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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

TUESDAY, 11 AUGUST 2015

(17th day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

COMMISSIONER NEAVE: As I have said on a number of previous occasions, the functions of the Royal Commission can be performed by one or more Commissioners separately. Today we are sitting two Commissioners, as Patricia Faulkner cannot be present. Mr Nicholson has something to say as well.

DEPUTY COMMISSIONER NICHOLSON: Yes. Before we commence I wish to state that I am Executive Director at the Brotherhood of St Laurence. This morning we have Gabriel Aleksandrs giving evidence. He is a social worker and employee with the Brotherhood of St Laurence. In that capacity he has no direct reporting relationship with me. I don't believe that my role of Executive Director at the Brotherhood is in conflict with my role as Commissioner this morning.

COMMISSIONER NEAVE: Thank you, Ms Davidson.

MS DAVIDSON: Thank you. Commissioners, the definition of "family violence" is broad and there is a diverse range of victims. Intimate partner violence does not just occur between heterosexual couples. While women are more likely to be victims of intimate partner violence, there are also male victims and female perpetrators. Intimate partner violence can occur within gay and lesbian relationships. There are also different experiences of family violence within different cultural groups and additional barriers to receiving help for victims.

Family violence is not limited to intimate partner violence. It includes elder abuse as well as violence by a child, including an adult child against a parent. These areas of violence have been the subject of much less research, but can clearly involve both male and female victims and male and female perpetrators. In

today's hearing we will explore the different experiences of family violence in these diverse groups, what services are available for victims and perpetrators and the barriers to accessing support and services.

We will be having five panel sessions today exploring these issues. Firstly, for LGBTIQ communities; that is, lesbian, gay, bisexual, transgender, intersex and queer communities. We will then have a panel session in relation to people with disabilities. We will then have a session in relation to older people, including those who experience what is termed elder abuse. We will have a panel session after the lunch break in relation to what are often called CALD communities, which means culturally and linguistically diverse communities. Finally, we will hear evidence in relation to men as victims of family violence.

The first session, as I say, will be LGBTIQ communities, and for convenience we will use the acronym rather than the full name on each occasion, and Mr Moshinsky will lead the evidence in that case.

COMMISSIONER NEAVE: I think you might have omitted to mention the very last witness, am I right, and our very last witness will be Superintendent Charles Allen from the Victoria Police who will be discussing some of the police responses to this.

MS DAVIDSON: To all of those issues, yes.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: The first panel comprises Dr Philomena Horsley, Anna Brown and Gabriel Aleksandrs. If they could please come forward to the witness stand.

<ANNA SHELLY BROWN, affirmed and examined:

<PHILOMENA ANNE HORSLEY, affirmed and examined:

<GABRIEL ALEKSANDRS, affirmed and examined:

MR MOSHINSKY: Could I start with you, Ms Brown. Could you please state what your current position is and give us a brief outline of your professional background?

MS BROWN: I am currently for this purpose the co-convenor of the Victorian Gay and Lesbian Rights Lobby. That's a voluntary organisation. So, my professional current role is at the Human Rights Law Centre as Director of Advocacy and Strategic Litigation and I previously worked as a commercial litigator and also in government as a lawyer and as an adviser to a minister.

MR MOSHINSKY: Thank you. Have you prepared, together with Sean Mulcahy, a witness statement for the Royal Commission?

MS BROWN: Yes, I have.

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

MS BROWN: Yes, they are.

MR MOSHINSKY: Attached to your statement is the submission made by the Victorian Gay and Lesbian Rights Lobby to the Royal Commission?

MS BROWN: Yes, that's right .

MR MOSHINSKY: Thank you. Dr Horsley, can I turn to you. Could you please outline for the Commission what your current positions are, and I note you have a number of academic posts, and also give an overview of your professional background?

DR HORSLEY: Certainly. I am a Research Fellow and a Senior Trainer at Gay and Lesbian Health Victoria and at the Australian Research Centre in Sex, Health and Society

which is part of La Trobe University. I also hold a position as an Honorary Senior Research Fellow and Sessional Lecturer at the University of Melbourne, and in that position I lecture on gender and violence, sexual violence and gender and health.

MR MOSHINSKY: Thank you. You referred to Gay and Lesbian Health Victoria. Could you just give us a brief summary of what that organisation is?

DR HORSLEY: Gay and Lesbian Health Victoria was funded by the State Department of Health around 13 years ago now. It was funded in order to do a range of things to improve the health and wellbeing of LGBTI Victorians. So we conduct research, both state and national research. We run training through a range of health and community sectors and run a number of programs such as the Safe Schools program of Victoria. So we are across a range of areas, including training, research, resource development and advocacy in terms of policy to government.

MR MOSHINSKY: Apart from the things you have already mentioned, in terms of your work over the years have you also dealt with issues relating to people with disabilities?

DR HORSLEY: Yes, since the 1980s I've held a position - I'm working specifically around the sexual rights and the sexual assault experiences of people with intellectual disabilities in Victoria when I was based at Family Planning Victoria. Since then I have maintained a long-term interest in that particular area. I'm currently a member of the duty of care committee of Scope Victoria, also the Human Rights Ethics Committee and I provide input to a number of projects, including one at Women With

Disabilities Victoria on the issues around gender and disability.

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

DR HORSLEY: I have.

MR MOSHINSKY: Attached to that statement is a submission that you provided to the Royal Commission on behalf of Gay and Lesbian Health Victoria?

DR HORSLEY: That's right, yes.

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

DR HORSLEY: Yes, they are.

MR MOSHINSKY: Thank you. Could I then turn to you, Mr Aleksandrs. Could you please outline what your current positions are and give us an overview of your professional background?

MR ALEKSANDRS: Yes, certainly. Currently I work as a social worker at the Brotherhood of St Laurence in aged care, retirement and community programs. I work specifically with people who are homeless or at risk of homelessness, many of whom have experienced family violence or are experiencing current family violence. Some of them also experience violence from carers and various other family members or families of choice.

I also work as a consultant in the area of community services and have a keen interest in the area of family violence and particularly the health and wellbeing of LGBTIQ communities, and I have been a long-term committee member of Transgender Victoria and I recently completed my final term with them, which is a transgender advocacy organisation.

MR MOSHINSKY: Thank you. You have prepared a statement for the Royal Commission?

MR ALEKSANDRS: Yes, I have.

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

MR ALEKSANDRS: Yes, they are.

MR MOSHINSKY: Attached to your statement is the submission put forward to the Royal Commission jointly by No To Violence and Safe Steps.

MR ALEKSANDRS: Yes.

MR MOSHINSKY: You were one of the co-authors of that submission?

MR ALEKSANDRS: That's correct, yes.

MR MOSHINSKY: Can you tell us a little bit about what brought about that submission coming into existence?

MR ALEKSANDRS: Sure. I suppose I have a perspective of a person who has worked in the family violence sector as well as being a member of the LGBTIQ community. When I first worked in the family violence sector I noticed there was a strong desire by services to treat everybody equally and that there was a real sort of pride, I suppose, in sort of addressing a diverse range of communities in the service provisions.

What I experienced as part of the LGBTIQ community on a personal level was very sort of different to that. So I saw a lot of people who were in my community who had experienced family violence or relationship violence and they were hesitant to actually use the services and the sort of services that I had worked at and worked with. That sort of held a curiosity for me over the years after I had ceased working in the

family violence sector and I guess I was interested to know how things had flowed over the years. It seemed to me that things hadn't really changed. I'd originally worked in the sector in 2003 and, yes, prior to approaching No To Violence with some of these issues I couldn't really see that a lot had changed that was being reflected back to me in the community. So I spoke to Safe Steps and No To Violence about those issues and we started to go from there on ideas about how to work and address those issues.

MR MOSHINSKY: The submission has two parts to it. Could you just outline what the difference is between the two parts?

MR ALEKSANDRS: Sure. So the first part of the paper is more or less an overview of some of the recent research, available research. There is not a whole lot of research, really, and I will let Philomena sort of discuss a lot of that. I just wanted to have a bit of an overview of some of the issues that have been raised so far. So, that's the part 1. Then part 2 is a consultation that we undertook, Tanya Phillips and I, just going through some of these issues with both LGBTIQ organisations, community run organisation, and also some mainstream family violence services as well.

MR MOSHINSKY: Thank you. I should just note, in terms of use of language, in my questions to the panel I will be referring to LGBTIQ people or LGBTI people, and I don't want it to be assumed that the experiences of different groups within that acronym are necessarily the same. So, even though as a matter of convenience I may express a question in that way, please feel free in the way you are answering the questions to point out differences that may

exist between different groups.

The first topic I would like to ask the panel about is what do we know about the prevalence of family violence in relation to LGBTI people. Dr Horsley, could I start with you and direct you to your submission at pages 3 to 4 and ask you to explain to the Commission what we know at the moment about prevalence of family violence among LGBTI people?

DR HORSLEY: It is important to note there is very little data available in Australia in terms of this issue, both in terms of domestic violence specifically and family violence more broadly as it affects the LGBTI populations.

We do know from our own national research that one in three LGBTI Australians have reported being in a relationship that was abusive and in our Victorian-specific study that figure was essentially the same. This pretty much accords with the limited international research that exists and that in essence seems to be saying at least this abuse or violence within intimate partner relationships specifically exists at at least the same level, if not a slightly higher level, than the heterosexual family violence sector has indicated. So we are looking at a situation where it is very similar, if not worse in terms of its prevalence.

MR MOSHINSKY: On page 3, about two-thirds of the way down, you refer to a Victorian study from 2008.

DR HORSLEY: Yes.

MR MOSHINSKY: Is that the most recent data that we really have about the position in Victoria?

DR HORSLEY: The most recent would be our Private Lives 2 study, so that was published in 2014. Because these are

broad studies, the issue around in general LGBTI population's experience of violence and then being able to drill down in terms of specifically intimate partner violence or family violence, it's fairly general and raw, but certainly those two projects and a number of others have accorded with that.

I might add that in terms of transgender people, even though they are included in our research, the numbers are not sufficient to be able to give necessarily specific data on that. But certainly international data, in particular a Scottish study that was done just a couple of years ago, certainly indicates that it is very high levels for the transgender community. Our national and state research certainly indicates that, in terms of overall experiences of violence, both transgender men and transgender women experience higher levels of violence overall in their lives than people who identify as lesbian, gay or bisexual.

MR MOSHINSKY: Further down on page 3 you refer to homicide statistics. What do we know about homicide rates in this area?

DR HORSLEY: The Australian Institute of Criminology just last year published I think the first analysis of the gender of both victim and offender in terms of domestic homicides. They indicate that in 2 per cent of cases these have involved same sex couples, but they also indicate that this would be underreporting, that in many cases the gender of both offender and victim are not necessarily identified. So they are suspecting that it would quite possibly be higher than that.

MR MOSHINSKY: Ms Brown, in your submission, and I am referring

to the page numbers across the top of the page, at pages 6 to 7 you refer to some data available about statistics. Do you wish to add anything to what Dr Horsley has said in terms of what we know about the prevalence of family violence among LGBTI communities?

MS BROWN: No, I think Philomena has really covered it quite well and I guess the main point to make is the lack of data, that we know it's the same if not worse for the various communities, but those different communities have very different needs and experiences and we need to better understand what those are.

MR MOSHINSKY: One of the points that you make, and this is further up on page 6, I think is that family violence in LGBTI communities often manifests itself in different ways. I was wondering if you might be able to speak to that briefly?

MS BROWN: Sure. Page 6. I think I might have a different page.

MR MOSHINSKY: In the third line where you say "Other examples could include" and then there is a list of examples.

MS BROWN: No, I have a different page. I think I have a different version, sorry, Mark. Okay. This is covered also in the other submissions as well, but there's obviously unique circumstances in LGBTI couples, for want of a better expression, and particularly the emotional or psychological abuse that is used includes threatening to out a partner to family or friends. That's outing as a lesbian, gay or bisexual person, outing as a trans person or as an intersex person.

They can tell a partner that they will lose custody of children as a result of being outed, using

homophobia, transphobia as a tool of control, so they will tell their partner, "You'll be unable to access a police or justice service or other support service because the system is homophobic or transphobic." We can see that partners tell the other partner that they deserve the violence or abuse because they are LGBTI. They will tell their partner they're not a real lesbian, gay or bisexual person. They might threaten to disclose HIV status and they might hide or withhold or stop a partner from taking medication or treatment such as hormones or HIV and, in the case of transgender people, as the GLHV submission covers, it can also include deliberate misgendering or withdrawing affirmation of that person's gender identity as a man, a woman or indeed a non-binary gender.

MR MOSHINSKY: Can I invite the other members of the panel to comment about different ways in which family violence may manifest itself among LGBTI people?

DR HORSLEY: I think one of the key things is it is often more difficult to recognise domestic violence and family violence from the perspective of being the victim or indeed the offender, that because the language has been extensively relating only to heterosexual couples or in fact families that are all heterosexual, there is an invisibility and exclusion over this whole issue so people don't necessarily have the vocabulary or the sense of recognition around the dynamics that occur.

So particularly for victims it's more difficult, as Anna said, to really name or recognise what's happening to them. That in a sense makes it more difficult to leave, both as Anna said because of increasing isolation or we know that particularly older LGBTI people are much

more isolated than other people of their age, they are less likely to have networks, and so having that opportunity even to seek support around friendship networks.

Because it's also such an invisible issue within the community there's a high level of shame associated with it. So in the anecdotes and the stories that we hear it's very common for friends not to be aware at all of same sex violence that is occurring, which can be a little bit different to the heterosexual community where often women's friends are aware of abuse that may be occurring, and certainly in the case of men in same sex relationships it would be almost impossible for friends to identify because it's seen so much as a woman-specific issue.

I think the other issues that come out from both our comments is the cumulative impact of violence, prejudice and discrimination throughout the lives of people who identify as LGBTI means that sometimes that absolute accumulation of violence and its impact on psychological health, for instance we know that LGBTI people have higher rates of depression and anxiety and mental illness overall, combined with the social isolation means that the experience of violence just becomes part of a spectrum of experience of violence and abuse or negative reactions within the whole life of a person. So it becomes - it's almost less distinguishable for many people and certainly leads to other issues around services which we will come to.

MR MOSHINSKY: Mr Aleksandrs, do you wish to comment on different ways family violence may manifest itself among LGBTI people?

MR ALEKSANDRS: Yes, certainly. I think the issue with trying to identify those things is trying to access more disaggregated data where we are going to individual communities and speaking with them. I think also the issues that both Philomena and Anna have touched on in terms of the research and the difficulties of gaining figures.

One thing that you could add there, apart from the overlap between hate crimes and family violence, is you are collecting data on very marginalised communities and you really need to, I suppose, consult with the communities as well first before you even go about collecting the data to see what the most appropriate ways are and most respectful ways are of collecting the information to start off with.

One example that was raised with me was through an intersex organisation most recently who were raising the issue of medical interventions on people's bodies and normalising of intersex bodies, so to speak, by the medical profession, which wasn't a consensual arrangement with intersex people. Some intersex people have experienced medical intervention like that as a form of family violence, that there has been sort of a coercion of family and doctors to normalise them.

Certainly if you are talking about family violence and people accessing a family violence service where they are already quite traumatised, then it's very important to consider those sorts of things in the way that you would be working with somebody.

MR MOSHINSKY: Can I take up a point that I think each of you makes in your submissions, which is a particular situation

which is violence perpetrated by other family members. I wonder if, perhaps starting with you, Dr Horsley, you might be able to speak to that issue?

DR HORSLEY: I think it's a really important issue and it's often hidden behind the focus on intimate partner violence. Certainly in our broad national and state research, as well as our specific research that's involved young people aged 14 to 21 in Australia over a period of 18 years, it's fairly clear that young people face a significant degree of homophobia within the family. That can include from parents and certainly around one in five young people indicated that that had occurred, and that includes significant physical assaults like broken jaws, being locked in rooms by parents and being told to kill themselves "or else we'll kill you instead". So, it's not surprising then that within that family violence context young people we know who identify as not heterosexual are overrepresented among the homeless population of young people aged 12 to 20 in Victoria.

At the other end of the spectrum, of course, we have older people who, as we know and we will hear, elder abuse is a significant issue in the community generally, but older people who identify as LGBT or I have had five or six decades of a lifelong experience of exclusion, violence, non-recognition of relationships and so on, and very often are disconnected or alienated from biological family members. Therefore, when it comes to a situation where they are older, they are more frail and they are more dependent, those opportunities for family members to exploit financially, to abuse physically and generally make life very difficult come to the fore because there is

often a residual anger among family members, whether they are adult children or whether they are siblings.

As we have all said, those issues play out quite differently whether it's young people or old people, and certainly people with other diversities as well.

MR MOSHINSKY: Ms Brown, would you like to comment on that point of other family members perpetuating violence?

MS BROWN: I guess I really just want to affirm everything that Philomena has said about the difficulties faced by young people in the home, whether that's as a young lesbian, gay, bisexual person or a gender questioning person and the links between those issues and the rates of homelessness amongst LGBTI youth, with the limited data available they still establish. So it has flow-on consequences for other parts of the system as well. So I think we really do need to desperately understand and better address those issues for LGBTI youth specifically.

MR ALEKSANDRS: Could I also add too that the non-biological family as well, that due to so many people being estranged from their biological family they will often seek support from friends or kinships and non-biological families, so to speak, and the violence can also happen in those situations or in the relationship. So, if they experience, if the LGBTIQ person is experiencing violence in their intimate relationship or relationships, then they may have limited resources to turn to within their own biological family to seek support. So that, sort of coupled with the whole lack of access to so many family violence services, really does make people incredibly vulnerable in that sense.

MR MOSHINSKY: Dr Horsley, did you want to add anything?

DR HORSLEY: I just wanted to add the particular issues around diversity within diversity. We know from broad research done by La Trobe University, the Australian study of human relationships, that communities that are more recently arrived from other countries, communities in rural settings, are much more conservative and negative in their attitude to homosexuality. So therefore we hear, and again very under-researched, that there are specific issues around physical safety as well as emotional abuse for LGBTI people who come from CALD communities and certainly from those in rural settings where the negative attitudes can be hostile to the point of actually being life-threatening in some very conservative religious or cultural settings.

MS BROWN: Then that obviously compounds the difficulties in actually accessing services. They have this extra vulnerability and then also an additional barrier to accessing services as well, so it is particularly acute.

MR MOSHINSKY: Can I now ask you to address the sort of model or definition of "family violence" and the way that is often approached. Dr Horsley, in your submission at pages 6 to 7, down the bottom of page 6 you refer to, after the heading, "The predominant often exclusive explanatory models of family violence". Could you expand on that for the Commission, this issue of how we define or what model we use for family violence?

DR HORSLEY: I think the predominant approach to family violence and domestic violence particularly in Australia, from a Commonwealth policy level right through to state institutions, is very much of a gender based one using the Duluth model, which is essentially looking at issues

around the inequality between men and women. We know internationally that is a very, very important and key and the main factor in terms of what promotes or what allows violence against women.

The problem with that model is that it is pretty much focused only on a notion of gender being relationships between men and women or standard gender relationships within family settings, and it doesn't allow for the greater complexity of what is at play in terms of family violence generally and domestic violence specifically.

So we know that issues around homophobia and transphobia are also really strong factors. We know issues around socio and economic status, that issues around mental health, drug and alcohol use are all part of the interplay. But I think for the purposes of these kind of community discussions and policy the focus very much tends to be on gender inequality and the effect of that is that it renders invisible same sex relationships. It suggests that of course there can't be violence in a same sex relationship because two women or two men are equal and that leaves people with nowhere to go, as I mentioned earlier, in terms of understanding family violence or domestic violence. It leaves people who are trans or intersex nowhere to go in terms of fitting into that model that's both a service delivery model, but it is also a policy framework at both a state and a Commonwealth level.

So, I guess what we are suggesting is that both from the broader framework of policy, but also drilling right down to community understandings of what constitutes family violence and domestic violence, we really need to

actually look in more detail at the intersections of things that are at play there. For instance, disability. We know that people who are LGBTI have the same proportion of people living with disability. We know that people with disability generally, particularly women, are much more at risk of domestic violence and family violence broadly. So, when you add in an issue around sexuality or gender identity, you are actually potentially really magnifying the risk for those communities, and particularly then also we have issues around disadvantage, low education, all those kinds of things that we know have an impact.

So I guess what we are saying is it's a useful model to start with, but when we are approaching policy, when we are approaching service delivery and when we are approaching community education programs we need to open up those definitions and allow the diversity and the diversity within diversity to be acknowledged and made visible.

MR MOSHINSKY: Are you advocating that we need to broaden the model? Are you also advocating that we need to change definitions in the Act or is the focus more on the model and the way we address matters such as policy, service delivery and community education?

DR HORSLEY: I think it needs to happen across the board. I think one of the key things that leads us to better understand violence is recognising inequality and dependence as key factors which make people vulnerable, but also allow people to render violence against others with some impunity. So that issue around inequality of course can be gender based, but it also is based on other

socioeconomic and demographic factors such as disability, class, ethnicity and so on.

So I think it's important to keep the focus on women to a significant degree because we know women are the people who predominantly suffer, and of course children who witness violence if they are present, but we also need to allow for the fact that the violence and the perpetration of it and the experience of it is filtered through a range of prisms. Gender of course is one, but there are other factors that create inequality or vulnerability to violence.

MR MOSHINSKY: Ms Brown, could I invite you to comment on the breadth of the issue of family violence and also whether the current definition in the Act is broad enough?

MS BROWN: We had a look at the current definition in our submission, and this is in the Act, sorry, and the definition appears to be expansive and non-exhaustive and in fact gender neutral, so we are quite happy with it from that respect because it appears to be inclusive of LGBTI relationships and families.

But I'd agree with everything that Philomena says about the need to broaden the way we look at this issue and, without losing that focus on the gendered nature of much of intimate partner violence and the experiences of women, we still need to be inclusive of the diversity that's existing within our society. So that's incredibly important. I think given the legislation appears to be okay, the policy framework and the way that we deliver programs is utterly critical.

MR MOSHINSKY: Mr Aleksandrs, this is also a point you make in your submission. Do you wish to add any comments?

MR ALEKSANDRS: Yes, I think it's reflective down to the service provision level, that the definition of "family violence" is very much around a heterosexual experience of that violence. There's always been - through the hard work of many family violence agencies there's been a very clear establishment of a good, solid gender analysis of violence and I would agree that, yes, a large proportion, the highest proportion of people experiencing family violence are women.

I think, though, as Philomena has pointed out, a large part of feminist analysis also looks at inequality as an issue and, given that the LGBTIQ communities are so marginalised, that that fits within that analysis and I think there's room for that. I think the gendered spaces that the heterosexual view of family violence has sort of created for refuge and for support I think has made it very difficult for the LGBTIQ communities.

MR MOSHINSKY: Can I turn then to the topic of barriers to people seeking access and support, access to services but also support and assistance. Just starting sort of at a broad level, what are some of the barriers that exist? Perhaps if I could start with you, Dr Horsley. At page 6 of your submission you raise some of these issues. Would you be able to speak to that issue?

DR HORSLEY: Certainly. I think at an individual level the very basic barriers are people experiencing violence thinking, "What is happening to me? Where can I go? Who can I trust?" And that kind of opens up a whole range of issues. We know, for instance, that concealment of people's sexuality and gender identity is habitual in the LGBTI community. At least 50 per cent, so half of people

really generally or occasionally conceal their identity when accessing services. That becomes a habitual thing because of the fear of negative responses.

That is underpinned in many ways by fundamental distrust of services and what reception people might receive, whether a service will be appropriate, whether a service will be educated enough about the specific needs of LGBTI people, and do they appear open and welcoming, and does the model even fit.

So, for instance, a gay man who is experiencing significant physical abuse in a relationship, he may be thinking, "Okay, this is getting serious. Where do I go? What do I do?" But then the whole discourse around domestic violence is about a system that provides refuge and support for women. So, in that sense he can feel absolutely stifled or unable to actually think about where he could go, including whether it's safe to approach the police, let alone other services that specifically signify themselves as providing family violence services.

So, there are issues there around individuals being able to identify services. Then at the other end is I think the services generally in family violence, but also in broader mainstream areas such as aged care services, community health and so on, are moving towards a recognition that there are these barriers for LGBTI people to access services, but also feeling unsure or unconfident about how they might do that: what do they need to do, what would be appropriate or inappropriate, and even does the particular service model even fit the needs of that community?

So we have barriers at the individual level or

the friendship network of somebody in terms of where can we go, what would be safe, appropriate and so on, and then at the service level there are barriers there in terms of their lack of preparedness or information or skill level around dealing with these particular issues.

MR MOSHINSKY: Would either of the other panel wish to speak to this issue of barriers?

MR ALEKSANDRS: Yes. Certainly resourcing has been coming up throughout the Royal Commission and also definitely was an issue when we spoke to family violence services and also to an extent the LGBTIQ agencies during our consultations. To a degree there was a hesitancy from agencies to start to, I guess, promote a response to LGBTIQ intimate partner violence and family violence, and this was due in part to I guess a lack of faith that there will be enough resources and capability within those agencies to meet the needs of the increase of people attending or wanting to use their services.

So, yes, you have that sort of push and pull going on, and then the LGBTIQ community sort of don't know enough about the pathways to those services as well, so that came up for us.

COMMISSIONER NEAVE: Ms Brown?

MS BROWN: I agree with everything that's been said and would also add that I think the stigma and discrimination that LGBTI people face, an apprehension of experiencing that in the service provider context, is a very real factor as well, as well as I guess the general perception that these organisations, as well as the risk of discrimination, just simply won't understand their needs.

Some of the responses to the Coming Forward

survey cited heterosexism as a barrier and fear of hetero male ridicule or having gender history revealed or just embarrassment and ignorance among service providers. That is not just the sector, but also police and justice support agencies as well. I mean, I could go on for a while.

We talked specifically around regional and rural area issues and we do have some very limited specialist LGBTI providers or mainstream providers with some LGBTI understanding and competency in the metro areas, very, very limited as set out in the submissions. But this obviously is deeply lacking when it comes to regional and rural Victoria and also in those areas that's coupled with the real likelihood of higher rates of discrimination, homophobia and transphobia and more likely that LGBTI people will be in the closet and fearful of seeking help. So those experiences are very much compounded in those geographical areas. Obviously we can look at on-line or more remote delivery of services from those metro areas, but this is still quite difficult.

We also raise in our submission particular issues around faith based or religious service providers, and that is that the law in Victoria has exemptions for those providers when it comes to discrimination and, whether or not those providers do discriminate, the LGBTI people still fear the risk of discrimination and that is a very real barrier, in addition to all those other barriers we mentioned, in their ability or their willingness to access those services.

So we would strongly recommend that in this forum we explore possible amendments to discrimination laws and

limiting or removing those religious exemptions when it comes to these service providers, but indeed any service provider that's delivering services to vulnerable communities.

MR MOSHINSKY: Just on that point, do we have information available which indicates when faith based organisations are providing services to victims of family violence, whether that exemption is being utilised to deprive LGBTI people of services?

MS BROWN: No real data. We have anecdotal stories from people, particularly, for instance, transgender women, that have experienced difficulties and we know from work we did around federal discrimination reforms that LGBTI people experience discrimination from faith based providers in a whole range of settings. So I would assume that family violence is also there as a potential area of concern, but I don't have any concrete data on that.

I think a really important point to make is that it's the fear of discrimination. Even if faith based providers are doing the right thing, and I think more than often they are, it's that fear and apprehension that will stop someone from accessing those services or indeed disclosing the nature of their relationship and getting the help that they need.

MR MOSHINSKY: Mr Aleksandrs, in your submission you have investigated service provision and gaps?

MR ALEKSANDRS: Yes.

MR MOSHINSKY: And in particular at page 32 of the submission, where you set out the key findings down the bottom of that page, you summarise the service delivery and gaps. Could you outline for the Commission, based on your work, what

are some of the examples of gaps in the system where there aren't services available for LGBTIQ people?

MR ALEKSANDRS: My page is slightly different to yours as well.

MR MOSHINSKY: It's the section 1.2 "Key findings" and the second bullet point is "Service delivery and gaps".

MR ALEKSANDRS: Sure. One thing that really came up for us was people not knowing where to send LGBTIQ people for crisis housing in the incidence of family violence, particularly for transwomen and also gay men and intersex people. Although there are housing services and homelessness services, there are very few available in a crisis model that weren't sort of a kind of gendered form of accommodation, which obviously would make it quite difficult for an intersex person or a trans person if it is about how you are perceived.

Then I guess the other thing, too, is that although some LGBTIQ people knew that there were family violence services available, they were like, "Well, it'll all depend on how I'm seen on the day and what staff member I'm going to deal with." I suppose it is a very valid concern. There was response from the family violence agencies that we spoke with saying that they didn't really have a specific policy and procedure for LGBTIQ people attending the service. There were some procedures and policies for one agency and sort of some starting to be implemented for a second, but then the thing was that everybody again was sort of lumped into the one acronym and there wasn't really an awareness of what the differences in service delivery might be for each person under that umbrella.

Certainly another service gap was sort of even

during the processes of intake where people are sort of first accessing the service and there is no sort of discussions around relationship diversity or gender diversity or staff might not even know an intersex person would possibly come into the service, that was definitely putting people off.

We also did hear from some organisations in the LGBTI community stories about people sort of seeking support with police, also incidents in the courts where intersex status and transgender status became the focus of the issue rather than the violence itself, and that was something that was quite distressing for some people, feeling, "I have to come out in that sort of situation".

There is also no systematic referral for LGBTIQ people. A lot of family violence agencies might have lesbian in their overarching diversity strategy, but what we found is that some of the LGBTIQ organisations that we spoke with, who are very underresourced and literally run by volunteers, had had LGBT people referred to them from family violence services. So some of those were only operating in a volunteer phone line capacity and so the lesbian status or homosexuality of the client was the focus rather than the family violence issue and the LGBTIQ community didn't have the resources obviously to deal with that. They don't have social workers there and child protection workers and that sort of thing. So they were like, "Well, why are we getting it?"

So we sort of discovered there was this full circle of people just going from one to the other. Obviously those people, those victims and perpetrators, too, maybe, are going to give up along the way and fall

back out through the cracks of the system.

MR MOSHINSKY: Are there any organisations that provide specifically services for LGBTIQ people who are victims of family violence?

MR ALEKSANDRS: There were minimal services. There's one behaviour change program. But in terms of - - -

MR MOSHINSKY: I will come to that in a moment, perhaps, but just in terms of victims at the moment, are there any specific organisations in existence?

MR ALEKSANDRS: There was one that existed at one stage a couple of years ago and then no one really knows what's happened with that particular service. I have spoken to people who have worked in the said service and they have actually told me that they need more help understanding the issues because it's been so long since they promoted their service that way.

That gets down to another issue that was raised for us as well, which is that a lot of family violence services were saying, "Well, we hire lots of lesbian women, so that means our staff are going to be quite cognisant of the issues and so forth." Knowing how small the community can be, I would sort of reflect and be concerned that at some stages staff will know victims or know perpetrators as well. So, that's one side of it.

But also it just means that, like I experienced with this particular service who was meant to be a focused lesbian service, that this sort of really depends on the staff there and their awareness of the issues and how willing they are to sort of take it up, but there wasn't anything that was kind of really consistent and built in.

MR MOSHINSKY: So then, just picking up the behaviour change

point, what, if anything, is available for those who have used violence who may be from the LGBTIQ community? Are there any programs available?

MR ALEKSANDRS: There is one that has recommenced after a bit of a hiatus. There isn't really a built-in perpetrators program model for LGBTIQ people. The behaviour change program that I'm aware of also is just for gay men, so it doesn't cover everybody under the acronym, so to speak. So, it's extremely, extremely limited and it's a metro program, so there again we go and reflect on what people outside of the inner city might have.

Definitely individual counselling is an option, but then we miss I suppose the sorts of contexts and understanding of family violence that Philomena has already raised in terms of the inequalities and sort of how to respond to that kind of offending and perpetrating of violence.

MR MOSHINSKY: Can I invite the other panel to comment on what are the main gaps in terms of what supports or services are currently available?

DR HORSLEY: I think there are really significant gaps in terms of specific focus on the diversity of the needs within the LGBTI population, and then there are broader gaps. So I think we kind of recognise that there are family violence specific services, but then there's a whole outer connected range of services such as social workers at hospitals, counsellors at community health centres, people in the aged care sector who pick up a lot of domestic violence and family violence related areas.

So, we have no specific services really beyond temporary and ephemeral, and then within the family

violence specific services I think it would be very much seen and is very much seen as an optional extra if there is time and if there are resources, as opposed to an approach where we are all Victorian citizens, we are all entitled to services of equal access and of equal quality, and that just seems to be not on the table for a whole range of complicated reasons, I understand that.

Then there's the issue around the broader awareness. For instance, the last 18 months I have spent around Victoria running training in the aged care sector around LGBTI inclusiveness, and that's a sector that people would regard as fairly conservative and certainly had not a lot of access to this kind of inclusive practice approach. That's really been taken up and people have actually gone, "Wow, I'm more aware now than I was before." We have certainly done a lot of work around community health centre staff, drug and alcohol staff, mental health staff such as the services for young people.

So I think it's a process of integrating those, greater awareness among the broader support services in the mainstream and then also bringing that awareness and integrating that awareness within family violence or domestic violence specific services. But it requires leadership from the government and it also requires resourcing of the sector, because I think nobody who has any knowledge of this area would be unaware of the fact that this is an area that is significantly underresourced generally in the community and we need a whole range of services to meet the current needs and the developing needs. But within that there has to be an integration of understanding of the needs of people who are sexually

diverse or gender diverse.

It's just a basic human right to be able to access services that will support you and ensure your safety or in fact, if you are an offender who wants to change, that will support your desire to change your behaviour.

MR MOSHINSKY: Can I ask each of the panel to reflect on this question. What direction should we be moving in? You have outlined very, very significant gaps in terms of supports and services. Should we be moving to a model where the existing family violence sector organisations broaden their reach to include services and supports for LGBTI people or should we be looking at specialised services and supports which are dedicated towards LGBTI people? Do you have reflections on that issue?

DR HORSLEY: I'm sure there will be a range of views, hopefully, and that would be healthy, because I think what we have seen in terms of other sectors such as drug and alcohol and mental health, you need some specific services where possible, but the key ultimate aim is always to have accessibility everywhere, in all mainstream services. You need services that are welcoming, that are well informed and that are absolutely inclusive with all of the integrity in the way those services operate, because specific services will never meet a need.

They may in fact play a role in being able to capture data that will really add to our very limited knowledge in this area, so in that sense they would be very useful. For some people who will never trust mainstream services, they will be essential, but there is a problem then around where you roll them out, as we have

indicated, and how you roll them out.

So I think the key thing is to actually start consulting with the community, start having those conversations, funding more research, so that we can really drill down to a better sense of what the service needs are in a specific sense and how those needs could be met by a combination of specific services and broader general services.

MR MOSHINSKY: Other reflections from the panel?

MR ALEKSANDRS: I think that, looking at the issue of family violence and then looking at the experiences of LGBTIQ people, I think that the thing is no one really owns all of the expertise in this particular space. The LGBTIQ community to me are struggling with both understanding the issues and responding to the issues. It's an early discussion, I think, in the community itself, as we have already raised.

I think the LGBTI community really needs the expertise of social workers, counsellors, child protection workers, courts, police. The sector has been operating for a long time and there are some very skilled workers in there, but obviously the sector itself and some of the related services that come into contact with family violence, as Philomena has just mentioned, some of those service providers are really struggling with understanding the specific situations of LGBTIQ people.

So it would be a great benefit if government could support the collaboration and working together of both sides, so to speak, even though we know it is diverse within the acronym, but just to make it simple, from both sides and just sort of start it. Also from how are you

going to collect the data and do the research appropriately? When you are developing your policy frameworks and any legislative tools, who is on your reference groups and your committees and is the government also supporting, I suppose, those agencies or the organisations from the LGBTIQ communities who are very grassroots? Are they being supported and resourced to be able to do all these consultations and be part of these processes because they are all very volunteer run and very stretched. So there needs to be some respect there too offered to the community. Then hopefully that will increase the possibilities of a really healthy dialogue.

I think we are on the cusp of this. There are a lot of things that can be done through just simply a consultative process and using an integrated model. We have had regional family violence networks running for a long time where we've got sort of all these agencies getting together and sharing ideas, and I think if the LGBTIQ communities are involved in those sorts of things that would be really beneficial. So, that's where I think the possibilities for a more positive future in this area lie.

MR MOSHINSKY: Ms Brown, did you wish to comment on that?

MS BROWN: I agree with everything that's been said, really, and would just emphasise the points that have been made already about the need for research and data to inform this process going forward and for collaboration between the LGBTI community and the expertise that's there, also recognising that we lack expertise as communities and we particularly lack resources and funding. Whether it's Transgender Victoria or the Gay and Lesbian Rights Lobby

or some other body, most of the organisations in the LGBTI sector are completely volunteer run and this presents real struggles if we are going to grapple with these issues properly and it is a challenge for government to work out how to do that properly.

I would also like to emphasise in our submission we recommended specialist organisations and services and LGBTI inclusive, working towards LGBTI inclusive mainstream services as well, so I completely agree with what Philomena said, and I think Gay and Lesbian Health Victoria has developed some really good tools and training around LGBTI inclusion, including the Rainbow Tick that's referenced in their submission which could be a model for government and for service providers to look to. So there's lots of positive progress and I think learnings that we can build on, but obviously there's a need for a lot of work in this space.

MR MOSHINSKY: I might at this point see whether the Commissioners have any questions they wish to ask.

COMMISSIONER NEAVE: No, we don't have any questions.

MR MOSHINSKY: I might then take up another couple of questions with the panel.

COMMISSIONER NEAVE: Yes.

MR MOSHINSKY: One of the points that's raised in some of the submissions is the prevention programs directed at the population at large relating to family violence. I was wondering whether any of you wish to comment on that and whether they should be looked at differently?

DR HORSLEY: I think we need a combination of approaches. I think the larger community based programs, whether it's Respectful Relationships programs in schools or in

sporting clubs or whether it's broader, television ads and broader kind of education of the community, it needs to kind of start framing family violence and domestic violence in broader ways. I know this is a challenge in terms of those kinds of programs, but nevertheless it's a really key aspect of it.

Secondly, I think we really need targeted community education of the LGBTI community. We really have had very little, if anything, in terms of helping the community grapple with the issues, to even find the words to name it within our community, to recognise the struggles and the kind of barriers around naming it, and then recognising that we lack even basic information around referrals. If we're a friend of someone and we're worried about them or they're fleeing an abusive relationship, how can we as friends or workmates of LGBTI people actually assist in that process.

So, I think it's a combination of things. It is to actually open up the conversation more broadly in the general community, but also to target our community so that we have an opportunity to learn more, to actually see that it really relates to us, to the lives of our friends, our workmates, our partners, our children, and bring to life a conversation. It will be a difficult conversation because I think it's surrounded by secrecy and shame, but it has to happen and it has to happen soon, and through that process we really are starting to then spread that information and knowledge in terms of the services sector, whether it's maternal and child health services, hospitals or family or domestic violence specific services.

MR MOSHINSKY: Do either of the other panel wish to add

anything on that point?

MR ALEKSANDRS: Certainly I agree with everything Philomena has raised there, and most definitely not just approaching the mainstream awareness programs and also creating, like, campaigns aimed at the community, but definitely a structured program perhaps with educative workshops for people that are running the LGBTIQ organisations and community groups. There's a lot of also support groups out there where family violence has come up and I have been made aware of a few instances where support groups in the LGBTIQ community have been floundering around how to respond to an intervention order when it came up amongst one of their members, and also sort of the difficulties that people have as well in terms of discussing the issue.

As a social worker I have been quite alarmed sometimes when I have seen the responses, for instance, on the internet around alleged offences and I suppose I have been alarmed around that because I have been concerned for the victims, the impact that it might have on a victim's legal recourse because people have been naming and shaming on the internet and also maybe compromising victims' safety.

So I think there needs to be an awareness within LGBTIQ organisations about what they can do, what intervention orders mean, how people are meant to be responding to them, how to take them out, that sort of thing. I think that's a really fundamental thing that could be learned for those people because they are still getting it - because there's going to be this gap between when the services do step up their culturally appropriate service delivery to these communities, there will be some

time passing before that's fully implemented and rolling. So the community in the meantime kind of has to juggle a lot too. So I think it would be good to train both.

DR HORSLEY: Could I just add to that because we haven't really mentioned very specifically the justice system, but I do want to acknowledge the leadership of Ken Lay in terms of bringing this issue to the fore in VicPol and the fact that we are on a couple of committees with VicPol, the LGBTI Portfolio Reference Group and the External Education Advisory Group which is providing education for both current and new police. I think that's been a really key and supportive initiative on the part of VicPol.

I think it still leaves the issue around prosecutors and magistrates and the need for education there. We certainly hear of stories where people have had very negative experiences with lawyers who have not taken their experience of violence seriously, and certainly in the court system it's been seen as a trivial issue. I think that those areas, they are moving quite considerably with VicPol, but I think the broader justice system also needs some education and training around these issues.

MS BROWN: I agree with all that's been said, and would also add on the social marketing and awareness campaign front that obviously there's been invisibility of LGBTI people in those campaigns and it's not to say that we necessarily lose the gender focus, as we discussed earlier, but just having some visibility would be useful and send the message to LGBTI people that this is an issue that speaks to them.

Then, in addition obviously we need to do work

within the LGBTI community and there should be targeted programs and initiatives for the community, not only around family violence and domestic violence, but we made the point in our submission that campaigns targeting homophobia more broadly would actually assist the LGBTI community in dealing with violence and hopefully reduce the prevalence of violence more broadly.

The school programs, Respectful Relationships as Philomena mentioned, I think provide a useful model to expand perhaps for an adult context for LGBTI communities, and other anti-violence campaigns could also be tailored to our communities. So really again it is that combination of strategies that I think would be most successful.

MR ALEKSANDRS: Certainly somebody's opinion of LGBTI community members impacts, I suppose, how they feel about violence against members of that community. So when we have looked at campaigns around violence against women and people sort of evaluating the view of women in society, increasing the respect of women obviously is going to increase people's alarm at violence perpetrated against them and I think the same goes with LGBTIQ communities and a lessening in all the phobias associated with that acronym, that that would play a really big role in making people aware of violence perpetrated against them.

MR MOSHINSKY: Thank you. Do the Commissioners have any questions?

COMMISSIONER NEAVE: I just had one question. Are there any programs in schools that you consider effective that are dealing with the whole question of equality and people from an LGBTIQ background, the whole issue of sexuality

and sexual orientation and so on in schools?

DR HORSLEY: Our research over 18 years of young people and schools, the non-heterosexual group and the group who don't identify strongly as a binary gender have pretty much all said that the sex education or the human relationships education was next to useless, was uninformative and really they didn't relate to it.

We do have within our centre input into a broader national curriculum and I think there are different aspects now that are relevant in terms of the ways that this kind of inclusion could occur in schools' curriculums or currently. But there is not an overarching sense of it being a priority or a specific need, whether in the more traditional notion of sexuality or human relations education or in more broader areas around human rights education.

MS BROWN: Yes, I agree, and I'm not an expert in education by any means, but I would say that the Victorian Government has through the Gay and Lesbian Health Victoria established a very good program called Safe Schools Coalition which is about developing safe environments for LGBTI young people within schools and that program has been funded to roll out to all government schools in Victoria. It used to be just be voluntary, but now it is going to be mandatory. Obviously there is still a gap in the independent school system and there are also schools where we might see attitudes promoted that are not positive towards sexual and gender diversity.

COMMISSIONER NEAVE: So this is a program that is directed at, for example, homophobia?

DR HORSLEY: It takes a whole of school approach around keeping

young people at school safe. So, it actually requires the school as a whole community to take action to keep students who identify as LGBTI or same sex attracted or gender queer safe. We know from our statistics that it has been so successful in Victoria that the levels of violence and bullying that young people experience in schools is lower in Victoria than in other states. As a result of that, the Commonwealth Government just this year has funded a national rollout of that program which is overseen by FYA.

So, that's a really important thing. It doesn't necessarily address some of the specific issues we are talking about, but I think it does what Anna says, which is essentially saying, "These children have a right to feel safe at school. They have a right to respect and to equality within the school environment." It's clearly an evidence based program that has been shown to reduce the levels of physical violence and verbal bullying that's occurring in the lives of these young people, 80 per cent of which has been occurring at schools from both students and from staff.

COMMISSIONER NEAVE: Could you just tell me the name of that program?

DR HORSLEY: It's called the Safe Schools Coalition of Victoria.

COMMISSIONER NEAVE: That's the one that's being rolled out?

DR HORSLEY: That's being rolled out nationally. We have four staff at Gay and Lesbian Health Victoria who are involved in that program and they are doing a lot of intensive support for schools generally, but also for families of young trans children who are transitioning, and we are now

moving into and about to release in fact a manual around how to incorporate these issues into curriculums in schools. So that's a really welcome initiative. So we are looking forward to that launch, which is just about to be signed off by the Commonwealth.

COMMISSIONER NEAVE: Thank you very much.

MS BROWN: I might add also that Philomena is probably being modest, but the Victorian model has been recognised as a huge success and that's why it is being rolled out nationally. There has actually been some mobilisation within some fundamentalist Christian organisations against the program, which I think is indicative in some ways of its success, but obviously the campaigns and the work that's being done in Victoria I think is really first class.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Commissioners, if the witnesses could please be excused and could we now have a break for about 10 minutes to about 11.05.

COMMISSIONER NEAVE: Thank you very much indeed. You are excused.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

MS DAVIDSON: Commissioners, the next panel is one in which we will be exploring the issues that are particular for people with disabilities. This of course is not the first time in this hearing that we have been canvassing the issues of the effects of disability on the ability to access services and the experiences of people with disabilities with respect to family violence.

I particularly draw the Commission's attention to

the evidence that we had from "Melissa Brown", who was a victim of family violence. We heard her evidence on day 8 of the hearings and that was in circumstances where she was a woman with a physical disability and she talked about the impact that that had and her dependence upon her husband as her carer and how that impacted upon her experience of family violence and her ability to access services.

I will ask that the witnesses be sworn, but we have representatives from two agencies today; firstly, Colleen Pearce from the Office of Public Advocate and is in fact the Public Advocate. We also have two representatives from the Women with Disabilities Victoria agency who have also made a submission to the Commission. I ask that they be sworn.

<COLLEEN GEORGETTE PEARCE, sworn and examined:

<KERAN ELIZABETH HOWE, affirmed and examined:

<JEN HARGRAVE, affirmed and examined:

MS DAVIDSON: Thank you. Can I perhaps start with you, Ms Pearce. You are the Victorian Public Advocate?

MS PEARCE: Yes.

MS DAVIDSON: You have held that role since 2007?

MS PEARCE: Yes.

MS DAVIDSON: Can I just get you to outline the role of the Public Advocate and the role of the office?

MS PEARCE: As Public Advocate I'm appointed by VCAT as guardian of last resort for adults in Victoria with a disability, a cognitive impairment, for people who are in need of a decision being made in relation to their personal circumstances, so such as accommodation, healthcare or with whom they might have access to, people

they might have access to.

Other parts of my office concern the volunteer program. We have around 900 volunteers who work in a number of programs. We have the community visitor program. Community visitors are volunteers who are the eyes and ears of the community who visit closed environments, so mental health facilities, residential services for people with a disability, group homes, but also supported residential services.

We have a volunteer program, the independent third person program. Last year volunteers sat in on 2,700 police interviews for people who had an apparent cognitive impairment. This was victims, witnesses, as well as alleged offenders.

We have a community guardianship program and we have a policy and research team. I should also say that as part of the Guardianship and Administration Act my staff also undertake investigations on behalf of VCAT where a person may be subject to abuse, neglect or violence or considered to be in need of guardianship.

MS DAVIDSON: Just in relation to cognitive impairment, what sort of situations does that cover? I take it you are talking about people with an intellectual disability, but do you also cover older people who have diminished ability?

MS PEARCE: Yes. In fact the majority of people under guardianship in this state are people over the age of 65, so around 60 per cent of people under guardianship are over the page of 65, with the majority of those having some form of dementia. But we also cover people with mental illness, an acquired brain injury or an

intellectual disability. So there is a whole range of cognitive impairments.

MS DAVIDSON: Thank you. You have made a statement for the Commission in this matter?

MS PEARCE: Yes.

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

MS PEARCE: I am.

MS DAVIDSON: Can I move to you, Ms Howe. Can you just outline the work that Women with Disabilities Victoria does?

MS HOWE: Yes. Women with Disabilities Victoria is a systemic advocacy organisation and we are responsible for providing advocacy on behalf of women with disabilities around Victoria; that is, women from all walks of life and with all types of disabilities and experiences. So that covers women with physical, intellectual, other cognitive disabilities, women with mental health.

MS DAVIDSON: You are the Executive Director?

MS HOWE: I'm the Executive Director.

MS DAVIDSON: You have held that position since 2007?

MS HOWE: That's correct.

MS DAVIDSON: You have made a statement together with Ms Hargrave, who is beside you. Are you able to confirm that that statement is true and correct?

MS HOWE: I can.

MS DAVIDSON: Can I move now to you, Ms Hargrave. You have made a statement together with Ms Howe, and can you confirm that that statement is true and correct?

MS HARGRAVE: I can.

MS DAVIDSON: Can you just outline what your role is with Women with Disabilities Victoria?

MS HARGRAVE: My role is policy officer on violence against women with disabilities. This role, like the work of Women with Disabilities Victoria, is focused on systemic advocacy, working to build up connections between the family violence systems and the disability systems.

MS DAVIDSON: Perhaps we can just start with the topic of the experience of violence for people with a disability. I think, Ms Howe, you refer to women with a disability experiencing a double disadvantage?

MS HOWE: That's correct.

MS DAVIDSON: Can you explain that?

MS HOWE: Yes. Part of our work as an advocacy service is undertaking research and we have undertaken two significant pieces of research around the issues for women with disabilities who experience violence in Victoria. What we find from our research and also from listening to women with disabilities as our members is that women experience the same kinds of violence that other women experience. They experience violence from intimate partners, but also from other family members. In addition to that, we find women with disabilities experience violence from a broader range of perpetrators of violence than other women. So that can also take in paid carers and service workers such as transport workers and can be targeted in the general community.

In the same way that other women experience violence from predominantly men as perpetrators, that's also the case for women with disabilities. We also find that women with disabilities experience disability based violence. An example of that would be where a perpetrator of violence wants to control a woman by removing her, for

example, wheelchair or another mobility aid or it might be a communication aid, and also we have heard from women about having their medications increased or decreased and being socially isolated because they are more easily controlled because of their disabilities.

So that violence that women experience, we find women are at higher risk of violence because of their disabilities because as women we experience the same discrimination that all women experience on the basis of gender, but we also experience high levels of discrimination as people with disabilities. Research that's undertaken here in Australia finds that young people with disabilities are five times more likely to experience disadvantage and discrimination than other young people.

So, for women with disabilities we experience poorer socioeconomic status, poorer economic and social participation than both men with disabilities and other women. So that gives us what we might call a double disadvantage. If you are an Aboriginal woman, that's again compounded and this disadvantage compounds itself and significantly increases the risk that women with disabilities, and particularly women from other disadvantaged groups, experience.

MS DAVIDSON: I think you have also identified - I appreciate that your service is for women with disabilities, but you have identified that the area of men with disabilities experiencing family violence is poorly researched.

MS HOWE: Yes, we think that the area of particularly institutional violence against people with disabilities in general is very poorly researched and we need to

understand more about the dynamics of gender within disability services. Disability services have traditionally not been particularly cognisant of the issues for both men and women and the different needs that men and women might have, but we do know that both men and women experience violence because of their disability.

MS DAVIDSON: Ms Pearce, are you able to comment on that issue as well, the general topic of the experience of violence for people with a disability and how having a disability might impact upon that experience?

MS PEARCE: Sure. OPA has done quite a lot of research just into our own cases and of course there's our research with Women with Disabilities Victoria, our Voices Against Violence. We have been trying to establish, I guess, some baselines around what might be the extent of violence in the community against people with disability.

In 2010 we looked at 86 cases of violence and abuse. We found that 66 per cent of those were women and 20 per cent of those were men and they had been subjected to a range of violent and abusive acts, including physical and sexual violence, emotional and psychological abuse, including segregation and restraint and, as Keran said, impairment related abuse, financial abuse and neglect. The research found that the perpetrators included parents or a parent's partner, a sibling, another relative, a partner, a neighbour, a staff member, a co-resident or a stranger.

So you can see there's a wide variety of perpetrators for people with a disability. One of the differences, of course, is the dependency on carers, so both paid carers and unpaid carers, so we certainly see

many cases of that as well. In the 64 cases where the perpetrator was characterised as a relative or a partner, the actions could be categorised as family violence under the Family Violence Protection Act.

MS DAVIDSON: Thank you. Just picking up on that issue of where the perpetrator is a carer, we heard from the witness "Melissa Brown" on day 4 who talked about the impact that having a disability had and her reliance upon her husband as her carer - I'm reminded it's actually day 8 - how that impacted upon her ability or her reliance upon him, the changes in the power dynamic and how she felt unable to leave the relationship. Is that a sort of fairly consistent issue for women who experience family violence, and for men?

MS PEARCE: It is, and just when you were talking it reminded me of a particular case where we were the guardian for a woman. She had had a stroke. She was in hospital. She told the guardian that she wanted to go into care because her husband hit her. Now, she was in that relationship for 40 years. It was a very difficult decision for her, but her choices were very limited and she expressed the desire to go into care rather than return home. But she said, "Please don't tell him that I've told you that he hits me."

The power dynamic continued when she was in fact placed in care and he was continually at her bedside and interfering with the care that was being provided to her, and particularly around feeding time, insisting on - he controlled even her feeding. So, this control that we see is really a very common pattern.

MS DAVIDSON: Did you want to also add to that, Ms Howe and

Ms Hargrave?

MS HOWE: It certainly was affirmed in our research and many women spoke about feeling trapped. They are trapped because they have that dependence that Melissa experienced for personal care and a belief that in fact there is no other assistance that might be available, which is untrue. They are also reliant on their partners for care of their children sometimes and believe that there is no other assistance available in that situation also.

So we need to be able to promote more effectively the sorts of services that we do have. I might ask Jen to talk a bit more about some of those services. But I think that perpetrators of violence are aware of this power dynamic and are aware of this dependency and are also aware that they are more likely to be believed and that their word carries more authority than the authority of their partner. So, they play on this and women told us about how partners threatened them that they would put them into an institution if they tried to leave.

MS HARGRAVE: That's right. In Melissa's case she spoke about different professionals from services such as police and mental health asking her if she wanted to leave. In her mind that wasn't an option because she couldn't imagine who else might be able to assist her and her children. So I think it points to a need for workers to be resourced around having skills around asking questions; for example, What would you need in order to be safe?" or "I see that you have a disability. What sort of things might assist you?"

Although workers can feel very uncomfortable about asking these questions, there is more danger in not

asking them. In fact, if women know why the question is being asked and what's going to happen to the information, the majority of the time they are really comfortable to be asked.

The Disability Family Violence Crisis Response Initiative is something that the Department of Health and Human Services developed to replace this type of care that partners may be giving for the family violence crisis period to allow women and children a period of time to leave the violence or for the perpetrator to be excluded and for other alternative care arrangements to be made for the longer term.

But it is important to note that there are three important questions about the initiative. One is to look at the eligibility criteria for the initiative, which at the moment is in accordance with the Victoria Disability Act, which actually excludes mental illness, injury, preschool age children and people over 65. So, for example, a woman that we know of who was driven over during a family violence incident and was unable to walk and required daily assistance with her disability was not eligible because doctors weren't able to definitively say that that injury was permanent.

Another issue which was raised through Melissa's example was that while the initiative has lots to offer those who are eligible, many workforces and workers still don't know about the initiative. So, services such as disability, child protection and police could be more informed about the availability of the service.

Thirdly, this is the only initiative we know of in Australia that provides this funding for disability

support, but the future for the funding is completely uncertain with Victoria's transition over to the National Disability Insurance Scheme and we are very concerned that it might get lost in the national pool of funding and also that those relationships across sectors between disability, family violence and women with disabilities that are integral to building the initiative and making it work effectively would be lost in the national scale.

MS DAVIDSON: Ms Howe, you have talked about in your statement the right of women with disabilities to be recognised as parents and identified an issue in relation to how services or the lack of them or the reliance upon family members potentially reinforces or contributes to the control that a perpetrator is able to exert over a woman with a disability. Can you explain that issue and how you see that being potentially addressed?

MS HOWE: Yes. This is a very real issue and again our research found that women did have children removed from their care. There are two aspects of this that we need to think about. There is a strong belief in our community, an unfounded belief, that women with disabilities are not able to provide adequately for their children. In fact, it's very common, when a woman reports family violence, that the child can be removed from her care because the belief is if the partner isn't around that she's not able to provide adequate care.

There is nothing in the research that suggests that women with disabilities are less able to provide effective parenting and to be good mothers. What the research tells us is that it is the appropriateness of family support that's very important. So we need to be

able to tailor effective family support so that women with disabilities are able to provide the support they need.

In my experience in my previous role as chief social worker at the Royal Women's Hospital, I experienced on a number of occasions where women had mild intellectual disabilities that children were removed from the hospital at the instigation of Protective Services without any further follow-up, any further assessment of the woman and her capacity to provide care and no intervention plan to reunite the family. This was in my view based on attitudes that were unfounded and without adequate intervention.

So I think we need to look more carefully at the ways we are protecting children, and of course it is critical that we provide a caring environment for all children, but there are ways that we can do that that mean that women are not fearful that, if they come forward and report family violence, that their children will be removed.

Another way that we can I think address this is with disability services who haven't traditionally seen women in a caring role if they have a disability. So we tend to think about people with disabilities as individuals who might have families of origin that provide care, but we don't tend to think about people with disabilities who are providing parenting support to their children.

So, disability services need to be open to the idea that there is a role that they need to support through disability service support. We have an instance of one woman who told us about a disability worker that

was authorised to feed her and to assist with meal preparation for herself, but wasn't allowed to give a drink to her son who was there. There is no reason why through policy that this should be the case, but in practice disability services can have a very narrow view of what's reasonable in providing support to parents.

MS DAVIDSON: What does that mean in terms of the woman's capacity, a woman with a disability, her capacity to contribute equally to a relationship and have that equality within the intimate relationship? How do the disability services deal with that?

MS HOWE: This is another aspect of how we view families within the disability care system and we tend to see families as partners, if you like, collaborators in providing care. For example, if you were to apply for Meals on Wheels or other family support through home and community care, the first question to a woman is, "So, do you have a partner? Okay, he can do that." We could argue that it's perfectly reasonable for men to assist in and to contribute to domestic duties, but in reality we don't recognise that it's absolutely important for power balances within a relationship that both are seen to be contributing and have something that they can contribute in practical terms to the relationship.

So one woman spoke to us about how she had to insist with the new National Disability Insurance Scheme that it was reasonable for her to have assistance in preparing her husband's meal because she felt he did a great deal for her in terms of personal care and in reciprocating in that relationship and ensuring some kind of balance in that relationship that she needed to be able

to provide for him too and she was successful in the end in being able to advocate for her needs. But I think it's very important across all disability service provision that it's recognised that we have to be very aware of power within relationships and to be respectful of the need for women to be able to contribute equally to a relationship.

MS DAVIDSON: Ms Pearce, do you have anything additional to add to that?

MS PEARCE: Just in support of Keran, it's certainly our experience that women with disabilities have their children removed at a far greater rate than other people in the community. If you look at Child Protection itself, you will see that many of the families, but in particular the women that are there, are women with some form of disability, that they are significantly disadvantaged in the justice system and that many of these people may have been removed from families themselves, they may not have an experience of what a family life might look like and, as Keran said, they are not given any support in order to equip them to be able to parent their children in an effective manner.

So the first instance is whilst, like Keran, the protection of the child is paramount, but also children have a right to grow up in a family and people should be supported to be able to exercise that right.

MS DAVIDSON: Moving on to another topic in relation to attitudes towards people with disabilities, it's an issue that you have all raised in your witness statements. How does attitudes towards people with disabilities impact upon their ability to access services and leave or get

away from family violence?

MS HOWE: With regard to disability services, we are concerned that disability services do not have an adequate understanding of family violence and more broadly in terms of what women might need in providing an appropriate quality service. So, one example I can give is a woman recently brought to our attention - we will call her Monica - who is in a supported accommodation service and when she first went to that service checked whether in fact they would provide intimate care, whether they were able to provide the intimate care that she needed through a female worker, and she was assured that that would be the case.

As time has gone on, that has not transpired and at the moment she is receiving care with her catheter and care with showering and care with her menstrual care from male workers. She is finding this extremely distressing. She is going without showers. She is having all sorts of health problems as a result of refusing the care of male workers. There seems to be very little understanding by the disability service that this is in fact quite a violation of her human rights as a woman to dignity and she is experiencing that as a very humiliating experience.

So women with disabilities who have that experience of demeaning and degrading practices, they often have talked about internalising this experience and believing when they do experience violence that maybe it's their fault and perhaps they deserve it. Women spoke repeatedly in our research about that sense, and it again was reinforced by partners and others, that in fact "This is your fault."

So I think we have a real responsibility that we provide empowering services to women, to all women, and that the barriers to escaping violence are addressed. So I think that example provides a very clear example to me about the ways that we need to address this. We at Women with Disabilities Victoria are working with disability services to raise their understanding of women's rights to gender-sensitive services and also raising awareness of the existence of family violence and the critical importance of disability services in identifying that and making appropriate referrals.

MS HARGRAVE: If I may just add an example of how critical family violence training can be for the disability sector. I would like to point towards two recent examples that I received that were actually both quite similar regarding disability services, both involving women with communication difficulties. So they didn't communicate through speech, they communicated through gestures. Both were appearing increasingly withdrawn in their disability services and looking very reluctant to go home.

In one service the staff member was able to go to her manager, who'd recently received an introduction to common risk assessment training, and the manager was then able to have a conversation with the woman using assisted communication techniques to confirm, yes, she was feeling unsafe to go home and then to call the Family Violence Service who was able to send out an outreach worker who worked with the communication assistant to develop a safety plan and to give the woman important messages that the violence she was experiencing wasn't her fault and to look into options for the future.

In the other service the worker went to her manager, who did what is common practice in disability services and called the woman's mother. This in turn put the woman and her mother at greater risk of the violence they were experiencing and in fact resulted in a terrible outcome where the woman became withdrawn from the service and became more isolated and more exposed to the violence she was receiving at home.

So resourcing for disability service workers around identifying and responding to family violence is critical, both in disability services that are run in Victoria and nationally, and of course mental health and other associated services such as aged care.

MS PEARCE: If I could add to that and to say in support of Keran and Jen that what we are seeing in disability services, particularly in residential settings, is the normalisation of violence against people with disabilities. So we see that the tolerance is very high and what I think any reasonable person would consider violence is in fact tolerated.

I recently received a letter from the Department of Health and Human Services in relation to a notification. So, when I see a situation where I am very concerned about the safety and wellbeing of residents in a house, I notify the department. I got a response back from the department that said that they did acknowledge that what they called "episodes of behaviours of concern" can be a cause of distress to other residents and they then went on to say, "I have no evidence to substantiate the concern regarding resident compatibility."

Yet in the very next paragraph they talk about,

in a 12 month period, "28 incidents of reports were submitted relating to incidents involving physical assaults directed towards staff and other residents and a small number of incidents involving the attempt to pull down the pants of the residents." Now, who here would tolerate that? And would you describe that, if that was happening in your house, as "resident compatibility"? It's got nothing to do with resident compatibility. It's got to do with violence.

One of the things that the family violence sector has fought for for many years is to have violence and abuse named as that. What we see in disability services calling it "behaviours of concern" or "resident compatibility" and not naming it as violence and abuse means that it remains hidden, we are not getting the cultural change or the policy change that's required to in fact address what's happening in these houses, it remains hidden and if it's not named and it's hidden, we can't address it. I think the examples that Keran and Jen gave are just very much examples of that.

MS DAVIDSON: Ms Pearce, you talk in your witness statement about group homes and you make an argument that some residents would be regarded as family members under the Family Violence Protection Act. Can you explain what a group home is for people with disabilities and why you say that in some cases the violence that might occur between residents would be regarded as family violence?

MS PEARCE: Group homes, they are houses in the suburbs, in the community, when following de-institutionalisation it was thought that people would have better outcomes and be more included in the community if they in fact lived in the

community. So they are small houses with a home-like environment as opposed to an institutionalised setting where people live together. They can live together for a very long time. It could be years where they could live together.

In that same letter that I read from earlier, the department describes the relationships in that household as saying, in talking about an individual, that they had "made friends" with the other residents. They go on to say that they had "engaged in playful activity with other men and has an especially good relationship with one man who has taken on the role of 'big brother' towards him." They also later in the letter describe two of the people living in the house as siblings. So, there's a range of relationships. Many of them are long-term; some of them are more short-term. People don't have a choice about who they live with, so it is an arranged relationship. But, notwithstanding that, we know that in these relationships people can form long-term relationships.

Just by way of an example, I was speaking to a palliative care doctor recently who was talking to me about her experience of helping a person with a disability die at home because he wanted to be with what he perceived to be his family and for them to all be able to grieve with him. She said it's increasingly common that people might choose to die at home if that's possible.

We know from the department's own material that each of the residents will have what's called a "person centred plan" and in that person centred plan there is a description about the relationships with other people in the house. They are not described as family members, but

nor are they described as people who are just simply co-habiting in the house; they are more akin to family type relationships.

While the aim of the group home is to improve the quality of life of people who live there, part of the role of the staff is also to foster relationships. So that's why I think that they are in fact people's homes. They live there for a long time. They are not a shared household such as you might see in a university household. They are completely different to that.

Can I also add that in some houses they might buy white goods together. Historically that's happened in some houses where they have ISPs, so the supported packages. They might share that in terms of purchasing food for the house. So there's a lot more interdependence than there would be in a normal shared house setting.

MS DAVIDSON: In your experience, to what extent do residents of those homes get a family violence response from services in terms of a response that's been developed under the Family Violence Protection Act?

MS PEARCE: In my view they don't. If I could just take you through, and I have been using one household and I will stick with that one household because I think it characterises the relationships in the household, the fact that 28 incidents of violence are just considered - not even accepted as resident incompatibility, let alone acknowledged as violence.

But, six months after I got that letter, the community visitors were alerted there had been violence going on in that house, so continually, unabated. I just wanted to share with you an incident report, to just

illustrate the difference in the response that a person in a disability service might receive to a person with a disability residing in the community. I'm just paraphrasing from this incident report.

So, we have a resident sitting on a chair in the lounge area singing to himself. The staff can't see any trigger, but he's then attacked by a resident who grabs his shirt and his chest. The victim was screaming. The staff tried to redirect the attacker verbally, but with no impact. The attacker then proceeded to grab the victim by the neck and shake his head so that the head banged repeatedly on the hardwood of the chair backing. The victim was screaming. The perpetrator could not be redirected. Staff tried to block him from being continually hit and scratched and banging the victim's head against the wooden backing of the chair. The victim's shirt was ripped open and a wound started to appear on the victim's chest.

The victim was taken, rushed into the office and they were all locked in the office. In the meantime other residents were moved out of the lounge room. Somebody in the shower was attempted to be protected. In the office they sighted several bleeding scratches on the front and the back, the most prominent being on the upper right side of the chest. An ambulance was called in case of head injury. The perpetrator wouldn't let them out of the front door and so the staff locked the front door and escorted the victim out of the back where he was treated in an ambulance outside because the paramedics couldn't get inside.

This is categorised as a category 2 incident, not

even a category 1, and no police were called. So what's the difference? It's not recognised - I mean, that's a terribly frightening situation for everybody. The ambulance is called. We know this has been going on in this house unabated for nearly two years. The police aren't called. It's just simply another category 2. Then I think the department has the hide to say that it's about resident compatibility and not about violence and abuse of people with a disability.

MS DAVIDSON: You talk in your witness statement about personal safety intervention orders compared with Family Violence Protection Act orders. What is the usual mechanism - you have identified that these residents may be family members under the Family Violence Protection Act. How often would that Act be used by police to apply for an intervention order for a resident in that situation?

MS PEARCE: I haven't found one case where the Family Violence Protection Act has been used. To a certain extent, whether you get an intervention order under the Personal Safety Act or the Family Violence Protection Act, the thing is people have got protection. But the issue is what about those people who are residing in houses - so let's just take the house that I have been concentrating on, in that house.

In the first place police aren't called. So where is the access to justice there? But in the second case should police be called? There is the question: is this a family violence situation or is it a question of the Personal Safety Act? A lot of things flow from that.

So, for example, who will apply for the intervention order? Where there's family or a guardian

from my office, we will apply. So a person can gain protection in that manner. But a person with questionable capacity, how is one of these residents without family members going to be able to apply for an intervention order?

Secondly, when the police come, if it was considered to be family violence, there is the family violence code of practice and a lot of things flow because of that. But if it is not considered to be family violence and it's merely the Personal Safety Act, police have a choice about what they are going to do. They are coming into a situation which is extremely volatile. They may not be able to communicate with the residents. In another case where police did come capsicum spray was used against residents and one of the residents was charged.

But I'm very sympathetic to the police coming into that environment. It's very difficult. They are often relying on workers to intervene and to tell them what has occurred. We know from the case that I have cited it's only a category 2 . So in their minds it's not particularly serious in any case. It's serious enough to warrant a category 2, but not a category 1 nor to call the police.

So you are often stuck with what you do. What do you do in those situations? Many people do not have a family member nor do they have a guardian. So it's what flows for these residents. What is their access to justice in a system where the only protection they have is the personal safety intervention order and their ability to apply for it? I should say also that if you are applying for a personal safety intervention order then

your access to Legal Aid is somewhat more limited. So how can they get an intervention order? What can they do?

COMMISSIONER NEAVE: I just need to understand that. It would be helpful to the Commission for you to differentiate a little bit more. The police safety notice procedure that applies under the Crimes (Family Violence) Act does or does not apply to personal safety orders? I don't think it does apply, does it; that is, the police make the application on behalf of the affected person?

MS PEARCE: I think they can. I'm not sure. I'll need to take some advice on that. But they are less likely. If they are able to do so, they are less likely to do that.

COMMISSIONER NEAVE: Because it's not covered by the code?

MS PEARCE: Because it's not covered about the code.

COMMISSIONER NEAVE: So this is as much about police practice as it is about what the law might be.

MS PEARCE: It is indeed.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Can I move to another topic in terms of family violence services and the availability of accommodation, particularly for women or men with disabilities. This is an issue that I think you have raised, Ms Hargrave, in your statement. Can you identify what you see as barriers for women being able to escape family violence given the availability of accommodation?

MS HARGRAVE: Family violence response services, as we know, are under enormous demand and they are faced with an unenviable decision. As one service said to me and one refuge said to me, "We could take one woman who has disability support requirements or we could take five other women." So we would argue we need to be putting in

place things that allow them to prioritise women who have higher risks, because where else can that woman go?

In talking about disability access we should recognise that there are many different types of disability which require different types of access. For women requiring, for example, ramps or handrails or wider doorways we have on record from the Department of Health and Human Services and Safe Steps that there are up to nine refuges with those facilities across Victoria. Appropriately three of those are for Aboriginal women because nationally 51 per cent of Aboriginal women have a disability.

But in looking at those refuges, which will often not have availability and not all their beds will necessarily have accessible features in that area, they are not located in each region. So we can't guarantee that there's a crisis accommodation response that's accessible to women requiring universal access accommodation in each region of Victoria. There's also other types of access barriers that we need to talk about that might be based on attitudes or other types of resources.

MS DAVIDSON: In terms of longer term accommodation for women you have identified issues regarding the building industry and the lack of accommodation that would be suitable for women with disabilities fleeing family violence.

MS HARGRAVE: That's right. I might hand over to Keran in a moment to talk about the building industry, as she's done some work in that area. But not only do inaccessible housing options - so we know that housing options are very limited for all women in terms of being affordable and in

the areas that they have their social and service networks. But for women with disabilities that's even lower.

So, in terms of family violence prevention, that means that women with disabilities don't have housing options to live independently as much as other women, but also in terms of leaving short and medium-term crisis accommodation it means there are fewer exit options. Some refuges may intake according to what they see as the exit options for women.

For these reasons putting women in short-term and medium-term crisis accommodation isn't always ideal, and it's really important to look at what other things we have in place such as Safe at Home programs. These programs are able to assist women to stay safe in their own homes while maintaining their social and disability support networks. It's unfortunate that the national funding for the Safe at Home programs is continuously in doubt.

MS HOWE: If I go back to Monica for a moment, the woman who was living in supported accommodation and was unhappy about her care, she has said that she would love to move out and has a friend who would also move with her into a unit and she could then be eligible for personal care through other packages. But there isn't any accessible accommodation for her to move into.

So to address this we have to look more broadly at how we are developing housing. In Victoria we have looked at this. The previous Labor government looked at building regulations and making changes to building regulations so that there was a minimum standard of accessibility for all new housing and apartments. That

was held up with the election and it was never taken up again. I think this is a critical issue for us to take up both nationally and within Victoria; that we catch up with other countries where universal design standards have been around for years with regards to new buildings. Unless we do that, we are not going to deal with an ageing population that requires accessible, basic universal design standards and we are not going to address these issues with regard to women with disabilities and people with disabilities generally who need affordable and accessible housing.

MS DAVIDSON: I take it that that issue would also arise for able bodied women but who have got children with disabilities.

MS HOWE: Correct. That's right. We are talking about anyone with a disability, child or adult. If we look at the incidence of disability it is very high in our community. One in 20 people have a disability. It's higher if you look only at the adult population. One in 16 to 17 have a profound and severe disability . So we are not talking about a small minority. We are talking about a significant population that's at the moment excluded from affordable accessible housing.

MS DAVIDSON: Can I move perhaps to another topic that you have raised, Ms Pearce, about the independent third person program and the extent to which it is utilised in a consistent way by police. Can you identify, firstly, what that independent third person program does and what you have identified as being potential gaps in the way it's implemented?

MS PEARCE: The independent third person program are

volunteers. They sit in on police interviews wherever anybody has an apparent cognitive impairment. I say "apparent" because it doesn't have to be a diagnosis. In a police interview it's not possible of course to have a diagnosis. So it's really up to the police to make that determination.

Last year we sat in on around 2,700 police interviews. We know if we look at the number of people that are in our prison system who have either an acquired brain injury or a mental illness or an intellectual disability that there are many more than 2,700. So what we think is happening is that there's an under-utilisation of the independent third person program.

In part that's because it's not in law that it's mandated; it's in the police manual that police are required to have an independent third person attend the interview. But we know when we do the analysis of where we see police using independent third persons that there's a great disparity across the state. So some stations, such as Dandenong, are really outstanding in their use of independent third persons. But you might see another station, such as Sunshine, where one would think there's a relatively similar demographic with significantly less numbers of people interviewed by police with an independent third person. So it's the station by station analysis that tells us that there is a significant under-utilisation. We have also looked at data from the out court and we estimate that only 50 per cent of people going through the out court have in fact had an independent third person in their police interview.

MS DAVIDSON: That program would apply potentially to victims

and perpetrators and witnesses of family violence who might have a cognitive - - -

MS PEARCE: Yes. If I could also just make the point that a young person - so we would see young people - without a cognitive impairment has what's called an independent person, and that is in legislation. So it is there for young people. But what about people with a disability? Why is it that there is this choice?

MS DAVIDSON: Are you calling for it to be put into legislation?

MS PEARCE: Yes, we are.

MS DAVIDSON: I will move to another topic which you have all identified which is the possibility of an expansion of the Office of Public Advocate's powers to conduct investigations. Can I ask you to explain what you would be seeking in relation to the conduct of investigations and why you think it would be helpful in the context of family violence?

MS PEARCE: This was an issue that was canvassed extensively by the Victorian Law Reform Commission in its review of the Guardianship Act in 2012. So it isn't just my office and people like Women with Disabilities Victoria that are calling for it. There has been a lot of thought that has been put into this.

What we typically see is that the power of the Public Advocate to investigate abuse and neglect in a broader community setting is limited to cases where a person might be in inappropriate guardianship or an application for guardianship is likely to occur. There are many cases of abuse in the community where a guardianship order is not appropriate and the person is

not being held in appropriate guardianship.

If I just give you an example. The Aged Care Complaints Agency has contacted my office on a number of occasions where there is a person who is not in receipt of Commonwealth aged services funding, so they don't come under that scheme, but they hold significant concerns for the wellbeing of this person with a disability in our community. Their question is who and in particular is there anything my office can do. And these people are living at home.

So in one case we used my advocacy power and simply knocked on the door, and we found the person was in fact being very well cared for. But had the person or the family not let us into the house then it would have been very difficult for us to ascertain whether or not there was any question of abuse of that person. Police could have been called. But the question was around peg feeding and whether inappropriate materials were being used in the peg feed and whether the family understood how to care for a peg feed. So it was something that was going to be far more complex than I think the police could understand.

In my view we call it investigation, but perhaps it's more akin to a preliminary investigation and referral to an appropriate body, including guardianship should it be warranted. But in many cases guardianship itself won't be warranted.

MS DAVIDSON: That investigation power that you would be calling for, it would cover family violence incidents?

MS PEARCE: Yes. But with the advent of the National Disability Insurance Scheme and the Commonwealth establishing safeguards, and these safeguards would apply

to people who are in receipt of those services, there will be other mechanisms. So we wouldn't necessarily be looking at group homes where there are other regulatory environments. It's really for people with a disability in the community where there is no other option.

MS DAVIDSON: I'm conscious of the time. Does the Commission have any questions for these witnesses?

DEPUTY COMMISSIONER NICHOLSON: Yes. I would like to ask about the implementation of the National Disability Insurance Scheme where, as I understand it, it's creating a market of providers, both for profit and not for profit. Central to the whole scheme is this concept of consumer directed care, which should empower people to determine the type of care that they wish to receive. But it's also been put to me that it opens up the opportunity for coercion from family members about what sort of care is going to be determined and that under this scheme there may not be enough monitoring of that to be able to identify when it occurs.

MS PEARCE: I wouldn't mind commenting first. My office has had quite a lot of experience with the trial site in Barwon, and that's right. The philosophy is empowered consumers in a competitive market based environment. But the people that my office works with are people with cognitive impairments, particularly those with significant cognitive impairments, and it doesn't matter which way you look at it they are not going to be empowered consumers in this new model.

I think around 60 per cent of people who are in receipt of NDIS funding are people with cognitive impairments. It's far higher than they thought. So

initially not enough thought was put into how that might work. So, for example, the nominee provisions that are there that are akin to those under the social security system are not routinely being used because many people do not have family members and the nominees are not paid people.

So who is making decisions for people with significant cognitive impairment? Often it's the planners who are making those decisions. It's only recently been recognised that a support person needs to sit in on a planning session. People were left to their own devices and didn't cover all of their care requirements such as continence aids.

But I think NDIS is starting to recognise this and does have a number of priority projects coming under the NDIS Board where they are looking at the issues related to cognitive impairment. But I think there is a very strong disconnect between state based guardianship laws and this legislation, particularly around nominee provisions and who can make decisions.

MS HOWE: We also have concerns about the coming reforms and the present reforms in the Barwon area, and the extent to which the agency that's responsible for the National Disability Insurance Scheme, which is the NDIA, are aware of, for example, the issues of family violence and of the importance of ensuring that the person that's to receive support is comfortable with family members being part of the planning process.

There's not really, that I'm aware of, real attention being paid to the fact that not all families have the best interests of the person with a disability in

the family at heart and there are opportunities for exploitation. There are currently families where abuse is occurring and it's not being picked up as part of that assessment process.

So we think there is a very important role in workforce development within the NDIA to make sure that planners and anyone involved with the direct care planning is aware of these issues and that there are practices and policies in place so that these things are assessed as part of the assessment process.

DEPUTY COMMISSIONER NICHOLSON: Perhaps if you have specific ideas about the practices and policies you might like to forward those to the Commission.

The second thing about the NDIS, I was unsure as to what provision it makes for housing assistance, whether that's modifying accommodation or whether it's simply assisting a disabled person be competitive in a tight rental market.

MS HOWE: I'm not sure that I can fully answer that question. There was a housing strategy.

MS PEARCE: Which hasn't been released and we are all anxiously awaiting that to understand what the relationship with NDIS will be in relation to the funding of accommodation. We do know that there has been a long, hard battle by my office and many, many disability advocates to ensure small-scale accommodation, a home like environment, the group homes and for the closure of institutions. We need to see the accommodation paper to understand what will in fact NDIS fund. Will they fund large-scale congregate care facilities? Is that part of the agenda? So we need to understand that because there has been a long battle to

move towards people having the right to live in the community in small-scale settings. But I do acknowledge that some parents certainly do want their children to live in larger scale settings.

DEPUTY COMMISSIONER NICHOLSON: It would seem that if the NDIS doesn't adequately address the housing issue then the whole notion of consumer directed care is a bit of a nonsense.

MS HOWE: I think that's right, but I think also government has a broader responsibility through housing to ensure that housing - as I have made the point - is accessible because sometimes we are using congregate care because we don't have other options for accessible housing where you could use a support package. So I hear significant numbers of people who are in - - -

DEPUTY COMMISSIONER NICHOLSON: Would that be in terms of a rental subsidy, for example?

MS HOWE: It could be. But it's also about the practical lack of accessible housing, which I think needs government leadership.

MS HARGRAVE: I might just add there very briefly too. In a rental property you are not legally protected to make a disability modification even if you pay for that to be installed and removed at your own cost.

MS HOWE: Can I just add another area with the National Disability Insurance Scheme is advocacy, and with the move for all funding to go across from Victoria to the Commonwealth, advocacy services in Victoria such as ourselves could be at risk and in terms of the empowerment of people with disabilities and women with disabilities in particular this is a concern we have.

COMMISSIONER NEAVE: No further questions, thank you.

MS DAVIDSON: Perhaps these witnesses can be excused.

COMMISSIONER NEAVE: Thank you very much indeed.

<(THE WITNESSES WITHDREW)

MR MOSHINSKY: Commissioners, we may just change the order slightly and we will call Mr Fonzi later in the day and we will go directly now to Ms Blakey and Mr Chesterman. If they could please come forward.

<JOHN HENRY CHESTERMAN, sworn and examined:

<JENNY BLAKEY, recalled:

MR MOSHINSKY: Ms Blakey, if I could start with you. You have previously given evidence on Day 4 of the public hearings in relation to the topics of financial abuse and financial empowerment. Your statement on that occasion is also before the Commission today.

MS BLAKEY: Yes.

MR MOSHINSKY: You indicate in that statement that you are the manager of Seniors Rights Victoria.

MS BLAKEY: Indeed I am.

MR MOSHINSKY: In the interests of time I won't go over the introductory matters that we canvassed last time in terms of your position and the organisation.

MS BLAKEY: Yes.

MR MOSHINSKY: Mr Chesterman, you work at the Office of the Public Advocate?

DR CHESTERMAN: That's correct.

MR MOSHINSKY: Could you briefly outline what your position is and your professional background?

DR CHESTERMAN: I'm the Manager of Policy and Education at the Office of the Public Advocate. I have been there now for six years. Prior to that I was an academic at the

University of Melbourne where I lectured in political science. I have a background in law and history.

MR MOSHINSKY: In terms of your work, is part of your work or focus on issues to do with elderly people or older people?

DR CHESTERMAN: I'm the manager of our systemic advocacy arm, our policy and research unit, and we do have some involvement in the elder abuse area. I'm also a member of the Seniors Rights Victoria Council. In 2013 I was fortunate enough to be on a Churchill Fellowship, which looked at matters that are germane to the topic of elder abuse. It wasn't focused just on elder abuse. It looked at at risk adults and the adult protection system generally.

MR MOSHINSKY: I may direct questions to Ms Blakey and if you wish to add anything at any point in time please do so.

DR CHESTERMAN: Thank you.

MR MOSHINSKY: I also will just indicate that, given that the focus of the questions with you, Ms Blakey, on the last occasion was around financial abuse, I won't be focusing on that so much today in the topic as we have covered that to some extent already.

Can I start with this topic broadly, Ms Blakey. Can you briefly encapsulate what we mean by elder abuse and how that intersects with what is family violence?

MS BLAKEY: Yes. Elder abuse is a term which is defined by the World Health Organization, and it's defined as an act which causes harm to an older person and is carried out by someone they know and trust, which might be a carer, a family member or friend. It can take the form of a single or repeated acts in that relationship where there's the expectation of trust.

The relevance to this Commission is that we see a lot of - we are an organisation that focuses on elder abuse, but the people who contact us, a lot of it occurs within the context of family. So we see that for the most part our experience indicates that elder abuse occurs within the family. In fact we have some statistics which were produced over a two-year period which show that in 92 per cent of the cases the perpetrator is a family member, and in fact of those approximately two-thirds the perpetrator is the adult son or daughter. So it is very clearly abuse occurring within the family.

DR CHESTERMAN: Can I contribute just a word on that and just to say the only areas where elder abuse wouldn't be family violence would be probably in two areas: one where the abuse might not constitute violence, as such, and the other one would be where the trusting relationship wouldn't be seen as family-like. But largely, that's right, most situations of elder abuse would be family violence.

MR MOSHINSKY: What do we know about the prevalence of elder abuse? In the Seniors Rights Victoria submission at page 15 there's a section dealing with the prevalence of elder abuse. Are you able to indicate to the Commission the extent to which there is evidence about the prevalence?

MS BLAKEY: Yes. There is very limited evidence of the prevalence in Australia in that there haven't been the appropriate prevalence studies undertaken. But there is an estimate that it is 5 to 6 per cent of older people, so over the age of 65, experience elder abuse.

Overseas studies are much more disparate in terms of their estimates, but the World Health Organization says

that the estimate could be anywhere between one and up to 10 per cent of older people experience elder abuse. We consider that it's highly underreported, and that is also the reports from other research. So that may again be low figures. There is a reluctance and difficulty to know to what extent people may report elder abuse. In part that's because people don't know what they are experiencing might be considered elder abuse and therefore identified as such.

MR MOSHINSKY: Ms Blakey, in your witness statement at paragraph 26 you make the point that a distinction between elder abuse in families and other forms of elder abuse is this intergenerational aspect. Can you expand on that?

MS BLAKEY: Yes. A common conception of family violence is that it is intimate partner violence and generally between male and female. So therefore it has a very distinct focus on the enormous number of women who are affected by family violence.

Our experience is that the defining characteristic is the difference in ages. So the person who is experiencing the family violence is usually someone in the age group of 70 to 84 years old and the perpetrator is usually someone aged between 35 and 54 years old, according to our experience. So we are talking about people in their 70s and their 80s and sometimes older experiencing the abuse at the hands of someone who is younger, so someone in their 40s, 50s generally, and also 60s and 30s.

So whilst we also see the overlay of the difference between genders in that approximately 62 per cent of the people who experience elder abuse at

our service are women, and that means about 27 per cent are men, so still a high proportion of people who experience it are women, but also a significant proportion who are experiencing it are men as well. So the distinctive characteristic is the age. So it is the overlay of the age difference and the gender.

MR MOSHINSKY: I was wondering whether both of you may be able to comment on a situation that was referred to quite a number of times in the course of the community consultations that the Commission has carried out which is a situation of the adult child who is using violent behaviour to an older parent, and that situation poses a number of very difficult issues, particularly around engagement of the police by the victim. I was wondering if you are both able to speak to that situation and the difficulties in accessing help in that situation.

MS BLAKEY: Yes, I will start with perhaps just explaining there are different types of abuse for elder abuse. There was the mention of financial abuse, which we talked about last time, and then there is psychological or emotional, physical, social, sexual and neglect. The foremost experience that we see most of at our service are financial, which we have covered, but also emotional and psychological. So it can be the name calling, the abusive language and those sorts of things.

To come to your question, the difficulty for older people in seeking assistance is that it is a family member, and it is frequently their son and daughter, and so they are very loath to take action against that person. They try to keep it within the family. So there's a sense of saying, "I don't want to call the police on my son.

I don't want the police involved. I don't want it to happen. I don't want my son to go to gaol", or they are worried about, "If I engage in someone to take action in this matter, what are the implications for me and my relationship?"

So for some people they are prepared to tolerate the abuse at the expense of themselves because they don't want to lose the relationship. They are worried about that being fractured, it being lost and that that may mean that they are even further isolated. As someone ages, it's because of their health conditions and also their peers are dying, they have less social supports and networks available to them or able to access, and they become more reliant - they can become more reliant - on a few key people, and that can be family members. So losing those relationships can be very significant in terms of increasing their isolation, their loss of those significant relationships, particularly if they are sons and daughters, and also the threat for them that they may feel that they can't stay where they are and they may have to move into care facilities.

MR MOSHINSKY: Mr Chesterman, did you have any comments on that scenario that I have asked about?

DR CHESTERMAN: Sorry, I just missed your follow-up question.

MR MOSHINSKY: Do you have any comments about that scenario of the adult child who is using violence, it may be physical or it may be emotional or psychological or financial, against an older parent and the difficulties confronting the victim in that situation and who to turn to for help?

DR CHESTERMAN: Sure. The initial point I would make is obviously where there has been clear criminal activity

then police should be the first port of call. But for the reasons that Jenny has outlined sometimes the victim will be the only witness to the behaviour and they may be reluctant to call police.

One of the things that we have identified - and Seniors Rights as well - is there is what we have called an investigations gap at the moment where there's not obvious criminal activity - so if we are talking about, for instance, psychological abuse, even some forms of financial abuse, which I know you have covered - who do you call in that situation; who does the victim or others who observe kind of worrying signals, who should they call? In the absence of obvious criminal activity or an obvious medical emergency, then emergency services, police, ambulance officers are unlikely to be able to assist.

This is why we have said that there is a need to empower a statutory authority to conduct what we would call a supportive intervention or supportive investigation where they would go in and just assess what's going on, link a person to services where that's appropriate, refer matters to police where that's appropriate, but be able to go in in a supportive way and identify further what's actually going on.

MS BLAKEY: Can I add another response to that which fits with what I was saying before. Parents can have this sense of shame and not wanting to disclose what's happening and there can be a sense of, "I haven't parented well enough," or there can also be the sense of, "I need to keep trying," particularly where there may be issues with their adult child which may relate to substance use or alcohol

use or mental health or gambling or whatever, there is still this sense of wanting to be a parent and take care of that person and try and resolve it in some way.

MR MOSHINSKY: Can I turn then to the topic of barriers to seeking assistance if you are an older person who is experiencing family violence or elder abuse. What are some of the barriers that exist to reaching out to get support?

MS BLAKEY: I think the first barrier again is identifying what it is and knowing that such a thing as elder abuse exists; so being prepared to then talk about it and if it's spoken about with someone that they identify what it is as well. So the importance is that if they talk about it with someone that they trust, it might be another family member or it might be a professional such as their GP or it might be some other health worker that they have contact with, that there is the ability again on that professional's behalf to actually recognise it as elder abuse and be able to respond.

So it's important that there is an awareness not only within the general community and with older people that this is something which exists and what it looks like, but also with those parts of the service system that people might come in contact with, and that might be the banking system, it might be accountants, it might be hospitals, it might be GPs or whatever, it might be the support services that come into the house to help the person with their housekeeping or their shopping or whatever. So it's important that people are trained to recognise elder abuse and be able to respond and then act in some way.

The other barrier that I mentioned before is about the disclosure, so the difficulty of the older person actually disclosing and feelings of trust and feeling a concern about how will it be responded to, will they lose their relationship or will things be taken out of their hands so they will no longer have control over what they want and how they want their world and their relationships to exist.

The other difficulty of course is the isolation which I talked about before where people have less and less contact with others and so therefore are not able to have a place where they can go to and talk about it and comment. That may be particularly the case for people in rural and regional areas where there is a growing number of older people because younger people are leaving to find work and study elsewhere. So there's an isolation which is geographical as well as these other barriers.

The other barrier which is probably worth noting is for people of a different cultural background and their ability to access information in a way which is appropriate and culturally appropriate to them. So there are pockets within our community who may have difficulty having access to that information.

DR CHESTERMAN: Can I just add to that. I agree with everything that Jenny has just said. I think that's a good articulation of what the barriers are. One of the things I would just add to is in looking at the limited service responses we have currently available we have really got some pretty blunt strategies in this area which include a person losing control being moved into an aged care facility, for instance, or having a guardianship or

administration order taken out against them where we effectively remove their decision making authority. So as protective mechanisms they are fairly blunt ones. What we would certainly be proposing would be kind of more varied service responses that support a person and listen to what the person wants and support them better than we are currently able to do.

MR MOSHINSKY: At this point we might just show a short video which is not specific to family violence but what raises some other relevant themes. If you might turn around and watch it and then I will ask you to comment after we have watched it.

(Video played to the Commission.)

MR MOSHINSKY: I should just note that I think we missed a few seconds - - -

DR CHESTERMAN: There are some words at the start.

MS BLAKEY: I can tell you what that text is because I know this well and it moves me every time I see it. What begins is that you can see there's someone standing in front, which you assume is an aged care worker or nurse, saying, "What's this one's name? What do we call this one?" Then the woman comes in to see him and says, "These aren't your clothes. Where are your clothes?" I guess for me it highlights very strongly how older people can be regarded in our community as nameless objects, people who aren't individuals, who are just treated as something to be clothed and fed.

Then we go back through the richness of this person's life and we then immediately start to think of this person in a very different way and see him as a more complete person and someone we accord rights to, who has

wishes and desires and who may want to be in control of their life and be listened to and spoken to and speak. So I find that that illustrates the point of ageism which I guess underlies the point I was making before about the power abuse occurring between different ages, and that's the ageism that older people experience in the taking of control and the abuse they experience.

DR CHESTERMAN: Everyone who I show that to thinks it's just fantastic. I have shown it to my teenage children, who are moved by it. They have a grandfather in aged care. It is a very powerful rendition of the vulnerability and the lack of respect that can accompany ageing in our society.

MR MOSHINSKY: Can I move then to the issue of availability of services or gaps in supports and services that are available. What are some of the main gaps that you would identify in terms of older people seeking help for elder abuse within a family context?

MS PEARCE: I think again it comes back to services knowing about elder abuse and being equipped and able to respond to them. I have talked about that, so I won't go over that again. But the other issue is appropriate accommodation. So the family violence sector is set up for women and children and there can be needs for accommodation for people who are older. We are not talking about aged care facilities. People who are still very active and competent don't want to end up at that point in time in a facility which is established for different health needs. So accommodation is certainly one of those issues.

MR MOSHINSKY: Are you referring to crisis accommodation, for

example?

MS BLAKEY: Crisis accommodation and maybe some longer term accommodation. That can come up particularly where they may have lost their accommodation. They may have lost their home, going back to the financial abuse that we have talked about at another time. Also it may be because they have their adult child return home. Their adult child has gone through some crisis. They have separated from their partner. Maybe there has been family violence within that relationship. Maybe there are alcohol and drug issues or financial problems, they have lost their job, their business has gone broke, and they turn up and they need somewhere to live. So they return home.

There is no accommodation for them, and it comes to the family and mum and dad to take them back. For a lot of families that works really well; families manage that. But for some families it's just not appropriate and there is not alternative accommodation for the perpetrator or the person who may become the perpetrator.

I think that there is a greater need for the services for the perpetrator, and older people will frequently say to us, "Can you fix him?" So it's about services which are supportive to the family and the older person in their situation, but also to the perpetrator.

Certainly one of the things that we were interested in exploring and one of our recommendations was how there might be appropriate sort of anger management or appropriate sort of courses or programs perhaps is the right word for the person who is the perpetrator to assist them to change their behaviour and also to support the older person in undergoing that sort of change.

MR MOSHINSKY: Mr Chesterman?

DR CHESTERMAN: Yes, there are very few service responses that are geared towards supporting older people. If you remove aged care from the equation - and we are talking about situations of abuse and violence - there are very few that are specifically focused on older people. Those that tend to be utilised are, as I was suggesting before, fairly blunt strategies where the decision making authority often is removed or a person is moved into an aged care setting.

You would be familiar with the state's elder abuse prevention and response guidelines, which the most recent iteration of those was 2012 to 2014 which I have here, and there will be we believe some new guidelines drawn up. If you look at those, what we currently do is largely draw on existing services and try and pool them together in situations where there is elder abuse. We would be liking to see more specific support mechanisms geared towards, for instance, assisting older people to stay in their home and be safe in their home and have the recognition that they do often still have decision making authority over most of their lives as they have had since they have been an adult.

MS BLAKEY: Can I add a couple of other points that have come to mind, and that is again to think about older people from different cultural backgrounds and in terms of the services that would be very useful for those communities is of course around providing information in appropriate language and written in a culturally appropriate way because for some, for example, cultures the word "abuse" may only talk about physical violence, so they may need to use other language. Of course there are the other issues

around the roles within different cultures of family members and particularly how money might be handled and what the adult son's role is and how older people are regarded, particularly older women. So there is a need for the training of bicultural and bilingual workers and providing information in the language which is appropriate to them. For example, we gave advice to people from 49 different countries of origin over the last two years. So it's really important.

The other area of course which we haven't really explored in great depth and so we are not an expert to talk about is the Aboriginal community. But we are very aware that there are issues around the way older people are regarded in Aboriginal communities, and again their roles within those communities and how they are viewed by the other members in their extended families, so making sure that there is some resourcing to Aboriginal organisations to deal with that issue.

We also think that it's an issue which crosses a number of sectors so that there is the aged care sector, the health sector, the family violence sector, the accommodation sector and so forth. So what we are really keen to see is that there is some work at a regional level which brings together those sectors to respond to the issues in the areas. There are examples overseas of regional coordinators, and I'm thinking of New Zealand but also in Canada and in a different way in the UK, although the set-up there is a bit different because of the different government structures than here, so something which works across the services that exist in local areas and for us to be able to coordinate and to act as a bit of

a clearing house to share that information across regions so that we are not doing something in one area that the others don't know about, that they can learn from each other and actually leverage off each other in terms of their knowledge and responses.

MR MOSHINSKY: Mr Chesterman, I'm not sure whether you wish to make any further comments about the issue of investigating elder abuse beyond those you have already made so far.

DR CHESTERMAN: Yes, the point really is who does one call if a neighbour, for instance, appears to be at risk or suffering harm but it's not obvious criminal activity, it's not obvious that they are in a situation of medical emergency, who do you call in that situation. That's a question that confronts us, and that was the question that I took overseas in my Churchill Fellowship and came back with some responses to that. But both of our organisations think there is an investigations gap at the moment which could be cured by us doing in this state what the Victorian Law Reform Commission recommended in its guardianship final report in 2012 which was to empower in this case the Office of the Public Advocate to undertake investigations where people are at risk.

MR MOSHINSKY: Are there any other responses that you saw overseas through that Churchill Fellowship that would be relevant here that you might be able to refer to?

DR CHESTERMAN: That was the main one because I went and examined some quite interventionist adult protective service systems and I don't think they would translate well here. In large part they are kind of modelled on Child Protection. I don't think they have the balance right in terms of respecting the wishes and autonomy of

the people they are investigating.

Also there was quite a problem with the extent to which adult protective services would go and investigate and make a finding. They were then quite unable to link in appropriate services. So there was nothing that I saw from those interventionist systems that I would immediately adopt.

One of the things, though, that I did see particularly in Scotland, and this draws very much on what Jenny was saying, where they have adult protection committees which are cross-disciplinary local committees, I think there are 29 of them in operation in Scotland with a population of about the same as Victoria, and they meet locally and discuss individuals who are at risk in the community with a range of service providers and emergency services. So I think that works well in Scotland and that's an idea that I think we could draw from, especially not just in the elder abuse area but obviously family violence more generally.

MR MOSHINSKY: Ms Blakey, in your statement at paragraphs 40.3 and 40.4 you deal with the issue of training or education of GPs and also Victoria Police. I wonder if you might be able to expand on that.

MS BLAKEY: Yes. I'm aware that both of those areas have some information and training already, but I think it's fairly limited. Our experience is there is a lack of consistency in terms of GPs and their response and understanding, and I think there could be a lot more training that occurs. I'm aware that there could be particular questions that could be asked by GPs which may prompt and explore the condition of the elder person and it may be simply like,

"Have you noticed a change in your ability to pay your bills," which might then lead to a discussion. So there are some things that could be done. There can also be importance around training GPs to ensure that they make appropriate referrals and good referrals and good assessments around the capacity of older people and their ability to make decisions.

In terms of the police, our experience has been quite disparate. We have had instances where the response from the police has been excellent in dealing with a situation where we have called them to an elder abuse situation and other situations where it's been very poor. In fact we have had one situation where the police was called because an adult grandchild called them and they spoke to the adult children, who were the perpetrators. The older people were Vietnamese and couldn't speak English and weren't spoken to, and the police left. But, as I said, there have been other instances where the police have been very good.

So there needs to be some greater training and consistency across the police force to respond to these issues and, like us all in the community, to have a greater awareness of how we work and speak to older people and include older people in the conversation and hearing what they have to say.

DR CHESTERMAN: Just a footnote on GPs, people may be aware that medical practitioners from 1 September are one of the authorised witnesses for the powers of attorney that can be executed under the new powers of attorney legislation which means that they are attesting to the capacity of the person to complete the instrument. Often times we know

that when a person is at risk or is suffering some cognitive decline but there is some concern about their financial affairs in particular they will be encouraged to complete an enduring power of attorney. So this is of relevance, I think, that GPs will have this enhanced power and role to play.

MS BLAKEY: We think it also is important for other professions like accountants and within the banking industry that there is a greater awareness of elder abuse and more readiness to ask again some of those exploratory questions, particularly where there has been a relationship of trust. Also with lawyers. Lawyers might be involved in transferring assets and property. Again there's been training in that area but our experience is there has been different levels of response. We have had some situations where lawyers have not really made sure that the older person has had independent advice and has just treated as the son's come in and asked them to do that, they have brought mum along and they do it. So there has been a transaction which has occurred which has been to the detriment of the older person.

We would like to see greater emphasis, possibly within law, that if there is a transfer of significant assets and money at a point where someone is older that it's not necessarily an assumption that it's a gift - that can be the assumption that's occurring within that situation between the generations - but there might need to be more greater consideration about it being a loan or at least making sure that there are some clear arrangements about what the expectations are of this money, what will happen if something goes wrong and how it

might be repaid in future.

MR MOSHINSKY: I'm not sure if the Commissioners have any questions.

DEPUTY COMMISSIONER NICHOLSON: Yes, I did. We heard earlier about the introduction of consumer directed care in disability. Of course that's happening in aged care driven by the Commonwealth and the introduction of a more competitive market of service providers, and of course that opens up I think the potential of coercion of people receiving care by family members, particularly where there's now greater transparency around how many - the level of funds available to that person et cetera. Do you have any views about what sort of safeguards are required? Are there safeguards? Are they adequate?

DR CHESTERMAN: We have given this a lot of thought in the context of disability as well about which you will have heard. I think it's very important that the consumer choice philosophy is not being implemented to the detriment of those who have some decision making disability which can be something that's lifelong or it can be acquired through an injury, through an accident or, for instance, with dementia. So the question is - - -

DEPUTY COMMISSIONER NICHOLSON: Even where they don't have impaired decision making ability it's been said that the potential is for family coercion in determining what sort of care they get, the level of care et cetera.

DR CHESTERMAN: In that case I think a range of safeguards are needed. The availability of advocacy is one about which I think you have probably heard in the last session and monitoring of how money is being spent. It depends on the situation in which the person is living what monitoring is

appropriate. If they are in a private home it's more difficult. But in any supported residential setting we would say there needs to be monitoring.

DEPUTY COMMISSIONER NICHOLSON: The vast bulk will be in private homes receiving care packages.

DR CHESTERMAN: We won't go into the area of financial abuse, but that's in my view likely to be the most significant danger. So we would be recommending greater kind of police ability to monitor financial abuse and recognise it and respond to it.

DEPUTY COMMISSIONER NICHOLSON: Do you have any specific recommendations about the sort of safeguards that are going to be required in this new environment?

MS BLAKEY: The only recommendation I can make - and you have posed a great problem and we have the dilemma of how we respond to it - is if there is an independent case worker, so there's someone which is standing outside the family who has a role to work with the older person around the choices they are making and again maybe more attuned then to picking up where there is undue influence on the older person and decisions being made which perhaps are not representing the person's needs and then having the ability through that relationship to have the discussion separately with the older person about what they want and how they manage the difficulties which are occurring around perhaps other needs within the family. That would be my suggestion.

DR CHESTERMAN: Can I just quickly add. The safeguards would be both preventative and responsive. The preventative one would be education about what is appropriate and what is inappropriate in that kind of setting, because some family

members do think that they have an entitlement that they actually don't have. So that can lead to situations of abuse. In terms of responding, I would say again the idea of having an agency that could be phoned where there is a situation of concern to a neighbour or another family member who could then go and look at what is happening in that situation.

DEPUTY COMMISSIONER NICHOLSON: I had two other quick questions, if I may, counsel. Are you aware of any training given to people that are delivering care packages into the home, personal care attendants et cetera, that would enable them to identify or understand the risk of family violence?

MS BLAKEY: Yes, there is training. The State Government funded Victoria University to run training for home and community care workers, and there was a substantial amount of training that occurred over the previous two years. That funding to Victoria University has ceased and there is now an on-line training program which the State Government runs. There is also - I'm not quite sure of the right word - licensing or recognition to two agencies, two registered training organisations to deliver training, and that is fee based training. I'm not really convinced whether that's sufficient and whether there needs to be more that's done because I think that care workers who enter into the home are a key point to identify issues that may be of concern.

DEPUTY COMMISSIONER NICHOLSON: Is there any requirement upon service providers funded by the Commonwealth who are going into the home to have any training?

MS BLAKEY: Not that I'm aware of. I think the initial vision

was to have it incorporated into mandatory training, so particular diplomas and certificates, so it became a module that people had to undertake as part of their training.

I think there is also a need, though, for training to continue because once you have had the training that then becomes more and more distant with time. So there needs to be refreshers in terms of training and, I guess, the services that deliver that training. There was one service, Aged Care Channel, which we explored some time ago about delivering some training on-line which goes out to care facilities. But I think that's just residential. I'm not sure that would reach workers who would then go into people's private homes.

DEPUTY COMMISSIONER NICHOLSON: My other question was about the care packages that are delivered into the homes, because that's the bulk of the people, as I understand. There are far more receiving care in that way than in residential settings. Are those packages able to be easily and quickly adjusted or redeployed in circumstances of family violence; for example, perhaps enable someone to travel or to purchase temporary accommodation?

DR CHESTERMAN: I'm not sure.

MS BLAKEY: I don't have experience in that so I couldn't answer it.

COMMISSIONER NEAVE: I have no further questions, thank you, counsel.

MR MOSHINSKY: If the witnesses could be excused and if we could adjourn until 2 o'clock.

COMMISSIONER NEAVE: Thank you very much indeed for your evidence.

<(THE WITNESSES WITHDREW)

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

MR MOSHINSKY: Commissioners, before the next witness is called I would like to indicate to the Commission that some of the evidence this morning during the panel relating to people with a disability went beyond the evidence foreshadowed to the State. In the circumstances, the State would like the opportunity to consider whether it wishes to put on any evidence or make a submission in response and arrangements will be made in this regard.

COMMISSIONER NEAVE: Thank you, Mr Moshinsky. That's appropriate.

MR MOSHINSKY: The next witness is Mr Fonzi. If he could please be sworn in.

<ROCCO FONZI, sworn and examined:

MR MOSHINSKY: Mr Fonzi, could you please state your current position?

MR FONZI: I am the Director of the Client Outcomes and Service Improvement branch of the East Division of the Department of Health and Human Services.

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

MR FONZI: Yes, I have.

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

MR FONZI: Yes, it is.

MR MOSHINSKY: Your statement deals with the disability family violence crisis initiative and you explain in the statement how the fund came about and how it operates. I just want to ask you a few specific questions about the fund.

In paragraph 14 you indicate that the primary aim

of the initiative is to provide immediate disability support when required to women with a disability who are experiencing family violence or children with a disability who are experiencing family violence with their mother, and then in paragraph 15 you indicate the initiative is designed to achieve certain objectives. Perhaps if I could just ask you to sort of encapsulate briefly what sort of gap was this initiative designed to address?

MR FONZI: The initiative was designed to address the gap of where a woman with a disability or a woman caring for a child with a disability was experiencing family violence and the specific disability that she had or the disability needs acted as a barrier for her escaping the family violence. This initiative provides resources and funding in an immediate and flexible way to allow the woman to receive those supports, to basically supplement the support that she's providing so that it no longer acts as a barrier. I think the previous panel gave quite a detailed and good example about a woman who is relying on an intimate partner who is also the perpetrator.

MR MOSHINSKY: In terms of the criteria for being eligible to access this fund, you indicate in paragraph 16 that there are three criteria. I won't read them all out at the moment, but is one of the criteria that the person has to have a disability as defined by the Disability Act?

MR FONZI: Yes, it is.

MR MOSHINSKY: Is one of the implications of that criteria that the person needs to be assessed as having a permanent disability?

MR FONZI: Yes, that's right.

MR MOSHINSKY: So is one of the gaps in terms of this fund

that, if one isn't yet assessed as having a permanent disability, one would not be eligible to access this fund?

MR FONZI: That's correct.

MR MOSHINSKY: We had some evidence this morning, I think you have been in the hearing during the day, from Ms Hargrave who gave evidence of a situation of a woman who was driven over, was unable to walk, the doctors were unable to say definitely that her disability was permanent and therefore wasn't able to access the fund. Is that a situation where someone wouldn't be able to take up this initiative?

MR FONZI: Without hearing more about the specific case, if it wasn't determined that it was permanent, then they wouldn't be eligible. But I would just like to add that in situations where - we can show some discretion in some situations and if there was no other available funds to assist a woman to escape the family violence, we could show some discretion in that situation.

MR MOSHINSKY: But in terms of discretion, are you able to exercise discretion in terms of whether they meet a disability within the definition of the Act?

MR FONZI: No, that's pretty fixed. But I guess the point I'm trying to make is that where we are faced with a woman who has a barrier to escape family violence and if there is no other way of supporting that, then we would do all that we could to assist her to escape the family violence.

MR MOSHINSKY: Are you referring to perhaps drawing on other - - -

MR FONZI: Initially, yes, we would look at what other supports were available, yes.

MR MOSHINSKY: I think this has been drawn to your attention that the lay witness who gave evidence on day 8 was a

woman with a disability and she had been subject to violence from her partner who was also her carer. The police took out an intervention order which precluded him returning to the home and Child Protection were also involved. But, notwithstanding the police involvement and the Child Protection involvement, for a period of eight weeks there was no-one else provided as a carer and she didn't have a shower for some eight weeks. Is one of the issues communicating the message that the initiative is available to relevant people such as police and Child Protection?

MR FONZI: I think that's the case. From what I heard of the case, I think that's what happened in that instance. We do quite a bit of promotional activity. There's a full-time liaison officer and more and more of her time is spent visiting agencies and promoting the initiative and providing information about it. It was one of the issues that was identified in the independent evaluation that was undertaken after the pilot and so the promotional activities were significantly increased.

MR MOSHINSKY: The last question I wanted to ask you was about what will happen, so far as you are able to say, under the NDIS. You deal with this towards the end of your statement, but what's the bottom line in terms of will this initiative continue after the NDIS commences?

MR FONZI: The service type and the funding for this initiative are in scope to transfer to the National Disability Insurance Agency. So what that means is that, upon full implementation, the State Government would not provide this service. So what we are doing in the transition process is that we are advocating very strongly to the

National Disability Insurance Scheme about the need for this kind of response to continue. My understanding is that the NDIA are aware of that and they are doing some work to look at how they deal with crisis response across the whole of the population that's eligible for the NDIA, not just for this specific group. But we are certainly making it clear that this is a keen need that's required and needs to continue, and in the interim we will continue in the State Government to provide the service right up to the transition period to make sure no one falls through the gaps.

MR MOSHINSKY: What's the timing on finding out whether it will be continued under the NDIS?

MR FONZI: The bilateral agreement has to be signed or is planned to be signed later in August. It will give quite a bit more information about what the timing and the phasing will be. The full implementation is in June 2019, so it will be some time between August and that period and we will need to work with the NDIA about how we transition this particular function. So, I don't have any sort of more definitive dates other than that particular period.

MR MOSHINSKY: So is the position that it's as yet not clear whether this sort of initiative will be able to be available after the NDIS commences?

MR FONZI: My understanding is that crisis response will be available and that will be a service that's provided by the NDIA, and it will be provided so all of the clients that are responsible, and that's the type of service that will be able to take over from this particular initiative. So, as best I can tell, it's something that would be provided as part of crisis response, but at the end of the

day it will be up to the NDIA to decide how and when it phases that in.

MR MOSHINSKY: Thank you. Do the Commissioners have any questions?

COMMISSIONER NEAVE: I just have one. Will the crisis response deal with a situation where the woman herself would not be a recipient of support under the NDIS, but the child is disabled and because the women is escaping family violence she has an issue about where she is going to go and how she's going to manage?

MR FONZI: Under the current arrangements that would be eligible. My understanding is that that should be eligible under the new scheme and that's certainly something we will advocate to because it is the same eligibility as we require at the moment. As I said, the NDIA will make decisions about that, but I would have thought that that should be something that should be covered.

COMMISSIONER NEAVE: Does any other state have an arrangement of this kind, because if Victoria is the only one and an attempt is being made to get the Commonwealth to pick it up, it might be in a stronger position to do so if other states had a similar sort of arrangement; do you know?

MR FONZI: My understanding is no other state has one of these programs and that was identified in the evaluation.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: If the witness could please be excused.

COMMISSIONER NEAVE: Thank you very much, Mr Fonzi.

<(THE WITNESS WITHDREW)

MS DAVIDSON: I call the next panel of witnesses. We have Ms Maya Avdibegovic and Ms Elizabeth Becker, both of whom

are from inTouch, and Ms Joumanah El Matrah.

<MAYA AVDIBEGOVIC, sworn and examined:

<ELIZABETH BECKER, affirmed and examined:

<JOUMANAH EL MATRAH, affirmed and examined:

MS DAVIDSON: Perhaps can I start with you, Ms Avdibegovic. Have you made a statement for the Commission? Are you able to confirm that your statement is true and correct?

MS AVDIBEGOVIC: Yes.

MS DAVIDSON: Can you just explain perhaps what the role of inTouch is and the communities that it serves?

MS AVDIBEGOVIC: Intouch Multicultural Centre Against Family Violence is a statewide agency that provides services, programs and responses to culturally and linguistically diverse communities around issues of family violence and we have been around for more than 30 years and the work that we do is across the whole continuum of family violence. So we run prevention activities, early intervention programs, multi-disciplinary crisis response and post-crisis response, advocacy research and we do provide training to the mainstream services around cultural competency.

MS DAVIDSON: Can I turn to you, now, Ms Becker. You have also made a statement for the Commission?

MS BECKER: That's correct.

MS DAVIDSON: Can you confirm that that's true and correct?

MS BECKER: It is.

MS DAVIDSON: You are also employed with inTouch. Can you tell the Commission what your role is?

MS BECKER: I'm the Principal Lawyer at inTouch, so I run the inTouch Legal Centre.

MS DAVIDSON: So you are in the inTouch Legal Centre?

MS BECKER: I'm the Principal Lawyer at the inTouch Legal Centre.

MS DAVIDSON: How many lawyers does the centre have?

MS BECKER: We currently have four lawyers employed and a number of volunteers.

MS DAVIDSON: I think the statement and the inTouch submission identifies that you also have a registered immigration agent; is that correct?

MS BECKER: We do.

MS DAVIDSON: You are the only service that has an immigration agent within - - -

MS BECKER: A family violence setting, that's correct.

MS DAVIDSON: Can I turn now to you, Ms El Matrah. You have made a statement for the Commission?

MS EL MATRAH: Yes, I have.

MS DAVIDSON: Can you confirm that that's true and correct?

MS EL MATRAH: Yes.

MS DAVIDSON: Can you tell the Commission what your role is and what your organisation is involved with?

MS EL MATRAH: I'm the Executive Director of the Australian Muslim Women's Centre. We are a nationwide service. In Victoria we provide services, one-to-one support and also information to Muslim women around ostensibly anything that could be called the social welfare issue, and so we do do a lot of work on domestic violence and we provide training for service providers in Victoria.

MS DAVIDSON: Perhaps to begin with I will ask you, Ms Avdibegovic, you are a migrant yourself; is that right?

MS AVDIBEGOVIC: Yes.

MS DAVIDSON: Can you tell the Commission from your experience what the experience of a migrant is like, when does it

start and when does it finish?

MS AVDIBEGOVIC: Migration experience, and I'm talking about this again in the context of family violence, so migration experience on its own, it's a fairly important milestone and a very traumatic experience even under the best circumstances. But when you add other complexities to that and experience of family violence, it becomes really complex. Migration has a very big impact on perceptions of how you experience family violence.

In terms of the migrants and newly arrived communities, that whole journey starts pre-migration. We have communities who have different pre-migration experiences, and pre-migration experiences have big impact on issues around family violence and when they happen once families arrive to Australia. A lot of families, there are families who have spent all their lives in refugee camps, there are families who have had very traumatic pre-migration journeys.

In terms of the settlement experience, that's also another journey. Settlement is also not one point in time. It's a lifelong journey for the first generation of migrants and also experiences of settlement have a really big impact on the experience of family violence.

MS DAVIDSON: Can I address the question perhaps to all the panel members, but what is the role of culture and family violence?

MS AVDIBEGOVIC: I might start and then I will pass it to you. I think what we fairly often see when it comes to issues of family violence in CALD communities is we quite often hear the statement, "It's our family violence, but it's their culture," and we quite often focus on some cultural

practices and some very specific forms of family violence and very easily attach the label of culture to those forms of family violence. I'm talking in particular about issues such as honour killings, forced marriage, female genital mutilation, dowry, those kinds of things. I'm not saying they don't exist, I think that they exist, but they are only the tip of the iceberg when you look at the complexity of family violence issues in CALD communities.

I think what we really have to talk about is that universal culture and that's the culture that excuses violence and that's the culture of gender inequality, the culture of male dominance, the culture of power and control being perpetrated by men. So the causes of violence are the same as in the mainstream communities and we have to be very mindful of that. Saying that, where culture plays a really big role is in how we provide support and how do we develop and tailor the programs that target CALD communities from prevention to post-crisis support, that's where we need very a targeted approach and that's where we need to take into account the role of the culture.

MS DAVIDSON: Ms El Matrah?

MS EL MATRAH: The only thing I would add to that is that men who are violent against their spouses or children or so forth often themselves use the cultural defence. It's really typical for men who are violent to have excuses for their violence, anything else other than accepting responsibility. So it's really important at that point that people are well versed in exactly what violence is about and that it's not about culture.

The other thing that I would add to really

reinforce Maya's point is that unless you attend to the issues of culture when you are working on prevention and shifting community attitudes and the way gender inequality manifests itself in different cultures, you are unlikely to actually be able to manage change and to eradicate violence.

MS DAVIDSON: On the topic of accessing services and the support and providing support to women and children from culturally and linguistically diverse communities, we have a slide in relation to some research that was done by Dr Satyen which compares some of the reasons why migrant women might - I might need to have one of these passed up to you - not seek help relative to non-migrant women. I think each of you deals with these sorts of issues in your statements.

The first issue that often is discussed in relation to migrant women is knowledge. How does the knowledge of services differ within migrant communities compared to within non-migrant communities and how does that play out in terms of accessing services and support?

MS AVDIBEGOVIC: Talking about newly arrived communities, you obviously have someone who has just arrived to the country and they really do focus on what are the priorities for them when they want to settle. So, finding out about family violence at that point in the time might not be the priority for the newly arrived communities.

You also have to understand that those newly arrived families left everything behind and have come to a country, to a completely different system. So, apart from language barriers, there is also huge gaps in their knowledge about how the system works and what is available

to them. The current Australian system might be completely different from what is available in their own country, if there is anything existing at all. So there are a lot of those gaps, particularly in the first years of migrating to Australia, that newly arrived communities have to deal with.

On top of that there are some other barriers in terms of accessing services and in particular to family violence services but also to justice and legal services. In 2009 we did a research called "Legal barriers for CALD women experiencing family violence" and that research report talks a lot about the range of barriers on two different levels: first of accessing the services and then, secondly, once they are in the court and justice system, other barriers that they experience.

So there is a range of that, and I don't want to repeat all of them because they are all in our submission. But maybe Elizabeth wants to talk a little more specifically about legal barriers.

MS BECKER: Yes. What we found at the inTouch Legal Service is there are a number of steps that our clients fall through the gaps in mainstream legal services. There is the original issue of a lack of knowledge of the legal system, of fear of authority, of language barriers, of social isolation, but when they actually do try to engage a legal service, any kind of referral is extremely difficult for our clients. If they are referred to an alternative legal centre or if they are just being given, like at court, a brochure about legal services, they can't actually follow through that next step of where to go. That's how we at inTouch try to carry them through the continuum of the

legal issue.

MS DAVIDSON: Ms El Matrah?

MS EL MATRAH: I would support all those insights. I would also add that for some women they do experience a range of restrictions that are tied to their cultural entity. One may be a generalised prohibition within their community around not breaking the family apart and the blame that targets women when they try to leave a violent situation. Often their families actively try to restrict them from accessing assistance and help. I'm sure you guys would have had a lot of experience where women have come to court, say, to get an intervention order or something like that and have found not only the perpetrator there with a community leader, but in fact not only his family, but in fact her family as well, trying to prevent her from getting an order. So, those things are really important.

The final thing I would say is that when women go to religious leaders, this doesn't occur nearly as much as people say, but where they do go to religious leaders, often religious leaders use religion as a prohibition of seeking outside help as well.

MS DAVIDSON: The data in the slide identifies that not knowing that domestic violence is illegal is a much bigger issue for CALD communities than non-migrant communities. Not knowing how to get protection is also a much bigger issue. How do you go about breaking down those knowledge gaps in migrant communities?

MS AVDIBEGOVIC: Obviously prevention and awareness raising plays a big part in that, but I also think what is even more critical is provision of the crisis intervention services at that end. So when you finally have a woman

that is brave and courageous enough to seek assistance and disclose all the details of her personal life when she comes to the service, and I will talk about our service in this example, we have developed a model that is trying really hard to overcome a lot of those barriers.

So, engaging bicultural, bilingual workers is the first step. I know that we quite often talk about issues around interpreters a lot and how to overcome those. I'm not going to talk about it now, but I just want to say that even in the case where you have a perfect interpreter there, it's a third person between the case worker and the client and that whole issue of establishing trust and the relationship and enabling that client to disclose most personal details is actually a huge barrier.

So we promote that use of bilingual, bicultural workers and we developed a model in our service where we have 12 workers who provide services in 25 different languages and that makes a huge difference. In addition to that, and Elizabeth mentioned that earlier, a lot of our clients are women who don't have permanent residency, so that is obviously a huge barrier and a huge sort of risk factor for those women. We are the only service that has an in-house registered migration agent, the only family violence service, and she specialises in providing support to women who are on spousal visa and accessing family violence provisions under the Migration Act.

We supported 377 women in the last financial year to access family violence provisions, but I have to add there that that service has been provided by inTouch for the last 15 years and it's an unfunded service.

In addition to that, we established an in-house

legal centre. So, legal needs are obviously huge and access to legal system and to justice system is a huge issue for our client. So we again have that in-house legal centre which practices so-called therapeutic lawyering model which is based on social workers and lawyers working together. The clients are really transitioned softly from their case workers to the lawyers. There is ongoing communication between case workers and lawyers and they are continuously working together on client files.

In addition to that court support, we see a lot of clients coming to the court, in particular after the weekend, and the safety notice is being issued on the weekend. In most of those cases they are police initiated intervention orders; clients - it's not their will to be there and they don't know what to expect. So, having case workers at the courts is really important. That can make the whole journey very, very different for the clients, and really when you catch them at that early stages and provide information about services available, that can make a huge difference. At this stage we have case workers at Sunshine, Dandenong and Heidelberg courts.

So, those are sort of the elements of the model, I think, that is quite appropriate to meet the needs of CALD women when they experience family violence and the model that can support them and make sure that a lot of those barriers - that we overcome a lot of the barriers.

MS DAVIDSON: Can I just take it back just a step. How do they get to know, one, that it's illegal; two, that there is a service out there that can help? How do they even get to your service in the first place? What sort of things do

you think need to happen in the system in order to improve the knowledge of women in the first place of what the system can provide, that family violence is illegal, that they can perhaps approach police officers, that they can trust police officers potentially to do the right thing? How do we get women to a service like yourselves earlier in the piece? Do you have any ideas about that?

MS AVDIBEGOVIC: I think it's not only about how do we get them to come to our service. It's also about how do we get to them and how do we make ourselves more accessible. Obviously a lot of work in the prevention, awareness raising, providing information, that's quite important, but it's only the initial step. A lot of our clients come to us through the courts, so I think courts are a really good place where you can access those clients quite early, because we can see a lot of clients, even if there is an intervention order and they come to the court, you see them there and then they disappear. They either withdraw the intervention order or they don't provide the appropriate support and they just - they are lost to the system. So for them to come back to the system again, it's a real issue.

A lot of our clients come through other family violence services, but a lot of them are also self-referrals. About one-third of the clients that we see are self-referrals. I would assume that would be through specific agencies that we provide information with and work through them, that would be through settlement services that we also work with. So there are other ways of providing information to the other services and raising that awareness.

But, as I said, it's also a matter of us going to them and improving access for them. What I see from our service, we are a statewide service that has a head office centrally located, but what we try to do is to establish outposts at the courts. We are now partnered with Maurice Blackburn so we have access to their office space in Dandenong and Sunshine and can provide outposts there. From October this year we will have an outpost in Dandenong Hospital. So, it's those places where those women will come and seek the help.

I think that's something that we should think about how to improve access for them, particularly in those areas where we have a high CALD population, for example Dandenong where you have 60 per cent of the first generation migrants, and then it's the whole question of what is the mainstream there. Should we only have CALD services in Dandenong providing services to all the population?

But in those areas, Dandenong, Sunshine, Broadmeadows, it's really important to make sure that we have outposts there where clients can access the services.

COMMISSIONER NEAVE: Counsel, I have a question about that. At Dandenong and at Heidelberg there are applicant workers and respondent workers who deal with the victims of family violence and those against whom they are seeking orders. There will be a duty lawyer. There will be various other people. How does inTouch work with the other bodies that are at those courts? Not at all courts, but at those courts?

MS AVDIBEGOVIC: We are part of the court support network at both Dandenong and Sunshine and Heidelberg. I think the

roles - we have been there for quite a while, so the roles are quite defined and clear and they know which days we are on. That was all done in consultation with the court staff, that the magistrates and the court staff really knew what were the most important days for us to be there. So in Sunshine and Dandenong we are there on Monday and in Heidelberg we are on Friday because it's now under - - -

COMMISSIONER NEAVE: Just as a practical matter, if somebody goes to the registry at the court, they would be told, "There is a worker from inTouch here who may be able to speak your language," won't always, but may be able to and at least will have some insights into the difficulties that CALD women face.

MS AVDIBEGOVIC: Yes, the applicant workers would also refer them.

COMMISSIONER NEAVE: So they'd work together with the applicant workers, presumably.

MS AVDIBEGOVIC: Yes.

MS DAVIDSON: Ms El Matrah, from your perspective how do we overcome or are there other points in the service system where migrant women might make an early contact, health services, those sorts of places where there are greater opportunities, if we were to tap into them, to improve the ability for women to know about services and access services earlier?

MS EL MATRAH: I think there is always a lot of work that can be done on the service sector itself, raising their awareness how to engage with CALD women and specifically Muslim women and I think work can be done there. In my own experience, 20 years of working on violence, I find that the best thing has been community education and going

out to women and consistently doing that to inform them of what domestic violence is, the impact of domestic violence on their lives, because a lot of women don't understand that and, when they do, that can propel them forward, and what are the services available.

When we have done that work over a five-year period, one-to-one case work, the women who are accessing our support for domestic violence jumped from 40 per cent of our case work to 80 per cent of our case work, so this is really a very powerful strategy that unfortunately we have not rolled out very much. So, increasingly government and services have relied on written material about family violence. It just doesn't work in the way that actually going out to women's groups and working with them, getting onto the radio, getting community leaders to do some messaging around family violence, not to do the work but to do the messaging.

I think that to date we haven't made those investments and I think if the investments were made, in addition to work increasing the knowledge of the service sector about how to respond to CALD and having people present at the courts, that in itself I think would make a substantial difference. The sort of work we have done for the Australian community or the Anglo-Saxon community around awareness raising is far greater than anything we have done with CALD communities, so that needs to be done.

The final thing I would say is that I think a shift in the culture for Muslim communities around family violence and for women specifically would be greatly assisted by if there was a refuge specifically for Muslim women because we feel that that's the greatest barrier for

women wanting to leave a situation of violence. They are just too scared about where they're going to go and the consequences of that, and that's become a sort of cultural impediment, really.

MS DAVIDSON: Is that the case for other CALD communities and CALD women, not having access to a service that is specifically for them? Is that an experience that you would have observed?

MS AVDIBEGOVIC: Yes, definitely. In terms of the housing and the crisis accommodation, definitely there are other issues. We know the issues for Muslim women. We also know the issues around large families who have a lot of children. We know issues of the boys of a certain age not being able to accompany their mothers and go there. But also the women who don't have permanent residency, there are issues there because they are not eligible for a lot of other services like the financial support and because of the process of applying for permanent residency under the family violence provision, that whole process can take up to a year.

So, if you have a woman in a crisis accommodation and you don't actually have an exit plan for that client and she can stay there for a year instead of what is an average of six to eight weeks, it really creates a lot of blockages in the system. So we have seen a lot of refuges - I think they are doing their best to accommodate those clients, but they really have to be mindful of how many of them they can accommodate.

The other issue is also women on student visas. It's really conflicting for them. If they need to go to a refuge, most of the refuges are high security refuges.

They can't continue attending their university courses and if they stop attending their university courses that has immediate impact on their visa status. So they are really in a very, very difficult position. So I think some of the housing services and the crisis accommodation services that meet specifically the needs of CALD women, that would be really good.

MS DAVIDSON: We heard from a witness on the first day of the hearings who had four children and was unable to find accommodation for herself and four children. How much accommodation is there, in your experience, that would cater for large families?

MS EL MATRAH: It is not even 10 per cent, I think, of the housing stock caters for families of that size, and women have made choices about what children to leave behind, and it's worked against them later on when they have sought custody. It specifically disadvantages women.

MS DAVIDSON: Can I perhaps raise the issue of perpetrators, if they are from a CALD community. To what extent are there services available for men who use violence in a language and that are culturally appropriate to their needs?

MS AVDIBEGOVIC: There are almost none. As far as I know, there are few of them. We started, in partnership with other services, in 2009 the first Vietnamese men's behaviour change program. So that's been running for six years now, with very sort of sporadic funding opportunities and I think for the first two or three years it was funded by the partners. We are also in the process of establishing Arabic speaking men's behaviour change programs.

So all of these programs are designed according

to No To Violence standards for men's behaviour change programs. In addition to that we have three additional weeks and those are the first three weeks of the programs where we cover some specific issues such as pre-migration experiences, torture, trauma, settlement, migration experiences and their impact on family violence, and then gradually start talking about it.

But still it's a program; at the end of the day it's still a program that is designed for mainly Anglo men rather than taking into account what would work for CALD men. If you ask me what would work for CALD men, I don't have an answer to that because we haven't done any research on that. That's a huge gap.

Also there are some South-Asian programs designed for the South-Asian group that are delivered in English, but are taking sort of into account specific cultural issues, and that's all that is there. So if you have a perpetrator who is mandated to attend a program but he doesn't speak English, there is nowhere for him to go. So it's almost giving him again permission to continue perpetrating violence because there is no punishment for him.

So I think what we need to start looking at is more CALD-specific men's behaviour change programs. We also need to look into what are the other options and do a bit of research and actually talk to CALD communities, because I think that whole question about the difference between individualist and collective sort of communities has to be taken into account there, because the approach is it might not be that CALD men feel comfortable sitting in a group environment with 10 other men that they don't

don't know and talk about their most personal things.

There are also some other programs that we can look at, programs that are focusing on fatherhood. That might be an option. Some other early intervention programs that are quite important, in particular for newly arrived migrants. So, there is a whole range of unexplored sort of territory there that we need to look at.

MS EL MATRAH: I would agree with all of that and would add that for Muslims there hasn't really been any engagement in Australia, and actually not just for Muslims, but for religious communities, spiritual abuse, which is basically the use of religion to justify gender inequality and to justify violence against women. A lot of that work is happening in the US and it's happening in Canada and other European countries, and in Australia we seem to be completely silent about that and we focus on religious leaders rather than tackling spiritual abuse.

So there needs to be a way of actually dealing with that too. No sort of preventative program can be developed or is going to be useful unless spiritual abuse is actually looked at, because at the moment what you have is that men who promote Islam have one particular view to women and violence and western culture has another view to women and experience of violence, and religious leaders and men saying, "I'm not going to give up my religion just to fit into Australia." So we shouldn't even allow men to get into that sort of dichotomy. Any work with men has to attend to that issue.

MS DAVIDSON: There has been often talk about faith based approaches to preventing family violence. Do you have a

view on that issue?

MS EL MATRAH: The faith based approach was brought into Australia because of some research that had been done - some work that had been done in the US. That literature and the work that was done in the US is not in any way comparable to the sort of diversity of communities we see in Australia. So I would dispute whether the work done in the US has any relevance for us here in the first place.

The second thing is that the vast majority of faith based work that people have tried to undertake has actually focused on religious leaders. There is no way for us to make religious leaders accountable for their conduct, accountable for what they say, and we cannot monitor what they say to women and men when they are alone with them. We also cannot police community leaders' views. So it has been highly problematic, this sort of I would say slightly naive approach to the issue.

It is important to recognise where religion plays a role and most especially if you are undertaking preventative work and to recognise that women do have a religious identity that is important to them and must be catered for and respected, but that doesn't mean you need to work with religious leaders. It is more important to work with organisations and experts who actually can demonstrate their expertise, have undertaken work in the area and perhaps are even registered to do the work, and not with religious leaders who happen to be saying the right thing to the right people and perhaps saying something entirely different to their community.

The final thing I would say is that while

religious leaders may not agree with violence against women, a great number of religious leaders do see men and women as unequal and the idea of men being superior to women is one of the lead contributors to violence against women. Unless that shifts, no amount of support to them to eradicate violence is going to work.

MS AVDIBEGOVIC: We haven't had a lot of experience in working with the faith leaders. We mostly target community leaders and work with them, and with our previous prevention project we had some of our taskforces established in four different communities. Some of the members were faith leaders.

In terms of working with the faith leaders, I think it's quite challenging work and it is hard work, but I think some efforts need to be made in educating those who are responsive, finding those who are responsive in the right way. It's obviously quite challenging. I am aware of the Jewish taskforce against family violence, that they have done some really good work with rabbis and teaching them how to respond to women and how to refer. But it's getting that across sort of the whole community is quite different.

I would say engagement there, because you have a specific agency working with a specific community, it's a lot easier rather than inTouch as a statewide agency working with a huge number of different communities. The engagement with the faith communities would be an issue.

MS EL MATRAH: I think that work was led by women, actually, in the Jewish community.

MS AVDIBEGOVIC: Yes.

MS DAVIDSON: In terms of providing a culturally appropriate

response system and a service system that is responsive to the needs of CALD women and their children, I think you have talked about in your statement - I think you might have all talked about this issue - but the idea of workforce development in non-CALD specific agencies, so more mainstream agencies and workforce development going beyond being culturally appropriate but actually having an intention to employ and develop bilingual workers. Can I ask you to comment on that issue?

MS AVDIBEGOVIC: I think generally what we have in Australia and in Victoria is 26 per cent of the first generation migrants, 20 per cent of those speak languages other than English at home, so we have this huge potential there of the workforce, not only in family violence or community, but across all of the industries where we are not tapping in appropriately and using those resources.

But when it comes to family violence, I think it's even more important. I talked about it before. When you have an interpreter as the third person between the case worker and the client, it makes a huge difference, and we see that every day. Elizabeth can talk about it a bit more because she works with the family violence workers and the clients that are referred to her and what is the difference that is made by service provided in language.

I understand that we can't simply provide services in all possible languages or have people available who can support clients all the time in their own language, but making that first initial contact with a client, it makes enormous difference when it's done in a language by someone who understands the culture and the

whole understanding of family violence in that culture.

We heard occasionally that some women don't want to be supported by someone from their own community. I heard about it. We haven't experienced it in our service.

MS DAVIDSON: Ms Becker, perhaps you could identify how many languages you do provide services in at inTouch?

MS BECKER: Our case workers speak 25 different languages, which is an astounding amount. When we are seeing clients we do utilise interpreting services, but my main preference is to have our case workers present. The bilingual and bicultural element that they bring is so vital. The use of interpreters is obviously such an important element to the clients giving their instructions, to providing their story, and the ease at which the case managers at inTouch can establish a rapport with the client, allow them to feel that trust between the two that they can then convey their story.

When the case workers aren't there, when we have an interpreter, it takes so much more time to establish that system of trust and also just ensuring that the interpreters are actually interpreting the right information. There's quite often such variations in legal terminology that it's sometimes missed. It can be confused for the client, especially using telephone interpreters rather than on-site interpreters.

MS DAVIDSON: Ms El Matrah, is that your experience as well for Muslim women?

MS EL MATRAH: Yes. I think there is a general problem in the welfare sector around the homogenisation of the workforce. There are less appropriately skilled workers around.

Mainstream services and their workers are not required, there is no mandatory training for people who don't come from relevant communities or people who are not bilingual to make sure they undertake annual training and they keep up their training around cultural diversity and culturally appropriate practice.

The funding model that the government has gone with, the mainstreaming model, it argues can sufficiently service women. All the international research says that doesn't happen. In fact, women do not get a service when you mainstream, when you try to mainstream gender. So when you try to mainstream gender, ethnicity and faith, I think you are probably not servicing a whole variety of women who need assistance. Sometimes the government argues that it is a cheaper thing to do, but when services are referring women to each other because nobody has the exact skill base, that is not a more efficient way to run things. That is exactly our experience.

I think that it is not as difficult as government and organisations believe to employ a culturally diverse workforce. All our employees at the centre, and we employ eight, are multi-lingual. Sometimes people speak two or three languages. It is possible to get that level of expertise.

MS AVDIBEGOVIC: Can I just add to that that we don't forget that, in addition to being bicultural and bilingual, that those workers are actually accredited family violence workers. So, focusing on just the language and the culture skills, that doesn't mean that the service can be provided by the volunteers, and that's our great concern. We have seen a lot of small organisations coming up and

with the best intention of supporting the women, but not working within agreed sort of frameworks and codes of practice that are established within the sector, not being able to do appropriate risk assessment and I think a lot of them actually are putting clients at higher risk. So the workforce, what we are recommending is the family violence and culturally competent workforce.

MS EL MATRAH: Yes, I think you want a combination of mainstream services and specialist services, but really specialist services.

COMMISSIONER NEAVE: Counsel, I just wanted to follow up on that point. All of you may want to respond to this. What do you consider is the most effective means of providing this training? So we have somebody who is bi- or multi-lingual, but may not have any expertise in family violence. What sort of qualification would they have to do, or would it be based on their experience? How would you train your workforce? What do you do?

MS AVDIBEGOVIC: We have experienced a lot of issues around that where we employ our case workers, because I think that the model we are building is based around that bicultural, bilingual workforce. But you sometimes can't find all of that in one person, so they might not have enough experience or any experience here in Australia, they might have different qualifications, which I have seen with our case workers. I have case workers who are psychologists, I have case workers who used to be architects back home in their countries.

So what we are looking for is a range of issues, is a range of skills and attributes that it's really hard to find in one person. So what is not negotiable for us

is the language and the culture. What is also an added bonus is that all of our case workers are migrants or refugees themselves so they have that life experience and added understanding of the issues around migration and settlement. Other skills, which is the family violence competence, they can learn that.

We have the basic standards, so most of our case workers have qualifications either in community development or welfare, some of them as I said are trained counsellors, so it's a range of activities, and then once when they start working with us, if they don't have any family violence experience, there is a set of five modules that we expect them to complete before they start working with the clients and there's the training around risk assessment, around family violence, family violence law, case notes and then working with the database. So, those are the sort of five basic modules and then we build up on that.

COMMISSIONER NEAVE: Thank you.

MS EL MATRAH: I think the only thing I would add to that is some of the attitudinal stuff around gender equality. I have discovered you can't assume, you actually have to train for that, because so much of that is not spoken. So you do have to do some of the attitudinal training as well around gender.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: What about issues with interactions between CALD women and police? What issues have you identified arise for the Victoria Police and how would you see those being addressed?

MS BECKER: One of the main things for our clients is that fear

of authority, that fear of the police coming to the door. It prevents them from seeking assistance in the first place and it also prevents them from giving a full picture of the level of violence that they have faced when they are questioned about a violent situation.

The police have been fantastically supportive for a lot of our clients, but there remains a number of issues that are of concern where - I'm just recalling instances where the police will attend upon a residence for a family violence situation and there will be no interpreter present, obviously, they have just arrived at a scene and they will utilise family members to interpret for the client. That's always proving difficult.

Where the clients are completely confused, they have absolutely no idea where to go, what to do from that point once an intervention order or a safety notice has been taken out, and they are just completely lost. So they will quite often come to us as a result of being directed from meeting a case worker at court on a Monday and they will have no idea of what to do, where to go or sometimes no desire to continue with that intervention order because of the community influences that go from there.

MS AVDIBEGOVIC: Can I just add some of the really positive experiences with the police, because I think we deal with them on a daily basis and if there are issues - and we recently had an issue with a certain client and that was resolved in a matter of days. We basically had a whole team from that particular police station coming to our service, talking to our case workers and resolving the issues and there is now an ongoing relationship going on

there.

Also in terms of we do some post-crisis work and mainly around therapeutic group work, but also when we manage to get some funding we do family camps where we take mothers and children for three days and it's a combination of sort of a holiday but also a lot of therapeutic elements in that work. Every time we do that, we do it in partnership with the police. They normally provide us with transport. We would have two police officers coming with us, staying sometimes for the whole duration of the camp, in their civil clothes, and then on the third day they put their uniforms on, deliver a session, engage with children.

So, I think there is a lot of willingness and effort from the police to engage with CALD communities. I have to say that there are issues, but we are working on them and the partnership has been really good.

MS DAVIDSON: Is there any protocol in place to enable women who are identified as being from a CALD community, is there a protocol in place for them to be provided by police with your details, for example?

MS AVDIBEGOVIC: I think that's a bit of issue how the system works, and I think in particular with L17s, and L17s are going to the regional local family violence services. I know that they are under a lot of pressure to respond to them. I'm aware of the numbers. But I'm also aware of how many CALD women are not serviced appropriately at that end.

I know that some of those services actually use messages, text messages, to inform women. They receive L17 and the first contact with the clients to follow up is

done through SMS. It is done in a region that has a very high CALD population, which I find quite amazing, and then thinking how many of those women would not have access to the mobile at all, that might be sort of with their abusive partner. The second thing is that they will receive a message in English. We don't know whether they can read in their own language, let alone in English, and whether they will understand that.

The message on its own, it's probably not the way how you would engage someone from CALD communities, that they might receive that message, leave it. It's highly unlikely that anyone from CALD communities - any CALD women would respond to that message and contact the service.

I think we were there when we talked about it together, Commissioners, when we heard about the SMS messaging being used as a sort of way of contacting clients. I know that's the way how the system has been set up, so basically we receive them, clients are referred to us by those services. I think there is a gap there. There is something that needs to be changed in the system so that we are involved in that process a bit earlier.

MS DAVIDSON: What about data collection? How good is the data? In relation to CALD communities in order to help inform you about what services are required, the rates of family violence, the kind of violence that might be being experienced, how good is that data and what needs to be done there?

MS EL MATRAH: Vic Pol or the service sector in general?

MS DAVIDSON: In relation to family violence for CALD communities.

MS AVDIBEGOVIC: I think there is a lot of space for improvement there. In terms of L17, I know that there is a field that is labelled, I think, cultural - ethnic appearance, and it's not mandatory, it is optional.

In terms of the SHIP data that we use, the homelessness data, it's a database that's created for homelessness primarily and then for family violence. It's an issue of collecting all of these little - all of those things that are quite important for CALD women, the issues around permanent residency. There is a lot of data that we don't collect on that.

There is a lot of data that we don't collect in terms of the barriers. Even when we are assessing risk, risks for CALD women are different than for women from the mainstream communities, so in terms of that I think there is a lot of space for improvement. So, not having an appropriate data system is really disadvantaging this whole sector and the organisations working with the women, so we don't have evidence, we don't have appropriate data, we can't respond then in an appropriate way and it can't inform any of the programs and initiatives that we want to deliver.

MS EL MATRAH: I think at the moment, to sort of get any sense of what's happening from the sector, you have almost got to go service to service and just get little bits and pieces where you can. The Department of Human Services doesn't make its data available, which would be really important, for example, and there's other government departments. But even services don't make - some services won't give you their data even if you ring them and ask them.

Added to that, we have tried very hard to get data on Muslim women accessing services for domestic violence and nobody collects them. There seems to be the perception that Muslims would be offended if that was asked of them. I'm guessing some might be, but I think others would give the information if they felt that it was handled appropriately. We are of the view that that information is extremely important for service planning and it is difficult to service plan unless you have the data.

MS DAVIDSON: Those are all the questions I have. Do the Commissioners have any additional questions?

DEPUTY COMMISSIONER NICHOLSON: Thanks, counsel. I have one. The Commonwealth government funds settlement services. I was wondering to your knowledge does it include any information or education about family violence or about the law in Australia?

MS EL MATRAH: The Settlement Grants Program has moved away from civic and legal literacy, which it used to do about three or four years ago, and that allowed you to shift civic literacy to family violence and the Family Courts because that was women's area of interest. They no longer do that.

There is a new model, so to speak, in which services can dictate to a greater degree what they would like to do, but nobody knows what that looks like now. Nobody knows what services will choose to provide and nobody knows how the department will respond to that. So the department is talking at length about providing information that domestic violence is illegal in Australia once people arrive here, but that's a very complicated

thing to do and they are doing that with I think single-sided A4 pages. So I think domestic violence, sexual assault, early enforced marriage, and perhaps there's a fourth which I can't recall, but it's very limited information.

DEPUTY COMMISSIONER NICHOLSON: In the first year of settlement, in your view is that the best time to be trying to alert people to the Australian law and how family violence is considered?

MS EL MATRAH: We really always go with where women are at, and what we find is that they are interested in those issues where they relate to their children. They are very preoccupied with the welfare of their children and what things are going to be like for them in the country. That is the way we have used to start speaking about violence in general and family and so forth, and in every situation we have found women very open.

DEPUTY COMMISSIONER NICHOLSON: So under the new arrangements for settlement grants, you think there is still an opportunity to do some of those community education around this issue?

MS EL MATRAH: It's unclear where the department is going to go. It's upon services to run with what they think is important. My experience of government is that there are always limitations to that, so I'm not clear yet as to how committed they are to services assessing what communities need and then just providing it.

I should also say what hasn't shifted about SGP funding is that they want the one-to-one work with women to be very short-term and they want it to be more of a referral service. So, if you are getting a woman who has

a domestic violence situation, according to the funding rules you really can't spend enough time with her to do that work and you really need to be referring her on. Even if she comes back to you because she didn't get the service she needed from another organisation, technically you are supposed to refer her on again.

MS AVDIBEGOVIC: Can I just add to that? I think there are different points in sort of journeys of migrant communities where you need constantly to keep providing information and to keep raising awareness, because the responsiveness is not the same at all of those stages. When you first migrate to a country you are focused on employment, house, school for your kids, learning language. Even if you experience family violence at that particular point in time, you are so focused on keeping your family together because that's the reason why you migrate to a country, for that better life, for the better opportunities for your children. Again it's all responsibility again on women to - they simply can't make that decision in early stages unless their lives are really genuinely at risk.

So, I think at different stages we need to keep providing different information. We are not one of the settlement grant services providers, but I just want to mention a really good program which is called Complex Case Support and that's targeting migrants who have been in the country for less than five years and who face complex issues, so there is a whole range of issues. So we are one of the providers of that program and that program proved to work really well.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

COMMISSIONER NEAVE: I do have one more question.

Ms Avdibegovic, what do you do about people in rural and regional communities? How do you reach out to them? There are people scattered all over Victoria from CALD backgrounds. So is it a phone service?

MS AVDIBEGOVIC: There is a phone service and providing secondary consultations to the workers from those services, but that is really minimal. In terms, yes, we are a statewide service, but the resources that we currently have do not allow us to do any of that. We are currently looking into means of using technology to improve access, because I think there are great possibilities there. But at the end of the day our service is funded to provide support to 697 clients a year. Last year we had 1,034 women, so stretching us to beyond that is really hard.

But I agree with you that's something - on top of that is another sort of barrier, another issue for CALD women, if you have a woman experiencing family violence, she is from CALD background and she is in rural and regional areas where there is not that many services available for them, it's genuinely a very complex issue.

MS EL MATRAH: Can I just add to that. We have been to a certain area in Victoria where they must have had about 50 families located there from a country with a history of war, long-term war, and none of the women in that area had actually accessed any of the services there. The women had been there for at least two, three years. The men had, but not the women. So, those women weren't in any way going to be able to access support without a targeted sort of strategy.

The other thing is that some of the settlement patterns can itself create sort of vulnerabilities for women. So, for example, in Geelong we have the highest sort of concentration of women at risk in rural Victoria, women who came out on the women at risk category on their own with children all concentrated in a certain area. There's some funding towards that community, but the challenges those women have are profound, to say the least, and they do need not only additional support around family violence, but also the impact of family violence on their children which starts to become apparent a decade or so later.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: May these witnesses be excused?

COMMISSIONER NEAVE: Thank you all very much for your really important and interesting evidence.

<(THE WITNESSES WITHDREW)

MS DAVIDSON: Commissioners, the next witness is joining us via videolink from New South Wales. It's Stephen Lillie.

<STEPHEN JOHN LILLIE (via videolink), affirmed and examined:

COMMISSIONER NEAVE: There is a bit of an echo. I wonder if we might try to deal with that before you give your evidence, Mr Lillie. Is it possible to fix the echo?

MR LILLIE: I will just turn the volume down a bit. Is that any better on my side?

MS DAVIDSON: It's a little bit better.

MR LILLIE: I will turn it down a bit more and see how we go.

MS DAVIDSON: You still need to hear us, that's all.

MR LILLIE: Yes, that will help.

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

MR LILLIE: That's correct.
MS DAVIDSON: Can you confirm that that's true and correct?
MR LILLIE: That's true and correct, yes.
MS DAVIDSON: Sorry, there is still a bit of an echo. I will just ask our technical people. They are suggesting could you turn down your speaker or use headphones. I think there might be quite a significant delay, though, which might be the problem.
MR LILLIE: We just have a laptop. There are a set of headphones coming now. We will just see whether this works. Is that any better?
MS DAVIDSON: Can you hear me now?
MR LILLIE: I can hear you now.
MS DAVIDSON: The echo has gone. We still have a bit of a delay, but we will see how we go.
MR LILLIE: Okay.
MS DAVIDSON: Mr Lillie, you are a Men's Health Worker at the Hawkesbury District Health Service?
MR LILLIE: That's correct, yes.
MS DAVIDSON: Can you just describe your role and the nature of the hospital that you are in?
MR LILLIE: Hawkesbury District Health Service is a private hospital that's funded to deliver a public service and we are in Hawkesbury, which is about a 60 kilometre drive out towards the mountains just above Penrith in the Hawkesbury. Hawkesbury is about 65,000, is our population, and we deliver the same services that all other area hospitals deliver. It's just the contract is run by Hawkesbury District Health Service to deliver that service. So, it's no different to our counterpart, Nepean Health.

MS DAVIDSON: Your role as a men's health worker, how common do you see those sorts of roles in New South Wales?

MR LILLIE: As far as I'm aware, I'm the only full-time men's health worker in the health system within Australia, and definitely in New South Wales I can vouch that 100 per cent. In about 2009 the men's health policy was withdrawn, so there is no funding for men's health inside the health system.

MS DAVIDSON: You have been involved with the Yellow Card system in New South Wales that was identified in an ARACY research program as being an example of a program working with men who were victims of family violence. Can you describe what the Yellow Card system does?

MR LILLIE: Within the Hawkesbury, the Windsor area, local area command, we are sort of semi-rural, so we have a lot of contact as in most people that work in the Hawkesbury live in the Hawkesbury. So we usually can get things done a lot quicker because it is a lot more community focused. The DV Yellow Card is throughout New South Wales, but in the Hawkesbury, because of my position, all male victims of domestic violence, that card gets faxed over to myself and then I make the first point of call to the male victim to engage with them.

MS DAVIDSON: How common is that sort of process in New South Wales?

MR LILLIE: As far as I'm aware, Leslie, our domestic violence officer at Windsor Police Station, they catch up I think every three months with all the DVOs in New South Wales and she believes we are still the only service that actually offers support for male victims. All the other areas will just offer the MensLine business card to the

client and it's up to the client to do something.

MS DAVIDSON: From your perspective, how important is it to have a more proactive response to male victims?

MR LILLIE: Extremely high. A lot of the times people come to counselling when they're stuck and it's no different to what happens when they engage with the police service. They're usually at a dead end in what's going on in their life. So for them, even though I don't call them back in a day or two, sometimes it might be a week or two weeks because by the processes done, they feel validated that they have been spoken to, that someone listens to their concerns, and the majority of the time I'm giving either education or resources of where to go to help resolve a problem and I also make referrals into services like Partners In Recovery or FamS to finalise and help things and a majority of the time there are a lot of Family Court issues around custody battles and relationship breakdowns and family matters in that sense. But there are other areas of elder abuse and also blended families which still comes under the Family Law Act as well.

MS DAVIDSON: In the ARACY document a snapshot had been done of the male victims who had been referred to you under the Yellow Card program in 2011.

MR LILLIE: Yes.

MS DAVIDSON: That demonstrated one male victim of domestic violence reported for every five female victims?

MR LILLIE: Yes, in Hawkesbury.

MS DAVIDSON: Yes. It had an initial statistical review of the data showing 5.5 per cent of male victims of domestic violence were under 18 years of age and were the victims of their father's behaviour; 25 per cent of male victims

of domestic violence were the victims of their ex-partner's behaviour; 25 per cent of male victims of domestic violence were the victims of their son, grandson or son-in-law's behaviour; 30.5 per cent of male victims of domestic violence cited separation issues as the cause of the incident; and 30.5 per cent of male victims of domestic violence cited drugs and alcohol as the cause of the incident or a major contributing factor. Are they the most up-to-date statistics that you have?

MR LILLIE: They are currently the only statistics we have. How those statistics came about is I actually went over to the police station, we sat down and we went through every Yellow Card and that information is only given by what the general duties officer has written on the card. So there is no formal evaluation or research going into that process. The system is not that - it's very basic. This is goodwill work, let me say it that way to you.

MS DAVIDSON: You have talked about in your witness statement blended families being one of the more significant areas in which issues for male victims of family violence comes up. Can you explain what you have observed in relation to blended families and family violence for men?

MR LILLIE: The research - I don't know the exact figures, but a lot of the time when there are children to male victims or perpetrators of domestic violence in blended families, it's usually an introduced male into the family. So, a lot of times I will also see the actual blood father who has got concerns with his ex-partner's new boyfriend who has moved into the house and the children or the sons or the daughters are having relationship difficulties with the new male within the system and that spends a lot of

time around, I suppose, setting structures back in the family system and parenting issues and core values and core beliefs of family roles.

MS DAVIDSON: What sort of services are available to assist men in that situation and what kind of services do you see being needed for men?

MR LILLIE: In the Hawkesbury, in my role I do a lot of anger management work, I do a lot of stress management, I support males to Family Law Court. My history is in drug and alcohol as well, so I'm drug and alcohol trained. In the other areas, the majority of the time is around mental health or depression and anxiety, so sort of moderate mental health in that area. There isn't anyone to refer into from my service in the Hawkesbury. I have no one to refer out to. Then I also get a lot of referrals from other areas, so Penrith or Blacktown will try and refer clients to myself, but due to areas we can't pick these clients up.

I have been in this position since 2006, so I've been around a long time. So my reputation has sort of gone out into different areas because we used to do a lot of health promotion, but that's been dropped over the last couple of years as well.

MS DAVIDSON: In terms of the response that men need relative to what women might need, you have identified and you have talked in your statement about having a telephone response and the sort of shorter length of the response that might be needed for men and the different type of response that you would provide to a man compared with a woman. Can you explain to the Commissioners your views about the kind of response that's needed for men and how you are best to

engage them?

MR LILLIE: I can comment on the men's health side. I don't actually pick up any female victims. That goes to our Women's Cottage. But the males, as I said, all I get is their name, date of birth and 10 or 15 words of a description of what's gone on. In my belief that first phone conversation is quite important because when I introduce myself and I try to engage with the client and first of all I'm trying to build that rapport with the client that it's not a legal system that's trying to get to them. Then after that I look at what resources they need or do they actually just need a conversation and just to debrief the trauma they have gone through in their own way.

MS DAVIDSON: You have talked in your statement about the difficulty of engaging men on a long-term basis. How long would you ordinarily engage a man for?

MR LILLIE: The males that come through - I will answer it the other way. The ones that stay around for a long time are males that either have mental health or Family Law Court issues, purely because that old-fashioned case management is something we still do in the Hawkesbury, so we look after clients in not just a straight counselling format, we also do case management.

When we get the brief interventions and that follow-up, sometimes the males just need to know the phone number for the Family Law Court or what's their rights, what are they allowed to see when they see their children or where can they go. They may not be seeing an appropriate GP in the first place or the GP may not be giving them appropriate help, so my suggestion to them is

to get a second opinion with another GP. A lot of it is a common sense approach and very basic engagement with males and probably solution focused in, "What's the problem, let's resolve this and what can we work towards."

MS DAVIDSON: You have talked in your statement about where you contact men, that you are more likely to contact them at work?

MR LILLIE: Correct.

MS DAVIDSON: What does that mean? The information that you are given through the Yellow Card system, what sort of contact details does that seek? Does it get a home number or a mobile or what sort of system - - -

MR LILLIE: I'd say about 90 per cent of our clients - sorry, go ahead.

MS DAVIDSON: What sort of system is there to ensure that you are at a practical level able to contact a man if, as you say in your statement, they are more likely to be working?

MR LILLIE: I'd probably say about 90 per cent of our contact is through mobile phones. We don't usually get home numbers anymore. Then through - I'm not quite sure of the statistics, but there would be easily 50 per cent work and 50 per cent unemployed. But the ones that are working, I usually have a conversation with them in the afternoons on their way home or I organise a time to call them back. Sometimes they'll say "I can't talk" and I say "I'll call you back at 2" and they just go "Yes" and we make a time.

One of the downsides for services for men is that it is 9 to 5, five days a week. The time I work is the same time they - - -

MS DAVIDSON: I think we've just lost your voice.

MR LILLIE: - - - work and there isn't services after hours for

males to actually engage on that direct issue.

MS DAVIDSON: Can you still hear me okay?

MR LILLIE: Are we back again? I can see it flashing on and off.

MS DAVIDSON: Can you just repeat what you said about the fact that men are more likely to be at work when you're at work because the health system works around a 9 to 5 system?

MR LILLIE: Yes, that's correct. So, the time that I'm working, they're working as well, so there isn't any after hours services. After hours counselling in the Hawkesbury is pretty hard to get as well, but even for after hours counselling the majority of our counsellors in the Hawkesbury are females as well, so they don't feel validated or supported.

MS DAVIDSON: I think you have talked about this in your statement, that your role actually didn't involve new funding; it was just diversion of existing funding or use of existing funding and creation of a role called men's health worker; is that how it worked?

MR LILLIE: Yes, that's correct, and to sort of break it down for you, there's one day from a drug and alcohol position, there's two days from a generalist counselling position and there is two days from a health promotion position. It's just loose ends which Peter Blanchard, our GM, put together to deliver a service that we should be delivering in the first place, in my belief.

The reason for that, just to give you an example, is even our generalist counselling team, when it comes to couples work or a male comes in, the majority of our team is female counsellors for the generalist team. When an aggressive male comes in to a female counsellor, sometimes

it's good for the male just to say, "That's not appropriate behaviour and let's talk about what to expect." In that sense it changes that sexual gender issue. I think we've just dropped out again, have we?

MS DAVIDSON: No, we could still hear you, just couldn't see you.

MR LILLIE: Yes. So a lot of the times it's just standing up as a strong male within the system and also protect, inside the system, nurses. Even when I get called up to the emergency department, just when sometimes the males are up there aggressive, it's just having a male respond to the situation. There's plenty of females in the emergency department, but there are not many males and, if they are, they're a doctor and that brings a lot of perception that something different is going to happen than what I would offer.

MS DAVIDSON: I have no further questions for you, Mr Lillie, but the two Commissioners may have additional questions.

COMMISSIONER NEAVE: No, we don't have any additional questions.

MS DAVIDSON: Thank you, Mr Lillie.

COMMISSIONER NEAVE: Thank you very much, Mr Lillie. I'm sorry about the technical - - -

MR LILLIE: Can I just add something as well?

COMMISSIONER NEAVE: Yes.

MR LILLIE: That in men's health, how our role is set up, it's an unusual model in that sense, that it's very client focused but also it's quite assertive. So we don't tolerate - when males ring up or are aggressive, we actually deal with that behaviour in that moment. So I think it's important that it's the role modelling within

the service, because you could set up another men's health counsellor anywhere, that's not the issue, but I think the value systems you need, what you are trying to push out is also quite important to have within the system in the first place.

One of the downsides, if you were to deal with male victims in domestic violence, is having strong valued males that are quite assertive and able to stand up and educate the other male what is appropriate and not appropriate behaviour. They are in the counselling session, they are on the spot and I think that just brings a lot of honesty, but it also shows this is how you can perform in society but this is also teaching them communication with healthy people at the same time.

COMMISSIONER NEAVE: Thank you very much for that. Can I just clarify one point. You talk about the issue of blended families and as I understand it that is mainly a situation where the violence is by a child against the stepdad or the partner of his mother. Did I get that right? Have I interpreted your witness statement correctly?

MR LILLIE: Yes, in two ways. One example would be a 15-year-old boy, his mother has just introduced another man into the house and he is moving in, and there is that side. Then the other side is that the actual blood parent, who hasn't got any control into the family where his children live, is hearing what goes on in the community and is helpless, so he tries to communicate, but then the police are involved because of the conflict that goes on.

COMMISSIONER NEAVE: Thank you very much. And thank you very much for your evidence, Mr Lillie.

MS DAVIDSON: Thank you.

MR LILLIE: Thank you.

MS DAVIDSON: Perhaps we could have a five minute break.

<(THE WITNESS WITHDREW)

(Short adjournment.)

MR MOSHINSKY: Commissioners, the next witness is Superintendent Charles Allen, if he could please be sworn in.

<CHARLES THOMAS ALLEN, sworn and examined:

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

SUPERINTENDENT ALLEN: Certainly. Superintendent leading the Priority Communities Division with Victoria Police. My immediate work history, my previous role was with the Transit Safety Division implementing the Protective Services Officers across the system. Prior to that I was the Local Area Commander at Greater Dandenong for a period of some four and a half years, and have a 33-year history in policing across general duties, investigation, supervision and leadership roles.

MR MOSHINSKY: You have prepared a witness statement for the Royal Commission?

SUPERINTENDENT ALLEN: Yes, I have.

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

SUPERINTENDENT ALLEN: Yes, they are. I would just like to make one point of clarification, if I could.

MR MOSHINSKY: Certainly.

SUPERINTENDENT ALLEN: On page 24, paragraph 85, the paragraph is referring to the Koori family violence protocols. The

paragraph states, "The ongoing commitment to the family violence protocols and the rollout across the state will be a key area of focus of Victoria Police in the short to medium term." That is correct, but the statement "and the rollout across the state" may be interpreted differently. Certainly Victoria Police intend to continue to roll out the family violence protocols where there is a need based on priority.

COMMISSIONER NEAVE: Is that based on the fact that there is a Koori community in the particular area or something, is it?

SUPERINTENDENT ALLEN: Exactly. It's pointless establishing a protocol if there is no Koori community or a very small Koori community.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Could you please explain briefly what is the Priority Communities Division?

SUPERINTENDENT ALLEN: Yes. The Priority Communities Division is a relatively new division. It came into being as a result of a number of reviews, particularly reviews around how we engaged with community, so our focus is engagement both at the strategic level and at the local level with priority communities. Priority communities are communities we identify that are overrepresented as victims or offenders or underreport in crime or have over-representative contact with police.

So the communities we identify are Aboriginal and Torres Strait Islander people, people living with disabilities or mental health, including their families and carers, LGBTI community, CALD community, faith communities, seniors and youth.

MR MOSHINSKY: As I understand it, the division was established in December 2013 following a review?

SUPERINTENDENT ALLEN: That's correct.

MR MOSHINSKY: Some of the key themes from that review you set out in paragraph 19 of your statement. They include in 19.3 there was a need to strengthen Victoria Police's policies and procedures in relation to field contacts and to better recognise human rights principles in the Victoria Police Manual, and in 19.5 you indicate cross-cultural training for police officers provides an important skill base.

One of the issues that you then take up in paragraph 32 of your statement is the issue of low reporting levels by some of the priority communities. Can you expand on that? What is the sort of issue that you are concerned about there?

SUPERINTENDENT ALLEN: Quite a few of those issues have been borne out in the evidence today. So, underreporting of family violence across CALD communities, Aboriginal communities, LGBTI community and difficulty in reporting for people living with disabilities or people living with mental health.

MR MOSHINSKY: What sort of data is available to Victoria Police about underreporting? Is it possible for particular crimes to map whether there is underreporting among each of the priority groups that you have identified?

SUPERINTENDENT ALLEN: A lot of the data is anecdotal, qualitative in nature as opposed to quantitative. So, yes, it is very difficult.

MR MOSHINSKY: What about more specifically on family violence,

which is the subject matter we are concerned with for this inquiry. There is the L17 process that the Commission has heard many police witnesses give evidence about. Is it possible to look at whether, because of the L17 data that's available, there's underreporting from any of the priority groups that the division looks at?

SUPERINTENDENT ALLEN: I don't think that's evident from analysis of L17 data. Certainly we rely on external reports, and those reports are cited in my statement, as well as our engagement directly with community.

MR MOSHINSKY: So with the priority communities that you have identified and you have read out the names of them, they are listed in paragraph 13, is there a way - I'm not suggesting you have it at your fingertips now - but is there a way of analysing whether within one or more of those groups there is underreporting of family violence related matters?

SUPERINTENDENT ALLEN: Once again coming back to my previous answer, certainly we are relying on anecdotes, from engagement with community, from pieces of research that are available, many of which I have cited in this statement.

MR MOSHINSKY: In terms of that list of priority groups, to what extent does the L17 process capture data about whether either the victim or the perpetrator is in one or more of those groups?

SUPERINTENDENT ALLEN: Not very well. Capturing data on diversity is not well addressed by the L17. It asks two specific questions: ethnic appearance, which is predominantly relying on either the information that the attending constable is able to glean by direct questioning

or their view. There is also another question which is an open text question around country of birth.

MR MOSHINSKY: What about Aboriginal and Torres Strait Islander?

SUPERINTENDENT ALLEN: It also asks the standard Indigenous question and a large percentage is reported as unknown.

MR MOSHINSKY: Apart from ethnic appearance, country of birth and Aboriginal and Torres Strait Islander, in terms of the list of priority communities there is no field which requires any of that identification to be entered; is that right?

SUPERINTENDENT ALLEN: That's correct.

MR MOSHINSKY: Is there any plan to address that, that you are familiar with?

SUPERINTENDENT ALLEN: Not that I'm familiar with. Having said that, part of our division is certainly getting better visibility of offending and victimisation across priority communities. One area of interest for us is certainly the standard Indigenous question getting better data capture on DSIQ.

MR MOSHINSKY: So there is a focus on improving data on the Aboriginal and Torres Strait Islander question?

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: But currently, as far as you are aware, no plans to try to capture data about the other priority groups?

SUPERINTENDENT ALLEN: That's correct.

MR MOSHINSKY: Can I turn then to the topic of liaison officers that you deal with at paragraph 34. You list there the different types of liaison officers. Just at a general level, can you explain what a liaison officer is? What's their role?

SUPERINTENDENT ALLEN: There's a number of different categories. I think the easiest way to distinguish between the categories are those that perform the role full-time and those that have it as a portfolio responsibility. So, starting with those that have a portfolio responsibility, they are the police and Aboriginal liaison officers, the gay and lesbian liaison officers and the mental health liaison officers. They are all portfolio responsibilities. Those liaison officers, their full-time role would be generally a general duties role within Victoria Police, but also have portfolio time to deliver on their portfolio responsibilities. So, relationship building, working with community across projects and programs, and being a point of entry into Victoria Police for the particular community. It's similar with the YROs and the MLOs - - -

DEPUTY COMMISSIONER NICHOLSON: Can I just ask about that. In these portfolio categories, what proportion of time typically is devoted to the specific portfolio and what proportion to the general policing duties?

SUPERINTENDENT ALLEN: It varies . The resources are owned by the local area commands, usually at station level. So it depends on the depth of resource at a particular area and priorities at a particular area. So, to answer your question, it could be from a couple of days a week to grabbing moments when there's opportunity, and that's sort of the full range.

COMMISSIONER NEAVE: I have a follow-up question. Who were the officers who were not portfolio officers? Just the YROs? Have I got that right?

SUPERINTENDENT ALLEN: Yes.

COMMISSIONER NEAVE: So the YROs are the only non-portfolio full-time, is that right?

SUPERINTENDENT ALLEN: No, the full-time liaison officers are the youth resource officers and the multicultural liaison officers who are sworn police officers, but also the Aboriginal community liaison officers and the new and emerging community liaison officers are full-time liaison officers but public servants.

MR MOSHINSKY: So the first four that you have listed are full-time as liaison officers and then the last three, the police Aboriginal liaison officers, the gay and lesbian liaison officers and the mental health liaison officers it's a portfolio role. They have other duties as well.

SUPERINTENDENT ALLEN: That's correct.

MR MOSHINSKY: Just following on from those questions, if someone is in the last three categories and it's a portfolio role, what are their other duties? Are they front-line police who go out in a van or do they have other roles?

SUPERINTENDENT ALLEN: They do have other roles, and it would depend on their rank, predominantly either general duty officers or general duty supervisors. Some station managers take on the role also.

MR MOSHINSKY: What rank are the full-time liaison officers?

SUPERINTENDENT ALLEN: You are looking at a range of constable through to senior sergeant.

MR MOSHINSKY: You have indicated some of the duties of the liaison officers in terms of a point of contact with the community, building the relationship with the community. I was just wondering if you could explain a bit further what's the interaction between the liaison officers and

the actual front-line police members?

SUPERINTENDENT ALLEN: Once again it varies from site to site. General duty liaison officers will be interacting very much in the day-to-day process because they are embedded within general duties. The full-time liaison officers, it will depend. All regions or all divisions are tasked by a tasking coordination process, which sort of makes the decision about how we use our resources. Resources will often be tasked to similar concerns. So liaison officers and general duty officers are working on similar issues. They are situated within police stations. Good general duties police officers will use their LOs as a resource.

MR MOSHINSKY: Is it fair to assume that the liaison officers are located where it is most relevant for the particular priority community that they are associated with?

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: They are geographically located in stations where, if we are talking about an ethnic community, there would be many members of that community in that area; is that a fair assumption?

SUPERINTENDENT ALLEN: Yes. Generally, yes.

MR MOSHINSKY: Just at a sort of macro level, what's the process of communicating to the front-line police members the messages that you want to impart in terms of how to deal with a particular community, some of the sensitivities that might arise, some of the particular practices or policies that pertain to that priority community?

SUPERINTENDENT ALLEN: A number of ways. I guess first of all there's our education and training processes, and I talk to our cultural community and diversity education strategy

in my statement. The approach there is to use a golden thread, as we like to explain it, through training processes, so from foundation through to development and promotional programs.

There's also a wide variety of resources that we maintain around priority communities. So they are available on our intranet, so for officers who go seeking the information, the cultural awareness guidelines is an example, and also we will communicate via email, via other sources, whether it's the Police Gazette or Police Life around specific issues as they emerge.

MR MOSHINSKY: Is there some way of measuring success in terms of whether the messages are getting through and actually being adopted as matters of practice by police members?

SUPERINTENDENT ALLEN: As to the efficacy of the LO program, is that the question?

MR MOSHINSKY: No, I'm really focusing more now on the front-line police who are actually perhaps being called out to a family where there is a family violence incident, how they deal with it, when it might be from one of the priority communities that you have identified here. Is there a way of measuring success, whether practices have changed, whether members have taken on board the principles in your program, for example?

SUPERINTENDENT ALLEN: One measure is the complaints process. That certainly gives us an indication of where we're getting it wrong. Another process is feedback directly from community. I was very buoyed to hear some positive feedback today from some of the communities that are represented. So our priority reference groups, priority community reference group, which I also talk to in the

statement, a strategic way where we are able to gauge feedback directly from community at strategy level. So, what we are hoping to pick up there are issues, systemic issues across our service system, but also at the local level we are supporting good engagement processes at the local level, and once again through the feedback mechanisms of engagement at the local level.

MR MOSHINSKY: So one method is the complaints process. One method might be the reference groups where you meet with priority communities. I appreciate the priority division hasn't been going for that long, it was set up in December 2013, but are you able to comment on what feedback you've had so far?

SUPERINTENDENT ALLEN: I can certainly comment on feedback from the reference groups because I sit on all of them. Once again, some of the reference group members were actually represented in the witnesses here today, so we have worked very hard at connecting people who are attached to peak organisations representative of their communities.

We certainly don't feel we will get it right at first blush and we have just gone through our first 12 months of reference groups and part of the process I'm undertaking is having conversations with how we can improve those reference groups. The feedback I'm getting is about that two-way feedback process where we are feeding back on operational issues and communities are able to feedback to us on systemic issues they are seeing across their communities.

MR MOSHINSKY: Has it been positive feedback, negative feedback, concerns? What's the nature of it in general terms?

SUPERINTENDENT ALLEN: It's positive that the conversations are happening, but there's a long way to go for a lot of communities. Elder abuse was spoken at depth today. I think we are very early in that journey of how to deal with elder abuse and that's a conversation that we have within the seniors portfolio reference group.

MR MOSHINSKY: You get some feedback from the reference group. How do you then impart the message to the many, many front-line police members, because I don't think that's part of the liaison officer role, is it?

SUPERINTENDENT ALLEN: No. We can use the liaison officers as a resource and certainly we conduct development sessions with the liaison officers to share learnings and understandings around issues. But another part of the Priority Communities Division is the service delivery arm, so the service delivery arm have their relationships into operational policing. So it's their responsibility to meet either proactively or reactively in response to a particular issue at either a regional level, divisional level or local area command level, which is happening.

MR MOSHINSKY: Have there been any attitude surveys of attitudes held by police members, for example, to any of the priority groups?

SUPERINTENDENT ALLEN: Interesting; we are in the process of trying to - sorry, the community survey. We have finished a survey recently which was internally focused around the Globe program. We have also joined Pride in Diversity and through that Pride in Diversity process surveyed our people around attitudes with the LGBTI community.

MR MOSHINSKY: So you have done some survey of police member attitudes towards LGBTI people?

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: Do the results of those indicate concerns for you in terms of your program?

SUPERINTENDENT ALLEN: No. Results are relatively positive. I'm very conscious we have a lot of people working for us with wide-ranging views and biases. All of those wide-ranging views and biases we have to deal with as an organisation.

COMMISSIONER NEAVE: So you had an internal attitudinal survey relating to police attitudes to LGBTI people. Did you also say you had a CALD one or not? Did I mishear you?

SUPERINTENDENT ALLEN: No, not a CALD one.

COMMISSIONER NEAVE: So the sort of question - I'm just interested in the kinds of issues that you pursued in relation to the LGBTI community. What sort of attitudinal issues were you pursuing within the police?

SUPERINTENDENT ALLEN: We joined Pride in Diversity some 18 months ago, which is a national initiative. I think we were the first Victorian Government agency to join. Pride in Diversity have a standard survey that they use within organisations. We returned - 1,000 of our people responded to the survey, which was a very pleasing outcome. The questions were wide-ranging around LGBTI and contact with LGBTI community. The responses for our organisation were certainly pleasing. I wouldn't suggest that we haven't got work to do; we certainly have got work to do.

COMMISSIONER NEAVE: Thank you.

MR MOSHINSKY: Is there any consideration given to doing similar internal attitudinal surveys for any of the other priority groups?

SUPERINTENDENT ALLEN: Yes, it's a consideration.
MR MOSHINSKY: Do you think that would be a useful step?
SUPERINTENDENT ALLEN: Yes, I do.
MR MOSHINSKY: Is there any process to do surveys of attitudes within the priority communities of police, because one of the themes that you will have heard through the evidence today is that within some of the groups that we have heard evidence from I think it's accepted part of the issue is not necessarily police practices, but also perception of police. So has any thought been given or has this occurred of doing attitude surveys of members of the community and what they feel about the police?
SUPERINTENDENT ALLEN: Yes.
MR MOSHINSKY: It has been done?
SUPERINTENDENT ALLEN: No, it hasn't been done, but I think your question was is there consideration. We are actually pursuing a project at the moment to survey the LGBTI community.
MR MOSHINSKY: Any thoughts of doing surveys for the other priority communities?
SUPERINTENDENT ALLEN: Considerations, but we are actively pursuing that project around the LGBTI community. Seeing as we have a baseline about our internal attitudes, it would be complementary to have that community view.
MR MOSHINSKY: Because is it fair to say that one of the issues that the Priority Communities Division looks at, is concerned about, is the perceptions of police held by members of the particular priority community?
SUPERINTENDENT ALLEN: Yes.
MR MOSHINSKY: And in that light it might be useful to gauge what are the perceptions and then baseline them and then

do it again a couple of years later, perhaps. Do you think that would be a desirable thing to do?

SUPERINTENDENT ALLEN: Absolutely. I should also mention that there is a lot of material out there and a lot of other survey material that we can rely on. Once again, some of those I have referred to in my statement. Also our reference groups are another window into community attitudes. But would surveys be of use? Yes, absolutely they would be.

MR MOSHINSKY: Can I turn to the topic of recruitment.

COMMISSIONER NEAVE: Just before you do, Mr Moshinsky. It would be interesting to compare internal police attitudes with those of the general community. I don't know whether there are any surveys on LGBTI people. I know there are certainly surveys on things like community attitudes to gay marriage and so on, but I'm talking about something that's broader than that. It would be interesting to compare what attitudes the community generally hold with attitudes of police. Has any thought been given to doing that?

SUPERINTENDENT ALLEN: I agree it would be very interesting. The preface is that police are the community and community are the police. So, it would be nice for police to hold a mirror as to where they stand against the rest of the community. Hopefully we would be comparable or better, given our roles.

COMMISSIONER NEAVE: But at the moment nothing like that has been done.

SUPERINTENDENT ALLEN: No.

MR MOSHINSKY: Can I turn then to recruitment. Is there any policy to encourage recruitment of police members from the

priority communities?

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: Could you tell us about that?

SUPERINTENDENT ALLEN: Certainly. There's a diversity plan which is very focused on improving diversity from across a range of communities. There is a specific Aboriginal and Torres Strait Islander employment plan which has a specific target of - I think it's 1.6 per cent of police officers by the completion of the plan. There is a number of initiatives under way to support both of those plans.

MR MOSHINSKY: Does the plan extend beyond Aboriginal and Torres Strait Islander people?

SUPERINTENDENT ALLEN: Yes. There is a general plan, which is a diversity plan that's owned and managed by our human resource department, but certainly we contribute to that plan, so that's looking at diversity across the board. There's probably a focus there on recruitment from CALD communities, LGBTI and disability; also our accessibility action plan which is not far off launch has a focus on recruitment of people living with disability, but there is also a specific Aboriginal employment plan which is part of our Aboriginal Justice Agreement undertakings to improve representation of Aboriginal and Torres Strait Islander people within Victoria Police.

MR MOSHINSKY: In terms of where things stand at the moment, is there still work to be done in terms of improving diversity amongst some of the priority community groups?

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: Can I turn next to some of the evidence that we have heard today. In the session on elder abuse Ms Blakey gave an example of a situation where an adult grandchild

called police; the police came to the home; they spoke to the adult child, so the parents of the person who called, who in fact was the perpetrator. They didn't speak with the older person, who was of a Vietnamese background and was the victim. One infers there were language barriers. Can you perhaps comment on that scenario in terms of not obviously the specific case but just as a matter of proper practice what should occur?

SUPERINTENDENT ALLEN: Yes, you are right; I can't comment on the specific details of the case. It's certainly less than best practice that the police officers have spoken to the perpetrator as opposed to the victim. I suppose the question was hanging there for me, "Did they have a consciousness of who was perpetrator and who was victim on attendance?" If there was some doubt about that, then certainly the use of an interpreting service to get a full sense of the scenario as well as considering some isolation of the victims from the offenders so they can speak confidently in a safe location.

MR MOSHINSKY: This issue of interpreters, how is that managed in a family violence context? So the police are called to a home, they arrive, the family members don't speak English. How are police sort of instructed to deal with that situation?

SUPERINTENDENT ALLEN: Very difficult; difficult to get an interpreter on their feet at a scene in a timely manner. So second best is telephone interpreting services or reliance on networks, which is less than best because that could be bringing another community member which could create a barrier to a safe place to have a conversation.

MR MOSHINSKY: Police, do they have numbers available to them

or should they have numbers available to them to contact interpreting services?

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: One of the other points that was mentioned I think by Ms Becker was the issue of police using family members to interpret. Is there a practice or guideline around that issue?

SUPERINTENDENT ALLEN: Once again it's not ideal and either an interpreter or a telephone interpreting service - the complexity there, if the situation is very dynamic, police need to be able to draw out information quickly to be able to deal with the dynamics of a situation, hence why on occasions other approaches will be taken to try to get a sense of the issues at play.

MR MOSHINSKY: Can I turn to the topic of people with disabilities. As you will have heard referred to today, the lay witness who was called on Day 8 of the public hearings was a woman with disabilities. At one point in the violent relationship the police took out an intervention order, which in hindsight she was thankful for. But she was sent home and there was no-one to care for her because her husband was her carer and he had been excluded from the home. Again, I can't expect you to comment on the specific case, but what's the proper practice around that scenario in terms of the police's role?

SUPERINTENDENT ALLEN: You are right; I can't comment on the specifics of the case. I was provided with a copy of the statement, which I read. My interpretation of the scenario was a little bit different in that the husband was excluded after he had been charged, which was after

the issuing of the intervention order, was my understanding.

MR MOSHINSKY: Yes, I think that's right.

SUPERINTENDENT ALLEN: The case was handled by a SOCIT unit, as you would expect, because there were allegations of sexual assault. The SOCIT units are certainly very victim focused. I found it unusual that the victim had been released to return home without appropriate levels of care and it certainly seems a system breakdown there at some point. I don't know what that is.

It did concern me that there would have been an initial referral via the L17 process, but there would have been some distance between that initial L17 referral and the later charging of the husband. So I don't know if that created the system failure. Having said that, the SOCIT unit should have been conscious of the care needs for that individual.

MR MOSHINSKY: In evidence today from Ms Pearce, the Public Advocate, and in her statement, which I think you have had available, she refers in paragraph 71 to an issue of whether police are using, where they should, an independent third person. She quotes from the Victorian Police code of practice for the investigation of family violence and quotes the section dealing with people with disabilities. Could you just explain what the code of practice says about using an independent third person?

SUPERINTENDENT ALLEN: I haven't got the code of practice before me, but I certainly have the Victoria Police manual, our procedures and guidelines before me in relation to interviews of vulnerable people.

MR MOSHINSKY: What is an independent third person? In general

terms when should they be used?

SUPERINTENDENT ALLEN: If it is a young person, first of all, then there is a legislative responsibility for us to have an independent third person, which is identified as parent, guardian or if they are not available then an independent third person via the referral process, which is the YRIPP referral process. If it is a young person with a cognitive impairment then the independent third person is to be an ITP trained via the Office of Public Advocate.

MR MOSHINSKY: Can I just interrupt you there. You have provided through your counsel an extract from the Victorian Police manual. Could I just pass forward to you and to the Commissioners copies of the extract you have provided.

SUPERINTENDENT ALLEN: Sure.

MR MOSHINSKY: Is this the set of guidelines in the manual for dealing with interviews with vulnerable people?

SUPERINTENDENT ALLEN: That's right.

MR MOSHINSKY: What is the status of these provisions in the manual? Are these things that the police officers are bound to comply with under the code of practice?

SUPERINTENDENT ALLEN: Yes, is the answer.

MR MOSHINSKY: When dealing with vulnerable people in these categories this sets out the guidelines of when an independent person needs to be present?

SUPERINTENDENT ALLEN: That's right.

MR MOSHINSKY: The independent third person system for people with disabilities, I think the suggestion was that that's not always adhered to. Is that something you are able to comment on?

SUPERINTENDENT ALLEN: I have also seen the Public Advocate sit on our reference group that provides us with the data which is referred to today about the use of ITPs. I certainly agree with the witness Colleen Pearce that there appears to be inconsistency across police stations. I think that data needs a greater depth of analysis.

The independent third person does not necessarily have to be from the office - or ITP trained by the Office of Public Advocate. There are occasions when it must be, as in a young person with a cognitive impairment or for a person with a cognitive impairment who is involved in a bare interview. So there's a number of variables there.

Another variable is trained ITPs, independent third persons, are not always available, particularly in rural and regional areas. We are relying on a volunteer workforce. I get the difficulties in managing that, but they are not always available.

MR MOSHINSKY: So this issue of variable practice, which I think you have indicated may in fact occur - - -

SUPERINTENDENT ALLEN: Yes.

MR MOSHINSKY: Is there any plan to look at that of trying to improve the system?

SUPERINTENDENT ALLEN: Yes. So there's a ready reckoner which we have out there which provides advice and guidance to police officers. We are actually working with the Office of Public Advocate to re-work that ready reckoner. So the preference is that we are using a Public Advocate trained independent third person for individuals with a cognitive impairment.

COMMISSIONER NEAVE: So that ready reckoner, just to clarify, as I understand it what it does is provides the member

with some guidance as to whether the person might have a cognitive impairment, because that's not always immediately obvious; do I understand it correctly?

SUPERINTENDENT ALLEN: That's correct, and also refers the member to the forensic medical officer if they have some doubt to seek some advice.

MR MOSHINSKY: I have just been handed a sheet on a confidential basis which I understand to be the ready reckoner that you are referring to. Perhaps if I could just pass forward that to you and to the Commissioners. If you could just confirm that that is the document. Is that the ready reckoner that you are referring to?

SUPERINTENDENT ALLEN: This is the existing document. We are in the process of redrafting this.

MR MOSHINSKY: I see. Thank you.

SUPERINTENDENT ALLEN: But that's still a live document, having said that.

MR MOSHINSKY: Commissioners, those are the questions that I had for the witness.

DEPUTY COMMISSIONER NICHOLSON: I just had one question. Throughout the hearings the Commission has heard of circumstances where a young person is violent towards their parents in the family home. What are the circumstances if a young person is a 15-year-old and the police are called to the home to intervene with a situation where that young person was being violent towards a parent?

SUPERINTENDENT ALLEN: There are a lot of variables in that scenario. Certainly police would look at any criminal aspects, first of all. So it would be following the code of practice effectively; so looking at either criminal

remedies or the civil remedies, an intervention order, or looking at referral pathways is another option.

DEPUTY COMMISSIONER NICHOLSON: Would they be required to bring in an independent person?

SUPERINTENDENT ALLEN: If the young person was taken into custody for interview by the police then there would be a responsibility for police to contact an independent third person, which would be via the Centre for Multicultural Youth, CMY, who provide the service for YRIPP; unless the young person had a cognitive impairment, then it would be an independent third person via the Office of Public Advocate.

DEPUTY COMMISSIONER NICHOLSON: Thank you.

MR MOSHINSKY: If there are no further questions, may the witness please be excused.

COMMISSIONER NEAVE: Thank you very much, Superintendent.

<(THE WITNESS WITHDREW)

MR MOSHINSKY: That completes the evidence for today.

COMMISSIONER NEAVE: Thank you, Mr Moshinsky.

ADJOURNED UNTIL WEDNESDAY, 12 AUGUST 2015 AT 9.30 AM