that we do have a greater number of eyes on them and a greater level of coordination is something that I think as a sector we generally support.

DR MILLER: Can I add to that. There could be a greater expectation that some offenders who do have drug or alcohol problems, that they are ordered to complete a program. There could be more specified requirements in the intervention order even. When they go to gaol, when

they are incarcerated for breaches on the intervention order there is no expectation that they do any counselling or any reflection on their behaviour. So we could also improve what happens inside when they are in gaol. Also when they are released there's no automatic planning for the women and children upon the release and exit from prison. That's a problem.

MR MOSHINSKY: I would like to just come back to a few different points that Ms Allen referred to sort of one by one and invite your comments. One of them was intervention orders and Family Court orders. Can Child Protection apply to intervene to assist the parent who is wanting to be protective if Child Protection takes the view that there is a risk to the child? Does that happen in practice?

MS ALLEN: In the form of gaining intervention orders?

MR MOSHINSKY: Yes, to support the gaining of an intervention order.

MS ALLEN: Absolutely. Any stage of Child Protection involvement, if we believe that the mother would require support for an intervention order we can do that through the Children's Court or the Magistrates' Court to support the mother and child in that process.

MR MOSHINSKY: Does that happen in practice?

MS ALLEN: It does, yes. Probably I would say not as much as it could or should. Often what will happen is that mothers will initiate that process independently. What we are encouraging the workforce to do is to be engaging with mothers more frequently to offer greater levels of assistance where we are involved, to say, "Would you like us to go or, if not, have you got a family violence worker

you are already engaged with," or, "Do you understand how to navigate the Magistrates' Court. This is what it looks like. This is what you need to do when you get to the registrar. These are the courts to go to where there's family violence specialists" and so forth. So as part of all of the training that we referred to earlier, a lot of that is covered in the training to promote better engagement of Child Protection practitioners with women who are trying to navigate what is a really very, very complex service system.

MR MOSHINSKY: What about turning then to the Family Court system and parenting orders? Is there a role for Child Protection if there is a contest about parenting orders and Child Protection has investigated and has a view that there is family violence going on? Does Child Protection have a role there?

MS ALLEN: We do. So there's a range of different ways that we can become involved. One is certainly in the Federal Circuit Court you may be aware that earlier this year there was a new notice of risk form introduced where the Family Court now requires all parties to parenting order proceedings to identify whether the child is at risk of abuse or neglect. When a party indicates that that's the case Child Protection are notified and need to provide advice to the court about any involvement that we have had or whether or not an investigation is warranted on the basis of that, so what action Child Protection may take.

That's now done routinely and is in addition to previous practices that have enabled magistrates within the Family Court to make those sorts of referrals. In addition, though, Child Protection, where we know that

Family Court proceedings are on foot, we can apply to be either a party to proceedings if we believe that we have information that's relevant to the court and/or we can be a friend of the court. So there's different ways that we can assist the Family Court in reaching the best determination and providing information about any children who may be at risk.

COMMISSIONER NEAVE: Can I just follow up on that. Do you have any figures on the number of cases in which DHHS has applied to be a party, either in cases where the child is subject to a protection order or, alternatively, is known to the department and has been referred off through to Integrated Family Services? Do you have any figures on that, because my impression is that that is pretty rare. A number of submissions have commented that's the case. It may be that the practice has changed recently.

MS ALLEN: I'm not absolutely sure, but I'm more than happy to check whether that's something that can be extracted from the system. I know we certainly have data - we have been gathering data for quite some time about the number of referrals we receive from the Family Court through the new Form 4, and that's increased dramatically over the course of this year. I'm not sure specifically about applications to become a party or a friend, but I'm happy to check that.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: The other point that you mentioned a short time ago was keeping the person using violence in view and potentially different options there. To what extent does Child Protection make requirements, if at all, on the person using violence to attend a program or modify their

behaviour before Child Protection will close its file? Does that happen?

MS ALLEN: As soon as Child Protection would substantiate concerns about family violence we would be attempting to engage with the perpetrator of the violence and refer them to men's behaviour change programs, is probably one of the most common responses, and/or other forms of counselling or service provision that is needed, depending on whether they have mental health or drug and alcohol problems also.

So planning can occur at any stage of our involvement, and we are constantly referring men to required services. The degree to which that's complied with without an order is often problematic because a lot of these men don't respect authority. They are not going to undertake those sorts of programs voluntarily. We have heard a lot about the difficulties in engaging men in programs of that nature or any form of whether it be counselling or group work programs.

But I would have to say the extension of that in the post-voluntary and post-protective intervention phase is that even when a court order is obtained any Children's Court order can contain conditions that direct a father to particular services, and once that order was made that would be monitored through the Children's Court and breaches could be made of particulars order if it meant, for example, the child was living with the father and he was refusing to engage and continued violence. So all attempts are made by Child Protection with or without court orders to refer appropriately. But, again, the level of compliance given the profile of the men that we are often looking at and their attitudes to authority

doesn't always make that an easy task.

MR MOSHINSKY: One of the comments that comes through the submission is the lack of a feedback loop to find out what is happening when men are referred. Is that something that Child Protection could do more about?

MS ALLEN: If the case remains open, there would be an expectation that Child Protection would always be reviewing the intervention. So a plan being put in place and then services being engaged, we would always be seeking advice from those services about whether the father, the parent is engaged, cooperating, issues of attendance, whether or not it's viewed that their behaviour is changing.

I would have to say the degree to which adult services are willing to provide that advice to Child Protection is very variable because of the constraints and concerns about that damaging therapeutic relationships or the degree to which it's the adult services' role to provide that information or to interpret what it might mean for parenting is variable. So sometimes the information provided back might be that the father has attended X sessions rather than what they may have gained or changed as a result of attendance.

DR MILLER: Can I add to that. A way forward is to dialogue more with those adult focused services because frequently Child Protection are criticised because there's a shopping list of referrals, and it might be for the father to go to drug and alcohol, men's behaviour change, mental health. If we could skill up within drug and alcohol services and mental health services so that there's literally no wrong door, that the violence is actually seen as a significant

issue, rather than that part of him be compartmentalised and sent off to a men's behaviour change - men want to engage with a therapist generally or somebody they can talk to, not just about one bit of themselves. So it makes much more sense to be having conversations with those adult focused services I think about men's behaviour change and what it means to skill up therapists inside those services.

The Cummins Inquiry actually talked about, in terms of making children safe, those adult focused services stepping up and having a greater lens to think family, to think parent rather than just think being adult client. That goes to the way they are funded and also the way they view their statistics. On the forms - and I have worked in those services over the years - it's an adult individual focus rather than getting acknowledgment for having worked with the partner or the children of those men. There's also a need to case conference more and connect those adult focused services to connect with the child focused services.

MR MOSHINSKY: Professor Humphreys?

PROFESSOR HUMPHREYS: I totally agree with Dr Miller and all those issues around how you could develop a no wrong door approach, and when we do drug and alcohol on Friday we will have a discussion about those issues.

I guess two things. Firstly, a few years ago we did look at how the system was working together with men's behaviour change programs. So we did a survey of 26 of the men's behaviour change programs that were funded through the department and looked at this feedback loop as one of the issues on the survey. So a lot of the referral

was coming from Child Protection into men's behaviour change programs, but at that point - which is a few years ago - almost no feedback loop. So there wasn't a sense in which there was much of a follow-through and that it was a negotiated and contracted part of the process. But it wouldn't have taken much to make it a negotiated and contracted part of the men going into the program.

I guess the second piece of research is from Joanie Smith's PhD, which was based in one of the regions in Victoria where she interviewed men and she interviewed women at two points in time. These are men who had been on men's behaviour change program and women who had been in the partner support service at two points in time.

It was very clear actually that a lot of those men were referred from Child Protection. They hated Child Protection with a passion, which was kind of interesting. It meant that Child Protection was doing some work in this area with men. Actually, say, 10 years ago they probably wouldn't have cared one way or another with Child Protection because they wouldn't have had any interference by the State about their behaviour. So it was kind of interesting. But there was a missed opportunity in terms of the way in which that engagement may or may not have occurred.

The thing was that those men were actually motivated around - a lot of the men were motivated around their fathering. They made no connection between Child Protection and their issues around fathering. So it was sort of interesting. There was also no feedback loop still around them really seeing that they had a role to play and that Child Protection had a legitimate role in

their lives.

So it was sort of interesting and I would say probably an area where it wouldn't take much to develop the practice more. It is sort of one of those hotch-potch where just a little bit more work in that space could make quite an amazing amount of difference.

What we do know is that for men who are referred in through Child Protection that they tend to be the completers because there's the leverage of Child Protection that's being used, and that's both in the UK and here.

So it's an interesting role and it is one of the issues that there may be some unintended consequences, not just in this space, in terms of really saying, "Actually an awful lot doesn't belong in the tertiary system." If you actually take a lot out of Child Protection, you lose some of the leverage of the statutory authority. So that is potentially a loss.

But, on the other hand, just going back to the family law issues, about family law getting back in touch with Child Protection, "Has this case been there," et cetera, Child Protection is only investigating 16 per cent. So there's a huge amount that's not going to show up with family law. There's a huge problem for these women who are being protective, and some men as well, when they are being protective but there's no evidence.

So one of our problems is that family law doesn't have the capacity to investigate. It's just such an enormous problem about how do you get the evidence of family violence into the family law space so that women aren't seen as a failure to protect in one area - so when

they are in the Child Protection system if they are not acting protectively, they are failure to protect, and we are trying to change that, but actually there's a bit of that - as soon as they move into the family law system they are the alienating parent, and they allow large amounts of contact unsupervised to fathers who are violent.

So we have to be really thoughtful in this space. That's a bit of an oversimplification, but that's the space that some women are reporting that they are caught in.

MR MOSHINSKY: Given the time, I wasn't going to come back to intervention orders, family law or interaction with the person using violence. Do the Commissioners have any questions on those topics before I move on?

COMMISSIONER NEAVE: No.

MR MOSHINSKY: Dr Miller, did you want to add something on those topics?

DR MILLER: This co-located position, the value of that position is that there can be rapid information exchange with the relationship consultants within the Family Court jurisdiction, who are doing the assessments and advising the judges about applications from parents who are using violence. The value of that is instead of the 69ZW or a Form 4 or a 91B, all these sort of different legal processes that happen, if you have the right person who is able to get into the Child Protection system quickly you can have very good information exchange that's very supportive of women who are being, really, re-abused is their experience through this sort of battery by law, it's referred to in the literature, where you have the violent

partner who is constantly going back to the Family Court.

So we have a lot of interest actually from the Commonwealth in what's happening in this space in Victoria, and they have referred to it as sort of the arteries becoming unclogged between the two systems.

DEPUTY COMMISSIONER FAULKNER: Dr Miller, this relates to the arteries being unclogged between children who are already in the Child Protection system and the Family Court, the women who have avoided and who have been protective mothers and are not in the system, could they benefit from the same sort of intervention about the danger of parents? There are a lot of women who would say their partners are still violent but they have acted protectively but that battery thing happens, and it seems to me you are saying that only people who are currently active in the Child Protection system can get assistance.

DR MILLER: Not quite. Frequently there's been sometimes vexatious reports by the violent partner to Child Protection about the protective mother. That's recorded on intake. So the information exchange includes those cases that are no longer open or active or haven't been formally investigated because it was assessed to be vexatious at the front door of Child Protection.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MR MOSHINSKY: Ms Allen, I want to take up now a new topic, and that concerns Child Protection and Aboriginal children. We had evidence yesterday from Andrew Jackomos, who is the Victorian Commissioner for Aboriginal Children and Young People. He gave evidence about a number of matters but in particular the number of children in out-of-home care. I will just read you a portion of what he said yesterday

in his evidence.

He said, this is page 170, "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 overrepresentation is 63 out of 1,000 for Koori children compared to five out of 1,000 for Victorian children, and in a key rural hub we have close to 120 out of 1,000 Koori children in out-of-home care," and then he went on to say that "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 it's cumulative harm and dysfunction is happening for many families in generation to generation."

He then did point out that, "In some 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." Those statistics are alarming. I wanted to invite you to comment on the situation of Aboriginal children in out-of-home care and those figures and facts I have referred to.

MS ALLEN: Certainly the figures that were provided by Commissioner Jackomos yesterday in relation to the rates of children in out-of-home care are correct and they are reported in the Report of Government Services report for 13/14 and are deeply concerning to both the Commissioner and the department and sector more broadly.

I think the Commissioner spoke about the initiative Taskforce 1000, and one of the things I think

probably worth describing is the elements of that that then has led the Commissioner to cite further data. Taskforce 1000 essentially derived its name from the approximately 1,000 Aboriginal children in out-of-home care in Victoria, and it was agreed that we would undertake a very comprehensive review of each of those child circumstances to look at how we could improve their situations.

Essentially the process that we have embarked on, noting that it's been a little bit of action research along the way, was to start with a detailed survey instrument that goes through around 160 questions, from memory, for each Aboriginal child to understand what's brought them into care, what their parental characteristics are, issues for them across a whole range of life domains so that we can get a better understanding of those children; and then, following a survey being undertaken, the formation of area panels that consist of different government departments, community service organisations, Aboriginal Controlled Organisations that come together to consider a de-identified case presentation of each of those children with the view that each of the people around that panel provides consultation and advice about how to improve their circumstances.

In marrying up some of that survey data - because I think we are through 10 of 17 areas to date - the data from the survey and the information at the panels is revealing very, very high levels of family violence bringing children into care. I think the Commissioner cited 90 per cent of children coming into care primarily because of family violence.

We are not quite there yet in terms of completing all of that data and won't be for another couple of months yet. So I wouldn't necessarily say it's definitively 90, but it's in that realm of 80 to 90 to date; irrespective, very, very high levels which I think is really illuminating for us the importance of working strategically on those issues.

As an outcome of the taskforce I think what we need to understand is that this really was a strategy to better understand what's the driver of overrepresentation and what we can do. At the completion of each of the area panel processes the area directors are required to develop a very detailed 12-month work plan. We were very fortunate in this year's budget to have funded Taskforce 1000 coordinator positions in each of the divisions - two in fact in each of the divisions - to work on implementation of the issues that have been identified through the Taskforce 1000 process.

So for the first time ever what we are going to have is very, very rich data about the drivers towards overrepresentation, what are the things that we also need to do to improve outcomes for those children and a detailed work plan and a resource to implement that work plan in a way that we have not had before.

So I think, while we are to a large degree very discouraged by the data that we were uncovering and we really need to reflect on that very, very seriously to look at where we need to invest more heavily and turn our attention to, I think we are at a watershed moment of being able to better understand what our overrepresentation is about in Victoria and do something

very, very meaningful about that over the course of the next 12 months and beyond.

MR MOSHINSKY: There were some more particular points that Mr Jackomos made yesterday about Child Protection practice, and I just want to give you the opportunity to respond to those. One of them was in quite a number of cases children who are Aboriginal, their Aboriginality not being picked up in some cases for many years afterwards. He referred to either the question not being asked or being asked in a particular manner without explanation of why the question was being asked. Do you have any response to that evidence?

MS ALLEN: Sure. Currently the Child Protection program is required to always ask about Aboriginality or Torres Strait Islander status at the point of receiving a report. That's a mandatory requirement. You won't literally be able to move through the process unless that question is asked. I think it's fair to say that a large number of reporters don't know. Some may know; school teachers may know. But neighbours or other professionals may not know at that point. So the option of an unknown category is provided for at the time of intake.

Beyond that, the workforce is required to ask that question again if we are investigating. Again, it's substantiation. So there are a lot of touch points where people are required to ask that question. It's fair to say that the effectiveness of asking that question has improved over time because we are seeing that the number of Aboriginal children in the system are being identified better than they have been previously. But the Taskforce 1000 process has identified that there are still some

children for whom we are not identifying their Aboriginality until several years later, as Andrew indicated.

Part of the reason for that is that we believe in some instances the question hasn't been skillfully asked and we are now embarking on a process of improving our training in order to assist workers to explain very carefully to families why we ask the question and what it means, so that in asking this question if your child is Aboriginal it's not more likely to lead to removal or some other unintended or terrible consequence but rather we do that so that we can bring better services to your child's situation and apply other policies and requirements. So we are developing that up as part of a broader reform and training process around permanency planning for the second half of this year.

It is fair to say, though, that we do have some circumstances, irrespective, where families choose not to identify their Aboriginality for many, many years. That's largely as a result of forced removal practices and where we have very, very high degrees of mistrust. We are going to need to work hard over time to try and address that and work more closely with Aboriginal communities and families to gain that trust. But it may be that we may always have a small number where identification doesn't happen for quite some time. But we certainly acknowledge that we can do more in that space.

MR MOSHINSKY: There are Special Placement Principles that Child Protection has for Aboriginal children, and you have annexed them to your statement. Those placement principles relate to placement with extended family or

another Aboriginal family and a cultural plan, among other things. I'm just referring to a couple of aspects of it.

There was a concern raised I think by Mr Jackomos about placement, and at one point at page 190 he said, "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." Are you able to make a response to that issue?

MS ALLEN: The Aboriginal Placement Principle is legislated and requires that when we are placing an Aboriginal child in out-of-home care that we must follow certain criteria, and priority is given to their placement so in particular that we always explore placement with Aboriginal extended family; if not, if we can't find a placement with an Aboriginal extended family, other extended family; if not, moving down to Aboriginal community and so forth. So there's a tiering approach that must be followed.

What we know is that of all of the Aboriginal children in out-of-home care we have in Victoria 66.9 per cent placed in accordance with that Aboriginal Placement Principle as a proxy measure. So essentially they are placed with either Aboriginal kin or other kin or in another Aboriginal foster placement or residential placement.

What we can't do currently in our system is unpack in a way that we can extract data from our system to show that the Child Protection workforce has worked through each of those requirements methodically. So we don't have a tick a box where they say, "Have you considered X," and show evidence of that and we can

extract it to see the degree to which they are complying.

Having said that, the Commissioner has launched an independent own motion investigation to look at compliance with the Aboriginal Placement Principle and is trying to gather a whole methodology as to how we are going to do that in the absence of data screens that allow us to extract that particular data.

Having said that, though, we believe that in most instances our workforce does explore placement with Aboriginal extended family fairly thoroughly. Often, however, because of levels of disadvantage and family breakdown within Aboriginal systems, a number of Aboriginal families where they can be extended family can be identified, they indicate they are not in a position to care for another child for a range of different reasons and that often impacts on our ability to improve those rates.

In addition, we are working very, very hard and know that with the workforce we have to improve the way that they explore the Aboriginal kinship and extended family community. So we are working with them to develop better genograms to promote the use of what's called Aboriginal Family Led Decision Making, so again family conferencing that brings all of our Aboriginal families, elders, communities to the table, and we think that's paying benefits.

In addition, we have a particular project occurring at the moment where we are looking at how better to implement cultural support planning for children who do come into care with a view that that begins with an Aboriginal Family Led Decision Making meeting and then the

development of a plan. Irrespective of whether a child is placed with their extended family or not, that maintains their culture and cultural connectedness whenever they are placed in care. So that will be a newly legislative provision that will come into effect in March of next year, that every Aboriginal child must have a cultural support plan that's provided to them. So we are working hard on developing that particular module and model of development which includes the participation of the Commissioner.

MR MOSHINSKY: Do the Commissioners have any questions on that topic? There were some other matters, but in view of the time unfortunately we can't take up all issues with the witnesses. Could I thank all of the witnesses for their assistance and participation. I think Professor Humphreys is coming back, but I ask that Dr Miller and Ms Allen be excused.

COMMISSIONER NEAVE: Thank you very much.

<(THE WITNESSES WITHDREW)

MR MOSHINSKY: We have two witnesses in concurrent evidence, but I wonder whether it's convenient just to have a five-minute break before we start that evidence.

COMMISSIONER NEAVE: Yes. Thank you, Mr Moshinsky.

(Short adjournment.)

COMMISSIONER NEAVE: Thank you, Ms Davidson.

MS DAVIDSON: Commissioners, what I'm intending to cover in this last part of the afternoon is the question of the therapeutic response for children. I'm not proposing to take too much time on the issue of a need for a therapeutic response but rather focusing on what should that therapeutic response look like, how that should

happen and where our priorities perhaps need to be placed, and finally probably how do we build the capacity within the whole system to provide a more therapeutic response for children.

<EMMA TOONE, affirmed and examined:

<WENDY BUNSTON, recalled:

MS DAVIDSON: With Ms Toone of course we have Ms Bunston back, for anyone who wasn't listening or watching this morning. Ms Toone, you have made a witness statement for this Commission?

MS TOONE: I have.

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

MS TOONE: It is.

MS DAVIDSON: You are a child psychotherapist. You have some experience working in the community, educational and private consultancy settings. You are currently employed as the senior clinician in the Turtle Program at the Northern Domestic and Family Violence Service at Berry Street.

MS TOONE: Yes, I am.

MS DAVIDSON: Attached to your witness statement is also appendix 1 of the submission that Berry Street has made to the Commission.

MS TOONE: Yes.

MS DAVIDSON: Just before we deal with the issues that I foreshadowed with the Commission, were you present or did you hear the evidence that was asked earlier on in the afternoon of Ms Allen and Dr Miller about the adequacy of the therapeutic services that are available for children?

MS TOONE: Yes, I was.

MS DAVIDSON: At pages 56 to 57 you have specifically identified what you identify as several candidate services that are potentially available for therapeutic services for children, including sexual abuse services, the Turtle Program that you have yourself at Berry Street which you note isn't funded to work with fathers, which you identify as quite an important omission because of the child's relationship with the father also affecting development.

MS TOONE: Yes.

MS DAVIDSON: You have also referred to infant, child and youth mental health services, the Berry Street Take Two Program and the Berry Street family services programs. But more generally can you tell the Commission what your view is of the adequacy of the availability of therapeutic services for children?

MS TOONE: I think in terms of the adequacy of the therapeutic services that are available we are also harking back to some of the evidence given yesterday by Professor Louise Newman and also the comments that Dr Miller has also been talking about. What we are looking for in particular are therapeutic services that can respond to the children's relationships because we know that they are the most effective vehicle for healing.

We are also looking for services that can respond acknowledging the trauma that the child and the parents have experienced and, as Wendy Bunston said this morning, really a way in to kind of think about how we can engage parents when psychoeducational models might not be able to be taken up by parents and children that have experienced trauma. They don't have the capacity, I think as Dr Miller put it, to have access to their thinking brain

and we need to find ways of engaging with them at an emotional level after trauma.

The other thing to say is that we need services that have the capacity to do Specialised Family Violence Risk Assessments. So the services that we are talking about - there are several candidate services. But in terms of a comprehensive service, particularly for children, the referrals we mainly get and the area I'm interested in speaking to which is within my main experience are the children that are not in the statutory system. So Professor Humphreys also spoke about that. So we are talking about this 85 per cent that aren't necessarily in the statutory system and won't get access to, for example, an intensive therapeutic service like Take Two. They may not get access to a service like CAMS if they don't have an identified mental health diagnosis.

MS DAVIDSON: CAMS is what?

MS TOONE: Child and Adolescent Mental Health Service or Child and Youth Mental Health Service, and also depending on capacity the Infant Mental Health Services, which are few and far between as well in their own right.

The other thing to say is that if these children get referred into the community there will be varying expertise in community in private practitioners, even in community health centres in terms of both family violence expertise in terms of assessment around family violence risk and also the capacity to deliver a trauma informed response for infants and children, and also engaging parents in their parenting role in a way that, as I said, is able to access the part of their brain that can use our responses; so the emotional brain.

How we do that is quite a specialised field, as Wendy has talked to. So it's really about that capacity building of the different services. Some of them have some trauma expertise. Some of them have expertise in different psychological therapies. What we are really missing are services that have Specialised Family Violence Risk Assessment capacity and the capacity to work with children and their relationships in a trauma informed way.

Then the third issue of course is in the family violence service and perhaps in the Turtle Program where we may have some capacity to - I'm very fortunate to sit within a family violence service with a lot of expertise in terms of Specialist Family Violence Risk Assessment partnerships with the police, courts, maternal and child health services, but we have this issue in the post-separation population of where the kids are having contact with the fathers where we are kind of missing the capacity to do assessments of the dads and to intervene with the fathers as well.

MS DAVIDSON: What's your view as well about a therapeutic response for children and working with families if the parents are still together?

MS TOONE: There's two. There is the question of the therapeutic response where the parents are still together and also when they are separated but the children are still in contact. In terms of when the parents are still together, to speak back to Dr Miller's comments, it's really about building some capacity and specialisation around that ability to assess and engage with families that may be at risk where there may be violence in a way that doesn't escalate the risk to any member of the

family. So it's a quite specialised area.

The ideal time to intervene is in the perinatal period, which you have heard evidence about. It's a really effective time to find a way in to do some early intervention, and we do have some quite solid research from the States around intervening in this period. Wendy has research in this area in terms of her work. There is a body of infant mental health literature growing across the world saying in terms of bang for your buck, best outcome for the minimum expenditure, this is the best place really to intervene.

That said, we do have models in other parts of the world - the one I'm most familiar with is Professor Alicia Lieberman's work. She has very clear inclusion and exclusion criteria for working with fathers in a way that manages the risk. It brings into it the family violence specialisation, family violence risk assessment frameworks and also has the capacity to monitor whether when that child goes home to the families that the risk is actually decreasing. So there's communication and agreement with the fathers that participate in that program that that information will be shared and that's a prerequisite for the program.

Obviously it's not the work we are doing in Turtle. The work we are doing is very needed as well. But in terms of that kind of future planning I think there are models like that, and Wendy's too, in terms of partnering with men's behaviour change, how do we find a way to do child focused work with traumatised parents and effectively integrate family violence risk assessment frameworks. For that matter, I would like to see forensic

mental health at the table here as well in terms of thinking about how to intervene in a safe way with this population.

MS DAVIDSON: Ms Bunston, do you have anything further to add or to respond to Ms Toone's comments?

MS BUNSTON: To the question of?

MS DAVIDSON: Firstly, principally the availability of therapeutic services for children, and Ms Toone has also identified the need to work with the relationship.

MS BUNSTON: The therapeutic availability of services is pretty poor, and I think it's been already spoken about today where people start programs and then the funding ceases or people move on or whatever else. So I think the turnover is fairly large in lots of organisations. What is available sometimes lacks sophistication therapeutically in terms of what they are trying to achieve.

I think that children's work and even more so infant work is the first thing to go when there is a budget squeeze. It is almost like we have just been tacked on the end because there is a little bit of time left, and that's no disrespect to the Commission, but it is a metaphor really for what happens to the children's voice, that it often gets excluded because the adult business is more important.

I guess from my perspective as a service system we are not really going to radically change the way things operate until we start to think intrinsically more from an infant and child led perspective, because I think infant and child led perspectives actually tap into a vein of hopefulness and a level of motivation that parents have around change that perhaps doesn't exist that they have

around each other. So I think it's fairly poor.

The skill set that is out there is not brilliant, and not because there aren't people passionate about it and want to do that work, but there's not a huge amount of expertise out there anyway, and that's not supported and resourced. We could and should be doing way, way better. Kids and infants are entitled to better services than they are getting.

I would agree - getting on a run here - I'm not sure why CAMS isn't here at the table. I'm not sure why when the infant mental health expertise is in CAMS that is a sector that does not see this work as core business. But, anecdotally, my experience in working in a CAMS system for 16 years is scrape the surface and a bulk of those kids coming through the door with mental health diagnoses have also experienced family violence. I don't work for anyone now, so no-one can tell me off for saying that.

MS DAVIDSON: What has been identified by you, Ms Toone, particularly in your statement is a very large unmet need. You identified the number of single parent families and the high rates of family violence that are potentially present or have been present with those families. You have identified the idea that an ideal is around 12 months of therapy. Is 12 months of therapy needed in every case or is there a range of options?

MS TOONE: No, there are different subpopulations. I think one of the problems that we have in the family violence sector and understanding children that are affected by violence is it feels like a big amorphous kind of group. One of the things we need to think carefully about is how we

separate out children with historical trauma, they have had an historical experience of family violence, they are not at current family violence risk, versus those children that are at current risk from family violence. If they are at current risk, they are in contact with a parent who uses violence, we need to understand that a different response is needed and a different level of expertise needs to be brought into that population.

The other thing that I will say is I think there are windows of opportunity, which Professor Newman also spoke to yesterday. It's identifying different subpopulations within this group of children affected by family violence and then tailoring our therapeutic responses to their needs. One of the populations is parents where there may be violence beginning for the first time, for example, in pregnancy. It's an ideal time to intervene.

We have heard the evidence for that in terms of infant mental health services and that expertise. So that is one group for us to think about. I still believe more work can be done in terms of integrating family violence risk assessment frameworks into even working with that population, which I think also Professor Newman was talking about, at the Women's Hospital trying to do both.

Another group we can talk about are some of the children that we would categorise at high risk, high risk of homicide. They have experienced perhaps or witnessed - experienced in another way - a recent perhaps physical assault. They may be in refuge, where it's an ideal opportunity for intervention, which Wendy is doing a PhD on in terms of this work - brief work that can really

have a good impact on helping mum to respond to her infant, talking to the infant in their own right as a subject and what that does in terms of for mum in terms of modelling that way of relating and capacity building the service providers around that group.

For the ones that don't go into refuge, which are more my group in terms of that I have experience with - I work within a specialist family violence service that was one of the services that piloted one of the RAMPs, the demonstration projects, so the Risk Assessment Management Panels, in terms of identifying women and children that are at high risk - we saw for that population, once they had engaged with one of the senior case workers - and we at that point had more capacity to do a little bit more work over a longer time period for the family violence practitioner to engage with that woman. But, if there was a recent assault or recent potentially traumatic event, we basically could take a therapist in, riding on the coattails of the engagement that the specialist family violence provider had already achieved with that woman and do a brief infant-parent or child-parent family intervention when dad was too unsafe, it was too unsafe for them to be living at dad's, but something very frightening had happened.

We, in our practice experience, saw that there was a capacity to help support mothers who lose their confidence as parents. One of the impacts of violence on mothers that have been subjected to it is a loss of confidence - I'm making a generalisation, but in their capacity as a matter. They may have had a past history of trauma, but we cannot underestimate what a current trauma

or repeated experiences of current trauma, of being in fear for your life, what that will do to a woman's capacity to mother but also her capacity to attune to her child, and also to provide space for play, which we know is so important for these children to have an experience of playful attuned to feeling joy, to feel understood, to feel listened to.

So for that group after a potentially traumatic event we can do brief interventions and also follow-up support, capacity building for the primary practitioners. In those situations brief work is very much indicated, and brief work can also be achieved a lot more for the perinatal group. So there is the perinatal and also this high risk after a recent assault or in refuge.

There is a third group that I would like to identify - I think there is a fourth group, which is the out-of-home care population, which is outside my area of expertise. But the third group I will identify is - the referrals that we get or get asked about are the post-separation population of women and children where there may be some capacity to do longer term work, and we know that the evidence really says in terms of for those kids an intervention for the mother and child together of 12 months duration, so one session a week for 12 months, has been shown conclusively really to decrease the mother's post-traumatic symptoms, decrease the child's traumatic symptoms and depressive symptoms, decrease their problematic behaviour. So there is a way of intervening together that benefits both the individuals. So there are different therapies for different populations, really.

MS DAVIDSON: Ms Bunston, you have identified in particular the

importance of working with children in refuges and that as being an important opportunity. Can you expand on that for the Commission?

MS BUNSTON: In terms of my research?

MS DAVIDSON: Yes.

MS BUNSTON: So my research is looking at how refuges provide refuge to infants, and it's focusing on infants 12 months and under. It is born from some work that myself and the addressing family violence program team did with a local refuge where we had two of my team were working there for six months, one day a week with the refuge staff. One of them was an infant mental health specialist and one of them specialised in children's work, and I think that had a big impact on how the workers in that refuge thought about the opportunities that were available to do work in the here and now with families. So that was my interest in that area, and I produced with Robyn Sketchley a book called "Refuge for babies in crisis", which was nationally funded and distributed to refuges, looking at this work.

Essentially I guess I see, and I hope this is the trend that's going to stay in Victoria, that, whilst other states and countries are looking at closing down women's refuges, I hope that we actually see them as opportunities to actually grow specialist work. We have a captive audience of the most vulnerable, most at risk infants who are at most risk of being harmed. So the research is consistently saying that infants under 12 months are most at risk of being harmed, either physically harmed or some sort of illness that results or injury into hospital, but at greatest harm of death. I think that this is a client group that, whilst they are at greatest harm, perhaps get

the least amount of resources.

Infants that come into refuge with their mother - and, as Emma has talked about, we've sometimes got mums who are highly traumatised when they come in, so not necessarily emotionally available themselves to the infant, not because they are bad mothers but because they are so traumatised that they are just trying to recover. Babies can't afford to wait. They cannot afford to wait to have attuned responses, because the developmental trajectory is being developed at such a rapid rate they need to be responded to, they need to be engaged. If they are remaining in a dissociative shutdown state, then essentially what that means is that their neural development is being thwarted by their traumatic response instead of growing and developing like it should be.

So I guess the call needs to go to not just the families but to the workers out there working with babies and children to say that we can be what's called a contingent caregiver. We can be available to infants. We can be available in the here and now to be responsive to infants.

I think it was Elizabeth Scott that said child abuse is everybody's business - I think that was her statement. Is it Elizabeth or Dorothy? It was Dorothy Scott who said that. Yes. It is. It so is that if you don't have a mother or father emotionally available to an infant then who else can step in and be emotionally available to them whilst the mother and/or father can have some work done with them that enables them to move quickly to a spot where they can be emotionally available.

Some of the work of Frances Thomson-Salo and

others at the Infant Mental Health Program at the Children's Hospital talks very much about that capacity, if you engage - when this system is really stuck - and we are talking about probably the most stuck families, where there's horrific and ongoing family violence. We are talking about there being quite rigid sort of patterns of relating; that sometimes in those families if we can work with the most available, the most flexible, the most responsive member of that family system we can sometimes facilitate changes in the rest of the system.

Who is the most available? Who is the most responsive? Babies and children. They are ready. Go on the tram and you have a baby in a pram and you look at it and you do peekaboo with them, they will respond to you. You do that to the mum and she might look at you like "I'm going to ring the police".

The reality is that infants and children are available and ready and hardwired to engage and connect to others, and we as a service system need to be available to do that. Refuge workers need to be and are in a beautiful situation to do that very quickly at a time when infants are dysregulated, and it is incredibly neurologically important to bring them back to a state that is regulated, incredibly important to their development.

CAMS workers, adult workers - I guess this divide we have between the women's workers, the men's workers and the children's workers is not getting us anywhere particularly fast. So I think it's the responsibility of all of us to be available to infants and children that come in. If you have spent some time with infants and kids, they pick who they like. They will work out who it

is that's going to be receptive to them and they will make a beeline for them. We need to be able to support those people that those kids pick as the person that they are going to trust. So I guess I think we need to think more broadly and more creatively about how we do this sort of stuff.

I was talking to I would say Dr Fletcher in here but Richard at lunch, and basically talking about why aren't we getting some of our retired professionals, like I will be one day, coming in and doing supervision for refuges? Why aren't we making smarter decisions and moves around trying to bring in people that have got skills that might want to do something once they have retired to come in and support some of those systems that get no support? Refuges don't get clinical supervision.

There is a program in America that's done some really effective work around supervising refuge staff, and by "supervision" I mean reflective practice, not saying how you do your work but encouraging them to think about what they might be able to do in the here and now to be more child sensitive and infant sensitive in the worker's working life.

Maternal child health nurses are in a brilliant situation to do some of this work. I supervise quite a lot of maternal child health nurses and I can see the difference between groups that I have been supervising over three years to ones that I have just started in terms of their ability to be more bold about their capacity to think about violence in relationships and to think about the fathers and to think about all sorts of things.

So there's some smarter ways we could target

those groups that are really at the front line and support them, give them more resources. That doesn't mean they have to do all the more sophisticated therapeutic work, but, boy, they can make a difference on the ground. Child-care workers make a difference, teachers make a difference.

So I think it's that knowledge that if you have an available adult who will take an interest in an infant or a child, perhaps until the parent can come on board and do so as well, can make a huge difference neurologically and developmentally to that infant. But as we keep sort of having this top-down, adultcentric, let's fix the mum and dad up first and that's going to fix the kids up, well,we know that work takes a long time, and by that time we have infants who within the first 12 months of life are probably equivalent to what an adult would do within 10 years of their life, we have missed opportunities and we keep missing those opportunities, and then we are saying, "Why is it that we have this issue that keeps going on intergenerationally?" Maybe because all our focus is on the part of the system that's most stuck instead of the part of the system that's most receptive to this work.

MS DAVIDSON: In terms of building that capacity within refuges and, say, family violence services, what do you see are the potential ways of kind of building that? We have heard this morning this idea of perhaps building more partnerships between the family violence specialist services and adult services and mental health and so on. Is that one potential way - - -

MS BUNSTON: I believe we should have services coming into

refuge to support refuge doing their work, and working alongside them to skill up refuge workers. So I did the BuBs on Board pilot in Tasmania in 2008, and at the end of that I recommended that I think CAMS workers should be going into refuges to support refuge staff. I think we should be having speech therapists going in to refuge. I think we should be having OTs going into refuge.

These children as a cohort are incredibly developmentally delayed on the whole. There's lots of emotional difficulties. If we had other services coming in to support refuge, then I think we can skill up refuge, we can get them fired up and passionate about working with infants. But I think a lot of people are scared about working - and you can comment on that too, Emma, that a lot of people are a bit scared. They don't know what to do. It's like they are too fragile and we go along, collude with this belief that it's not going to impact them. I think it's because it is too painful to think about how much it does impact them, so we just try not to think about it, and as we are trying to sort of busily not think about it we are leaving children in horrific situations.

So I think there's lots of front-line workers we could support a lot better. Maternal and Child Health workers are run off their feet. I think more and more they are being squashed down to their half-hourly appointments and not given the freedom to follow up families when they know something is going on, and I think that's very soul destroying for people who can see that they could do more but they are constrained by the budgets and the funding opportunities.

We don't have to re-invent the wheel. There are some things out there that we could just put more energy into and support better, and we might start to see some better outcomes.

MS TOONE: Just to add to that as well, that sense of what Wendy is saying, what we are asking practitioners to do is to identify with the most vulnerable person in the room. It is a big ask to ask practitioners who are already carrying and navigating horrendous levels of risk and fragmentation in service systems to also then consider the infant's wellbeing, which is why we need to help them in the way that Wendy has been piloting over many years and evaluating in terms of this work.

It's a sense of bringing some of the specialist skills that therapists - family therapists, child psychotherapists, infant mental health clinicians - can bring in terms of these - capacity for relational intervention with infants and young children, and older kids as well, to walk alongside the practitioners that are doing the work, to provide a reflective space for them to help them think about how they can speak directly with and engage infants and children, and women in their mothering capacity as well, and also to be able to model in the way that Wendy is talking about wherever possible to do sessions with them alongside these workers so it's almost as if they are being co-opted. As a co-therapist, they are seeing exactly how you are relating to that infant and the mother, and they also have that as a kind of learning opportunity and skill-building opportunity.

What we can say about - why Wendy and I can do this work with these high-risk populations is that we are

depending on the specialist family violence risk assessment and management expertise that we are both working in those systems where we know that the family violence risk is being effectively managed by specialists in the area. There are sometimes things we can add in terms of concerns we might have about an infant's or child's wellbeing or sometimes Child Protection concerns that we may reflect on with them.

One of the difficulties and the challenges and the opportunities is how do we bring this capacity to bring together infant and young child work, child focused work with parents, work with parents and children together of different ages, and that clinical capacity to work with traumatised families with family violence risk assessment and management, how do we bring those together, how do we kinds of bring those skills into the community, into our work - you know, private practitioners, CAMS, different services - so that all practitioners working with these families have some skills in these different areas.

The third area again is that capacity then when we can or when we can't work with fathers and in what way we do that in a safe way, and what extra expertise do we need to do that to ensure that everyone is safe.

MS BUNSTON: And when are we going to ask children what they want? That would be my point. I was just thinking then of a family that I worked with where there were three children and the youngest child - the father had recontacted and there had been quite horrible violence, but he had recontacted after a period of time and wanted access. Mum was obviously hesitant about whether that was a good idea or not. We spoke to the kids about what they

wanted. I was very hesitant. I was thinking "I don't think it's a great idea". But they went ahead with it.

The littlest one was - she basically - when she saw dad, she said, "Why did you hit my mummy," and he gave an explanation. Then she said, "You are not to hit my mummy," and just - it was just a beautiful example of a child in an opportunity where they were supported through the access visit to actually tell dad off for what had happened.

So when they came back and reported what happened and this little girl - one of the children wanted to have contact with dad but two of them chose not to after that visit. I was as a practitioner thinking, well, my experiences is I don't think that's a good thing particularly to put the kids in that situation. Those children taught me that for them what they needed to do was go through that situation, be supported in it but work out what they needed.

So for that little girl she was able to come back with some sort of resolution around how she had been able to say to this big figure who was looming in their lives, "Not good enough, daddy." I think that's the sort of stuff - how do we support children in their solutions - because we so quickly rush to what we think as adults is the best thing to do and we don't talk about with kids what are the things that they need to do; because some kids want to have contact. So maybe it's like how do we do that in a safe way for kids so they can still have that contact without - I think what can often happen in therapy is dad becomes the bad guy, sometimes some kids idealise dad, they don't really have a relationship with him, so

they have this imaginative figure that they have a relationship with, and that in itself becomes quite dangerous.

So it's like how do we manage the complexities of these relationships for children and how do we invite them into that process where they are part of that management strategy, that it's not always us saying, "We know what's best," because sometimes we actually don't.

MS DAVIDSON: Bearing in mind the time, are there any questions from the Commissioners?

COMMISSIONER NEAVE: No, I don't have any.

MS DAVIDSON: Thank you. Perhaps the witnesses can be excused and we will resume tomorrow morning.

COMMISSIONER NEAVE: Thank you very much, Ms Toone and Ms Bunston. You have had a hard day, really - thank you - yesterday and today.

<(THE WITNESSES WITHDREW)

COMMISSIONER NEAVE: Tomorrow 9.30.

ADJOURNED UNTIL THURSDAY, 16 JULY 2015 AT 9.30 AM