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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

FRIDAY, 24 JULY 2015

(10th day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

MR MOSHINSKY: Commissioners, the topic for today's public hearing is men's behavioural change programs and perpetrator interventions. Four of the themes for today are as follows: first, how effective are men's behaviour change programs and who should they be delivered to; second, how can existing programs be improved; third, what other treatments or programs should be explored or developed; and, fourthly, how can the system assess and provide individualised treatment given the large numbers involved.

Can I refer to the community consultations and some of the feedback that was received there. The Commission heard from many sessions that the availability of support services and programs for people who use violence is largely limited to the men's behaviour change program. There are no referral options for men deemed not suitable for the men's behaviour change program and no interventions for perpetrators who are not men.

These limitations notwithstanding, the men's behaviour change program was noted as being underfunded, underresourced and lacking in participant accountability. It was simply put that there are not enough of them in enough places for enough people and not enough follow-up for those referred as voluntary participants or mandated to attend by court order. In one regional area there were 2,000 potential referrals in nine months and only 120 places funded over a 12-month period, resulting in a waiting list of six months to two years.

The Commission also heard divergent views on the effectiveness of men's behaviour change programs. It was suggested that the current program reflects a harm

minimisation model which lessens the severity of the violence rather than effecting longer term change.

Noting that the program has not been evaluated, questions were raised about its therapeutic limitations. One comment was it stopped the physical but not the psychological abuse. The one size fits all approach of the program model was criticised as not being culturally appropriate or tailored to suit diverse communities. Consultation discussions differed on whether or not perpetrator interventions should be court mandated.

Could I now outline the evidence that will be called today. We start with Dr Katreena Scott, who will speak about a program known as the Caring Dads program, which uses the fathering role to seek to effect change.

We will then have evidence from a lay witness - that will be subject to a Restricted Publication Order - who will speak of his experience of a men's behaviour change program and his perspective on such programs.

We will have evidence by telephone from Dr Caroline Easton from the United States about combined alcohol and drug and men's behaviour change programs conducted there.

We will then have a panel discussion involving Rodney Vlais and Jacqui Watt from No to Violence, Professor Andrew Day and Professor Jim Ogloff.

Then this afternoon we will have evidence from Michael Brandenburg, who will speak in particular about delivering men's behaviour change programs in regional areas. We will have evidence together from John Byrne about the Dardi Munwurro healing and leadership program within an integrated health service. Finally we will have

evidence from two State witnesses concurrently, Mr Andrew Reaper and Ms Marisa De Cicco.

Could I mention four potential recommendations which might be considered through the course of the evidence today among other possible recommendations which will be raised by the evidence. One is to develop a broader suite of evidence-based treatment programs addressing a range of risk factors, including programs for co-occurring alcohol and drug abuse and family violence; programs focusing on fathering; and cognitive based therapy.

A second is to deliver programs on the "risk needs responsivity" principle which we will be hearing about in evidence in the panel discussion; third, to develop a screening tool to assist with the assessment of treatment needs of perpetrators; and, fourth, to resource individualised assessment of perpetrators identified as higher risk and provide more intensive individualised treatment for those perpetrators.

I will now hand over to Ms Davidson to call the first witness.

COMMISSIONER NEAVE: Thank you, Ms Davidson.

MS DAVIDSON: Thank you, Commissioners. The first witness today should be on a videolink with us. It's Dr Katreena Scott from the University of Toronto. Can you see and hear us okay?

DR SCOTT: Yes, good morning.

MS DAVIDSON: Dr Scott, the first thing I will do is ask that you be sworn or affirmed to give your evidence.

DR SCOTT: Yes.

<KATREENA SCOTT, (via videolink) affirmed and examined:

MS DAVIDSON: Thank you, Dr Scott. You have made a statement for the Commission, have you?

DR SCOTT: I have, yes.

MS DAVIDSON: Are you able to confirm that that is true and correct?

DR SCOTT: I am.

MS DAVIDSON: Dr Scott, I will ask you a few questions to draw out some of the matters that you have discussed in your statement, but you are an Associate Professor and Research Chair at the Department of Applied Psychology and Human Development at the University of Toronto?

DR SCOTT: I am.

MS DAVIDSON: You have developed a program called "Caring Dads"?

DR SCOTT: Yes.

MS DAVIDSON: That program is run in a number of places throughout Canada. It's also in the United Kingdom and somewhere else. Where is - - -

DR SCOTT: It is run in a number of places in the United States, also in Germany and in Sweden.

MS DAVIDSON: Thank you. When did you develop the program?

DR SCOTT: We developed the program about 15 years ago now, so the first pilot program was run in 2002.

MS DAVIDSON: Can you outline to the Commission why it was that you developed the Caring Dads program?

DR SCOTT: I would be pleased to. I wonder if I could just also let the Commission know that their work might be short because I agree with all four of the recommendations that are potentially going to be put forward. My work on Caring Dads and also on a number of other programs that I have been involved with is really about engaging with

men who have been abusive in their families and with systems, be that the criminal justice system or the civil or family court system or the child protection system, in the shared goal of keeping women and children safe from repeat victimisation.

So if I just break that down a little bit, it means that I am committed to working collaboratively within systems that have the power to assess and address risk and harm, and I do that in an open and transparent manner both with the systems and with the men. I come in with the assumption that men want to be non-abusive fathers and in fact often are driven to be good dads, and that in the vast majority of cases they don't see themselves or wish to be that crazy guy who beats his wife. It is my job as a treatment provider to find ways to join with him so that we can share a goal of keeping his children and partners safe with him in the system.

You asked about Caring Dads and why we started to develop Caring Dads. Really, it has to deal with what I see as the central importance of men in this project to keep women and children safe. In previous testimony you have heard witnesses talk about the lack of attention to men as parents and as co-parents. You have heard people talk about the potential advantages to children and to marriages of focusing on fathering and co-parenting. You have even heard stuff around breaking the cycle of abuse and the recognition that fathers often stay in families but even if they don't they move on to other families.

I agree with all of these, but even more important to my work is the understanding that if we don't work with fathers we are not doing everything we can to

address risk.

In Canada I have been involved in an inquest and know of many more. The fairly consistent or one of the pictures that comes out of this is that there have been a number of domestic violence related deaths of both women and children where although everything possible was done to protect her - so, for example, she may have had a no contact order or been involved in a shelter - he ended up killing her.

When we look into what was happening with those cases what we see is a situation where when we have tried to put things together and protect her we have often inadvertently ended up increasing risk to him, because what we have done is we have pushed him out, isolated him and - in one case I think of the guy is out living in a trailer spinning.

So we know that separation is a risk factor. We know that legal involvement is a risk factor. We know that depression is a risk factor. We know substance abuse is a risk factor. When we looked into these cases, what was so apparent was that nobody was looking at monitoring or addressing that risk with him, but made us realise that if we want to be successful in our efforts to protect her then we needed to be doing things with him. So that's part of it.

MS DAVIDSON: You also talk in your witness statement about the way that Child Protection often has dealt with things where they aren't actually engaging with the perpetrator of violence. Can you expand on that?

DR SCOTT: Love to, because that's the second part of that first part, but I thought I'd better take a break. So

really related to this, when we get this guy and then he has kids we have to ask ourselves, "What's happening with them?" So often when we ask him, "Is anybody else involved," he will say, "My partner is involved with Child Protection," or, "My children are involved in Child Protection." But what we know is that he's not, even though his children are - child protection services have really struggled to think about engaging fathers. Instead, the focus is really on mother's capacity to protect, an assessment about whether or not she is being sufficiently protective.

This focus on mum's capacity to protect over fathers' need to change, it is unjust to women and it's inappropriate. So we have done a lot of work to argue that it is simply unfair of us to use our powerful social institutions, and Child Protection is a powerful social institution, to come down on her for failing to protect children from somebody she can't protect herself from. It is also bound to fail because, again, we are not addressing monitoring his risk.

Just as an aside, I wonder if I can say that once you start to see how failing to engage fathers ends up increasing risk to women and children you see it everywhere. Just very quickly, there's some excellent examples of evidence based programs to address child physical abuse, so again a child protection concern. These programs have been developed and evaluated almost exclusively with mothers and children, but when you really break down the statistics on child physical abuse what you find is that at least half of physical abuse that's substantiated by child protective services is

substantiated as fathers as perpetrators, and the more severe, injurious and potentially lethal that abuse is the more likely it is to be dads. So even here, when we are talking not about domestic violence but about child's physical abuse, why are we intervening with mums instead of with dads?

MS DAVIDSON: Is the Caring Dads program that you have outlined in your statement a program that requires a person to have first gone through an intimate partner violence program?

DR SCOTT: It does not require that a person first go through an intimate partner violence program.

MS DAVIDSON: In terms of the program that you run, can I just ask you to identify the methods that you use. I note that you have identified that it's important to go beyond psycho-education. But can you explain what sort of methods you use in the Caring Dads program in order to ultimately change behaviour?

DR SCOTT: Again, can I kind of speak a while on this one?

MS DAVIDSON: Yes, you can.

DR SCOTT: Thank you. The Caring Dads program, just to give people a very brief description, it's a 17-week program that's run with about 12 men at a time. Most of it is done in groups of men but there are also individual sessions built in. It's a treatment program, not a prevention program. So it's designed for fathers who have already behaved in ways that are harmful to their children and/or their partners.

The referrals come from criminal justice, from the family or civil court and from Child Protection, and in order to participate men must have some contact with their children. I'm happy to talk a little bit more about

that later if you want.

But I think when I'm talking about Caring Dads what I want to convey is that one of the things I actually like about current intervention research is that we finally are starting to get away from this black box of empirically supported copyrighted programs and into thinking about what are the ingredients, what are the successful components of change. So I will use Caring Dads as an example, but I want to talk about what I see as essential in Caring Dads as those ingredients that should be built into any program that's addressing this intersection of child maltreatment and domestic violence and fathering.

So the first of those components is this aspect of collaboration within a system where the goal of the program, where the eye is kept on reducing violence and ensuring safety. There are a lot of different components of that, and it is a hard line to keep because I think sometimes it's easy to start to get distracted by all the other things that might be going around in men's lives or in their family's lives. But I think our first and foremost goal when we are dealing with abuse is to end the abusive behaviour and so we need to be embedded in a system that does that.

One of the principles of the Caring Dads program is that children should have the potential to benefit from the program regardless of whether or not the men do. So ideally we want men to go through the program to make positive changes to reduce their risk for abuse. But if they don't, we need to be ready to do something about that. So that means the Caring Dads program is ready to

have some really difficult conversations with men to help them make choices to keep their children safe, be that be complying with no contact orders, reducing their level of contact. So, again that's not our ideal outcome, but we will work within the system to do what we need to to get everybody on board in terms of keeping children safe. Part of that is keeping children's mothers safe. So, that's one component, the system aspect.

The second component is that Caring Dads is a decent length. Although we can do some excellent prevention work in shorter periods of time, in treatment we have to promote change. To do that it needs - from my read of the literature - a minimum of 12 weeks and then when we deal with the population that is not motivated when they come in the door, we need to tack a few more weeks on so we can build that motivation. So I think we have to think about programs that are sufficiently long.

Then if we go into the components of the intervention itself, Caring Dads starts with an initial focus on motivation. Motivational interviewing is an empirically based strategy for getting men into group and keeping them in group. Some of the research that we have done on other programs has shown that, when we take our highly resistant men and we give them motivationally focused intervention, we can reduce drop-out by as much as 50 per cent.

Then after we get them in the program and after we have them staying and after we have convinced them that there's enough of a relationship between us that we can do some good work together, then we have to figure out what to do. The second part of Caring Dads combines a variety

of different educational, awareness, empathy building strategies to help men hold a mirror up to their own behaviours, understand what's going wrong, understand the impact that they are having on their children and really to have a vision and some hope for a different kind of relationship.

Consistent with the emphasis on the integral connection of women and safety and children's safety, as part of this we also talk about men as co-parents. The Caring Dads program is "You can't be a good dad and an abusive partner or ex-partner."

When we have done a good job, then the next component of successful intervention is to change. So if we have a man who comes in, for example, he might come in and we might get him to the point after the first few weeks of saying, "You know, I want to have a closer relationship with Sarah so she will come and visit with her siblings." So wants to have a closer relationship with one of the kids. By the time we get part way through the program, about half way, we need for him to identify the kind of abusive behaviour he needs to change in order to make that happen.

So during those sessions we are working with him so he can say, "You know, if Sarah is going to come to see me again, I'm going to have to stop bad-mouthing her mother." And then we need some time to get him to change that behaviour, to monitor it, to promote it, to practice it so that he's actually changing in a way that makes him safer around his children and family.

Then the final component of Caring Dads is really thinking about what are we then communicating to mums, how

are we making sure that she's safe, how are we making sure she has information about the program.

So, just to kind of summarise those seven components: thinking about the system part, making it a decent length, having a focus on motivation, helping men recognise their abusive behaviours and have hope for a different kind of relationship, what does healthy parenting look like, the emphasis on being a good dad means being a non-abusive partner, and then a really clear understanding that an effective program actually needs to specify, monitor and promote change in behaviour, and then some outreach to mums to really think about how we fit within the system from a violence against women perspective.

MS DAVIDSON: Thank you. You have identified in your statement that it's important that programs use trauma informed approaches. Can you identify what you mean by having a trauma informed approach?

DR SCOTT: We know less about trauma informed approaches with perpetrators than we do with victims. I would say that in the Caring Dads program one of the things we emphasise is being open and transparent with men about what we are working together on, and that is their children's safety and wellbeing. Some of the work on trauma informed care with offenders emphasises that part of that is recognising that with trauma there are difficulties with empathising with victims, that the kind of typical kind of minimising responsibility, putting aside presentation, needs to be or can be understood as in part having some level of a trauma base. So, efforts to kind of break that down by confronting it just don't make sense. What we need to do

instead is find ways to join with men on shared goals that move gradually towards the goal being about reducing the abusive behaviour.

MS DAVIDSON: You identified that a program needs to be sufficiently long and you said it needs to be at least 12 weeks. Your program is 17 weeks long; is that right?

DR SCOTT: It is.

MS DAVIDSON: And do you identify that that's a reasonable length of program?

DR SCOTT: Yes. I think that if you have a well-motivated group or a well-motivated population, which this population is not, that are seeking services voluntarily, you can do a lot in 12 weeks. The reason why 12 weeks is not long enough for a Caring Dads program is because we need to spend time engaging, building motivation, developing that trust and alliance before we can start doing the work. That's why we need the extra programs.

If you were going to ask me how long would I want a program like Caring Dads to be, I'm not sure that I would want it to be too much longer. It's not that by the end of Caring Dads everything is perfect and we're all ready to go, but at that point we have hopefully been able to reduce the core risk for abusive behaviour. Then the needs of the fathers and the children and the families in the program are divergent.

So there are some people - Carlos Stover, for example, in the US is playing around with sort of didactic father/child work. That makes sense for some of the men in Caring Dads, but not for all of them. For some of them there are other directions they could go and some of them could stop after this. So, again thinking from a

risk/needs/responsivity perspective, I think that a sort of 16, 17 week chunk is a good starting point.

MS DAVIDSON: You have also talked about drop-out rates. We have heard that there can be quite high rates of drop-out for some of the men's behaviour change programs that are run elsewhere. What sort of drop-out rates do you have for Caring Dads?

DR SCOTT: It depends on when you look at it. So, if you look at referral, to actually making it to one or two sessions, so that initial engagement piece, that's really hard work. Initially, when new organisations or new communities are running it, if you want to get a group of 12, I would suggest you start with 18, because it takes a while to get skilled at referring men into the program and getting them in.

Once men start to attend the program, they stay. So about 80 per cent of the men who have actually managed to hit two sessions of Caring Dads stay in Caring Dads until the end.

MS DAVIDSON: Are you able to attribute that to any particular aspect of the program compared with other sort of programs that are specifically focused on intimate partner violence?

DR SCOTT: I think it's because we have a very clear focus on the use of the empirically supported motivational interviewing strategies right at the beginning to get that to happen. As I said before, some of the research we have done on other programs, that even our really highly resistant guys are quite responsive to that kind of approach, so I really think it's about the way we engage with them to begin with.

The other part of it is that I find that fathering is a very strong motivator overall, so it tends to be easier for a system to engage men in the project of becoming better fathers than it might be to becoming better partners. So I think that works in our favour, as well as the way in which we engage with men at the beginning.

Just to talk a tiny bit more about that, we do do some work with them around what their history of fathering has been, who they want to be as a father, what are some of the deal breakers in the relationship between them and their own fathers, what are some of them that they want to avoid for their own children. So we really start by joining with men on this idea of who they want to become.

MS DAVIDSON: Your program has had some evaluations; is that correct?

DR SCOTT: It has, yes.

MS DAVIDSON: I think you have identified you haven't had any randomised controlled trials as much, is that right?

DR SCOTT: I have, yes. However, I have got great news. We have a pilot project going on and we just the other day got word that we have finally got the funding we need to run a very large high quality Caring Dads RCT which is making me extremely happy because it's been a long time since I have been trying to get this funding.

At this point what we can say is that there are components of the Caring Dads program - again if we think about this from a component perspective versus the black box perspective, we can provide empirical support for a variety of the components of Caring Dads, but we do not have an RCT study of Caring Dads at this point.

The biggest evaluation - we have done some here in Canada - but the biggest evaluation has actually been done by the NSPCC, National Society for the Prevention of Cruelty to Children, in the UK. They've done a fairly large evaluation of their implementation of Caring Dads that has included information from fathers, mothers and children and also has a small waitlist controlled group comparison.

The results of that program show positive results in terms of father self-reported hostility and overreactivity towards their children. Also mother reported experiences of domestic violence pre and post program, and also some effects in terms of mothers' mental health.

MS DAVIDSON: You also identified at the beginning the role of child protection in engaging men. Have you done any research on what the impact of running a Caring Dads program together with child protection workers' involvement, have you done any research on what - do you have anything to say about the outcomes for improving child protection engagement with fathers?

DR SCOTT: Yes. Thank you very much. When we first started to talk about the Caring Dads program, one of the things that ended up happening is that some of our child protection partners went back into their files and realised that although the family may have been referred a number of times over a number of years as a result of fathers' behaviour, that in the vast majority of cases there had been no contact done at all with dads as part of the child protection work.

The Caring Dads program, it gives a reason and a

requirement for the child protection worker to speak with the father and ideally we are running this program in close collaboration with Child Protective Services. When we do, we require that the child protection worker has some contact with dads. We check in with that child protection worker when we are making risk reduction goals to make sure that's consistent with the child protection evaluation.

So some of the research that we have been doing here in Toronto in a very large child protection agency has found that with Caring Dads participation comes a much higher rate and frequency of contact between workers and fathers as a result of this program.

MS DAVIDSON: Dr Scott, those are all of my questions, but the Commissioners may have some questions for you.

DEPUTY COMMISSIONER FAULKNER: Dr Scott, I wanted to ask what's known about the cost and who pays in relation to these courses, and I'm also interested in the extent to which child protection authorities in Canada can compel men to do these sorts of courses in respect to child protection applications.

DR SCOTT: Let me start with that, because I would say that when we initially start speaking with Child Protective Services in Canada and in communities the initial reaction tends to be, "But we can't get men to come." Our trading back has been, "Let us help you do that." So we have this sort of side bit around how do we help support child protection workers in engaging with fathers and engaging in making those calls.

At the beginning we often use a kind of coaching model to make that happen. In the first year of a Caring

Dads program in any child protection agency, referral is low, and by year 4 they have more referrals than they can manage. So I would say that, yes, we absolutely can use our social resources to compel men to go to the program. Men are not generally under a court order to attend, they are under voluntary service orders, but with the child protection worker who has become skilled at saying, "This is the behaviour that's of concern to me. This is what needs to change to reduce your risk and this is how I expect you to do it." So I would say that there's a growth process that happens there, but that, yes, Child Protection does successfully compel men into the program.

Then you asked about funding. So, the Caring Dads program is a very odd program in Canada because it's funded differently in practically every community it runs in, despite the fact that it is running in many communities. In many communities it is funded through some discretionary funding of the Child Protective Services. In a couple of communities it's become part of what our high risk child and family mental health services are doing. In some communities it's become part of the core service of our Men For Change programs so that they run both our sort of intimate partner violence programs and our Caring Dads programs.

When possible, we run the program in such a way that we have facilitators, co-leaders from both the Child Protective Services and from men's services or from the violence against women services so that we are actually sharing in knowledge and training through this cross-agency co-facilitation model.

DEPUTY COMMISSIONER FAULKNER: Is there any rough estimate of

what it costs per person? It doesn't have to be produced now.

DR SCOTT: Can I get back to you on that, because I think one of my main practice partners will do that.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: I just wanted to follow up your answer to the question on trauma informed approaches. I'm sorry, I should have introduced myself. Marcia Neave. I'm the Commissioner. Is there a tension between adopting trauma informed approaches and your goal to encourage men to recognise what they have done and not to minimise the effects of what they have done on their children?

DR SCOTT: You know what, I think that has been a struggle for the field in general. One of the things that I remember coming to recognise at some point is that we need to understand that the more traumatised he is, the more dangerous he is, because of all the impacts of trauma, all the impacts in terms of disregulation, in terms of his dissociation potentially, but we need to recognise that the more damaged men are more damaging.

So when we start to make that connection, then I think that we are able to engage in a way that is respectful, understanding of that past trauma, but yet continuing to put victims' safety at the centre. So again, if we think about the kinds of conversations that we have with men, we have - we call it safety planning with them. We do safety planning with men as well. So, "Recognising that this is what is going to trigger you, recognising that this is your trauma, how are you going to plan, because you don't want to hurt those people around you, so how are you going to keep yourself safe from doing

that?"

I would say that - and we do in Caring Dads. As I said, one of the things we do is we think about "What was your history with your own father?" And we have men talk about what that pattern was. I sometimes feel a little bit sneaky about it because that is such a helpful piece of information clinically, because once we know what he went through we have a hint of what he is doing to his own child. So we use that information to help develop empathy for his own child's experience because somebody in the room will have the same experience as this current child is. So if he is thinking about walking out on his child, someone else in the room will have been walked out on. So, we can build empathy that way. We can anticipate the kind of problems that he is going to run into and we can have a conversation with him about not wanting to behave in those kinds of traumatic ways.

I think where people might get caught is if we start to think about that trauma, do we then start to excuse the abusive behaviour. I just don't see why acknowledging trauma needs to then somehow translate to excusing behaviour. I think acknowledging trauma means that we have a more keen appreciation for the level of danger and the safety strategies that might be needed.

COMMISSIONER NEAVE: Thank you for that.

DR SCOTT: Does that make sense?

COMMISSIONER NEAVE: It was very helpful.

MS DAVIDSON: If there are no further questions, perhaps this witness could be excused.

COMMISSIONER NEAVE: Thank you very much indeed for coming. I'm not quite sure what time it is in Toronto at the

moment, but thank you very much, Dr Scott.

DR SCOTT: Thank you very much for this opportunity.

I appreciated the opportunity to testify.

<(THE WITNESS WITHDREW)

MS DAVIDSON: Can we have perhaps a very short adjournment for the next witness, just to enable the technological things to be organised, maybe just three minutes.

(Short adjournment.)

(CONFIDENTIAL SECTION FOLLOWS)

MS DAVIDSON: We have on the telephone line Dr Caroline Easton, and I ask that she be sworn.

<CAROLINE EASTON, (via telephone link) affirmed and examined:

MS DAVIDSON: Dr Easton, this is Joanna Davidson speaking. I'm one of the Counsel Assisting the Commission. I will first just get you to outline briefly your current position and background, and then I'm intending to ask you a few questions in relation to in particular the substance abuse domestic violence treatment program that you have developed in the United States. But first can I just get you to confirm that you are a Professor of Forensic Psychology in the College of Health Sciences and Technology at the Rochester Institute of Technology, as well as the Director of Clinical Care and Forensic Drug Diversion at Yale University School of Medicine?

DR EASTON: Yes, I am.

MS DAVIDSON: You are a licensed clinical psychologist and consultant to the criminal justice system, both statewide and in other states?

DR EASTON: Yes, I am.

MS DAVIDSON: You are also a consultant to other universities regarding the use of integrated services for defendants and individuals that have got co-occurring substance abuse and domestic violence issues; is that correct?

DR EASTON: Yes, I am.

MS DAVIDSON: And you also provide training on the use of evidence based therapies within the addiction and domestic violence fields?

DR EASTON: Yes.

MS DAVIDSON: We have heard briefly already from Associate Professor Miller a small amount about the substance abuse

domestic violence program that you have developed. Can I first get you to outline what sort of programs are generally available in the United States and why it was that you developed the SADV program that you have?

DR EASTON: Yes. Do you want me to talk to you about the evidence based approach or the various approaches that exist?

MS DAVIDSON: The evidence based approach that you have used and how that fits within the scheme of treatment programs that are available in the United States generally.

DR EASTON: Okay. Regarding the approaches that are grounded in science and theory, are basically developed from what's called cognitive behavioural therapy. We started these trials in 1997 because our treatment usual approach, which was derivative, that were basically psycho-educational, were not showing good treatment outcomes.

So we decided to take a subpopulation of offenders of intimate partner violence who were substance abusing or dependent on different substances and pulled them out and sort of give them more thorough psychiatric evaluation for other psychiatric disorders. If we found that they were dependent on alcohol and/or cocaine and marijuana we would give them a cognitive behavioural therapy approach that was very intensive and active and very prescriptive. Every week we knew exactly what we were going to cover in terms of skill set to help them reduce or abstain from their addiction and teach them skills to decrease aggressive behaviours and manage their anger every week while actively monitoring their breathalyser and their urine toxicology weekly, sometimes two times a week, across three months of treatment -

again, very active, very intensive, very prescriptive. We knew we had to go in and get them to be abstinent and teach them the skill sets.

We found in the randomised trials that were funded by the National Institute of Health here in the United States that we were able to get good treatment outcomes, we were able to see that we could significantly decrease their addiction and aggressive behaviours compared to an equally intensive evidence based addiction treatment. So we used an integrative approach that targeted both the addiction and the aggressive behaviours compared to a control condition that was excellent but that would just target only their substance use. The idea was we didn't want to just use the approach of any control condition because we didn't want to put the victims at risk. So we wanted to use something that was also grounded in science as a control condition but we wanted to make sure we didn't put the victims at risk. The integrative approach made sure that every session we targeted two maladapted behaviour, both the addiction and the aggressive behaviours, compared to just solely targeting addiction.

So in two different randomised control trials we found that we had excellent treatment outcomes, and other investigators were replicating these results as well from the veterans (indistinct) in the United States and finding good results. So we have been doing in the past - essentially the past - since 1997 to the present.

MS DAVIDSON: What is now happening in terms of that treatment approach? How widespread is that treatment approach being used in the United States?

DR EASTON: It is being used in New York State across different counties and the State of Connecticut and parts of Canada and parts of Florida, and other states are starting to sort of - and the Federal Government, actually, in the veterans (indistinct) are starting to write up policies and procedures and guidelines that state - if there's an addiction problem with veterans and there is intimate partner violence, they are basically stating that the approach needs to be grounded in science and at the very least should be grounded in cognitive behavioural therapy because offenders are known to have complex treatment issues and psychiatric problems, so that thorough evaluations and treatment matching should be done and they are prohibiting other treatment approaches.

So it's just now really starting to become more widespread, especially really with the veterans having problems with trauma and PTSD and addiction and IPD that especially the Federal Government here is really starting to crack down on what is being used to treat addiction and intimate partner violence.

MS DAVIDSON: How does the program that you have developed and those structured programs, how do they compare with the other sort of programs that are run in the United States such as those based on the Duluth model?

DR EASTON: We have been very prescriptive in how - the approach we believe it should be run, which is licensed credentialled clinicians, whether it is psychologists, psychiatrists, social workers, basically trained and supervised clinicians should be doing the evaluation. We limit the number of offenders in a group because the large groups of offenders are showing poor outcomes, and it sort

of makes sense to have large groups of men or offenders in one group, how are they possibly going to learn skill sets when a lot of different people are talking and - so limiting the number of offenders in a group, limiting who is providing the evaluation and treatment, making sure they are licensed and credentialled, making sure of what we call treatment fidelity, are they adhering to the treatment approach, are they competent in administering the content of the treatment. When a medication is being prescribed, do we know they are getting the dose, do we know that - the skill set being implemented in the right amount across the specific number of weeks, we know they are getting that skill set, not mixing a high-risk offender with a low-risk offender because we know from the research that if you mix a high-risk offender - someone who is like antisocial or sociopathic - with someone who is low risk the research suggests that you are going to have a contagion effect and that high-risk offender is actually going to have a negative effect on the lower risk offenders, so the treatment outcomes will be poor.

So we know that we need to do more thorough evaluations to screen out the high-risk offenders. If we can really classify and diagnose those low-risk offenders and treat those specific psychiatric problems or specific maladapted behaviours, if we specifically treat those we can get better treatment outcomes.

The high-risk offenders - the literature shows that judicial involvement, if you watch them more intensively over a period of time and you separate them from the low-risk offenders, you get better treatment

outcomes. So we are trying to just be better at screening and treatment matching and oversight.

MS DAVIDSON: When you talked about large groups and mixing high-risk and low-risk, has that happened in your groups or are you talking about Duluth model programs that are also run?

DR EASTON: Both. Right now there's an initiative being done in different states in the United States. In the groups that I run and the training that I have done we do not allow more than 10 offenders in a group. So the smaller the better. You are very specific in your diagnosis so that you can classify those offenders. So if they are substance dependent, what specific drugs are they dependent on; you target that. If they have other psychiatric diagnoses, you screen them out and you assign a psychiatrist. Maybe they are bipolar disorder, depressed, they may need specific medication in conjunction with cognitive behavioural therapy. You just have to be very good at diagnosing and linking them up with the appropriate evidence based cognitive behavioural therapy approach.

With the Duluth models, they tend to be larger here in the United States. I'm not sure about other international approaches, but I know that here in the United States they tend to be large and the treatment outcomes are very poor. So there's new guidelines and procedures being set that state that they really should be smaller groups, that the more offenders in a group you have got poorer treatment outcomes.

There tend to be high- and low-risk offenders all mixed together. You could have different psychiatric

disorders together and the outcomes are very poor. So the better at diagnosing and linking up with an evidence based psychotherapy approach - and here we have learned that cognitive behavioural therapy is an evidence based approach that has been used to - large randomised control trials that are excellent, you know, methodologies have shown across different drugs of abuse excellent outcomes, other psychiatric disorders, depression, generalised anxiety, post-traumatic stress disorder, phobias, eating disorders, psychosis - all this psychotherapy approach in large randomised trials. So we know that if you use this approach and you train the clinician really well to use it and target those behaviours you will get good treatment outcomes.

MS DAVIDSON: In terms of assessment how do you, practically speaking, deal with assessment of perpetrators and identify what kind of program is appropriate for them?

DR EASTON: Again, it comes to using excellent diagnostic assessments and making sure that people who are doing the diagnosis are skilled, trained and supervised. So it starts from diagnosis and assessment, and then once you diagnose and assess you can link them to the evidence based treatment.

MS DAVIDSON: Apart from the substance abuse domestic violence program that you have developed, what other models have been developed in the United States for co-occurring substance abuse and domestic violence?

DR EASTON: So the other approaches that exist, there are a few that have been actually shown to be - again, they are grounded in science and they have been shown to have excellent treatment outcomes. But again it's been very

specific about diagnosis and treatment matching. There's an approach called behavioural couples therapy, BCT, by Timothy O'Farrell at Harvard. He has worked more specifically with veterans, who are couples, who are substance dependent and there's intimate partner violence but they rule out other psychiatric conditions. So they rule out someone who may be psychotic or manic. They sort of rule these sort of - exclude them. They refer them to a different treatment modality, and they sort of work with a small group of offenders who are in an intact relationship, very specific skills, how to decrease substance abuse or abstain from their substance of choice, how to resolve conflicts in healthier ways, how to do safety planning.

His group, excellent trials, very good research methodology funded by the National Institute of Health here. He has had excellent outcomes. But again this is with a group of couples who are intact, there's low risk of serious violence, because this kind of approach can be clinically contraindicated. If there are protective orders or more severe violence is there you want to not use this therapy. But for lower risk clients who are in an intact relationship it's been shown to be effective.

Then there's some approaches from - that the veterans (indistinct) uses here across the United States that use a cognitive therapy approach with small groups of offenders, and that is like three to five offenders in a group. Again, they target trauma and addiction and anger management, again using a cognitive therapy approach and they are getting excellent treatment outcomes.

So those are like basically CBT approaches,

cognitive behavioural therapy, targeting very specific behaviours, teaching healthy coping skills, decreasing substance abuse, leading to good outcomes. But, again, it's very prescriptive, are the clinicians trained, skilled, supervised, are they adhering to the treatment modality, are we making sure these offenders have appropriate psychiatric treatment and oversight; and when you do that in an intensive way you get really good outcomes.

If you treat them in large groups it may look more cost effective but the relapse, the recidivism is high, outcomes are really poor, re-arrests, re-victimisation is high. So it may look more cost effective because you are treating them in large groups, but it's a more generic therapy and bad outcomes. So, the better diagnosis upfront and prescriptive evidence based therapies, you get better outcomes.

MS DAVIDSON: In terms of the size of the groups what is, do you think, the maximum sort of size for these sorts of programs?

DR EASTON: The consensus now, you read about in the literature, is no more than 10. Under 10. Here in the United States the treatment, more than 10 and you don't get good treatment outcomes with that because it starts to get more general and generic and too much going on in the group and not client centred. So under 10. The Federal Government recently has been stating that keeping around five is probably a good number. Not a lot of facilities can do that because of the amount of money, clinicians and reimbursement to treat the client. But we know for sure that under 10.

MS DAVIDSON: You have identified them as quite intensive programs. How long are the programs and how many hours are we talking about and how frequent are these sessions?

DR EASTON: So with the cognitive behavioural therapy most of the literature has shown that it's 12 weeks, three months of treatment. Any more than that you don't really - it's like the same. At least 12 weeks of treatment is sort of standard. So that's three months. A lot of people think it should be 26, 56. The literature doesn't really show that. It shows that if you adhere and you are very specific in the behaviour you treat with licensed credentialled people you really can start to see changes within three months. So if it's a group, a small group, you are talking about 90 minutes, one to two times a week across 12 weeks. Again, it's very specific. You are targeting very specific behaviours.

MS DAVIDSON: Dr Easton, those are my questions but the Commissioners may have some questions for you.

DR EASTON: Sure.

COMMISSIONER NEAVE: It's Marcia Neave, Dr Easton. The question I have is: are the programs directed to people who are actually incarcerated - the program that you run, is that people who are incarcerated or have been released on some sorts of conditions? You used the word "offenders" and I just wasn't quite sure what group you were talking about.

DR EASTON: Right. The group I'm talking about tend to be offenders who are arrested. They are not incarcerated. So they are basically - they could be on probation, meaning if they don't do this they are going to go to gaol, or they could be - it's a misdemeanour here in the

United States, like a low-level charge, but the court is saying, "Obviously they need treatment, so we are going to basically tell them if they do this treatment it will decrease their fine, they won't have to do as much gaol time." It's a misdemeanour. It's not as serious.

So I'm talking more about non-felony offences. Like the really violent offenders, I'm not talking about that type of offender. Violent in terms of those who threaten to kill or strangulate, I'm not talking about that type of offender. I'm talking about those that are isolated incidents, there tends to be some remorse, there's a specific psychiatric disorder that can be targeted. Those who are more sociopathic, lack remorse, it's severe violence, I'm not talking about that type of offender.

COMMISSIONER NEAVE: So these are in effect mandated programs, and that's how you can require urine analysis and all those other things that you have spoken about because they are part of the mandated participation in the program?

DR EASTON: Right. They are not necessarily - most of them are mandated, meaning there's a legal referral, the criminal justice system is involved. Depending on the teeth in terms of whether they could do time or not, that could be very - not a lot of teeth, meaning the offender is told, "Okay, we think you should do this. It could really benefit you," versus those who are told, "If you don't do this you are going to go to gaol." We do have different severities in terms of legal motivators. But we sort of view it as a legal motivator is a motivator. There's medical motivators, there's social motivators, there's income motivators. It is still a motivator, and we find

from the research that a legal motivator is a good motivator.

Just we make sure we separate out the high-risk sociopathic offender. We don't want to confuse them with a low-risk offender who is remorseful, they are more isolated incidents, there is some motivation in wanting to do better, they want to get treatment. That's who I'm talking about.

COMMISSIONER NEAVE: Thank you very much.

MS DAVIDSON: Are there any further questions? Thank you, Dr Easton. We much appreciate your time with the Commission today and especially given that I know that it is very late in the evening for you, I think.

DR EASTON: Okay. Thank you very much.

COMMISSIONER NEAVE: Thank you.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: Commissioners, the next session is a panel of four witnesses. If I could ask for them to come forward, please.

<JAMES OGLOFF, recalled:

<ANDREW JOHN DALLIN DAY, affirmed and examined:

<JACQUI WATT, affirmed and examined:

<RODNEY STEPHEN VLAIS, affirmed and examined:

MR MOSHINSKY: Could I start with you, Professor Day. Could you please tell the Commission what your current position is and just give a very brief outline of your professional background?

PROFESSOR DAY: Sure. I'm a Professor of Psychology at Deakin University, based at Geelong, and I'm a registered psychologist, clinical and forensic psychologist, who has worked in correctional services and mental health services

before joining the university system.

MR MOSHINSKY: Have you prepared a witness statement for the Royal Commission?

PROFESSOR DAY: I have.

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

PROFESSOR DAY: Yes.

MR MOSHINSKY: Ms Watt, could you please tell the Commission what your current position is and just give a very brief outline of your professional background?

MS WATT: I'm the CEO of No To Violence and the Men's Referral Service in Victoria. I have worked in human services public policy and service systems for over 30 years.

MR MOSHINSKY: Have you prepared a joint statement with Mr Vlais for the Royal Commission?

MS WATT: I have.

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

MS WATT: They are.

MR MOSHINSKY: Mr Vlais, could you please tell the Commission what your current position is and also give an outline of your background, professional background?

MR VLAIS: I'm Manager in No To Violence. My background is a registered psychologist with a specialisation in clinical psychology. I'm also a men's behaviour change program practitioner.

MR MOSHINSKY: Have you prepared a joint statement with Ms Watt for the Commission?

MR VLAIS: Yes, we did.

MR MOSHINSKY: Are the contents true and correct?

MR VLAIS: Yes, they are.

MR MOSHINSKY: Professor Ogloff, I note that you have prepared a statement which was referred to yesterday. Therefore, I won't take up the time now to go over your background, which is set out in that statement.

PROFESSOR OGLOFF: Thank you.

MR MOSHINSKY: Panel, I'm going to direct questions to various members of the panel. If at any point in time you wish to comment on a contribution from another member of the panel, please feel free to do so.

Could I start by asking you, Mr Vlais, if you could tell us a little about men's behaviour change programs as they exist at present in Victoria, an outline of what's typically involved and how many of them are there, these sorts of basic facts?

MR VLAIS: Sure. There are approximately 35 men's behaviour change programs currently operating in Victoria run by about 27, 28 providers. They aren't standalone interventions. They all operate as part of integrated responses, coordinated community responses, managed by agencies as part of partnerships with Child Protection, police, courts, Corrections, other non-government organisations, specialist women's and children's family violence services. As such, they try to contribute towards an integrated approach and a coordinated community response.

Changing men's behaviour is a critical part of what they do, but assisting these other agencies and practitioners from these other agencies to strengthen their ability to manage risk, to create a web of accountability around perpetrators who commit family and domestic violence, and to work towards the safety of women

and children is just as critical as changing men's own behaviour, and, as such, they take risk assessment seriously, risk management, partner contact components are very, very important, and try to assist Child Protection, Corrections, police, et cetera to do their very difficult but important job in holding perpetrators accountable.

So men are referred to these programs through a variety of different pathways, and most programs contain a mix of referrals. Some men are referred through mandated means, whether that be through family violence court intervention program through courts, whether that be through Child Protection where he still definitely has a choice whether to attend or not but there are consequences if he doesn't, and then others self-refer, though their motivation is still quite low even when they self-refer. It's usually a crisis, such as their partner really strongly saying, "Unless you attend a program, I'm going to leave." So they generally don't want to be there.

The men are often at moderate to high risk. While a high proportion of the men don't have significant other criminal or offending behaviour, if we look at family violence risk indicators, unfortunately a number of the men have taken severe steps to limit the freedom of their partner's lives - threats to kill, attempt at strangulation, et cetera. Obviously not with all but with many. Most of the men have engaged in an entrenched pattern of domestic violence using a range of financial, economic, emotional, psychological, sexual and physical abuse tactics over a sustained period of time against their partners.

Just really briefly in terms of what the programs

look like, they start off with a comprehensive assessment process whereby one of the main aims of that assessment process is to address what are the issues that's related to that man's use of violence, what's his level of motivation, what's his risk, are there other issues like alcohol and other drug use, mental health issues, acquired brain injury, et cetera, that need to be part of the intervention approach.

They look at information from other sources, where available, and unfortunately because there are aspects of an integrated service system that aren't working as well as they could program providers often don't have the information from other sources - police, Child Protection, et cetera - that could help them, and try to start partner contact as soon as possible.

Based on that assessment process, most men - not all but most men - are suitable or eligible to then do the group work component of the program. The reality on the ground is that these groups are often of a length of between 12 and 24 sessions. Many program providers would like to work with men for longer periods but don't yet have the resources to do so, and would also like to take more of an individualised approach to supplement the group work. As well as the men going through the psycho-educational components of the group, programs providers want to address alcohol and other drugs, work with other agencies towards mental health issues, develop individualised plans to coincide with the group process. But, unfortunately, the resources aren't there to have that individualised tailored approach which many of our member agencies would like to have.

Parallel to that there's partner contact, and there's also a desire amongst many of our member providers too to work with men as fathers and to strengthen the assessment of how children are affected by the man's use of violence. Again, that is an issue which program providers can't turn into practice.

Just finally, the programs adhere to No To Violence minimum standards, which were published 10 years ago and which provide an operational guide towards minimums for effective or potentially effective program delivery. A lot has happened in these last 10 years, and we are all too aware that there are many aspects of our minimum standards which now set the bar too low in terms of program provision, and that could be placing some constraints on potential program effectiveness.

DEPUTY COMMISSIONER FAULKNER: Mr Moshinsky, just a question for clarification. You said you start with a comprehensive assessment process, which I'm going to ask two questions. Is that intended to screen in and out, or is it intended to work out how the course operates for that person? Secondly, I understand that's the second screening for court-ordered processes. I observed a screening process at the court, which took about a minute, which seemed to be attempting to screen out certain sorts of people that are not suitable. Is that part - am I describing the system, how it works, and is there ever a circumstance with a court-ordered person who has been screened in that then you screen out?

MR VLAIS: There can occasionally be someone who is screened in through that family violence court intervention program screening who then doesn't become screened in at the

second comprehensive assessment, but the majority are. The comprehensive assessment, which is at least one face-to-face session with a man - it's sometimes two, sometimes three, and if it is one face-to-face session it's usually at least a duration of 75 to 90 minutes.

It certainly is partly around screening. There are some men whose level of alcohol or other substance abuse is so severe that they are not going to be able to participate in the program unless that is brought under control, or they might have a florid psychosis, which again needs to be worked at.

Men who do have alcohol and other drug issues or mental health issues or problem gambling or homelessness, they are not automatically screened out because often these issues can be worked with in parallel. However, the screening process is to make sure that he can participate and is able to participate. Some men who have very high levels of psychopathy, no capacity for empathy, they might be screened out because that might require more of a psychiatry or forensic psychiatry approach.

Also, the comprehensive assessment process, it looks at risk. The most valuable sources of risk are from his partner, are from information we might know from police or Child Protection, because what he says often can't be taken as a reliable source of risk. He's usually underreporting the real risk he poses to his family members.

There is a risk assessment. We ask questions that start to build an internal motivation to change, and for some men that journey for them to want to be in the program takes weeks or months. So we might start to ask

him questions along those lines.

DEPUTY COMMISSIONER FAULKNER: I suppose the precise end point of that is: are many screened out at that point? You said "the majority". The majority can be 51 per cent. Are we talking about - how many do we lose at that point?

MR VLAIS: Probably no more than about 10 or 15 per cent.

MR MOSHINSKY: Can I just follow up a few other questions by way of clarification. You referred to the reality on the ground being usually 12 to 24 sessions in most of the programs. How long are those sessions - you may have indicated that - and over what period of time are we talking?

MR VLAIS: For most of our member provider programs they are within the 12 to 18 session mark. A few are longer than 18. They are generally weekly sessions of two-hour duration. So a program that has 12 sessions would run over three months, generally. A few programs are able to have a stage 2 and work with some men for a bit longer than that.

MR MOSHINSKY: You referred to group work mainly after that initial comprehensive assessment process - the rest is group work. How large are the groups typically?

MR VLAIS: The average size of a group would be probably around 12 participants. Groups can on occasion become as large as 16 or 17. However, once we get to that size, then often program providers start to place a ceiling. Most program providers would not want more than about 13 or 14 in the group. Some might be working with eight or 10.

One of the other issues too is that the group numbers aren't necessarily the same each week. So programs are trying to be as flexible and responsive as

possible, which means multiple entry points so men can come into the group at different times. So it can vary a bit across the course of a program.

MR MOSHINSKY: How many people, approximately, are participating in men's behavioural change programs in Victoria on an annual basis?

MR VLAIS: If we look at community based programs funded by the Department of Health and Human Services, by the Department of Justice and also historically by Corrections Victoria, up to the beginning of this financial year we are generally looking at about 2,000 funded places.

MR MOSHINSKY: So it's 2,000 across all three sources of funding: DHHS, DOJR and Corrections?

MR VLAIS: Yes. Mostly has been the Department of Health and Human Services. That's 1,440 places, I believe, from Health and Human Services out of that approximate 2,000. That is going to be increased this year. The government, through Corrections Victoria and also the Department of Health and Human Services, have put some - one-year or two-year funding to increase that approximately to 3,000.

What we know, however, is that most programs work with more men than that. So for just one example, in August/September 2013, of the 19 men's behaviour change programs based in the Melbourne metropolitan area, nine of them had to close their books because they were already working far too far above targets, and some of them didn't open until February of the next year. So we certainly work with more men than that.

MR MOSHINSKY: Sorry, when you say "more men", are you indicating that the numbers you have given are the numbers of funded places but some of the organisations take on

more than their funding allows?

MR VLAIS: Most organisations do. I think in one of the other witness statements, for example, of Kildonan Uniting Care, which provides a men's behaviour change program in north metropolitan, I think they have referred to their number of funded places as approximately 220 but over the last financial year worked with 340. That is quite typical.

MR MOSHINSKY: Really, the next question is: what are the waiting lists like in practice to get into a men's behavioural change program, and is there a difference between mandated and voluntary participation?

MR VLAIS: The latest stats we have are of March this year, and the environment is going to change a bit with this renewed temporary government funding. But at that stage there was a thousand men in Victoria, approximately, who were waiting. Seven hundred of those were waiting for the first assessment phase. In one program in south-east metropolitan there were over 200 men who were waiting just to be assessed, and that program had to close its books because that waiting time was too strong.

About 300 of that 1,000 had been assessed as suitable and eligible but were waiting from a period of a few weeks to unfortunately up to several months to be able to start the program proper. So waiting lists are a significant issue. We are finding that because so many other agencies - police, Child Protection, Corrections, Family Services, alcohol and other drug providers - are improving their response to family and domestic violence. They are detecting it more, they are getting better at risk assessment, so they are referring more men.

MR MOSHINSKY: You referred to two periods of waiting. One is

waiting for that initial assessment, and the second, waiting then to get into a program. What is the waiting time approximately for the initial assessment?

MR VLAIS: That varies. Our minimum standards really emphasise it's so important to start that assessment off early because, if not, the man's motivation - which is already fickle - decreases. That changes. It varies through the year. When we get to the spring time, some men actually have to shop around themselves to actually find a program, and it's one of the reasons why in our submission we have put forward the concept of a centralised intake, because we have hundreds of men a year, more than hundreds, who call our Men's Referral Service. We need to give them four or five referrals because we know the waiting time might be six or eight weeks to get into an assessment for one program. They are not going to wait that time. So they might then ring another program and another program after that. That's how men drop out. If we give men an excuse to drop out, many will.

MR MOSHINSKY: Can you just comment briefly - I realise this is somewhat complex, but the psycho-educational model of men's behavioural change programs, what does that refer to, if it is possible to explain that in lay terms?

MR VLAIS: Yes, absolutely. The work is complex, so I really appreciate trying to explain it in lay terms, which is difficult. It's so highly specialised. Basically, the work with the men in the group programs combines a range of areas, a range of issues, which men need to be taken through to develop new understandings, new beliefs, new skills and new behaviours. So what we mean by psycho-education is that there's a series of topics, but

these aren't just educational topics. These are areas in which the men need to make some major, major changes to their attitudes and beliefs.

They need to, for example, understand the range of different types of violence they are using, not just only physical violence but how they are controlling their partners and their children in other ways. They need to be able to understand what are their values, what's important for them in their life, what is being a father mean for them, what does family life mean for them, so that we can develop this real tension between who they want to be as men, how they want their families to be and their actual behaviour, which gets in the way of often what the men really want. So we need to spend time so that men can articulate what's important for them.

We need to help men to understand that children are often so deeply affected by the men's violence, and for some men unlocking a motivation to change comes through that.

Men need to understand what their partners are experiencing and going through. They need to understand that if they become a bit safer and change some of their behaviour and their partners start to become more assertive in their own communication - it's not because she needs a women's behaviour change program. It's because she's feeling a bit safer to talk about so many things that he stopped her talking because he's made her too afraid to address issues in the relationship.

So we have group based activities. I have just given four or five examples of many things we need to cover in a short space. The men reflect upon their

experiences. We have structured activities. Throughout all of this we are watching each man. We are hearing how he is going at home through partner contact, if she wants to have contact, and we are on the look-out for how is his mental health, are there alcohol and other drug issues that are affecting his ability to work hard in the program.

So the psycho-educational approach is a combination of looking at his beliefs and attitudes which is related to his use of violence and his offending; a series of topics that helps him to realise that his violence is about power and control and that he is sabotaging what he wants for his life by trying to dominate; helping him to realise where he gets that from in our society. All of the influences as men try to encourage us to be competitive, to be right, to not value women, to see that our role is to protect, and then to develop the skills to change these behaviours, all at the same time addressing a whole lot of other things that can be related to his offending.

This is why this is long, complex work and why we believe that accreditation, proper training and longer programs are required. There's a lot going on here that we need to address.

MR MOSHINSKY: Just in terms of what's happening and what's available at the moment, the men's behavioural change programs that we have been discussing, as I understand it, are concerned with men who have used intimate partner violence against women. Is it the case that there aren't other types of behaviour change programs, for example a young adult male who uses violence against a parent?

MR VLAIS: The whole area of adolescent violence in the home has fortunately now had some policy and program work over the last five years due to the efforts of Jo Howard and others. Up to then there has been a real gap. So there's some really promising initiatives in adolescent violence in the home. However, there are so few of them. For young men, 18 to 25, or adolescent boys or adolescent girls who are using violence, there's small pockets in Victoria where they will receive a strong integrated approach and a proper adolescent violence in the home intervention, but many areas where they don't.

So, yes, there is a need for some specialist interventions with young adults, with men of all ages with acquired brain injury, with men from particular new and emerging communities, and also to support Aboriginal community controlled organisations to work with men who use violence as well too. There definitely are opportunities to be able to strengthen that work. Those programs aren't alternative to men's behaviour change programs, but they are specific adaptions and those adaptions need careful evaluation, pilots, and in learning from those evaluations and to spread them out more thoroughly across the state.

MR MOSHINSKY: I want to move now to the topic of evaluations of men's behaviour change programs and the evidence base that exists and ask a number of members of the panel to comment on that. Perhaps can I start with a further question to you, Mr Vlais. There was a relatively recent report called the Project Mirabal report from the United Kingdom, January 2015. Would you be able to just briefly describe what that report did and the outcomes of that

report?

MR VLAIS: Sure, and I will be really brief here because I'm aware that I'm doing all the talking here and I obviously want my colleagues to share an equal amount of the space.

This evaluation was of accredited domestic violence perpetrator programs in the United Kingdom, so it only evaluated accredited programs that went through a thorough accreditation system. The evaluation is unique because its starting point was the question: What do domestic violence perpetrator programs potentially - what can they potentially do to contribute towards coordinated community responses? Can they add anything more to what's already been done by women's services, police, child protection and corrections to work towards perpetrator accountability?

The second unique bit is in terms of developing outcomes they actually did research with women themselves, and to a smaller extent children, women whose partners were going through the program, to find out "What matters to you?" So they developed a set of six measures based on women's reports of what they wanted changed, and that included things obviously like preventing or stopping the man's use of physical and sexual violence, but also included just space for action. Women were saying "I want my life back. I don't want to be controlled and be in terror all the time just to be able to spend this bit of money." They wanted the men to be more involved fathers and to have stronger family relationships, et cetera.

So, based on these matters the research then followed a group of men who were going through men's behaviour change programs and did a pre-test/post-test

evaluation about to what extent did the men change based on these evaluation measures. Finally, the evaluation also looked at what are the other sometimes intangible ways that the programs contributed. Did they help child protection practitioners to not use a failure to protect paradigm and to actually work with men rather than only working with mothers, and rather than blaming mothers, actually trying to look at the source of the child protection concerns, et cetera. So it was quite unique in this way.

MR MOSHINSKY: And the outcomes from that?

MR VLAIS: They are promising outcomes. Methodologically it is not a controlled randomised trial. So they are promising outcomes and certainly at No To Violence we believe that it is very important for governments to invest significantly more research and evaluation.

The results showed that over a 12 to 15 month period there were very, very strong reductions in physical and sexual violence; this is from the women's reports; that women reported much more space for action in their lives. They reported some changes in the man's parenting and more child-centred approaches to children; however, not as much as required. They saw major changes in men's empathy and understanding of the women's points of view.

I think just finally these women-centred evaluation measures are critical, because sometimes what we find with evaluations is that a strong domestic violence perpetrator program that's part of an integrated approach can increase police call-outs, can increase Magistrates' Court business around family violence because the service becomes better at detecting family violence,

becomes better in its accountability systems, women feel safer to report breaches, and that means paradoxically a strong program can actually create more criminal and civil justice activity and more work for child protection practitioners because we are becoming better at having that web of accountability.

So this evaluation is really important at trying to find what are the measures that count for the victims themselves.

MR MOSHINSKY: Just before I move on to other members of the panel, in terms of the overall evidence base in terms of outcomes from the men's behaviour change program approach, do you have a general comment on what the evidence looks like?

MR VLAIS: Evaluation work of this kind is extraordinarily hard. It's hard because strong, potentially effective programs work as part of a coordinated community response. So, if there are changes in the men's behaviour, is that totally due to the program? Is that partly due to the five or six different messages a man gets from a range of different organisations trying to hold him accountable? Is it because of the partner contact component of the program where she, the woman, the victim survivor, feels stronger to draw a line in the sand and feels safer to actually leave him because she knows that he's going to be involved in the program and we can help to manage that risk?

So, evaluation is very complex. It's very, very expensive. We need to triangulate data from police, Corrections, from women's own reports. As a result of that, there have been very few high quality evaluations

being done. So we recognise that the evidence is mixed. It is a very young evaluation field and in rolling out programs in Victoria, more programs, longer programs, programs in specialist areas, accompanying them with evaluation is extremely important and there's a role for State Governments, for Commonwealth Governments, for ANROWS, et cetera, to work together with us on that.

MR MOSHINSKY: Thank you. I will give you a bit of a break, Mr Vlais.

Could I ask you, Professor Ogloff, to comment next because in the Forensicare submission there are comments made about the evidence base and Project Mirabal in particular?

PROFESSOR OGLOFF: Yes. I think I have to start out by saying that the starting point should be what are men's behavioural change programs and what aren't they? I think, as we heard from Mr Vlais, and it is consistent with descriptions, they really are brief by any stretch. If you think about trying to change, as he described, entrenched views and values which have accumulated oftentimes over a lifetime, even 24 sessions at two hours each is simply inadequate.

The second thing is, as he mentioned, while they would like to address a range of co-occurring issues in greater detail such as substance misuse, mental illness, personality problems, broader issues pertaining to violence and aggression, they simply can't at the present time.

Also, the facilitators themselves in a recent report, 2011 report from No To Violence, they indicate on average I believe salaries were around $28 per hour. So

the facilitators themselves, while they obtain qualification in men's understanding violence, they don't have a broader background as a group, as we heard from the previous witness from overseas, who were, for example, licensed and qualified mental health professionals. So when they try to look out for things like mental health or other issues, oftentimes facilitators themselves may not be properly qualified to do that.

So the approach again - and it's also a one-size-fits-all approach typically, so there's very little opportunity for individual sessions, and again in the report certainly there are some, but they are very, very limited and again the facilitators may not be qualified or have the time to deal with these issues.

The final issue, of course, is that within these programs they just don't have the opportunity to interact to the extent they need to with the broader service community. I think that's something that is being developed, but that continues to be a significant problem.

So I think if you strip away what the programs are, they certainly have a role. From the perspective that I have, they would be suitable for a group of people who would have less of the problematic complex behaviours that we know contribute to family violence and they would be suitable for the people who are motivated and have, for want of a better term, a general pro-social demeanour, so people who are amenable to change in a short time.

Having said that, I think what's missing and I think is woeful and shameful in the state, is having any semblance of programs on a broad base for these complex issues. So I think that's why the outcome results are

mixed, in terms of Mr Vlais's word and in the literature, because you really are trying to put a large, large number of men through these programs, more than 2,000 a year, of all different backgrounds, types and complexity and of course the results will be mixed.

For some people, as we heard from a witness this morning, it will be very, very positive. For other people there will be no change and in a small group of people I think there will even be a sense of, "I can't change through this. Perhaps I will give up."

So I have grave concerns about - not specifically the programs themselves, but how we have tried to use these what started out as relatively straightforward programs to fix what is a very complex issue.

MR MOSHINSKY: Are you able to offer any comments about the Mirabal report, the methodology or the outcomes from that?

PROFESSOR OGLOFF: Yes. As Mr Vlais says, first of all it is one report. It is not peer reviewed. It's really unpublished other than an internal report. It doesn't have - in any kind of area of research and science, to make sure that something is actually working there does need to be control. So many, many elements were not controlled for, so it is essentially impossible to determine from the report what components of programs or indeed the broader service system contributed to change. Although there are, as Mr Vlais said, indications of success, those indications of success are still relatively limited and certainly not measured over the long-term.

MR MOSHINSKY: Speaking more broadly than Mirabal, in terms of the overall evidence base for the men's behaviour change approach, what is the evidence base like?

PROFESSOR OGLOFF: Again, I think "mixed" is a good term. It is a hotly contested, highly controversial field. There are some studies which show success, some studies that don't show success, and people have been critical again, not so much about the focus of the program, but about the fact that you are asking to do too much with too little.

Again, I think if we just step back logically and think, as I mentioned, that we are looking at people whose behaviour is entrenched sometimes over a lifetime. Of course, we are going to try to remediate that by having them come in once a week for two hours in a group of other people over a short period, we heard most of them were 12 to 18 sessions, and you are going to expect that's going to produce long-term lasting change. I think it's inherently unsensible.

MR MOSHINSKY: Professor Day, do you wish to comment on that?

PROFESSOR DAY: Yes. Let me say that men's behaviour change programs can have a significant profound impact on the lives of some participants. I don't believe that there's enough evidence to conclude that they are effective in changing the behaviour of most of the people who go through the programs. That's largely I think due to the diversity of the characteristics of people that are referred to programs and the mixing of high and low risk people with different levels and needs within the programs.

So, I think program effectiveness is undermined considerably by an approach - one-size-fits-all is how it has been described - which isn't sufficiently tailored to meet the needs of the individual participants. So what we find is that people do quite extensive assessments, but

the content of those assessments or the conclusions of those assessments aren't used to guide the actual content of the intervention.

In terms of what we mean by evidence and evidence based practice, which I think is a field that should be moving towards meeting the standards of evidence based practice that are common across both health care and in crime protection, the randomised design is really important to establish causality. The actual intervention is causal in terms of reductions or changes in behaviour. There have been very few experimental studies of the outcomes of different programs. Most of those have concluded that the programs have little or no effect on behaviour.

Whilst I agree with the point that men's behaviour change programs can have multiple goals and aims and can have impacts on other areas of service provision, I think there's a basic assumption in my mind that they should be able to demonstrate that they can change behaviour and for me that means reductions in violent behaviour towards intimate partners.

If I could just add one more thing about when we are talking about intimate partner violence programs. We know very little about interventions for perpetrators of other types of family violence. We are doing some work at the moment on elder abuse and reviewing the knowledge base or the evidence about interventions for perpetrators of elder abuse and we have found almost no literature to guide practice in that area.

MR MOSHINSKY: Mr Vlais, would you like to respond to any of the comments that we have just heard?

MR VLAIS: There's a difference between a lack of evidence and negative evidence. I think one of the key things that we have to do over the next five or seven years, or could do over the next five or seven years, is work out what are the localised evaluation methodologies that we really need to be able to see how much is worth investing in this work, because to some extent interventions with perpetrators are going to happen. They happen across the system. They happen through child protection practitioners who aren't wanting to just focus on work with a mum who's experiencing family violence and see the case as the children are at risk because of the mum being neglectful.

Many child protection practitioners are understanding, "Well, her behaviour is a result of or because of his use of violence" and that the mums are trying to do the best they can to actually protect their children, and that for those mums in child protection contexts who are as protective as they can be, that doesn't mean that he won't kill her child or won't kill their child.

So, we are going to see increasing pressure to work with men, to engage with men, to have accountability around men. There is a role for specialist expertise in assisting a range of different interventions to engage women, in all sorts of different places. Part of that is working with men to change their behaviour. I definitely agree at the end of the day we want programs that are going to change men's behaviour. But even if there is a decision not to fund in this work at all, we will be finding so much demand for perpetrator interventions, for

perpetrator accountability and a real need for specialised practice in that area.

So for me the question is what sort of evaluations do we need that look at not only the potential of programs to change men's behaviour, which men are they best designed for at which points, but also how do they contribute towards what police, Corrections and Child Protection do? For us, that's at least 50 per cent of what we are here talking about today.

It's a bit like the expectation that we would have an increasing range of people in the community working with women who experience family violence, and we need that, we need more general practitioners, we need more financial counsellors, child and mental health nurses. There is such a wide range of family community services that need to be better at assessing risk and doing some front-end work with women. It's the same with men. We can't ignore that. So there is definitely a critical role for perpetrator interventions.

MS WATT: Just to add I think to what Rodney has outlined there, is that our members we think are doing the absolute best they can with the resources available to them and in the process have learnt much about what could be done better, differently, how we could be more integrated, how we could do better at individual case management, how we could evolve and develop the strengths in working in the mental health area, in alcohol and other drugs.

So there's a wealth of knowledge in there which may not be sitting in there as a one-off evaluation of men's behaviour change programs, but it's sitting there, that knowledge, and to engage with that knowledge and

understanding that's been built up over the last 10, 15 years of doing this work, I think would be the starting point.

But just to say I think our view is that we have never said men's behaviour change was the be-all and end-all as the solution to family violence and making perpetrators accountable. What we have said is it is a really important part of the jigsaw and we should build on that knowledge to strengthen the evaluation and that way we get to know better what changes things.

But also a word of caution, which is that if we make men's behaviour change programs all about the fact that has he changed after the weeks of intervention, the danger is the pressure will then be on the woman to say, "Yes, he's fine now, thank you," and the nature of family violence is so complex and so we must develop very sensitised and sensitive evaluation tools to be clear about what we are actually measuring and what the change will actually mean.

The analogy I would use is people go to rehab to become cured of their drug and alcohol addictions. How many people actually come out the other side of that and are actually clean and sober for the rest of their lives? So, we don't give up on them. We refine and we accept that for some people they will not make that journey. So, my appeal would be to say let's use the knowledge we have, and what Rodney has been describing and what our members know, and build more sensitised, sensitive and effective evaluation tools.

PROFESSOR DAY: Can I just make an observation, really, that there are considerable constraints placed on service

delivery in this area at the moment and we talk about psycho-education based approaches. My view is we really can't expect those type of approaches to have the impact on behaviour in high risk, complex perpetrators of violence that we would hope they should be able to. So psycho-educational programs should raise problem awareness, it should raise motivation to change, and it should increase people's knowledge about the reasons for their violence. But I think that does need to be supplemented with some skills based training and some intensive therapy that addresses the developmental origins of their violence if we can expect those programs to be effective.

One of the problems we have in the service sector at the moment is a reliance on a relatively brief type of psycho-educationally dominated program that doesn't meet the needs of some of the more complex and high risk clients that they are expected to manage.

MR MOSHINSKY: I will come back to that topic shortly. Just before I do, I just wanted to touch on potential other outcomes of participation in a men's behaviour change program, including the contact that the programs have with the victim, and just refer you to some evidence that the Commission has heard during the hearings from lay witnesses.

On day 8, which was the day dealing with mental health, we heard from a lay witness who referred to her partner attending a men's behavioural change program. He went twice, but then quit that and called her with an abusive phone call, and it was at that point that she realised he wasn't going to change and decided to make a

statement to the police. So, it was a useful catalyst from her perspective.

Then yesterday on day 9 we heard from a lay witness who, after experiencing a particularly violent incident where her partner tried to smash his way into her house, she then discussed it with the men's behavioural change program where he had been attending and was given advice that her life had potentially been at risk and that she should cut all contact, and she said that she found the contact with behavioural change program facilitators invaluable and it helped her realise that he wasn't going to change.

I'm just wondering whether any of you wish to comment on that potential outcome of the programs?

MR VLAIS: Yes, just briefly. It's one of the reasons why program length matters because we are focusing on risk assessment and risk management here. When a man goes through the program, some men will change, some men don't, some men will change some aspects of their coercive controlling tactics and not others. His partner, former partner, will need to make sense of this. "What does that mean? Is there a future together for us? What does it mean to the risk to our children? What does it mean about the risk to me?"

That's a journey that can take months and months and months. The fact that we are engaging him can really enrich the work that can be done for her and that's a part of risk assessment safety planning and risk management and it is part of her making her own decisions. I think they are two very, very strong examples.

Just finally, it really for us - it's about

capacity for programs to maximise these examples. Whether we are talking about sufficient, strong partner support over a long enough period, whether we are talking about risk assessment for each of their children, whether we are talking about a sufficient individualised approach to look at his mental health and alcohol and other drug needs and the capacity of the program to have the skills to do that.

There is a lift in capacity that's really required to be able to give our members a proper chance to be able to do more of what we are talking about, not do a brief limited intervention when we have such complexities. I think we have those skills and we have that desire amongst program providers to do that and to work towards producing a range of different outcomes, including risk assessment, risk management, supporting women's journey in healing, supporting children who are living through the violence.

The men's work is an important part of that. But there is a certain threshold where this work has to be done properly and has to have the capacity resourced and with proper updated standards. Otherwise, we are thrown interventions that are really only at half capacity. It's a bit like a cancer treatment where there's a pill being given only every second day rather than every day. It's just not giving it the go that it needs.

PROFESSOR DAY: I think there are also dangers associated with referrals. Certainly men blaming their partners for being mandated to attend a program and that can increase the risk of violence. There's certainly perpetrators that we have interviewed that have returned to their relationship and said, "Well, I've addressed the causes of this

problem," and then put pressure on the victim to do something and blamed the victim again for lack of progress.

Certainly the interviews we have done with victims has suggested that they largely feel invisible so that the perpetrator gets a lot of attention and services and intervention, that sometimes the experience is supportive and they don't receive any communication or information about what's going on or any support for their own needs.

My final observation is that I think in the current programs in Victoria two-thirds of participants in programs don't have a partner either at the start or the end of the program. So, we can't assume that every person that's going through a behaviour change program will have a partner who's present and an active participant in that process.

MS WATT: Could I just add something? Andrew is quite right to point that out. However, they will have previous partners and they may have children and they will go on to form relationships. So, anything they can do in that context to shift their control and aggressive behaviour is positive. But you are absolutely right .

MR MOSHINSKY: Can I move to a new topic which is a matter that you deal with, Professor Ogloff, in the Forensicare submission. There is a section in the submission at page 12 and following where you talk about the general approach that the criminal justice system now takes more widely of risk, need and responsivity. I was wondering whether you could explain that approach and how it links with the current topic.

PROFESSOR OGLOFF: I will be very brief on that point. I think first of all it's important to say that - you mentioned criminal justice system. This particular area has been developed around offender behaviour change, but it has been restricted to just people who are, for example, in prisons or even under Community Corrections Orders. For example, at Forensicare we use that approach for a broad range of our clients, both self-referred, referred from basic mental health services, other health providers, all the way up to people in criminal justice.

So, just very briefly, over the past 35 years there has been a huge development in the capacity to manage the behaviour of people who are offenders across a broad range of areas and the principles which have emerged, which have been well validated, are called risk, need, responsivity, or RNR is the acronym.

Very, very briefly, the principles are that the risk principle, which is the first one, is that the intensity of the intervention needs to be commensurate with the degree of complexity and risk of the individual, so that low risk people require less intervention and in fact often no intervention, high risk people may require more than intervention, they may require something like detention.

The need principle then addresses what are the factors that contribute to the individual's risk and behaviour. That for individuals will vary, but there are a uniform set of these sorts of variables that we know exist.

Then finally the responsivity principle, which is an unfortunate word, "responsivity", is really how to

treat and the goal there is to match the individual's needs to the mode of treatment and intervention.

In summary, the risk principle really tells us who to treat, the need principle tells us what to treat and the responsivity principle tells us how to treat. So that framework has been used with success across a range of areas, including family violence. There has been a lot of work done, for example, in Corrections Victoria recently developing intensive family violence programs and moderate family violence programs based on those principles. I think that's very, very positive because experience from overseas shows that they can be highly effective.

Very recently in 2014 an evaluation was published in a well-recognised journal by a group of researchers from Canada who evaluated the correctional service of Canada family violence programs. Those programs were developed in the late 90s and operate across the prison system. In an extensive evaluation which included good comparison groups they were able to show that if you look at moderate intensity groups, so these address the people who are at moderate risk of reoffending and re-engaging in family violence, the untreated people were actually about three times more likely to engage in family violence over time than treated people. The ones who went through high intensity programs, the untreated ones were four times more likely to actually end up reoffending.

So you can see a lot of very positive change through these intensive programs. I just use that as an example. Many of these programs run outside of prisons and in community, and I myself worked in such programs in

the old days, where we still called them assault of husbands programs. So from 1982 to 1991 we did work and then evaluated and published a number of papers looking at not only the efficacy of the program, but issues such as do people who are mandated to be there, do they benefit and so forth.

So I think the simple point is, as I mentioned before, there's a real need for programs that address the higher risk, higher need people, and I think certainly with Corrections Victoria and other potential we can begin to develop those programs.

MR MOSHINSKY: If you take the risk, need, responsivity approach, what would change? What would be different to what we are doing at the moment?

PROFESSOR OGLOFF: It would be very different. First of all, using the risk principle, Mr Vlais said they do comprehensive assessment. Respectfully, you could not do that in 75 minutes. He mentioned things like if there are high levels of psychopathy, they may not be eligible. One can't evaluate high levels of psychopathy in 75 minutes, let alone anything else. So I think the starting point has to be that principle that higher risk, higher need people need more intervention. So we do need to look at a better assessment model which we talked about yesterday.

The needs principle again tells us what to treat and what would flow from this better assessment model is the identification of the panoply of factors that are required to remediate behaviour for this individual. So the key ones that have been identified in the literature include, and there's been evidence before the Commission on alcohol and other drug use, mental illness and issues

around mental health, obviously men's attitudes and their own background, issues men face in their own lives. All of these are essentially the needs that need to be addressed.

Finally the responsivity is how to treat. So, some people simply aren't amenable to treatment in a group format, some people are amenable, and that would look more carefully at how people are treated. So we would move from a one-size-fits-all system where you try to, for want of a better term, cram as many people as you can into programs, hoping that like a sieve some positive ones will come out; we'd move from that to a more streamlined system where the people who are lower risk, lower need would get briefer intervention and, at the other end, the high risk, high needs people would get more intensive interventions addressing the complex needs.

Just parenthetically again, Corrections Victoria certainly has gone through that exercise with the development of programs within prisons and community, and they start with a broad assessment of the individual's broad areas of risk and need. Then where there's family violence issues identified, they move to a specialised assessment of the family violence risk assessment. Then the programs they offer are moderate or high intensity. These are yet to be entirely rolled out, but that's the kind of model I think that's useful as well in the community.

MR MOSHINSKY: Professor Day, do you want to comment on that and the extent to which different risk factors that may be present can and should be taken into account in the response by way of intervention?

PROFESSOR DAY: I'd strongly agree with the idea of differentiated case management. We offer different types of interventions in programs with perpetrators and offenders at different levels of risk. I'd also agree that Corrections Victoria have recently made a lot of progress in refining and developing their suite of programs, not just for family violence, but for other types of violence.

I think it raises some questions for me where some work is needed around assessing risk and the validity and the quality of the risk assessment tools that we have for family violence. There's certainly some evidence from the Home Office that general measures of predicting risk don't apply very well to family violence, so we need to adopt specialist measures of family violence risk. They tend to be fairly poorly validated and there's certainly not been any local evaluations of the validity of those tools, as far as I'm concerned.

So if we are going to make legally binding decisions based on risk assessment, we need to do some work really I think to strengthen and develop the assessment tools that we use.

Then I guess the second point I would make is really about the distinction between the probability of committing further acts of violence and the level of harm or the dangerousness of those acts. I think that's something that's clearly a consideration in family violence. So we may have someone that's very likely to commit further acts of violence, but those acts aren't very harmful, or we have someone who is quite unlikely to commit violence, but those acts have a high level of harm.

Obviously we need to intervene immediately in those circumstances, and making the distinction and identifying who is who in those groups is an important part of the assessment process.

MR MOSHINSKY: Are you able to comment on the topic of typologies which you refer to in your witness statement. Does that sort of assist here in terms of this complex process of risk assessment that you have referred to?

PROFESSOR DAY: I think so. I think our knowledge about the different subgroups of perpetrators is only just beginning to be realised in something that might be used practically in service delivery. But there's been a body of work around the world in trying to identify different subgroups of perpetrators and probably the most important distinction is someone that has a pattern of antisocial behaviour, coercive control in violence across a long history, so they have longstanding entrenched problems with violence, and setting those aside from a group of people whose violence is more situationally dependent occurs in the context of arguments and generally isn't associated with the level of entrenched attitudes and beliefs that support violence that would occur in the other group.

I think there's a relationship between those typologies and the level of risk that people present with, but we need to do more again in terms of finding ways to reliably assess and categorise people into those categories and then to develop services that meet the specific needs of people whose violence follows those patterns.

MR MOSHINSKY: So in terms of the typologies, is one situation,

and I think you refer to this in paragraph 40 as family only violence, situations where there may be environmental triggers such as substance abuse, extreme stress, loss of job, severe work challenges which might create risk in the family environment but they may not create risks in other environments?

PROFESSOR DAY: Yes. So for some people where violence is restricted to a family setting, it may be sufficient to manage or to intervene with those triggers for violence and that may be enough to keep people safe. One of the problems is when you intervene with attitudes and beliefs that support family violence with people that don't subscribe to those attitudes or beliefs or don't feel they need to, so they often resist intervention, they don't see intervention as relevant to their needs, and the task of the facilitator of the program is to persuade them that they hold these beliefs that they don't recognise in themselves. I think that creates a lot of problems in effective program delivery and distracts the task of treatment away from some of the behavioural change goals that the programs often have.

MR MOSHINSKY: Do any other panel members wish to comment?

MR VLAIS: For our member men's behaviour change program providers, probably the typology is different. There is certainly a small proportion of men who have high levels of psychopathy who have used violence in a wide variety of circumstances where they probably are not suited to a men's behaviour change program approach where a forensic psychiatry approach is very much indicated. That could be 10 or 20 per cent of referrals.

Amongst the other 80, 85, 90 per cent, it is very

difficult to differentiate. Most of those men pose at least a significant risk. Most of those other 80 or 90 per cent are using a range of different types of violence over a large number of years through a pattern of coercive control where not only the partners and the children's lives are limited, but they are certainly living under a fair bit of fear.

So, it's very difficult in the community based setting to use a typologies approach. My understanding of the research in the community based setting, as distinct from a more corrections setting, is that we don't yet have that at a sophisticated level to be able to stream men into different categories in the community based setting.

But what this whole discussion does really highlight for us is that amongst that 80 or 85 per cent we can have different approaches. We could have a feminist approach which sees men's use of violence as choices, developed from our sexist and misogynist culture, where men have a series of entitlement based beliefs about their partners and then they paradoxically feel the victim when their partners don't live up to those entitlement based expectations; that work on helping men to identify their privilege, their attitudes and beliefs, that work with men in helping them to change those attitudes and to realise how those attitudes that we get from men from a bigger culture actually defeat their own lives and what we want to do as men.

We can have a feminist approach, but still apply RNR principles and we believe that programs need the capacity, not to have a different type of program, but to overlay what they are already doing with a capacity for

the strengthened assessment, with a capacity to be able to have an individualised tailored approach and to address some of these other issues, but that doesn't necessarily mean abandoning a gendered based approach to the work. They can act together in a really comprehensive, integrated approach.

COMMISSIONER NEAVE: Counsel, can I just ask a simple question. Is there any reliable data on the proportion of people who use family violence who also use violence in other contexts?

PROFESSOR OGLOFF: I can briefly speak to that. Again, the complication which Mr Vlais spoke to is a real issue; that is, what is known, is primarily known about people who have at least been arrested. So, Australian Institute of Criminology have recently published a trends and issues paper on that topic looking at people who have been engaged in family violence and what's their pattern in other offending.

In my own work, but this was many years ago, we did a similar project where we went into the prisons and we actually looked at people in detail and we found that even though they may not have been identified as family violence, there were a high percentage, in fact in our study a quarter of them, their current offence was a family violence offence, even though it might have been recorded as something like assault.

So the short answer is it's relatively well known for people who have been arrested in context to family violence, but certainly there's less information in community about what other offences exist. I think that is one issue we talked about yesterday around information

sharing, because I don't know, for example, and Mr Vlais would know, the extent to which the facilitators in men's behavioural change programs actually get someone's criminal history so they can determine what exact sort of pattern do we have in the behaviour.

COMMISSIONER NEAVE: The knowledge is broadly restricted to people who have been arrested and what's the proportion - arrested for anything or arrested for family violence?

PROFESSOR OGLOFF: Again, in the research that they've done they identify the whole range. So, from non-violent property offending up to violent non-family violence offending, and the pattern shows that the majority of people who have been arrested for family violence also have a history of other offending, and indeed a smaller per cent of non-family violence offending, but still, from memory, in the order of 20 per cent, but a high range of other types of offences.

In fact, in the general research we know that the presence of those sorts of histories are as predictive of future family violence perpetration as many other risk factors that have been identified. So, it's a very important point.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Can I ask the panel about the concept of a trauma informed response in terms of treatment or programs. I have referred you each to the statement of Joanne Howard who is going to be called to give evidence on the integrated services day in these public hearings, who at paragraph 85 and following talks about the use of trauma informed approaches for adult male perpetrators. To what extent does this inform current practice in

programs and to what extent should it inform practice?

MR VLAIS: I will start off here, but again try to be really brief. There's a couple of really critical issues here. One is that we need men to work towards stopping their use of violence before they have worked through a number of their own traumatic issues. There is no doubt that perhaps 40 to 50 per cent of men in men's behaviour change programs have experienced some significant family of origin trauma. That leaves a lot who haven't, but there is certainly a significant amount who have.

We need to work with those men towards them understanding and starting to stop - because it's a journey, starting to stop their use of violence before those underlying traumas are actually worked through.

However, that doesn't mean that we don't address it. Program providers do take a trauma informed approach. I will just give one concrete example. A man might have a very intense emotion. He experiences it as anger. His partner does something. Because of a family of origin attachment based issue or because of real trauma he has experienced his emotion is intense. He might be shaking. He may be falling apart a bit internally. A lot is going on for him.

Because he has a low level of emotional literacy he sees it as anger. Because of his entitlement and privilege, because as men we have certain expectations of women, he immediately starts activating some of those cognitive thinking that she has done something to make him angry, "She has done something to really attack me or again she's trying to get me to talk about something I don't want to do or I don't want to talk about. She's

going on at me again and again," and he works himself up.

There's a complex array of factors there. The fact that he's targeting her is because of his sexist attitudes and because of male privilege. But they are intense emotions. How we work with that is we can't heal that intense emotion to begin with but we can help him to recognise it. We can help him to recognise what is happening in his body and then to start to make different choices. At a later stage he might need work to heal that emotional response so he doesn't have that falling apart feeling in the first place.

So I give that concrete example to show that we can understand that men's experiences of feeling the victim can come from both a sense of entitlement and their own real traumas that they have experienced as children from other sources. It doesn't mean we need to heal the trauma, but we can have a trauma informed approach to help him to be more aware of that emotion and then make different choices; interrupt his thinking, stop blaming her and do something different than a choice to use violence when he is having that intense emotion.

MR MOSHINSKY: Do other panel members - - -

PROFESSOR OGLOFF: I would agree particularly with the need to focus on the behaviour immediately. I think that that's agreed upon in intervention generally, is that there will be a range of issues that need to be addressed but of course the most immediate issue is making sure that the person is not engaging in that behaviour if they are in an opportunity to do so. At the same time, though, those underlying issues do need to be addressed for individuals. They will vary considerably.

In my own work, primarily in assessment now, I see a number of people who have histories of of course abuse and damage in their own lives as children and young people, and even a high degree of anger that they are now being - they have been charged or they are being prosecuted for things that they were victims of and nothing happened to the perpetrator. So those issues do need to be addressed. But I agree the starting point has to be trying to change the behaviour in the first instance to make sure if there's an opportunity to harm a family member that that's changed first before you can begin to address these issues. But the issues do need to be addressed.

PROFESSOR DAY: It's clearly important that we understand the onset, maintenance and development of those beliefs and attitudes and feelings that allow perpetrators to feel entitled to act violently in their family relationships. I think key developmental experiences like trauma are really important to understand as part of the assessment.

There's a thought in my mind really, though, that we need to establish the relevance of the trauma to their current behaviour and identify whether that's something that represents a criminogenic need or a dynamic risk factor that we should target explicitly in treatment as a way of managing or reducing the risk. That will be the case for some people but not all people. But certainly an understanding of trauma and the development of beliefs and feelings that lead to violence is a really important part of the assessment and intervention process.

MS WATT: I would agree with all of that. I think the additional factor of how you introduce that trauma

informed work to men who have used violence is to be, as Rodney has suggested, cautious about how you apply that because any excuse - giving men an excuse for why they use the violence is something we have to handle in a really skilled way and a really specialist way in the family violence field. So I think it has to be acknowledged, it has to be worked with, but it can't be done in a way that they say, "I'm doing this because my dad did it to me" or "I saw violent incidents as a child." Some sophistication around applying that practice again is something we would welcome.

PROFESSOR OGLOFF: I think that's really critical because offenders, as a group, irrespective of if they are doing family violence or other things - and probably like all of us, if we do things that we shouldn't, to preserve ourselves we externalise the reasons we do it. I think in treating and assessing people over many years that's something clinicians have to work very much against, is allowing perpetrators to believe that there's one or two factors that are truly the reason they do this, because then I think it removes the objective that you are trying to change their behaviour but also increase the understanding that they do have control over their behaviour.

So these things need to be addressed again by highly skilled clinicians who can balance the need to address it and how they approach it against the tendency we have as humans to want to blame our behaviour on factors that are outside our control to some extent.

MR MOSHINSKY: Is this something that is realistically capable of being done well in a group setting or is this something

that requires one-on-one counselling?

MS WATT: I don't think we feel that group or individuals are exclusive. I think that when you are working with men who are perpetrators of violence you probably should be doing both. But I think the lens through which that counselling and trauma informed one-to-one work is done has to be informed by the feminist viewpoint of how men respond to women, and similarly in the group. I think the trauma informed work can be done in both settings, but it needs to be done through that lens.

PROFESSOR DAY: There are also different levels at which trauma informed practice works. So it's very important for men to feel safe, for example, if they are expected to disclose openly and freely in a group. Part of trauma informed practice is to set up an environment where that's possible.

MR VLAIS: I was just going to add really briefly again it's that tailored approach. There might be one man where his level of jealousy is so severe that if it is addressed in the group he will become incredibly defensive or he will fall apart because his shame response is too intense. He might need a little bit of individual work; whereas there are many other men where we can work with their shame responses and we can work with them around jealousy and they can identify that they are actually controlling their partners' lives because any time when she speaks to another male he's got this incredibly triggered response, he feels jealous and then he shuts down her socially and makes her too afraid and threatens her to talk with any other male again. That of course interferes with her basic human right to have any friendships.

With many men we can work with that, and work with that emotional response and the shame that comes up with that in a group context. But for some men we might need to do some individual work because otherwise he will just feel too threatened, fall apart too much and then drag the rest of the group down with him. So it's that tailored approach, that need for individual work as well as the group work that our members would love to have that capacity to be able to do.

MR MOSHINSKY: I wanted to now touch on something you referred to in your statement, Professor Day, at paragraph 45, which is using a strengths based approach. Could you explain what that means and whether that is taking place, should be taking place?

PROFESSOR DAY: My interest in strengths focused approaches are really related to the engagement of people in behaviour change processes and programs. One of the big problems facing the sector is the high levels of drop out and attrition from programs. So up to half of people who start programs don't complete them. There's some reasonably robust evidence from the correctional field that if people start programs and don't complete them then that elevates their risk. So there is a real danger here that we could be doing more harm than we are doing good by providing programs that aren't completed by participants.

Strength focused approaches are important because they focus on what people can achieve and what they want to achieve in their life rather than the things they have done wrong. So they are inherently more engaging, motivational and appealing to participants, and involve really starting off with people's goals and personal

aspirations and then relating the content of the program as a way of helping them to achieve those goals. I think that's a really important part of practice that's really become a feature of practice only in the last maybe five or 10 years.

MR MOSHINSKY: Could you give us a couple of examples of what a goal might be that one would work - - -

PROFESSOR DAY: I think you have had some evidence about the role of perpetrators as fathers and the goal to be good fathers, good parents and support healthy non-violent child development. So talking to people about their role as fathers, the modelling that they do for their children would be an example of where that would be a good element of practice, I think.

MR MOSHINSKY: Is that part of current practice? Should that be increased?

MR VLAIS: It is. To give an example, program providers recognise that some men - not all - want to protect their families. There's a positive, honourable aspect of that wanting to protect. But the protection is about the masculine - hypermasculine protection that as men we get from our culture. That means, "We are right. They are wrong. We need to economically provide. At the end of the day we make the right decisions. If she disagrees with me that means she's not being loyal and she doesn't respect me." It's the power down approach whereby he sees himself as superior and she is inferior. He may still honourably want to make his family safe, but paradoxically he tries to control her and threaten her in order to protect.

What our program providers would do is take

protection and work with a man around that but to actually see the way that he is going about it is actually undermining what he really wants to achieve and what a different way that as men we can work equally with our partners and with other family members towards creating a protective environment for all of us without using the hypermasculine power over, "I must protect you. You are smaller than me, and therefore if you don't do what I say for your own good you are being disloyal and I therefore have the right to control you because you are actually having a go at my skill and my ability to protect you, so therefore I'm the victim and I can lash out and use violence." That's what goes on in the men's lives. It is an example of how we do use strength based approaches.

MR MOSHINSKY: Can I raise the topic of combined programs, for example, bringing together alcohol and drug programs with behavioural change programs. You have heard the evidence earlier today from Dr Easton about programs that exist in North America . Should we be developing programs like that here? What opportunities are there do you see for combined approaches?

PROFESSOR OGLOFF: I start with that "across a range of" because we don't do it now, certainly not here. But across a range of other behaviours that we try to change that's a model that's very, very useful. So again in an organisation like Forensicare who treats - in the community everyone we treat is by definition a high-risk, complex individual and the vast majority of people within our service we have to always juggle these range of issues.

The experience shows and probably the best

evidence is in the co-occurring disorder substance abuse mental illness literature and co-occurring substance abuse and violence literature that the best way to treat these things is in fact simultaneously addressing them in a concurrent model. That's why it may well be that in the future rather than having - for want of a better term - a one size fits all approach you would have streams of programs that people might go to.

So, for example, someone who has a persistent substance misuse disorder that is strongly related to family violence might go into the kind of program we heard about through evidence. Someone who has mental health problems might go into a program with a mental health framework. These are the sorts of ways we should be going rather than simply looking at one program that can try to treat everything for everybody.

MR MOSHINSKY: Do other panel members wish to comment on that topic?

MS WATTS: I think I would just like to add that as long as that's done through the lens of perpetrator accountability. I think there's always a danger of designing programs that we think are going to try and fix all of these things, and I think it has to be about strengthening the connections and the data sharing and the tracking and the case management work around perpetrators of violence and controlling behaviour, and as part of that building our skill sets around how to better engage around the drug and alcohol issue or the mental health issue.

So I think, again, there's some learning and some wisdom in the sectors that exist at the moment that could help to co-design or design something like that, and that

we should be using that knowledge as our starting point for - we could be just strengthening case management and intake processes, and find that by doing that, and giving people the skill sets to really work together, understand each other's languages, we might actually have an impact, rather than having to create a bright, new, shiny program.

PROFESSOR DAY: There's clearly a need for a broader suite of programs, options and treatment options that are currently available. So for people who are substance use dependent of course we should have substance use interventions available for them, either co-occurring or concurrent interventions. I think Dr Easton's work is a good example of what's possible and the evidence that she's been able to collect about the effectiveness of those programs.

I think I would make the same comment about mental health programs. There would be a small number of people who have significant mental health problems that really need specialist mental health services to address. At the moment the integration between family violence perpetrator programs and mental health services is weak, I think. So there's room for great levels of development there.

I will just make an observation. We did some work in a Queensland program. Nearly all of the men that we spoke to about substance use issues at the start of the program also had substance use issues at the end of the program. But that wasn't something that was a focus of that particular intervention. So I think that's a scenario where I think we would like to see some progress being made in that area. There's clearly an area of risk.

MR MOSHINSKY: The program you are referring to was a family

violence program?

PROFESSOR DAY: Yes, it was a men's behaviour change program.

MR VLAIS: Just really briefly, so many of the men in the programs have a substance abuse issue that it is really important that the programs themselves, as well as being able to work with other providers, have that capacity to respond. There are some men who don't have a current alcohol or other substance abuse issue but they had one recently, and if they persist with the program and it gets tough they may well fall back on their substance abuse to cope. We have to be ready for that and have the capacity to do that.

So it is partly about different program streams, but a lot of it is, as you were saying, Jacqui, around being able to have an intervention that can be tailored, to have that case management, and for the program to have the skills to not always stream someone into a very different type of program but to be able to address a range of different case management issues.

One final comment is that one area where No To Violence would disagree with Dr Easton is the behavioural couples therapy. It sounds as though that the sample that she was talking about were men for the behavioural couples therapy who weren't using many high-risk examples of violence against their partners, because in general when a man poses any significant level of risk or control or controlling behaviour over his partner, working with them co-joint often isn't indicated. It can create a whole lot of risks to do couples therapy when he is using significant coercive control against her. That's one area where we would disagree.

DEPUTY COMMISSIONER FAULKNER: I'm wanting to reconcile two pieces of information that we have had put before us today. One is the very strong statement from Professor Ogloff that the 75 minutes is not sufficient to make a good assessment, and then the subsequent evidence, Professor, from you in relation to people who have penetrated the correctional system, both in the community corrections and well within the incarceration section, that you do now have assessments being made and people being triaged into different programs. I'm just interested in the resource that you use to do that assessment. Presumably it takes a lot more than 75 minutes, and I'm trying to assess how reasonable it is to think that we will ever get that level that applies to people who have already penetrated the system to work in the community system.

PROFESSOR OGLOFF: I guess I just want to say I think that's exactly the problem with the way we are thinking is we are thinking within the box in which we live, and we are trying to fit things in. What I'm trying to say is that if we look around the world, if we look at other jurisdictions, many jurisdictions aren't confined by one particular model. I think that has been to our detriment.

I can't speak broadly for Corrections Victoria but I can speak in general terms what they do. Everybody gets a general risk needs assessment. That's done by community corrections or prison intake workers. It's a fairly extensive assessment based on evidence based approach that's well developed.

Again, if they are identified as having family violence issues or offences, then they are streamed into a

further assessment, this time by a clinician, so a social worker or psychologist who will engage in a more comprehensive assessment of their factors narrowly pertaining to family violence. Based on that assessment plus the broader assessment, a review of their history and behaviour and background, decisions are then made which program to stream them into. So that's the sort of model that I think is useful.

In the community it's exactly the same thing. Again, we talked about information sharing, and that's a problem. The submission that Mr Vlais has made, I think it's very sensible to have some sort of central point where assessments could be undertaken, different service agencies could have involvement and you could essentially have an evaluation.

For example, if someone has a history of a serious mental health problem, then mental health and forensic mental health services would have the capacity to evaluate, look at their history, including accessing their public mental health record, which other services can't access, and undertaking assessment . So you would do that across the range of significant issues just to make sure that you are not trying to place people in programs that won't possibly be suitable for them.

DEPUTY COMMISSIONER FAULKNER: Thank you.

COMMISSIONER NEAVE: I have a follow-up. At the moment we know that there are very large proportion of men who are not in behavioural change programs even if they want to be. There's long waiting lists. The process that you are suggesting is a very expensive one. So I suppose that people think, "We better have a community based model

because we can't do any better than that, and maybe we need to tweak it, maybe we need to extend it." But given that there will always be limited funds how would you - perhaps this is a question to the whole of the panel - come up with a system which is (a) affordable, (b) which recognises the different level of risks, and (c) is going to be acceptable to government?

PROFESSOR OGLOFF: I think affordable is part of the problem, because how do you determine what's affordable. It's how big the need is. Generally the Commission has seen that probably as a particular area this is a woefully underfunded area. So I think that's the starting point.

But very, very briefly, the whole sense of these approaches are that what you do is, say you have 3,000 people a year who require programs, rather than putting them all into the same bin and having one program, essentially what you do is you streamline it. You may well find that a percentage of people don't require much and certainly more than a behaviour change program, and at the other end you will have a small number that require truly much more involved programs. That's I think what you have to begin to do, is think about how we stream people through, just like we do for every other problem in society. We don't use a "one size fits all" approach and expect that will solve everything.

MR VLAIS: The potential need is vast, but one of the things which makes it a bit easier is of the potentially 40,000, 50,000 Victorian men who perhaps should be going through a men's behaviour change program at this point in time - if we look at the number of adult male respondents to intervention orders and then we double that for each of

those men who are not through the police or justice systems, we can easily come up with tens of thousands - many of those men are not going to go to a program. They won't be mandated or they decide not to go, or they go for a bit and then they drop out. So the numbers always shrink down.

Even though the potential pool is large, the numbers will always shrink down. But certainly they will shrink down to more than what we are funding now. So I definitely agree for us we can't get around that to give this work a proper go there needs to be a significant increase in investment tied to evaluation.

But what the programs will do with all those other 15,000, 20,000, 30,000 men is support the child protection practitioners to better engage with them or to work alongside our colleagues in community corrections to improve supervision practices which at the same time will improve facilitator practices. I think there's a great opportunity for alcohol and other drug workers, corrections, police, child protection workers, men's behaviour change practitioners to share a lot of skills together.

So the programs don't need to work with all of the men, because that will never happen. Men will always drop off. The invitations we can make to men, kind of like the sticks and carrots that we can give to encourage them to attend, are important and some men will only attend because there is a mandate. But so many men will drop off. That's where we want to work together and not only improve the skills of all of these other systems agencies, to engage men, manage risk, risk assess, they

give us skills too in working better with alcohol and other drug or being able to monitor men, so that we can all help each other in the work.

When we look at it in that way, yes, we are looking for a significant step up in investment, but it's not a 10- or 20- or 30-fold increase or anything like that.

PROFESSOR DAY: The key point for me is about targeted intervention. I guess one of the things we have not talked about is not intervening with people who are regarded as low risk or low dangerous. Obviously there is a threshold that the community can tolerate in terms of the level of risk that people can bear in the community. But certainly the correctional model or the risk needs model gives permission for correctional services not to intervene with people for whom there may be concerns, that overintervention increases their risk. The model at the moment is that everyone with an identified history of family violence is potentially referred or mandated to attend the program.

MS WATT: I'm happy to add a final comment on that if it helps ultimately. That's a fabulous question, Commissioner, and one that is ultimately a political judgment, I guess. I was actually looking for the part of our submission that talks about the cost of keeping a man in prison compared to the cost of men's behaviour change programs, and weighing those resource decisions up I guess is part of the work that the government and yourselves at the Commission have to do.

But one of the things I was going to suggest is that we were told last week at a session I was at

42 per cent of police activity is family violence and what's that costing us, and there was some discussion in the group I was in about what do we want the police to do, do we want them to be social workers or psychologists, and the response from the family violence sector was very strong, saying, "No, we actually just want the police to do their jobs and do it better." So there is something about, if all the parts of the systems that are interfacing in family violence did their jobs better, to standards, and were able to do all the different bits that are needed, that in itself would deliver a value to the wider society, rather than just always new resources needing to be found for new programs.

Part of our submission has been about training people to look through the family violence lens, so supporting Child Protection, the courts, Corrections, the wider community to understand family violence, and do exactly what Andrew suggested about seeing that risk for what it is and putting it into the right bucket, if you like, in terms of who can help.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Commissioners, I'm conscious of the time but also that there's about three or four points that we really need to cover with this panel.

COMMISSIONER NEAVE: Sorry.

MR MOSHINSKY: No, not at all. I'm not sure whether the panel has any capacity to continue from about 2 to about 2.20? Is that massively inconvenient or is it possible?

PROFESSOR OGLOFF: I probably can't.

MR MOSHINSKY: Would it be possible for us to continue now and have a later lunch break?

COMMISSIONER NEAVE: Yes.

MR MOSHINSKY: Is everyone okay to continue for about another 15, 20 minutes? Thank you. The next topic I want to raise with the panel is this one of mandated treatment, which has been referred to in other evidence that you have heard today. Can I invite you to comment on whether mandated treatment works or whether it's a barrier to the programs working, whether combining mandated and non-mandated participants is a problem?

PROFESSOR DAY: I can start with that. There's certainly evidence from the sexual violence field that mandated treatment outcomes are comparable with those when treatment isn't mandated, and the key factor seems to be length of time in treatment. Obviously engaging coerced or mandated clients in treatment is a clinically challenging task which requires considerable skill. But if you can maintain them in treatment over a longer period of time, then the outcomes associated with the treatment don't seem to be any worse than for voluntary clients.

PROFESSOR OGLOFF: We've found the same. I published this in the work that I talked about previously, specifically with family violence. It was the first article that actually - the first study that looked at that. The program that I was involved with, we did get mandated clients and we were actually quite resistant to take them as clinicians. We had a mindset that people couldn't change if they weren't voluntary. So we decided because we had to treat them we would treat them and evaluate.

In an evaluation what we found is that the people again who came through under mandatory processes did just as well as others, and, as Professor Day has mentioned a

bit earlier, we focused more on engagement, in motivation, trying to provide a mechanism for people to understand why they are there. So it required us as clinicians to operate differently, which is to provide mechanisms for getting people motivated to understand why the treatment would be of benefit.

But the outcome was, again, positive and equally positive for the people mandated as those who were there voluntarily. But it required us as clinicians to do things slightly differently.

MR VLAIS: Yes, that's my understanding as well, that there isn't research demonstrating that men who are mandated to attend through different criminal justice systems or civil justice systems or other pathways do worse than non-mandated. I think many of our program providers do mix both mandated and non-mandated sources, and it's a continuum. The man who is referred from a child protection practitioner, it is not a legal mandate. There is no actual legal or judicial consequences, but there's other consequences if he doesn't attend . So that's a form of a mandate. So I think the outcomes are the same.

But going back to RNR I think what's really critical is perhaps not to think so much about mandate or non-mandate, we can have both, but what is that for the community based programs that a smallish, but definitely there, proportion of offenders who perhaps wouldn't benefit from a men's behaviour change program due to very high levels of psychopathy and other very intense personality disorder, et cetera, needs; and similarly - it's only a small proportion, but there could be a small proportion of men who go through men's behaviour change

programs who are particularly low risk. We don't see a lot of those men but there are some. Even amongst men referred through, say, Corrections Victoria's program over the last few years, which is building up to refer more men who might be at low risk of general offending in some ways, unfortunately a number of those men are still at quite high risk of using significant and near-lethal forms of violence against their partners.

That comes back to your point, Andrew, that there is still work to do in being able to fine-tune family violence risk as distinct from risk of general offending, and family violence dangerousness is its own specialty within the specialty.

MR MOSHINSKY: One other point I want to raise is the length of the programs. There's been some reference in the earlier evidence today about whether length actually matters. I think there may be different views about that. Could I invite the panel to comment. Should we be having longer programs than we have at the moment?

MS WATT: Yes.

PROFESSOR OGLOFF: I think the answer is it depends what you are doing in that time. I think that's the bigger issue. So I think if you are having longer programs with the same model, the same facilitators, I think there's maybe some benefit but certainly not the benefit you would get from having longer programs that are looking at different ways to remediate the behaviour.

Just for example, the programs I already mentioned that have been validated, what they call the moderate intensity program actually is about 80 hours of intervention, and the high intensity program is up to

300 hours of intervention. So it's not just a small increase, it's a very large increase, and it's again a very different way of what you are targeting. So it's a very vexed question.

MR VLAIS: Certainly as a peak body we need to stay in tune with international expectations for community based programs about minimum length, and certainly in the UK, in New Zealand, in the United States a minimum of about 50 to 60 hours - a minimum of 50 to 60 hours - of intervention in community based programs for men of at least moderate risk, which is most of the men we see in men's behaviour change programs. Including those referred through Child Protection or Corrections, they are at least a moderate risk of continued use of significant family violence against their family members.

Our current minimum standards, which are now 10 years old, look at a minimum of 24 hours. So we have been advocating for a while to be able to update our minimum standards and have sought funding for that for quite some time. While we don't want to pre-empt what the specifics of that would be, it would be quite brave of us to go against international industry opinion and set the bar as a minimum of anything less than that 50- to 60-hour mark.

As we have discussed in the panel, some men will certainly need more. If a man has got some significant substance abuse issues which are related to his use of violence, not causing it but is related, or has, say, a clinical depression, again not causing his use of violence but constraining his ability to participate in the program, that needs some time and specialty to work

through. So we would see it as a minimum of 60 hours of intervention.

MR MOSHINSKY: Can I ask you briefly to comment on cultural appropriateness of programs? Is there a need for programs which are targeted to particular cultural or ethnic groups?

PROFESSOR OGLOFF: That's certainly again within the RNR model. The answer is absolutely yes. That's a responsivity issue. You do need to do that. It also can be a criminogenic need issue, which is where things like people's attitudes, values about power and control fit into that frame. So it may well be that different cultural groups have different belief systems, and that needs to be addressed, and also the way that people work in programs, their own cultural values need to be considered in any kind of intervention model. It doesn't mean you need entirely different programs for everybody, but it certainly needs to be culturally informed intervention.

PROFESSOR DAY: Just briefly, I would say, yes, family violence is a socially and culturally constructed problem, and we need to attend to that during the intervention. So it's very important that we don't just pathologise the problem within the individual and our treatment approaches, but we contextualise it within the family, social and community environments in which they grew up and in which violence occurs. So, yes, there is a need for specialist attention to cultural issues, and often that's limited by practical and administrative problems around how you convene specialist groups for smaller subsets of the population.

MR VLAIS: Just briefly adding to that, in Victoria we are

privileged to have two current men's behaviour change programs in specific cultural contexts - the Vietnamese-speaking men's behaviour change program and a South Asian men's behaviour change program; that's in English because that's a common language amongst a number of South Asian cultures - and there is an Arabic-speaking men's program in development.

Culture is relevant for all groups. I have a culture, and all men who perpetrate family and domestic violence share similar tactics to control their partners and their children, and draw upon similar ways to limit their lives for privilege.

But there are also cultural specific tactics as well too and cultural stories. Patriarchy is done differently in each culture. So that cultural specificity is a very, very important risk issue, and that means not only some separate group interventions at times for different cultures, and including the different ways that men identify - trans men, men who are, again, bisexual. We have a gay and bisexual men's behaviour change program as well too. Men from different identities and cultures all can use different tactics to control family members. But culture is relevant for us all. In all programs we need to reflect on how all of us men, including in privileged cultures, use our privilege and entitlement to maintain gender based advantages over the people we love.

MR MOSHINSKY: Commissioners, those were my questions. I don't know whether you have any questions?

COMMISSIONER NEAVE: Thank you very much, Mr Moshinsky, and thank you very much, witnesses. That's been a very, very interesting discussion. 2.15?

MR MOSHINSKY: Yes, thank you, Commissioner.

<(THE WITNESSES WITHDREW)

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.15 PM:

MS DAVIDSON: Thank you, Commissioners. The next witness is Michael Brandenburg.

<MICHAEL GERARD BRANDENBURG, sworn and examined:

MS DAVIDSON: Mr Brandenburg, you have made a statement for the Commission?

MR BRANDENBURG: I have.

MS DAVIDSON: Are you able to confirm that the contents of that are true and correct?

MR BRANDENBURG: That is correct.

MS DAVIDSON: Can you just outline for the Commission what your role is?

MR BRANDENBURG: I'm the Manager of the Family Violence, Family Relationships Services and Housing Services at Child and Family Services in Ballarat.

MS DAVIDSON: This is with Child and Family Services Ballarat. What sorts of services does your organisation provide?

MR BRANDENBURG: CAFS is a large welfare organisation in regional Victoria, about 180 staff. We offer services across a whole range. So we were born out of an orphanage, and since then we have expanded into family services, I guess the services that I listed - out-of-home care, foster care, resicare, financial counselling - a role range. I think there's 64 programs.

MS DAVIDSON: You have identified that the men's behaviour change programs that you run have three different funding streams; is that right?

MR BRANDENBURG: I have, that's correct.

MS DAVIDSON: Those funding streams are what?

MR BRANDENBURG: We are funded through the Department of Health and Human Services, through Magistrates' Court of

Victoria, and we receive some funding from Corrections Victoria for clients.

MS DAVIDSON: How does it affect your service having - what do you see as the challenges of those different funding streams?

MR BRANDENBURG: I think there's a whole range of challenges, but probably one of the most significant ones for us is, if I just talk a little bit about, the specialist family violence court counselling program, which is the program that's linked to the specialist family violence Magistrates' Court. That program was rolled out 10 years ago, and it came with it a whole range of elements other than group work. So this morning there was a lot of conversations around men's behaviour change group works. That program brought with it the capacity to do some intensive work with men before group, it allows us to do some work with men on a one-on-one basis during group, and allows for some work to occur with men after group. So that model in itself offers a whole range of additional I suppose packages to the work that we do. So, therefore, that one is funded and costed differently, for example, to the program that is funded by DHHS, which is predominantly funding intake and assessment and group work. So that's probably one of the significant ones.

Corrections Victoria purchases the work in a little bit of a different way, so they will purchase components, and once we complete components men then go into the program. That's probably one of the major differences in those models.

There is compliance that's linked to the different funding streams that are required to be carried

out. In some instances there are conversations and requests about how long groups should actually be or how long groups are being funded within that context of which funding body is paying for what.

MS DAVIDSON: You are in a regional area?

MR BRANDENBURG: We are, yes.

MS DAVIDSON: Do you run different groups based upon which funding streams?

MR BRANDENBURG: No. We made a decision probably when the Magistrates' Court program started 10 years ago that we would just run the same group for the same men. So when we talk about mixing, which is not a very nice word, but we mix Corrections clients, voluntary clients, any man that comes in the group.

MS DAVIDSON: Why do you do that?

MR BRANDENBURG: Apart from it being practical - - -

MS DAVIDSON: You can start with the practical.

MR BRANDENBURG: Yes. Just listening this morning, I think we forget that the men in group are no different to men in society. In some ways we work with the men who have been caught, and I say that respectfully to all men. So in some ways we don't distinguish between where men come from . We offer them a service. We offer them the same service. They get a different type of service occasionally, depending on which funding stream they come in through.

But in terms of group work I guess we just see that there is - if you can get a man into group who is ready to do group, the conversations that happen amongst those group of men are no different to the work, from our experiences of if you had separated those men out.

MS DAVIDSON: But some of the funding streams do also attract different levels of individual work; is that right?

MR BRANDENBURG: Just referring to the Magistrates' Court program, that allows us to do some of that intensive response work, which has been mentioned this morning about the importance of gauging men into the work. You can put a man in group but, if he's not ready to do the work or doesn't want to do the work, you are basically wasting your time.

What we refer to as our IRP program, which is three sessions, allows us to address particularly with our court-mandated men and to an extent the Corrections Victoria clients their resistance to do the work, their resistance to change, their resistance to want to sit in in a group. So we spend those three sessions really working on those. So that work there allows us to put men into group who are ready to do the work as opposed to putting men - I think this is one of the advantages of that program, that we are not putting men into group who aren't ready to do the work in a group setting.

MS DAVIDSON: Does the DHHS funding - - -

MR BRANDENBURG: No.

MS DAVIDSON: So does that just cover group work?

MR BRANDENBURG: The DHHS funding really picks up an intake and assessment, the enormous amount of referrals that we get from the police every year, but really it's an assessment into group.

MS DAVIDSON: Comparing those three different models, do you see any of them as being better than others or easier to operate than others?

MR BRANDENBURG: Look, I think in my submission we talked about

the importance of what we refer to as that IRP work, that initial work before men go into group. We really see that as crucial in our model that we would support being - and it was mentioned a few times this morning in some of the presentations about how important it is to do that work before a man goes in group.

So for us the Magistrates' Court model, which also is obviously men are referred on a counselling order, so there's a court override on that order as well, so there's the mandation or the compliance model that sits behind that - we actually believe that that's got some really great strengths, and that was originally rolled out in Ballarat and Heidelberg, and they are trialling a couple of what I might say are watered down models, not disrespectfully, but watered down models, in a couple of other sites at the moment. So certainly for us that program allows for more work than just group work to occur with the men.

MS DAVIDSON: Can you expand a little bit further about how that specialist family violence court impacts upon how you work and whether or not you see it as being a useful model to improve changing men's behaviour or managing their risk?

MR BRANDENBURG: I certainly think - and, again, we have probably been lucky because we are in Ballarat and we have had a consistent magistrate up there, Magistrate Toohey, for 10 years, we have had specialist respondent workers, we have had specialist registrars who engage with the men.

One of the questions this morning that one of the Commissioners asked about was that assessment into our

programs. I have been around long enough that I was around when the program started, and the initial assessment at court was you were assessed in unless you were out, which is a bit different in the thinking. So there was very few men who weren't referred to our program, and court would pick up very quickly if there was really severe drug and alcohol or mental health issues that would impact on the person doing the work. They were referred to us. We would then do our own assessment, and a lot of our assessment was around men's readiness for the work, their motivation to do the work.

But most men were referred rather than not being referred. The only limitation on the referral was that we were funded for 100 places a year. So you work that out and that's two a week. The Magistrates' Court sits on the Tuesday in Ballarat, and I know there's more than two cases of family violence incidents occurring on a Tuesday being heard by our magistrate. One of the good things that has happened just recently is that they have expanded that a little bit and we can do three referrals a week now instead of two.

So I think there's a package that comes with that man coming into our program. We have really clear compliance models around if he doesn't attend in terms of our role in following up that compliance but also then that being fed back to court if he continues not to attend and then appears in court I guess to answer the questions back to the magistrate.

MS DAVIDSON: How long is your waitlist?

MR BRANDENBURG: Our waitlist is about eight weeks, roughly, but we run a rolling group model. So we run three groups

a week in Ballarat and one group in Ararat. So at any one time we have about 40 men, 40 to 50 men going through our program. We use the rolling group model, and that was primarily implemented to manage demand. Over time, though, we would now suggest that that works pretty efficiently in terms of the group work program.

MS DAVIDSON: Does the ability to do the individual work assist with the rolling group, if you are able to do some work before they move into the rolling group - - -

MR BRANDENBURG: Exactly the same model, yes. If the man needs those three sessions to get ready for group, we will do that before he goes in. We have been running a 14-session program, and we are about to move to a 26-session program. But historically men, once they are ready for group, because we are running three groups a week we have always been able to probably find a spot for a man in a group.

MS DAVIDSON: A rolling group means that men can just join the group any time?

MR BRANDENBURG: Any time, yes, and we just track their attendance over that period of time until they have completed the numbers.

MS DAVIDSON: When you have your risk assessment and suitability assessment, or your intake assessment, what happens if someone has particularly high risk or complex needs? Say they have drug and alcohol or mental health issues, what happens in your service?

MR BRANDENBURG: If I just talk about the Magistrates' Court model for a moment. The actual counselling order that men get, which is up to 50 hours, at this point in time doesn't have an end date. So men are with us until they finish their time in lots of ways. Probably what we have

decided is that if when we do our assessment a man has a need that's going to impact on his capacity to do group work at that point, so, for example, drug and alcohol or mental health, we would refer that man off to that service to do some work on that, and then for him to come back into our program once he's been assessed by that service but also been assessed by us as then having capacity to do group work.

MS DAVIDSON: In terms of someone who has alcohol and substance abuse issues, are you able to say how many men - what sort of proportion of your clients have got those sorts of issues?

MR BRANDENBURG: Look, it would be a guesstimate. Maybe 50 per cent of those men. But, again, if I ask my workers across all the numbers we might only be referring maybe 10 a year to drug and alcohol or mental health services. I think at the end of the day most men have the capacity to do the work.

MS DAVIDSON: At the moment they would get referred to drug and alcohol if it impacted on their capacity to do the work, but would they get referred to drug and alcohol at the same - to be able to do drug and alcohol - say they had the capacity to do the work but they also still had a drug and alcohol issue, do they get also referred for drug and alcohol counselling at the same time?

MR BRANDENBURG: The short answer is yes. Our assessment in terms of some of that stuff is about our capacity to manage that man in group if he has a drug and alcohol issue or if he has a mental health issue. So we might refer him to drug and alcohol services or mental health services but still deliver a group and have him in that

group. I think it's when we make a decision that his capacity to do the work or his impact on the group would be - we would put on hold his work in men's behaviour change while he addresses his drug and alcohol or his mental health or whatever those issues are.

MS DAVIDSON: At Child and Family Services in Ballarat do you have alcohol and drug programs?

MR BRANDENBURG: No, we don't.

MS DAVIDSON: Or mental health workers?

MR BRANDENBURG: No, we would refer out.

MS DAVIDSON: They would be referred out?

MR BRANDENBURG: Yes.

DEPUTY COMMISSIONER FAULKNER: Can I just clarify then, when you refer out you said only about 10 per cent - there was a figure of 10 per cent in 50 per cent - - -

MR BRANDENBURG: Yes, about 10 men maybe a year.

DEPUTY COMMISSIONER FAULKNER: Sorry, I beg your pardon. So does that mean that the cost of any drug and alcohol for anyone referred by the court is picked up by the court or are they just referred off to the more generalist services?

MR BRANDENBURG: The more generalist services. So the referrals actually come from our organisation, not from court. If court do an assessment where the person's capacity to be referred to the counselling program is impacted because of their drug and alcohol or mental health services, the court would make that referral to those services. That man may not get referred to the family violence court counselling program.

DEPUTY COMMISSIONER FAULKNER: So the extent to which the court supervises drug and alcohol depends on - so if they are

doing the men's behaviour change program and they should be doing drug and alcohol as well, the court doesn't supervise that drug and alcohol; they only supervise the - - -

MR BRANDENBURG: Not that I'm aware of.

COMMISSIONER NEAVE: Because this is the counselling order which is hung off the intervention order process. If they were convicted of a drug offence, then presumably then you would have a different process?

MR BRANDENBURG: Yes, I would assume that would be the case, Commissioner.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: What about men who want to do the program voluntarily? Do you take - - -

MR BRANDENBURG: We take all men. Yes, they are all welcome. The word "voluntary" - - -

MS DAVIDSON: How do you fund - - -

MR BRANDENBURG: Our services are free at this point in time. But they are funded by government.

MS DAVIDSON: So someone who wants to do it voluntarily you would just use one of the funding - - -

MR BRANDENBURG: They would come in through the DHHS funded stream because that historically has been the stream that's picked up a whole range of referrals . So when CAFS started 20 years ago it was funded by DHS and it was open to anyone.

MS DAVIDSON: So the DHS funding is for effectively an open stream?

MR BRANDENBURG: Anyone, yes.

MS DAVIDSON: That would include voluntary. Do you get very often referrals from child protection agencies or Child

FIRST?

MR BRANDENBURG: Yes, Child FIRST, and probably increasing. Some of the work we have been doing more recently with Family services has been around - probably one of the challenges that we have picked up is - or one of the questions our service has always asked is why isn't Child Protection or Family Services doing some of this work. So we have probably now formed a - and we have family services in our organisation, so it makes it a bit easier. We are starting to do some joint work with families at the moment around addressing family violence and family services work at the same time. But Child Protection makes referrals. Yes, look, anyone can come in on the DHS - - -

MS DAVIDSON: I think you said that historically that didn't necessarily happen from Child FIRST and Family Services but it's a more recent - - -

MR BRANDENBURG: Certainly in our region it's been one of the issues that's been picked up and addressed and there has been some alliances between family services and family violence occurring, so joint meetings now to look at this specific issue, for lots of reasons. It doesn't seem that Child Protection and Family Services have done a lot of family violence work previously, although the stats would indicate that I think it's about 70 per cent or 75 per cent of cases that come through Child Protection family violence is an identified issue.

So I think our work is moving more towards that integration model, and that was spoken about this morning. It's not just about the integration of the family violence system but it's the integration of services like Child

FIRST and family services to work with the families and those individuals.

MS DAVIDSON: You also talk in your statement about a men and family relationships service?

MR BRANDENBURG: Yes. We get some Commonwealth funding to deliver a men and family relationships program through the family relationships stream. In my submission I indicated that for those men who for lots of reasons may not be suitable or eligible or have other issues going on in their lives before they do family violence work, that they can be referred to the men and family relationships program. Those workers will do some work on them.

I think I highlight, and it's been mentioned this morning, that separation is an extremely highly dangerous time for families and for men. So a lot of our men who come into our program where they are still going through that separation cycle, we would actually encourage them either to do work across both streams or do one work, which is mostly about addressing the separation issues, as part of their journey through the family violence service system.

MS DAVIDSON: You have identified recently separated partners as an area of particular need. How does the service address those needs?

MR BRANDENBURG: Part of our family violence assessment, although part of all of our assessments in our organisation, would track where a man is at in his journey, and certainly for us if a man comes in and he is recently separated we already know that there's crisis points in that journey. So part of our thinking is more about addressing and trying to stabilise that man through

separation. We know that women and men separate differently, and the risks are quite high, and therefore we probably prioritise a lot of those safety issues around for those women and children but also for the man.

MS DAVIDSON: When you say "separate differently", what do you mean?

MR BRANDENBURG: Our experience is that women work through their separation before they separate physically from the home, and men tend to be quite surprised by the fact that when they come home she's left and can't quite understand why. Our work is quite easy to identify that the woman's journey and the man's journey occurs at different times and different paces. So our experience is women have done a lot of work before they leave and then leave; men start doing the work when the woman leaves, and very much still in the denial framework, and therefore thinking very much around actually wanting to get her back rather than managing the separation, and therefore that journey - we talk three or four months for a man from that point to where he might be stable, that there's high risk for everyone in that period of time.

MS DAVIDSON: With that in mind, how important is it that access to services and support for the man is timely in that context?

MR BRANDENBURG: It's crucial, and we would prioritise men in that separation phase, within our organisation.

MS DAVIDSON: Does that mean that they wouldn't necessarily wait eight weeks for a - - -

MR BRANDENBURG: There are probably men in family relationships probably receiving a service much quicker than eight weeks, yes.

DEPUTY COMMISSIONER FAULKNER: Could I understand - it's a Commonwealth funding program, and it's described in your witness statement as improving family functioning and a number of other things. I can't tell whether it's targeted specifically to family violence or is it a more generic - - -

MR BRANDENBURG: No, it is a more generic service. So it is a broader service that was established back in about 2000 by the Commonwealth Government which was built around trying to get men to access services before the crisis. We know, again, that most men access support when the crisis occurs. There was a big push around men's health at that time to get men to go and have regular checkups every six months. The Commonwealth Government also thought about how can we get men to look at their relationships as well before they break down. So the Commonwealth Government funded a very broad and generic men and family relationships program primarily trying to encourage and engage men into services to improve a whole range of elements of their life, including their relationships.

DEPUTY COMMISSIONER FAULKNER: And through the department of what?

MR BRANDENBURG: Department of Human Services, the Commonwealth Government level.

MS DAVIDSON: In terms of the men who are accessing that program, are you able to say what sort of proportion have engaged in some sort of violence? I'm not meaning just physical violence but coercive controlling behaviours.

MR BRANDENBURG: The program probably sees about 50 per cent of their clients where family violence would be part of their life. I think the other part I make reference to is that

Baby Makes 3 program, which again in terms of high-risk areas we know that when parents have their first child it's a high risk, and Men's and Family Relationships is doing a fair bit of work in that Baby Makes 3 area to try to work with parents around the impact of that first child coming into their life, because we also know that there's an increase in family violence in relationships in that period of time as well.

MS DAVIDSON: You have also got a post-separation cooperative parenting program?

MR BRANDENBURG: We have, yes.

MS DAVIDSON: Tell us about that.

MR BRANDENBURG: It sort of picks up that - all those referrals come through the Family Court. So those families that are in high conflict and, in simple terms, the parents hate each other's guts and have forgotten why their children actually exist. So that program is really directed at trying to get the parents to redirect their energies into what the best needs of their children are rather than the energies that they waste on fighting over things like shared parenting and who is buying what.

I think our program would say that there's a fair amount of success in both parties, and particularly men, because there's a lot of high conflict and family violence in those families. They gain a better understanding of the importance of having a better relationship with the other partner because of the children, which was sort of touched on this morning a bit about the role of using children to engage dads into behaving differently or better. So the parenting program is kind of built around that model, and we would say that it has some success.

MS DAVIDSON: Does that operate in conjunction with your children's contact service as well or - - -

MR BRANDENBURG: All people using our children's contact service have to do the post-separation parenting program, yes.

DEPUTY COMMISSIONER FAULKNER: Both funded by the Family Court, those two services?

MR BRANDENBURG: Both funded by the Attorney-General's Department at a Commonwealth level, yes.

MS DAVIDSON: Finally, can we just touch at least briefly on the program that you operate for adolescent violence?

MR BRANDENBURG: Yes. So we were successful in getting some money from the Potter Foundation back in 2012 after we identified a significant increase in referrals particularly through the L17s from police of young adolescence, both male and females, perpetrating violence on their parents and particularly single mothers.

The Ian Potter Foundation funded us initially to run a program, and that program is linked to the step up model that was delivered in America. Jo Howard had been over there on a fellowship, so we'd formed a relationship with Peninsula Health, where Jo Howard was working at that time, and we rolled out the step you program.

The journey then became the Department of Health and Human Services became involved in that and recently has funded three programs across the state delivering adolescent family violence programs. That model in our region engages both the parents and the young person, and a component of that work is group work. So once a week the families come to meet together, and then we break off into adolescent groups and parent groups, and do work with

both parties.

MS DAVIDSON: How do families come to be in that program?

MR BRANDENBURG: Currently referrals are from L17s. Again, I think because of the relationship we have in Ballarat the L17s through the police, so the police we have engaged them to understand a bit more around adolescent violence, so they will send us directly those referrals.

MS DAVIDSON: So the police have to be involved effectively before you get - - -

MR BRANDENBURG: At this point in time, yes.

MS DAVIDSON: Those are my questions for Mr Brandenburg. Does the Commission have any additional questions?

DEPUTY COMMISSIONER NICHOLSON: Just one. The three programs you operate give you some scale.

MR BRANDENBURG: They do.

DEPUTY COMMISSIONER NICHOLSON: I'm just wondering whether how much your ability to have skilled practitioners and provide a quality service is dependent upon having a certain scale.

MR BRANDENBURG: It's always difficult to get staff in regional areas. So that's not a new scenario. I think we have been really lucky in our organisation that we have held staff. Men's behaviour change work is really complex and draining work. I have workers who have certainly been doing group work for 10 years, and they are certainly feeling the strain of working with a group of men every week.

It's part of the challenge, and I think part of this sector moving forward in the family violence area is very clearly about how we train good staff and then how we keep those good staff and what supervision and support

models we have in place.

DEPUTY COMMISSIONER NICHOLSON: I'm assuming, because you have some scale, you have an ability to offer a continuity of work to skilled practitioners. So if you only had one of those streams would it still be as viable as it currently is?

MR BRANDENBURG: I suppose because of the scale we have we employ a lot more people than probably some of the other programs that are in other regions, particularly in Melbourne. So workers have always got work. I know a lot of programs in Melbourne use casuals or sessionals who float around. But I have never struggled for staff, touch wood, and I hope I don't in the future.

MS DAVIDSON: Thank you, Mr Brandenburg. Can the witness be excused?

COMMISSIONER NEAVE: Thank you very much, Mr Brandenburg.

<(THE WITNESS WITHDREW)

MS DAVIDSON: The next witness is John Byrne.

<JOHN BYRNE, affirmed and examined:

MS DAVIDSON: Thank you, Mr Byrne. Have you made a statement in this Royal Commission?

MR BYRNE: Yes.

MS DAVIDSON: Are you able to confirm that the contents of that statement, which you made together with Alan Brown, are true and correct?

MR BYRNE: It's true and correct.

MS DAVIDSON: I understand that Mr Brown isn't able to be here today but that you are in a position to talk to most of the issues that he could have talked to?

MR BYRNE: I would certainly like to make it clear that I'm speaking on behalf of Dardi Munwurro, which is the program

that I work with and the organisation that I work with. I do work with the Victorian Aboriginal Health Service as well. I would actually probably not like to speak on their behalf. But I can include in the conversation some of the work that we do together because we have a partnership with the Victorian Aboriginal Health Service with Dardi Munwurro.

MS DAVIDSON: You have operated a consultancy business called Men's Evolvement Network since 1990?

MR BYRNE: Correct.

MS DAVIDSON: It provides counselling, personal development programs, and health and wellbeing workshops for men. You have facilitated programs with Aboriginal men through Dardi Munwurro?

MR BYRNE: Yes.

MS DAVIDSON: And Dardi Munwurro means?

MR BYRNE: It means "strong spirit" in Gunai language from Gippsland.

MS DAVIDSON: The program was originally established in 2000 by Alan Thorpe; is that right?

MR BYRNE: That's correct. Alan does send his apologies. He's actually quite tied up in some of the programs at the moment.

MS DAVIDSON: It is principally yourself and Alan Thorpe that deliver these programs for Aboriginal men throughout Victoria?

MR BYRNE: Pretty much, including elders from the communities as well, from the communities that we work in.

MS DAVIDSON: One of the points that you make in your statement is that you don't call it a men's behaviour change program.

MR BYRNE: We tend to call it a healing program. One of the reasons we do that is because we see that the violence is absolutely a part of why the man is there, but also there are other issues going on in the man's life. So we include other issues as well, and those might be things like drug and alcohol or family relationship issues, separation, parenting.

MS DAVIDSON: Some of these programs are run in conjunction with the Victorian Aboriginal Health Service, which is an Aboriginal community controlled health organisation; is that right?

MR BYRNE: Correct.

MS DAVIDSON: You have spoken in your statement that VAHS, as it is known, is actually able to provide a number of other services that can run alongside or together with the Dardi Munwurro healing program; is that right?

MR BYRNE: That's true, and also VAHS provide the case management for some of the men. Not all of the men that we see come through the Victorian Aboriginal Health Service, but some of the men who come through are actually also case managed by the Victorian Aboriginal Health Service.

MS DAVIDSON: If an Aboriginal man walks through the door of VAHS how does he end up being in your program?

MR BYRNE: If he walks through the doors in VAHS he would see the intake worker and then he would have an assessment, what we call first contact. That would give certain information, depending on where the man has come from. It could be he's self-referred, it could be court, it could be Corrections or it could be a community corrections order, basically comes through the system.

MS DAVIDSON: What happens if they have a number of needs like drug and alcohol or mental health issues or any of the other sort of needs that might be related to their offending?

MR BYRNE: Within the Victorian Aboriginal Health Service, or VAHS, they have drug and alcohol workers. So there's a couple of different sites where VAHS work from. One of the sites is in Preston. It's 238-250 Plenty Road, Preston. So in that particular office there's family counselling, there's drug and alcohol workers, there's housing, we have a psychiatrist, psychologist, a medical doctor, we have Koori Kids and there's a youth justice program as well.

MS DAVIDSON: How often would it be that the men who are engaged in the healing program that you run would also be engaged in other services?

MR BYRNE: It's pretty common. There's a lot of connection between - because also the Victorian Aboriginal Health Service, or VAHS, is a bit of a hub as well. So it's like a place people can go to, even though it's a healing - I suppose it's a service, but it's also a community place for people to drop in to.

MS DAVIDSON: Your programs operate differently to the mainstream men's behaviour change programs.

MR BYRNE: I just wanted to also clarify that. I'm not a qualified practitioner in the No to Violence model. I'm not an expert in that. It obviously is a little bit different already in that sense. But Alan Thorpe is a practitioner and is qualified to run the No to Violence behaviour change program. He's actually completed that. I haven't myself.

MS DAVIDSON: But the program you and Alan run is different from the men's behaviour change program?

MR BYRNE: That's what I believe, yes.

MS DAVIDSON: The first thing you do, I understand, is have a camp, a three-day camp?

MR BYRNE: Yes, we actually have one coming up pretty soon. We have something like that, like a flyer like that. We've advertised a program. The next one is in August. That will be held in Gippsland, in a place called Paynesville, just outside of Bairnsdale. We will have 15 to 20 men. It's three days. So we leave early Monday morning and we come back Wednesday evening, and it's residential. We see that as part of the program. The reason we do that is part of it is about cohesion and building community, and also it's a time for concentrated time with the men, and each man in that gets some individual time to look at his journey as part of why he's at the program.

MS DAVIDSON: During those three days there would be a combination of sometimes individual work and sometimes group work?

MR BYRNE: It's mostly group work, but we do individual work as well. But it is, I have to say, mostly group work.

MS DAVIDSON: Who else accompanies you for those camps?

MR BYRNE: Usually it's myself and Alan and an elder from the community and also maybe a cultural man as well, if we have a man who teaches culture, will be present as well.

MS DAVIDSON: So what does the group work at the camp involve?

MR BYRNE: It's difficult to describe, but it's really about - if I just describe sort of a session, you might say. We do what we would call a normal circle check-in. We identify some of the issues that men are there for. We

might already have some of that information as part of the intake, otherwise we have to do a bit of exploration, find out what the main issues are. As I said, some men come voluntarily, some men are sent by the courts, some men are community corrections because they are doing community hours as well and part of the order might be that they have to do a behaviour change or part of this program.

So men will talk about the issues, we will identify some of the difficulties that they are struggling with. We look to see what are the strengths and weaknesses of where they are at in their journey and look to see how we can support them to take a step forward. Of course the camp is really just the beginning of the journey because when we come back we then continue to groups ongoingly.

MS DAVIDSON: How important is the camp part of the program?

MR BYRNE: For some people it's really important. Part of it is also some of the identity stuff, because we are dealing with some issues that may not always be obvious but for some of the men some of them are part of the Stolen Gen, and so there are some identity issues around culture, about who they are as a man, as an Aboriginal man. So part of that reason why we have the elder and we have maybe a culture man there is to sort of help support that part of the man.

I just want to say also that at times we do have non-Indigenous men in the group because some of those men are married to Indigenous women. So we do actually support them as well, because if they are seen as part of the Aboriginal community we will support them.

MS DAVIDSON: You talk about the foundation of your work being

community and culture. Why do you see that as being important for Aboriginal men?

MR BYRNE: It seems that a lot of the men - it seems like roles and responsibilities seem to be a bit - what's the right word - I'm struggling with the words here, but I suppose we are trying to strengthen the man's identity around what it is to be a man, and for some of those men some of the role models, particularly the ones who have got themselves in trouble, whether it is through family violence or other issues, there's a lot of institutional you could say behaviour almost. People will tell you what you want to hear. So some of these men have been in and out of institutions from a very young age, maybe 10, 12 years of age, 14 years of age. I'm not saying all men, but a fair percentage of these men have been around in different forms and institutions.

So what we are trying to demonstrate and reinforce is that the relationships are really important and how do you act in a relationship, how are you going to be in a relationship, how do you be respectful in a relationship.

MS DAVIDSON: After the three-day camp you then have group sessions. You say you offer either eight week or 20-week programs.

MR BYRNE: Yes.

MS DAVIDSON: You have group held once a week?

MR BYRNE: Once a fortnight. The group is ongoing. So men can actually come in - what was stated earlier on, men can come and join the group. I think we have sort of modelled it in a way, you might say, on a No to Violence in terms of hours. I think the hours are approximately about

50 hours, I'm not sure about that, but I believe it's something like that. So we tried to use that amount of hours as part of the - that's, you might say, the expectation that we have that the men participate in. A lot of men will continue on after the amount of sessions that's requested of them, that they will continue.

MS DAVIDSON: How good is the engagement rate of men? Do you get many dropping out?

MR BYRNE: Occasionally, but not much. Most of the men continue on. We do have men who for different reasons will drop out, yes, for sure. I guess it depends on how stable a man is. If he is travelling - because we deal with men from all around the state. So we have men from Mildura, from Gippsland. So they might be in Melbourne for a period of time and then go back to their hometown.

MS DAVIDSON: What's available at the end of the program? Is there an ongoing support group? What sort of support continues beyond the program?

MR BYRNE: Beyond our program there are other men's support groups which are a bit different, we call yarning circles, and they are available on a weekly basis, or there's a fortnightly yarning circle and there is an art program as well where the men can come and do maybe some pottery or some painting or woodwork. Most of that is done in Thornbury. That's only the Melbourne program. We have other programs in different parts as well, like in Mildura.

MS DAVIDSON: You have identified two opportunities you think for improvement of the program that you run. One is to have a partner contact by an Aboriginal woman.

MR BYRNE: Yes.

MS DAVIDSON: Can you identify what partner contact facilities are funded at the moment?

MR BYRNE: For our organisation, for Dardi Munwurro and for the Victorian Aboriginal Health Service, we have no Aboriginal woman partner contact. There is a partner contact with Berry Street, which we really don't have a lot of contact with. I think VACCA may have a family violence - which is the Victorian child-care, they may have a worker there in their organisation as well. But for our organisation what we do, we don't have one and we would really like to have one.

Also I just wanted to say something about the numbers of men that we work with, just to go back to the men. We probably work with three times the amount of men that we are actually funded for. So we are funded for a certain number of men each year, and we probably work with three times the number, three times that number. So that's the sort of resource that we are working with.

MS DAVIDSON: The other issue you have identified is emergency accommodation for men.

MR BYRNE: Yes.

MS DAVIDSON: I think you have identified that some of the men that you are working with end up living in the big house while the women and children are out in a refuge.

MR BYRNE: Yes.

MS DAVIDSON: Do you see that there are more opportunities for women and children to remain at home?

MR BYRNE: Absolutely. I think that is probably one of the essential parts of the equation, is that women shouldn't have to move out, the children shouldn't have to move out or leave school or whatever. The accommodation, it's

really dire, in Melbourne, short-term accommodation, particularly for men. There's some rooming houses. But, you know what, there are just absolutely abysmal some of those rooming houses that men get put into. They are just horrible, drug-infested places. It's not the sort of place that I actually really want to send men to.

MS DAVIDSON: I have no more questions for Mr Byrne. Do the Commissioners have any questions?

COMMISSIONER NEAVE: No, thank you.

MS DAVIDSON: Thank you. Can the witness be excused?

COMMISSIONER NEAVE: Thank you very much, Mr Byrne.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: The next two witnesses are being called together, Mr Reaper and Ms De Cicco. If they could come forward, please.

<ANDREW ARTHUR REAPER, sworn and examined:

<MARISA DE CICCO, affirmed and examined:

MR MOSHINSKY: Mr Reaper, if I could start with you. You hold the position of Deputy Commissioner of Offender Management within Corrections Victoria?

MR REAPER: That's correct.

MR MOSHINSKY: Have you prepared a statement for the Royal Commission?

MR REAPER: That's also correct.

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

MR REAPER: Indeed. They are.

MR MOSHINSKY: Ms De Cicco, you hold the position of Deputy Secretary in the Department of Justice and Regulation?

MS DE CICCO: That's correct.

MR MOSHINSKY: You, too, have prepared a statement for the

Royal Commission?

MS DE CICCO: That's correct.

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

MS DE CICCO: They are.

MR MOSHINSKY: I just want to start at a high level to identify the different situations in which men may participate in men's behavioural change programs. Perhaps if I could go to your statement, Ms De Cicco. In paragraphs 9 to 12 you refer to three different situations. The first is voluntary programs to which a man may be referred. The second is programs within a corrections setting, so that could be either in prison or on a community corrections order.

MS DE CICCO: That's correct.

MR MOSHINSKY: And the third is where a relevant court, being one of the four Magistrates' Court sites, makes a counselling order in connection usually with an intervention order.

MS DE CICCO: That's correct.

MR MOSHINSKY: If we can just identify the funding streams for each of the three scenarios. With the first scenario, the voluntary programs, as I understand it from your statement, Ms De Cicco, the funding stream is the Department of Health and Human Services?

MS DE CICCO: That's correct.

MR MOSHINSKY: Then in the second scenario, corrections, the funding stream is the corrections part of the Department of Justice and Regulations?

MS DE CICCO: That's correct.

MR MOSHINSKY: And the third scenario is the counselling order

made by one of the relevant Magistrates' Courts?

MS DE CICCO: Yes.

MR MOSHINSKY: What's the funding stream for that?

MS DE CICCO: That's in the Magistrates' Court of Victoria budget. So that funding is provided by the Magistrates' Court.

MR MOSHINSKY: Mr Reaper, did you want to add anything to that summary?

MR REAPER: Just as a point of clarity. In regards to the individuals on a community corrections order, some of those men's behaviour change programs have historically been funded by Corrections Victoria directly, but also those individuals can access some of the programs that are already offered in the community generally funded under the Department of Health and Human Services; albeit my statement obviously talks to the proposed funding model for community correction orders going forward.

MR MOSHINSKY: So, going forward, someone who is on a community corrections order who attends a program will be funded through which stream?

MR REAPER: As of this week, indeed, we have released a public tender that will allow Corrections to contract directly the delivery of men's behaviour change programs for offenders both in the community and for the first time we are intending to offer those programs in prison. That tender was only released as of Wednesday this week. So that will certainly acquit our responsibilities of those individuals who are court ordered via the community corrections order to meet the needs of that program.

DEPUTY COMMISSIONER FAULKNER: Can I just clarify. Up until this point they have been largely met by DHHS?

MR REAPER: To be fair, they have either been met by DHHS or since 2011/12 Corrections has funded programs: 16 in 2011/12; eight plus individual places in '12/13; and on a more ad hoc basis since; and then they have accessed the DHHS funded or indeed they haven't been able to access those programs.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MR MOSHINSKY: Mr Reaper, can I now just take up with you the topic of what data is available to Corrections Victoria about family violence offending or a history of family violence for offenders who come through the corrections system. If someone is given a custodial sentence, for example, to what extent does Corrections know whether the offence itself involved family violence?

MR REAPER: There are three ways that Corrections tries to identify if the offender is a family violence perpetrator. The first is self-disclosure from the offender, and I can certainly talk about some of the issues with that. There are other external sources, being obviously police summaries or, if they are coming from the higher courts, the judge's sentencing remarks. Then obviously the final part of that is the offender's criminal history. If they have directly had a breach of an intervention order and subsequently received a criminal component or sentence, then we will be able to identify via those three means.

MR MOSHINSKY: When you started your answer you said "the three ways Corrections tries to identify". Is there actually a policy or a practice for Corrections to try to find out if there is family violence involved in the offence?

MR REAPER: Certainly the practice is those three means as I have described, the three avenues that we can identify

if they are a family violence perpetrator.

MR MOSHINSKY: But do you set out to look for it, for example, by looking at sentencing remarks or police summaries?

MR REAPER: We look at police summaries and sentencing remarks for all offenders, and obviously that gives us the capacity to identify if they are family violence offenders. That assists more generally with all of our offender types: general offenders, violent offenders, sexual offenders and now family violence offenders. That's common practice for how we go about assessing an individual offender who comes into our custody or onto a community corrections order. So that's also the means that we try to identify if they are a family violence perpetrator.

MR MOSHINSKY: Is there some sort of flagging process where if you do see it that is sort of marked that there is family violence?

MR REAPER: As my statement goes to, if we identify that they are a family violence perpetrator that will have direct implications for the pathway that they will go down in regards to intervention. Obviously that material and that information is also vitally important as we prepare for the individual if they are in a custodial environment as we prepare for them to return to the community. So either on parole or on straight release that information is again vital to us.

COMMISSIONER NEAVE: Can I just follow up on that. If you have a community corrections order there will normally be some conditions attached to it, and I understand that process. If it is just a straightforward sentencing matter there is normally a prisoner's return which accompanies a prisoner.

That, as far as I know, does not identify whether it's a family violence matter. I haven't seen one that has. So, what, there's a standard procedure for collecting sentencing remarks in all cases where prisoners are sentenced; is that how it works?

MR REAPER: There's been some inconsistent ways in which we have gone about getting sentencing remarks over the last few years. We have now just worked very closely, particularly with the County Court at this stage, to have a much more streamlined consolidated process. We used to seek it in Corrections through many different areas. It might be community corrections; it might be our offending treaters; it might be those who are looking at a sentence placement, and certainly they used to be sent to the Adult Parole Board directly. In order to assist the court we have identified a much more streamlined process so they send it to Corrections once, we hold it in a central repository and then all of those areas that need that information can access it at the point in time - - -

COMMISSIONER NEAVE: So what happens in the registry of the court now requires those sentencing remarks. I'm now thinking of County, because if it was in the Magistrates' Court you mightn't have a great deal. But what you are saying is there is some procedure that's been adopted by the courts where that's actually forwarded to Corrections, the actual sentencing remarks?

MR REAPER: That's correct. We are finalising that procedure direct with the court to ensure that we have a much more streamlined approach.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Will there, nevertheless, often be cases where

the information available to Corrections Victoria doesn't disclose whether or not the offence involved family violence?

MR REAPER: Those three measures that I talked about are no guarantee that in every instance we will have the family violence perpetrator identified to us.

MR MOSHINSKY: Would that be often the case if the matter has been in the Magistrates' Court; there just isn't enough data available to Corrections?

MR REAPER: I would separate those out. So when a community corrections order is being considered where our people are in court and obviously part of the assessment process for the consideration of community corrections order and through that process might be able to or are in a better place to glean whether there are family violence issues for that offender. That's obviously not the case when they are sentenced to a period of imprisonment. So there's more of a risk there. Having said that, the self-disclosure and the risk assessment process that can be enacted once they come into prison gives us a better opportunity to identify it via that means.

MR MOSHINSKY: Do you have a sense, though, of what catchment you are getting in terms of picking up when there is a family violence offence versus situations where it might be an assault or a serious assault but you just don't know that that involved a family member?

MR REAPER: I'm not quite sure I can answer that. We don't know what we don't know is probably how I would answer it.

MR MOSHINSKY: What about a history of family violence; so not necessarily an offence itself upon a family member but the offender themselves being affected by family violence

perhaps in childhood? Is that something that gets picked up by Corrections?

MR REAPER: Their involvement as a child where they may have been a victim?

MR MOSHINSKY: Yes, for example.

MR REAPER: It would be likely that would be picked up via the clinical assessment process if they are streamed into that offence specific pathway. It is obviously reliant again on self-disclosure, but that clinical assessment process will certainly look at the offender's childhood and upbringing.

MR MOSHINSKY: What about other cases of incidents involving family violence? For example, a person is convicted of one offence but they may have had an intervention order against them a year or two earlier. Do you have that information available to you?

MR REAPER: So generally in regards to intervention orders we look for that information towards the end of a person's period of custody, so when we are preparing that individual for parole and potentially provided a parole assessment report to the Adult Parole Board. At this stage it's not an automated system. We don't have an IT system that allows for it to happen, that exchange of information between us and Victoria Police and/or the courts automatically. So that won't be in place until mid-2016. So it's currently operating under a manual system where our intelligence officers who are embedded within Victoria Police are able to do that check. Obviously with the volume of prisoners that we have that's not done for every individual. So we are looking at it particularly as part of a parole assessment, and even then

we focus on particular cohorts of offenders, being those that are most likely to cause the most significant harm to the community, being serious violent offenders or sex offenders, then we will manually check if there has ever been a history of an intervention order.

MR MOSHINSKY: But that's towards the end of their sentence, not when they come in?

MR REAPER: That's at the end of the sentence for people within prison. If we talk about people being subject to a community corrections order, we will enact that process if we are intending to recommend a restrictive condition as part of the community corrections order where we may put a condition on about where that individual can live, whether they are going to be subject to a curfew, electronic monitoring et cetera. So it's at that point.

MR MOSHINSKY: Can I ask you a double-barrelled question. Would it be desirable in your view for Corrections to know more about whether there is family violence involved at the outset and, if so, what are your suggestions for how that could happen?

MR REAPER: I will try and answer both barrels. If I start with the first one. My statement refers very much to the pathway that we are building for intervention and treatment of family violence perpetrators. Similarly, we have the same models in place for either sex offenders, violent offenders or general offenders. It's rare, in my experience, that offenders stay within one of those streams. They are quite often a general offender, a violent offender, a family violence perpetrator. Our clinical assessment process does place us in a solid position to identify the best treatment pathway for those

individuals that cross multiple streams of offending.

That being said, obviously the more information we have immediately upon someone's reception into our custody or onto a community corrections order the quicker we can enact our assessment process and stream them into the right model. I suppose I would answer it by saying any way that assists us in that identification would clearly be beneficial.

MR MOSHINSKY: Do you have any suggestions about how the system could be improved to pick up more cases than currently happens?

MR REAPER: I will be very blunt and say I have not turned my mind to that at all, no. I don't have any suggestions.

COMMISSIONER NEAVE: If we were dealing with people who are convicted in the County Court, could you not have a simple tick box on the prisoner return which indicated whether it was a family violence related offence? Could it be done in that way?

MR REAPER: If it came on any of the sentencing documentation that would of course be a simple way of us knowing.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Can I turn to the prison setting first and then come to community corrections orders afterwards. In the prison setting, just at a high level, what are the different programs that exist which are directed to family violence offenders?

MR REAPER: If the Commissioners allow, I think I would prefer to talk to the proposed model rather than the historic model we have had in place. As I have already stated, for the first time, subject to the outcomes of the tender process, we are intending to offer men's behaviour change

programs in a prison environment, both for sentenced prisoners and also for remanded prisoners.

Subject to the outcome of that tender process, we are hopeful that those will commence as early as October this year. They will certainly be targeted at low-risk offenders. As my statement says, in regards to the RNR process that Professor Ogloff and others talked to earlier today, certainly the psycho-educational basis of those programs in our view is suitable to low-risk offenders.

What we have also recently developed is a new cognitive behavioural therapy based program called Change About. That will certainly be targeted at moderate and high-risk family violence offenders. As my statement acknowledges, that program will be 88 hours in duration as a minimum. But we have with all of our clinical programs what I would call a treatment readiness component, sometimes known as exploring change, where we prepare the individual for participation in that full clinical program. Then there's also a maintaining change component that will come subsequent to them having completed that program. So, all up, the program could be closer to 125 hours in duration.

We will intend to offer that program early in the sentence. Our entire offending pathway now for violent offenders, general offenders and also family violence perpetrators is to offer those programs at the front end of a person's term of imprisonment. The only exception to that is we will continue to offer our sex offending specific programs towards the rear end of an individual's sentence. As my statement identifies and as Professor Ogloff and Professor Day spoke to this morning, it's based

on the RNR principles, CBT, offence specific as distinct to the psycho-educational.

That program will certainly be offered in prison. It's also available for community corrections, and indeed we recently have commenced our first one of those programs in a community correctional setting.

MR MOSHINSKY: I will come back to Change About in a moment. You said there's two programs. There's a more traditional men's behaviour change program for the lower risk offenders and then there's the Change About program for the moderate and high risk.

MR REAPER: That's right.

MR MOSHINSKY: So with the first group, the men's behaviour change program, is that also at the front end of a sentence?

MR REAPER: That will be the intention, is to offer it as early as possible and, as I have stated, even for those subject to a period of remand.

MR MOSHINSKY: What period of time will that run over?

MR REAPER: Well, it's currently subject to a tender. So we will be reliant on those existing providers to come back to us and identify the duration of that program. I think there's been some evidence led today about their particular views of whether their current programs of the 12 to 18 sessions are enough or whether they should be longer. So I ultimately will wait and see the outcome of that tender and then choose those providers that obviously will best fit our cohort.

MR MOSHINSKY: Let's say it's a 12-week program. Does that mean that someone who has a sentence which is less than 12 weeks won't be able to participate in the program?

MR REAPER: Not necessarily. I will be participating in a full industry briefing with all the providers next week, but obviously with this being a public hearing I'm happy to talk about it. We will be looking at a flexible model. We will be hoping that our providers can run those programs potentially over a much shorter weekly duration with more sessions being offered throughout that week. Obviously a prison environment does offer some opportunities. The prisoners have the time and capacity to attend much more sessions over a week than potentially people in a community based settings where they have other obligations. So a very flexible model where we could offer those programs in a very short space of time is what we will be looking for.

MR MOSHINSKY: With the Change About program, which you have indicated is 88 hours or possibly more, do you know what period of time that runs over?

MR REAPER: It's likely to run in sessions of approximately two and a half hours in duration. With it being an offence specific clinical program we will much likely offer it in one to two sessions on a weekly basis. The literature and research would suggest to do that sort of offence specific intervention on a more intensive rate presents some challenges to the participant. They need to be able to prepare, participate and then process the information and then return and build on those learnings for the next session. Obviously we also need to consider these are group based intensive sessions and we need to consider our very skilled, capable clinicians right across the state and be mindful of their burnout factor as well. So the duration of the 88-hour program will be much longer.

MR MOSHINSKY: It might be five to six months, based on those figures?

MR REAPER: Potentially, yes.

MR MOSHINSKY: The other thing I wanted to ask you was about the Change About program, which looks quite different to what you have done previously. Can you just very briefly give us a bit of an idea of how that came about?

MR REAPER: Yes. Historically, as a more intensive program targeted at moderate and high-risk offenders of family violence, we had offered a program called the Domestic Abuse program. Its duration was about 40 hours in length. It was almost entirely, if not entirely, focused on intimate partner abuse.

On reflection and in work with my team in head office and across the state, we were keen to develop a program that offered a more broad range of interventions for all of those areas of family violence perpetration. We engaged an expert to assist in the development of that program, a gentleman by the name of Ken McMaster.

Corrections Victoria also has an independent accreditation assessment panel where we take all of our clinical programs to and ensure that their efficacy and effectiveness meet international standards. So that occurred with the Change About program. They recommended some changes. It's been provisionally accredited and we are now off and running it.

It is a much more holistic program. It certainly has all of the offence specific areas, the offence mapping. It also has now built in a component that looks at the impact of alcohol and drug use and abuse in regards to family violence offending. So we are very hopeful that

it becomes a very viable treatment program for us.

We also more broadly for our entire offending behaviour program suite have developed an evaluation model in conjunction with the Australian Institute of Criminology. That will certainly kick off early next year as a process evaluation about how we have gone about the creation, development and introduction of that program, and then by 2018/19 hopefully be able to start to provide us some evaluation outcomes in terms of the effectiveness of that program both for participants but also in regards to their recidivisms.

MR MOSHINSKY: Would you be able to tell us about any programs that are specific for Aboriginal men who have family violence offences?

MR REAPER: We certainly offer the Dardi Munwurro program in both prisons and community corrections. As I recall, I think we currently have five of those programs under way and two more scheduled for the remainder of this year with the potential to contract more in. Of course Aboriginal prisoners can participate in any of our offence specific programs. Change About is the one that I have talked to for family violence. We also have a violence intensive program for more general violence perpetration that can also include family violence, and Aboriginal prisoners and offenders can participate in those.

It's rare that we have ever run a program specific to Aboriginal prisoners, just in terms of the number of people who have been assessed and ready to run that program at any one time. As a result, over a number of years we have developed our cultural guidelines and cultural wraparound model where we have been able to train

and support our clinicians to offer culturally appropriate and specific support to the Aboriginal prisoners through those more clinical based programs. So that's also been trialled in recent times. It has proven to be very successful. It can include very simple things like ensuring that all the examples and case studies are culturally appropriate and specific to Aboriginal people. So that's how we have endeavoured to support our Aboriginal cohort of prisoners.

MR MOSHINSKY: With offenders generally and programs for them, and bearing in mind there may be offenders who in fact have committed a family violence offence that you are not aware of, is there any family violence component in programs that are made available generally to offenders?

MR REAPER: Certainly our violence program has a component in it called interpersonal relationships which really, while not specific to family violence, deals with interaction with your family, others. So all of those offenders - and, let's be clear, a number of these offenders are both perpetrators of family violence but violence more broadly, and through the clinical assessment process could be identified to have a preferential treatment of more general violence. But that does allow for a component that does deal specifically with family violence.

MR MOSHINSKY: Turning to the community corrections order setting, what are the different program options that are available in relation to family violence?

MR REAPER: They are not different. For our community corrections setting we offer both men's behaviour change and also the Change About program for family violence perpetrators subject to a community corrections order,

again based on the RNR principle of their level of risk.

DEPUTY COMMISSIONER FAULKNER: Mr Moshinsky, can I just clarify. For both the Change About program and the men's behaviour change program they are totally funded from in the Corrections portfolio, is that right; into the future I'm talking about? Is that the intention?

MR REAPER: That's absolutely the intention, that we will be able to meet the court's requirements in regards to community corrections order for men's behaviour change. The only exception to that will be if there's an offender who is ordered to participate in a men's behaviour change on a community corrections order that's in a more remote part of rural Victoria and we only have one or potentially two, and an existing program can accommodate them within their program and we may fund that individual places or indeed there may be capacity. But, in general, we are intending to have a panel of providers who can meet the needs for Corrections Victoria and fund it ourselves.

DEPUTY COMMISSIONER FAULKNER: Does that apply to any other service that might be needed by someone on a corrections order and that might have family violence and drugs, for example, that the drug treatment would also be provided if that was mandated? Would that be provided within Corrections or would that be still in the community sector?

MR REAPER: That's within the community sector at this point in time. Obviously we are reviewing a number of components of the community corrections order. There's significant demand pressures on that sector right at the moment and a significant growth of people being placed on community corrections orders. But currently they will be subject to

the community sector funding.

DEPUTY COMMISSIONER FAULKNER: Is the policy objective to try and make you self-contained in delivering these services? What's been the drive to do this?

MR REAPER: In regards to the men's behaviour change there is just significant and regular feedback from the court that we are not ensuring that offenders have access to those programs when they are court ordered. It appeared that there was a significant waitlist being created for people on community corrections orders. We received funding in the last budget from the government to meet some of those demands. So that and the development of our new model and introduction of men's behaviour change into the prisons environment gave us an opportunity to redress that issue.

DEPUTY COMMISSIONER FAULKNER: You have used the words "clinical services" quite often. What's the position currently? Who supervises corrections or health in Victoria? Is it Corrections? In the past it's been the Department of Health. Where does it sit at the moment? Who is responsible for making sure that adequate clinical service is provided within the prison system?

MR REAPER: When I'm talking about those clinicians, they are employed by Corrections Victoria. There are about 90 FTE across the state operating both in prisons and community corrections. So they are employed by us. They obviously receive their clinical supervision external to us, but they are Corrections Victoria staff.

MR MOSHINSKY: Could I turn to you, Ms De Cicco, and just ask briefly a couple of questions about the court ordered men's behavioural change programs. In the situations where the Magistrates' Court makes a counselling order, so

someone is mandated to attend a men's behaviour change program, do you know what the waitlists are like in practice for attending those programs?

MS DE CICCO: I haven't got the detail of the waitlist. The court will have those. But certainly I understand that the waitlists differ between each of the four courts that are able to mandate the program. So we can provide that information with the courts if the Commission desires.

MR MOSHINSKY: If a court makes a counselling order does the person go into a dedicated program or is it just one of the programs that are already out there?

MS DE CICCO: The court itself - when the two first instance family violence divisions were created, the Ballarat and Heidelberg programs, they were dedicated programs. So funding was provided specifically to the court so that that priority could be provided to those particular programs, and similarly with the Frankston and Moorabbin courts were made relevant courts for the purposes of the program and then they too received additional funding. So the object was to try and prioritise the mandated program so that those individuals would have a shorter wait time.

MR MOSHINSKY: I think both of you have been in the hearing room for most of the day. Are there any matters that have been covered by other witnesses that you wanted to respond to?

MR REAPER: Not from me, no.

MS DE CICCO: No.

MR MOSHINSKY: Those are the questions I have, Commissioners. Do you have any questions for the witnesses?

DEPUTY COMMISSIONER FAULKNER: I was just wondering if this is the only time we see Ms De Cicco - - -

MR MOSHINSKY: No, Commissioner, Ms De Cicco will be coming back a couple of other days.

DEPUTY COMMISSIONER FAULKNER: I want to signal I have some interest in the issues that were raised on the day on financial abuse in relation to the infringement system. So I don't expect you to answer them today, but if that were possible that be would very good.

MR MOSHINSKY: We will take that up and address that in another way.

DEPUTY COMMISSIONER FAULKNER: You will recall there were issues relating to that that were raised by a previous witness. So I don't need it today.

COMMISSIONER NEAVE: I do have a question. Given the differences of view about what is the most effective way of changing behaviour or preventing recidivism or however you define the purpose, what process has Corrections adopted to get good clinical advice about these issues? Do you have a panel of people that you sit down with and discuss and make a judgment call about what sort of a service should be provided? How is that actually done?

MR REAPER: I think I can answer that. I referred earlier to the independent accreditation panel. When I say "independent", it's made up of both independent people but also some of our most senior clinicians. That certainly gives a level of oversight to the development of particular programs and ensures that they are structured in an effective and efficient way. So that's one component.

We regularly engage independent experts, such as Professor Ogloff, such as Professor Michael Davis, to offer us expert advice. That is in regards to both

program models but also best forms of assessment. So I think my statement refers to the assessment process that we have tried to build for the identification of family violence perpetration, and Professor Ogloff has certainly been involved in training our staff and giving advice on the use of the SARA, the spousal assault risk assessment, as well as both the HER and VRS.

We also employ very capable clinicians as part of my team who are charged with the responsibility of doing research, looking at world's best practice, proposing models that then go through a governance process at Corrections Victoria with the executive to ensure that each is seen as a viable option and one we can afford. Generally that also includes independent clinical advice such as that I have referred to.

COMMISSIONER NEAVE: If I may say so, that seems a sensible model and I wonder whether you are aware whether there's a similar process adopted in DHHS. You may not be, but I was interested in how you actually select the services you fund, and you have answered that question. But I wonder if that's the approach that's adopted across government in terms of getting expert advice on what works and what doesn't, and enabling the cost benefit analysis, because I presume that's also what you have to do. You have to look at the cost of what you are buying and the likely benefits to flow from it.

MR REAPER: Yes, that's absolutely correct, Commissioner. The final part that Corrections has now built is the evaluation framework in conjunction with the Australian Institute of Criminology to ensure that what we are delivering and buying is effective. I'm not able to

comment; I'm not aware of the model that's in place at other departments.

COMMISSIONER NEAVE: Thank you. We will pursue that.

MR MOSHINSKY: Commissioners, if there's no further questions, if the witnesses could please be excused.

COMMISSIONER NEAVE: Thank you very much indeed.

<(THE WITNESSES WITHDREW)

MR MOSHINSKY: Commissioners, that concludes the evidence for today, a little early but it's been a long week.

COMMISSIONER NEAVE: It has. Thank you very much, Mr Moshinsky and Ms Davidson. 9.30 on not this Monday but the following.

ADJOURNED UNTIL MONDAY, 3 AUGUST 2015 AT 9.30 AM