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VICTORIAN ROYAL COMMISSION INTO FAMILY VIOLENCE

MELBOURNE

MONDAY, 12 OCTOBER 2015

(21st day of hearing)

BEFORE:

THE HONOURABLE M. NEAVE AO - Commissioner

MS P. FAULKNER AO - Deputy Commissioner

MR T. NICHOLSON - Deputy Commissioner

COMMISSIONER NEAVE: Thank you, Mr Moshinsky.

MR MOSHINSKY: Commissioners, today we commence the final week of public hearings of the Royal Commission. This week is supplementary to the main block of public hearings that took place in July and August, and will focus generally on the subject of governance; that is, the overall structure and arrangements that should be put in place to lead the work of prevention and response to family violence across the community.

The question of governance was not directly addressed during the main block of hearings, although much of the evidence you heard during those four weeks was relevant to it. It was left until this week of hearings not because it is less important than any of the themes addressed in July and August but because how the system is to be structured and governed depends very much on the kind of system it is meant to be and the purposes it is designed to serve.

The evidence in July and August revealed, as did the community consultations and submissions process, that there is substantial agreement about the ways in which the present structure is failing to meet the needs of victims or to respond appropriately to those who use violence.

At the end of the earlier hearings we noted the extraordinary and admirable resilience of the victims who gave evidence as lay witnesses before you and the dedication and commitment of those working in the present system at every stage through prevention, intervention and response. That resilience and dedication needs to be matched by the system. Nothing less is required if we are to respond to and ultimately reduce family violence.

Since August the Royal Commission has continued its work, including through the conduct of a series of expert round table discussions covering issues including perpetrator interventions, sustainable reform, family law issues and the role of the Magistrates' Court. The contribution of those experts will be of great assistance to you in your deliberations, and some of their ideas have informed the evidence you will hear this week.

The issues that will be the subject of evidence this week are raised by paragraphs 2, 3 and 4 of the terms of reference, which require the Royal Commission to investigate the means of having systemic responses to family violence, particularly in the legal system, police, Corrections, Child Protection, and legal and family violence support services; investigate how government agencies and community organisations can better integrate and coordinate their efforts; and provide recommendations on how best to evaluate and measure the success of strategies, frameworks, policies, programs and services put in place to stop family violence.

The structures and arrangements to deal with family violence have an important practical dimension. In the course of the July/August hearings there was evidence about different parts of the system not always working together. For example, the lay witness on Day 8, referred to as "Melissa Brown", was unable to take a shower for eight weeks after her husband, who was her carer, was removed from the house and arrangements were not immediately put in place for her to receive the support of a disability worker.

Another example is provided by the recently

published finding of the coroner Judge Gray in the inquest into the death of Luke Batty. As the finding demonstrates, there were several instances where information relevant to risk was not shared between different parts of the system. One of the coroner's recommendations, and all of his recommendations will be relevant to the work of this Commission, was that the State ensure that all agencies operating within the integrated family violence system have clear rules and education about their respective capacity and obligation to lawfully share information between agencies and/or members of the public.

The evidence during the July/August hearings of this Royal Commission highlighted a number of problems or issues which are relevant in considering the structures and arrangements that should be put in place. First and foremost was the strain the system is under as a result of the increased number of reports to police, intervention order applications and people seeking help from social services. Any consideration of the structure of the system must be cognisant of this increased level of demand.

Another issue is what might be called "pilotitis". There were many examples of good local programs being run on a pilot basis for three or four years but the funding was not continued at the end of that period even if the program was successful. Moreover, there did not appear to be a good system for sharing knowledge about what worked so that successful local programs could be implemented more broadly.

Another issue that emerged from the evidence

concerned the focus on outputs in the way government contracts for the provision of social services. Non-government organisations are contracted to carry out certain specific functions or tasks in return for a financial payment. A number of criticisms were raised regarding this model. One was that it imposes a wasteful administrative burden on non-government organisations, who may need to report to multiple agencies in relation to different contracts.

Another problem is the siloing or fragmentation of services. An individual who needs help from a number of different services usually will have to access those services separately. Rather than being structured around the individual or family, the services tend to be structured around the service provider.

Another comment was that, apart from receiving a report that the tasks have been performed, there is little active management by government of the quality of the services being provided.

Another point is that the focus on outputs can skew the allocation of scarce resources. For example, because part of the family violence budget comes through the housing assistance funding stream, if the KPI is the number of nights of crisis accommodation provided this may distract from the goal of keeping women and children safe, which may be best achieved by their strategies in their own home.

It also does not permit any analysis of whether interventions have left victims better or worse off in the longer term. Also, the current contracting arrangements do not seem to promote adaptive management; that is, a

process whereby a program is evaluated as it progresses and the learnings from the evaluation are fed back to drive improvements in the way the program is carried out.

Another issue that emerged from the earlier hearings was the lack of good data to monitor family violence. The main data source at present is the number of cases reported to Victoria Police, currently over 70,000 per year. But we know that many people who experience family violence do not contact the police. While some additional information may be gleaned from the Australian Bureau of Statistics Personal Safety Surveys, there is little good quality data about the prevalence of family violence over time or data which enables informed decisions to be made about what works and what doesn't work in relation to both prevention programs and responses to family violence.

The issues and problems that we have referred to suggest that it is likely that the Commission will recommend changes to current governance structures and arrangements. This week's evidence will address the question: assuming that to be the case, what should those structures and arrangements look like?

For the purposes of addressing this question we, that is Counsel Assisting, have formulated six working assumptions about what the new governance system might be intended to achieve. Without some sense of what one is trying to achieve it is very difficult to discuss what the new system should look like. It should be noted that the working assumptions are those of Counsel Assisting and may not reflect the views of the Commissioners.

The six working assumptions are as follows:

first, that the system should be developed in a way that increases the focus on children, is responsive to the needs of all victims of family violence, better reflects and addresses all of the risk factors associated with victimisation and perpetration of family violence - these include but are not limited to community attitudes to gender inequality as well as poverty, homelessness, substance abuse and mental health issues - and promotes recovery of those who have experienced family violence.

Second, that the system should seek to reduce and prevent family violence.

Third, that the system should seek to identify vulnerable families and address risk factors earlier. In other words, there should be a greater focus upon prevention and early intervention initiatives aimed at addressing risk factors for family violence and reducing children's exposure to family violence well before a crisis point is reached.

Fourth, that changes should be made to improve the capacity of service systems to identify and respond to the needs of vulnerable families and their children. Questions arise as to the areas of government which should take the primary role in this area.

Fifth, that the measures available to courts to deal with perpetrators of family violence, for example swift and certain responses and alcohol/drug treatment programs, should be expanded; that is, more options and more availability.

Sixth, that more effective treatment or rehabilitation programs for perpetrators should be developed.

We would now like to outline the structure of this week. Today we will address the topic "Engaging the community". The focus of today's evidence will be on the process by which community engagement is supported rather than the content of any particular initiative. We will be examining how government can empower and support communities to prevent and intervene in family violence.

Some of the questions we will look at are: what is necessary at a statewide or national level to support community initiatives; what are the role of community health services and local governments for prevention and early intervention initiatives; how do we integrate the work of bodies at the national, state and community levels.

The evidence tomorrow will address the topic of "Developing the workforce". The focus of the evidence will be on developing key family violence capabilities of all relevant stakeholders, including within the family violence sector and beyond, rather than focusing on any particular tools. The context for this issue includes the Commonwealth's recent funding package of $100 million across the states over the next four years which includes $14 million to expand domestic violence alert training for police, social workers, emergency department staff and community workers and to work with the College of General Practitioners to develop and deliver specialised training to GPs.

Some of the questions to be addressed tomorrow will be: how do we develop the skills of family violence workers to better address the multiple needs of victims and to identify and address the needs of children; should

there be a central body responsible for professional development; how do we develop other workers and professions to prevent, identify and respond to family violence issues; what is the role for advanced practitioners embedded in universal services; how do we ensure consistency and quality and ongoing skills development compared with one-off training; how do we develop a diverse workforce that is representative of the communities they serve.

On Wednesday we will address the topic of "Evaluation, reporting and reviewing". The focus of this day will be on the data and systems required to measure and review the effectiveness of the family violence system.

Some of the questions to be addressed are: what existing mechanisms are available to review the system and how can they be improved; what data and mechanisms would be desirable to ensure regular review of the system and continuous improvement; what mechanisms are necessary to ensure that programs are evidence based, best practice, continuously improve and do not unnecessarily re-invent the wheel; who should conduct evaluations; what should the link be between evaluation and funding.

On Thursday and Friday we will address the questions, "What should the system look like and how should it be funded?" Questions to be explored on these two days include: what measures or structures can and should be put in place to ensure that family violence is considered and prioritised at the governance, policy, planning and delivery levels across all relevant parts of government; what should be the respective roles of

non-government agencies and how should they be funded and governed; what existing structures for the delivery of services could be built upon to improve outcomes; what is the right balance between a central and a regional focus; what levers does government have in funding, regulating or overseeing services to improve outcomes; what are the priority areas for reforming funding arrangements; and what mechanisms should be put in place to oversee implementation of the Royal Commission's recommendations.

Having outlined the structure of the week we would now like to identify the witnesses for today which, as mentioned, will deal with the topic "Engaging the community". First we will be hearing evidence from a panel of witnesses comprising Emma Fitzsimon, Dr Susan Rennie and Dr Robyn Gregory. Their evidence will concern the role of the community health sector, including primary care partnerships.

Second, we will have a panel on the role of local government comprising David Turnbull, Ricky Kirkham and Sarah Carter.

Third will be a panel comprising Sharon Fraser from Go Goldfields and Seri Renkin from the ten20 Foundation. They will deal with the collective impact approach to engaging local communities.

After lunch we will hear evidence from Teresa Pomeroy and Sheryl Hann from the Ministry of Social Development of New Zealand. They will give evidence about the "It's Not Ok" campaign, which has been run for several years now in New Zealand which involves a mass media campaign across the society as well as support for local prevention initiatives.

Then we will have evidence from Patty Kinnersly from Our Watch and Jerril Rechter from VicHealth. Lastly, we will call Professor Leah Bromfield to give evidence about the lack of data and of prevention work in relation to child abuse and neglect. We will outline the witnesses for each of the other days at the commencement of each day.

Commissioners, that completes our opening statement. I will now hand over to Ms Davidson to call the first panel of witnesses.

COMMISSIONER NEAVE: Thank you, Mr Moshinsky.

MS DAVIDSON: Thank you, Commissioners. I call Dr Robyn Gregory, Dr Susan Rennie and Emma Fitzsimon.

<SUSAN RENNIE, affirmed and examined:

<EMMA FITZSIMON, affirmed and examined:

<ROBYN GREGORY, affirmed and examined:

MS DAVIDSON: Can I perhaps turn to you first, Dr Gregory. Can you explain what your role is and what your organisation does and how it is structured?

DR GREGORY: Sure. I'm the CEO of Women's Health West. We are one of the nine regional women's health services across Victoria. We have both the family violence response services for the western metropolitan region of Melbourne, from crisis response to police referrals, through case management, intensive case management, counselling for women and children, court support and housing options.

We also have a health promotion, research and development arm, and one of the key priorities for that arm is the prevention of violence against women. So Women's Health West, in partnership with a range of organisations across the west, have been leading

Preventing Violence Together, which is a regionally based prevention of violence against women and children plan.

MS DAVIDSON: In terms of the structure for women's health services, you say that there's nine regional women's health services?

DR GREGORY: That's right.

MS DAVIDSON: Is there a statewide structure, a regional structure?

DR GREGORY: Yes, there is.

MS DAVIDSON: Can you explain what that is?

DR GREGORY: The Women's Health Association of Victoria is an incorporated body, and that makes up all of the women's health services and other organisations like Positive Women and the Women's Mental Health Network, Women with Disabilities Victoria, et cetera, and there is a committee of WHAV and that's made up of the CEOs of each of the nine regional and the two statewide women's health services. The two statewides are Multicultural Centre for Women's Health and Women's Health Victoria, and together we meet on a monthly basis as CEOs, and then our staff meet across the priority areas of prevention of violence against women, sexual and reproductive health, and mental health and wellbeing.

There are regular meetings between staff that you would probably call communities of practice. The WHAV committee meets on a monthly basis in order to plan joint work. What we have found is that each of our regions might be quite different in terms of demographics and in terms of need. So the regional services are able to be responsive to the very specific needs of either rural or multicultural demographic populations, et cetera. But by

working together across the whole state we are also able to have impacts simultaneously. So we have found that planning those projects together and then rolling them out regionally has been a really successful strategy in a range of different areas and most particularly prevention of violence.

MS DAVIDSON: Can I move to you, Ms Fitzsimon. Can you explain what your role is and what organisation you are involved with?

MS FITZSIMON: Sure. I am the Executive Officer of the Inner North West Primary Care Partnership, and we are one of 28 Primary Care Partnerships, or also known as PCPs, across Victoria. We work within a local catchment. So our local catchment is the inner north-west, which are the local government areas of Moreland, Moonee Valley, Yarra and Melbourne. We have 38 member organisations that have signed our partnering agreement who are made up of a range of diverse organisations which include women's health, community health, local government, the Primary Health Networks, drug and alcohol services, mental health, homelessness services. So a really diverse range of organisations.

We facilitate partnerships. We bring our partners together to try and work on system level issues in the areas of prevention and health promotion, service coordination and integrative chronic disease management.

MS DAVIDSON: Can I turn to you, Dr Rennie. Can I ask what your role is and the organisation that you are involved with?

DR RENNIE: Thank you. I'm the Manager of Policy and Strategy for Victorian Primary Care Partnerships, and this is the

statewide alliance that supports the 28 Primary Care Partnerships that Emma was talking about. It isn't an incorporated structure. It's a collaboration of those 28 Primary Care Partnerships that have looked to actually create a statewide entity to support them.

MS DAVIDSON: Across all those 28 Primary Care Partnerships what are the sort of key areas that the partnerships have been set up to do?

DR RENNIE: So all of those partnerships were set up by the Department of Health and Human Services - it was the Department of Health, I think - 15 years ago, and their primary brief is to work in the areas of service coordination and integration, chronic disease management, prevention, and partnership and capacity building. So those are the key platform areas that all 28 Primary Care Partnerships work across, and within those areas they are able to choose their own priorities.

MS DAVIDSON: How do the women's health services and the Primary Care Partnerships relate to other structures that also exist at that community level, such as community health, Primary Health Networks, local government - those sorts of structures?

DR RENNIE: Many of those structures and groups that you have talked about are members of local Primary Care Partnership. So the sort of core membership of Primary Care Partnerships across the state, whichever one you go to, is typically community health, women's health, local government, the local hospital and some of the other sort of services, and then other services may choose to be part of those partnerships because they recognise the benefits that accrue from working in collaboration with others, and

that might include mental health services, drug and alcohol services, family violence services and various other community services that exist.

So across Victoria there are over 800 agencies that have signed up to their local Primary Care Partnership, and that means that each partnership would typically have between 15 and 30 members, depending on the size.

MS DAVIDSON: Can I ask you to explain the difference between a Primary Care Partnership and the Primary Health Networks?

DR RENNIE: Primary Health Networks have only just been set up by the Commonwealth Department of Health. They replace the Medicare Locals that were set up four years ago, which were in turn a sort of replacement, I suppose, or a morphing of the divisions of general practice. So Primary Health Networks have a key focus on the primary health sector, in particular GPs, and on pathways between GPs in the acute sector, I think will be their first significant area of work.

Primary Care Partnerships intend to work quite closely with Primary Health Networks, as we worked closely with Medicare Locals, to avoid duplication and look at those areas where we could add most value to each other's work.

MS DAVIDSON: Dr Gregory, how does women's health fit with community health, Primary Health Networks and local government? What exists there?

DR GREGORY: Sure. I can talk about both Women's Health West in particular and also the fact that that structure is replicated across each of the regions in Victoria, so Women's Health West in the area of prevention of violence

against women in particular, and there's other priorities where we have similar kinds of partnerships and structures.

We began probably close to a decade ago to recognise and build on the work that had happened over the previous two decades where the women's health services were first funded in the late '80s and looked at what are the kinds of areas that if we concentrated on these they would make an absolute difference for women and their children and communities, in fact. The primary prevention of violence against women was one of those areas.

So we have done significant work to advocate for funds and for concerted work in that area, and that included work over some years with the Primary Care Partnerships to encourage prevention of violence against women to be a priority area, and I think about six years ago we succeeded in having each of the then three Primary Care Partnerships in our region prioritise prevention of violence against women.

We then built with the Primary Care Partnerships a lead agency structure. So Women's Health West is the lead agency, and it also has the mandate across the partnership of the PCP. The structure or the governance structure for the region is called PVT, which stands for Preventing Violence Together. That's a whole-of-region partnership that in a sense mimics the structure, the settings, the actions that were put together in the original Victorian statewide plan for the prevention of violence against women. I think it was A Right to Respect, I think the plan was called. So we articulated each of those regional structures with that statewide

plan.

The partnerships are then each of the local councils, the seven local councils in the region, each of our community health centres, the indigenous family violence regional action group, and a number of other parties who are relevant, and they meet together to develop and to action a series of different projects and programs for prevention of violence against women that work in a range of different settings.

So in a sense it's a jumping off platform. So you have a whole heap of different partners that work together, and then each of those partners, like a local council or a community health service, et cetera, also have the remit to work within their own communities. So you are bringing in all of those varied partnerships.

I could keep going, but I think that probably answers for now.

MS DAVIDSON: Ms Fitzsimon, are you able to explain within your particular Primary Care Partnership what sort of work you are doing in relation to violence against women?

MS FITZSIMON: Sure. Preventing violence against women and children is - we have two strategic priority areas, and that is one of them. We work very closely - we have two women's health agencies in our catchment, so Women's Health West and Women's Health Inner North. So we align our work with their regional plans and, as Robyn said, the Preventing Violence Together partnership we are heavily involved in that work and facilitating partnerships, making sure that we are working on those priorities across the sectors.

We also have a current project which we are

looking at with our alliance, our health promotion alliance. We have noticed that there is a gap in evaluation practice in our catchment, particularly around primary prevention. What we are wanting to do is to have a picture of our catchment around all of the efforts within our organisations when we are evaluating our projects so we can have - basically look at the impact of primary prevention of violence against women projects.

We have a partnership with Melbourne University, and we are developing an evaluation framework that is looking at shared indicators and data collection methods so that when our partners are doing their primary prevention work we are all measuring the same, and then we will hopefully be able to develop a picture across the catchment and share that across the region and state within the other PCPs if they are interested.

There is another project that we are leading, which is identifying and responding to family violence project, which we have received extra funding for. What we are trying to do is work with our mainstream organisations who have identified that they are struggling with being able to appropriately identify family violence victims and then what do they do if they get a disclosure and what are the referral pathways. So we have 14 organisations who are sitting around the table from many different sectors trying to look at how do we improve the system so that women and children when they enter the system can have a seamless journey through the system, and it is focused on women and children. So they are the two main projects in alignment with the women's health work.

DR GREGORY: Can I add one thing to that, sorry, that I didn't

mention before. There is also work that the women's health services were funded through the Office of Women's Affairs for a project that's been led by WHAV but it's located with Women's Health Victoria as the statewide service. That's managed to or through the funding has employed a coordinator at a statewide level who is also - who is doing two main things.

One is facilitating a community of practice so that each of the project workers in each of the regions who are leading the regional strategies for prevention of violence against women come together in that community of practice in order to share the lessons that they have learned, what works, what doesn't work, and to be able to do a broader evaluation, which is under way at the moment, also funded. Certainly the work that Women's Health West is doing across the region with the PCPs, et cetera, also has an external evaluation.

As well as the communities of practice, the work at that central level, statewide level, has set up a toolkit and a website that's soon to be launched, and that brings together all of the different tools and processes into that one area. It's a bit of a web portal that's then available across the state, not just to the women's health services but to anyone who is working in that area.

I think that work over the last couple of years has been really instrumental in consolidating the statewide work. Whilst the work that's happened with the PCPs has been longer term, certainly in the west and in the north, that more recent, really coordinated integrated work I think has been great with some funding to support it.

DEPUTY COMMISSIONER FAULKNER: Dr Gregory, as I understand it, your women's health service is a specialist family violence service as well.

DR GREGORY: Yes.

DEPUTY COMMISSIONER FAULKNER: Is that true of most women's health centres?

DR GREGORY: No, it's not. A number of the women's health services, I think at least five of the nine regional services, also house the regional integration coordinator, who coordinates that response service, as does Women's Health West. Whilst that's an auspiced position, it means that there is a much greater link between the response sector and the women's health sector. For instance, the Western Integrated Family Violence Committee that is the response integrated committee for the west has a representative that sits on the Preventing Violence Together regional governance group and vice versa, that regional governance group sits there, and that also occurs in different ways in each of the other regions.

Women's Health Inner North, for instance, are very strongly integrated in their prevention plan with a lot of the response sector as well. So it's looking at broader partnerships, but we are certainly - we are much bigger as a service and have a very large integrated family violence - - -

DEPUTY COMMISSIONER FAULKNER: That was a preliminary to understand whether or not in the PCP world you would generally have an engagement from the specialist family violence services. I tried to pick through, looking at the list of membership, whether that was the case and there was some commentary made somewhere in someone's

evidence about the development of the tool having engagement of that sector but not since. I'm just interested in the PCP and the engagement with the specialist family violence services.

DR RENNIE: I think that depends very much on the PCP catchment. So the answer would be different for each of the 28 PCP catchments. In some areas it would be quite a strong engagement, in other areas a much looser kind of engagement in that the specialist family violence services might be affiliate members, and in some instances they are not particularly engaged.

DEPUTY COMMISSIONER FAULKNER: Thank you.

MS DAVIDSON: Dr Rennie, you have a reasonable idea of what the 28 PCPs are doing in relation to family violence. Is it the case that they are all doing work in relation to preventing violence against women or is it only some?

DR RENNIE: Fifteen of the 28 Primary Care Partnerships have selected preventing violence against women as a priority area for their prevention work. So PCPs are completely able to select their priorities. They are encouraged to select priorities from the list that was available of statewide prevention priorities from the Department of Health, and in fact preventing violence against women was not on that list. So 15 PCPs actually chose that as a priority area despite the fact that it wasn't on the list.

In the latest Victorian public health and wellbeing plan preventing violence against women has been included, and I think that we will see a further increase in the number of PCPs that select it as a priority because it is now endorsed, as it were, in a situation where it wasn't endorsed in the past.

In addition to 15 agencies having selected preventing violence against women as a priority area, 11 agencies have work in the area of service coordination and integration relating specifically to family violence as a priority area as well.

MS DAVIDSON: In terms of other types of family violence that the Commission - is a part of their terms of reference would include elder abuse and child abuse where that occurs from a direct - direct child abuse where it occurs by a family member. Has there been other work done in those areas by Primary Care Partnerships?

DR RENNIE: Once again, it depends on the Primary Care Partnership in question, but because we are a platform that works across the lifespan from birth until death a number of PCPs have worked in the area of elder abuse over a number of years. So I suppose prior to really connecting this as an issue of family violence a lot of PCPs had shown an interest in elder abuse because it was coming back as a major issue from the member agencies of PCPs, and that's what informs PCP priorities.

In addition, in relation to child abuse, whilst it's not an area that most PCPs are specifically focused on, many PCPs are working quite closely with Services Connect or Child FIRST initiatives within their catchment, and PCPs catch a number of paediatric services within their membership, which means that we are looking at integrated responses to those issues.

MS DAVIDSON: Dr Gregory, what about from the perspective of women's health? Obviously violence against women is a priority, but in terms of the diversity of the range of family violence that is part of the Commission's terms of

reference, does women's health also work in any of those other areas?

DR GREGORY: Women's Health West, because we have both a response and a primary prevention service, children or violence against children is absolutely integrated into our strategic plan. We have children's counselling and group work, and obviously do a great deal of work with children in refuge and as part of case management plans with women who experience family violence.

In our health promotion service we do a great deal of primary prevention work in primary schools and secondary schools as well as TAFE and universities, across sporting clubs, et cetera. So there are a lot of activities. I think one of the things that WHAV has looked at is really that intersectionality, that idea of there being multiple different ways of approaching a topic like prevention of violence against women. So Women With Disabilities Victoria would really encourage us to look at that area of disability. Multicultural Centre For Women's Health look at the intersections with multicultural women and so on.

I think there's been a lot of different projects. But I think the biggest kind of hurdle in a way has been until quite recently child abuse has been seen as more siloed in the area of Child Protection, and family violence services have been seen to work more closely with women. Over the last perhaps five years there's been a lot more work that has looked at, one, the fact that if a child witnesses family violence in the home that is still child abuse. That still has extraordinary impacts on children.

I guess over the decades the child protection service in some ways has been probably, to put it frankly, a little more mother blaming - you know, why don't women keep their children safe rather than why don't men not abuse women and children in the first place. I think as the services are becoming much more integrated and having a much stronger system - for instance, we place one of our family violence outreach workers into the child and family service in the west and they sit on our governance structure for the women's and children's partnership, and so what we are finding is that our efforts to really look at the individual needs of children as well as the intrinsic links with women's safety, as that's become stronger and as the understanding of child protection in the context of family violence has become stronger, we are slowly seeing a much more integrated system. I think that's the starting point to then see prevention work.

I think the integration of the response sector with women more generally since 2006 has become stronger and stronger - still a bit of a way to go, but I think the very fact of how much stronger that is in a sense then allows to be some really good work for prevention as well. So I think that the child protection kind of end of violence is still early days to some extent in that prevention work.

MS DAVIDSON: Ms Fitzsimon or Dr Rennie, do you have any additional comments in relation to that idea of to what extent child abuse has been dealt with or integrated with or coordinated at the same time in terms of prevention work as violence against women?

MS FITZSIMON: I don't have anything to add.

DR RENNIE: I might just add that Primary Care Partnership work generally is very focused on better integration of various issues so that we don't consider anything in silos. Whilst some of those agencies haven't been active members of PCPs in the past, it's a very inclusive platform and very able to engage those agencies into the future.

MS DAVIDSON: You have talked about some of the primary prevention work that's being done and you have mentioned the health and wellbeing plan, which now has family violence in it. How did PCPs deal with or adopt family violence as a priority in the absence of family violence being a specific priority identified by the government?

DR RENNIE: I suppose the pathway to Primary Care Partnerships identifying one issue over another usually occurs locally in the context of networks of prevention or health promotion workers, who get together every time there's a new plan to be developed and look at what the priority areas might be. So the particular mechanics, I suppose, of any individual PCP deciding, that might vary a little, but typically what that means is that when workers from, say, 10 agencies sat together and looked at what were the needs in their catchment and what might the priorities be, they were determining between priorities such as physical activity, food and nutrition, smoking cessation, preventing violence against women, and when they looked at the data about health impact in their community and about the sorts of interventions that they might be able to do and the amenity to change any issue that they selected, they obviously determined that preventing violence against women ranked more highly on their list perhaps than some of those other priorities.

Essentially that's the kind of process that those networks of health promotion and prevention workers would go through with the endorsement of their agencies that they come from to determine that preventing violence against women should be a priority. I think it speaks volumes to how highly people considered this in terms of the burden of disease that it was creating for women in catchments, that it got up despite the fact that it wasn't one of the listed priorities in the Victorian health department's plan.

MS FITZSIMON: I was going to say that the PCPs work from the social model of health and consider the social determinants of health and obviously within preventing violence against women being a human rights issue and strong advocacy role that women's health and community health played in our partnership, it was before my time but I think that was critical for this prevention of violence against women being a priority in its own right and being able to say that it was going to stand alone and not sort of under the mental and emotional wellbeing priority.

DR GREGORY: I would probably add as well that I think the preliminary work that was done by VicHealth around the burden of disease, taking an international methodology and actually measuring what is the burden of disease of ill-health and morbidity and mortality around violence against women laid some really terrific groundwork that then built on the work that I think the women's health services' in particular - I won't use the word "harassment", but we certainly I think in each of the regions had done really concerted work with partners. But

that groundbreaking work by VicHealth I think really gave us a platform to jump off because we then had a methodology that said it actually is - you know, look at injury, smoking, low birth weight, mental health and wellbeing, depression, anxiety, et cetera, et cetera - such a strong burden. So that and whatever a more gentle word than "harassment" might be by the - - -

MS FITZSIMON: Advocacy.

DR GREGORY: Advocacy; thank you.

DR RENNIE: I would endorse that position by Robyn that I think the women's health services did an outstanding job of advocating for the prevention of violence against women within those Primary Care Partnerships. They were consistently around the table reminding people that if you look at burden of disease data for women between the ages of 15 and 45 no other issue even comes close to creating the same burden of disease.

MS DAVIDSON: You mentioned the health and wellbeing plan that now incorporates family violence as a priority area. When did that new health and wellbeing plan come out?

DR RENNIE: On 1 September this year, I think. So it's very recent indeed.

MS DAVIDSON: Is it named as family violence in terms of a broader - - -

MS FITZSIMON: I think it is community and family violence - is that right?

DR GREGORY: I don't think it's absolutely clearly family violence, but the body of the rest of the health and wellbeing plan makes it clear that that's what it is. I think they are just probably looking at a broader remit as well. So that's really exciting work. I think that

that shows real leadership on the part of the current government to include prevention of violence against women. I think it's great.

MS DAVIDSON: On that point, to what extent - obviously until 1 September - has that primary prevention work been driven or supported by government more generally?

DR GREGORY: Going slightly sideways and coming back to that question, the Women's Health Association of Victoria since 2006 has put together a three-year plan that looks at priorities for women's health, and it's very much been a vehicle for advocacy in relation to state government platforms for women's health regardless of who that state government might be or might end up being. Having prevention of violence against women as a health promotion priority has been on that platform since 2006. So there's been really concerted work.

We then wrote a local government version of that broader statewide priority document into a document called "Safe, well and connected" where all of the women's health services connected with people who were running for local council, asked them to not sign onto but to indicate their interest in furthering that work in each of their council areas should they be elected, and then engaging with local councils. So that work was happening alongside the work of influencing the Primary Care Partnerships.

I would say we have at different times probably done a similar job with the state government as well as advocating for the priority area, and also we advocated for prevention of violence against women to be a crime prevention priority as well. I would say that different governments have probably - under the previous government,

I think the previous state government, we would often hear things like "that's Mary's work", meaning Mary Wooldridge, who did an absolutely extraordinary job in this area, but really getting - and I think David Davis as well as the previous health minister did understand the social determinants of health, but actually convincing government that having prevention of violence against women was a whole of government and therefore health priority and not just a response with Human Services.

So some of our advocacy or the work that we did was from time to time perhaps despite the opinion of government as to what funding should be used for. So there wasn't always enormous encouragement to use funding for the primary prevention of violence. But I think as the women's health services continued to advocate it, as the PCPs took it up as a mantle, as local council started to get on board and certainly the work of the regional management forum in the west and Ken Lay's leadership there and across Victoria, I think it's taken on a momentum where it's just so clear that it's now kind of funded work, really.

The women's health services have now been slightly separated as a program as they were originally from community health. The priorities are now prevention of violence against women, sexual and reproductive health, mental health and gender equity. I think having gender equity is absolutely core business to make sure that that continues to be alive and well when the Royal Commission is finished, when Rosie Batty is no longer Australian of the Year doing an astounding job for advocating for family violence. Over the years, as it's not front and centre in

the news, I think maintaining that as core business will be really supported by clarity through this Commission and the long-term outcomes or encouragement of government to keep prevention of violence as an absolute priority and to fund it.

MS DAVIDSON: We have heard through the earlier hearings as well that there's a lot of work being done in communities and by different organisations in relation to preventing violence against women. It might be sporting clubs, community organisations, local government, now women's health, Primary Care Partnerships, quite a broad range of people involved in doing that sort of work. Do you consider that there's one single platform from which this work should be done or is it a matter where the platform or the organisation that might be most appropriate will depend on the particular community?

DR RENNIE: I think this is whole of community work. So I don't think you can do whole of community work from only one platform. But I think that we also need to be clear that there needs to be leadership at a statewide level and then leadership at regional or catchment levels as well. It's probably not entirely clear what that structure will look like, and I suppose that's what these hearings are all about.

But you can't silo this or even say only one platform is going to get all of the results because the number of stakeholders, the number of departments, agencies and groups within the community that need to be engaged to create the sort of change that we need to see are so enormous, whether it stems from schools and the education department, sporting clubs and community

agencies, employers in the public and private sector, and that's I think about the leadership that comes at a statewide level and how it's supported by robust regional structures.

COMMISSIONER NEAVE: How would you envisage the leadership being provided at a statewide level? We have had leadership from at least two Commissioners of Police. Is there a need for some sort of independent body that oversees all of what's happening on the ground either or both in terms of prevention and service provision, evaluation, all of those sorts of things?

DR RENNIE: I'm not certain about whether it should be delivered by an independent body or not, but I think there does need to be leadership held by a person or persons or body that has real political clout. So there has to be a structure where if someone says, "Hang on a second, I have identified an issue or we have identified an issue," there is a structure for them to be able to veto or to have a mandate to actually put in place the change.

That's the difference between just leadership and leadership with power to back it up. So I think for me it's that question of what is the mandate that the leadership person, persons or body has and how is that going to be operationalised.

COMMISSIONER NEAVE: One model for that has been the creation of independent commissioners, for example, the Commissioner for Children as one example. Is that something that is a possibility?

DR RENNIE: I think that the Commissioner for Children has shown that that can be a very powerful voice. It hasn't always resulted in the change that might have been

advocated for. So I think it would be worthwhile looking at in what instances has the Commissioner for Children been effective in actually being able to get change and say, "Look, not good enough" and what are the limitations to that, because in setting something up it would be good to feel as though we could set up a system that will overcome some of the limitations that that key position might have experienced.

DR GREGORY: Can I add to that as well. It's something that I have thought about a little bit really just over the last week or so. I guess my overwhelming sense is that keeping women and children safe and holding perpetrators to account is an absolutely key responsibility of government, and there would be part of me that would be a little bit worried about seeing an independent body doing that. I think with gambling I can see it. There is absolute vested interests outside of government and there are funds that come through the TAC - sorry, through gambling funds and similarly through the TAC; whereas I think it's a core business of government to keep communities safe.

So I would really like to see a very strong whole of government structure, as we are starting to see now where we don't hear things like, "That's Mary's job". Having the Office for Women back in The premier's department I think is fantastic. Rather than have it in Human Services or Attorney-General's, it actually says, "This belongs to the whole state." Then having the ministers that are responsible, so around crime prevention, around justice, policing, courts, Human Services, education, sport, the arts, businesses and

workplaces actually having a structure where government is absolutely clear that it is everybody's business. I would feel more comfortable with that structure.

Just adding one other thing to your previous question. I think the balance is between having really good regional and statewide structures that hold plans so that you both have a whole heap of organisations jumping off that platform, but that it happens in a coordinated way so you don't have different sectors duplicating their work.

The women's health services do some great work around Respectful Relationships education in schools. Grab that work, use it. We built up relationships with the education department to roll it out. Ditto with other groups, local councils, community health. It's finding a way to ensure you don't have duplication but without limiting the possibilities for everybody doing this work, including communities.

Again we have some fantastic work; "Our community, our rights" at Women's Health West that works with different ethinised specific communities around a human rights program and builds that work over the course of a year and those women who work in that area then go out and work in their own communities. Interestingly enough, of the three groups we have had each of those three chose prevention of violence against women even though they could choose whatever. That was the area that they said most affected their communities. So how do you cut down duplication and make it everybody's business simultaneously I think is the challenge.

MS FITZSIMON: I was just going to add to what Robyn had said.

There has been so much momentum in previous years and it would be good to build on existing structures rather than creating new ones. I think we will lose a lot of momentum if we do create new structures. I just wanted to add that.

The other thing was I think when looking at the strategy I think there needs to be a stand-alone primary prevention framework. I am concerned that when you are looking at the response end and preventing violence before it occurs, I think that needs a separate funding stream and separate framework that's underpinned by the whole of the family violence strategy.

COMMISSIONER NEAVE: Is that because you think if there is a danger that if funds are limited then prevention is what's usually cut? Is that your thinking behind that?

MS FITZSIMON: I think funds can be siphoned into the response side of things. I have seen it happen on the ground. I agree across the spectrum, but it is easy to focus on the service system. It can be easier to work on. So it would be good just to make sure there is dedicated funding and a separate primary prevention strategy that stands alone, but as part of a coordinated framework.

DEPUTY COMMISSIONER FAULKNER: We have been sort of having two concepts debated in the last five minutes, one being the extent to which the centrality of government as a deliverer of services and therefore the possibility that an independent might not have the same power almost, but the second one that I'm really quite interested in is the fact of who determines whether a PCP works on family violence. You have talked about the fact of government putting it in its Victorian public health and wellbeing

plan as a priority - it doesn't say "family violence"; I have looked it up; it says "preventing violence and injury"; so it is not quite there plainly - and then the choice that PCPs make on behalf of the community of practice not to work on it.

Are you advocating that government should have it on its list and PCPs can ignore it so you have an uneven response across the state? I'm not quite sure what people think about that middle piece, which is do PCPs - if they think it's a bigger priority to work on obesity, should that be permitted or should government be doing more to force a PCP into working on this? It's a dilemma I find difficult. Ms Rennie, I'm interested in your view particularly.

DR RENNIE: Certainly all PCPs have autonomous government structures. So they are not mandated to work on particular priorities. They have been mandated to work in particular areas of practice, for example, service coordination or prevention.

A few years ago the Department of Justice was very interested in the Primary Care Partnership platform and actually wanted PCPs to be doing some work to prevent harm from gambling. That was not a priority issue that was ever going to get up if left to PCPs, and the Department of Justice actually said, "We are going to fund you." They offered additional funding, in effect I suppose buying that onto the table so that all PCPs did prioritise it.

It was an interesting model and the extent to which that got sort of truly embraced varied, although eight years later there are some Primary Care Partnerships

that are demonstrating exceptional statewide leadership in that area. Without all of them being funded that dropped off the radar again. But, once again, from a point of view of burden of disease that was never going to compete in the way that prevention of violence against women and obesity might compete.

I think it would be unrealistic to say every PCP is going to select this as a priority area just because it is now in the public health and wellbeing plan. I think that if the government wants to see every Primary Care Partnership working in this area it probably would need to be directed or mandated.

Having said that, more than half have picked it up even though it wasn't in the previous plan at all, and in fact in the face of some questioning by the Department of Health at various times around, "Why have you selected that as a priority? How does that fit within the priorities in the" old Victorian public health and wellbeing plan.

DEPUTY COMMISSIONER FAULKNER: I'm also sort of asking a philosophical question which is when you set up a structure that is meant to reflect community priorities should government then mandate something to happen everywhere. Is this the community determining the priority or is it the central government determining the priority? If anyone else wants to comment on that, I'm happy.

DR GREGORY: I think it's really important that communities be able to determine priorities that make sense for themselves. There are competing priorities. Local government has competing priorities. Community health

does. PCPs do. There are a range of competing priorities. I think one of the reasons that I'm a strong advocate for governance and regional action plans to be sitting with the women's health services is that it is core business.

Gender equity is what sits behind changes around preventing violence against women and children. So having it in an area that is core business means it won't drop off the agenda; not that I'm saying it's dropping off other agendas, but there are competing priorities - smoking, drug and alcohol, gambling - there's a whole range of different areas that each organisation does need to consider.

So if we are going to keep this on the table and make sure that there's always someone there advocating, then I think locating it with organisations that are already government funded, that already exist, that already have both regional and statewide mandates and where gender equity is core business makes absolute sense.

MS DAVIDSON: Just picking up on Commissioner Faulkner's last question, in terms of PCPs how much money do they get for primary prevention itself?

DR RENNIE: Each of the 28 PCPs around Victoria is funded between $300,000 and about $600,000 for the bigger PCPs; most more down at the $300,000 end. That's a total funding pool of about $9.5 million across the state in any given year.

In relation to prevention, probably about $70,000/$75,000 in a lower funded PCP would be the prevention bucket, although it's not siloed as neatly as that, I suppose. It depends a little bit on the

governance arrangements of the partnership and how they decide to prioritise the spending of that money.

DEPUTY COMMISSIONER NICHOLSON: Did I hear you say that in a PCP there would be on average about $75,000?

DR RENNIE: For prevention work, generally. That's not just prevention of violence against women. That's the prevention work that they might undertake on whatever the selected priorities are. However that is, I suppose, thinking of a narrow view of PCPs being those staff that are employed through that bucket of funds directly.

Primary Care Partnerships are actually about the whole of the partnership and the whole of the membership. So when you look at that what you have in any given PCP might be 20 members, and a number of them might also have specific prevention funding from the Department of Health, particularly the community health services. So, when we talk about Primary Care Partnerships, thinking more broadly about the total member of those Primary Care Partnerships, what then comes into play is the total resources sitting within those partner agencies that might be applied to any priority issue that's selected.

DEPUTY COMMISSIONER NICHOLSON: So that $75,000 is for prevention. What does it pay for?

DR RENNIE: Usually when it sits within a Primary Care Partnership, and as I say that's only those sort of staff dollars sitting with the PCP and not all the resources that exist within the partnership, that would pay for a skilled prevention or health promotion worker who would have expertise in prevention activity.

DEPUTY COMMISSIONER NICHOLSON: So it would be part-time?

DR RENNIE: Yes, it would be part-time. Most PCPs have a

health promotion worker who is about 0.6 EFT. Larger PCPs might have more resources.

MS FITZSIMON: For example, our PCP annual funding is around $417,000 for this financial year, and we have a 0.5 EFT project coordinator, so a five-day fortnight, who works on prevention.

MS DAVIDSON: You were asked about the issue of mandating priorities. Putting aside mandating, if the department were to make additional funds available for priorities for prevention of violence against women or other types of family violence would PCPs who might not otherwise have done that work perhaps put their hand up to do it?

DR RENNIE: I'm certain that all PCPs would want to be in contact with their regional women's health services and look at what could be achieved with additional resources, and certainly that would make a difference for some PCPs. Short of a mandate, I wouldn't say that every PCP would adopt it because you would still have some partnerships that would say, "It doesn't compete in our catchment with obesity or with smoking rates."

I can think of a rural community in Victoria where they identified that 55 per cent of children in schools were overweight or obese. That stood out for them. That was going to be the priority. It was very hard for anything to sort of pull them away from that, notwithstanding that the same community would have high rates or think did have high rates of family violence.

MS FITZSIMON: I disagree with that. I think if PCPs were mandated, and obviously working with women's health, I think if there were extra resources being brought into the partnership I think that they would take that up.

DR RENNIE: I wasn't talking about if they were mandated. If they were mandated they would clearly do it, and they did do it when that happened with additional gambling funds. But just funds enough - I think in most cases it probably would make a difference, but I think the reality is you want people who are committed to do something and do something genuinely. You don't want people who think, "Oh, God, not another thing people have lumped on our desk for another $20,000." This is what happens at times with small amounts of money and that's why I would rather see something that was a kind of whole of system response that was backed up by great leadership that was in partnership with the regional women's health services. I think there would be very few PCPs with that kind of structure that wouldn't actually voluntarily take it up because they would want to.

MS FITZSIMON: It would also bring in a range of different partners. I think it would be attractive whether it was mandated or not whether there was extra funding and it was done in a coordinated way. Even if obesity, say, for example, was a priority area, I think preventing violence against women would bring a different range of partners around the table and more across different sectors.

COMMISSIONER NEAVE: Can I just ask about women's health in the west and other women's health services. How does the funding provided for the PCPs compare with the funding that you get in the area of prevention?

DR GREGORY: The women's health services, if we take the family violence part out of Women's Health West, if we look at just the funds that are under the women's health program, which is a health promotion program, it varies across the

women's health services from, off the top of my head, probably about 400,000 to probably 1.5 million. Women's Health Vic are the biggest because they have that statewide mandate for coordination as well. Women's Health West would be just under $1 million, and that includes family planning and the FARREP program.

COMMISSIONER NEAVE: Is this just for prevention or is this total funding?

DR GREGORY: That's the total funding for the women's health component all of which is focused on prevention and capacity building. Under prevention there's a number of different things we would do, but that's all prevention money.

Then each of the women's health services, we meet together and develop a strategic plan each year and we have longer term plans with shared priorities. So everybody shares prevention of violence against women as a priority. Everyone shares sexual and reproductive health as a priority. Everyone shares gender equity as a priority.

We also have mental health and wellbeing in our rural communities. Women's Health Inner North and Women's Health Goulburn North East have done some incredible leading work around disasters and violence in communities that have led to some really fabulous outcomes for the bushfire Commission et cetera. So they have a priority around climate change and the impact that has on communities.

But, going back to the question, those funds are all prevention funds and they will be divided between those priority areas. On top of that, Women's Health West

and some of the other women's health services picked up some funds under the crime prevention grants that unfortunately finish in November this year, and that's meant for us three years of fantastic, really concerted work particularly across workplaces, building the capacity of community health and local government in particular to then become jumping-off points themselves for prevention of violence against women.

COMMISSIONER NEAVE: But in addition to that you have a service provision component as well which is a separate funding stream.

DR GREGORY: A separate funding stream for our family violence service, yes. So I haven't included the funding for family violence, only the part that's around our health promotion funds.

COMMISSIONER NEAVE: Thank you.

DEPUTY COMMISSIONER NICHOLSON: Just to be clear, of the funds that your organisation has for health promotion how much is actually spent specifically on primary prevention of family violence?

DR GREGORY: On primary prevention of family violence, obviously if you take out the infrastructure part of funds, we put about 22 per cent towards infrastructure, the other 78 per cent goes into programs and staffing. Of that 78 per cent of funds, we would share those funds across priorities. So sexual and reproductive health - and this is a rough guide - might get about a third of those funds; primary prevention of violence about a third; mental health and wellbeing about a third. So we are looking at probably $250,000 a year, if my maths is any good there. Yes, probably sort of $200,000 to $250,000 a

year.

DEPUTY COMMISSIONER NICHOLSON: What would that be spent on?

DR GREGORY: We have at the moment, and this includes the crime prevention grant as well, three workers that work specifically in the area of primary prevention. Each of those people are part-time. They offer both the secretariat for the regional strategies, so all of the governance structure for that regional plan, and we also have a number of particular programs. So we have Respectful Relationships education programs in schools. We have "Our community, our rights" program that works specifically with different communities. We do training and development with all of our partner agencies building their capacity to develop policy and procedures and practices that work towards our regional goal, which is communities that are violence free, respectful and something else - - -

DEPUTY COMMISSIONER NICHOLSON: In short, the $250,000 is used to employ staff to carry out all those activities you list?

DR GREGORY: Largely it's used to employ staff. We also out of those funds would pay for interpreters, catering for venue hire, child minding, all the things that you need to have communities be able to participate in programs. We work with particularly disadvantaged and isolated communities. So in some circumstances we would also reimburse travel costs and so on. It really depends on the particular project. So it's not just staffing. It's also all of the program costs, catering, venue, child minding, interpreters, travel.

But if the Commission are considering the amount

of funds that go to primary prevention, I think we worked out in the women's health services about 0.2 per cent of the health budget went towards primary prevention per se and the rest towards clinical services et cetera. Some balancing up would be really important.

COMMISSIONER NEAVE: So the 0.2 per cent is health prevention across the board or - not just violence against women?

DR GREGORY: No, prevention across the board. That figure was done probably three years ago. So it would be fair to say an update would be in order. But at the time we were quite shocked by how low it was.

COMMISSIONER NEAVE: Do you have a source for that, that figure, the 0.2 per cent?

DR GREGORY: What we looked at were the budget papers. So we looked at what is the overall health budget, and then we looked at the prevention programs that are the component of that and divided one by the other.

COMMISSIONER NEAVE: We have been engaged in a similar exercise in relation to family violence, but I'm not sure that we have factored in some of the health prevention stuff. Thank you.

MS DAVIDSON: Can I turn to you, Ms Fitzsimon. In terms of the projects that you are running at the PCP at the moment, developing measures for sort of an evaluation kind of framework and also the work that you are doing in relation to improving the capacity of mainstream workers to identify and respond to family violence, do you see that those are matters that should in fact be done purely at a local level or is there a need, do you think, for something more statewide to support that sort of work? I can imagine that the work in relation to a framework,

you would ideally want it to be applied across Victoria so that everyone is measuring the same thing.

MS FITZSIMON: Yes. So if we are looking at the evaluation framework project ideally there would be - I know VicHealth have developed a framework, but it's really looking at process measures and supporting agencies around evaluation. So ideally there would be some impact measures that all organisations would be using in their primary prevention of violence against women efforts that they could use to measure the impact of their work and then somehow collectively build a picture across the state around the evidence of primary prevention.

I think there's value, though, to bring partners around the table to actually inform that work. This is a three-year project where we are working with Melbourne University and our partners are informing what those indicators are. So it's really local action and it's on the ground. So that work is really important as well. But I do think there needs to be a statewide framework. But what we are doing at the moment in the absence of a statewide framework is really valuable.

Partners, because they are involved in developing those indicators, they really own that so that when they go back to their organisation we know we have built some evaluation capacity and they have helped to contribute to those measures.

As far as the identifying and responding to family violence project, I think the value of the local PCP to be a neutral platform where we can bring organisations around the table and listen to all of the voices of all of the different types of organisations that

we have equitable decision making, I think to be able to look at the system and to get practitioners or team leaders or managers together and say, "What are the issues that you are facing in your system", and then to be able to map that out and look at where the lumps and bumps are in the system and then collectively come up with ways about, "How do we go about improving that," that's the real value of the PCPs.

We did an expression of interest process for this project, and 14 organisations in our region put up their hands to say, "We absolutely need to be working on this and we want to come along and look at all of the different parts of the service coordination framework," which include the initial needs identification and screening processes, but then working very closely with women's health and to give us sort of best practice and specialist advice around those referral pathways or what we are doing as a mainstream service I would like to see a bigger integration. So the PCPs have that strategic helicopter view where we can look at a whole of system and look at what's working. We are not service providers but facilitators of change.

MS DAVIDSON: The Commissioners mentioned the possibility of if you were to have, say, a separate body, a commissioner or some sort of body, do you see if there was some separate body that there might be a role for some sort of coordination and evaluation and sort of helping to develop best practice for things like delivering training to mainstream workers?

MS FITZSIMON: Absolutely. Some sort of monitoring and evaluation framework, quality assurance measures and some

consistency around workforce development would be great.

MS DAVIDSON: Currently is it obvious who is doing that work at a statewide level? Is someone doing it?

MS FITZSIMON: Yes.

DR GREGORY: Women's Health Victoria have been leading work with all of the women's health services around developing tools and resources, putting a website together, having a communitive practice, and that work is currently being evaluated. I think the evaluation will be ready early next year.

But I do think that strengthening that role and having it in that one place, having it in a place that has that statewide mandate that then has a kind of a central portal where a whole range of different information is available and as people learn and provide more and more evidence based rules and as evaluation occurs they can go into that central place and everyone knows where to find that information I think is really useful.

MS DAVIDSON: Can I just finally turn to the work that the PCPs have done in relation to service coordination and the SCT tools that you use. Can I ask you perhaps, Dr Rennie, and maybe Ms Fitzsimon, to explain what work has been done in relation to the development of those tools and what it's actually meant for service coordination within PCPs.

DR RENNIE: Sure. This is a really key plank of Primary Care Partnership work over the past 15 years. The service coordination tool template, otherwise known as the SCT tools, are only part of the broader piece of work that PCPs have led around the development of service coordination guidelines. These are really guidelines for best practice in managing referral and intake and making

sure that people don't fall through the gaps. It was in response to an understanding that what was happening was that people might ring up one service, go through a whole lot of questions, find out it is the wrong service and basically get told to call somebody else, and that was typical of people's pathway through the service system.

So the SCT tools were really just about developing better referral forms, assessment forms or initial needs intake and making sure that when people gave their information it was documented and that that could be used across various different agencies. So, to give you an idea of what that's meant, around the state more than 300 different forms have been replaced by one form. That means that if you call up a service and give your information it's been documented and if you want a different service even within the same agency you won't have to go through it all again, and yet that used to happen. If you used to call up for OT you would give all your information, and then if you needed speech services or if you needed counselling you would have to give it all again even within the same organisation.

So that's meant an enormous shift in practice. You can imagine that with giving up people's individual forms there was always some sense of, "Hang on a second, this new form isn't as good." So there were a lot of compromises and a lot of willingness to compromise, I suppose, by those agencies to see the greater good in actually having a system that streamlined access and that created a no wrong door approach. That's been a big part.

MS FITZSIMON: I will just add to that. I think there were around 350 tools brought into one, like Susan said. When

looking across all of those 350 tools the information was very consistent. So I think it was quite easy to sort of draw and have a negotiation around what information was included in those tools so it did really improve communication between service providers and ensure quality referrals.

There has been a new version of the SCT tools, SCT 2012, which includes a single page screener. That screening tool screens for a range of different social needs of a client and includes a question around family violence. So I think particularly with family violence questions there's been a lot of other PCPs now, even though family violence or prevention of violence against women isn't a priority in its own right, just including that question within the service coordination tool templates is actually - most PCPs are kind of interested in, "How do we support our organisations? If our agencies are asking that question, then how do we support them to ask the question and then provide an adequate response?"

There's also another tool which is around an accommodation and safety template which has been developed by family violence and homelessness services.

COMMISSIONER NEAVE: That's an enormously attractive option in this area where people often have to go to multiple different agencies or are referred to many different agencies. Was funding provided for the development of that tool by Health?

MS FITZSIMON: Yes, by the Department of Health it would have been.

COMMISSIONER NEAVE: A significant amount of money, presumably, or not?

DR RENNIE: I suppose it was also core PCP business. So for years PCPs were working on that through their service coordination workforce, being part of working groups, doing the consultation back with agencies and local areas to get people to agree that this was a good way to go and what the tools might look like.

COMMISSIONER NEAVE: Presumably you said to people, "When I take these details, these will be available for other people providing a service to you related to the same problem"?

DR RENNIE: Service coordination guidelines have an enormous amount of information backing them up in relation to privacy and consent. So no information is shared without appropriate privacy and consent arrangements. But those are worked into the tools and are a standard part. Right across those agencies that use these tools we have also seen a significant improvement in practice in relation to consent and privacy and also secure transmission of data.

You can't just have a form and say, "That can be shared with everyone", without giving careful thought to how is it that it is going to be shared and making sure that the transmission of data is secure. That's another really significant part of Primary Care Partnership practice and one that's really critical in this area where security is vitally important, in fact potentially life saving, for people who need family violence services.

COMMISSIONER NEAVE: Just as a matter of interest, if you are not talking about within an agency but you are talking about involvement of different agencies, how is that actually done? I'm interested in the practicalities of it.

DR RENNIE: PCPs across the state operate from two different platforms for secure transmission of referral information. One is called S2S, and that is a secure web based transmission of information. The other is Connecting Care, and that's an encrypted email system for transmission of information.

COMMISSIONER NEAVE: That's not rocket science, is it?

DR RENNIE: It is not rocket science, but it is amazing how many agencies, particularly agencies in the specialist family violence service sector, are not using what we would consider to be secure transmission of information. That might include ongoing use of fax or in some cases - I'm not so sure about specialist family violence services, but I know generally in the sector there is still some use of unencrypted email to send information.

COMMISSIONER NEAVE: Can I just ask Dr Gregory whether any thought has been given in the women's health network to developing a similar sort of tool?

DR GREGORY: In terms of this particular tool is a response.

COMMISSIONER NEAVE: I understand that. But, for instance, in your service which does provide some services as well as doing the prevention - - -

DR RENNIE: Some family violence services are using - not all, but it's obviously available to family violence services to use.

COMMISSIONER NEAVE: Right.

DR GREGORY: We continue to receive the bulk of our police referrals via fax. So that has been I think more the Victoria Police have been concerned that they don't have a platform that's safe for the transmission of data by email, and so the bulk of our referrals come in that way

and then different agencies prefer using their own tools, some of whom use the SCT tool and some of whom use other tools.

DEPUTY COMMISSIONER FAULKNER: Can I ask about the SCT form. Somebody is doing intake, say, for physiotherapy and somebody indicates that they are uncomfortable, frightened at home. Does that just get collected or then is there an active referral process? I just want to know what happens with it and whether Families First services, if they are members of PCPs, use that same form as well. It's a double barrelled question.

MS FITZSIMON: If there was a physio that someone disclosed family violence to - I think it is quite varied across organisations. So some organisations have got very clear processes in place around if someone is disclosing around what the referral pathways are. There have been referral pathways developed in our region. But some agencies aren't aware of those or it's very general. So it's sort of like, "If you get a disclosure, then you refer to a specialist family violence service."

The work that we are doing is trying to look at what else needs to happen. So across our collaboration is having some sort of resource that will support staff to know what the steps are if they do get a disclosure around then what do they do with it and in what circumstance. So it's very varied, basically, across organisations.

DEPUTY COMMISSIONER FAULKNER: Then the second bit was whether Families First services, if they are members of PCPs or loosely related, do they use the SCT form?

DR RENNIE: I don't think there would be a uniform answer to that question. It might depend on the catchment. They

are not uniformly using it.

COMMISSIONER NEAVE: I have one last question which is: have these forms been used for any data analyses purposes? I understand the privacy constraints, but this would be a way of getting a hold of - - -

MS FITZSIMON: I think within organisations they can extract some data. I'm not quite sure. It depends on their client management system. So some organisations who are using the SCT would be able to extract some data.

DR RENNIE: The roll-out of the SCT has been accompanied by a huge amount of training for staff and that typically it's filled out not by those practitioners who are delivering the physio service, for example; there's often specialists intake and initial needs identification staff who have that, and we would expect that those staff would have received training in what to do with the answer to the question if people do disclose violence.

MS FITZSIMON: I would also like to add to that. We did do a needs assessment to inform our project in 2013, and it is very varied. There are a lot of staff who say they know that family violence is occurring, particularly the home and community care workers who are going into houses, and they don't know what to do. So they just keep silent. So I think it's very varied and I know a lot of organisations, practitioners on the ground are saying, "We need more support. We are not getting enough training." So there's definitely a lot of those themes.

MS DAVIDSON: I'm conscious of the time. Are there any matters that we haven't covered that any of the panel members specifically want to raise with the Commission?

DR GREGORY: I probably had a couple. I think one was kind of

strengthening that response around governance; that as well as having ministers with that whole of government response, I think the Women's Health Association of Victoria put forward a governance structure that looks at having then something similar to statewide advisory councils, as they were previously, having one that looks at response and a separate structure that looks at primary prevention for exactly, as Emma was saying, to avoid response swamping primary prevention. So I draw the Commission's attention to that particular governance structure rather than talk about it in detail, but having the women's health services, PCPs, local councils, community health, VicHealth, they are the organisations that have absolute expertise in primary prevention, so having them in those structures and then a regional structure coming from it, which kind of jumps into the second point which would be my take home message, I suppose.

Response has quite understandably been absolutely front and centre with the Commission because of the devastating impact of violence against women and children. I think sometimes the attractive error is to put response and primary prevention on a continuum that doesn't necessarily recognise that the skills and the knowledge required to prevent violence against women are different from the skills and knowledge required between response and prevention. The settings are different. The workplaces are different. With primary prevention it's workplaces, the arts, education et cetera. With response it's police and courts and primary care services et cetera.

In the past the attractive error has been to put everything together and to say, "Let's look at a continuum from primary prevention to response," and I think that continuum doesn't recognise the overwhelming demand that agencies experience and how that can swamp the quite different and long-term 30-year-plus work that's required for primary prevention. I have been a little bit worried that that's been missing at the Commission.

COMMISSIONER NEAVE: Precisely why we have had you today.

DR GREGORY: Exactly. I really appreciate it.

COMMISSIONER NEAVE: And prevention was certainly raised in our earlier hearings as well.

MS DAVIDSON: Unless there are any further questions from the Commissioners, can these witnesses be excused?

COMMISSIONER NEAVE: We will have a 15-minute break.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

MS ELLYARD: Thank you, Commissioners. May I ask that the panel be sworn in, please.

<SARAH HELEN CARTER, sworn and examined:

<DAVID ANDREW TURNBULL, sworn and examined:

<RICKY ALAN KIRKHAM, sworn and examined:

MS ELLYARD: May I ask each of you in turn, and starting with you, Ms Carter, to identify your present role and your professional background?

COUNCILLOR CARTER: Absolutely. Obviously I'm a councillor at Maribyrnong City Council and former mayor, first elected in 2008, and I'm also currently the Australian Aid and Parliament Project Coordinator for Save the Children.

MR TURNBULL: My current role is the CEO of the City of Whittlesea. I have been in that role for nine years,

previous to that 12 years as the Director of Planning again at the City of Whittlesea, and urban planner by original training.

COUNCILLOR KIRKHAM: Currently the Mayor of the City of Whittlesea, first elected in 2012, in October, and I currently work for the Department of Defence as an adviser.

MS ELLYARD: The topic of the evidence that the Commission is receiving today is about engaging the community, and primary prevention of family violence. Can I ask each of the members of the panel, but again starting firstly with you, Ms Carter, please, what's the role that you see local government playing in the area of primary prevention of family violence, and why is local government a place that makes sense to be a focus for primary prevention work?

COUNCILLOR CARTER: I do see local government as playing a lead role. I really do believe that there's I guess a strong position, given that local governments are - anywhere between 80 and 140 services are provided through local government, and they are essentially touch points, I believe, within the community. Rather than harp on an old cliche, but it is the level of government closest to the people. We know our communities to provide those coordinated responses. So I would say that there's a lead role to be played.

MS ELLYARD: Can I turn to you, Mr Turnbull.

MR TURNBULL: I would have to agree with the substance of what was just said. We actually recently mapped our service delivery and we actually discovered that we are out there administering about 315 service functions right across the community. We are the only level of government that would

have direct contact with every household on at least a weekly basis, if you think about, for instance, picking up the garbage, and right across all of the service function areas there's contact with tens of thousands of people on a weekly basis. So I think the ability of local government to know its community, to be in constant contact with its community as well as a very strong focus on planning that local - and I'm not just talking about land use planning but planning for service delivery and also the advocacy that local government can do on behalf of its community, I think those are the sorts of things that make it well placed to be at the preventive end of these sorts of issues.

MS ELLYARD: Mr Kirkham, to what extent does primary prevention of family violence fall within the mandate of council? We have heard that council could do it because of its interface with the community. Why should local government do it?

COUNCILLOR KIRKHAM: I would agree with the other points made that we are indeed the closest to the community. If you look at, as has been stated, our contact points. From birth you have maternal and child health services right up to aged and senior services. We have integration with a range of our own community stakeholders, with our own council officers. So we have that contact with the community at a grassroots level. So the ability to be able to identify issues is far greater than at any other level of government.

MS ELLYARD: But why should local government do it? What is it about the mandate given to local government that makes family violence an issue that's made it onto the agenda

not only of your council but of a number of other councils across Victoria?

COUNCILLOR KIRKHAM: It's because I believe that we know our communities so well. In the City of Whittlesea we have a very, very diverse community. We invest heavily in making sure we have services in the right area, so we can actually identify issues on the ground a lot quicker than other levels of government. So that is certainly to our advantage. If we look at our investment in the City of Whittlesea in particular, we have certainly been able to put a lot of advocacy around trying to get other levels of government to invest to help us to address the issue locally.

MR TURNBULL: Could I just very quickly add to what the Mayor said that local government is, apart from everything else, mandated in the Health and Wellbeing Act to make sure that we mitigate - understand and then mitigate any negative outcomes to the health and wellbeing of the community, and that's one of the major reasons why the City of Whittlesea and I know Maribyrnong City Council are in this space.

MS ELLYARD: Thank you. Can I turn then to the different levels at which primary prevention might occur. In your submission on behalf of the City of Whittlesea there's a table which acknowledges the determinants of family violence and also the contributing factors to family violence, where one of the determinants is identified as gender inequity and the imbalance of power perhaps that might exist between men and women.

Ms Carter, I know that you are the gender equity ambassador at the City of Maribyrnong. Can you speak a little about the primary prevention work focused on gender

equity that's taken place in your city?

COUNCILLOR CARTER: Yes. We have been very fortunate to be resourced through a partnership with VicHealth to have a dedicated resource, but also from the leadership of the council. One of the ways in working with a similarly culturally diverse community, we facilitated the "Have your say" events, and these resulted in a number of gender equity statements. It wasn't so much that the statements themselves that carried the greatest weight; it was the process by which we went through creating those statements. That was actually looking at women's - the barriers to their participation in civic life. We actually brought together the most wondrously diverse group of women, and I guess it was a process of collaborating with them and what they saw as the challenges for striving for equality.

Through a series of workshops, and a lot of it was storytelling and looking at I guess in different cultural groups what they saw as the triggers or what kept us from realising that, we were able to come up with a series of statements which ended up on fleet vehicles - and it was quite wonderful, really. But these statements then became something that we read out at the start of official council meetings as representative of our community. It was that engagement in the process of crafting, creating and agreeing on those statements that really saw a diverse group come together.

MS ELLYARD: Some of the statements are "She deserves respect just like you", "Courageous dads raise courageous daughters", "Champion teams champion women and girls". How have those statements then played a role in or how

have they been relevant to the broader gender equity work of council?

COUNCILLOR CARTER: They've fed directly into the gender lens that we applied across all council services, because they are key statements that were formally adopted by council, but throughout the gender lens we have actually been able to integrate those messages into the fleet vehicles and our messaging out in the community. We have been able to take it into schools. We had boys I think it was from your 8 that launched the messages via text message.

We have also been able to feed those themes into the "She's game" initiative. We're providing small grants of up to $2,000 - I launched it four weeks ago, five weeks ago at Whitten Oval - to local sporting clubs that will carry out their own gender audits and provide access for women to participate in sport. So it's really I guess been the underpinning of a number of primary prevention strategies that we have enacted.

MS ELLYARD: Turning to you, Mr Kirkham and Mr Turnbull, Whittlesea, like Maribyrnong, has a formal gender equity strategy and a number of initiatives have fallen out of that strategy. From your perspective, what has been the importance of that strategy and what kind of outcomes have you seen?

MR TURNBULL: I just headline it by saying that we do see gender equality or gender equity as underpinning our prevention approach to family violence. So if we can get that as right as we possibly can we think that that will flow on to preventing family violence. But I will ask the Mayor to talk about a couple of specifics.

COUNCILLOR KIRKHAM: Some of the things we have done is

initiate gender audits across some of our facilities, where we have identified where there is a gender imbalance particularly in regards to women's participation in sport. Obviously a lot of sports like AFL a long time ago were heavily dominated by men. These days not so much the case. Some of the women kick the footy better than the men, which is such a good thing. But certainly to try and lift women's participation in sport and breed good club cultures, we are really, really trying hard as a local government authority to make sure we have the right capital expenditures aside to make sure we can do that.

In new facilities we are rolling out we are making sure they are gender equal, so there is a good balance there. So even if women may not participate in a sport locally now there is the capacity for them in the future, so we don't have to worry about retrofitting facilities later on.

MR TURNBULL: The other thing I would add, and it might seem to some that this should go without saying, is that when we looked at the way we consulted with our communities, whether it is on new services or augmented services or, as the Mayor said, facilities, we now pay a lot more attention to make sure that the consultation that occurs is actually equitable in terms of the input from both genders and also young and older people, whereas previously you might have gone out and consulted and just taken the outcomes of that consultation without actually analysing who is necessarily saying what.

MS ELLYARD: So now there is greater attention paid to making sure that you are genuinely consulting the community as a whole rather than, by default, particular voices?

MR TURNBULL: Correct.

MS ELLYARD: Can I ask you then particularly Mr Turnbull about your reflections about the way in which councils can and your council has tried to play a role in prevention through addressing some of the contributing factors that you have identified in your submission, which includes issues like economic stress, alcohol, things of that kind? What role have you seen your council try to play in preventing violence through looking at those sorts of factors?

MR TURNBULL: You are right. Some of those contributing factors are very present in the growth areas. Our municipality is basically 100,000 people living in post-war suburbs, another 100,000 living in growth areas, as we would call them, 8,000 people come in a year. So we paid very close attention to the way that we designed the growth areas right down to the - we have gone back through a grid based design now rather than the '90s approach of a curve or linear street network, where people couldn't actually connect with each other or connect to support services or to open space.

We pay very careful attention to the way open spaces are designed, very careful attention to early provision, on the council's part, of places for people to actually meet and happen across each other, for want of a better term, and even down to the local parks, where it used to be the right thing to have a vegetation buffer along the sides of the parks. We have taken all those out because they were a real security issue particularly for women walking through those parks. So right from the base of our planning approach we plan to prevent problems or

plan to prevent those issues that we identify as contributing factors from happening.

We do run into some issues when we deal with state government, who tend to have a "one size fits all" approach. The example I like to use very quickly is that at Epping, which has a very high level of family violence incidence, we know that one of the contributing factors in Epping is high alcohol consumption, and yet when we, from I believe a very well researched position, tried to limit or at least restrict the number of packaged alcohol outlets, that ran contrary to what the state government's approach was at the time, which was in fact to liberalise the ability for packaged alcohol outlets to open in virtually any location, so long as it was in a commercial zone, but you could have 15 or 20 of them in a shopping strip.

So those sorts of state policies up here interacting with very well founded local policies, interacting again with the sorts of issues that are happening in growth areas, there's basically a disconnect.

MS ELLYARD: Can I ask you to speak a bit more, either you or Mr Kirkham, about the particular issues faced by what you have referred to as growth areas. You have identified in your submission that growth areas might have higher percentages of those people who are known to be at greater vulnerability of family violence. What are some of the issues that you have observed when you try to prevent family violence in such an area?

COUNCILLOR KIRKHAM: In the growth areas - it's one of the areas that I represent as a councillor, not just as the Mayor - from a town planning perspective we do, as the CEO

has indicated, try to make sure that our town planning is providing an environment where we can try to prevent a lot of these issues from occurring, so from a town planning perspective and a land use planning perspective. But we do run into issues, once again, as David has said, in regards to those state government elements.

In areas like Mernda we are talking about a lot of young families moving in, first home buyers, one-income families, a lot of issues in regards to mortgage stress popping up in those areas, but then they're also having issues in relation to easy access to gaming facilities and a whole range of other issues. So as a council we try very hard to be proactive through some of our adopted strategies to mitigate some of those risks to community. But we do run the gauntlet when we are fighting against other levels of government to try to protect our community from what the VCGLR might see as a process which is a legality activity as opposed to what we are trying to do as a council to try to I guess protect our community.

MS ELLYARD: Can I ask all members of the panel, and perhaps starting with you, Ms Carter, to reflect upon the potential role that might be played by local government together with the state government in planning. Local government administer the planning code and have certain degrees of power, but the state government is also a player. From your perspective, and thinking about your municipality, what are some of the ways in which the use of the planning code, for example, might have a primary prevention or an early intervention role for family violence?

COUNCILLOR CARTER: Absolutely. As we know, accommodation is a

big issue. There isn't an endless bucket of money for the State to supply the housing that's required. In my submission I had spoken about I believe the collaboration of local and state government, but I think getting - innovating a little bit. We look at I guess - I'm quite inspired by what's been achieved in New York and working within the planning scheme. We don't have their rights, but basically adopting a model where there is support for local government to articulate a skyline in metropolitan city areas of density where there is the co-location of services and also good access to public transport. But, with an articulated skyline, then working with developers to I guess provide some leniency with heights in return for a community benefit. So being able to negotiate I guess three per cent, four per cent of social housing to provide for that medium term. So I would say that it's probably more appropriate for medium-term accommodation as opposed to crisis accommodation, but it could be either way. I know that's probably a little bit left of centre, but it's certainly being achieved by actually working, because we can't - the state government doesn't have the money to be able to provide just the sheer volume of accommodation that's needed.

So I think just a collaborative and innovative approach, and looking at what has been done around the world to provide for marginalised groups or where a need is identified.

MS ELLYARD: Did you have a particular example from your own experience of where it might have been possible had certain things been different for something innovative to be done in a family violence context?

COUNCILLOR CARTER: Yes. Very quickly, there are two. I was approached by an NGO in my role as a councillor and they had had designs for a crisis centre put together by Melbourne University. They had significant funds that they had been noted or acquired through private donors, and they had identified a parcel of land that they had entered into negotiations with VicTrack - and, as we know, there is a directive or appetite within VicTrack to divest itself of significant properties - perfectly located, but then there was the commercial price asked. I think it was just a crying shame, really, that that opportunity fell to the wayside.

I would also say Amanda Burden, the town planner for New York, had identified that in the face of gentrification they wanted to keep artists in their community, because they saw that that played a key role in liveability. So they had this artist accreditation scheme which speaks to that working within the air rights scheme to provide - where they negotiated with private developers to return a certain amount of stock of housing to be able to - so they could provide that affordable housing. So I think it just - it speaks to being a little bit creative and potentially changes to the planning scheme.

MS ELLYARD: Can I turn to the members of the council - you have already identified there is a lot of new suburbs being built in your municipality and a lot of interaction, no doubt, with developers. Do you see any role for the planning code and the way in which the council might be empowered to act under that code in the prevention of family violence?

MR TURNBULL: If I could start. I agree with the previous

comments. I don't think it should be seen as creative or left of centre. I think it should be core business. Numerous overseas examples that I'm aware of in Canada and also in Great Britain where low-cost housing is part and parcel of the development cycle.

The only thing I would say about growth areas is low-cost housing by definition in some respects is for people who really need to also be located very close to transport and services. So I'm probably not in favour of developer bonuses or low-cost housing schemes literally where there is no public transport in prospect or delivery, let alone other services. So closer into our more established areas, and we are getting a lot of pressure now for probably what's happening in Maribyrnong with the five, six, seven - those sorts of developments, I think, it ought to be open for councils not to run the risk of VCAT but have it institutionalised in the planning scheme where there can be some form of density bonus in return for low-cost housing product in the right location . So I would support that 100 per cent. It is not available at the moment.

MS ELLYARD: At what level would that change need to occur to empower councils to act in that way?

MR TURNBULL: The state level.

MS ELLYARD: Can I turn then to a different issue. All members of the panel have identified the diverse nature of the communities in which you work. Starting with you perhaps, Mr Kirkham, Whittlesea has a particular initiative to engage members of the CALD community in family violence prevention. Would you tell the Commission a little about that?

COUNCILLOR KIRKHAM: We do. A lot of that is led through our CALD family violence project, which is a project of our partners through the Whittlesea Community Futures. Effectively what we are trying to do is engage with a lot of, and facilitate a lot of engagement through, our local non-government organisations in the CALD communities. So a recent project which was run was an Iranian community project which has had a participation of a small group of Iranian men to participate in a program that was also run through Melbourne City Soccer Club, where they had a lot of men come together and participate in a mutually engaged sport, and had the opportunity also to participate in an awareness raising session around a whole range of factors, particularly around family violence.

So those are the sorts of areas that local government can be a real powerhouse in in facilitating our roles with local NGOs to try and drive outcomes particularly in our CALD communities.

MS ELLYARD: Ms Carter, are there similar things happening in the Maribyrnong Council?

COUNCILLOR CARTER: Absolutely. I think one of the key learnings has been that essentially in that situation, working with diverse communities, I have seen more success where council is the conduit and providing - whether it be the physical space or the support. Rather than being the ones that lead the discussion, it's finding those community leaders within those cultural groups and empowering them, because I do recall - and there was this lovely quilt that had been made at the opening of "Our say", but to get women from Africa to come to present at that was quite a big task, to even get them to Town Hall.

So they had actually gotten together to create a message through a quilting and sewing group at a community centre which engaged them in the discussion, which then empowered them to brave Town Hall. So it's really knowing your community, knowing how to identify the leaders and then empowering them to have that discussion.

MS ELLYARD: Mr Turnbull, can I turn to you on another topic again. To what extent is there some overarching structure that joins together the works being done by different local government areas in the area of family violence prevention and, to the extent there isn't one, do you think there should be one?

MR TURNBULL: Specifically for family violence prevention there isn't. There are a number of broad-reaching bodies which councils are all members of, whether that's regionally or statewide. But they are very diluted in their purpose. They wouldn't have the resources or the wherewithal to invest in prevention of family violence. So I do actually see that this is a real need for what I would call a peak body.

I'm a bit of a centralist by nature. So I think any peak body that is set up to perhaps oversee this with local government ought to have just a few teeth, and I would see the roles of this peak body are to research, monitor, evaluate, prioritise and coordinate, and I can expand on those at another time. But they are very specific roles. If you drop any one of those out, it's almost a self-fulfilling prophecy that it won't work.

MS ELLYARD: Would this be, in the vision that you have, a peak body only for local government or might it have application beyond local government for other

organisations engaged in primary prevention work?

MR TURNBULL: I think when I talked about research and monitoring, by definition that's going to mean not just what local government is doing but what the whole, let's call it, not-for-profit sector are also doing in partnership with local government. So I would actually see it as being broader than just local government, but one of the roles should be - and I agree with the opening comments about there's real value for money in investing in local government undertaking the prevention work - to prioritise that investment, say to government, "Well, this is what is working. We know this from our research. These are the areas you need to invest, and this is how local government can spend it."

MS ELLYARD: Having had the CEO perspective, can I invite either of the elected council members of the panel to comment on the need for some overarching body or central body that might support the work done by various disparate councils in the area of family violence?

COUNCILLOR CARTER: I absolutely believe, and it is at a time when the Local Government Act is being reviewed, that we really need to really imagine what core business is for local government. I see this as being core business. I do believe in a peak body. As someone who comes from a communications and community background, and that is what I do, I believe for us to - and we are serious about this, there is no doubt that everyone here is very serious about tackling this, but consistency of message and the saturation - we are each doing wonderful programs, but if those resources, whether it be through a peak body mandated by the state government, were rolled out across

the state we are going to see a much greater return on investment in the sense of acknowledgment within the community, with the message reaching who it needs to, and I guess a general consensus that local government as one of many key players will not tolerate family violence.

MS ELLYARD: Mr Kirkham, would you wish to add to those remarks?

COUNCILLOR KIRKHAM: I agree. There probably is a perception that it isn't core business, but I tend to agree with Sarah's comments and say that in the modern environment I say it definitely should be, particularly with, as we have touched on before, our contacts with community which can be quite valuable in identifying and trying to prevent some of these issues from occurring.

But certainly I think if there was a peak body it would really need to establish also a framework, whether it be through the Crown, around what the expectations on local government are to do. If we look at Whittlesea, we look a Maribyrnong, we go out as far as Wodonga, we go as far west as Surf Coast Shire, there is a very, very different approach to these sorts of things on a local grassroots context. So if we are going to establish a peak body or a framework it would need to really apply some consistency. So if people did move from Whittlesea out to Surf Coast the same sort of frameworks, the same sort of facilitation, the same sort of partnerships are consistent across the sector.

MS ELLYARD: Thank you. Did the Commissioners have any questions?

COMMISSIONER NEAVE: I just had one question which I address to all of you. I understand that your work in this area is

still fairly new, but have you built in any evaluation component or are you able to tell in any way whether your strategies are working?

MR TURNBULL: No, to be fair, probably not. In fact since we have undertaken a lot of what I will call the approach in planning to prevent problems our statistics, anyway, have gone up. But I understand that to be more along the lines of the reporting is a lot more prevalent than what it was previously.

You have raised a good point because the other danger is, in the tradition of state and local government relationships, we might get funding for a year or two and then it is all over and the pilot's gone. This has to be a long-term process and the evaluation, likewise, I think will be necessarily quite longitudinal in its approach.

COUNCILLOR CARTER: There are two angles to this. Applying a gender lens, we are seeing results in the sense that we have identified areas that need to be changed and whether that be at our local sporting facilities within our own parks and gardens we have a depot as well where it has typically been a very male dominant culture, identifying that we need to have more women representing on council's committees and reference groups as well. So I guess you can see some change coming from that. But to say that's directly having an impact on the prevalence of what we see as it being a contributing factor to family violence, anecdotally I would say that we do have our messaging on social media and things like that, there's been uptake from the community and I guess there's an acknowledgment that council is active in that space. But to say that it's qualified at this point in time would be premature.

COUNCILLOR KIRKHAM: Commissioner, I agree and, as David has mentioned, a lot of the work that we are actually doing in the community through our facilitation roles but also through also enabling community organisations through grants to actually establish a whole range of different initiatives and groups to gather women together or gather families together to discuss these sorts of issues is actually pushing the disclosure rate up, which in some aspects is a good thing, but certainly if you look at it statistically you could always say that we are not meeting our obligations. But I would say we certainly are.

COMMISSIONER NEAVE: Can I just have a follow-up question. Sport has been I think mentioned by at least two of you, perhaps all of you, and you are providing some support to local sporting clubs to involve women more. I'm just interested to know whether you actually require the clubs to report back to you about what the effects are of those policies. Do you say, "Now we have a girl's soccer team when we didn't have one before," something along those lines? Are you doing those sorts of things?

MR TURNBULL: We run an annual process. Clubs don't get a facility for life. They have to effectively re-apply annually. Some of the criteria in terms of the council decision whether or not to allocate the facilities to whatever sport it is has to be that the increase in women's participation is evident and also promoted by the club.

COUNCILLOR CARTER: I think in the application for this year's grants they are required to articulate very clearly how they will be including women or what - and it is quite detailed in the sense of what they will actually be aiming

to achieve. It is quite specific, the project detail. Obviously there's a follow-up to that as well.

COMMISSIONER NEAVE: Thank you.

COUNCILLOR KIRKHAM: I also see a role particularly in regards to senior participation in sport. If you look at particularly AFL, for instance, I know at a local context level I have spoken with our community safety officer at length about looking at establishing ways we can try to get clubs to sign up to some sort of code of ethics in regards to their behaviour more generally, probably in a social context around breeding a good club culture that is inviting for women's and children's participation in sport. So that's something I think local government can certainly take on a lead as well to try to change those club cultures, because some are quite toxic.

COUNCILLOR CARTER: Counsel, may I please interject only because - I had flagged before - I have a plane that's boarding at 12.55. I really wanted to stay here for all of this but I do need to get to Canberra very soon.

MS ELLYARD: Can I perhaps ask that Ms Carter be excused - - -

COUNCILLOR CARTER: I'm very sorry. It has been an honour to be here and speak with you all.

COMMISSIONER NEAVE: Thank you very much, Ms Carter, and you are excused.

COUNCILLOR CARTER: Thank you very much.

COMMISSIONER NEAVE: I think Mr Nicholson has one more question, not directed to you.

COUNCILLOR CARTER: Okay.

<(THE WITNESS WITHDREW)

DEPUTY COMMISSIONER NICHOLSON: I was wondering whether you see any efficacy in councils being required to undertake a

family violence impact assessment and all the decisions should take - that that might actually ensure that there's a consistency of effort across all aspects of council business.

MR TURNBULL: I would probably describe it slightly differently. We probably haven't got yet to the stage of what I call running that lens over every decision the council makes, but what we are aiming to do in all of our policy and strategic work is, for want of a better term, family violence in all policies. I think this should apply at the state level as well. So when the council adopt policies and strategies, embedded in that is that family violence preventive lens.

So what ought to flow from that if decisions are based on the policies or strategies, if individual decisions are based on policies and strategies, it ought to be implicit without necessarily saying - I think what you are saying, which is for every, say, decision on a facility or even a planning application there's an overt reference to the degree to which that decision might offend or at least comply with our approach to family violence prevention. We are doing it at the policy and strategy level but not yet at the individual decisions.

COUNCILLOR KIRKHAM: I think it's a good idea, Commissioner, and in saying that, once again if it was to be standardised, if it was something that was driven by government to standardise these things across the board, particularly in regards to future proofing, if you look at capital investments, and making sure that our capital investments do provide the opportunities in the future to be - if they are not already - inclusive of all sexes,

participation in sport in particular, community centres and the like.

But I would agree with the CEO and say that at the moment we do apply a gender lens to a lot of our decisions in council; in regards to family violence lenses across the board, where possible. There is certainly some contexts where it wouldn't probably apply or have a direct relevance, but certainly in a planning context I would certainly say that is an opportunity for local government to really take a leadership role on.

MR TURNBULL: The other for instance I would give is that the council does dispense a lot of community grants every year, and certainly part of that evaluation process by officers before it gets put up to council, that lens is put over those grants principally made to community organisations. So if a community organisation is seeking a grant for something that we could, after applying that lens, quite clearly see is contrary to the policy about preventing family violence and also for gender equity, it wouldn't get recommended to council.

MS ELLYARD: May I ask that this panel be excused with the Commission's thanks, and I will ask the next witnesses to come into the witness box.

COMMISSIONER NEAVE: Thank you very much indeed.

MR TURNBULL: Thank you. Thanks for your time.

<(THE WITNESSES WITHDREW)

<SERI FRANCEYS RENKIN, affirmed and examined:

<SHARON LOUISE FRASER, affirmed and examined:

MS ELLYARD: Could I begin with you, please, Ms Renkin. Could you tell the Commission who you work for, the role you perform there and a little bit about your professional

background?

MS RENKIN: My personal professional background?

MS ELLYARD: Yes.

MS RENKIN: I'm the CEO of the ten20 Foundation, which is a philanthropic entity focused on supporting early childhood outcomes, particularly with children in vulnerable communities. My professional background is actually originally as a management consultant in the business sector. I then moved into philanthropy and have spent the last 13 years working, firstly, at Social Ventures Australia and now as CEO of the ten20 Foundation.

MS ELLYARD: Ms Fraser, could I also ask you to explain to the Commission where you presently work, the role you perform there and your professional background.

MS FRASER: I work as a general manager for Go Goldfields, which is a collective impact initiative in central Victoria where we are aiming to basically all work together to achieve better social outcomes for children, youth and families.

My professional background, I started originally as a speech pathologist and then moved into community health and health management, and then into service re-design and then into community re-design basically.

MS ELLYARD: Ms Fraser, could I ask you to describe in a little bit more detail what Go Goldfields is and how it came to exist.

MS FRASER: Go Goldfields came to exist in 2009. The SEIFA index came out and yet again Central Goldfield Shire was 79 out of 79 shires on the SEIFA index in Victoria. At that time there was a charismatic mayor who wanted to do something about it and there were a good three service

leaders in the area who wanted to do something about it. People were basically sick of the outcomes being as they always were. These four people got together and looked at both what the data was and also what would we need to do to make a difference and, from a whole lot of conversations with many, many people came out with the notion of really changing the outcomes for children, youth and families will basically change the outcomes for the community.

MS ELLYARD: What flowed from that? What kind of approach was adopted to try to effect those sorts of changes?

MS FRASER: What we have done is we have tried to define what are the outcomes that we are all working towards within the community, and then we have tried to look at how we are all going to work together to achieve those outcomes. So initially this started in the service sector, but in recent times now includes broader decision makers from government departments. It also includes community and business leaders. It also includes people who we are calling people with lived experience, which in this space means women and children who have been personally affected by family violence.

MS ELLYARD: Ms Renkin, can I turn to you. How did the ten20 Foundation come to exist and what's the focus that it's adopted in its work?

MS RENKIN: Interestingly it actually came out of the wind-up of an old non-profit organisation called Gordon Care, which existed for 125 years and its primary focus was vulnerable children and young people, and in the last iteration of its structure was really a child protection agency for State Government. It wound up for a variety of

reasons and decided that it wanted to put its small amount of funds that it had left into a foundation to focus on some of the complex issues it understood were being faced by the communities that it had served around child and family vulnerability.

When we started to look at what would our focus and strategy be, I think a primary driver for us starting to look at approaches like collective impact and place based collective impact was that philanthropy has so often played a role with many others in funding programs and in funding isolated solutions to a problem that we know actually has many different facets, and particularly so often where the people in the community who actually live the experience of vulnerability don't have a voice either. We didn't want to keep contributing in our small way to this what I sometimes call a bit of a toxic system that's in absolute chaos at the moment.

We really needed to rethink or we felt we had a chance to rethink in our own small way, change our mind set and practice in philanthropy, and we are a catalytic philanthropic organisation, to focus on systems change which are the harder issues, they are the longer term issues, but they actually need capacity in order that all elements of the system can move in the right direction to reframe around some of the issues, certainly around childhood vulnerability.

So that led us to really say we were very interested in calling out that we wanted to work with others to change outcomes for 65,000 children over the next 10 years, 65,000 vulnerable children living in communities that on the SEIFA index, like Go Goldfields,

are not rated very highly, and we wanted to understand what it took as a catalytic philanthropic organisation to actually help fund and support through both our resources and our corpus what do you need to do to create the conditions for aligning all the resources in communities - it is a community asset based model - but aligning those resources and supporting the right leaders to drive long-term change in quite a new way and recognising that that capacity just doesn't happen and that early investment in helping communities remobilise and align what they have got around the shared agenda for change actually is what it is going to take for us to move the whole system to think quite differently about solving the problems and that if we keep just mandating we are never going to get anywhere, and the costs of that are just going to increase.

MS ELLYARD: You mentioned collective impact which, as I understand it, is the model that Go Goldfields uses. Can I invite both of you to outline what are the elements of the collective impact approach and how does it differ perhaps from other models of prevention that have existed in the past.

MS FRASER: The collective impact approach espouses basically five core elements. The first is having a common agenda. Really that's saying that there is a common point that everybody wants to get to. It's quite different from a vision. People often talk about visions. This is actually a point you really want to get to. It's not a far-flung thing.

The second thing is that you have mutually reinforcing activities. So you are not all rowing in

different directions but you work in a way to align the efforts against that common agenda.

The third element is shared measurement. So that is: how do we measure what we are doing now to help change practice now, how do we also measure to see what impact we have had over the last 12 months, and how do we measure long-term changes?

The fourth is called continuous communication. That is very much about making sure that you are constantly listening and you are constantly talking and you are constantly keeping the communication channels open.

The fifth is called a backbone organisation, but is really a backbone function, and that is that there is a core place that holds that vision, holds the work, makes sure there's resourcing, makes sure that when things go off track that they are pulled back on track et cetera.

There is sort of a sixth element that is emerging at the moment in the literature which is around equity, and the equity is around equity of voice. It's not so much gender equity in the literature. It talks more about the equity of powerful vulnerable communities. I think that's going to sneak in there as well.

MS RENKIN: I concur completely with what Sharon has articulated. But, just building on the equity bit, it has been very interesting for us. We have been working quite closely with communities like the Go Goldfields but a number of others across Australia, and the more that we have looked at it there are these kind of elements of this approach that frame up all the things that you need to do and that are driven, if you like, by coordinators in

community. But the more ten20 engages in this work the more it strips it back to the heart of it, which is relationships. You cannot get strategic alignment in any sector, let alone a system, without really strong relationships and, at its core, trust.

It doesn't take much to look at where our businesses are moving. Everything is around collaborative practice and these shifts in new relationships at global levels. Really what communities are trying to do in order to solve these complex issues, along with the service delivery system and I think government and business, is to say, "What's the nature of the relationship, and then therefore the contributions that each of those relationships can bring and be organised in a very different way to achieve a shared goal and outcome?"

I think it would be safe to say that the system, and certainly our organisation, has underestimated the capacity building, the mind set change and the practice change that needs to occur in order for those new relationships to form and - - -

MS ELLYARD: Who is it whose mind set needs to change? Is it the service sector? Is it government?

MS RENKIN: It is actually everybody, and that's the complexity of this work. But it doesn't need to be taken off all at once. It can be developed in a very strategic way and in a very explicit way, which is the difference a little bit from this model to what have been typical community development models, which are very important and are at the essence of this. I think what we like about it is it brings about an explicit strategy and accountability structure to this work so that everybody who is involved

is held accountable and knows where their contribution sits in terms of the end game.

But the mind set and practice changes are everybody because even in the gender equality space we know the gender lens - it's very difficult to get a gender lens shift from people who have sat in situations where they are perhaps in a dominant power position and don't see what the issue actually is.

But the simplicity of it, or the complexity, is really it's about re-aligning the relationships and contributions of lots of different resources in a community, and at the heart of it is the community having a say and being equal decision makers for where their future is.

MS ELLYARD: In practical terms, Ms Fraser, if I can ask you, how does the community, using the model that you are using in Go Goldfields, ensure that it is the community setting the agenda and deciding on the outcomes that it wants? What practical steps do you engage in to make sure that the voice coming up is indeed the voice of the community?

MS FRASER: I will use the example of family violence and how we have done that, which is quite fitting. So what we have done is we have run a series of conversations with women, closed sessions with women, with lived experience of family violence. It might be now or it might be some time ago. We have also run sessions with community leaders and business leaders in the community. In fact today we are running a combined session, which is the first time we have brought the women into the room with the decision makers and the service leaders et cetera. The others have been together, but this is the first time

we have brought the women into that session.

It's taken a significant length of time to get to the point where the women can come into that session. There are 31 women who we have included and involve and inform our strategy and practice, and all of them have got quite confronting stories about their lives and living currently or in the past with family violence. So it's quite a significant risk for them in a rural setting to come into that environment.

What the women did even on Friday afternoon, bless them, was to say, "We don't want the police there." So I said, "No police." Of course the police have been on this journey with us all the way through and they are a valued and positive partner. So then what I do is I step in and say, "The police can't come to this session, but I want to talk to the women about how we get the police in the room," because it is not about the police staying out. It is around, "I understand why it needs to happens, but how do we get you back together?" That means conversations with the Inspector of Police et cetera. He's offered to meet with the women in his jeans, in his T-shirt, just him, just to hear them. So it's really creating those sort of safe environments for things to happen in.

It's also hearing what's been said. I know I have had to say to specialist family services, who I think do a fantastic and terrific job, but often have a primary prevention lens. So everything gets looked at through gender equity. I think that's really important. However, I have had to say to them - I don't mean to be flippant, but this is what I have said - if somebody from

the community says, "Family violence is caused by skateboarders, you have to hear it." You have to hear what is being said. You can't just try and use it as an opportunity to get your own ideas across. You have to really sit with the information.

As Seri said, a part of sitting with it is it moves you as well. I have moved. The specialist family services women who we have had involved in this have moved. Community leaders have moved, and the women themselves are moving. No one of us has the answer to this. But to get that sort of common agenda around family violence it's taken lots and lots of pre conversations so that people could be in a space where they could think maybe a little bit differently or could hear things maybe differently.

MS ELLYARD: Ms Renkin, can I ask you to comment on, given what Ms Fraser has said, the role of the backbone function which she performs in the Go Goldfields initiatives is a very complicated and multifaceted role, from your perspective, trying to engage in multiple collective impact initiatives across Australia, what is the importance of the backbone aspect of the collective impact approach?

MS RENKIN: It is absolutely critical because you need a leader, in a sense, in the community who is not overt, it's a leadership from behind position, and there are a number of functions that are important, but who is able to move everyone into a context that is actually structured. A lot of thought and process goes behind thinking about creating the right context in which the different players then are brought in and the alignment, if you like, what

I call the strategic alignment is then enabled.

So the backbone facilitator and leader has to be a highly, highly skilled person and actually has to have quite a range of skills that you wouldn't necessarily traditionally find in the front-line. I think in the non-profit you might find them, but they could equally be from any other sector, actually. So there's a range of skills that are really important in creating those contexts and holding those conversations and then translating and moving those from conversations to actual strategic actions, alignment contributions and holding people accountable. Moving through that requires an incredibly sophisticated person, and Sharon is one of the real stars, I have to say, at this work.

I think the challenge, too, is within the backbone function. It's not just one person per se. This work is driven by data. It's about looking at data and using data to inform your practice and the way that you work. I think so often - philanthropy does this all the time - we have a view and it can be a really good view, but we don't go back and look at what the data is telling us. It's not just the data that researchers pull together. It is the data of the narrative that's going on in the community and what Sharon just referred to as the voices. There is that saying that often what is not spoken is what you hear the loudest. So it is that sensing ability, too, that the backbone has hold of, using the data then to inform the practice of the work of convening, aligning and moving everyone together to the shared outcome.

MS ELLYARD: Can I ask you, Ms Fraser, about this issue of

data. We heard from an earlier panel, and perhaps from both earlier panels, and the Commission has had other evidence as well about the difficulty of measuring outcomes when we consider primary prevention work which by its nature works in the long term rather than the short term. From your perspective, how hard or easy has it been for you to try to measure the successes that you have been making?

MS FRASER: In areas that are not politically sensitive, so, for example, oral language for children, literacy levels for children, it's quite easy to get access to the data and there's national and state measures for the data. You can get that data from a government department quite easily, as long as it is de-identified, as long as you don't name an individual school, all of that sort of stuff is fine.

The more sensitive the data the harder it is to get. So I can access family violence data the same as anybody else can on the net. It's very difficult to get anything more sophisticated. When I have it's been through local relationships with police, and I can get access to the data but I can't use it publicly. When you think of the impact family violence has on the child protection system, it's harder again once it gets into a child protection space.

It is only very recently that we have gotten access to real-time data around children in out-of-home care. I was told I could get the numbers but I couldn't get the names of the families or the names of the children et cetera. I said, "The numbers actually don't mean anything to me. We want this data to make a change. We

actually need to know the names of the children. We need to know the families. We need to be able to put things in place to support these children, and we can't put them in place if we don't know who they are."

MS ELLYARD: So, given the difficulties associated with getting data from other sources, how have you gone about trying to measure for yourself or for yourselves as an organisation whether you are making progress towards the outcomes that you said are the focus of this work?

MS FRASER: For the first three years we developed a range of indicators, and some of those indicators were quantitative data. For example, we looked at the number of children requiring speech path when they started school, the number of children who reached level 5 reading when they started school. We looked at the number of initial reports around family violence. We looked at the number of recidivism reports around family violence. So that sort of data.

But the majority of the real data came in the qualitative work that we did. Interviewing parents. Interviewing early year service providers. Interviewing business and community leaders, interviewing decision makers and talking to them about things like the most significant change that's happened and what they think is behind that change. Some of that worked and some of it didn't.

What we are really interested in at the moment and what we are currently developing is how do we capture some of that data so that we can have that inform our practices a lot sooner than every 12 months. We would like to sit down monthly and look at some of this stuff et cetera. So at the moment we are re-looking at how we

do those indicators. So that's how we have done it to date. We have done two annual evaluation reports, one at the end of 2013, one at the end of '14. Our next one is due at the end of 2015.

MS ELLYARD: What would you say to the proposition that some things can't be measured; that some of these changes in attitudes or otherwise, it's just not possible to measure them?

MS FRASER: I think you can measure them. I think you can measure anything you want to measure. You absolutely can. But you need to think differently about how you are going to get the information. If somebody will only consider something evidence if it's been tested through Skinner rats in a university, you are never going to win them over in this sort of social space.

For example, you can have people come together and all tell their story around the table. I can ask the five of you now what is the most significant thing you have heard in this Family Violence Royal Commission. You would all tell a different story. Then I would say, "Which one of your stories do you think most represents the changes that you have heard spoken of? What do you think are behind those changes?" So there are ways of exploring the conversation. There are ways of getting to the nub of the thing. But you need to be open to the qualitative; you need to be open to the story and the narrative of it, I think.

MS ELLYARD: Ms Renkin, from your perspective you have a number of these initiatives. How are you going about the task of evaluating success?

MS RENKIN: It is a big task and this is a new approach for

philanthropy. I think the way we have framed it is if we are about long-term systems change and that's an adaptive learning process we almost need to look at it as how you would evaluate a learning system, to look at it that way.

There are measures that you can put in place clearly for tracking metrics around what a safe community looks like and what safety for children looks like. Every research organisation in Australia would have a view on what they are, and the challenge is to actually synthesise in to something that everyone can share and work to that has a common language. But that's there.

The truth is, as we know, with long-term change it's much harder to prove quick fixes and getting the needle to shift on those metrics. So what we have really said is, whilst that is clearly what we are here to contribute to, what we want to see is - our hypothesis is that to mobilise communities and get the system to work differently together we need to set learning questions as philanthropy connected into this system, and so with Sharon and we are just starting this process now, "What does the developmental evaluation look like around this work? If we want to see some progress on greater alignment, better use of resources, greater trust in relationships, what does that actually look like? How can we start to measure that and how can we, as philanthropy, sit with the community to understand that?" As they start to get outcomes on that, that will actually inform the next intervention that someone like Sharon would start to make on the basis of the level of trust and the strategic alignment and the contributions that are starting to be made by organisations and individuals in that community.

We call that a developmental evaluation. We are finding it actually gives us a lot of insight because it also gives us feedback on how effective we are in making a contribution and adapting our practice to meet the needs of the community, which ultimately is what it is all about, particularly if you are starting to see a much greater focused and cohesive effort. The test is obviously to see whether that significantly shifts outcomes. I think the hypothesis is it will, it just takes time.

The challenge for us is we can't fund developmental evaluations in every collective impact initiative, and it's something we are exploring with other partners and also something that I think we would like to raise with government because it helps us as funders track progress in a very rigorous way, but with a completely different lens. As Sharon said, it's not a random control trial. If we did that we would be here for a long time with no outcomes.

MS ELLYARD: From your point of view, if one was to think about the parts of the collective impact approach that require direct input in terms of money from the funder, whether it's philanthropy or government, is the developmental impact analysis part of what the funder should contribute?

MS RENKIN: Absolutely. I think there's a bit of a power shift for the funders in this. What happens with evaluation and certainly in philanthropy is we constantly say, "We want to see impact," whether it is from a collective impact initiative or a new program or an organisation, and we expect those organisations and communities to somehow then find the resources to fund the evaluation approach.

I think this is so important for the whole system. The funders have an obligation to support the communities in the hard work that they are doing to help them develop the evaluation strategies through funding and support so that we can all learn together. We would see that as a big responsibility.

COMMISSIONER NEAVE: I had a question about that. As I understand it, the developmental evaluation would include lots of conversations with people involved in the process about their perceptions about what's working, about what's not working, about what needs to change. I know it's much more sophisticated than that, but I'm trying to translate it into something that I can follow.

MS RENKIN: Yes, it's complex stakeholder management and feedback, absolutely.

COMMISSIONER NEAVE: If that's what you are talking about there will always be the suggestion that anyone who is doing something new will be inherently bias towards believing that it's working because all of these people are putting huge amounts of effort and time and commitment into this. How do you counter that criticism; that is, "Look, that's your perception. You are naturally inclined to think that it's working"? So how do you deal with that if you are dealing with sort of funding bodies or critical people from the outside?

MS FRASER: I think there is a pocket of research that's called real world evaluation that's as valid as any other research. A lot of the strategies and techniques are used in African countries. We have actually used some of those in our space. There are experts around that that we have used and we also partner with the Murdoch Children's

Research Institute. You have to pick your partners wisely. You have to pick the institutes, the philanthropists, the people who are willing to go on a learning journey with you and they are not just going to say, "You didn't hit the (indistinct) kids out of poverty by the end of 2000-and-whatever, so therefore we are withdrawing your funding." You have to have someone come on that journey.

But if you have someone with credibility like the likes of the Murdoch Children's Research Institute, they come on a learning with you but they have their own professional integrity that they bring with it as well. It is those sorts of partnerships that help you get around that messaging.

MS RENKIN: Can I just add in answer to that question the mind set shift around this work is very much that you don't need to say that everything is working all the time, because the reality is you are learning from the things that are not going so well. So our experience in engaging in these evaluations is such that many stakeholders have many different views, and not all of them are positive. The challenge is to synthesise those to see actually in the negative commentary what is it actually saying about what the initiative needs to look at next to address. So if there is just positive feedback I would be deeply concerned in the complexity of stakeholders in this. I have not seen it yet, actually.

MS FRASER: No.

MS ELLYARD: Could I then turn to some of the issues that this kind of approach might throw up for the more conventional ways in which services have been delivered and services

might have been funded by government. Ms Renkin, you mentioned the need for some mind set shifts. How does this sort of approach differ from the way in which government might traditionally have or philanthropy might traditionally have funded projects and looked for outcomes from those projects?

MS RENKIN: I guess there's an orientation here around capacity funding as opposed to program funding, and that's not to say that evidence based programs are not needing funding because they are. It's the "and". If we are expecting communities to work better together, to use Sharon's language, to achieve outcomes and to resolve complex social issues, we need to look at the way the funding for capacity to do that works.

My view would be for philanthropy that's about changing our practice to understand more what capacity is. We are still in philanthropy dealing with the issues of - some philanthropists have problems about funding admin and infrastructure within non-profit. So this is quite a sophisticated end of it when you look at catalytic philanthropy.

But capacity funding, it's not about programs and it is holistic to driving change programs. In a business you would have a whole pool of funding that would sit across the deal that's about the merger and acquisition. It could be anything from legal support to data collection to change management, communication processes. These are the sorts of the things we are talking about that need funding, including the evaluation.

From a philanthropic point of view it's also about getting alignment of different funders to fund it.

One philanthropic can't do it on their own either. So there's an alignment bit there. I think governments in thinking differently about it, my recommendation would very much be to separate some of this funding, see it as innovation funding at this point for capacity to change the way we work and the way communities work together, and to keep it separate from program funding.

MS ELLYARD: Ms Fraser, from your perspective this kind of approach which is very community led, how has that sat with some of the people you have been working with, for example, service providers who might be funded in quite a specific way by government?

MS FRASER: I will just say one thing before I answer that question, and I think it's one of the things that's different from the sort of 1970s community development. This is not community led. Everybody's voice is equal. So the decision makers, the service leaders have as much say and as much voice as a community member. But everybody has to have a voice, really. Now I have forgotten your question.

MS ELLYARD: My question was how does this kind of approach where everyone has a say and so that the outcome sought by everyone might not be what any particular service provider is funded to do, how does that approach affect or get affected by the way in which particular service providers might be funded by government?

MS FRASER: It's the very hardest part of my work. People will often say to me, "Gee, working in a community like Maryborough must be really challenging. The community is really hard." I say, "No, the community is not hard. The service system is hard." What is hard about the service

system is the policy framework, the funding and service framework, the fact that in Victoria we micro-implement policy. At the moment if you look at what's happening to, say, supported playgroup policy changes, they are even saying how many groups should be run on what days a week. It's micro-implementation of policy. Everybody does just their little patch. So, although there's talk about the breaking down of silos of government, from my position I'm yet to see evidence of it.

So what tends to happen is the success I often have in a patch depends on a particular middle manager in a particular government department. I might have one person who is completely understanding and behind what we are doing and how we are doing it, and she will say to me or he will say to me, "Don't worry about what you do. I will sort out Melbourne. You just do what you need to do to achieve the outcomes for your community." I will have another middle manager go, "No, the funding and service agreement or the guidelines say this . So you must do this."

At the same time we have CEOs and senior people in organisations whose whole performance and whose boards hold them to delivering on those funding and service agreements and those policies. So they will have a KPI and a bonus stacked against having to meet these arrangements. They have also, too, grown up and been successful in this environment. It is by doing these things and doing these things well that they have grown into CEO positions. Nothing personal there, Tony.

MS ELLYARD: So, from your point of view, it is hard for them to shift the mind set into the approach where, "You are

not going to decide everything. The whole table is going to decide."

MS FRASER: And also, too, the whole structure; so the whole way we do our stuff is to try to get some of the business rules out. You try to get some of the business rules out because it lets the community in. "Do we really need to have MOUs? Do we really need to have terms of reference? Do we really need to have an agenda that goes out a week before the meeting? How do we capture information for the meeting? Do we really need to have formal minutes? How much do you really need a risk analysis around some of this stuff?"

When you take out these tools from the service leaders they start to get really scared because it's their world, it's the thing that they think is the work. I have been guilty at times of taking out far too much of that and having to put some back in so that I don't scare the horses too much. But if I leave all of that in and you are a long-term single mum, victim of family violence who has never been to a meeting in your life, how are you going to come into that environment and feel empowered? You are not.

MS ELLYARD: Ms Renkin, would you comment on this issue of perhaps striking a balance between the way in which organisations might be looking to measure their own success and whether they can come on board in a more collaborative approach like this?

MS RENKIN: It is one of the biggest challenges and I think it is going to take some very courageous leaders in CEOs and non-profits to move in this space. We are seeing it start to happen. In some respects they almost have to live this

decision making context that Sharon is talking about and have someone like a Sharon take away some of these structural props that we all have in order to get people really focused on what's the real work. The real work is the kids and the outcomes and we do what it takes to get there within the bounds of our organisation and the contribution our organisation can make.

This is the mind set and practice change that needs investment. The key, certainly ten20 feels, is in supporting some of the early stage successes of communities like Go Goldfields and Sharon, and there are others around Australia and there are a lot of others in Victoria too, then people can start to get a sense of what it's going to take and also see that taking some of the risks that it does require as an individual is not going to - nothing is going to fall over. In fact in working differently you can achieve your own organisational mission.

But there's give and take. We know that the incentives that underpin so much of the way our system works and the way these organisations are driven are not the right incentives. They don't drive the right behaviour. We are talking about a very different set of behaviours and working assumptions. So you almost have to throw out everything you started with and be brave enough to come in and say, "We don't know the answers, but everyone who needs to be here is here and we will rebuild these working assumptions and as leaders we will take these back to our organisations" - and I'm trying to do this with relative success in my own philanthropic organisation and build in the changes within my own

organisation that can then respond and keep working in the context of, say, Go Goldfields.

MS ELLYARD: Ms Fraser, just as this process requires perhaps a quite creative or radical rethinking on behalf of those who are around the table because of their professional responsibility, is there also a role in upskilling or changing the mind set of those who are around the table because of their personal experience or community responsibilities?

MS FRASER: Absolutely. To come together to make a change everybody has to move. If anybody was around the table and had the silver bullet we would all know about it by now. Everybody needs to move. I don't know where we are moving to either. But you know when you get there because the energy in the room changes. You know when you are on the spot. You know when you are working on what you should be because the whole room becomes quite focused around the work that you are doing. That's really how I pick where we go next.

Seri was saying before about the importance of relationship, and we have talked about the importance of capacity. I actually think that the other thing that comes into this is capability and it's a part of that stuff we have talked before around - I often say, and I stole it from Bernie Geary, so you know it's not my own, but seeking out pockets of bravery. There are CEOs who want to do things differently, who want to really achieve meaningful change for children and families. There are service leaders who really want to challenge the way that this stuff is to achieve better outcomes. So a part of it is finding those people to support others who need to move

as well.

I think the other thing that underpins it is the processes have to constantly be enabling. You have to actively do that because the natural tendency is for them not to be enabling. The natural tendency is to push everything back into how it's been done before. So you really do have to constantly make sure the environment is right.

The other thing is making sure the structures allow the power sharing; so things like it's not just having a community rep on a committee. It's thinking quite deeply around what does power sharing really mean and how do you know that people are having a real say in this. So we do things like we convene meetings now, not chair them. We facilitate them as if they are workshops. It's a way of trying to get every voice in the room have a bit of a say in a different way, because you can get a decision maker come in and they expect their opinion to be the decision. The other thing that happens is they are so anxious about stepping on a community member's toes that they defer to the community member every time the community member opens their mouth. That's not right either. Everybody has to bring themselves and their best selves to the work. So it's how do you constantly balance that. That's how we try to do it.

MS RENKIN: In terms of capacity, if you hear Sharon speak about what she actually does as the backbone facilitator leader it's the capacity ultimately of these people like Sharon that we really need to unpack more and get a sense of what that is, where do we find it and how do we build it, because there's actually a lack of, to use business

jargon, supply of them. Communities really need them, these sorts of people.

MS FRASER: I'm going to ask for a pay rise when I go back.

MS RENKIN: And the context in which and the skill it takes to think through all those different elements that Sharon is doing all the time is everything from strategy, planning, evaluation right through to organisational behaviour and psychology. There's a lot she's holding.

MS ELLYARD: If we were to think then about the key elements of the collective impact approach that could be perhaps scaled up, if you were going to try to invest in more initiatives of the kind that your organisation is funding, Ms Renkin, or that you are involved in, Ms Fraser, what are the key elements that, for example, government could resource and pay for?

MS FRASER: I would say backbone and shared measurement.

MS RENKIN: I would just add the developmental evaluation. Without that learning and insight we don't know if we are making progress.

MS ELLYARD: When we talk about backbone, is it possible, for example, Ms Fraser, that we could unpack everything that is in your brain and produce the book on how to do collective impact and give that to people and that be a sufficient resource or are we talking about resourcing in terms of a body of people that hold the knowledge?

MS FRASER: I think it's a body of people who hold the knowledge. It's lovely that Seri said those beautiful things about me, but there is a whole group of people who hold the knowledge. It's through sorting it out with those people, and there are also other experts that we need to turn to. There are some really interesting stuff

that's happening in other parts of Australia. There's interesting stuff that's happening in Canada. There's interesting stuff that's happening in America. It's trying to magnify that learning and see how it applies here and having the right people to have those conversations with.

I don't do all the leadership. I don't do all of the backbone by any stretch of the imagination. It is held by a group of people. Some of those people, it's their paid jobs to do that, and other people it's because they are in leadership positions in organisations and they want to make a real change.

MS ELLYARD: Ms Renkin, can I ask you from your perspective of having some sense of a number of these initiatives across Australia is there any commonality to where the backbone has to sit and what part of the table needs to hold the backbone function? Should it always be in local government or can it be - - -

MS RENKIN: No, I think this is the wonderful thing about this work, is that the backbone tends to emerge from where the initial effort is started and where there is a small group of people who share a common focus. It can be in a non-profit. It doesn't have to be, though, and often it perhaps shouldn't be because the non-profit has so much at stake in service delivery in the community. It could be in a Bendigo Bank community banking arm. It could be just a couple of community people who have decided that they are going to focus their efforts on getting something up and running and they are completely running pro bono. It really does start in different places.

So there's no really one starting point, but

I guess there's a group of players that in all the communities we are working in are there from the early stages and that would include some member of local government working in relation to the backbone. In some cases the backbone is actually someone that the community decide they need from outside of the community, which can be problematic because then you don't necessarily see the capacity to drive the backbone and coordination sitting in the community in an ongoing way and there is a sustainability issue there. But sometimes it is an expert that comes from outside of the community.

I think the other thing to add here just from a funding point of view, certainly what we have started to see is that the initial investment in backbone function, particularly if it's required to be a separate group, such as in the case of Go Goldfields, over time as you reach strategic alignment and more and more of the resources and the organisations and the people within the community start to contribute what they need to to the effort, it becomes a case of the funding of the backbone doesn't necessarily have to happen from outside, from government or philanthropy. It actually can be pooled.

Certainly some of the case studies we have looked at in northern America that's what's happened. The service delivery system can find some of the resources, not always money, to start to contribute to the functions that sit within the backbone. So the capacity building, and that is an upfront cost, if you like, if the effort is progressing the way it needs to in the first, I would say, three years, possibly three to five years, I hate to put timeframes, expectations around things, you start to see

the business model is a self-mobilising of all the assets and resources in a community. So that initial funding, there is a benefit to it for philanthropy and for government.

MS ELLYARD: Thank you. Do the Commissioners have any questions for this panel?

DEPUTY COMMISSIONER NICHOLSON: Yes, thank you. I think this discussion has really raised a very important issue for this Commission. On the one hand what we have heard in the discussion is you have talked about the importance of community actually setting the agenda, identifying the small number of targets, and this idea of creating space for relationships to emerge and perhaps to change.

On the other hand, this Commission has had to review nationally set frameworks, and we will be talking about this this afternoon, frameworks that are set in consultation with people, organisations and others that have emerged nationally and some at state level, and they are reasonably prescriptive.

MS FRASER: I know.

DEPUTY COMMISSIONER NICHOLSON: They tell us, "You should understand the issues in this way." That seems to me to be a little bit at odds with what you are saying. So, from your experience, what would your advice be about how a Commission like ours should think about national frameworks and the application at the local level?

MS FRASER: The way that I look at them is they are a voice in the room, they are not the only voice in the room. They are evidence based. They have often been thought up by very informed, well-researched people with high levels of expertise. They absolutely need to be listened to.

But, for me, it's around how do I then look at the local context and what's the framework that supports the work that needs to be done in the local context. If that framework is in any way at odds with the local context, who do I feed that back to? What conversations do I then need to be involved in to say, "Actually, this part of the framework isn't working very well locally for us. It would be good to understand why."

That's how I would suggest that it's looked at. It's looked at as a tool. It's looked at as a part of the work. But, if we look at these frameworks as the only way that things can be done, we are setting the framework itself up to fail because we are saying we are placing upon your shoulders the burden that this framework will deliver social change in family violence when no other framework ever has gone before.

So you have to be respectful of it and you have to use it as the tool that it is. But also, as I say, for the bits that don't work give the feedback. It's not worth just going, "This national framework doesn't work." It's not like that. There are things within it that will be very, very useful and powerful, and there will be other things that don't and we need to make sure that that's heard by the people who are holding the framework.

DEPUTY COMMISSIONER NICHOLSON: There was one other question that I had, and particularly to Ms Renkin. Your organisation is providing support to a number of locations across Australia. If communities across Australia chose to want to give priority to tackling preventing family violence, does your mode of operation provide opportunities for sharing of learnings across sites for

disseminating information so that various community sites can adapt not only from their own experience but from what they are learning from elsewhere?

MS RENKIN: It's a great question. Very early on in our work as a new organisation we quickly realised that working in isolation with learning and insight is not helping the system either. So we have actually funded an initiative that is a collaboration of some of the national partners, large organisations in Australia, with local community. I have to say we are still working out how this is all going to work, but it is actually about sharing insights and learning. It is called Opportunity Child. Everybody in that learning system shares the same goal for better outcomes for vulnerable children and is working together, and we have a session coming up next week, to look across the 16 communities and just the seven national partner organisations how can we be better about sharing and connecting what we are learning. That's not to just hold it there, but in this work you do have to start small before you go big, because if you go big you are never going to work anything out and there are too many people and voices and a lot of noise.

So we are very focused on learning and sharing capacity. We are also looking at enabling technology - this is another role philanthropy can play - what is the technology to organise the dissemination of that information so that even remote Indigenous communities have some access. They don't have to pay thousands of dollars to get people into a room in Melbourne. We see philanthropy as playing a really critical role in that.

MS ELLYARD: If there are no other questions, I ask that the

panel be excused and invite the Commission to return at 2 o'clock.

COMMISSIONER NEAVE: Thank you very much for your evidence.

<(THE WITNESSES WITHDREW)

LUNCHEON ADJOURNMENT

UPON RESUMING AT 2.00 PM:

MR MOSHINSKY: Commissioners, the next witnesses are in the witness box. If they could please be sworn in.

<SHERYL LEIGH HANN, affirmed and examined:

<TERESA JANE POMEROY, affirmed and examined:

MR MOSHINSKY: Ms Pomeroy, Ms Hann, thank you very much for coming over from New Zealand to give evidence today. The main subject that we would like to hear from you about is the "It's Not Ok" campaign that has been run in New Zealand through the Ministry of Social Development. Could I first ask each of you to outline what your positions are and just give a brief outline of your professional background, perhaps starting with you, Ms Pomeroy.

MS POMEROY: My position is Team Leader in the Social Action Team within the business unit of community investment in the Ministry of Social Development. It's a team of five people and myself, five senior advisers, and we comprise backgrounds in social marketing, community development, communications, and we lead national social change campaigns. The primary campaign that we work on is family violence "It's Not Ok".

I don't have a family violence background. My background is in public health campaigns and social marketing. I have worked previously in areas including mental health, disability exclusion and problem gambling.

MR MOSHINSKY: Thank you. Ms Hann?

MS HANN: I'm the Lead Adviser, Quality Programs and Practice for Community Investment in the Ministry of Social Development. That's a new role. Until just recently I have been on the "It's Not Ok" team for the last six years. My background is working in the domestic violence

and family violence area, started working at a local women's refuge, and I was part of the team that helped start the New Zealand Family Violence Clearinghouse, which is a research and information based centre for family violence. My role at the moment is support - service development and research that will align with and support the "It's Not Ok" campaign.

MR MOSHINSKY: Thank you. Perhaps can I turn back to you, Ms Pomeroy, would you be able to give the Commission an overview of what is the "It's Not Ok" campaign, sort of when did it start, how is it structured, what have been some of the key components of it?

MS POMEROY: Sure. We might split this question a little bit. The "It's Not Ok" campaign is a social change campaign. It uses the approaches of public health or population health, community development or community action and social marketing. By social marketing I mean a lens that we apply to the way we work. So we are thinking about a range of complex behaviours that we are trying to shift beyond just the person using the violence or experiencing the violence. So at the centre of our planning and our development is the audiences that we are engaged with, what are the motivators to behaviour change, what are the barriers to behaviour change.

We have a number of strategies that we use. So we use mass media advertising. That's to create a supportive environment for change. The second key strategy we use is funding community initiatives. So generally local "It's Not Ok" campaigns. We give that a lot of support through capacity building. So we invest in building the capacity of community people to drive change

at a local level. That can include working with the news media, how to be a champion, understanding community mobilisation, so delivering workshops, delivering how-to-help workshops. We partner with them in terms of developing local messages. So the whole idea is that the local campaigns replicate the national outcomes that we are seeking but they are made visible and relevant to local communities. That means that we end up with some really interesting messages, but they are messages that are true and authentic to those local communities.

The other key strategies we use are communications and resources. So that's everything from a website, social media - so we have a Facebook page and a Twitter account. We have a whole lot of resources, which we may go over later if we have time, that are designed to increase people's knowledge and understanding about what family violence is, about what they can do, what I would call maybe social change or advocacy tools for communities that support that ability to drive change at a local level.

We also use champions, which we can talk about in more detail later. So champions of change. They are men who used to use violence, predominantly, sometimes quite brutal violence, and who are violence free and they champion that as a new way of being a man, as a new way of life; and we also use research and evaluation.

So that's the campaign in a nutshell. I might hand over to Sheryl to talk about the - - -

MS HANN: There is one other element about the media advocacy - this actually started before the launch of the national media - the idea that the way that lots of New Zealanders

know about family violence and understand it is through the national media. So we have had a media advocacy strategy going all the time where we are trying to change the way the media represents domestic and family violence, in a two-pronged strategy.

One is to train people who are student journalists and people in the newsroom to report domestic violence more accurately and to see it as an important social problem and to give it the profile that it needs nationally; and, on the other hand, training people in the community to be able to better engage with the media to get their messages across to get their community understanding and survivor's understanding into the media so that we have a better knowledge of it across the country. So that's the other strategy that fits with the ones that Teresa was talking about.

But I was just going to talk about where the campaign came from - that's what you wanted to know. In 2002 we had a national family violence strategy called the Te Rito: Family Violence Prevention Strategy, and that had a whole lot of work right across the prevention continuum from what we were going to do around improving services. Part of that recognised we needed to invest in community education and prevention a little bit more.

So some work started on scoping out what a national campaign could look like, and that didn't actually come to fruition until about 2006. By that time we had a national taskforce for action on violence within families. That was made up of chief executives from the key government agencies, from NGOs, the chief judges and the Children and Families Commissioner, made up this

national body that was overseeing a work plan to try to improve the family violence system. That was the group that the "It's Not Ok" campaign reported to until recently. That was disbanded last year - - -

MR MOSHINSKY: Can I just interrupt you. In terms of the membership of that taskforce, was there a police presence on that as well?

MS HANN: Yes, there was. The Ministry of Social Development, Justice, Police, Health, Education.

MS POMEROY: Corrections.

MS HANN: Yes. Maori Affairs.

MR MOSHINSKY: So that was an executive level government across all relevant parts of government?

MS HANN: That's right, and it was overseeing a whole lot of different work in the family violence sector.

COMMISSIONER NEAVE: Did you say it had NGOs on it?

MS HANN: Yes, it did.

MS POMEROY: And the judiciary.

MR MOSHINSKY: So there was the taskforce set up in - which year was that?

MS HANN: I think that was 2005, 2006.

MR MOSHINSKY: And then "It's Not Ok" campaign, how did that come about specifically?

MS HANN: So that was identified in the first strategy, in the Te Rito strategy, in 2002, and then again in the first work program of the taskforce that this was an urgent priority for the country. So Ministry of Social Development was given responsibility to start scoping out and looking at what that could look like. So the people who were in charge of working on another campaign, which is around preventing physical punishment of children,

started looking internationally about what's emerging as new evidence or good practice evidence in terms of campaigns in community education, and that's where the model that Teresa was talking about - building social change thinking, you know, incorporating social marketing thinking, incorporating community development approach seemed to be emerging internationally as a good practice model, and that's where the campaign developed from.

MR MOSHINSKY: The campaign, over what period of time has it run? Is it since 2007 until now?

MS HANN: It took a year of development before it was launched nationally, and then since 2007 it's been operating.

MR MOSHINSKY: In terms of funding, what sort of funding was there for the campaign and how has that changed over time?

MS POMEROY: When the campaign was announced there was a budget appropriation, and it was four years time limited. That was about $11 million over the four years. Other government agencies contributed on top of that some funding. So the initial budget appropriation didn't include mass media advertising. When that was identified as the best way forward, about three or four government agencies - I think it was Education, Police, ACC and the Families Commission - contributed some further funding to develop a mass media campaign. So over the first four years it was approximately 14.4 million.

MR MOSHINSKY: In total?

MS POMEROY: In total, yes. That funding ended after those four years and there was a new appropriation. That was significantly less. So it's about 500,000 a year for television advertising, and we have about 340,000 a year to fund community projects. Then we have a baseline that

pays for the FTEs and allows us to do that campaign delivery, so research and evaluation, and communications and resources, and travel and - - -

MR MOSHINSKY: I see. You have outlined the various different sort of components, and we will come back to some of those in more detail shortly, but perhaps if we start with the mass media campaign. Has that gone through a number of phases?

MS POMEROY: It has. Initially the campaign was going to - we have what we call three phases. But I would just like to point out that they are not linear. So we haven't moved from one to the other. It's like another layer that we add on. So initially the campaign was going to start with phase 2, which is the stories of positive change. That was around prompting help seeking, primarily from people, and primarily men, who use violence against their families.

When we went out and did some audience research - so we did a literature review on successful social marketing approaches around family violence, and we also did some qualitative research with former perpetrators, as well as some market research from our general population - what was clear was that New Zealand wasn't ready for those messages yet. What we needed to do was increase people's understanding - and I mean general population - about what family violence is, so it's not just physical, and the fact that it happens everywhere. We also needed to give people a language to use around saying it's not okay, which is what the campaign ended up being called.

So we developed the first phase of advertising, which we call "It's Not Ok", and that's around challenging

the social norms. So the campaign uses a socio-ecological model in terms of trying to respond to the determinants, and at a societal level we really needed to shift people's - we needed to shift the tolerance of family violence and the acceptance, and try and challenge those norms that promote violence, particularly around gender and family roles, like privacy and people speaking out.

So we developed our phase 1, which is called "It's Not Ok". Very soon after that, less than 12 months I think, we moved to phase 2, which is "It's Ok to Ask For Help". We had four different ads with four different real men who talked about their stories of change; because what we have learnt a lot through this campaign, because most of our work, really, apart from changing (indistinct), is trying to encourage men to change their behaviour and trying to encourage everyone else to support men to change their behaviour. So it's something that's really huge for many men, is believing that they can change. We talk about self-efficacy a lot in terms of people realising that there is hope and that they can do it, especially if they are supported by others.

So we have these four ads, "It's Ok to Ask For Help". Interestingly, that prompted help seeking from a whole range of other people too, especially people who were worried about others. So there was a big increase in calls to our information line from grandparents, employers, people worried about victims and people worried about their own family who might be using violence.

Then the third phase, which you will see, is "It's Ok to Help". That came about, and we can talk in more detail about that, because we realised that the

problem is so huge we need more than services and crisis services. I think only 75 per cent of violence is reported in New Zealand - - -

MS HANN: Twenty-five.

MS POMEROY: Sorry, 25. Seventy-five per cent isn't reported, I should say. We know that a huge number of people who experience violence or who use violence want to get help from what we call their intimate social networks - their family, their friends, the people who they live - they share their lives with.

We also found out from our evaluation and our audience research that people wanted to do something but they didn't know what to do and they didn't know whether it could be effective. So we did a whole lot of research around what is effective help giving, and launched a third phase in 2010 called "It's Ok to Help", and a lot of that in terms of the mass media advertising was trying to motivate people to take action and to understand the impacts on people both who experience violence and who use violence when we ignore it. So that's setting up the three different phases.

MR MOSHINSKY: We have available to show some of the ads from each phase. Is there anything else you want to indicate before we show the first phase ad?

MS HANN: I just think that it's important to remember that there's the mass media advertising but there's everything that sits underneath it. So the mass media advertising was about starting really an initial conversation but there is a lot of resources and information and other kind of community education and development approaches that support that with a lot more detail. So it might seem a

little bit simplistic if you are just looking at the ads. There is a whole lot of other things that happened to back that message up as well.

MS POMEROY: It created a supportive environment for other action to take place.

MR MOSHINSKY: Perhaps if we show an example of a phase 1 ad.

(Video shown to the Commission.)

MR MOSHINSKY: Perhaps can I ask you to describe to the Commission perhaps where that was - was that shown nationally, over what period of time, what sort of reaction did it have?

MS POMEROY: So there was a significant investment in purchasing television placement for that to launch it. It launched - I think it was about 10 weeks advertising over the first year, but we continued to play it when we launched the other phases. It is fair to say that it had a significant impact. I think the creative was really powerful. That was a mixture of everyday New Zealanders and a few actors and real New Zealanders. So a former Governor-General was there, entertainers, singers, actors, current affairs presenters. So it was a real mixture of New Zealanders.

You were saying the other day, because you were working at a women's refuge when it went to air - - -

MS HANN: Yes.

MS POMEROY: People started talking about it. I think there was a number of things. There's a bit of a narrative that New Zealanders tell each other, I think, and it's a cultural and societal narrative around who hurts their families, and the stories we tell are that they are poor and they are brown.

So I think one of the (indistinct) we needed to make was actually it happens everywhere, and this was really successful at that. What our follow-up evaluation showed us was that it really helped people shift their understanding, increase their understanding of the range of behaviours, particularly around coercive control, that constitute family violence, and it can be damaging and harmful, beyond the bash.

MR MOSHINSKY: In terms of audience reach, how many people saw it or remembered the ads? What did the research show?

MS POMEROY: I think it started just over 90 per cent, but after about 18 months we actually got up to 98 per cent unprompted recall - I think that was just as we launched phase 2 of that advertising - which was kind of extraordinary, I think, and something we are really proud of.

MS HANN: It did create a lot of community conversations, people talking about it in all sorts of places. The interesting kind of thing that it also did was create a mandate for the work. I was working in the sector at the time, and all of a sudden it had gone from nobody really caring about family violence to actually thinking, "Yes, this is a social problem. We can do something or we should do something about it." So it really kind of shifted straight away people recognising it as a serious social issue and understanding a little bit more and seeing it as something that might affect them, because it affects all New Zealanders.

So that happened within a year, I think, and people started using that phrase, "It's not okay", attaching it to family violence. So it was really

recognised that you could use it as a phrase if you were trying to challenge violence. So you can say "that's not okay to behave like that", but also it was a kind of rally call for communities starting to talk about, "We can do something. It's not okay."

MS POMEROY: In terms of preparing for it, there was a lot of work taken in terms of consulting with sector partners, consulting with communities, market research, but also we didn't know what sort of reaction it would prompt in terms of help seeking both from victims and perpetrators. So a fund was set up called the Community Response Fund that particularly national service providers could apply for just to anticipate any kind of quite sharp rise in help seeking.

MR MOSHINSKY: Did that occur? Was there a sharp rise?

MS POMEROY: It occurred not to the extent that some people thought it might do, but it did occur, yes.

MR MOSHINSKY: Perhaps we will go through the three phases of the mass media campaign and then come back to those other initiatives underpinning each phase.

COMMISSIONER NEAVE: Just before we do, one of the issues that I picked from that ad is it is not confined to intimate partner violence. It also covers violence against children, and I think one of the speakers referred to violence against other family members generally. Presumably that was a deliberate decision?

MS POMEROY: Yes.

COMMISSIONER NEAVE: That you would do it that way rather than focus - we all know that the majority of victims are women and the majority of perpetrators are men, but was there any debate about that in New Zealand, the fact that it was

broader?

MS POMEROY: There was great discussion particularly amongst the taskforce members in that the initial strategy planned to - because, remember, the first stage was going to be the ad you are about to see, which is around perpetrators of intimate partner violence. The initial thinking was that we would do a series of ads on intimate partner violence, a series of ads on child abuse and neglect, and then a series of ads on elder abuse and neglect. What we started to notice through our audience research and our tracking research is that people don't separate out these things in their lives, that in families where harmful behaviours are occurring there are multiple issues. Increasingly, what we noticed with our community projects, who can use whatever messaging they like, is that they were putting in alcohol messages about easing up on the drink, and some of our community projects talk about the impact of alcohol-fuelled violence on children.

So we started to understand that it's not about the type of violence. It's about the kind of messages that you are giving people and the permission that you are giving them to talk about it and to take action, if that makes sense.

MS HANN: There is also another thinking behind that in terms of the audience focus for the whole campaign, and that talking about victims and perpetrators, talking about men as perpetrators, is important in terms of services and it is important in terms of our policy and our strategy frameworks, but when you are trying to engage an audience to help them care about the issue and to think it is personally relevant, to think it is something to do with

their life and their community, family violence as a kind of phrase or a concept works really well because it helps people identify, "This is about my family. This is about my community."

So in that sense the kind of real strong gender focus can lead to a shaming and a blaming that is not helpful in terms of a social change campaign and supporting behaviour change. So it definitely is underpinned by that analysis and thinking. But the audience focus, you would use a different kind of language, I think, and that's why family violence worked quite well.

MS POMEROY: So phase 2, "It's Ok to Ask For Help", had four different ads. Three of them were men that used to use violence against their families and no longer do. One of them is a man, who is now an MP, actually, who talked about being an influencer, so challenging his friends about their behaviour. So the one that we are going to show you features Vic Tamati, who had such an impact that we now employ him full time to be a champion of change.

MR MOSHINSKY: If we could show the phase 2 ad.

(Video shown to the Commission.)

MR MOSHINSKY: So that's one of the four ads that were part of the phase 2. Are there any comments that you would make about the impact that that phase of the ad campaign had?

MS POMEROY: It was tricky, this phase, because, as you can imagine, in terms of trying to respond to family violence for many decades there has been just a small number of people trying to change the world and they are largely groups that have been looking after victims and their children, and there was a real need - I think people

wanted those stories to be heard. But we had to stay really focused on the behaviour change that we were seeking. So we had to really work with people to try to be clear around why we were telling perpetrator stories.

But I think in the first few months after that ad launched there were 7,000 calls just to our information line and over half of them were men wanting to talk about becoming violence free. That's just prompted a whole wave - we fund several champions of change, we call them, and they are in huge demand, and they're now mentoring other men who have been violence free for a significant amount of time.

MR MOSHINSKY: You mentioned that Vic Tamati, who that ad featured, was subsequently employed by you to do work as a champion of change. What sort of change?

MS POMEROY: He tells the story of change, and he tells that to everyone from police in terms of training, to gangs, to the Rotary clubs - do you have Rotary clubs in Australia; you do, don't you - Lions clubs, sports clubs. We work really closely, like some people in Victoria do, with sports clubs. It is that thing about that change is possible and encouraging a different kind of masculinity. Vic has now formed his own organisation called "Safe man, safe family", and that's probably another discussion. But all sorts of things are happening.

MS HANN: I think it was about he tells his story to help people realise that some men can change, and he also tells his story to encourage men to stand up around domestic violence. That has been led by women - the work to prevent violence has largely been led by women in New Zealand, as it has been around the world, I think. So he

is really focusing on mobilising men as leaders for change, and he tells his story to help people connect who feel they are totally alienated and isolated by mainstream services. So he's really focusing on people who aren't currently getting help from, you know, stopping violence programs or counselling or mainstream family services. But also he really focuses around engaging men who are not violent to be leaders to stop violence as well. So it's really about community mobilisation, men showing leadership right across the country.

MR MOSHINSKY: The second phase, which is called "It's Ok to Ask For Help", is that message directed more to people using violence or people experiencing violence or both?

MS POMEROY: Both. It's more directed to people using violence, but it was picked up by everybody. So it works for everybody, including people who are concerned about someone else that they care for.

MR MOSHINSKY: Do you want to introduce the phase 3 ads before we show them?

MS POMEROY: Yes. Phase 3, there are two ads, and one is a person, Angela, who has been experiencing violence, has violence used against her, and the second ad is Geoff, who is a man who was using violence against his family. It's based on a concept called cardboard cutouts that tested really, really well that shows - - -

MR MOSHINSKY: Just to interrupt, when you say "tested really well" do you mean in your market research?

MS POMEROY: Yes. So we tested the concept, and then we made the ads and tested them again, which was quite brave because if they didn't work we had spent all the money. We also did quite a bit of formative research trying to

understand what was effective and safe helping.

So the target audience is all of us, so everyday people who are worried about someone who is either experiencing violence or using violence, trying to help them understand the impacts of when we do nothing, and then some of the communications that supported that television advertising were around telling people what they could do that was helpful.

Our research showed us that there were two - we thought that we had one key audience, which was helpers, but the research shows we had two key audiences. We had helpers and influencers. You might be able to see in the ads that we targeted both of them.

One thing I will say is that we were very, very specific and intentional about using Pakeha, or European, actors in these ads because a number of things had happened in New Zealand - the thing that we measure in our reach and retention is the degree to which people understand that family violence is everywhere. Over the previous year prior to this campaign, for a number of reasons they started to go backwards again in terms of people only thinking it happened in Maori or Pacific families or communities. So we tested the concept with general population, Maori and Pacific, and it tested well with all of them. After we made the ads we found that the response was better from Maori and Pacific even though the actors that you will see in the ads are European.

MR MOSHINSKY: So if we could show the phase 3 Angela ad.

(Video shown to the Commission.)

MR MOSHINSKY: Should we play the other one now before we discuss them.

(Video shown to the Commission.)

MS POMEROY: It was an Australian accent you heard. We had to use an Australian actor because New Zealanders found it too hard to engage with an actor who they recognised.

MR MOSHINSKY: Please tell us a bit about the phase 3.

MS HANN: The thinking behind those ads were a few different things, firstly that idea of a coordinated community response and that everyone has a role to play in trying to stop violence. So it's not just a problem for the police or the services or government. We can all do something. No matter where we are, no matter where we are in our lives, we can all take some action that will help contribute to ending violence. So it is kind of based on that idea that friends, family, neighbours can all do something that would help.

It also came from our research around helping where we heard that from our WHO violence against women research in New Zealand that women were telling people that they were experiencing violence or they thought they were making it obvious that they were experiencing violence but no-one was helping. People were just ignoring it. But also when people were helping we found that they weren't necessarily doing the right things.

So we did some research, asked people, "Have you helped someone around family violence, either a victim or a perpetrator," and then, "Was it successful," and people said, "Yes, we thought we did quite a good job." Then we did a 360 and actually asked the person on the other end, "Was it useful," and they said, "No, not always."

So we learned some stuff that people were doing that wasn't working, like, for example, they were

intervening - they were waiting until the violence was happening and then trying to intervene, when actually people wanted support early and they wanted just general kind of help and support not necessarily about the family violence but just someone to be there to support them to talk to. It was all that kind of stuff that we built into this messaging around the fact that you can do something, it can be something small, just reaching out will make a huge difference.

The research also showed that people wanted help from their friends and family. They would much rather that happened than go to police or to Child Protection. They wanted their community to help them. So we were building on all that to try to encourage - give people the permission to help, and then once they were doing something to know to do the right things, just small things but the right things that would be safe and effective to help others. That was backed up with a whole lot of information on the website and community workshops and stories and resources that were provided for people on how you can help someone close to you.

MS POMEROY: Some of the stuff was just really basic and really simple but hugely powerful. So if they were people who were experiencing violence, because it's become so normalised they needed to be told that what was happening to them wasn't their fault. Just reminding them that they don't deserve this was hugely important, because when we talk about tolerance we talk about it at a sort of societal level, but it also happens within this intimate social network level. When people don't say anything or don't respond or minimise it or underplay it or accept it

or even promote it or sanction it in some areas, people don't seek help either for the violence that they are experiencing and they don't seek help or have any motivation to change for the violence they are using.

So for many women they just needed to be reminded that it wasn't their fault. They needed just really practical help. They also needed people not to sweep and not to swoop. So what was happening was that often especially older women in the family who might have experienced violence themselves would sweep it under the carpet. That's what the sweeping is - you know, "Just get over it. It happened to all of us. You just have to deal with it" kind of thing; or swooping, which, as mothers of adult children, we can relate to. They swoop in when they find out what's happening because they are so incredibly worried. But they take control, and for many women experiencing IPV it's just one more person taking control of their lives that they have to manage. So it was really important for us in our messaging to tell people "get permission to help" but let people know quite simply what effective and safe help looked like.

For men using violence - or people, but largely men - they needed to be challenged by other men and men who they know. So we talked about the courageous challenge. The previous witnesses talking about pockets of bravery really struck a chord with us. So it is a courageous challenge. If it is by a person who is also a former perpetrator it is even more effective. So it is really about challenging your mates, if you like - what White Ribbon has been doing in Australia, actually.

MR MOSHINSKY: I want to come back in a short time to

evaluation. But before we do that can we talk a bit more about the other parts of the overall strategy, particularly what happens at the local community level and what work you do to facilitate change at the local level?

MS HANN: The national campaign and the national team provides like a scaffolding or a framework for a campaign. So that's the mass media advertising which creates that supportive environment. There's the branding. There's a whole suite of messages. There's resources and communication, and also what we have learnt about what works around mobilising communities.

The idea is that we will support local communities to be able to pick that up and drive that themselves. So it's really taking a linking national to local kind of approach. The community mobilisation or community action is about local communities who want to do something about family violence but are not sure where to start or what to do, and the campaign team will help support them in terms of identifying where their community is at, what they are ready for, what are the right messages, what's going to work, what might work in this community.

We are using kind of a model that looks at community change in the same way that there's personal change, that communities can go from a kind of process of not really knowing about the issue to kind of needing to understand a little bit more, to needing to embed the action. Like the transtheoretical model of personal change where you go from pre-contemplation to contemplation to action, communities go through that kind of similar process as well.

So some of them will be in total denial about the issue of family violence and they will need different kind of activities going on in that community compared to one that does care about the issue but just doesn't know where there's help or what they can do. So the campaign team will support a community to identify the right kind of messages, the right kind of action to do and how to start implementing that.

It's at a very small steps kind of - there's some common vision and some common outcomes, but it is really about just starting where people are, finding the people who care about it, getting them together and building that action within the community.

MR MOSHINSKY: What type of organisations or community groups are you talking about?

MS HANN: It can be a range. In some communities there's an interagency family violence network. So that's government and community organisations who come together in that community around leading family violence, and often they will be doing services but I think sometimes they are doing prevention and community mobilisation work as well. So they could be the group that leads it.

Sometimes it's a sports club. So we are working with rugby league and rugby union clubs who - they are wanting to do something around family violence. Sometimes it could be a faith community. It could be a local council that's decided. So it is one group that is actually just going to take some leadership in their community. We will encourage them to bring others around them, though, to take a collaborative approach to build a project within their community. But it can come from

different places.

MR MOSHINSKY: Did these groups come to you or did you go to them?

MS HANN: Because there's not a huge resource available at the moment it's just waiting for people to come to the campaign. It's quite well known across the country. So when someone wants to do something about violence that's one of the logical places that they go to.

MS POMEROY: We also share the successes of other communities through our Facebook channel or our Twitter or websites. So we really promote the campaign. It's not just being a national campaign but the campaign exists within communities. Recently we have had this project - there are like whole-of-community champion projects like Sheryl was describing, and there's been about three or four recently that we have heard of that have just sprung up and have done it themselves. They haven't even come to us for funding or support, which is just remarkable, really. It's great. So I think it's communities showing each other and inspiring each other around what they can do and how to take action.

MR MOSHINSKY: How does the link work between the national campaign that you have described - we have seen the mass media campaign - and what happens at the local level, given what you have said that it needs to be tailored to the particular audience?

MS POMEROY: It is a bit like the question the Commissioner asked earlier around having a national framework that is not necessarily too prescriptive. We talk a lot about being intentional or tight/loose. So in terms of responding to the determinants or those factors that

support or encourage harmful behaviours we need to be clear on what we need to change, and there are multiple factors. What we are a bit loose about is how we do it. Partly that's because we don't always know. We need transformational change - so what's going to support a community to take positive action and what's going to work in that particular community.

I guess we also think in terms of complexity. So it's about being clear what changes we are looking for, funding pockets of innovation or pockets of bravery, and being observant. The more that we notice what works, that becomes our focus, that's the kinds of projects we promote. We will develop tools and resources based on what we've learnt both as a national team and with our community partners. So it is a very emergent space. It's messy.

MR MOSHINSKY: You were hearing the evidence earlier today about the collective impact approach that we had just before lunch. Have you got any observations about the similarities or differences between what you do with local groups and that collective impact approach?

MS HANN: Yes. We haven't really used the term "collective impact" to describe the way the campaign works, but I think it does fit with that model very well. The national team provide the backbone support. So they are doing the kind of technical assistance, they are doing the facilitation, capacity building, training and things like developing resources and keeping the communication going, and that's bringing all the different parties together.

Also really important in the collective impact approach is the common vision. I think that's what the

mass media has helped build, a common conversation across the country, a common vision that we all want to do something about preventing violence, actually a common vision that we all want to create safe families, thinking about it in a prevention way.

So I think a lot of the elements that you would see in the collective impact approach are what the campaign is doing, trying to support that at the national level to be the framework and then encourage that local innovation, local relevance, making it real in your community at the same time.

MR MOSHINSKY: Can we turn then to the subject of research and evaluation. You have already covered the research that goes into formulating the mass media campaigns. What sort of evaluation has there been of the whole project, and what are the main lessons that have come out of that?

MS POMEROY: I guess there's the different types of research reviews. So, as well as the formative research around what are the current beliefs and attitudes that contribute to or are barriers to or that motivate positive behaviour change, we have done audience research. So we develop concepts and we test them, and we test them with general population and Maori and Pacific, and then once - so most of the evaluation has gone into the mass media, which has started to pick up other aspects of the campaign.

Between 2008 and 2011 or 2007 and 2011 we did five tracking surveys - or we call them reach and retention surveys, and that's using phone technology, CATI surveys; it is done by a market research company - of about 1,000 people, and roughly a third are general population again, a third are Maori and a third are

Pacific, and that's twofold - I guess partly it's a performance measure - has the campaign reached enough New Zealanders? So what is the reach of the campaign, who recalls the advertising, have they retained the messages, do they understand what we are asking of them, and have they done anything as a result? We have done that across all three phases. We did two for the last phase.

MR MOSHINSKY: So this document here is an example of one of those evaluations?

MS POMEROY: Yes, that was tracking survey 5. That was the final one we did in November 2011.

MR MOSHINSKY: What about other evaluations of the program, for example this one I think you have also there?

MS POMEROY: That's the most recent. Because we are investing so much of our resource now in terms of our funding but also our own time and priorities into community projects we were wanting to know what's actually happening at the community level. Sheryl can talk more about the findings, but we wanted to know in those communities whether a locally led campaign, like "It's Not Ok" in Taupo, "It's Not Ok" in Queensland - are they having an impact and, if so, what are the impacts that they are having, is it sustainable, and across - we went to seven communities with that bit of evaluation - are there any kind of key critical factors that we are seeing in all of them that can give us some clue as to what we should be looking for, what kind of conditions we should be fostering in the communities that we are partnering with.

MS HANN: That's the kind of thing that may be of interest if you are thinking about how this model might work in other places because they were looking at what worked right

across these different communities - some of them were geographical communities, and then some were communities of interest, like an actual sports club - and what worked there; so the fact that there was a national media to create that supportive environment, the fact that there was a team to provide that kind of backbone resourcing and support, that the campaign allowed local innovation for people to make it real and relevant in their own space and to build local leadership.

There was also the fact that there was - having a dedicated coordinator was a really important thing. So someone who had the time to lead the prevention work to hold that space to do the kind of backbone support I think that people were talking about as well. There needs to be a sense of urgency or something in the community that drives people to take action right now, and building the local capacity for leadership, so actually creating local champions, that it's not held really tightly by family violence services or by government agencies but actually it is about spreading it out right across the communities so that all sorts of people can emerge as leaders for this work. So there's a whole lot of information across those case studies that might be relevant.

MR MOSHINSKY: Is there a process by which the team picks up what works or doesn't work in one place and then sort of draws on that in developing programs for other places?

MS POMEROY: Yes.

MS HANN: Yes. I think all the projects that are funded or supported will report back on what's been happening, and many of them do their own local evaluation as well, and the campaign team will pick that up and have developed it

into like capacity building workshops or training or communicating that back out to other communities and projects to say, "They have learnt this in this community. This has worked really well. We tried that and it didn't work very well at all." So maybe steering communities in different directions that we are building on the evidence base as we are going through.

MS POMEROY: I think initially we looked at what was happening in Uganda with the Sasa program, and we recently watched a presentation from Lori Michau about what's been happening there, and there are real similarities. It's remarkable, really. I think the need for a community mobiliser and then whole-of-community activists almost. She talks about "delicate activism", doesn't she? People actually standing up for change. Some of that is around gender. Some of that is around family.

MR MOSHINSKY: Can I ask you also about the structure of where the team fits in government? One of the things the Commission will be looking at this week is different models of where this type of primary prevention work could sit. Your team is in the Ministry of Social Development. How does that fit with what else is going on in government that relates to family violence?

MS POMEROY: That's an interesting question. The taskforce was disestablished last year, and there is currently a program of work happening that's led at a ministerial level across social development and justice, with police and corrections and health, I think.

We are kind of a specialist team, really. We could have been serving in health, ideally, or possibility the Health Promotion Agency, which is another Crown-owned

entity.

We work in partnership with other agencies around the campaign, so that we have a really clear focus around behaviour change or social change. So, while some of us with specialist expertise might feed into policy development, we are really focused on the delivery of the campaign, really, and that feeds into other government outcomes. But we are quite a specialist team.

MR MOSHINSKY: So until it was disestablished, the taskforce, was that the mechanism which provided the whole-of-government approach?

MS POMEROY: The whole-of-government, across government approach, yes.

MR MOSHINSKY: Is there a family violence unit as well?

MS POMEROY: There is a family violence unit that sits within the Ministry of Social Development but it serves across government.

MR MOSHINSKY: What is the role of that?

MS POMEROY: That's largely, I would say, operational policy. That was set up to serve the taskforce. So I think the role of the unit's probably being slightly adapted. It's the family violence/sexual violence ministerial working group looks at services - - -

COMMISSIONER NEAVE: So there is a ministerial working group?

MS POMEROY: Yes.

COMMISSIONER NEAVE: Then there was your unit, and then there is this other family violence unit which serviced you but which is now operating what? Servicing the ministerial committee?

MS POMEROY: Partly. The family violence unit was set up to serve across government in terms of supporting the

taskforce for action on family violence. That taskforce has been disestablished, and there is now a family violence/sexual violence ministerial working group that is leading I think a review of our system's response. So I think the role of the unit will be dependent on what that group finds.

MR MOSHINSKY: Until it was disestablished, the taskforce really provided the overarching whole-of-government strategy?

MS POMEROY: Direction.

MR MOSHINSKY: And the work that your team did fitted into that general program?

MS POMEROY: Into that strategy, yes.

MS HANN: Also I think the important thing there is that a lot of the other work has focused on intervention, like response once violence has already occurred. Because the campaign was working in a different way actually from the beginning the strongest partnerships were with NGOs and communities. So right from the beginning of the campaign there was very strong relationships like with the national Women's Refuge and Stopping Violence Services and Child Services, and that was where the focus around partnerships were because they were the people in communities doing the work.

MR MOSHINSKY: There was reference earlier, I think you referred, Ms Hann, to the clearing house. Could you just explain what the clearing house is and where does that sit and what does it do?

MS HANN: It's a contracted service from government and sits within the Auckland University at this moment, and that's a research and information centre on family violence. So

they collate all the research that happens in New Zealand around family violence and the evidence. They do issues papers. They keep all the information about latest events and inform the sector of the latest evidence. They sometimes run research symposiums. I think it's similar to the clearing house that operated in Australia until recently. It's about improving practice and the evidence base for policy and research as well. But they were just a very small team. They managed to keep the library and the resources going, but that's kind of the extent of what they are able to do at the moment.

MR MOSHINSKY: Just going back to the topic of performance monitoring in terms of the overall system and is progress being made, the type of evaluation that has taken place of the overall project, and it's a very long-term task to shift behaviour, to what extent is it possible to measure if there is success?

MS POMEROY: It's tricky. I think one of the witnesses earlier today said we are talking about a 30-year - if we are going to see change at a population level that is sustainable we are talking one, probably two generations. If you use that population health approach if looking at the determinants, if we are addressing the determinants of family violence, everything from the societal norms through to do we have communities that support behaviour change, then they are the things we need to measure.

So I think in terms of our campaign we have these five kind of key objectives. We want to increase people's knowledge and understanding of family violence. We want to increase people's willingness and confidence to give and receive help. We want to encourage action by family,

friends, neighbours, work mates, communities. We want to create a social climate that supports behaviour change, and we want to address the social norms that promote or support the tolerance of violence. So they are the kinds of things that we need to measure. If these are the determinants that we are addressing, then we need to measure are we making a difference here.

So some of the things that we were trying to gauge through our reach and retention survey or our tracking survey was people's willingness to intervene or did people believe that they could make a difference; did people feel comfortable challenging people about their attitudes, beliefs or behaviours; were people taking any action.

In 2008 when we launched the first mass media campaign I think 21 or 22 per cent of people said that as a result of the campaign they took some kind of action. There was about five identifiable actions, everything from looking at a website or calling an 0800 number to talking to a family member, right up to calling the police.

We expanded that out to about eight actions by the time we got to phase 3. But we had increased that from one in five, or 22 per cent, to one in three. It was 32 per cent, I think, or 31.5 per cent, of people who had taken some kind of action as a result of the campaign.

So to the very best of our ability and our resource we are using evaluation to try and measure the shifts and the campaign objectives in terms of the environmental or societal or cultural factors that contribute to or promote violent behaviours or violence.

We also work with anecdotal evidence. We work

really closely with the police. They have been a really key partner of ours, everything from as part of our media advocacy strategy where we started to identify the kind of ways that the news media were reporting on family violence that contributed to beliefs about victim blaming or minimisation. So we partnered with the police and did a media handbook for detectives on how to report family violence.

So we work closely with the police. They tell us too, them and the social service providers, things like people are seeking help earlier now, and they say that's because of the campaign. What else are they telling us? That it is easier to do their job, it is easier to raise the issue of family violence.

MS HANN: I was going to say at the beginning, though, there is a difficulty around the social change kind of work and how you are going to measure it. So we were really careful to say we are not going to see a reduction in family violence, in fact we are going to see an increase, because if we are encouraging people to talk about it and to take responsibility and to ask for help there's going to be more people going to services and calling police. Actually, over the time of the campaign reports to police have doubled. They have gone from 50,000 to 101,000 over that time. So it's a huge increase in that work.

But we did get asked right from the second year perhaps have you saved any lives, have you stopped any deaths, and that's really going to be difficult for us because that's a population based kind of measure and we will be contributing to that over the long term, but that's not something that we can report on now. So that's

why the intermediate outcomes are really important.

Through the theory of change we know that if people are talking about it more, if we are overcoming the stigma and shame about it, if people are taking action, their friends and families are helping, that will be contributing to ending violence, and that's the stuff that we can measure.

MR MOSHINSKY: Do the Commissioners have any questions of the witnesses?

COMMISSIONER NEAVE: I have one question. You referred to the Community Response Fund, which I think you said was set up because it was thought that there might be a big increase in reports of family violence and that the increase wasn't as big as you had anticipated. But I wondered if there had been an increased demand on services for men - I'm not sure what you call them in New Zealand; we call them men's behaviour change programs - whether there has been an increase and whether that's created problems, and were there programs that men could go into if they wanted to?

MS HANN: They were available, and they all have reported that there's been a huge increase on calls for service in stopping violence programs or behaviour change programs. We don't have the exact numbers, but we have the anecdotal reports from them that a significant number, especially self-referrals. So in some of the stopping violence programs they relied on referrals from courts and police, and now many of them - half of their men turning up to services - are self-referred. So that's been a significant growth in the last few years.

The stopping violence programs also report that men are turning up ready to work, like they are actually

owning their problem, knowing that they need to change their behaviour, and not so defensive about the issue, and that's a significant change for them too. So I think that's from the supportive environment. But, again, we don't actually have the numbers from the services. They just don't have the capacity to gather that at the moment, unfortunately.

COMMISSIONER NEAVE: That's very encouraging. But are there enough places for people if they want to go?

MS HANN: No.

COMMISSIONER NEAVE: Thank you.

MS HANN: It needs to be increased.

DEPUTY COMMISSIONER NICHOLSON: I think you said that the funding for the campaign has been reduced after the initial four-year tranche, and I was interested to what was the rationale for that reduction and in dollar terms what is the current funding for it?

MS POMEROY: So the funding - to be accurate, the funding wasn't reduced. The funding ended. It was four years time limited when it was appropriated. As a public servant how do I say - there was a shift in government, there was a shift in priorities. New funding was found but I guess at a reduced amount compared to the initial funding. So currently there are different sources of the funding, but it's probably 1.2 million a year in total through Crown and non-Crown funding sources.

DEPUTY COMMISSIONER NICHOLSON: Was that different level of funding because of an evaluation or what? That's one of the challenges, isn't it, to keep the effort going?

MS POMEROY: Yes. There was a shift in government and new ministers, and they had different priorities, different

views on where to vest a limited resource.

DEPUTY COMMISSIONER NICHOLSON: So that new level of funding cutting in after the taskforce had finished, was it?

MS POMEROY: No, before. The time-limited funding ended and new sources of funding were found. They were just not at the same levels as the initial appropriation.

MS ELLYARD: If there are no other questions, Commissioners, could the witnesses please be excused with our thanks and could we have a 15-minute adjournment, please.

COMMISSIONER NEAVE: Thank you very much.

<(THE WITNESSES WITHDREW)

(Short adjournment.)

MS DAVIDSON: I will ask that the next panel be sworn.

<PATRICIA LUCY KINNERSLY, affirmed and examined:

<JERRIL SAMANTHA RECHTER, affirmed and examined:

MS DAVIDSON: Thank you. Perhaps, Ms Kinnersly, I can ask that you start first and tell the Commission what your role is and perhaps give an overview of the work that Our Watch does.

MS KINNERSLY: Sure. At Our Watch I'm the Director of Practice Leadership. We have three teams in Our Watch. One focuses on media and communications and focuses on sort of whole of organisation, media strategies, communications, that sort of thing. One on policy and evaluation, and that team has been developing the framework for prevention of violence against women, a national framework, in partnership with VicHealth and ANROWS, and the practice leadership team is focusing on the activity of doing primary prevention - so how do organisations, how do sporting clubs, how do other people across the country in this instance actually undertake primary prevention

activity.

I also today will draw on my experience as the CEO of a regional women's health service undertaking primary prevention activity through the nine years previous to this role, and for that part of my experience I can talk to some of the difficulties and barriers in undertaking primary prevention activity in the absence of centralised leadership and coordination of primary prevention activity.

MS DAVIDSON: Was that a Victorian organisation?

MS KINNERSLY: Yes, that was a Victorian organisation in the Grampians region, west of Melbourne.

MS DAVIDSON: Our Watch is established at a national level; is that right?

MS KINNERSLY: That's right. We have a national mandate to coordinate prevention of violence against women and their children activity across maintaining a conversation around providing frameworks for other people to undertake prevention of violence activity and to undertake activity. As I said before, our role is not to do primary prevention around the country. Our role is to be a backbone organisation.

We are very respectful of the fact that people have been undertaking work for decades in this space. What Our Watch's role is to do is to bring it together, try to improve communication, make sure the standards are right, look at what's happening around the country and around the world to make sure that we are leading best practice, if you like; and Victoria, because of its history and governments and organisations like VicHealth, has a really strong history in prevention of violence

against women activity and so in some ways Our Watch is drawing on the experience of Victoria, but we are certainly looking at the ways we can take that around the country.

MS DAVIDSON: Ms Rechter, can I ask that you explain what your role is and just briefly outline - we have already heard a little bit about the work that VicHealth has done in this space, but just briefly outline what VicHealth has done in the past and what its current role is in relation to violence against women?

MS RECHTER: I'm the CEO of VicHealth, a statutory body founded under the Tobacco Act. I won't go into the details of all of our formation, but we have been working in the area of prevention of violence against women for over a decade now and had a leadership role across the state in looking at some of the practice and strategies, communications and research around the prevention of violence against women.

MS DAVIDSON: VicHealth as a broader organisation is involved in broader public health promotion; is that right?

MS RECHTER: Yes. We are there to promote good health and prevent ill-health, and we have a 10-year vision, and under that vision we are looking at outcomes of 1 million more Victorians with better health and wellbeing under five strategic imperatives.

MS DAVIDSON: And those five imperatives are?

MS RECHTER: Physical activity, tobacco control, reduced harm from alcohol, increased physical activity - did I say that already - healthy eating and mental wellbeing.

MS DAVIDSON: Where does violence against women fit within those five activities?

MS RECHTER: It sits under three of them but predominantly in

the mental wellbeing area, but also sits under physical activity and a little bit of work in the alcohol area as well.

MS DAVIDSON: In the past VicHealth has done quite a lot of research in the area of violence against women, and we have heard from a number of witnesses about how a lot of the work that VicHealth has done has been picked up and assisted in developing that primary prevention work at the local level.

Does VicHealth's work so far, has that involved any of the family violence outside of violence against - the violence against women as such, have you done much work in relation to the other areas such as elder abuse, child to parent abuse and direct child maltreatment?

MS RECHTER: In response to your last question in terms of direct child maltreatment, it is more for us a protection services space. So we have really been working on building the evidence around the prevention of violence against women, making sure that we translate the practice and also build international and leading Australian evidence, I guess that we see that our work will also flow into those other areas that you mentioned but we haven't specifically focused on elder abuse or children.

MS DAVIDSON: Just to clarify as well, Our Watch's work is about violence against women and their children; is that right?

MS KINNERSLY: That's correct.

MS DAVIDSON: And doesn't directly - it doesn't directly address parent to child abuse outside of that violence against women and their children sort of context?

MS KINNERSLY: Not directly. Our evidence base is around the causes of violence against women and the gendered nature of that. But, as with Jerril's point, that will flow into other areas of the community, but our focus is on women and their children.

MS DAVIDSON: Just focusing on violence against women, what we have heard throughout the hearings is that there are a lot of community organisations doing work in relation to prevention of violence against women, and there would seem to be multiple different platforms that can be used for that work. What is the consequence of all of those individual organisations doing things? Who is at the moment or is anyone at the moment responsible for coordinating that work at a statewide level?

MS KINNERSLY: The consequence - I don't actually agree with you that there are a lot of organisations doing prevention of violence against women. There are a lot of organisations across the spectrum, some doing prevention, some doing early intervention and many, many doing response, which is a reflection of the data and the appalling figures, really.

But over the last decade or 15 years we have had some organisations doing a lot of work, like VicHealth, in the research of the causes and how to undertake prevention of violence activity. So there has been some coordination. It's not fair to say there has been none. But there hasn't been a centralised body organising or leading prevention efforts in Victoria that link to government, that link to community services, that link to legal services, all of those sorts of things. As a result of that there's short-term funding led by different

organisations. So VicHealth has done some, Department of Justice - Victorian Department of Justice recently.

So what's happened in that absence of that kind of vision, if you like, housed within a structure that can do evaluation and monitoring and all of those sorts of things is that there has been short-term funding, project funding, which we know is not an effective way to do prevention - prevention is a long-term effort - and so there can be competitiveness in the sector because there's only a small amount of money and people needing to access that money; the skill base moves around, so it is hard to invest long term in building the skill base because the funding is short term.

In the funding that has gone out, there have been - because it hasn't been coordinated, despite people's best efforts there hasn't always been the capacity to set measures across that funding and therefore be able to incrementally gather the evidence over time about what's working and what's not. So you get that. Victoria has the best evidence base in the world, just about, on primary prevention of violence against women, and we could have done it better had we have had one place where the evidence was being gathered.

One of the other key results that have come from not having a centralised way of doing primary prevention is that we haven't been able to say, "I have developed a really good primary prevention activity out there in the Grampians. In Gippsland you can use that." What happens is it gets housed in organisations rather than being shared.

The other component is that we know with any good

community change or attitudinal change there needs to be - there are several levers. Some of those sit in policy and legislation, some of them sit with community campaigns like the ones we heard from the New Zealand women previous to us, and some are in practice. That is happening in bit part because we haven't had a state vision, state leadership.

So the consequences have been many and varied, if you like, that bring us to a point where Victoria is doing better than most, but it has a really - we are in a key position and an opportunity to build that and really to lead a world's best practice, whole-of-state, whole-of-government, coordinated way of doing primary prevention.

MS DAVIDSON: Ms Rechter, do you agree with what's been said in relation to the way that the system is currently working or has worked?

MS RECHTER: Yes, VicHealth and I would certainly agree with the description that Patty gave, with the lack of leadership that's happened particularly from the government level. There has been attempts to do that over many, many years with the formation in 2007 of - actually, 2006 around statewide steering committees, both for family violence and sexual assault. But what we find is those committees get changed every time there is a new government. Also prevention isn't necessarily high on the agenda of those committees. So what we are not seeing is a continuum of leadership and a continuum of governance across this particular sector in order to continue to develop and build upon the practice that is happening.

We have heard about it all today. But where we

could take it to the next level is around having that coordination at a statewide level, and everybody driving in the same direction to deliver some really strong outcomes for the state.

MS DAVIDSON: We have heard a bit today, including from the New Zealanders, about this idea of a consistency of message and mutually reinforcing activities, whether it's in that collective impact approach at that local level or, in relation to the New Zealanders, the idea that the national campaign is supported by the community level work. Where are we at in terms of developing that sort of consistency of message at a statewide and potentially the national level right through to the local community level?

MS RECHTER: If I may start an answer for that one. VicHealth very much by its mandate is that we work outside of the health sector. We work with the environments where people live, learn, work and play and exist every single day. So that collective impact model that was talked about in one of the sessions earlier is how we have been realising and coordinating our work in this particular area for the last decade. So we work in all of those areas where we find local leaders, where we can get people that are I guess champions within those local areas, where sporting organisations can take the lead, where local government can take the lead, et cetera. So that's very much about the collective impact model that VicHealth has been working on for the last decade.

I have forgotten the last bit of your question - the bringing it all together. I think for VicHealth we have really been trying to develop up the practice and the research and the policy over that period, and I think we

are now at a time in the state - and this Commission is a really important part of where we are as a state - where we are ready as a community to really face some of the messages that need to be put out there holistically, and I think the New Zealand example showed us or demonstrated that the community wasn't quite ready yet to hear some of the messages and they were very much focused on how to talk to the community about a very complex issue. In Victoria we are well advanced in that, and that's very much through the work that not just we have been leading but many people have been leading across the state.

So there is definitely a coordinating piece that needs to happen in terms of a statewide campaign, and again with a true social marketing campaign. It's not just ads on television. It's everything from that mass media right down through to how it is delivered at the local level and supported by community programs as well.

COMMISSIONER NEAVE: Can I just ask a question about that. I don't quite understand how VicHealth works with bodies such as the ones that we have heard from this morning, for example, Women's Health West or indeed perhaps even some of the Primary Care Partnerships, although that may not be appropriate. But they are both in a health area. You are in a health area. What are the sorts of relationships - how does that work? How does that relationship between VicHealth and those bodies work?

MS RECHTER: We don't work with necessarily Primary Care Partnerships. That hasn't been an area that we have connected with strongly. We have worked with the women's health networks, and very much so because they are the ones that have been out there doing this work, championing

this work for many, many years. So they have been a vehicle by which we can work with them to then deliver practice on the ground in local government, in workplaces, in sporting clubs. So we have been working through them to reach not necessarily health workers or health people but organisations that they connect with on the ground.

COMMISSIONER NEAVE: What form does that working together take? You don't provide them with funding, or do you?

MS RECHTER: We do. We have provided them with funding, but also we have developed communities of practice. So people that we fund in this area come together quite often. I'm not sure how many times a year, Commissioner, but they come together to share the best learnings and the practice so they can learn from each other and then take that back out into their specific areas across the state.

COMMISSIONER NEAVE: So knowledge and information sharing, and, what, a little bit of funding or not a lot?

MS RECHTER: Yes, certainly funding has been part of what we have worked on in the past. Through that we have also - I guess our funding model has evolved, and the most significant investment we have at the moment is through one local government here, and that is in the Monash City Council area. We have worked, as you heard today, with the City of Maribyrnong. We have also worked with Whittlesea in the past as well, and we have worked with many of the women's health organisations too.

MS KINNERSLY: Could I just add a practical example of VicHealth's leadership was the development of the VicHealth framework to prevent violence against women and children in Victoria. In my previous role in a women's health service we were able to use that framework, that

knowledge that had been built through VicHealth, to work with people talking about a collective impact out into the region, whether that be health services, schools, the PCPs occasionally, and we were able to use that. One of the things it gave us was some validation of the issue, because it had the evidence research to it.

One of the things I forgot in terms of the absence of a centralised sort of vision for this work across the state is that without that we didn't have a validation of roles. So people would say, "Hang on, surely we are worrying about smoking", or, "Surely we are worrying about alcohol or obesity", and we would say, "Well, actually violence against women is a serious issue, economically, personally, impacting on da, da, da, da", and to be able to use the knowledge that had been built through VicHealth we were able to get purchase in that collective impact way. So women's health service in this instance leading work in regions and using the validation and the knowledge that had come from VicHealth.

COMMISSIONER NEAVE: It is sort of a repository of best practice knowledge that you could then rely on when you were having discussions with the other organisations with which you were working.

MS KINNERSLY: Absolutely.

COMMISSIONER NEAVE: Or they could have when they were working with local government and so on.

MS KINNERSLY: That's right. The non-government organisations throughout Victoria were absolutely not funded well enough to do the kind of research that VicHealth were able to put in.

COMMISSIONER NEAVE: I understand that, yes.

MS KINNERSLY: Our Watch, at the national level, again in partnership with VicHealth and ANROWS, is building on that work to develop a national framework to prevent violence against women and their children. We aim to use that in many, many ways but one of the ways is the same in terms of if you are using the Our Watch framework it will buy you a conversation and will give validation. So I guess in the absence of a statewide role, the role that organisations like VicHealth and their research have done has given the arms and legs out in the regions a great deal of purchase.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: Would it be fair to say, though, that VicHealth's role hasn't been one that has been mandated as being the sort of exclusive - you haven't been identified by government as being, "This is going to be VicHealth's role. It will coordinate all of the prevention activities," and it has been possible for primary prevention activity to be developed, different Respectful Relationship programs in different areas, those sorts of things that don't necessarily have to go through VicHealth or report back to VicHealth; is that right?

MS RECHTER: Yes. VicHealth was not mandated to work in this area, but certainly we could see that the evidence was building around the power and the potential to work in this area and the health burden, the health costs associated with it. So it is very much in keeping with the VicHealth model where we will look at an area, an emerging area, and we will innovate in that area. So the burden of disease piece that we did back in 2003-ish was really that cutting edge piece and we have been building

the practice, the knowledge, influencing policy and we are now into the integration component which is the relationship and the partnership that we have with Our Watch. There is still more work to be done, but the work that we have been developing up over that decade we are now integrating into other areas across the state and nationally.

MS DAVIDSON: You have identified the need at statewide level for some sort of coordinated approach. We have heard different views from witnesses already today about whether or not that should be in a separate institute or a commission or a model like VicHealth, or whether it should be within government, because I think it was Dr Gregory who referred to it as being the sort of work that should be core business. Do you have a view about what kind of mechanism would be appropriate to coordinate that sort of primary prevention work and lead the research or gather together the research?

MS RECHTER: In VicHealth's submission we say that we believe a separate statutory body should be created. I think, reflecting upon the evidence presented today, Dr Gregory did talk about it should be mandated - it should be the core business of government. I think we just heard in the last presentation from the New Zealanders that that's great that it's core business of government, but as soon as there's a change in government then the focus changes.

So the VicHealth model certainly shows us with a board that is tripartisan - so has three members of parliament - that is jointly elected by the parliament, it has experts from the fields that we are influencing and working in, and it has a dedicated line of funding allows

us to take a horizon view that is very, very difficult for a department to take.

Certainly in support of our submission for an agency to be able to work at all the levels of policy research, communications and practice across the spectrum from prevention right through to crisis response is what we think could be the next stage for what should be happening in Victoria, to have an effective coordination, not to centralise everything - and I think that's important too, that it's not about absolutely centralising every piece; that it is about allowing on the ground work to happen but it is coordinated effectively, it is drawing on the best possible evidence, the best practice and everyone is pulling in the same direction as opposed to repeating and programmatic funding and finding new evidence that actually was potentially found somewhere else. So there is certainly a coordination function, we believe.

MS KINNERSLY: Our Watch put a similar suggestion in our submission. We again supported the idea of a statutory Safety and Equality Commission or similar that does all the things that Jerril's talking about. We would also agree it's not about centralising everything. Because of Victoria's history, there is good work going on around the state and it wouldn't do to have to duplicate that or set those things up again. The women's health services are doing good work already and have done for two decades. Local government has a part to play. PCPs haven't been in this place in the past, but they are also in each region.

So we are not talking about bringing everything into one spot, but what we are talking about is a

centralised organisation that can oversee, can make sure there's not duplication, can make sure that evaluation is being managed properly. A Safety and Equality Commission or similar needs to focus on the drivers of violence against women. It needs to look at the structural elements, the normative elements and the practice elements. Some of that does live in government. We agree with Dr Gregory's comment that it should be core business for government. Every arm of government should be putting a gendered view across their policies to make sure they are not inappropriately acting on women and blocking their path to a healthier lifestyle.

But we are also saying that a Safety and Equality Commission has an opportunity to focus attention and bring it forward in an organised way so that over the next decade we actually can keep the momentum going and make serious change through community, through structures and practices and in the normative behaviours of people as well.

DEPUTY COMMISSIONER FAULKNER: Just in relation to safety and equality, are you drawing on the Health Quality and Safety Commission sort of idea? What are you drawing on specifically? That sets standards, essentially.

MS KINNERSLY: Thinking of something like the Transport Accident Commission that, as Jerril is talking about, is not directly in government. So it is not as impacted by the change of government, for example, but has a focus through government through time and has genuine capacity to oversee change at all levels in the community. The monitoring and evaluation component certainly needs to sit outside government. So it might also need to sit in an

organisation like that.

DEPUTY COMMISSIONER FAULKNER: The TAC also gives a level of service. They are very different concepts. That's all I'm trying to get at. The Quality and Safety Commission is standard setting for the whole of Australia and sets standards against which people can be audited, basically. The TAC runs campaigns, it does a range of commissioning insurers and those sorts of things. One of them is funded from appropriations and the other is funded from your registration and things that you pay. So I'm just not sure which concept is dominant, basically.

MS KINNERSLY: It is difficult do draw a direct correlation with another commission. So I take your point. This commission, whatever it looks like, it needs to be set up based around the drivers of violence against women as identified by VicHealth in the past and now Our Watch's new work. So the work of that commission would need to be underpinned by the drivers of violence against women.

So that's what we are saying, that it needs to have a focus on the structural drivers, the normative drivers and what's happening in the community. So it might oversee quality and standards around prevention of violence activity so that we make sure that it's focused on prevention, but then it also might oversee a grants round so that we can look at innovative practice and make sure the evaluations are good.

MS RECHTER: It is hard to draw comparisons because you have the TAC, you have WorkSafe, also probably the Responsible Gambling Foundation is the most recent example in Victoria of an agency that has drawn staff from what was Justice and had some other staff - and I can't remember the name

of the agency; I just cannot remember it, sorry, Commissioner - but it is now centralising that work.

It is doing primary prevention, but is also delivering services as well. It's the body by which those bodies that are delivering service on behalf of the Responsible Gambling Foundation, they are able to monitor those standards. They are managing all the contracts and making sure again that everyone is driving in the right direction to make sure we get the outcomes that we need.

COMMISSIONER NEAVE: I have a follow-up question. I think we have asked some of our witnesses whether there is an inconsistency between the primary prevention function and the overseeing service provision function. I would be interested in hearing either of your comments about combining those two functions. I think what you are both saying is you could combine them and you don't see there being an inconsistency in that situation. Am I right?

MS RECHTER: That's right, Commissioner. I think, though, that what we do need to make sure is however the potential organisation is set up that there is a quarantining of funding towards primary prevention. That can be in your statute or wherever. But there does need to be a quarantining because it is so easy for it to disappear down the other end.

COMMISSIONER NEAVE: Our terms of reference of course are not confined to violence against women. Would you contemplate that if there were such an independent body it would deal with other forms of family violence?

MS RECHTER: Yes.

MS KINNERSLY: Yes. You would need to make sure that the attention, though - the rates of violence against women

and those, we believe, to be caused by gender, that this is a serious issue that we have happening. So we would need to make sure that the attention doesn't slip off that, because in the same way that it's easy for us to - Australians are doers. They like doing things. So a conversation around prevention of violence can often slip down to, "How can we help women?" The drivers of violence against women are a much higher level than that. They involve the whole community. They involve government. They involve organisations. They involve media. Everybody has a part to play, not just women.

So we would say, yes, that it can deal with other forms of family violence, but we need to make sure that the balance is appropriate towards violence against women and the gendered nature of that violence.

COMMISSIONER NEAVE: Thank you.

MS DAVIDSON: The flip side of that of course is that violence against women isn't just family violence and includes things like sexual violence outside the family context. Would you be anticipating that that sort of body would not be limited to family violence in that sense?

MS KINNERSLY: Yes, I agree with that. If we were able to bring together the skills and expertise and a commission or however that was constructed then I think it would be unfortunate to miss the opportunity to look at all of those sorts of violence as well.

MS RECHTER: Agree.

MS DAVIDSON: VicHealth has I think a relatively unique structure in that it does have membership of parliamentarians on its board. Why do you think that's important?

MS RECHTER: Twofold. One is that by the very nature of having parliament do a joint sitting and appoint members onto our board there's a shared commitment to the vision of health promotion at the very highest levels. So that's at parliament. We report through the Department of Health to parliament. So that's an incredibly important piece of how we are set up as well.

The other part is that often we find our parliamentarians - sometimes, if I can use this language, they are the rising stars and they go on to lead and champion the work that needs to happen across the state in terms of making sure we build a state with good health and wellbeing. So the opportunity to continue that education of parliamentarians through those representatives and more broadly than across parliaments is an incredibly important piece because they are voted by the people and they have a role to play back within their parties. So it is an important piece.

I think one of the other things is certainly the longevity of VicHealth. It helps when budgets are tight that we have tripartisan representation on our board and it shows the parliament's commitment to improving the health and wellbeing over a long period of time for the people of Victoria, not just term by term of office.

MS DAVIDSON: Finally, you saw in the campaign in New Zealand that, firstly, the ads were very inclusive in terms of the types of family violence that dealt with - I think there was some elder abuse, some child abuse, intimate partner violence, I think that might be at least three of the types of family violence that was dealt with. Also there was quite a significant focus on engaging men in relation

to that behavioural change. Do you have a view on the campaign that has been developed in New Zealand and delivered?

MS KINNERSLY: Not particularly on the New Zealand campaign, but the notion of focusing on men is one that Our Watch spends a lot of time considering. For an activity to be primary prevention and to focus on the drivers, that is not only focusing on men. That is focusing on the structural elements and what happens in organisations and what happens in government and involves the whole community because those rigid gendered stereotypes live in women and men and in all the things that influence women and men, and we do need to accept that men are the primary perpetrators of violence against women.

So in campaigns that Our Watch is starting to build we are trying to tread that balance a little between recognising that men are the primary perpetrators of that violence but also it is the whole community that needs to focus on this issue in order for change.

MS RECHTER: The Commissioners could really see how thoroughly evidence based and researched the "Are you OK" campaign is. It is also very specific to New Zealand in the context that New Zealand have a very family structure and family way of talking about their community. It is often done through Maori communities. It is done through the church. So it has a very strong family orientation.

That doesn't necessarily mean it wouldn't translate to an Australian context. It would just mean that we would need to do the type of research that they were developing in order to make sure that if we took that approach that it was just resonating with the audiences

here in Victoria and Australia.

MS DAVIDSON: Commissioners, I have no further questions.

COMMISSIONER NEAVE: We have no further questions. Thank you very much.

<(THE WITNESSES WITHDREW)

MS DAVIDSON: I think our next witness is via videolink. I think we have Professor Bromfield. Can you hear me?

PROFESSOR BROMFIELD: I can hear you. Can you hear me?

MS DAVIDSON: Yes, we can. I will ask you, Professor Bromfield, if you can be sworn.

<LEAH MAREE BROMFIELD, (via videolink) affirmed and examined:

MS DAVIDSON: Professor Bromfield, can I just ask that you outline your current role?

PROFESSOR BROMFIELD: My usual role, forgive me, I will iron out the technology and I will get used to not interrupting you. I apologise. I am currently the Deputy Director of the Australian Centre for Child Protection at the University of South Australia. The Australian Centre for Child Protection is the only research centre that is nationally focused purely on child abuse and neglect research.

I am also currently seconded to the Royal Commission into Institutional Responses to Child Sexual Abuse, where I am leading the research agenda for that Royal Commission. I wanted to make it very clear that I appear today in my role at the University of South Australia.

MS DAVIDSON: In relation to child abuse or neglect, what do we know about the prevalence of that within Australia?

PROFESSOR BROMFIELD: We believe child abuse and neglect to be both serious and prevalent based on cross-sectional

studies, available service data. However, the reality is that we actually don't know the extent of child abuse and neglect in Australia. We lack a community based prevalence or incidence study. This is quite a substantial evidence gap for Australia. It means we compare quite poorly against other developed countries that do have those sorts of studies.

MS DAVIDSON: What are the implications for not having that prevalence data in terms of how we develop responses and seek to prevent child abuse and neglect?

PROFESSOR BROMFIELD: In my view it is a very substantial evidence gap. Ideally what we would have is a larger scale community based prevalence or incidence study that was undertaken as soon as possible. That would provide some baseline data that would tell us about the extent of abuse and neglect within Australian society. However, we would need to be repeating that study repeatedly, whether it's every four years, five years.

The routine collection of that data is crucial. It does two things. One, it basically then allows us to start planning our services, whether we have actually got enough services to deal with the problem. But also we see so many inquiries, statewide reform agendas, huge amounts of money spent within the tertiary child protection sector and in the - to try to tackle the problem of child abuse and neglect. We also see huge variability in the service data of child protection services. We see the notifications and substantiations going up and down, with quite a bit of variability across the country.

Without those community based prevalence or incidence studies that are being routinely collected we

don't know why those service responses were to have those rises and falls in demands. We don't know if the investment we are spending on child abuse and neglect is in fact making any difference to the incidence.

MS DAVIDSON: This Royal Commission is state based. Is this a data gap that Victoria can fill, or is it important to have national prevalence data?

PROFESSOR BROMFIELD: In my view it's important to have the national prevalence data. We see released annually the Child Protection Australia report, that's released by the Australian Institute of Health and Welfare. It tells us about the service activity across the states and territories. As soon as that's released, states and territories start comparing themselves to each other and start questioning why is someone higher than another.

If we really are to understand whether state based reforms are having an effect or not we do need the data nationally. It gives us a comparison. We can start then saying, "In another jurisdiction which didn't have a statewide reform, that didn't do this sort of thing, was there also a decline, or does it seem that our reform efforts are in fact making a difference?"

MS DAVIDSON: In relation to child abuse, what do you see as its relationship with intimate partner violence?

PROFESSOR BROMFIELD: They are intertwined in every way that I can think of. So child abuse and neglect is - domestic violence, intimate partner violence, sorry, is a risk factor for child abuse and neglect. So in households where there is intimate partner violence children are at heightened risk of experiencing neglect, of experiencing physical abuse, of experiencing sexual abuse and of

experiencing emotional abuse. Exposure of children to intimate partner violence is itself a form of abuse for children. We know how traumatic it is for them.

They are also intertwined in that, where children are exposed to intimate partner violence in childhood, there is then a greater likelihood as adults of also being involved in intimate partner violence themselves as a victim or a perpetrator.

Finally, given the focus that you have on prevention, child abuse and neglect and intimate partner violence also share some common risk factors. So if you were looking at some of those social determinants for child abuse, they would be common to some of the things you are looking at in trying to reduce the incidence of domestic violence.

MS DAVIDSON: Which social determinants in particular would you be referring to as being ones that are in common between child abuse and intimate partner violence?

PROFESSOR BROMFIELD: So I guess at the more proximal level, so close to the violence occurring, things like substance misuse, mental illness - they are big risk factors for child abuse and neglect. We also know that there are disproportionate levels where there is intimate partner violence.

Taking a step further, starting looking at some of those social structures, particularly in gendered violence against women and gendered violence against children, looking at roles of gender and masculinity, entitlement.

I guess the other area in which we are seeing the crossover is in communities where there are heightened

disadvantage of both. So areas of high socioeconomic disadvantage where you are seeing heightened levels of both child abuse and neglect and of intimate partner violence, and in some vulnerable populations, such as in Aboriginal communities, we are seeing heightened levels of child abuse and neglect and of intimate partner violence.

MS DAVIDSON: What is the research about what works in terms of primary prevention in respect of child abuse? Where are we at in terms of that research?

PROFESSOR BROMFIELD: That's a big question. I'm going to do my best today, but our centre will also be happy to provide a submission to the Commission in the event that I don't do it justice today. Thinking about primary prevention of child abuse and neglect, first of all with child abuse and neglect we are talking about five maltreatment types. We are talking about sexual abuse, physical abuse, neglect, emotional abuse and exposure to domestic violence. Some of the things that you would do for those different maltreatment types would be the same at a primary prevention level but there will also be things that are different for each of the abuse types.

At a primary prevention level there are things that we would be doing to try and increase the protective factors around children, so population based interventions that try and enhance parenting skills and normalise help seeking. Those would be helpful for neglect, for physical abuse and for emotional abuse.

For sexual abuse you might be looking at things like education within child care - sorry, kindy, so four-year-old onwards, the curriculum based education of children to know what abuse - what abuse and neglect is,

to know about how to disclose. That sits within the primary prevention space.

We also do need to look at the things that decrease the risks for children. So we are increasing protection, so parenting skills, connections around families, (indistinct) families to seek and get help. We would also be looking at trying to decrease risks within the community, so things like the extent to which alcohol use is normalised within Australian society. I already feel overwhelmed by the extent to which the issue - the bigness of the issue of primary prevention of child abuse and neglect.

MS DAVIDSON: It's been identified by some of our witnesses during the first round of hearings, including Dr Robyn Miller, that we also know that some children who experience maltreatment suffer more harm and are more likely to go on to either be a victim or perpetrate violence themselves, but that some children don't or seem to have sufficient resilience so that they don't suffer that sort of consequence. Where is the research at in terms of developing that sort of resilience and treating children in order to ameliorate the harmful impacts of being exposed to family violence or child maltreatment?

PROFESSOR BROMFIELD: There is some - it's patchy as well. Across this field of child abuse and neglect, and depending on what specific issue that you are looking at, there are some areas where there is good evidence. With parenting interventions there tends to be fairly good evidence. In terms of trying to assist children in recovery, that evidence is much more patchy. I guess again there's so many variables when you are thinking

about child abuse and neglect - at what age during the child's development did the abuse start, what type of abuse was it, what kind of protections are there around that child in terms of other supportive adults? So it's a difficult area to research.

There's two things that I would say as key messages. One is that we do need more research to inform our efforts into what are best practice interventions for child abuse and neglect, but also that where there is available evidence I'm aware that that is - I'm aware of services where the evidence base has not been well utilised. So even where we have (indistinct) practice evidence it's not necessarily being used. I think that there are two (indistinct). What we really need to do is to support excellence in intervention with children and their families where there is child abuse and neglect.

The expert panel that's recently been established by the Commonwealth Department of Social Services, programs that are funded under its family support program, what they have done there is they have said, "We recognise both the lack of evidence and the lack of the use of evidence based interventions within the family services field and we would like to establish something to try to support agencies to use best evidence and develop best evidence."

The expert panel has several functions. One, it assists services to use the best available evidence in selecting programs and in developing programs if there is no evidence based program to select; so that sort of service planning element, program selection and program development.

They also are then supporting the non-government organisations who are providing services by assisting them to set up good evaluation parameters so that they can be developing the evidence base where there is innovation occurring and where there is promising practice across the nation.

Finally, agencies are able to access implementation support because the other issue we have is that services may select an evidence based program and still when we evaluate them we find that the program is not being implemented as the program was written. Once again families and children are missing out on best practice because of the gap between program selection and what's actually provided on the ground.

The expert panel there is offering implementation support, and that's where we are able to access experts who are utilising what we know from the field of implementation science about how to best implement something to actually get that translation from research into practice. To me that's kind of - - -

MS DAVIDSON: Is that the expert panel that's been established I think by the Australian Institute of Family Services? Is it hosted by that organisation?

PROFESSOR BROMFIELD: Yes. It is the Australian Institute of Family Studies hosting the expert panel on behalf of the Department of Social Services.

COMMISSIONER NEAVE: Sorry, can I just go on with that because that's an interest model which is certainly something that you could implement at state level in relation to contracted services. You could say, "Well, we will take it to an expert panel before we fund it, and at the end of

the period we will have a look and see whether the expertise should be rolled out across similar contracts in the future."

The implementation support, I don't quite understand how that works. Does that mean that somebody tenders for a contract or gets a grant and then discovers that for one reason or another they can't quite do it in the way that it was contemplated, and then they go back to the department and say, "We need more"? How does that work?

PROFESSOR BROMFIELD: The expert panel is being retrofitted to existing services in recognition that that service sector are not using evidence based programs in the majority of circumstances. So they have set a target. I think they have set a target of about 30 per cent perhaps, but that would need to be confirmed with the Department of Social Services, for programs to be evidence based. When you are looking at the family services sector there are substantial gaps. We talk a lot about wanting to rebuild community and decrease social isolation around families. There is no excellent evidence base when it comes to community development work, but there is certainly a lot that is happening across the nation in trying to establish innovation and promising practice in that space. So that's one area where there is not a strong evidence base.

There's a lot of family support programs that are provided. There is an evidence base in relation to family support programs for particular purposes. For whatever reason - and that's sometimes capacity, sometimes it's cost, registration, availability of the trainers - those programs aren't being implemented either. So what DSS

have said is, "We need to support our existing funded services to increase the extent to which they are using evidence based programs."

COMMISSIONER NEAVE: I see.

PROFESSOR BROMFIELD: So there were three ways to do that. One was to help people to select evidence based programs. Two was if an evidence based program didn't exist that was fit for purpose that they could get support in adapting or developing a program that would be fit for purpose. They could get support in evaluating what they were doing if they felt that what they were doing was promising and was achieving outcomes. Finally, they could get support in implementing whatever was their intended model with (indistinct).

There is emerging evidence, it's called implementation science, which is increasingly demonstrating that there is quite a big gap between what might be research evidence found to be a best practice program through kind of the randomised control trial and a scale-up of that, and a lot is lost to move from randomised control trial to the scaled-up intervention, and more and more there's evidence around how we can best support the transfer from the RCT to the scaled-up program to maintain those parts of the program that are actually core to it working.

It includes the usual things. Training, which is obvious, but also ongoing mentoring and support. It also starts to look at the organisational factors. It looks to the extent to which the leadership is supportive of whatever it is the program that you are putting into place, the extent to which the organisation has the

capacity to do it.

I have seen an example of an evidence based program being selected for a statewide service, a family support program being implemented. When it was rolled out to the regional areas they just didn't have the numbers to do some of the main things like have two facilitators and have a weekly phone contact to work with the families. So they started dropping components of the model based on capacity and in so doing they started to lose what it was that made that model actually effective. While you are saying, "I'm implementing program X," if you are incrementally changing little bits of that and dropping bits, by the time you are out in a regional area you might say you are implementing program X but it may look very different to what the program designer would say was program X.

COMMISSIONER NEAVE: Thank you for that. It sounds to me as if what you are saying is that the purpose of that panel is to provide support to the people who are providing the services to go through the process of using the evidence to produce good programs rather than to advise the department on which programs they should fund or contract, or is it both?

PROFESSOR BROMFIELD: It's the former. I believe that they can also provide advice. So the way it's set up, the department can access advice or the local agencies can access advice. It can be done at various levels. So there is a lot of flexibility within it.

But it was rolled out in the first instance to the Communities for Children. The way that the Communities for Children are set up is that they provide a

quantum of funding for an area, and that area then determines what they need and they establish and fund programs within that quantum of money using a local decision making model. So that's why they also are requiring the assistance in program selection and planning, not just the department.

COMMISSIONER NEAVE: Thank you very much.

MS DAVIDSON: Just to clarify, the expert panel is really about the implementation of existing research, is that correct, rather than doing research itself?

PROFESSOR BROMFIELD: Yes, the expert panel is about using the best available evidence, whether it's in program selection, program adaptation and planning, or program implementation. It has an additional component which is about, I guess, supporting evidence generation, and that's around advising some of those organisations about how to establish rigorous or embed rigorous evaluation methods within their program.

MS DAVIDSON: At the national level we have the National Plan for Violence Against Women and we have the National Framework for Protecting Australia's Children. In terms of the prevention work in relation to children, how do you see the implementation of that national framework compared with the National Plan for Violence Against Women?

PROFESSOR BROMFIELD: In my view there's a big difference between the two national plans. They seem to have the same potential and emerged about the same time. I think the big difference has been the level of funding and priority given to the plan. The National Plan for Violence Against Women, I note two things that were established to fill big gaps there and that was the

establishment of ANROWS and Our Watch.

There has not been an equivalent under the National Framework for Protecting Australia's Children. To illustrate, there was a research agenda that was agreed under the National Framework for Protecting Australia's Children with a substantial range of evidence gaps that were articulated and agreed for that research agenda. To date there has been $600,000 released for research and three research projects under the National Framework for Protecting Australia's Children, which is clearly very different from the investment in filling evidence gaps under the National Plan to Reduce Violence Against Women and their children. If you are not spending the money it is hard to fill gaps.

MS DAVIDSON: Are they gaps that can be filled by Victoria alone or is this again something that needs to be done more at a national level?

PROFESSOR BROMFIELD: I suppose Victoria could try and fill the gaps alone. It wouldn't be the pathway that I would choose for a couple of reasons. One, the gaps are quite substantial. The resource it would take to fill that gap would also be substantial. It would seem to me that if you could prevail to take a national approach there would be more resource to go around.

Secondly, if you are looking at how to fill that gap then you are looking at rolling out a large research agenda. Victoria only has so much of a population. You don't want to keep researching the same people. You would get what's called participant fatigue. It's actually not ethical to keep trying all of these different, new, wonderful ideas on the same population of vulnerable

people in order to generate evaluation data. It really needs to be shared across a nation this size.

Finally, the problems are shared. The problems in Victoria are much the same as the problems in New South Wales, in Queensland, across the nation.

MS DAVIDSON: A number of people have raised the possibility of a separate statutory body of some sort to do a number of things, including perhaps some primary prevention, coordinating primary prevention initiatives and perhaps some research or at least some evaluation and a coordinating role and perhaps similar to the expert panel some sort of role that assists in relation to implementing research and evidence based programs. We are talking about family violence in its broader sense which includes intimate partner violence and child abuse and elder abuse and other forms of violence. How do you see such a body if it was to deal with that broad range of family violence?

PROFESSOR BROMFIELD: I was listening to the last two people giving evidence with some interest in relation to this kind of coordination function. I would be cautious about this in relation to child abuse and neglect. Child abuse and neglect is quite a regulated field. There are a number of existing functions. So I would be cautious about duplicating other (indistinct) that exist. I think that it is important to map out what are the functions that you think this coordinating body might provide and then to assess specifically for child abuse and neglect does that function exist already and, if it doesn't, then does it seem like it would be necessary for child abuse and neglect.

So I have been listening to the last two people. I may not have this entirely right, but if I run over what I think are the functions that were discussed, the function that was really around having a unified message, the social marketing campaign function, and a true social marketing campaign where you have your multifaceted messaging.

In relation to child abuse and neglect there tends to be discussion around whether we need a social marketing campaign or not. My view for that has always been you need to be really clear, "What do you want a social marketing campaign for? What's your message?" For violence against women there is a clear message, I guess trying to get at those gendered issues to attack norms.

For child abuse and neglect, social marketing campaigns have been used with some positive effect internationally in relation to increasing disclosure. But you have to have something concrete for people to do for a social marketing campaign to be really effective. So it tends to work if you have underreporting and you want people to pick up a phone and perform a simple act, a simple concrete action. We don't have evidence that we have underreporting of child abuse and neglect within Australia, and particularly Victoria. In fact I would think that the Department of Human Services would probably say that they are struggling to manage demand, the demand that they have at the moment. So a social marketing campaign that increased reporting right now probably wouldn't serve to help children.

So I'm not saying no social marketing campaign, but I'm still not clear what the purpose would be. It has

been used in one study internationally where they were implementing a population based parenting approach, a positive parenting program at a population level. That was paired with a social marketing campaign. That's kind of the only example that I can think of off the top of my head. So I'm not so sure that that would be as good for child abuse and neglect in this coordinating body.

The other functions that you mentioned of the coordinating body should be about trying to work out what's going on and avoiding duplication of effort, be able to build on emerging best practice. I can see some benefit to that.

With the field of child abuse and neglect, though, there are things that are happening in the prevention space that are helpful in preventing child abuse and neglect but they may not have been funded to prevent child abuse and neglect. Particularly when we think about primary prevention, often the things that exist that are preventing abuse and neglect in that primary prevention space were not funded to prevent abuse and neglect: kids attending schools, kids going to high quality child-care, parents who are socially connected, parents who have access to high quality information about parenting. We have those kind of things that exist. They are really helpful for preventing child abuse and neglect, but they weren't funded for that purpose.

We see more direct funding at the secondary prevention level for child abuse and neglect where we are targeting families who we know have got vulnerabilities. So families that do have parents with substance misuse, families where there is domestic violence, families where

there are parents with mental illness, parents with learning difficulties or disability, housing instability, social isolation. But they don't tend to be the sort of things that would seem to be an intervention that would fit well with the coordinating body that you are talking about, families with those kinds of circumstances, and often they are experiencing joined up problems. So it's not that they are experiencing one of those problems. They tend to require a family based one-on-one intervention rather than a population based intervention, which again doesn't seem to be a good fit with your coordinating body.

I mentioned already the Australian Institute of Family Studies is funded for the expert panel. I can certainly see some real benefits to that in the child abuse space.

There is also at the Australian Institute of Family Studies an audit for child protection research. That's a live audit. Anybody can add to that audit. I was part of establishing that that audit exist. It was about trying to have a repository that showed us both what research is undertaken within Australia but you could also register studies that are under way so you can see what research will be emerging within the field. So again that does exist.

I have to say that I was really convinced on that being a wonderful idea when I was part of calling for it. I'm not sure that it works well in reality. People have to actually register their study for it. We still see a large number of evaluations that are what we call (indistinct) literature. The evaluation has been funded

by the local agency. It's not ever published in an academic journal. Sadly, that literature gets lost over time when the program (indistinct) boxed up and no-one sees it again and we lose that evidence. I'm not sure that the audit has overcome that problem in the way that I had hoped it would.

I'm still I guess more and more of the view that the best way to secure the evidence base is to fund rigorous evaluation; that when we are developing and funding programs, if there is no evidence base for it that we require it to be evaluated rigorously. The academic literature that (indistinct) those databases that you can search for years and years back and find out whether something has been evaluated previously. As a researcher when I am asked, "What works for X," it's the first place that I go to in order to answer that question. Sadly, when I also try to look at the (indistinct) literature it's much harder to find.

I hate to kind of be in that position because I would like a method where research was more readily accessed, it wasn't about the privilege of the academic databases, but years of experience that's where I see research evidence living.

MS DAVIDSON: Thank you. Commissioners, those are my questions for Professor Bromfield, unless you have any additional questions.

COMMISSIONER NEAVE: I do have one question. Suppose one were to entirely accept what you have said about the independent body in relation to children, child abuse and neglect, that would not necessarily be an argument against having such a body in the area of family violence to deal

with violence against women and possibly elder abuse and various other forms of violence, or would you think - I know that's not your area of expertise - that the same arguments you have made against having such a body in the area of children would also be arguments against having such a body to deal with family violence more broadly?

PROFESSOR BROMFIELD: I guess two points. I have no reason to think that it wouldn't be useful for violence against women. As you say, it's not my field and I would defer to people with greater expertise than I.

In relation to child abuse and neglect, my primary arrangement was that I couldn't see that, establishing this coordinating body, you could roll child abuse and neglect into it. Whether it is required for child abuse and neglect, I think it is worth saying, "What are the functions of this? Would they be helpful for child abuse and neglect, and where could they best reside?" I'm not saying abandon the entire idea. I'm just being a little more careful about it.

COMMISSIONER NEAVE: Thank you very much.

MS DAVIDSON: Thank you, Professor Bromfield. If Professor Bromfield can be excused with our thanks.

COMMISSIONER NEAVE: Thank you very much for your evidence, Professor Bromfield. You are excused.

<(THE WITNESS WITHDREW)

MS DAVIDSON: We adjourn to tomorrow morning at 9.30.

ADJOURNED UNTIL TUESDAY, 13 OCTOBER 2015 AT 9.30 AM